



**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT  
BUREAU FOR GLOBAL HEALTH  
OFFICE OF HEALTH, INFECTIOUS DISEASE, AND NUTRITION  
USAID/GH/HIDN**

**GUIDANCE FOR  
DETAILED IMPLEMENTATION PLANS (DIPS)  
FOR PVO CHILD SURVIVAL AND HEALTH PROGRAMS  
FY 2004**

**CHILD SURVIVAL AND HEALTH GRANTS PROGRAM  
Revised September 2003**

GH/HIDN is grateful for the many contributions to this document from public health specialists consulted through the ORC/Macro International Child Survival Technical Support Project (CSTS+), other USAID-funded contracts, offices of USAID and PVOs.

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## **I. Introduction/Purpose**

The guidance set forth in this document serves to assist those grantees (PVOs) who were awarded cooperative agreements as a result of the FY 2003 Child Survival and Health Grants Program RFA, in drafting Detailed Implementation Plans (DIPs). In keeping with changes made to the DIP review process last year, including a Child Survival and Health Mini-University/DIP Review event, the due date for the final DIP is **June 30, 2004**, with a first draft submitted by April 30, 2004 for review and comment. In addition to this guidance, PVOs should utilize the CSHGP's "Technical Reference Materials" (TRMs) which describe the important elements of the child survival and health interventions and several cross cutting strategies. Both the TRMs, as well as the DIP guidance should be part of the PVO resource materials and institutional memory and utilized by the PVO.

The DIP should provide results of baseline assessments, measurable objectives for results to achieve by the end of the project, changes in program interventions or strategies, with a revised budget (if applicable) based on those studies, the overall approach to each technical intervention, and a detailed work plan including major activities and time frames for the life of the project. Thereafter, annual work plans and budgets should be provided (by October 31 of each project year) to the appropriate Cognizant Technical Officer (CTO) for approval. At the time of the DIP submission, a PVO may submit a request for changes in the selection of interventions and implementation strategies from what was proposed in the original Cooperative Agreement, with a clear and sufficient justification for the changes. For PVO programs considering a major change to a Family Planning or Tuberculosis component (e.g., a change in intervention selection or level of effort), PVO key personnel should first consult with the CTO before submitting a request for a change in the DIP.

The DIP, including the detailed work plan, will be used by the CSHGP team to monitor progress in program implementation. It should also serve as the working document for the PVO field staff, guiding day to day implementation and keeping the program on track towards achieving stated targets and results. It is expected that the PVO program will be implemented according to the approved DIP. Any further changes in the program description after the DIP has been approved, such as the interventions, site, or beneficiaries, must be proposed to and approved by the CTO and the USAID Agreements Officer prior to implementing the changes.

Last year's changes to the DIP guidance were based on input from PVOs in various forums (e.g., the CORE Group meeting and the FY 2003 RFA post-conference meeting), CSHGP and CSTS team members. Further input was received from DIP writers and implementers during the FY 2003 DIP Review Process and CSH Mini-University. The intention of this new version is to ensure that the final product is a technically sound document, used as a management and implementation tool. The final DIP submitted to USAID/W should contain, at a minimum, only that information requested in this guidance, however, a PVO may include, in the attachments, any additional information they feel relevant to the program, but not included in the guidance.

The PVO should utilize the CSHGP TRMs, as they are a key to ensuring that the proposed technical interventions are based on internationally accepted standards and approaches.

## **II. DIP Preparation and Review Process**

The DIP preparation and review process is intended to enhance the quality of PVO child survival and health programs. Specifically, the process provides the opportunity to:

- collect baseline quantitative and qualitative data to inform program priorities and strategies;
- create a shared vision among all program partners and strengthen partner relationships;
- revise, if necessary, and refine program goals, objectives and indicators;
- strategize on major interventions;
- plan critical project tasks and activities;
- clarify roles and responsibilities of implementing groups; and
- prioritize planned activities.

All these elements should be part of a deliberate effort to develop the project's strategy with a view of maximizing the prospect for sustained child health improvements beyond the project timeframe. Collaboration and effective partnerships are a necessary first step in this effort.

Generally, the PVO and its local partners develop the DIP collaboratively at the field level. Many PVOs have found that conducting a "planning workshop" with the appropriate stakeholders greatly facilitates the "buy-in" of those groups into the goals and objectives of the program, as well as facilitating implementation. The workshop is an opportunity to review the findings of baseline surveys and develop key sections of the DIP. Translation of the DIP into the local language and distribution of copies of the DIP (or key parts) to all partners and staff members involved in project implementation is encouraged. This facilitates the full participation of all staff in the program and serves as a "common road map" to guide the program towards achieving its goals and objectives.

Including partners and other stakeholders in the DIP process has in some instances led to the creation of a "technical advisory group," which then meets, on a regular basis, during the implementation phase, to review progress and to advise on project implementation. These advisory groups can tap into national and regional technical expertise (universities, the MOH at a national level, UNICEF, WHO, local USAID Mission, other bilateral partners, etc.) to provide input and oversight on the design phase, continuing throughout the project.

### **DIP Review Process:**

For FY 2004 grantees, PVOs are again invited to participate in a face-to-face DIP review as part of an integrated technical workshop or "Child Survival and Health Mini-University." This past year, the first Mini-University was held during the week of June 2-6, 2003 at Johns Hopkins University, Bloomberg School of Public Health. It was generally perceived as a success, as it provided PVOs the opportunity to learn about other CSHGP programs, as well as exposure to technical information that was relevant to their programs.

For participation in the Mini-University event, PVOs are encouraged to send one headquarters staff (i.e., the HQ Technical Backstop), the field-based project manager, and a local partner to the extent that this is feasible (budget realignment may be necessary and will be supported). All sessions will be conducted in English, so PVOs should take this into consideration when selecting their team. Please notify the CSHGP team (Technical Advisor) no later than **March 1, 2004** of how many representatives will attend. Specific names of attendees will be requested closer to the date of the Mini-University. If you foresee any problems in having at least one representative at this event,

please contact the CTO so that other arrangements can be made.

This DIP Review format, with the Mini-University event, benefits the PVO as it allows for interaction between the PVO, CSHGP team and other technical experts, to assist in the finalization of the DIP while also providing an opportunity for technical updates. The Mini-University event is scheduled to coincide with the annual Global Health Council meeting (planned for June 1-4, 2004 in Washington, DC) and is **tentatively set for June 7 - 11, 2004 in Baltimore, MD.**

Topic areas for the Mini-University sessions are identified based on an analysis of the interventions and strategies included in the funded applications for grantees writing DIPs. The CSTS+ Project will also send out queries on areas of interest for inclusion as Mini-University sessions, early in the year.

In preparation for the Mini-University DIP review, PVOs are required to submit a **DRAFT DIP by April 30, 2004, at least 4 weeks prior to the workshop.** It is expected that this “draft” will be as close to final as possible, and provide sufficient information for reviewers to understand the project design, baseline data and implementation approaches to key interventions. This draft will be reviewed by the CSHGP team and technical experts and will serve to help Mini-University presenters and facilitators to fine tune the sessions they are preparing. Reviewer comments will be provided to participants by the week before the Mini-University and then discussed, as needed, depending on the work done in the intervening month since DIP submission (the PVO should continue to work on the DIP during the month of May if necessary).

The purpose of the workshop is for grantees to consult with technical experts and colleagues through panel presentation and sessions; to assist with fine-tuning selected CSH interventions in terms of programming and technical content; and to hold consultative discussions with representatives from the CSHGP team, CSTS+, CORE, USAID/Global Health and its Collaborating Agencies, PVO peers and other technical experts. Final approval of the DIP could occur during the Mini-University workshop or, based on comments and suggestions made during the workshop, the PVO team may opt to revise the DIP, consult with partners and then submit a final version to the CSHGP team by **June 30, 2004.**

To enhance opportunities for cross-learning between grantees, the CSHGP will encourage at least one representative from each DIP-writing organization to serve as a peer reviewer for another organization’s DIP. This responsibility will include review of that organization’s DIP during the month of May, submission of written comments by May 31, and participation in the corresponding DIP presentation at the Mini-University.

The Mini-University will include:

- ◆ Opportunities for presentation/peer review of DIPs by region (e.g., all the AFR projects will get a chance to hear, at a minimum, about other projects in the region).
- ◆ Technical Updates on intervention areas that are addressed in DIPs. At present, it is envisioned that these updates will feature:
  - Basic components of the TRMs
  - Observations from the DIPs reviewed
  - Dialogue/Q&A between DIP submitters and technical experts.
- ◆ Management and M&E related sessions targeted to common issues across DIPs in these

areas.

- ◆ Opportunities for DIP writers to meet one on one with individuals who have reviewed their documents to discuss specific comments.
- ◆ Approval-decision meetings, in which each grantee's team will meet with CSHGP to discuss specific next steps required for submission and approval of the final DIP.

As a reminder, the DIP review process does not serve to make funding decisions about the PVO's program, since DIPs are required only for already funded programs. Upon returning to the field, it is hoped that the results of the workshop will be shared with the field staff and partners, to provide feedback to those involved in the program and its planning process.

PVOs are reminded that participation in the Mini-University is not a requirement; however, draft DIPs are due on April 30, 2004, and PVOs are strongly encouraged to participate as it is an excellent opportunity to learn and share with others. PVOs may also consider having a telephone conference review, or having the review in a venue other than the Mini-University which can be negotiated with USAID. Grantees choosing not to participate in the Mini-University are asked to contact USAID by March 1, 2004, so that DIP presentations scheduled for the Mini-University can be finalized. Regardless of which option the PVO selects for the DIP review, the CSHGP staff will send a formal letter to the PVO stating DIP approval status.

### **III. Submission Instructions**

#### 1. General formatting instructions:

- On the DIP cover page, please include the following: name of PVO, program location (country and district), cooperative agreement number, program beginning and ending dates, date of DIP submission, and (on the cover or on the next page) the names (including consultants) and positions of all those involved in writing and editing the DIP.
- Include in the body of the DIP other relevant aspects of the program that may not be covered in the DIP Guidance. Please include enough detail so that the intervention is clear. This will enable reviewers to provide meaningful feedback.
- If a topic in the DIP Guidelines does not apply to the program, please indicate this in the DIP. If the program has not yet obtained sufficient information to fully describe an element, then describe plans to obtain this information.
- Limit annexes to those that are essential to understand the program (See Section V). All annexes should be in English or accompanied with a translation. One annex should include a copy of the jointly developed and signed agreements, which clearly delineate the roles and responsibilities of each partner. An organizational chart for the project may be helpful to illustrate the various partner roles.
- Use a 12-point font that is clearly legible.

2. Complete the online CSHGP Project Data Form for each project. This form includes the template for reporting on the Rapid Catch indicators with standard definitions. The form can be found at <http://www.childsurvival.com/projects/dipform/login.cfm>. A password has been assigned to each PVO in order to access and enter project information (and can be used to access all child survival projects for a given PVO). To obtain a PVO password, please contact the CSTS Project directly at (301) 572-0823, or send an email to [csts@orcmacro.com](mailto:csts@orcmacro.com). Detailed information on completing the form is available through individual 'Help File' links.
3. A draft DIP is due at GH/HIDN/CSHGP on or before **April 30, 2004**. The draft DIP should be as close to a final version as possible, and provide sufficient information for reviewers to understand the project design, baseline data and implementation approaches to key interventions. An unbound, single-sided hard copy of the draft (including attachments) should be sent to USAID/CSHGP as well as an electronic copy. Also, send an electronic copy (with attachments, if possible) to CSTS.
4. The final project DIP is due at GH/HIDN CSHGP on or before **June 30, 2004**. Failure to submit a DIP on time to USAID could result in a material failure, as described in 22 CFR 226.61. If there are circumstances beyond the PVO's control that have had an impact on the ability to complete the DIP on time, please contact the CSHGP Technical Advisor or CTO (see attached responsibility list).
5. Send GH/HIDN/CSHGP, on or before **June 30, 2004**, the original and two (2) copies of each field program DIP, and one diskette of the DIP in Microsoft Word 97. The original hard copy of the DIP should be one-sided and unbound. The two hard copies of the DIP should be double-sided and bound separately. DIP annexes that are available in hard copy and not on disk may be excluded from the version submitted on diskette. Address to:

Attention: Susan Youll  
 USAID/GH/HIDN – Child Survival and Health Grants Program  
 Room 3.7-074  
 Washington, DC 20523-3700

5. Send CSTS, on or before **June 30, 2004**, a one-sided unbound copy and an electronic copy (by email, CD-ROM or diskette) to:
 

Attention: Deborah Kumper, Administrative Assistant  
 ORC MACRO – Child Survival Technical Support Project (CSTS)  
 11785 Beltsville Drive  
 Calverton, MD 20705  
[Deborah.K.Kumper@orcmacro.com](mailto:Deborah.K.Kumper@orcmacro.com)
6. Send one copy of the DIP to the concerned USAID Mission on or before **June 30, 2004**.
7. In accordance with the USAID AUTOMATED DIRECTIVES SYSTEM (ADS) 540.5.2, please submit, on or before **June 30, 2004**, one electronic copy of the **final** DIP to the USAID/PPC/CDIE Development Experience Clearinghouse (DEC). Please include the Cooperative Agreement number on the electronic DIP submission. Electronic documents can

be sent as e-mail attachments to [docsubmit@dec.cdie.org](mailto:docsubmit@dec.cdie.org). For complete information on submitting documents to the DEC, see <http://www.dec.org/submit/>.

#### IV. DIP Guidance

The following sections should be included in the DIP.

##### A. Executive Summary

The Executive Summary from each DIP is used by GH/HIDN as an informational document for decision-makers, Congress, public inquiries, the press and others. Therefore, this section should contain the information that the PVO believes best represents its program. The executive summary is limited to two pages and should briefly include **all** the following (essentially cut and paste from the original application – with changes, if any):

- *Program location.*
- *Problem statement.*
- *Estimated number of beneficiaries, broken down by children under five and women of reproductive age. For TB, estimate the population that will be covered by DOTS and the estimated number of TB cases in the area. For FP, estimate the population of the target group by category (i.e., WRA, men, youth).*
- *Program goals, objectives and major strategies.*
- *A break down of the estimated level of effort devoted to each intervention using the list of interventions in Section I of the FY 2004 RFA (e.g., immunization – 30%, control of diarrhea disease – 45% and pneumonia case management – 25%. If IMCI is proposed, do NOT list as IMCI X%, rather break out the component interventions and list as above, stating that IMCI will be used as a strategy).*
- *Indicate any proposed Operations Research and/or anticipated documentation strategy for the project.*
- *Local partners involved in program implementation, including roles and responsibilities.*
- *The category of the original CSHGP application (entry, standard, cost extension, mentoring or expanded impact).*
- *The start and end dates.*
- *The level of funding.*
- *Name and position of the local USAID Mission representative with whom the program has been thoroughly discussed.*
- *Main writers of the document.*
- *Contact person at PVO headquarters for the program.*

##### B. CSHGP Data Form

**Please include a copy of the completed on-line form, including the Rapid CATCH indicators, and place it after the Executive Summary.** See “Submission Instructions”, #2 (on the previous pages) for details on how to complete the form on-line. **For 100% TB programs, use**

**the indicated TB indicators, not the Rapid Catch indicators.** These indicators can be found in Attachment C along with a description of how to use the indicators.

### **C. Description of DIP Preparation Process**

Briefly describe the steps taken to prepare this DIP, as well as project start-up activities which have taken place since the award, including baseline studies. Include a list of the staff, partners and various stakeholders who participated in planning, the methods used, the number of days spent on DIP preparation, and planned follow-up activities.

### **D. Revisions (from the original application)**

Describe the changes made in the DIP from the proposed application, if applicable. For PVO programs considering a major change to a Family Planning or Tuberculosis component (e.g., a change in the selection of an intervention, or the level of effort), PVO key personnel should first consult with the CTO before submitting a request for change in the DIP. If there are changes in the program description (including goals and objectives), budget, site, additions or deletions of child survival or health interventions, please state these changes and describe the rationale for any changes between the corresponding sections in the Cooperative Agreement and those discussed in the DIP. Include in the discussion any responses to proposal review comments and, if applicable, final evaluation recommendations.

- If there have been changes to the program's site, location, selection of interventions, number of beneficiaries, international training costs, international travel plans, indirect cost elements, or the procurement plan that have budget implications, include a revised budget with the DIP. The revised budget is to be submitted on revised Forms 424 and 424A with supporting information on all cost changes.
- If there have been no changes, please state this, and do NOT submit a revised budget.

### **E. Detailed Implementation Plan**

Based on the original proposal and a more in-depth analysis/assessment of the health situation at the project site, describe: the overall program monitoring and evaluation plan (see #1 below); a summary of the baseline studies (#2); proposed goal, objectives, and more in-depth description of technical interventions and activities (#3); and a work plan table (#4) which provides a snap shot at any given time, of the activities, timeframes, persons responsible, etc. for each intervention/activity.

#### **1. Summary of Baseline and Other Assessments**

Provide a summary of the findings of baseline assessments and other quantitative/qualitative analysis carried out that support the proposed interventions/strategies. Include a discussion of any programming priorities identified and/or confirmed as a result of the findings from the baseline assessments and what implications these may have for selected child survival and health interventions, budget, staffing, etc. Describe any differences between the population proposed in the original application and the population now targeted in this DIP. Include the baseline survey report(s) in an annex to the DIP.

- Briefly describe the types and methodology of baseline assessments conducted by the project, both qualitative and quantitative. Examples of baseline assessments may include, but are not limited to, a census, a population level baseline survey (i.e., KPC survey), a health care providers assessment (i.e., during a facility assessment or a health worker competency survey), a PVO and or partner capacity assessment. If completed, include baselines of PVO and local partner capacity. Discuss the sampling technique and interview process used for the baseline assessments.
- Compare baseline findings with the current country context and describe any differences. Analysis should address relevant information on the current health status of the target population, which may include under-five and maternal mortality rates, nutritional status, major causes of mortality and morbidity, or other intervention specific indicators. Please cite sources of data.
- Discuss the constraints to achieving program objectives based upon the local or country context.
- Give the most up-to-date coverage estimates in the service area relevant to each intervention. Use intervention specific statistics (e.g., include the DPT drop-out rate for EPI).
- Provide the most recent disease surveillance data available for the program area, and discuss the quality of the data, including the completeness of reporting.
- Discuss MOH policies, strategies and/or case management policies or current services for each intervention.
- Describe overall quality of existing services including client-health worker interaction, standard case management and availability of drugs.
- PVOs should consider collecting **all Rapid CATCH** (CORE Assessment Tool on Child Health) **Indicators** as part of the baseline assessment. The rationale for this recommendation is that even if some of the CATCH indicators do not relate specifically to project interventions, they provide information on critical, life-saving household behaviors and care-seeking patterns that assist projects in program management and decision-making. For final evaluations, the program may opt to collect only those indicators relevant to its program objectives and activities. Collection of data on indicators at the Mid-term evaluation, in order to monitor progress on objectives, is optional. It is suggested that in order to collect these indicators, PVOs conduct a population level baseline survey, using the KPC2000+ which includes the Rapid CATCH, and is available on line at: <http://www.childsurvival.com/kpc2000/kpc2000.cfm>.

**NOTE: Programs that are exclusively TB or FP in focus, or which have a mixture of either TB or FP with traditional CSH interventions, should speak to the Primary Contact or CTO before proceeding. As TB and FP are relatively new interventions, indicators are still being developed. A KPC module for TB will not be available until 2004.**

- Send the Rapid CATCH data (all records for each indicator) electronically to CSTS+ (csts@orcmacro.com) and include a paper copy as an annex to the DIP with the average value for each indicator.

USAID/GH/HIDN believes that collecting, analyzing, interpreting, using and sharing this information (specifically, the Rapid CATCH data) has the potential to save the lives of children and mothers, and USAID will use the data for results reporting and to examine trends across the CSHGP portfolio of child survival grants. This information will be essential to ensuring continued support for the program from Congress and tracking changes in child health. **PVO programs will not be held accountable for achieving progress on indicators for which they have not proposed specific interventions.**

## **2. Program Description by Objective, Intervention and Activities**

Based on the above assessments, and the applicant's original proposal, provide program objectives and explain how these objectives assist with achieving the CSHGP's Intermediate Results. Under each objective, describe the CSH interventions and activities that will be implemented to achieve the objective. In addition to the guidance provided below, please refer to the Technical Reference Materials (TRMs) as a reference guide for specifics for each intervention area.

### **INTERVENTION SPECIFIC APPROACH**

Under each intervention area, please address the following (as applicable).

#### **Behavior Change & Communication**

- Based on the recent KPC and other assessments discuss, how current beliefs, knowledge and practices and care-seeking behaviors of mothers, families and other caretakers and healthcare providers, will influence each technical intervention and how the program will work to influence change in those behaviors which negatively impact on the health of women, children and other affected populations.
- Describe how information from the research will be used to contribute to the change of practices and behaviors.
- Activities that will be carried out to facilitate the behavior change at each level from policy to community and individual.
- Describe the training and supervision that will be undertaken and how this relates to the capacity building of the partners.
- Discuss which behavior changes are to be sustained and how the interventions may contribute to their sustainability.

#### **Quality**

- Provide examples of how Quality Assurance (QA) methods will be applied for each intervention.
- Discuss how quality will be addressed in the partnerships that are formed.
- Describe the training and supervision that will be undertaken to promote quality of services delivered.
- Discuss how improvement in quality of services and products will be sustained.

**Access: (1) Services; (2) Health-Related Products (Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.)**

- What commodities are essential to the success of the intervention?
- Discuss how reliable the supply of essential commodities is now and how the supply will be ensured during the life of the program, including the source from which the program will obtain supplies (such as antibiotics, vaccines, micronutrients, etc.).
- Discuss likely constraints to the success of “supply” activities and approaches to overcome these constraints.
- Discuss how the supply will be sustained after the end of the program.
- Describe how the quality of supplies will be monitored (e.g., cold chain maintenance and monitoring).
- Discuss how the program will ensure safety (i.e., disposal of syringes and sharps, avoiding misuse of antibiotics, safe use of insecticides for re-dipping nets).
- Describe the training and supervision that will be undertaken and how this will work to build the capacity of partners to improve access in all areas.
- Discuss how improved access will be sustained in selected interventions.

**3. Program Monitoring and Evaluation Plan:**

- Describe the current information system in the target area (community, district, region, etc.) and how/if the project’s HIS will differ. Describe points of overlapping data and how data will be integrated. Discuss how facility-based data will be combined with community-based data.
- Describe the monitoring tools which will be used (such as PRA, PLA, other participatory methods, LQAS, ISA, QA, others), the tools developed by the project (if any), who will develop the tools, and who will field test the tools and produce them.
- Describe how the data will be collected by including the following descriptions:

- (a) Sources of data (e.g., facility-based records, household surveys, rosters, etc.)
  - (b) Process to determine the population denominator and how eligible women, children, newborns and others will enter and participate in the program.
  - (c) System for data collection including frequency, sources, process, and how the process will be supervised to ensure data quality.
  - (d) Indicate how program staff (including that of PVO and partners) and beneficiaries will participate in data collection.
- Describe how and by whom data will be analyzed and used to monitor program progress, improve program processes and program performance. Describe how the results will be shared and used with the stakeholders and partners (e.g., district level health officials, MOH authorities, PVO home office and the larger PVO community). Specify how results may be used for advocacy in-country or internationally. Discuss how the community/beneficiaries will use the data and benefit from it.
  - For programs that strengthen health worker performance, describe the methods that will be **used to monitor and improve the performance of health workers** and the quality and coverage of intervention activities (including those carried out in cooperation with other organizations).
  - Discuss the project's plans for on-going assessments of essential knowledge, skills, practices and supplies, pharmaceuticals and equipment of health workers and facilities associated with the project, and the use of findings to improve the quality of services.
  - Describe **the tools to be used by the project to promote quality of service** (such as guidelines, training curricula and manuals, protocols, algorithms, performance standards and supervisory checklists, etc.). Briefly describe how these tools will be used to assess and improve performance.
  - Describe how M&E skills of local staff and partners will be assessed and strengthened.
  - Discuss operations research ideas that will be carried out during the program.
  - For TB programs, keep the following in mind:
    1. The primary target group is infectious adults, not children.
    2. Internationally recognized indicators and standardized reporting, monitoring and evaluation criteria have been established by WHO and should be used.
    3. The development or strengthening of the TB information system should not be done independently of the MOH health information system.

#### **4. Work Plan (Table):**

The “table” should facilitate easy monitoring of specific program activities. USAID believes that the work plan is a working document, for use as a tool throughout the implementation of the project. The PVO may use its organization’s table format; however, it should include the following detailed information (a sample work plan template is provided in Attachment A):

- The results-based objectives for selected child survival and health interventions;
- Indicators used to measure program objectives and method(s) of measurement;
- Major activities planned by level (i.e., household, community, health facility, district, etc.) with identified target groups;
- Specific time frames for the implementation of major activities;
- Responsible personnel identified from PVO and partners;
- Benchmarks and targets for activities including any tools and/or existing resources to be used to monitor progress towards objectives and targets; and
- Status on these activities is to be reported on in Annual Reports. (See Work Plan Template in Attachment A).

## V. Annexes

1. Response to Application Debriefing: Discuss the weaknesses identified in the debriefing package summary score-sheet and external reviewer comments, and how they will be addressed in the program. Attach a copy of the summary score sheet and the external reviewer comments in this Annex.
2. Response to Final Evaluation Recommendations (if applicable): If this is a DIP for a cost extension, and a final evaluation has been completed, describe how the program is addressing each of the recommendations made in the final evaluation. Reference the section of the DIP that addresses each recommendation.
3. Report of baseline assessments: Include a description of the methods employed, and copies of questionnaires and other tools used during the baseline assessment.
4. Agreements: Memorandums of Understanding, agreements, or Terms of References signed with other organizations.
5. Resumes/CVs and job descriptions of key personnel at HQ and in the field: (if different from application). Also, include the current hiring status of all staff.
6. Other Annexes: (as necessary)  
Maps, RAPID CATCH summary data (use reporting template), Organizational Chart

**ATTACHMENT A**  
**SAMPLE WORKPLAN TEMPLATE**

Program GOAL: \_\_\_\_\_

Child Survival or Health Intervention (and % Level of Effort): \_\_\_\_\_

<b>Objective #1:</b>					
<b>Indicators (with Measurement Method):</b>					
Indicator #1 – (i.e., <i>percentage of children aged x to y months who...</i> ) (Measurement Method)					
Indicator #2 (Measurement Method)					
<b>Major Activities</b>	<b>Activity Focus <sup>1</sup></b>	<b>Time Frame</b>	<b>Personnel</b>	<b>Benchmarks/ Targets</b>	<b>Status/ Comment <sup>2</sup></b>

<b>Household</b>					
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
<b>Community</b>					
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
<b>Health Facility</b>					
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	
<b>District</b>					
Activity	A, BC or Q	Dates	Staff	Benchmark/Target	

**<sup>1</sup> Which of these does the Activity address: A=Access; BC=Behavior Change; or Q=Quality**

**<sup>2</sup> To be completed for Annual Reports**

- **NOTE:** Try to keep objectives comparable to internationally accepted ones. See the KPC 2000 Modules and Technical Reference Materials for sources of recognized indicators.

**Other resources:**

PVC RFA 1999 Results Framework Overview (Powerpoint)

<http://www.childsurvival.com/documents/ppt/results/index.htm>

KPC Field Guide, August 2001, p. 3-5 for an example of Objectives and Indicators within a Results Framework for a Child Survival Intervention

<http://www.childsurvival.com/documents/ppt/results/index.htm>

CSHGP Project Start-Up Hints, June 2003, from Mini-University at Johns Hopkins

<http://www.childsurvival.com/documents/workshops/MiniUniversity/PROJECTS/TART-UP.ppt>.

## ATTACHMENT B

### USAID PRIMARY CONTACTS & CTO

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India	Tom Hall	Susan Youll
Indonesia	Tom Hall	Susan Youll
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Kyrgyzstan	Tom Hall	Susan Youll
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## ATTACHMENT C

### TB Indicators

This is the first year that Detailed Implementation Plans (DIP) will be developed for tuberculosis prevention and control activities as part of the Child Survival and Health Grants Program. Traditionally, the Rapid Catch and the KPC Survey have played an important role in the monitoring and evaluation process of these grants. However in TB prevention and control the primary target population is infectious adults, therefore the current structure of the Rapid Catch & the available KPC Survey modules are not appropriate for TB programs.

Listed below is a set of indicators to be used in the development of DIPs and the monitoring and evaluation of TB programs funded as part of the FY03 cycle. More comprehensive indicator guidance will be available in 2004. Please note the following guidance based on the composition of the proposal.

#### *Complete TB proposals*

- Programs that are 100% tuberculosis in focus should not conduct the Rapid Catch or the KPC Survey at this time.
- The program should use the indicators under Sections I and II.
- If the proposal includes an IEC component that educates the public on the general signs and symptoms of TB the indicators in Section III should be collected as well.

*Partial TB proposals*

- Proposals that are not 100% in focus will need to conduct the Rapid Catch and the appropriate KPC to address the non-TB aspects of the program.
- Given that the Rapid Catch will be conducted the indicators under Section III should be collected.
- The program should use the indicators under Sections I and II.

The indicators under Sections I and II should be collected as part of a routine National TB Program (NTP). Programs that are not directly addressing these issues will need to coordinate with the appropriate counterparts at the NTP to obtain this data.

### TB Indicators

Indicator	Calculation	Data Source	Level	Periodicity
<b>Section I</b>				
% of new smear positive cases who were successfully treated (Treatment success rate)*	<i>Numerator:</i> Number of new smear positive cases who were cured plus the number of new smear positive cases who completed treatment <i>Denominator:</i> Total number of new smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
Case detection rate (per WHO formula, and adjusted for HIV)	<i>Numerator:</i> Number new smear-positive registered TB cases <i>Denominator:</i> Estimated number of new smear-positive TB cases	Quarterly reports on new cases and relapses (form TB-07) and WHO estimates	National Province	Annual

Indicator	Calculation	Data Source	Level	Periodicity
<b>Section II. Cohort Indicators</b>				
% of new smear positive cases cured (Cure rate)	<i>Numerator:</i> Number of new smear positive cases who were cured <i>Denominator:</i> Total number of new smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
% of new smear-positive cases who completed treatment (Completion rate)	<i>Numerator:</i> Number of new smear-positive cases who completed treatment but does not meet the criteria for cure or failure <i>Denominator:</i> Total # of new smear-positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
% of new smear positive cases who died (Death Rate)	<i>Numerator:</i> Number of new smear positive cases who died during treatment <i>Denominator:</i> Total number of new smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
% of new smear positive cases who were failures (Failure rate)	<i>Numerator:</i> Number of new smear positive cases who remain or become smear positive again at 5 months or more of treatment <i>Denominator:</i> Total # of cases new smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
% of new smear positive cases who default (Default rate)	<i>Numerator:</i> Number of new smear positive cases who default <i>Denominator:</i> Total number of new smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
% of new pulmonary smear positive cases who were transferred to another district (Transfer-out rate)	<i>Numerator:</i> # of smear positive cases who transferred to another health facility outside the district with a proper referral/transfer slip <i>Denominator:</i> # of smear positive cases registered	Quarterly report on treatment results (Form TB-08)	National Province District	Quarterly Annual
<b>Section II I</b>				
Proportion of population who are aware of at least 2 symptoms of TB	<i>Numerator:</i> # of people who correctly identified at least 2 symptoms of TB <i>Denominator:</i> Total # of people surveyed	Population Survey	National Province District	1-5 years
Proportion of population who know that TB is a curable disease	<i>Numerator:</i> # of people who correctly answered that TB is a curable disease <i>Denominator:</i> Total # of people surveyed	Population Survey	National Province District	1-5 years

