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Maternal and Child Health Integrated Program

Zimbabwe

FY12 Fourth Quarterly Report

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Acronyms and Abbreviations

ACT	Artemisinin-Based Combination Therapy
ARK	Absolute Return for Kids
BFHI	Baby Friendly Hospital Initiative
CHC	Child Health Card
cIYCF	Community-based Infant and Young Child Feeding
DHE	District Health Executive
DHIO	District Health Information Officer
EHT	Environmental Health Technician
EmONC	Emergency Obstetric and Newborn Care
ENMR	Early Neonatal Mortality Rate
EPI	Expanded Program on Immunization
EQOC	Equity and Quality of Care (study)
FP	Family Planning
FY	Fiscal Year
HBB	Helping Babies Breathe
HF	Health Facility
HMIS	Health Management Information System
HW	Health Worker
IMNCI	Integrated Management of Newborn and Childhood Illness
IRS	Indoor Residual Spraying
IYCF	Infant and Young Child Feeding
KAB	Knowledge, Attitude, and Beliefs
KC/KMC	Kangaroo Care/Kangaroo Mother Care

MCAZ	Medicines Control Authority of Zimbabwe
MCCM	Malaria Community Case Management
MCHIP	Maternal and Child Health Integrated Program
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOHCW	Zimbabwe's Ministry of Health and Child Welfare
MPH	Mutare Provincial Hospital
MPMA	Maternal and Perinatal Mortality Audit
NIHFA	National Integrated Health Facility Assessment
OJT	On the Job Training
PCN	Primary Care Nurse
PCV	Pneumococcal Vaccine
PHE/T	Provincial Health Executive/Team
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PQI	Performance Quality Improvement
QA/QI	Quality Assurance/Quality Improvement
RDT	Rapid Diagnostic Test Kits (for malaria)
RED	Reaching Every District
SBA	Skilled Birth Attendant
SBM-R	Standards Based Management and Recognition
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
UZ	University of Zimbabwe
VHW	Village Health Worker
WHO	World Health Organization
WHT	Ward Health Team
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council

1. Introduction

Completion of FY12 Quarter 4, covering the period July to September 2012, signaled the end of MCHIP's second full year of implementation in Zimbabwe. As with previous quarters, Q4 saw continued progress in MCHIP/Zimbabwe's programmatic implementation at national, provincial, district, and community levels. The MCHIP team maintained course across each of its four major objective areas as well as in cross-cutting areas like monitoring and evaluation. This Q4 report describes in detail technical and operational achievements made in the quarter (as well as during the year) and presents data and analysis on select key indicators from the MCHIP/Zimbabwe Performance Monitoring Plan (PMP). This report begins with a summary of the project's highlights for the quarter, then presents in graphical form data on select project indicators. These sections are followed by a description of challenges and opportunities experienced in the quarter, a project success story, and a detailed breakdown of the project's Q4/annual achievements against our FY12 indicators and annual targets (Annex 1).

2. Highlights of This Quarter's Achievements

MCHIP/Zimbabwe continues to make significant achievements, both programmatically and operationally. A summary of highlights from FY12 Q4 is listed below:

Highlights of Q4 Technical Achievements

At regional level:

- In August, MCHIP/Zimbabwe's Child Health and Immunization Advisor provided substantial technical assistance to MCHIP/Malawi and the Malawian Ministry of Health's National Immunization Program. The Child Health and Immunization Advisor supported MCHIP/Malawi in its efforts to assist the Malawian MOH to conduct a data quality self-assessment (DQS).

At national level:

- In Q4, MCHIP together with the Ministry of Health and Child Welfare (MOHCW) and other partners participated in multiple international commemorations including World Population Day in July, World Breastfeeding Week in August, World Humanitarian Day in August, and World Malaria Day in September. In addition to providing technical and financial support to these events, MCHIP exhibited materials at these commemorations, providing an opportunity for MCHIP staff to disseminate information about our work to a broad audience as well as enhance networks with other partners.
- During Q4, MCHIP continued to support the Zimbabwe National Family Planning Council (ZNFPC) in promoting family planning



Children wear t-shirts with the message "Exclusive Breastfeeding Worked for Me" on the back during the World Breastfeeding Week commemoration.

issues. In early July, MCHIP and other partners supported ZNFPC to hold a national stakeholder's meeting focused on "repositioning family planning in Zimbabwe". This meeting provided a forum for in-depth discussions on family planning issues and provided MCHIP with an opportunity to advocate for strengthened efforts around post-partum family planning (PPFP). Results from this meeting will help guide ZNFPC's strategy in coming years. Meanwhile, MCHIP will continue to support ZNFPC in the development of a PPFP training package, which is anticipated to be completed in FY13.

- In Q4, MCHIP continued to provide substantial technical and financial support to the MOHCW through various training of trainers (TOTs) activities. MCHIP staff helped facilitate (and supplied training equipment for) two Helping Babies Breathe (HBB) TOTs held in mid-August. In addition, MCHIP's Child Health Technical Officer participated in a Child Health Card/WHO growth chart TOT in mid-July 2012, as well as a Baby Friendly Hospital Initiative (BFHI) TOT in September. MCHIP's Child Health Technical Officer has subsequently helped to cascade CHC/growth chart training in Mutare and Chimanimani and is now a recognized BFHI "assessor" who can participate in BFHI health facility assessments.
- In July, MCHIP's Newborn Health Coordinator supported the MOHCW and Absolute Return for Kids (ARK) in conducting a national newborn corners assessment aimed at identifying existing services, gaps, and opportunities surrounding essential newborn care service provision in 20 district hospitals. MCHIP's Newborn Health Coordinator also assisted in drafting the assessment report, which has since been circulated. In addition to these activities, the MCHIP Newborn Health Coordinator also attended a regional newborn corners training in August.
- MCHIP is supporting the National Malaria Control Program (NMCP) in developing a Malaria Community Case Management (MCCM) training package. The purpose of this training package is to standardize MCCM training nationally. MCHIP supported a 2-day stakeholder's meeting at the end of September focused on developing a facilitator's and participant's manual, based on existing MCCM protocols and guidelines. A draft package is expected during FY13 Q1.
- MCHIP continued to support the MOHCW's Quality Assurance (QA) Unit throughout Q4, in its efforts to raise the profile of quality assurance and quality improvement (QI) concepts nationally and to develop a national QA/QI policy and strategy. MCHIP supported a stakeholders' sensitization meeting in September on QA/QI, which was attended by 52 Hospital Managers, Quality Assurance Focal Persons from 20 District Hospitals, and the consultant team tasked with drafting the QA/QI policy and strategy. Recommendations from this meeting will feed into the development of the national QA/QI policy and strategy, which MCHIP will continue to support in FY13.
- Throughout the quarter, MCHIP continued to support the MOHCW in developing MNCH-related IEC/BCC messages/materials. MCHIP supported the MOHCW Health Promotion Unit in formulating, pretesting and finalizing BCC materials on child health conditions as well as MNH topics. A pretest for MNH materials was conducted in September by staff from the MOHCW RH Unit, the Manicaland provincial RH focal person, the MOHCW Health Promotions Unit at provincial and district levels, and MCHIP. Pretested materials included: translated versions of the *You and Your Pregnancy* booklet, a Kangaroo Care pamphlet, and a Newborn Care pamphlet. The pretest yielded interesting insights on community behaviors, such as the taking of African herbs



Part of the IEC/BCC material pretest group at Chakohwa Clinic. Community members were shown various health materials and asked to give feedback. Child health-related IEC/BCC materials focused on topics including diarrhea, measles, pneumonia, and key household practices. Community feedback has since been used to improve the messages and materials.

before labor and reluctance towards institutional deliveries and seeking of neonatal health services. One recommendation resulting from the pretest exercise was to conduct a community-level baseline assessment in order to formulate an advocacy and communications strategy.

- During Q4, MCHIP continued to provide technical support to the National Integrated Health Facility Assessment/Equity and Quality of Care {NIHFA/EQOC} Task Force and consultant team. In mid-July, MCHIP participated in a 5-day review workshop on the draft NIHFA/EQOC reports, providing detailed feedback and suggestions for improvement to report writers. It is anticipated that the final reports will be ready by end-October 2012.
- In July, as part of ongoing support to the national Nutrition Unit, MCHIP's Nutrition Consultant led an external verification meeting on the Breastfeeding KAB report and the IYCF Program Review preliminary report. A brief on the IYCF Program Review findings was distributed at the meeting and the final report is anticipated in October.
- Finally, throughout the quarter MCHIP staff participated in discussions around the oxytocin potency study, which MCHIP will conduct in conjunction with MOHCW and the Medicines Control Authority of Zimbabwe (MCAZ). Data collection is being planned for November 2012.

At provincial, district, and health facility levels:

- MCHIP continues to support provincial-level planning and review, by participating in: 1) a Provincial Health Team (PHT) meeting and 2) a provincial maternal and perinatal mortality audit meeting (MPMA), both held in August. The PHT meeting – the first held in Manicaland since 2009 – provided an opportunity for MOHCW and health partners in Manicaland to gather, review progress in the districts for the previous six months, and make plans for the second half of the year. Presentations were made by district offices, provincial offices, and health partners. One result from the meeting was a request made by partners for strengthened provincial-level coordination, to reduce confusion, competition, and waste among partners. Regarding the MPMA meeting, MCHIP staff gave presentations on the national MPMA guidelines and how to document information using audit tools. Challenges identified during the MPMA meeting include: blood supply remains a problem in most districts, with some districts struggling to buy blood; the lack of availability of urine dipsticks and oxytocin in the province remains a problem; there is low knowledge among nurses on use of the partograph; a reminder was given to health workers (HWs) to respect clients' rights when offering family planning methods and not to impose particular methods on clients.
- In early September, MCHIP supported a "mop-up" emergency obstetric and newborn care (EmONC) training for high-volume hospitals and polyclinics in Mutare district. Twenty-nine HWs (14 participants from Mutare Provincial Hospital, 8 from Mutare City Health and 5 from Sakubva District Hospital) were trained by EmONC trainers who were themselves trained recently at an MCHIP-supported EmONC TOT. This training thus provided an important opportunity for new trainers to get training practice, as well as for MCHIP to observe and follow the new trainers up. Post-training follow up (PTFU) of eight trainees from this course was then conducted with MCHIP support. PTFU and supportive supervision for EmONC-trained HWs will be the priority focus for MCHIP in FY13.
- From mid to late-September, MCHIP supported training of 78 HWs from Mutare and Chimanimani on the revised Child Health Card/WHO Growth Standards. The objective of this training was to train HWs on how to monitor child growth using the new WHO Growth Standards. New child health cards are reportedly available now in Mutare and Chimanimani.
- In Q4, refurbishments for the Biriiri Kangaroo Mother Care (KMC) unit were completed. The unit has four beds and is now operational (to date, one baby has been admitted). Discussions on the establishment of a KMC unit at Mutare Provincial Hospital (MPH) are in their final stage, and we hope to have it functional in FY13 Q2. Procurement of KMC goods for Marange Rural Hospital, Biriiri Hospital, St. Andrews, and Nyanyadzi Hospital was completed in Q4, and a formal handover of these goods will be done in FY13 Q1.

- Finally, throughout Q4, the MCHIP team continued to support quality improvement activities in the districts. In August, the Chimanimani district team, with support from the District Nursing Officer and the involvement of district health facility managers, conducted supportive supervision (SS) and MNH-focused clinical peer reviews at two sites (Chakohwa and Nyanyadzi). Most of the MOHCW officers involved had been trained previously in clinical SS supported by MCHIP. Participants used SBM-R MNH standards to guide the peer reviews, with providers assessed generally performing well across all areas (64% of standards achieved during the Chakohwa visit). Other findings from Chakohwa included:

- The facility has diligently worked on its QI action plans since SBM-R Module 1. Most of the gaps remaining are minor and can be overcome with continued support.
- There is a need to further capacitate supervisors whose skills are almost at the same level as those they are supervising.
- There is a need to involve community members of HF quality committees in assessing client satisfaction and inputs.



Health workers participating in a supportive supervision visit and clinical peer review. Here, one nurse acts as clinical supervisor and provides practical skills training and feedback to her colleague on assisting a vaginal delivery.

At community level:

- In Q4, MCHIP reached a breakthrough with its community MNCH activities and was able to launch the implementation of its community MNCH Performance Quality Improvement (PQI) activities with Village Health Workers (VHWs). In early July, a meeting was held in Nyanga to sensitize both the Provincial and District-level Health Executives (PHE and DHEs) on MCHIP's cPQI approach and at the same time to develop implementation plans. This meeting was followed by the sensitization of health workers from implementation sites in Mutare and Chimanimani. The two meetings helped map the way forward for a long-awaited VHW baseline assessment, which was conducted in early August. VHWs from PQI "intervention" and "control" sites were assessed. The baseline assessment report, which will be ready by the end of FY13 Q1, will inform MCHIP and the MOHCW about quality improvement needs among VHWs and will provide guidance for subsequent cMNCH PQI activities.

Highlights of Q4 Program Management Achievements

- During Q4, the MCHIP team developed its FY13 workplan and budget and refined the project's Year 3 performance targets. The FY13 workplan and budget have since been reviewed and approved by USAID/Zimbabwe and USAID/Washington.
- As part of the FY13 workplanning process, the MCHIP senior management team developed ideas for a new staffing configuration in MCHIP's learning districts. Full details of the staff restructuring and envisioned benefits of the new configuration are included in the FY13 workplan document. In addition to staff restructuring, senior management reviewed current office spaces/locations at Harare and district levels, and has decided to relocate its Harare office based on cost-cutting and other considerations. An office move is planned for the first quarter of FY13.
- The MCHIP Finance and Administration (F&A) team conducted an internal F&A review in early September. The F&A team briefed senior management about the findings of the review and action items identified are already being carried forward.

3. Analysis of Select Indicator Data from the Quarter

In this section we present quarterly results in graphical form for select project indicators. Complete quarterly data for all project indicators can be found in the table in Annex 1.

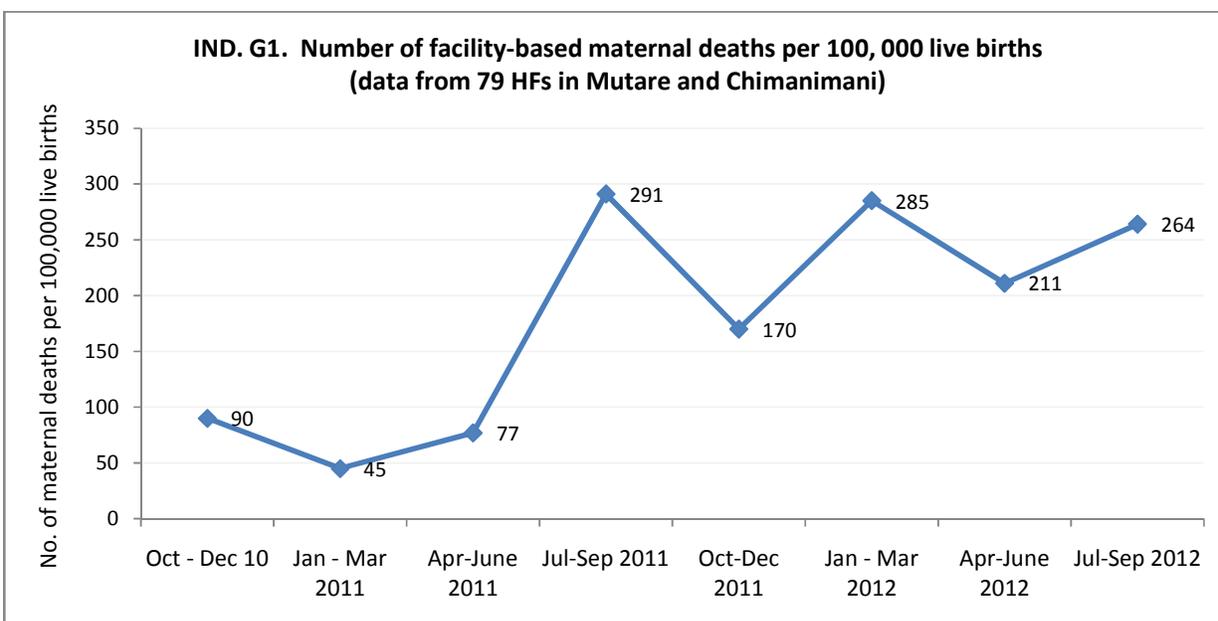
Objective 1: Support the MOHCW to formulate national health policies, strategies and programs that increase the population's access to affordable, evidence-based, high impact MNCH/FP interventions

Detailed results for indicators 1.1 and 1.2 can be found in Annex 1. Under indicator 1.1 (# of national policies/guidelines/protocols/strategies developed with MCHIP support), in July, MCHIP provided substantial technical support to the Zimbabwe National Family Planning Council (ZNFPC) and other stakeholders in the conductance of a national stakeholder's meeting focused on "repositioning family planning in Zimbabwe". During this meeting, stakeholders built consensus on high priority, achievable long and short term FP interventions, discussed models to improve access to FP and expand method mix in Zimbabwe, and drafted an action plan to strengthen FP services in Zimbabwe. During this meeting, MCHIP highlighted the need for strengthened PFP services and further committed its support to assist revision of national PFP training materials. Other activities supported in the quarter included: finalization of the RED Field Guide, continued work on finalizing national EmONC training materials (including supportive supervision tools), continued work on finalized national KMC training materials, technical support for drafting of a national MCCM training package for VHWs, review of the IYCF Policy, and support for the drafting of a national QA/QI Policy and Strategy, among others. Support for each of these activities will continue during FY13 as needed.

Under indicator 1.2 (# of MNCH/FP evaluations/reviews conducted with findings shared with stakeholders), this quarter MCHIP provided support for finalization of the IYCF Program Review, the results of which will feed into development of the National Nutrition Strategy. In July, MCHIP's Newborn Coordinator provided technical support to the MOHCW and ARK in a national baseline assessment of newborn corners, draft results of which were disseminated in September. Throughout the quarter MCHIP also provided continued technical support towards finalization of the NIFHA/EQOC reports, which will be completed in FY13 Q1. Finally, during Q4 MCHIP conducted baseline assessments of VHWs in Mutare and Chimanimani, the results of which will be used to guide MCHIP's community performance quality improvement (CPQI) activities in the coming year.

Objective 2: Improve the quality of maternal, newborn and child health services provided at health facilities in learning sites and support national level scale up plans

MCHIP has two "goal-level" indicators: "G1. Facility-based maternal mortality ratio (MMR)" and "G2. Facility-based early neonatal mortality rate (ENMR)". Data for each of these indicators are shown in the graphs below.



The graph above shows the facility-based maternal mortality ratio (MMR) for FY11 and FY12 for Mutare and Chimanimani districts. The table below shows the actual numbers of facility-based maternal deaths occurring in Mutare and Chimanimani during this same period, as well as comments about where deaths occurred and, for the period Jan-Sep 2012, a breakdown of the causes of maternal death.

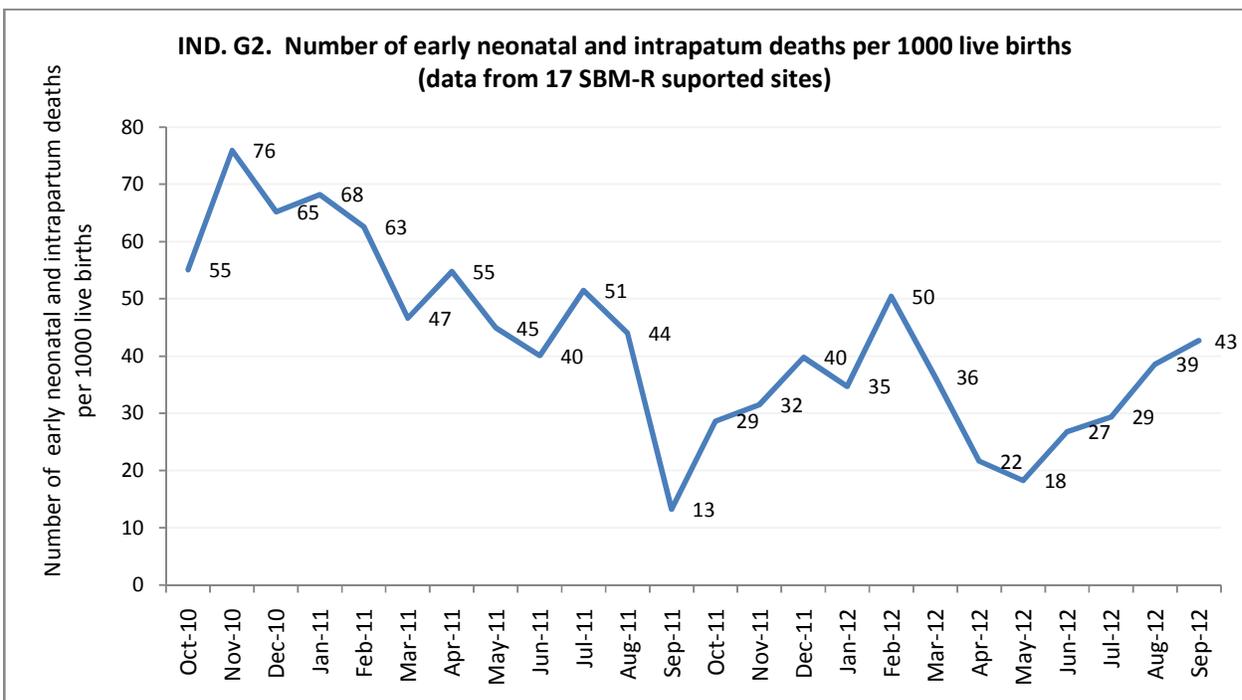
Facility-based maternal deaths in MCHIP districts for:	Total #	Comments
FY11	18	All occurred at Mutare Provincial Hospital (MPH). Mortality cause data was not available.
FY12	32	31 of the 32 total deaths occurred at MPH and 1 occurred at Mutambara Hospital. For the period January-September 2012, 39% of deaths were from postpartum hemorrhage (PPH), 30% from eclampsia, 16% from sepsis, and 15% from other causes like complications from abortions (source: MOHCW maternal line listing data). For FY12 Q4, there were 10 total maternal deaths in the two districts (9 of 10 total deaths occurred at MPH and 1 occurred at Mutambara Hospital).

Maternal mortality data is challenging to interpret given the many difficulties in obtaining accurate mortality data over time, variance in reporting behaviours of health workers over time, issues affecting service delivery over time (such as logistics issues/drug stock outs), the absence of reliable community-based mortality data, and other factors. In terms of the project's achievements for the year in this area, MCHIP's FY12 annual target for this indicator was to reduce the MMR in the districts to 239 maternal deaths/100,000 live births. As of the end of Q4, the facility-based MMR for FY12 was 232 maternal deaths/100,000 live births, indicating that MCHIP met this annual target.

This achievement notwithstanding, it is useful to look more specifically at the data to try to understand what has occurred in the districts over time in this area. Based on the figures presented above, it appears that facility-based maternal deaths increased sharply from FY11 to FY12, but this increase is likely due to improved reporting of maternal death data from one year to another (MCHIP has provided significant support throughout Manicaland province since 2011 for HMIS strengthening among health workers and

health information personnel). In terms of the location where facility-based maternal deaths are occurring, the vast majority of deaths (all but one) reported in Mutare and Chimanimani occurred at MPH, which makes sense given that MPH is the provincial (referral) hospital and all facilities in the seven districts of Manicaland refer to MPH. This is important to understand as mortality statistics reported at MPH are not actually all “Mutare district” cases, but rather represent cases originating from other districts of Manicaland province (where MCHIP is not supporting intensive MH-improvement activities). MPH itself is an SBM-R-supported facility, and as such has received significant amounts of MCHIP support during FY12 in terms of training, supervision, and material support, but mortalities occurring at MPH due to the “first and second delays” of patients originating from non-MCHIP districts will continue to contribute to high mortality at MPH. Finally, logistics issues such as oxytocin stock-outs could have also contributed to maternal deaths in the province throughout the year, especially given that from Jan-Sep 2012, PPH was the most common cause of maternal death in these districts. Although no official statistics are available, MCHIP has monitored the oxytocin supply situation throughout the year and has noted that health facilities in Mutare and Chimanimani have faced both shortages and stock-outs in FY12.

Based on the information above, in FY13, MCHIP’s approach to reducing maternal mortality in the districts will include supporting activities like the SBM-R quality improvement interventions; supporting routine provincial-level maternal and perinatal mortality audit meetings; strengthening district-wide referral systems; and strengthening of community skills in birth preparedness and recognition of pregnancy-related danger signs. In addition, MCHIP will work on strengthening delivery of comprehensive EmONC services at select high-volume HFs (such as MPH), and will explore ways to provide technical assistance to other districts in Manicaland which refer cases to the provincial hospital.

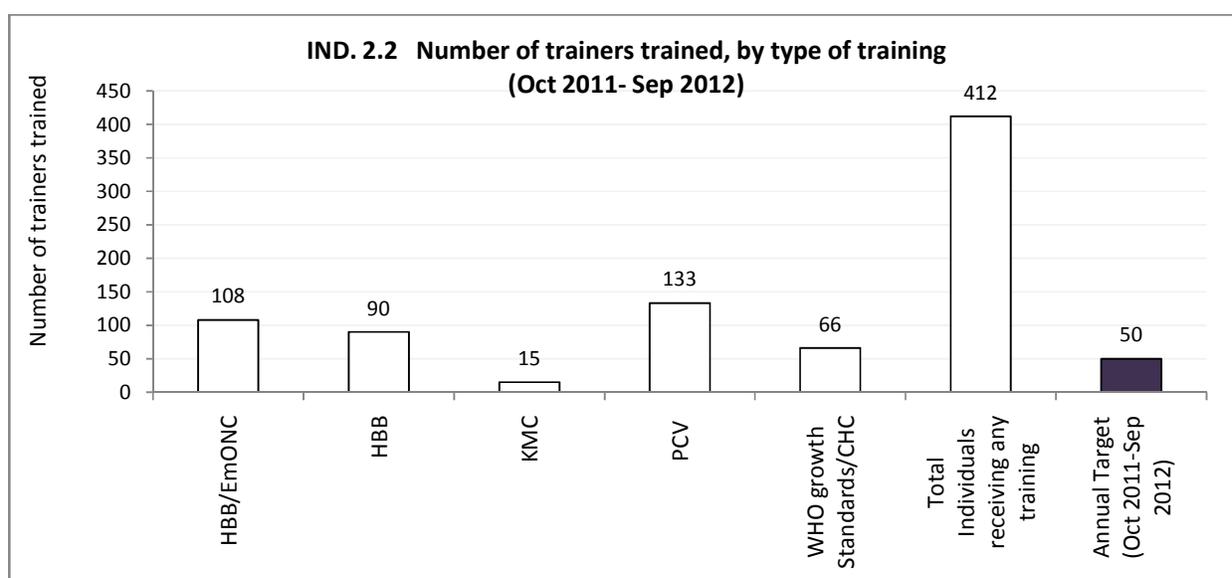


The number of facility-based early neonatal and intrapartum deaths per 1000 live births is plotted by month for the period October 2010 to September 2012. Though monthly data tends to be “noisy”, over time the data indicate a generally downward trend in facility-based neonatal and intrapartum mortality in the 17 SBM-R supported facilities. This trend might be attributed to a number of factors, such as improvements made in the quality of care provided in these facilities. For example, most of these facilities have shown an improvement in the use of the partograph and in achieving standards for managing newborn complications. During SBM-R baseline assessments, none of the 17 facilities met the standards for use of partograph or

managing newborn complications. However, at the second SBM-R assessment, 63% of the facilities achieved standards in use of the partograph and 70% met the standards for managing newborn complications correctly.

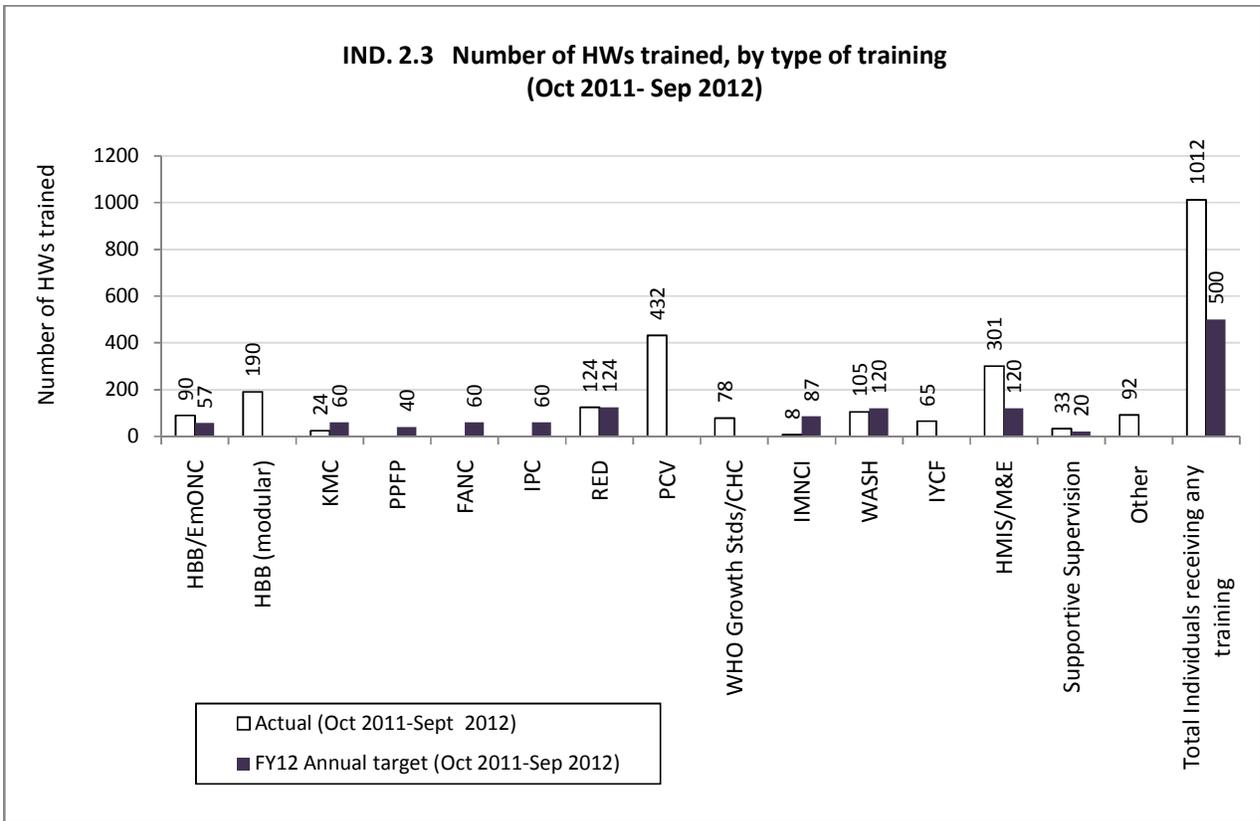
MCHIP's annual target for this indicator across both districts (not just within the 17 SBM-R-supported sites) was to reduce the facility-based ENMR by 10% relative to FY11 levels (FY12 target=51/1,000 total births). As of the end of FY12 Q4, the facility-based ENMR for Mutare and Chimanimani districts was 33/1,000 total births, indicating that MCHIP exceeded its annual ENMR target.

In FY13, MCHIP's approach to reducing early neonatal mortality in the districts will include supporting activities like the SBM-R quality improvement interventions; supporting routine provincial-level maternal and perinatal mortality audit meetings; and strengthening health worker skills in essential newborn care (including neonatal resuscitation).



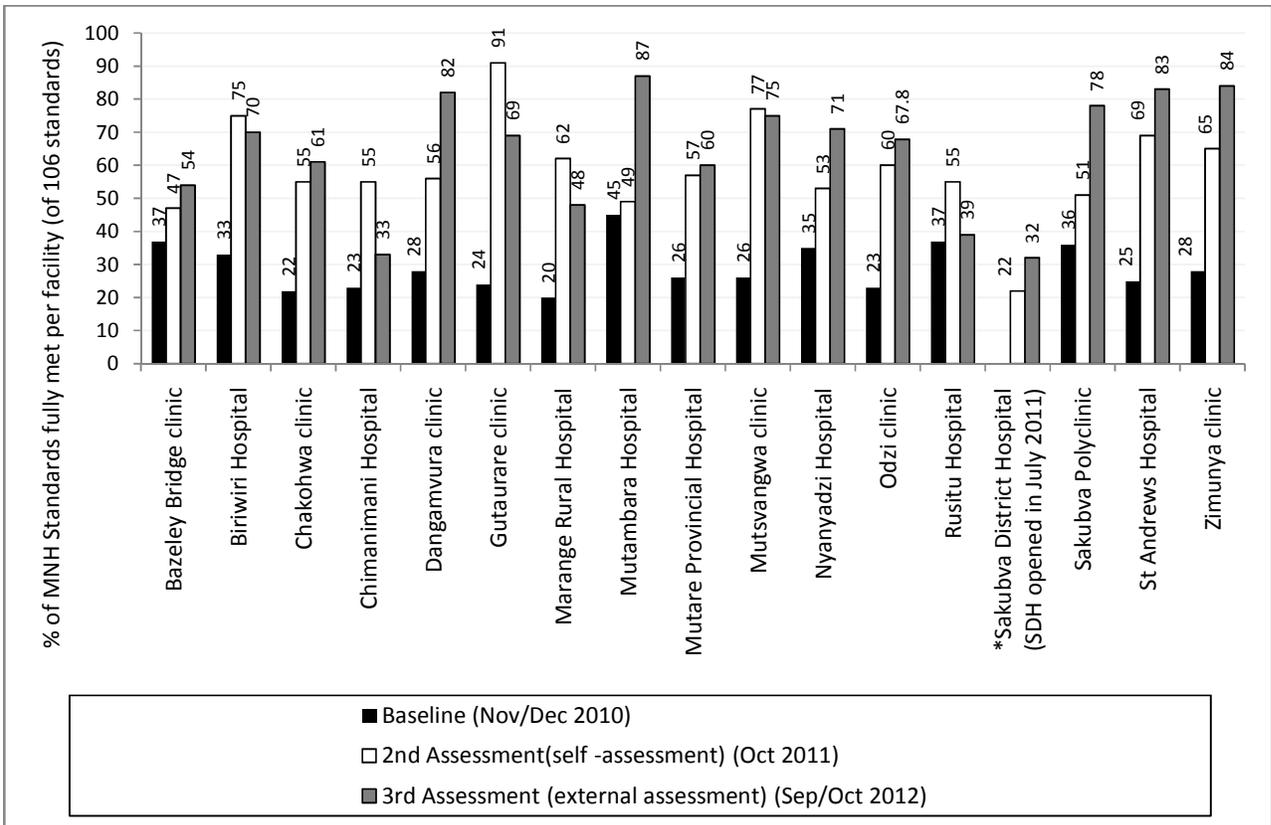
The graph above presents MCHIP's annual target for training of trainers (TOT) as outlined in the PMP (target=50 trainers). In terms of sub-targets by training area as outlined in the FY12 annual workplan, MCHIP planned on conducting one TOT in EmONC, one in IMNCI, one in KMC, and one in post-partum family planning (PPFP). In Q3, MCHIP supported two additional TOTs in EmONC at national level to validate/standardize the national EmONC training package that neared finalization in Q2. In Q3, MCHIP also supported three TOTs (two at national level and one at provincial level) on the introduction of the Pneumococcal Conjugate Vaccine 13 (PCV 13). In Q4, MCHIP supported two national-level TOTs in HBB (in collaboration with the MOHCW, UNICEF, and the Church of Latter Day Saints), as well as one national-level TOT on the recently revised WHO child growth standards which is now included in the national child health card.

As of year-end, MCHIP had far surpassed its annual TOT target, though we were not able to meet our TOT goal for IMNCI or PPFP trainings. MCHIP continues to provide support to ZNFPC regarding revision of the national FP/PPFP training package, and plans to provide technical assistance to ZNFPC for PPFP training for health workers in FY13 as needed. Regarding IMNCI roll out, discussions with the MOHCW Child Health Unit progressed in Q4 and training support for health workers in Manicaland is planned for FY13 Q1.



The graph above presents MCHIP’s annual training target for health workers as outlined in the PMP (target=500 HWs), as well sub-targets by training area, as described in the FY12 annual workplan. In Q4, MCHIP focused training efforts in the areas of EmONC/HBB, HMIS, and WHO growth standards/child health card trainings. Cumulatively speaking for the year, MCHIP met or surpassed its training targets in some areas (EmONC/HBB, RED, HMIS, supportive supervision), did not meet its training targets in other areas (IMNCI, PFP, FANC), and provided training support in unanticipated areas (PCV introduction, new child growth standards) as the need arose. In general, MCHIP strove to be strategic, targeted, and responsive to the situation on the ground and to adapt to changing training needs and realities within the external environment throughout the year. MCHIP’s experience in FY12 has helped to shape its training approach and targets in the coming year.

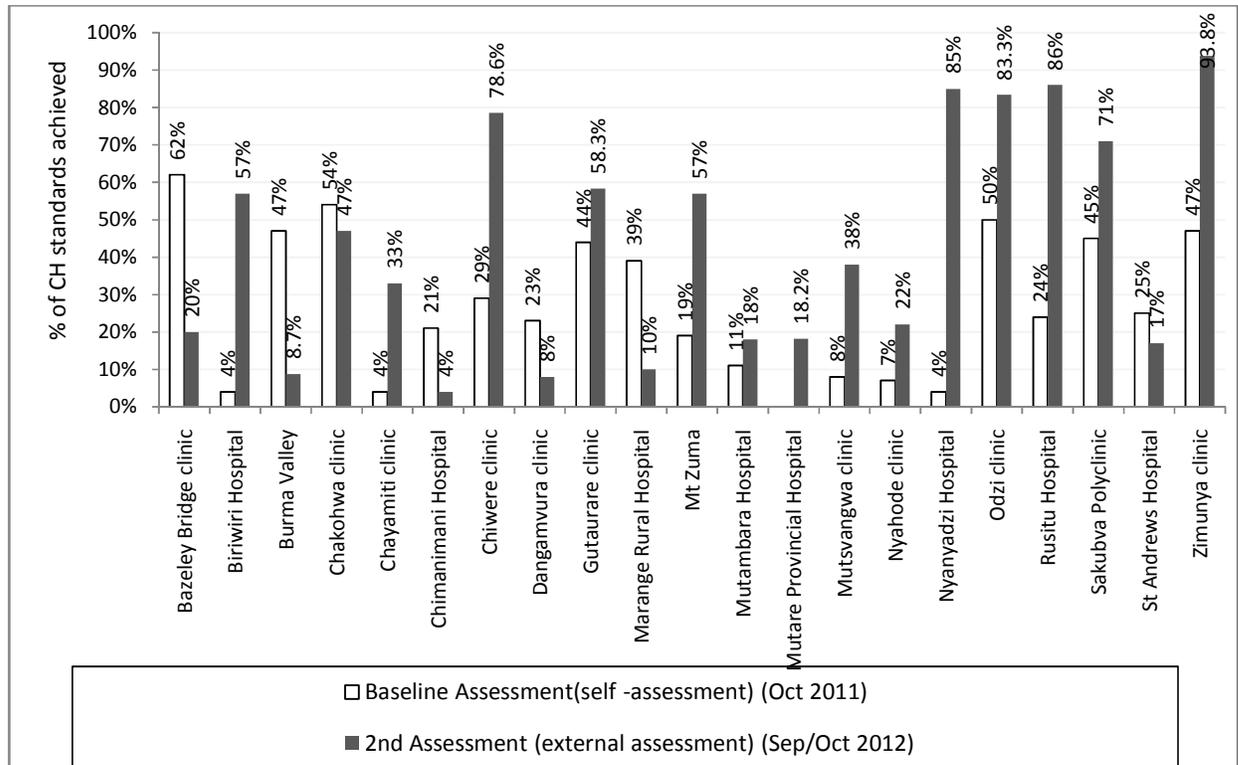
IND. 2.4 MCHIP SBM-R supported facilities achieving set target for MNH clinical standards for the year (17 SBM-R supported sites)



Indicator 2.4 reads “percent of MCHIP SBM-R supported facilities achieving set target for MNH clinical standards for the year”, with the FY12 annual target being “100% of 17 HF’s reaching at least 80% of MNH standards”. During Q4, MCHIP supported MOHCW staff in conducting a third SBM-R assessment, focused on maternal and newborn health areas. The graph above presents assessment results for the MNH area specifically (CH results are discussed below). According to this assessment, as of the end of FY12, only four of the 17 facilities assessed (24%) met at least 80% of MNH standards. A 24% achievement falls short of the 100% target MCHIP had set at the beginning of the year, though there are still signs of significant achievement among those facilities not meeting the 80% standard after 12 months. In all cases shown above, health facility performance has improved relative to performance measured at baseline, with noted performance improvements in the areas of management of normal labour and delivery and management of neonatal complications. Noted challenges for why some facilities may be struggling to improve their performance include pressure from competing programs (with too many workshops being held resulting in staff being away from facilities too often) as well as infrastructural issues that some HF’s will struggle to overcome (such as those needing to physically expand in order to meet standards for privacy, improved patient flow, improved access to sinks in exam rooms, etc.). In addition, the Primary Care Nurse up-skilling program has also contributed to staff shortages, with some health facilities like Odzi, Mt Zuma, Bazeley Bridge, and Gutaurare being manned by Nurse Aides (who have not been trained as part of SBM-R support). The MCHIP team has observed major problems with inconsistency of care provision given the constant movement of health workers in and out of their stations.

In FY13, MCHIP will continue to support SBM-R activities, with a shift in emphasis from training of health workers to support for post-training follow up, supportive supervision, on the job mentoring, and health information recording and use. These activities will help consolidate gains seen in FY12 and aid in institutionalization of quality improvement concepts and activities.

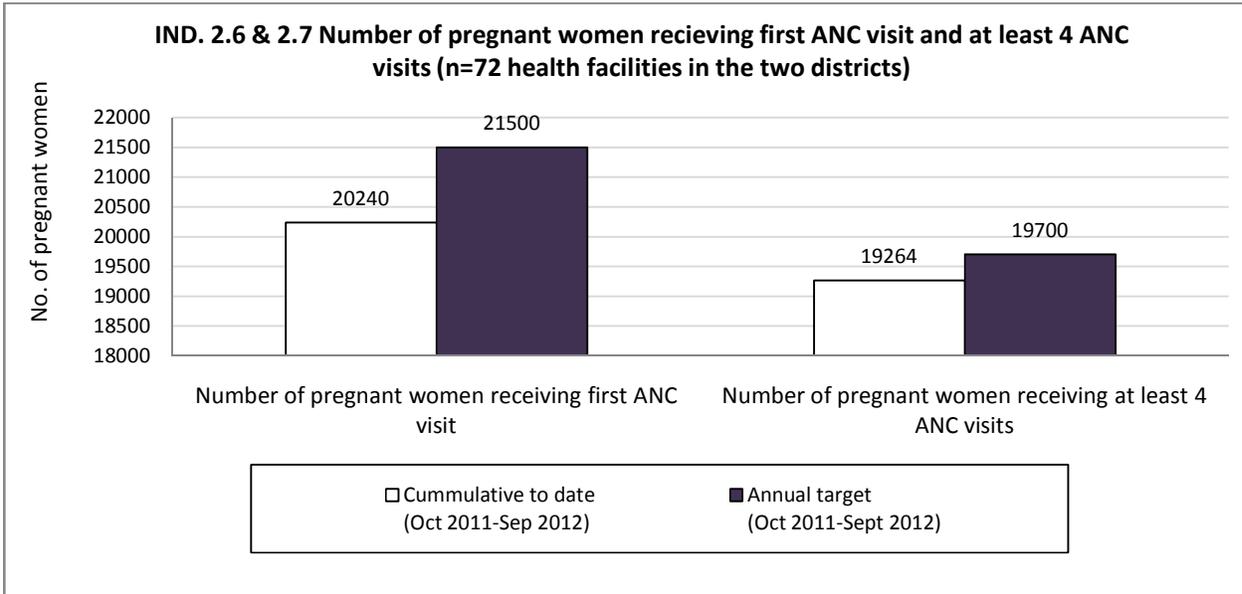
IND. 2.5 MCHIP SBM-R supported facilities achieving set target for CH clinical standards for the year (21 SBM-R supported sites)



Indicator 2.5 reads “percent of MCHIP SBM-R supported facilities achieving set target for CH clinical standards for the year”, with the FY12 annual target being “100% of 22 HFs reaching at least 60% of CH standards”. During Q4, MCHIP supported MOHCW staff in conducting a second SBM-R assessment focused on child health, despite the fact that MCHIP’s child health-related quality improvement activities were known to have lagged behind relative to MNH areas. Throughout FY12, MCHIP met great challenges in terms of initiating CH-related quality improvement activities, for example, in training health workers in IMNCI. These challenges were largely related to coordination issues at the MOHCW national level, as well as delays in the availability of a national IMNCI training package. As IMNCI training was to be the foundation for subsequent quality improvement activities (procurement support, post-training follow up/on the job training, supportive supervision, resource mobilization, etc.), delays in training resulted in significant implementation challenges down the line.

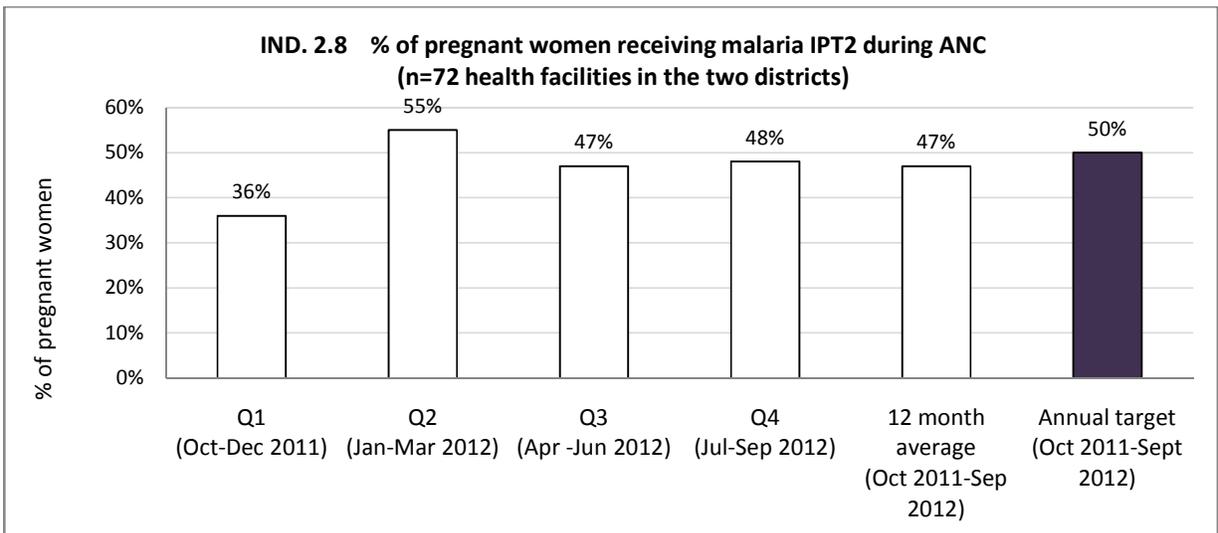
Given this, the results shown in the graph above should be interpreted with caution. According to this assessment, as of the end of FY12, six of the 21 facilities assessed (29%) met at least 60% of CH standards, but it is unlikely that these achievements can be attributed to the SBM-R process (rather it might reflect other general support that MCHIP and others have provided to these facilities). However, at second assessment, most HFs did show improvement over their baseline performance.

In FY13, MCHIP again plans to provide training support for IMNCI and is hopeful that activities will move forward. As with MNH areas, MCHIP will also continue to support SBM-R activities, and will strengthen SBM-R CH implementation with MOHCW support.



MCHIP's achievements under these two indicators (women receiving first ANC visit and at least 4 ANC visits) came very close to meeting the annual targets. For FY12 (Oct 2011 –Sep 2012), the total number of expected pregnancies district-wide for the two districts was 25,547. These figures were obtained from ZIMSTAT 2011 and 2012 census projected figures. Based on this denominator, the percent of expected pregnant women receiving first ANC in MCHIP learning districts for FY12 was $20,240/25,547=79\%$.

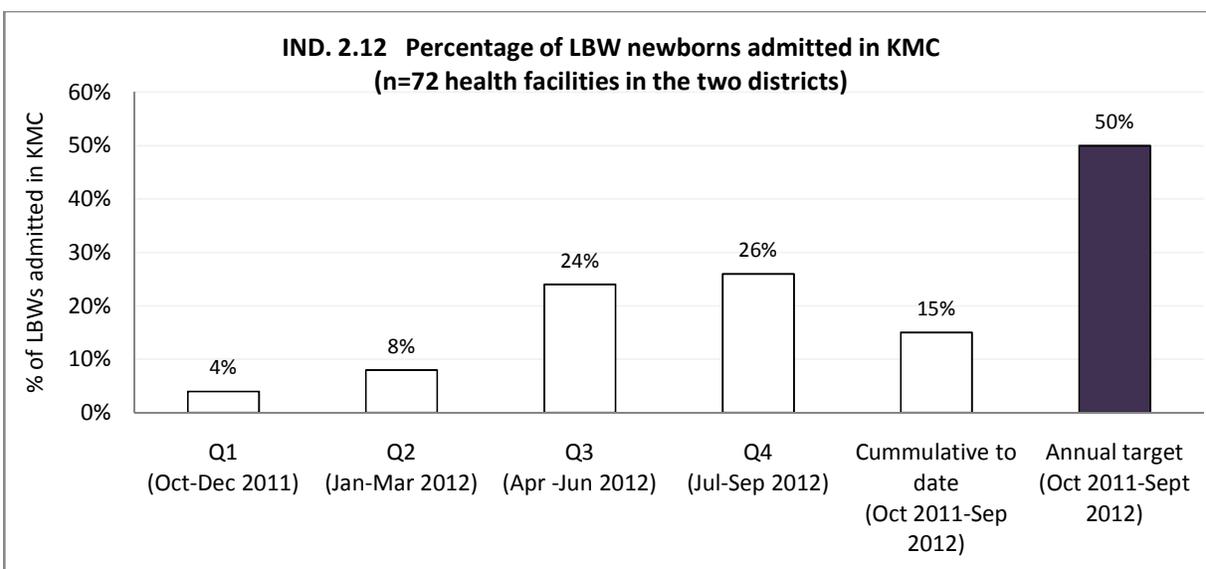
In terms of the percent of pregnant women in MCHIP learning districts receiving at least 4 ANC visits in FY12 relative to the expected number of pregnancies in the districts, 75% of expected pregnant women (Mutare and Chimanimani district-wide) received at least 4 ANC visits. These figures are consistent with the general understanding that ANC coverage in Zimbabwe tends to be high.



MCHIP came close to meeting its annual target for percent of pregnant women receiving malaria IPT2 during ANC. Relative decreases from Q2 to Q4 could be due to the decline of the malaria season, which occurred during Q3. According to recent WHO Zimbabwe Weekly Epidemiological Bulletins, malaria cases have been on a steady decline since mid-April and Q4 tends to consist of low-burden months.

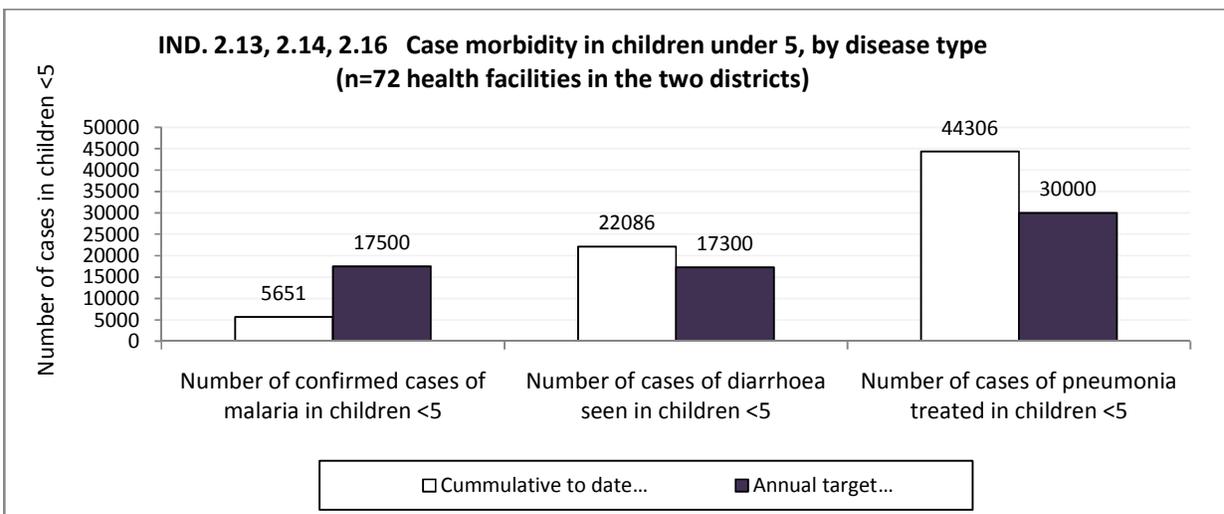


Based on cumulative results to date, MCHIP surpassed its annual target of 11,000 in this area. In terms of the percent of women district-wide delivering with a SBA relative to all deliveries occurring in Q4 (facility births plus recorded home births), for Q4, 91% of all deliveries in the districts had a SBA present (NB: the number of home deliveries reported through the HMIS for Q4 was 375, thus the % of SBA deliveries for the two districts in total was $3,858 / (3,858 + 375) = 91\%$). Note however that this percentage is likely an overestimate, as the number of home births only reflects those captured by the HMIS system. Thus, while the real percentage of women delivering with an SBA is likely lower than 91%, the figure is useful for observing general trends over time.



The percentage of low birth weight newborns admitted in KMC increased in Q4 relative to previous quarters as all four MCHIP-supported KMC units (Mutambara Mission Hospital, Rusitu Mission Hospital, Sakubva District Hospital, and Chimanimani Hospital) continued to admit patients. For FY12, cumulative KMC

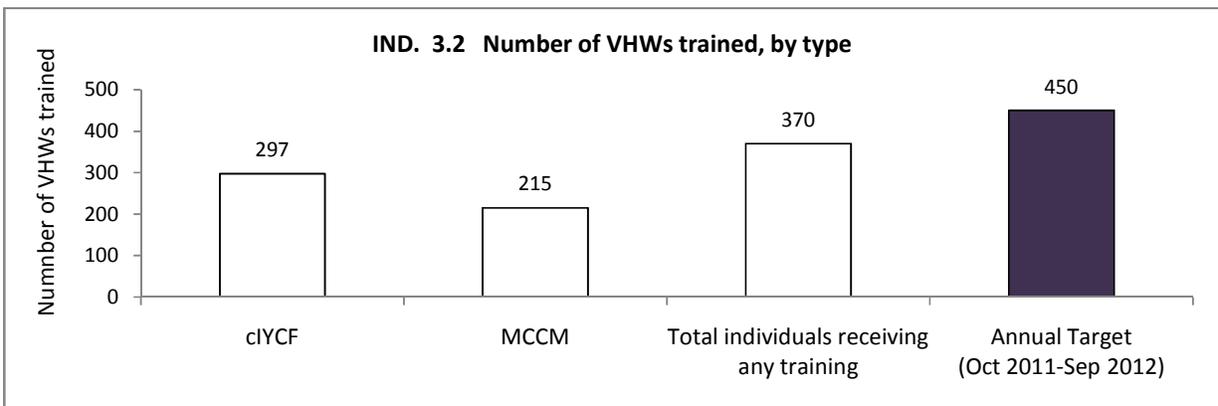
coverage within the two districts was 15%, which was below MCHIP’s annual coverage target and reflects a continued high rate of unmet need for KMC services in the districts. In order to meet some of this need, in Q4 MCHIP continued work with five additional facilities in Mutare and Chimanimani (Marange Rural Hospital, Biriwiri Hospital, St. Andrews Hospital, Nyanyadzi Hospital, and Mutare Provincial Hospital) to establish or revitalize KMC units there. Opening of these additional KMC units in FY13 will increase availability of KMC services and ease pressure on existing KMC units.



The malaria “cumulative to date” figure suggests lower malaria disease burden in FY12 relative to the same period last year (the basis for the FY12 target). Accurate data on current morbidity and mortality due to malaria would be useful in interpreting this data, but unfortunately is not currently available. However, according to 2011 Mutare and Chimanimani MOHCW district reports, there was 92% coverage of indoor residual spraying (IRS) in Mutare district and 80% IRS coverage in Chimanimani. These high IRS coverage rates could explain low rates of malaria transmission seen in FY12. In addition, starting in Q3 of this year, 60 VHWs in Chimanimani and 47 VHWs in Mutare began malaria community case management (MCCM) activities, and were reporting testing and management of confirmed malaria cases at village level. Though accurate data is not yet available regarding numbers of cases being treated in the community, it is possible that MCCM activities are resulting in reduced numbers of cases being seen at health facilities. Even so, it is likely that routine malaria case data being reported through the HMIS system is not as reliable as it could be, as health workers continue to struggle with case definition and recording malaria cases (“suspected”, “confirmed”, “treated”) consistently.

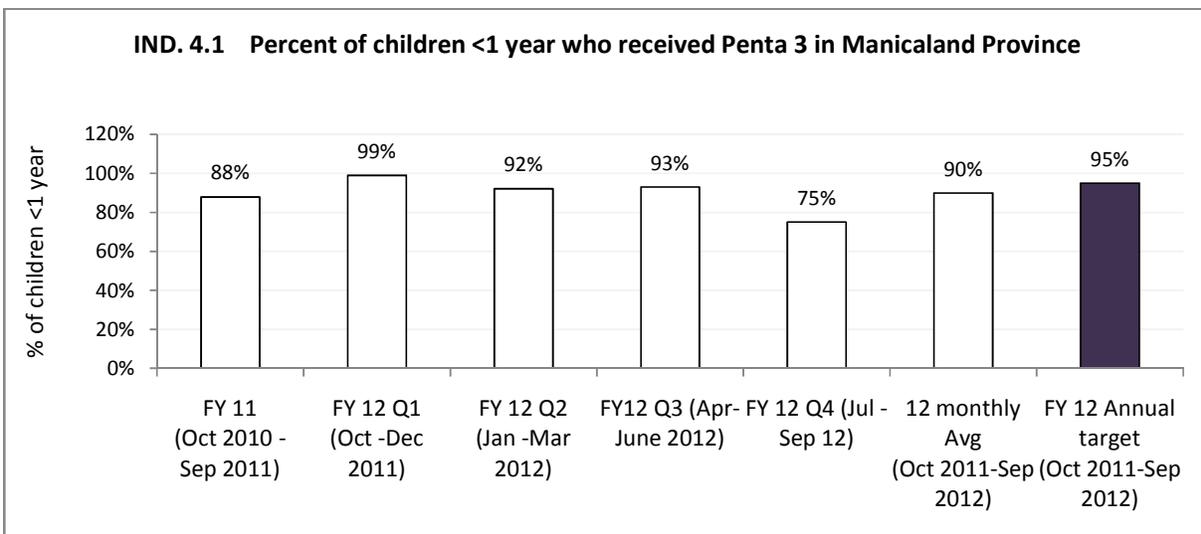
Regarding diarrhoea and pneumonia disease burden at the end of FY12, the number of cases of each continued to increase sharply between Q3/Q4 and previous quarters. It is unclear what the explanation is for this sharp increase, but it could be due to seasonal variations in disease incidence (Q3 was the start of the winter season), improved community care-seeking behaviours when children are sick with diarrhoea and pneumonia symptoms, and/or issues with HMIS reporting (i.e., health worker confusion regarding the case definition of pneumonia, leading to over reporting of cases).

Objective 3: Improve the coverage and quality of high-impact MNCH/FP interventions provided by health care workers in the community, including VHWs and other agents



The graph above presents MCHIP’s annual training target for VHWs as outlined in the PMP (target=450 VHWs having received any type of training), as well as achievements as of the end of FY12. The graph reflects the same information reported in Q2 and Q3, as no VHW training took place in Q4. Instead, focus in Q4 was on sensitizing provincial and district-level stakeholders on MCHIP’s community-based MNCH Performance Quality Improvement (PQI) approach, working with VHW supervisors on providing supportive supervision to VHWs in their catchment areas, and conducting a cPQI baseline assessment in both districts. Results of the baseline assessment will be shared with stakeholders during the first quarter of FY13.

Objective 4: Increase routine immunization coverage in Manicaland province and support the nationwide introduction of PCV by 2012 and rotavirus vaccine by 2013

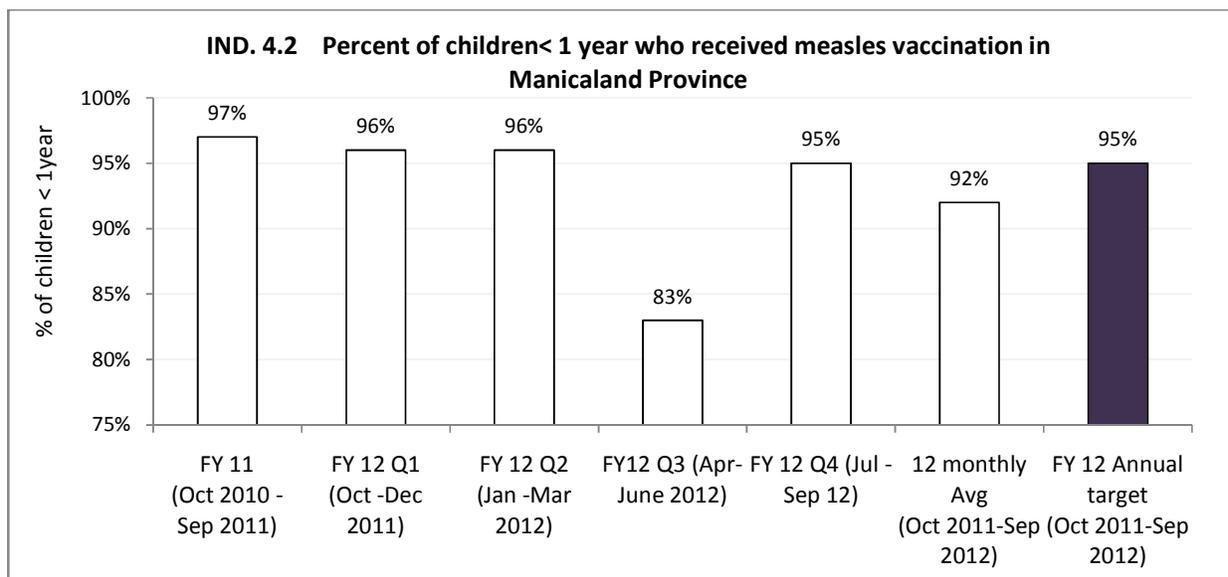


As of the time of writing, EPI data for the province was complete for July and August 2012 but one district’s data (Mutasa) was missing for September 2012*. Once complete data is received, it is possible that Q4 coverage could increase, but even so, the decrease in Q4 relative to other quarters is odd. One possible explanation for the decrease in Penta 3 coverage for the quarter is that there may have been a vaccine shortage, though we have confirmed with the national and provincial-level EPI officers that no vaccine

shortage for Penta occurred in Q4. Another explanation could be that various districts did report disruptions in outreach services during the quarter due to shortages of vehicles and fuel, but this needs to be further investigated given that measles coverage for the quarter appeared to be normal (see below). We will cross check the Penta 3 coverage data with OPV 3 data, to see if there was a similar decrease in OPV 3 coverage during Q4 (as Penta 3 and OPV 3 are given to children at the same time). If OPV 3 coverage appears normal, then we suspect the Q4 data for Penta 3 could reflect reporting errors. Again, this will be explored further.

Despite curious Q4 data, overall at the end of FY12, MCHIP generally performed well in this indicator, though it is acknowledged that issues with data quality and population denominator figures still persist. In FY13, MCHIP plans to intensify its support for RED supportive supervision and implementation, data quality improvement activities, training in basic immunization practices for health workers, and training for EPI mid-level managers. The aim of all of these activities is to continue to improve health worker knowledge and skills in EPI, in order to further increase EPI coverage rates.

** Notes on data: Q3 data was incomplete at the time of the Q3 report submission but has since been updated in this report to include all data for April – June 2012. For Q4, all districts reported EPI data in July and August, and 6 districts reported for September (all except Mutasa).*



As of the time of writing, EPI data for the province was complete for July and August 2012 but one district’s data was missing for September 2012*. Once complete data is received, it is anticipated that Q4 will show similar coverage as previous quarters. Overall, by the end of FY12, MCHIP performed well in this indicator, though it is acknowledged that issues with data quality and population denominator figures still persist. In FY13, MCHIP plans to intensify its support for RED supportive supervision and implementation, data quality improvement activities, training in basic immunization practices for health workers, and training for EPI mid-level managers. The aim of all of these activities is to continue to improve health worker knowledge and skills in EPI, in order to further increase EPI coverage rates.

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M&E/HMIS: to improve the quality, availability, and timely usage of health information for internal and external decision-making and learning

- MCHIP continues to support health management information systems (HMIS) strengthening at national, provincial, district, facility, and community levels. In July, MCHIP supported the MOHCW to conduct a data verification exercise for the period October 2011 to June 2012 in six sites in Mutare and four sites in Chimanimani. The main objective of this exercise was to assess whether data reported at facility-level mirrors what is being tallied in primary data collection tools (i.e., registers and tally sheets). The assessment generally found that there is no standard data collection and reporting system in most sites, particularly as there is no dedicated health information person within health facilities. A resultant recommendation is to have national routine data verification standard operating procedures and to develop national reporting guidelines.
- In mid-July, the MCHIP M&E Officer supported HMIS training of 31 HWs from Buhera district. The main objective of this training was to enhance HW skills in health information management, reporting, and use. Anecdotally speaking, it appears that there has been some improvement in Buhera already, in terms of timely reporting by facilities in that district. Following MCHIP-supported M&E trainings, Buhera's reporting has improved significantly, from 62% completion in 2011 to 94% T5 submission and 100% timely reporting on the weekly routine disease notification system (RDNS). The Buhera training marked the end of MCHIP-supported HMIS trainings in Manicaland, as all seven districts have now been trained; supportive supervision will be prioritized in FY13.
- MCHIP provided technical support to the District Health Information Officers (DHIO) in Q4, for example in conducting supportive supervision (SS) visits in 7 SBM-R facilities in Chimanimani in September. Data for MCHIP indicators for July and August was collected during these SS visits. Issues noted during SS include: general difficulties with completing the T3, T5, and T12 forms, as well as confusion on how to handle data submitted by VHWs (especially now that they are treating malaria). Some facilities were noted as adding VHW data onto to the health facility T5 data whereas according to the DHIO, VHW data should be submitted separately but attached to the facility T5.
- Finally during the quarter, Vikas Dwivedi, the MCHIP/Washington M&E Advisor visited the project. Mr. Dwivedi visited the Harare office as well as sites within Mutare, assessed FY12 progress, made recommendations for the FY13 workplan, and developed an action plan for next steps.

4. Management, Finance, and Administration

MCHIP has had a productive quarter with the following management and administration accomplishments:

- During Q4, the MCHIP team developed its FY13 workplan and budget and refined the project's Year 3 performance targets. The FY13 workplan and budget have since been reviewed and approved by USAID/Zimbabwe and USAID/Washington. In FY13 Q1, MCHIP will share the workplan with counterparts at national, provincial, and district levels in order to inform them about the types of support MCHIP plans to provide during the year.
- As part of the FY13 workplanning process, the MCHIP senior management team developed ideas for a new staffing configuration in MCHIP's learning districts. Full details of the staff restructuring and envisioned benefits of the new configuration are included in the FY13 workplan document. In addition to staff restructuring, during Q4, senior management reviewed current office spaces/locations at Harare and district levels, and has decided to relocate its Harare office based on cost-cutting and other considerations. An office move is planned for the first quarter of FY13.
- The MCHIP Finance and Administration (F&A) team conducted an internal F&A review in early September 2012. The MCHIP/Zimbabwe team, assisted by Meghan Anson, reviewed the project's

internal systems and processes as well as assessed (via survey) the MCHIP/Zimbabwe team's understanding of F&A functions, procedures, and products. The F&A team briefed senior management about the findings of the assessment and action items identified are already being carried forward.

- In September, the MCHIP Project Administrator attended a presentation on audit and fraud, held by the USAID Regional Inspector General's office.

5. Challenges and Opportunities

5.1 Challenges

- *Inappropriate cadres being selected for participation in MCHIP-supported trainings and TOTs* – MCHIP invests significant resources each quarter in building the capacity of health workers through clinical trainings, workshops, and meetings. During Q4, in response to specific requests from MOHCW counterparts at Mutare provincial/district level, MCHIP provided support for a “mop-up” BEmONC training for health workers in Mutare. MCHIP had received earlier feedback from the province/district that some major facilities (e.g., Mutare Provincial Hospital (MPH), Sakubva District Hospital, and a few Mutare polyclinics) had few providers trained in BEmONC; these facilities requested extra support to train more of their providers, in order to increase the proportion of skilled health workers available for duty at any one time. In response to this request, MCHIP supported a mop-up BEmONC training in September 2012, but was disappointed by the specific individuals who were selected for training. In this case, relevant participants selected for BEmONC training would have included nurses and midwives who actually deliver hands-on clinical maternal and newborn care, for example in labor/maternity wards. In contrast, actual participants selected for training included providers from male wards and eye care units, who are not likely to put new knowledge or skills to good use and who present a challenge in terms of post-training follow up and ongoing supportive supervision. In addition, inclusion of inappropriate cadres means that training resources are reduced for those who could actually benefit from training and who could provide a return on training investments. Besides trainings, MCHIP has also faced similar challenges in terms of inappropriate cadres being identified for TOTs (e.g., people being trained as trainers who are not based in facilities, who do not have any clinical exposure in their daily jobs/duties, and/or who are unable to be independent when it comes time to actually deliver training or post-training follow up effectively). To combat this challenge, MCHIP has and will continue to advocate strongly among stakeholders to identify appropriate participants for training and TOT activities. However, this is a persistent and difficult issue which is motivated by issues outside of the project's control.

5.2 Opportunities

- *Collaboration between MOHCW, University of Zimbabwe (UZ), and MCHIP in support of provincial-level public health research* – during the quarter MCHIP finalized discussions between the MOHCW and the UZ School of Public Health regarding MCHIP support for public health research in Manicaland. UZ students in the Master's of Public Health program are required to conduct research as part of their degree program. At the request of the MOHCW and UZ, MCHIP has agreed to provide technical and nominal financial support to one Master's student (who will be based in Mutare) as he conducts MNCH-related research projects of interest to the Provincial Health Executive and to MCHIP. The student has already prepared several concept notes/proposals on research related to intermittent preventive treatment (IPT) for malaria in pregnancy, the effects of maternal nutrition on pregnancy outcomes in Mutare district, and the analysis of maternal and perinatal mortality data in Manicaland province. MCHIP support for these studies is envisioned as a “win-win opportunity” whereby the MOHCW will benefit from extra research assistance, a Master's

student will gain valuable research experience, and MCHIP will further its learning agenda objectives.

- *Adoption of a new “non-residential” per diem schedule* – in the past MCHIP’s per diem schedule has generally followed a “residential” system, whereby travelers receive meals and incidental expenses and MCHIP pays for hotel accommodations. This system is expensive (as hotel accommodations are costly), requires more effort for MCHIP to administer, and is less preferred by travelers who often do not require hotel-based lodging. In FY13, MCHIP will shift as much as possible to a “non-residential” per diem system, where travelers will receive a flat amount of per diem each day, to cover meals, incidentals, and lodging as they choose. The non-residential system follows the published Ministry of Finance schedule, and offers the advantage of being much less expensive to the project (the costs of an activity can be reduced by 50% or more). It is also easier to administer, is preferred by participants, and is fostering more creativity in terms of venue selection, as people are encouraged away from the “hotel-based training” model of the past.

6. Success Story: Motivating VHWs to better performance – a little support goes a long way

Mrs. Joyce Nyamunda is a village health worker who lives in Rubatso Village in the Marange Hospital catchment area of Mutare district. She is one of the VHWs with whom MCHIP has been working on community MNCH and performance quality improvement (PQI) activities. Joyce was visited by MCHIP and MOHCW staff during the VHW baseline assessment that was conducted in August 2012. As part of that assessment, Joyce was assessed in conducting a postnatal care home visit (traditionally done on the third and seventh day after a baby is born) to a recently-delivered mother and her baby.

On the 16th of September 2012, baby Enock Timbe was born to Patience Mangwana (not their real names) at Marange Hospital. Enock was Patience’s first baby and he weighed 2500g at birth.

The nurses at the hospital experienced communication challenges with Patience (who is from Mozambique but is married to a Zimbabwean), and so decided to keep her at the hospital for a few days to teach her about kangaroo mother care and to monitor her progress before discharging her to return home. Patience and the baby were discharged on the 19th of September and went home to Rubatso Village. On that very day, VHW Joyce paid mother and baby a postnatal home visit, to check on their progress. Both the mother and baby were fine and Joyce reinforced the need for Patience to continue with kangaroo care, to exclusively breastfeed the baby, and to return to the hospital for her Day 7 postnatal check up.

On the 20th of September, VHW Joyce went away for a workshop but returned on the 24th. On the 25th of September, she paid another follow up visit to Patience and the baby, to remind Patience to go back to the



Mrs. Joyce Nyamunda, a VHW serving Rubatso Village in Mutare District. Motivated by support she has received from the MOHCW and MCHIP, Joyce is committed to providing the best service she can to mothers and children in her catchment area.

hospital for her Day 7 postnatal care visit if she had not already done so. On arrival at Patience’s house however, Joyce discovered that things were not right. There were many people in the house, including a traditional birth attendant. Joyce asked for permission to see the mother and baby. She discovered that Patience’s legs were swollen and that the baby was not breathing well or breastfeeding. Joyce noted that the traditional birth attendant had been invited to the house because the baby was not breastfeeding and that this was considered a bad omen for the family.

Immediately Joyce told the husband to find money to take Patience and Enock to the hospital because the baby needed hospitalization. Joyce told the family that she would go to the hospital ahead of them to inform the nurses and would wait for them there. Fortunately, the husband took heed of Joyce’s advice and brought his wife and baby to the hospital around 1300hrs that day. The nurses assessed the baby and classified it as having severe disease. A call for an ambulance was made. The ambulance arrived about two hours later and the baby was transferred to Mutare Provincial Hospital (MPH).

Very sadly, baby Enock died the next day at MPH but VHW Joyce had done her best to save the life of the mother and baby (Patience survived and is making a full recovery). When asked by the MCHIP District Community Officer what motivated Joyce to conduct such regular postnatal home care visits and to follow up with Patience and her baby, Joyce mentioned the MCHIP-supported VHW PQI baseline assessment in which she had participated. Joyce said that she had never had an experience like that of having people accompany her into the community and observe her doing her work. The experience challenged her to do her work better and to document what she is doing in the community. The baseline assessment experience also raised Joyce’s profile in the community and she now feels motivated because the community now values her advice. Joyce’s hope is that when the next PQI assessment is done, she will have improved her skills in conducting antenatal and postnatal care home visits and identifying danger signs in mothers and newborns.

7. Visitors/International Travel

During the reporting period, MCHIP/Zimbabwe received several headquarters staff for short-term technical assistance (STTA). Individual trip reports are available upon request.

Name of Consultant/STTA	Scope of Work	Approx. Dates
Vikas Dwivedi, M&E Advisor	Reviewed the project’s overall M&E and HMIS-related technical activities and progress to date, as well as helped the team develop its FY13 workplan activities in the M&E/HMIS areas.	.29 July – 4 August, 2012
John Varallo, MNH Advisor	Assisted the team in the areas of clinical training, supportive supervision, and implementation of MNH activities, as well as helped the team develop its FY13 workplan activities in the MN health technical areas.	20 August – 14 September, 2012
Pat Taylor, MCHIP Country Team Leader	Participated in a review of the team’s overall progress during FY12 and assisted the team to develop its FY13 workplan.	20-31 August, 2012
Meghan Anson, MCHIP Program Coordinator	Participated in a review of the team’s overall finance and administrative systems and procedures, as well as assisted the team to develop its FY13 workplan.	26 August – 13 September, 2012

In addition to STTA, MCHIP/Zimbabwe staff traveled internationally during the quarter as follows:

Name of Traveler	Scope of Work	Approx. Dates
Rose Kambarami, CD	Traveled to the US to attend the JSI International Division Meeting.	16-30 July 2012
Adelaide Shearley, CH/I Advisor	Traveled to Malawi to provide STTA to the MCHIP/Malawi team in immunization. <i>NOTE: this trip is being fully funded by MCHIP/Malawi and therefore does not technically "count against" the trips budgeted in the Zimbabwe budget.</i>	4-25 August 2012
Hillary Chiguvare, Technical Director	Traveled to Mozambique to participate in an MCHIP SBM-R workshop.	25-28 September 2012

Short-term technical assistance visits expected during FY13, Quarter 1 are shown below:

Name of Traveler	Scope of Work	Approx. Dates
No travelers anticipated at this time		

MCHIP/Zimbabwe staff international travel expected during FY13, Quarter 1 is shown below:

Name of Traveler	Scope of Work	Approx. Dates
No travelers anticipated at this time		

Annex 1. MCHIP/Zimbabwe Indicator Table: Achievements in FY12 Q4 against Annual Targets

NB:

1. Health facility data for FY12 Q4 is partially complete for Mutare; data was reported for 100% of sites (52 of 52) for July 2012, 94% (49 of 52) for August 2012 and 92% (48 of 52) for September 2012. None of the missing sites is an SBM-R supported site.
2. Data reported for Chimanimani is from 100% of facilities. Note however that of 27 HFs in Chimanimani, 6 sites were not operating during the reporting period according to the Chimanimani DHE. Thus data reported here is from 21 (100%) of the remaining open sites.
3. Where ZIMSTAT census data is used but only provided on an annual basis (e.g., # of expected pregnancies in a district), the annual figure was divided by four to reflect a quarterly figure.

Indicator	Indicator Definition	Baseline Value (Oct 2009 - Sep 2010)	Actual Achievement Year 1 (Oct 2010 - Sep 2011)	Year 2						Notes and Analysis
				Q1 Actual (Oct-Dec 2011)	Q2 Actual (Jan-Mar 2012)	Q3 Actual (Apr-Jun 2012)	Q4 Actual (Jul-Sep 2012)	Cumulative (and/or average) to date (Q1-Q4)	Target Year 2 (Oct 2011 - Sep 2012)	
GOAL: Reduced maternal, newborn, and child mortality										
G1. Facility-based maternal mortality ratio (MMR)	# of facility-based maternal deaths, divided by the total # of facility-based live births in MCHIP learning districts (Chimanimani and Mutare), multiplied by 100,000.	296/100,000 live births (n=79 HFs in 2 learning districts) (Jan -Dec 2009 data; source: MOHCW, 2009)	265/100,000 live births (n=79 HFs in 2 districts) (for Mutare reporting period is Jan-Sep 2011; for Chimanimani period is Oct 2010-Aug 2011)	170/100,000 live births (n=79 HFs in Mutare and Chimanimani districts) (Oct - Dec 2011)	285/100,000 live births (n=79 HFs in Mutare and Chimanimani districts) (Jan -Mar 2012)	211/100,000 live births (n=79 HFs in Mutare and Chimanimani districts) (Apr - June 2012)	264/100,000 live births (n=79 HFs in Mutare and Chimanimani districts) (Jul-Sep 2012)	232/100,000 live births (n=79 HFs in Mutare and Chimanimani districts) (Oct 2011-Sep 2012)	Reduce MMR by 10% = 239/100,000 live births (n=79 HFs in 2 learning districts)	
# of facility-based maternal deaths in MCHIP learning districts for Q4: 10 (9 in Mutare and 1 in Chimanimani); n=as described in note above										
# of facility-based live births in MCHIP learning districts for Q4: 3,794 total (3,064 live births in Mutare and 730 live births in Chimanimani; n=as described in note above)										

G2. Facility-based early neonatal mortality rate (ENMR)	Total # of facility-based fresh stillbirths and neonatal deaths within 24 hours of delivery, divided by total # of facility-based births (live births plus still births) in MCHIP learning districts, multiplied by 1,000.	63/1,000 total births (n=79 HF in 2 learning districts) (Jan –Dec 2009 data; source: MOHCW, 2009)	54/1,000 total births (n=79 HF in 2 learning districts)	40/1,000 total births (n=79 HF in Mutare and Chimanimani districts)	38/1,000 total births (n=79 HF in Mutare and Chimanimani districts) (Jan – Mar 2012)	21/1,000 total births (n=79 HF in Mutare and Chimanimani districts) (Apr – June 2012)	34/1,000 total births (n=79 HF in Mutare and Chimanimani districts) (Jul – Sep 2012)	33/1,000 total births (n=79 HF in Mutare and Chimanimani districts) (Oct 2011 –Sep 2012)	Reduce ENMR by 10% = 51/1,000 total births (n=79 HF in 2 learning districts)	
	# of facility-based fresh stillbirths and early neonatal deaths in MCHIP learning districts in Q4: 132 total (115 fresh still births and early neonatal deaths in Mutare and 17 in Chimanimani; n=as described in note above)									
	# of facility-based births (live births plus still births) in MCHIP learning districts in Q4: 3,861 total (3,121 live births plus still births in Mutare and 740 in Chimanimani; n=as described in note above)									
OBJECTIVE 1: Support the MOHCW to formulate national health policies, strategies and programs that increase the population's access to affordable, evidence-based, high impact MNCH/FP interventions										
1.1 # of national policies/guidelines/protocols/strategies developed with MCHIP support	# of national policies, regulations, strategy documents developed or revised with MCHIP support.	0	4	1 (KMC training manuals)	1 (Immunization Policy)	1 (PCV13 training manual)	2 (EmONC training package, RED Field Guide)	5	3	For details of other activities under this section, see the description above under Objective 1.

1.2 # of MNCH/FP evaluations/r views conducted with findings shared with stakeholders	# of evaluations and reviews conducted to gather information relevant for a particular program or activity in order to improve knowledge or understanding about the program/MNCH	0	3	2 (NIHFA/EQO C study and the IYCF Formative Research study)	1 (National EPI review)	2 (Breastfeeding KAB study analysis and IYCF Program Review)	2 (VHW PQI baseline assessment, national baseline assessment of newborn corners)	7	3	For details of other activities under this section, see the description above under Objective 1.
OBJECTIVE 2: Improve the quality of maternal, newborn and child health services provided at health facilities in learning sites and support national level scale up plans										
2.1 # of health facilities receiving MCHIP support for MNCH interventions	# of health facilities receiving MCHIP-supported MNCH interventions.	0	20 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	22 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	22 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	22 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	22 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	22 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) supported with other activities 283 HFIs (100% in Manicaland supported with EPI activities)	20 SBM-R supported HFIs 79 HFIs (100% in Mutare and Chimanimani) + others TBD supported with other MNCH activities 283 HFIs (100% in Manicaland supported with EPI activities)	All 22 SBMR supported sites received significant support from MCHIP throughout the quarter, in the form of training, supportive supervision, material support, etc. MCHIP also provided technical assistance to 100% of non-SBMR sites in the form of training and material support for areas including immunization and

2.4 % of MCHIP SBM-R supported facilities achieving set target for MNH clinical standards for the year	# of MCHIP SBM-R supported facilities achieving the set annual performance and quality improvement target for MNH clinical standards, divided by total # of MCHIP SBM-R supported HF.	0	41% of HF (7/17) reaching at least 60% of MNH standards (n=17 HF in 2 learning districts)	n/a	n/a	n/a	n/a	n/a	4/17 = 24% HF reached at least 80% of MNH standards (Oct 2011-Sep 2012)	100% of HF reaching at least 80% of MNH standards (n=17 HF in 2 learning districts)	
2.5 % of MCHIP SBM-R supported facilities achieving set target for CH clinical standards for the year	# of MCHIP SBM-R supported facilities achieving the set annual performance and quality improvement target for CH clinical standards, divided by total # of MCHIP SBM-R supported HF.	0	5% of HF (1/20) reaching at least 60% of CH standards (n=20 HF in 2 learning districts)	n/a	n/a	n/a	n/a	n/a	6/21=29% HF reached at least 60% of CH standards (Oct 2011-Sep 2012)	100% of HF reaching at least 60% of CH standards (n=20 HF in 2 learning districts)	
2.6 # of pregnant women receiving first ANC visit	# of pregnant women receiving first ANC visit in MCHIP learning districts.	17,215 (n=79 HF in 2 learning districts) (Jan –Dec)	10,467 (n=17 SBM-R supported HF in 2 learning districts)	2,627 (n=22 SBM-R supported sites)	2,510 (n=22 SBM-R supported sites) (Jan –Mar 2012)	2,335 n=22 SBM-R supported sites (Apr–June 2012)	2,380 (data from 22 SBM-R supported sites) (Jul-Sep 2012)	9,852 (data from SBM-R supported sites) (Oct 2011 – September)	21,500 (n=79 HF in 2 learning districts)	First ANC rates are traditionally high in Zimbabwe and MCHIP is on track to meet its annual target in this area. MCHIP	

	2009 data; source: MOHCW,2009)	18,946 (n=79 HFs in 2 districts) (for Mutare and Chimanimani reporting period is Oct 2010-Aug 2011) (NB: 18,946 = 14,545 women in Mutare from Oct 2010-Aug 2011 plus 4,401 women in Chimanimani from Oct 2010-Aug 2011)	4,894 (3,691 in Mutare and 1,203 in Chimanimani) i) n=as described in note above	5,382 (4,034 in Mutare and 1,348 in Chimanimani) (Jan –Mar 2012) n=as described in note above	5,017 3,795 in Mutare and 1,222 in Chimanimani) (Apr –June 2012)	4,947 3,557 in Mutare and 1390 in Chimanimani (Jul-Sep 2012)	2012 20,240 (15,077 in Mutare and 5,163 in Chimanimani) (Oct 2011 – September 2012)	is also working to improve the quality of care provided during ANC visits.
<p>Total # of expected quarterly pregnancies for MCHIP learning districts (Mutare and Chimanimani): 3,390 (22 SMB-R supported sites); 7,015 (5,314 in Mutare and 1,701 in Chimanimani district-wide). The expected number of pregnancies was obtained from ZIMSTAT 2011 census projected figures for SBM-R supported sites and ZIMSTAT 2012 census projected figures for the district wide data.</p> <p>% of pregnant women receiving first ANC in MCHIP learning districts Q4: 2,380/3,390=70% (22 SMB-R supported sites); 4,947/7,015=71% (Mutare and Chimanimani). Numerator for SBM-R sites represents 100% of sites. Denominators for both figures are likely underestimates because they are based on ZIMSTAT 2011 census projected figures. Figures should be interpreted with caution.</p>								
<p>Total # of live births in MCHIP learning districts for Q4: 3,794 total (3,064 live births in Mutare and 730 live births in Chimanimani; n=as described in note above)</p>								
<p>% of live births to the number of women receiving first ANC in MCHIP learning districts for Q4: 3,794/4,947 =77% (both Mutare and Chimanimani). Numerator and denominator figures from the T5. n=as described in note above.</p>								
2.7 # of pregnant women receiving at least four ANC visits	9,139 (calculated given 71% utilisation rate for ANC 4+ reported in ZDHS 2005/06, multiplied by ZIMSTAT	11,209 (n=17 SBM-R supported HFs in 2 learning districts) 17,198 (n=79 HFs in 2 learning districts; reporting period	2,970 (n=22 SBM-R supported sites)	3,709 (n=22 SBM-R supported sites) (Jan –Mar 2012)	2,446 n=22 SBM-R supported sites) (Apr –June 2012)	2,595 (data from 22 SBM-R supported sites) (Jul-Sep 2012)	11,720 (n=22 SBM-R supported sites) (Oct 2011-Sep 2012)	19,700 (n=79 HFs in the 2 learning districts)
receiving at least four ANC visits			4,995 (3,822 in Mutare and 1,173 in	4,923 (3,858 in Mutare and 1,065 in	4,729 (3,537 in Mutare and 1,192 in	4,617 3,367 in Mutare and 1250 in	19,264 14,584 in Mutare and 4,680 in	

2.8 % of pregnant women receiving malaria IPT2 during ANC	# of pregnant women receiving malaria IPT2 during ANC, divided by # of pregnant women receiving first ANC in MCHIP learning districts.	14% (Source: national estimate, MIMS 2009)	New indicator introduced in Year 2	1,751/4,894 =36% 1,390 (Mutare) and 361 (Chimanima ni) n=as described in note above	2,942/5,382= 55% 2234 (Mutare) and 708 (Chimanimani) (Jan –Mar 2012)	2,360/5,017=4 7% 1727 (Mutare) and 633 (Chimanimani) (Apr – June 2012)	2,391/4,947=48 % 1,761 Mutare and 630 Chimanimani (Jul-Sep 2012)	9,444/20,240= 47% (Mutare and Chimanimani) (Oct 2011- Sep 2012)	50% (n= 79 HFs in the 2 learning districts)	A decrease between Q2 and Q3 could be due to the fact that during the reporting period it was not a malaria season.
<p>Total # of expected quarterly pregnancies for MCHIP learning districts (Mutare and Chimanimani): 3,390 (22 SMB-R supported sites); 7,015 (5,314 in Mutare and 1,701 in Chimanimani district-wide). The expected number of pregnancies was obtained from ZIMSTAT 2011 census projected figures for SBM-R supported sites and ZIMSTAT 2012 census projected figures for the district wide data.</p>										
<p>% of pregnant women receiving at least 4 ANC visits in MCHIP learning districts in Q4: 2,595/3,390=77% (for 22 SBM-R supported sites); 4,617/7,015 =66% (Mutare and Chimanimani district-wide). Denominators for both figures are likely underestimates because they are based on ZIMSTAT 2011 census projected figures. Figures should be interpreted with caution.</p>										
<p>Total # of live births in MCHIP learning districts for Q4: 3,794 total (3,064 live births in Mutare and 730 live births in Chimanimani; n=as described in note above)</p>										
<p>% of live births to the total number of women receiving at least 4 ANC visits in MCHIP learning districts: 3,794/4,617=82% (Chimanimani and Mutare district-wide; n=as described in note above). Numerator and denominator figures from the T5.</p>										
2011 expected pregnancies for Mutare and Chimanima ni)	for both Mutare and Chimanimani is Oct 2010 – Aug 2011) (NB: 17,198=12,862 women in Mutare from Oct 2010-Aug 2011 plus 4,336 women in Chimanimani from Oct 2010-Aug 2011)	Chimaniman i) n=as described in note above	Chimanimani) n=as described in note above (Jan –Mar 2012)	Chimanimani) n=as described in note above (Apr -June 2012)	Chimanimani (Jul-Sep 2012)	Chimanimani) n=as described in note above (Oct 2011 –Sep 2012)				

2.9 # of deliveries with a skilled birth attendant (SBA)	# of deliveries with a SBA in MCHIP learning districts. "SBA" includes medical officers, nurses, or midwife.	10,460 (n=79 HF in the 2 learning districts) (Jan -Dec 2009 data; source: MOHCW,2009)	9,310 (n=17 SBM-R supported HF in 2 learning districts)	3,032 (n=22 SBM-R supported sites)	3,216 (n=22 SBM-R supported sites) (Jan -Mar 2012)	3,464 (n=22 SBM-R supported sites) (Apr -June 2012)	3,370 (data from 22 SBM-R supported sites)	13,082 (n=22 SBM-R supported sites) (Oct 2011 -Sep 2012)	11,000 (n=79 HF in the 2 learning districts)	Total home deliveries for the 22 SBM-R supported sites for the period Jul - Sep 2012 is 169; this means that the % of SBA for these sites in total is 3,370/(3,370+169) = 95% . District-wide, # of home deliveries reported through the HMIS for Q4 is 375 (NB: this is likely an underestimate of the true # of home births occurring in the community). Based on this, the % of deliveries with a SBA for the two districts is 3,858/(3,858+375) = 91% . Institutional delivery rates are relatively high in Zimbabwe (65% overall; 2010/11 ZDHS).
			8,952 (n=79 HF in 2 districts) (for Mutare reporting period is Jan-Sep 2011; for Chimanimani period is Oct 2010-Aug 2011)	3,133 (2,379 (Mutare) and 754 (Chimanimani)) n=as described in note above	3,666 (2,952 (Mutare) and 714 (Chimanimani)) (Jan -Mar 2012)	3,902 (3,054 (Mutare) and 848 (Chimanimani)) (Apr -June 2012)	3,858 (3,118 (Mutare) and 740 (Chimanimani)) (Jul - Sep 2012)	14,559 (11,503 (Mutare) and 3,056 (Chimanimani)) (Oct 2011 -Sep 2012)		

2.10 % of MCHIP SBM-R facilities meeting set performance and quality improvement targets for AMTSL	# of MCHIP SBM-R supported facilities achieving the set annual performance and quality improvement target for AMTSL, divided by # of MCHIP SBM-R supported HF's.	0	76% (13/17) (n=17 facilities in 2 learning districts)	n/a	n/a	n/a	n/a	n/a	11/17=65% HF's (Oct 2011-Sep 2012)	100% (n=17 HF's in 2 learning districts)	.
2.11 % of women with vaginal births receiving a uterotonic immediately after birth	# of women giving birth who received a uterotonic during the third stage of labor in MCHIP SBM-R supported facilities, divided by total # women giving birth in MCHIP SBM-R supported HF's.	72% (n=17 SBM-R supported HF's in 2 learning districts) (Source: MOHCW, Oct 2010)	87% (n=17 SBM-R supported HF's in 2 learning districts)	n/a	n/a	n/a	n/a	n/a	2,872/3,219 =89% (data came from 17 SBM-R supported sites)	95% (n=17 SBM-R supported HF's in 2 learning districts)	Data collected for FY 12 Q4.
2.12 % of LBW newborns admitted in KMC	# of LBW newborns (below 2.5 kg) admitted in KMC, divided by total # of LBW newborns born in Mutare and Chimanimani.	0	719 (Absolute figure not % due to missing denominator data)	12/328 = 4% (Mutare and Chimanimani districts)	29/382 =8% (Mutare and Chimanimani districts) (Jan – Mar 2012)	92/377=24% (Mutare and Chimanimani districts) (Apr-June 2012)	82/314=26% (Mutare and Chimanimani districts) (Jul-Sep 2012)	215/1,401=15% (Mutare and Chimanimani districts) (Oct 2011 – Sep 2012)	50% (n=4 KMC supported HF's in 2 learning districts)	All 4 KMC units in the two districts are now fully functional.	
# of LBW newborns admitted in KMC in MCHIP learning districts for Q4: 82 (66 in Mutare and 16 in Chimanimani); n=4 KMC units).											
Total # of LBW newborns born in MCHIP learning districts for Q4: 314 (266 in Mutare and 28 in Chimanimani); n=as described in note above).											

2.13 # of confirmed cases of malaria in children under 5 years of age at health facility level	3,585 (n=79 HF in the 2 learning districts) (Jan –Dec 2009 data; source: MOHCW, 2009)	5,129 (n=17 SBM-R supported HF in 2 learning districts) 13,003 (n=79 HF in 2 districts; for Mutare reporting period is Jan-Sep 2011; for Chimanimani period is Oct 2010-Aug 2011)	364 (n=22 SBM-R supported sites) 822 (Mutare) and 472 (Chimanimani) n=as described in note above	1,147 (n=22 SBM-R supported sites) (Jan –Mar 2012) 2,273 (Mutare) and 902 (Chimanimani) (Jan –Mar 2012)	732 (n=22 SBM-R supported sites) (Apr –June 2012) 1,830 (Mutare) and 760 (Chimanimani) (Apr – June 2012)	442 (data from 22 SBM-R supported sites) (Jul-Sep 2012) 726 (Mutare) and 331 in Chimanimani (Jul-Sep 2012)	2,685 (n=22 SBM-R supported sites) (Oct 2011 –Sep 2012) 5,651 (Mutare) and 2,465 (Chimanimani) (Oct 2011 –Sep 2012)	17,500 (n=79 HF in the 2 learning districts)	Lower figures reported for Q3 relative to Q2 may be due to the fact that malaria season ended in early Q3.
Total # expected number of children under 5 years of age in MCHIP learning districts: 85,701 (20,544 in Chimanimani and 65,157 in Mutare). This is an annual figure based on ZIMSTAT projected figures.									
Total # of suspected malaria cases in children under 5 years in MCHIP learning districts for Q4 (as reported on the T5): 1,205 (n=22 SBM-R supported sites); 2,038 (910 in Mutare and 1,128 in Chimanimani; n=as described in note above).									
2.14 # of cases of diarrhoea seen in children under 5 years at health facility level	1,746 (n=79 HF in the 2 learning districts) (Jan –Dec 2009 data; source: MOHCW, 2009)	6,412 (n=17 SBM-R supported HF in 2 learning districts) 12,900 (n=79 HF in 2 districts; for Mutare)	2,937 (n=22 SBM-R supported sites) 5,809	1,980 (n=22 SBM-R supported sites) (Jan –Mar 2012) 4064 (Mutare) 2,949	2,710 (n=22 SBM-R supported sites) (Apr – June 2012) 6,238 (Mutare) and 4,846	2,838 (data from 22 SBM-R supported sites) (Jul-Sep 2012) 5,975 (Mutare) 4,606	10,465 (n=22 SBM-R supported sites) (Oct 2011 –Sep 2012)	17,300 (n=79 HF in the 2 learning districts)	"Cases seen" means cases "with dehydration" plus cases with "no dehydration" on the T5 form.

2.15 % of MCHIP SBM-R facilities meeting set performance and quality improvement targets for diarrheal case management	# of MCHIP SBM-R supported facilities achieving the set performance and quality improvement target for diarrheal case management, divided by total # of MCHIP SBM-R supported HF's.	09)	reporting period is Jan-Sep 2011; for Chimanimani period is Oct 2010-Aug 2011) (NB: 12,900=9,713 cases in Mutare from Jan-Sep 2011 plus 3,187 cases in Chimanimani from Oct 2010-Aug 2011)	4,549 (Mutare) and 1,260 (Chimanima ni) n=as described in note above	and 1,115(Chimanimani) (Jan –Mar 2012)	1,392(Chimanimani) (Apr –June 2012)	1,369 in Chimanimani (Jul-Sep 2012)	22,086 16,950 (Mutare) and 5,136 (Chimanimani) (Oct 2011 –Sep 2012)	60% (n=20 HF's in 2 learning districts)	
2.16 # of cases of pneumonia treated in children under 5 in health facilities	# of cases of pneumonia treated in children under 5 years of age at facility level in MCHIP learning	New indicator introduced in Year 2	New indicator introduced in Year 2	n/a	n/a	n/a	n/a	8/21 = 38% HF's (Oct 2011-Sep 2012)	30,000 (n=79 HF's in the 2 learning districts)	"Cases treated" means "moderate (pneumonia)" plus "severe (pneumonia)" on the T5 form.
		19,002 (n=79 HF's in the 2 learning districts) (Jan –Dec 2009 data;	14,458 (n=17 SBM-R supported HF's in 2 learning districts)	5,210 (n=22 SBM-R supported sites)	5,678 (n=22 SBM-R supported sites) (Jan –Mar 2012)	4,521 (n=22 SBM-R supported sites) (Apr –June 2012)	5,373 (data from 22 SBM-supported sites) (Jul-Sep 2012)	20,782 (n=22 SBM-R supported sites) (Oct 2011 –Sep 2012)		

districts.	source: MOHCW,2009	districts; for Mutare reporting period is Jan-Sep 2011; for Chimanimani period is Oct 2010-Aug 2011	(Mutare) and 2467 (Chimanima ni) n=as described in note above	7,308(Mutare) and 2,265(Chimanima) (Jan-Mar 2012)	and 2,479(Chimanima) (Apr-June 2012)	13, 049 (10,524 in Mutare and 2,525 in Chimanimani) (Jul-Sep 2012)	44,306 34, 570 (Mutare) and 9,736 (Chimanimani) (Oct 2011 -Sep 2012)		
2.17 % of MCHIP SBM-R facilities meeting set performance and quality targets for pneumonia case management	New indicator introduced in Year 2	New indicator introduced in Year 2	n/a	n/a	n/a	n/a	9/21 = 43% HFIs (Oct 2011-Sep 2012)	60% (n=20 HFIs in 2 learning districts)	
OBJECTIVE 3: Improve the coverage and quality of high-impact MNCH/FP interventions provided by health care workers in the community, including VHWs and other agents									

3.1 # of VHW trainers trained in MNCH	# of VHW trainers trained in MNCH with MCHIP support. Data will be disaggregated by sex (male/female) when reporting.	0	0	0	23 (16 females and 7 males)	0	0	0	23 (16 females and 7 males)	0	23 (16 females and 7 males)	10 (to be selected from MCHIP supported districts in Manicaland)	No TOTs were held for VHW trainers during Q3 and Q4.
To be disaggregated by gender (male/female)													
3.2 # of VHWs trained in community MNCH	# of VHWs trained in community MNCH services (e.g., cIMNCI) within MCHIP supported districts. Data will be disaggregated by sex (male/female) when reporting.	0	297 (248 females and 49 males)	215 (197 females and 18 males)	0	0	0	0	370	450 (to be selected from catchment areas of the 17 SBM-R supported HFs in 2 learning districts)	450 (to be selected from catchment areas of the 17 SBM-R supported HFs in 2 learning districts)	There were no VHW trainings during Q3 and Q4.	
To be disaggregated by gender (male/female)													
3.3 # of pregnant women receiving at least two ANC home visits	# of pregnant women receiving at least two ANC home visits from MCHIP supported VHWs in MCHIP learning sites.	0	179 (n=4 out of 22 SBMR supported sites)	714 (n=18 out of 22 SBMR supported sites) (Jan – Mar 2012)	593 (n=15 out of 22 SBMR supported sites) (Apr-June 2012)	728 (data from 17 SBM-R supported sites)	2,214 (n=4 of 22 SBMR supported sites for Oct 2011-Dec 2011; n=18 of 22 SBMR supported sites for Jan –Mar 2012; n=15 of 22 SBMR supported sites for Apr –June 2012)	2,400 (from catchment area of 17 SBM-R HFs in the 2 learning districts)					
New indicator introduced in Year 2													

3.4 # of newborns receiving a postnatal home visit within the first 3 days of delivery	# of newborns visited within the first 3 days of life by MCHIP supported VHWs in MCHIP learning sites.	0	New indicator introduced in Year 2	61 (n=4 out of 22 SBM-R supported sites)	170 (n=18 out of 22 SBMR supported sites (Jan –Mar 2012))	234 n=15 out of 22 SBMR supported sites (Apr-June 2012)	479 (data from 17 SBM-R supported sites)	944 (n=4 of 22 SBMR supported sites for Oct 2011-Dec 2011; n=18 of 22 SBMR supported sites for Jan –Mar 2012; n=15 of 22 SBMR supported sites for Apr –June 2012)	2,400 (from catchment area of 17 SBM-R supported HF in the 2 learning districts)	
3.5 # of cases of malaria treated by VHWs in children under 5	# of cases of malaria treated by VHWs in children under 5 in MCHIP learning districts.	0	New indicator introduced in Year 2	0	0	499	719 (data from 17 SBM-R supported sites)	1,218	1,080 (from catchment area of 17 SBM-R supported HF in the 2 learning districts)	The Q3 and Q4 figures include both children <5 and adults treated for malaria by VHWs. Data for children <5 only will be provided in FY13.
OBJECTIVE 4. Increase routine immunization coverage in Manicaland province and support the nationwide introduction of pneumococcal vaccine by 2012 and rotavirus vaccine by 2013										
4.1 % of children less than 12 months of age who received Penta 3	# of children less than 12 months who received Penta 3 in MCHIP supported districts, divided by # children <12 months in MCHIP supported districts.	52.1% (Source: Manicaland provincial estimate, ZDHS 2010/11)	6,910/7663 = 90% (n=17 SBM-R HF; denominator = ZIMSTAT 2011 projection)	2,135/2,214 =96% (n=22 SBM-R supported sites)	1,928/2,214 =87% (n=22 SBM-R supported sites (Jan –Mar 2012)	1,934/2,214 =87% (n=22 SBM-R supported sites (Apr –June 2012)	1,628/2,214=74% (n=22 SBM-R supported sites (Jul – Sep 2012)	7,625/8,856=86% (n=22 SBM-R supported sites (Oct 2011 –Sep 2012)	95 % based on census projected data and 60% based on RED head count data	In the previous quarterly report, Q2 coverage statistics were calculated using ZIMSTAT 2011 projected figures in the denominators. In this quarter, ZIMSTAT 2012 projected figures were obtained, and so the
			16,323/18,214=90% (n=79 HF in 2 districts; for Mutare reporting period	3,755/3,546 = 106% (Mutare and 1,042/1,008=103% (Chimanima	4,584/4,554=101% 3,538/3,546=99% (Mutare and 1,046/1,008=	4,733/4,554=104% (3,677/3,546=104% in Mutare and 1,056/1,008=	3,732/4,554=82% (2,754/3546=78% in Mutare 978/1008=97% in Chimanimani)	17,065/18,216 =94%; 12,943/14,184=91% (Mutare) and 4,826/4,032=	(n=100% of Manicaland HF; 2 learning districts + 5 additional	

