



**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 CHILD SURVIVAL AND HEALTH GRANTS
FY 2007**

**CHILD SURVIVAL AND HEALTH GRANTS PROGRAM
Revised October 2006**

TABLE OF CONTENTS

I.	INTRODUCTION/PURPOSE.....	1
II.	DIP PREPARATION AND REVIEW PROCESS.....	2
III.	SUBMISSION INSTRUCTIONS	5
IV.	DIP GUIDANCE.....	8
	A. Executive Summary	8
	B. CSHGP Data Form	8
	C. Description of DIP Preparation Process	9
	D. Revisions (from original application)	9
	E. Detailed Implementation Plans:.....	9
	1. Program Site Information	9
	2. Summary of Baseline and Other Assessments.....	10
	3. Program Description	12
	4. Intervention Specific Approach	15
	5. Program Monitoring and Evaluation Plan	16
	6. Program Management	18
	7. Organizational Development (for Entry/New Partner Grantees)	19
	8. Training Plan.....	20
	9. Work Plan and Table	20
V.	ANNEXES TO THE DIP	21
	ATTACHMENT A: DIP Review Agenda	22
	ATTACHMENT B: Rapid CATCH Indicators Table	23
	ATTACHMENT C: List of Interventions	24
	ATTACHMENT D: Tuberculosis Indicator Guidance	26
	ATTACHMENT E: Sample Results Framework	28
	ATTACHMENT F: Sample M&E Plan Template	29
	ATTACHMENT G: CSHGP Performance Management Plan	30
	ATTACHMENT H: Sample Work Plan Template	31
	ATTACHMENT I: Sample Behavior Change Strategy	32
	ATTACHMENT J: Beneficiary Calculation	34

I. Introduction/Purpose

The guidance provided in this document serves to assist those grantees awarded cooperative agreements as a result of the FY 2006 Child Survival and Health Grants Program RFA, in drafting Detailed Implementation Plans (DIPs). The due date for the final DIP is **April 16, 2007**. Grantees will receive written feedback on their DIP on or before May 29, 2007. Feedback will be discussed at the Child Survival and Health Grants Program's Mini-University during the week of June 4—8, 2007. At the Mini-University, the CSHGP will approve the DIP or request the grantee to make specific revisions before formal approval is granted.

In addition to this guidance, grantees should utilize the CSHGP's "Technical Reference Materials" (TRMs), which describe the important elements of the child survival and health interventions and are based on international standards. Both the TRMs and the DIP guidance should be part of the grantee's resource materials.

At the time of the DIP submission, a grantee may request to change the selection of interventions and implementation strategies from what was proposed in the original Cooperative Agreement, only with a clear and sufficient justification for the changes. Grantees considering a major change in the Family Planning or Tuberculosis categories should first consult with the Cognizant Technical Officer (CTO) before submitting a request for a change in the DIP. All CTO assignments are noted on Country Reports, which are available at www.childsurvival.com.

The DIP will be used by the CSHGP team to monitor progress in program implementation. It should also serve as the working document for the grantee's field project staff, guiding day-to-day implementation and achievement of stated targets and results. Grantees are committed to fulfill the approved DIP. Any further changes in the program description after the DIP has been approved, including changes to the Project Objectives and Indicators, Intervention Mix (including LOE), Specific Activities, Location of Project, Number of Beneficiaries, Local Partner, and Budget, must be proposed to and approved by the CTO and the USAID Agreement Officer prior to implementing the changes. Annual reports based on the Annual Report Guidance should be submitted by October 31 of each project year to the appropriate CTO for approval. Mid-term and Final Reports should be submitted according to the report guidance provided and timeline agreed upon in the cooperative agreement.

The DIP guidelines have been updated this year to ensure that the final DIP is a technically sound document to be used as a management and implementation tool. The final DIP submitted to USAID/W should contain, at a minimum, the information requested in this guidance. However, a grantee may include any additional information relevant to the program to better facilitate program implementation and monitoring. The grantee may also modify the format of the DIP to allow for less repetition.

II. DIP Preparation and Review Process

Important Dates: DIP Preparation and Submission

April 16: Registration for Program Staff to attend the CSHGP Mini-University Event in Baltimore, MD (at www.childsurvival.com)

April 16: Final DIP Due to CSHGP and CSTS+

June 4—8: CSHGP Mini-University; Baltimore, MD

The DIP preparation and review process is intended to enhance the quality of 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/results, indicators and targets;
- 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 grantee and its local partners develop the DIP collaboratively at the field level. Many previous and current grantees 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:

Grantees will participate in a face-to-face DIP review process as part of an integrated technical workshop or “Child Survival and Health Mini-University.” The Mini University provides technical updates as well as exposure to other CSHGP grantees and their partners. The Mini-University event is **tentatively set for June 4 - 8, 2007 in Baltimore, MD** and is usually scheduled to follow the annual Global Health Council meeting (planned for May 29 - June 1, 2007 in Washington, DC).

In preparation for the Mini-University and DIP review, grantees are required to submit their final **DIP to USAID by April 16, 2007**. The DIP will be reviewed by the CSHGP team and technical experts who will provide comments and feedback to DIP writers the week before the Mini-University.

Topic areas for the Mini-University sessions are identified based on an analysis of the interventions and strategies included in the FY 2006 funded applications. Grantees may also suggest additional relevant technical areas of interest to be addressed by sending ideas to csts@orcmacro.com, with the title “Mini-University Suggestions”. Technical updates, presentations and agendas from past Mini-Universities are available at http://www.childsurvival.com/documents/workshops_1.cfm.

The purpose of the Mini-University is for grantees to consult with technical experts and colleagues through panel presentations and sessions; to assist with improving selected CSHGP interventions in terms of programming and technical content; and to hold consultative discussions with representatives from the CSHGP team, the Child Survival Technical Support Plus contract, USAID/Global Health Bureau and its Collaborating Agencies, NGO/PVO peers and other technical experts. The format of the event changes from year to year, but normally includes DIP review meetings; technical updates on important global health interventions; practical sessions on tools/techniques that are appropriate to community-based programs; and updates on lessons learned and promising practices that are emerging from the larger portfolio of CSHGP Grants.

An approval decision of the DIP will occur during the Mini-University. Based on reviewer feedback, the DIP may be approved, or the grantee may be requested to make revisions to the DIP before final approval is granted. After the Mini University, the CSHGP will send a formal letter to the grantee stating DIP approval status.

Grantees who are preparing a DIP for 2007 will be expected to participate in the following activities at the Mini-University:

- Presentation of their Detailed Implementation Plan at the DIP review meetings. These meetings are attended by CSHGP staff, individuals who have reviewed the grantee’s

DIP, and others who are interested in learning more about the project. Guidelines for preparing these presentations are included in ATTACHMENT A of this document. Grantees will be contacted in April 2007 by a representative from the CSTS+ project to schedule the specific day on which the DIP review meeting will occur during the Mini-University event.

- Peer review of one other DIP in this cohort of grantees. This responsibility will include review of the assigned DIP during the month of May, submission of written comments by May 29, and participation in the corresponding DIP presentation at the Mini-University. Peer reviewers are matched with DIPs for programs that have similar interventions or will be operating in similar countries/regions, and believe that the peer review process is often the first step in building long-term, in-country collaborative relationships between grantees.
- In some cases, participation in a panel discussion. Grantees may be asked to participate in a panel discussion on a specific topic or cross cutting theme related to their grant or to their organization's experience in a specific area. Panel topics are normally confirmed in mid-April. Grantees will be contacted by a CSTS+ representative in early May, 2007 if they will be requested to contribute to a panel discussion.

Grantees are strongly encouraged to send at least one headquarters staff member (i.e., the HQ Technical Backstop), the field-based project manager, and a local partner, to the extent that this is feasible, to the Mini-University for the full five days of the event. If a grantee has not budgeted for this level of participation, budget realignment may be necessary and will be supported by the CSHGP CTO. All sessions will be conducted in English, so grantees should take this into consideration when selecting their team. Please register grantee participants by April 16th at www.childsurvival.com.

If a grantee foresees any problems in having at least one representative participate at this event, please contact the CSHGP CTO so that other arrangements can be made for the DIP review.

The success of and degree of learning accomplished by the Mini University event depends to a large extent on the full and active participation of all partners.

III. Submission Instructions

1. General formatting instructions

On the DIP cover page, please include the following: name of grantee, project location (country and district), cooperative agreement number, project 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 attachments of the DIP other relevant aspects of the project 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. Keep in mind that reviewers of the DIP will not have read the original project application; therefore, the DIP should be considered as a stand-alone document for this DIP review process.

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.

Use a 12-point font that is clearly legible.

2. Complete the online CSHGP Project Data Form for each project

This form is the CSHGP's central source for project data that can be accessed quickly to respond to questions from interested stakeholders about the overall portfolio of grants.

It includes key contact information for the project; a project description, including a description of the project area; information on key project partners and subgrantees; information on key project strategies and activities within each intervention area; information on project beneficiaries; and 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 grantee in order to access and enter project information (and can be used to access all child survival projects for a given organization). To obtain a password, please contact the CSTS+ Project directly at (301) 572-0823, or send an email to csts@orcmacro.com. Detailed information on completing the form is available through individual 'Help File' links.

When you complete this form for your project's DIP, please also check the project data forms for any other CSHGP projects that your organization has, to ensure that they are up to date. The data on the overall portfolio of grants is only as accurate as what your organizations enters into this system.

3. Baseline Assessment and Rapid CATCH Indicators

CSHGP Grantees are required to conduct a baseline assessment of their target site. Grantees (except 100% Tuberculosis and Family Planning) are required to conduct a KPC survey and collect all the **Rapid CATCH** (Core Assessment Tool on Child Health) indicators at baseline and final evaluation stages. See ATTACHMENT B for the required Rapid CATCH indicators. Grantees are required to submit a copy of their survey report and questionnaire in English. CSTS+ staff are available to review survey plans and draft questionnaires.

For grantees implementing Tuberculosis and Family Planning interventions, specific TB and FP indicators are required for collection at baseline and final evaluations.

4. Submit a Final DIP to GH/HIDN/CSHGP on or before April 16, 2007

Submit the Final DIP to GH/HIDN/CSHGP in the form of **one (1)** original and **one (1)** copy, and one diskette or CD in Microsoft Word 2000. The original version of the DIP should be double-sided and unbound. The hard copy should be double-sided and bound. DIP annexes that are available as hard copies should be scanned and included in the electronic version submitted by email or on CD.

Also, please send one double-sided, unbound hard copy, and an electronic copy with attachments, via email or CD, to CSTS+.

Please send one double-sided bound copy to your respective USAID Mission contact in-country for their review.

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 grantee's control that have had an impact on the ability to complete the DIP on time, please contact the CSHGP Technical Advisor or CTO (identified on Country Reports on www.childsurvival.com).

Address DIP to:

Jill Boezwinkle
Attn: Aimee Rose, Program Assistant
USAID/GH/HIDN – Child Survival and Health Grants Program
1300 Pennsylvania Avenue
RRB, Room 3.7-44
Washington, DC 20523-3700

DIPs sent to CSTS+ should be addressed to:
Attention: Deborah Kumper
ORC MACRO – Child Survival Technical Support Plus (CSTS+)
11785 Beltsville Drive
Calverton, MD 20705
csts@orcmacro.com

5. Submit the Final APPROVED DIP to the CSHGP, CSTS+ and the USAID Mission

During the Mini-University, the CSHGP will discuss the approval of the DIP with grantees. Options are: approval with no changes, approval with slight modification, and not approved. For those approved during the Mini-U (with or without modification), please submit one hard copy and one electronic copy each of your Final APPROVED DIP to the CSHGP, CSTS+, and the relevant USAID Mission at the addresses outlined above. For those not approved during the Mini-U, please submit one hard copy to the CSHGP and CSTS+ for review. Once this version has been approved, you may proceed with submission of the electronic version and provide to the Mission.

6. Submit the Final APPROVED DIP to the Development Experience Clearinghouse

In accordance with the USAID AUTOMATED DIRECTIVES SYSTEM (ADS) 540.5.2, please submit one electronic copy of the Final Approved 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. 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 grantee believes best represents its program. The executive summary is limited to two pages and should briefly include all the following:

- Program location.
- Problem statement.
- Estimated number of beneficiaries, broken down by children under five and women of reproductive age. Disaggregate children under five in the following categories: under 12 months, 12-23 months, 24-59 months. Please see Attachment J for guidance in calculating the number of beneficiaries. 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/results 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 2006 RFA. (e.g., immunization – 30%, control of diarrhea disease – 45% and pneumonia case management – 25%.) This list is also included in ATTACHMENT C. 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, expanded impact, TB or FP).
- 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 grantee organization's 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. TB Programs should refer to ATTACHMENT D for guidance on indicator selection. Note: Rapid CATCH indicators do not apply to grants awarded under the TB and FP Categories.

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. The Detailed Implementation Plan should be in line with what was proposed in the application. 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 a supporting budget narrative highlighting all cost changes.

If there have been no changes, please state this, and do NOT submit a revised budget.

E. Detailed Implementation Plan

The Detailed Implementation Plan document should be comprehensive enough to allow the reviewer to have a strong understanding of the program context. If a topic in the DIP Guidelines does not apply to the program, please indicate this. If the program has not yet obtained sufficient information to fully describe an element, then describe plans to obtain this information. Based on the original proposal and a more in-depth analysis/assessment of the health situation at the project site, the DIP should include the following information:

1. Program Site Information

This information expands on that provided in the application.

- a. Please include in an annex, a legible map showing the location of the program impact area(s) relative to other regions of the country, and the program area itself. To the extent possible, label towns, existing hospitals, health centers, clinics, and/or health posts.
- b. State the estimated total population living in the project site. What are the totals of target beneficiaries? (i.e. number of infants, 0-59 month old children, women 15-49)

year old). Please disaggregate children under five in the following categories: under 12 months, 12-23 months, 24-59 months. See Attachment J for guidance, and include an explanation of the calculation, based on the example provided. 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).

- c. Discuss the health status of the population including under-five and maternal mortality rates, nutritional status and major causes of mortality and morbidity. Please cite sources of data.
- d. Describe other factors that influence health. This may include, but is not limited to:
 - Economic characteristics of the population such as: the general economy of the community and the nature and location of family members' work.
 - Social characteristics such as: religion, different ethnic groups, female literacy, the status of women
 - Cultural beliefs and practices and influential decision-makers and community networks relevant to promoting key family and community practices.
 - Any potential geographic, economic, political, educational, and cultural constraints to child survival activities which are unique to this location.
- e. Discuss the current status and overall quality of health care services in the site, including existing services (i.e. those of grantee organization, other U.S. NGOs/PVOs, the MOH, local NGOs, the private commercial sector, and traditional health providers), where people currently seek care, the current level of access, barriers to access (e.g. cost for services, distance to facilities, and transportation), client-health worker interaction, standard case management and availability of drugs. Include a table outlining resources per sub-area, e.g. a list of all health facilities with staffing levels, how many CHWs per village, etc. If more detailed information is needed for a specific intervention, describe this in the intervention section.
- f. Identify any groups in the program site that are considered disadvantaged, at high risk of death, under-served or living in extreme poverty.
- g. Linkages and Complementary Activities: Briefly describe health sector programs that other agencies are involved with in the same geographic area which may provide an opportunity for partnering and to ensure there is no duplication of effort (e.g., Agency X is distributing bed nets and Organization Y conducts malaria education). Briefly describe other sector programs that the grantee's organization is involved with in the same geographic area (e.g., Title II, education, agriculture) where innovative opportunities may exist for synergies of programs (e.g., C-IMCI in Title II programs).

2. Summary of Baseline and Other Assessments

Provide a summary of the findings of baseline assessments and other quantitative/qualitative studies and analysis carried out that support the proposed interventions/strategies. If this project is a continuation of a previous project, include recommendations from the final evaluation. 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) including the survey questionnaire(s) in an annex to the DIP.

- a. Briefly describe the types and methodology of baseline assessments conducted or to be conducted by the project, both qualitative and quantitative. Discuss the sampling technique and interview, or data collection process used for the baseline assessments. For those still to be completed, please discuss the timeline for these and how the project will use the results to inform project planning. 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), national TB review/assessment, a TB cohort analysis, an organization and/or partner capacity assessment and any complementary qualitative research.

A rapid health facility assessment survey tool has been developed, based on BASICS and WHO tools. It is strongly recommended for use with CSHGP-funded projects this year. The tool can be downloaded at www.childsurvival.com. Training on use of the tool will be provided at a CSTS+ workshop in December. If a grantee wants to conduct the assessment prior to the training, or is not able to attend the training, that grantee should consult with CSTS+ when planning for the assessment. Contact Jim Ricca (james.g.ricca@orcmacro.com) for more information.

Other tools and information for conducting assessments can be found at www.childsurvival.com, or contact CSTS+ (csts@orcmacro.com).

- b. Discuss the potential constraints to achieving program objectives based upon the local or country context, and project strategies for overcoming these constraints.
- c. 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).
- d. Provide the most recent disease surveillance data available (i.e. from local HMIS) for the program area, and discuss the quality of the data, including the completeness of reporting.

CSHGP Grantees are required to collect **all** the **Rapid CATCH Indicators** at the time of the baseline assessment. The rationale for this is that even if some of the Rapid CATCH indicators do not relate specifically to proposed project interventions, they provide information on critical, life-saving household behaviors and care-seeking patterns that assist projects and their local partners in program management and decision-making. (Please note the exception for non-malaria areas.) See ATTACHMENT B for the required list of Rapid CATCH indicators. For grantees implementing Tuberculosis and Family Planning programs, specific TB and FP indicators are required for collection at baseline and final evaluations.

At final evaluation, all programs are required to collect data on indicators relevant to their program objectives and activities, including all Rapid CATCH indicators. Collection of quantitative data at the Mid-term evaluation, in order to monitor progress on objectives, is optional. In order to collect these indicators, grantees should conduct a population-level baseline survey using the KPC 2000+ Survey Tools and Field Guide which includes the Rapid CATCH, and is available on line at: <http://www.childsurvival.com/kpc2000/kpc2000.cfm>.

Reminder: any indicators collected at baseline should also be collected during the final evaluation using the same tools and methodology. If the project collects quantitative data at the mid-term, then these same indicators and tools should be used, as well.

NOTE: Programs that are exclusively TB or Family Planning (FP) in focus are not required to collect Rapid CATCH indicators, but should collect data for the standard indicators designated for these types of programs. Grantees in these categories should speak to the Primary Contact or CTO before proceeding with baseline assessments. Guidance regarding indicators for TB is contained in ATTACHMENT D of this document.

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. USAID will use these data for results reporting and to examine trends across the CSHGP portfolio of child survival and health grants. This information will be essential to ensuring continued support for the program from Congress and tracking changes in child health. Grantee programs will not be held accountable for achieving progress on indicators for which they have not proposed specific interventions.

3. Program Description

Overall Program Strategy

Based on the above assessments, and the grantee's original proposal, describe the overall strategy for implementing the program. Present a results framework that clearly represents the program's expected results and overall objectives, and briefly describe the project strategy for achieving these results (e.g., through the C- IMCI strategy; through a strategy based on mobilization of cadres of community health volunteers; through a

strategy to effect policy changes at the national level). Please see ATTACHMENT E for an example of a results framework.

If this is an Expanded Impact project, including bundled programs, please discuss the project's approach and strategy for implementing a scaled-up program to promote the use of proven health interventions and/or strategies. As applicable, please discuss any planning and decision-making for prioritizing, streamlining, and phasing of technical interventions in the context of a scale strategy. Include a discussion of the data used to make decisions on project expansion.

Describe your project's full **Behavior Change Strategy**. Be sure to include the following elements in the strategy:

1. Broad behavior change goals and objectives that correspond with overall project health objectives and a summary of the Behavior Change Strategy of the project.
2. A description of how the strategy will be operationalized, e.g. with communication, describe the channels that will be used; if materials will be developed by the project, or adapted from existing materials (name source); how messages will be selected and tested; etc. Please also indicate mechanisms to involve relevant stakeholders in the decision-making process and any plans for capacity building of partners for implementing the BC strategy. For training, describe who will conduct the training and who will attend; which curricula will be used; etc. There may be other aspects of operationalizing the strategy that are not listed here.
3. A table (BEHAVE Framework) with columns listing the Priority and Supporting Groups, Behaviors, Key Factors, and Activities (see the BC TRM for reference). Include all levels that the project is working at to change behavior (i.e. community, health facility). List indicators for evaluating progress in behavior change at the bottom of each section.
4. A description of how behavior change will be monitored and evaluated. In terms of process monitoring, state what incremental progress looks like for each target behavior and audience in each of the following phases: awareness, knowledge, attitudes/skills, trial, and behavioral maintenance. It may be useful to create a table to display that information. Also, describe how and how often indicators will be measured, who will review the data, and how the information will be used for project decision making (cross-reference to an updated project M&E plan, if appropriate).

See Attachment I for an example of a Behavior Change strategy description.

Briefly discuss the quality improvement strategy, focusing primarily on the main components of this strategy and the levels of the system (community, facility, policy, etc.) at which these will be operationalized. Main components of a quality improvement strategy may include training; quality improvement verification checklists; improving the supervisory system; establishing a client feedback system for health services; ensuring

that national health policy is understood and implemented by health workers; ensuring that needed supplies and staff are in place; improving record keeping; and others.

Explain how the program will define, measure and improve quality to address the gaps and opportunities for quality improvement within the existing system. Provide examples of how Quality Assurance (QA) methods will be applied at the various implementation levels (i.e. district, health facility, community, etc.).

Please highlight mechanisms to strengthen the linkage between the different levels of input (e.g. community and facility), as applicable.

Describe the supervisory system that currently guides health service delivery at all levels in the project area. How will the project strengthen or change this system?

Describe any new or innovative approaches, activities or strategies to increase coverage, reach the under-served populations, involve the community to increase coverage or improve health status that may be applicable on a wider scale or beneficial in other areas or programs.

Please describe the program's sustainability strategy with respect to the health of the community and the delivery of services to this community, capacity and viability of local organization(s), and capacity of the community in its larger environment. Projects are encouraged, but not required, to use the Child Survival Sustainability Assessment (www.childsurvival.com) to organize and explain its sustainability strategy.

Include a discussion of how this project fits strategically into the grantee's other activities in the project area, or activities of other organizations working in the project area.

Describe the process undertaken to select and involve relevant in-country organizations in the design and implementation of the program. This section should briefly describe all in-country partners that are collaborating with the program.

Briefly describe the roles of major partners, and attach in an annex a copy of the jointly developed and signed agreements, which clearly delineate the roles and responsibilities.

Describe the overall training plan for the program. Discuss the topics, content, methods and duration of training; specify who will be trained, number of trainees, who will be trainers, and length of training (i.e. 240 CHWs for 10 days, in groups of 24, by 2 trainers plus 1 MOH, 1 grantee and 1 partner training on C-IMCI). Describe how the program will monitor and evaluate the effectiveness and impact of the training (e.g., performance-based training, ongoing supervision, refresher courses, training follow-up, etc.). In the M&E section, be sure to include any indicators of training effectiveness.

Explain how the project's objectives and activities contribute to the CSHGP's Program Results, and clearly identify the specific CSHGP program results that this project will support. See Attachment G for the CSHGP's Program Objective and Results Framework.

The CSHGP believes that USAID Missions are critical partners for their centrally-funded Child Survival and Health Grants. The USAID Mission represents and carries out the Agency's strategy for health at the country level, seeking to strengthen MOH efforts and policies through complementary health programming to maximize overall impact at the country level. The Missions and their bi-lateral programs are one of the present vehicles that the Bureau for Global Health is using to increase the scale of proven interventions, and the Mission can provide a forum for exploring ways to achieve scale at the country-level. In cases where CSHGP grantees have shown synergies with Mission priorities, Missions have sometimes co-funded these programs or taken on the programs once the once the CSHGP cycle has finished.

Please describe this project's planned collaboration with the USAID Mission, particularly related to the role this project plays in contributing to the Mission's overall health objectives. Include information on the frequency and nature of interactions with Mission personnel, any joint planning activities with the Mission, and use of project results and lessons learned by the Mission and its partners. Discuss how the project collaborates with or complements Mission bilateral programs, and how the bi-lateral programs or Mission utilize project results to inform their own activities. Also, please discuss the prospects for the Mission or bi-lateral supporting specific components of this project when CSHGP funding ends.

4. Intervention Specific Approach

Please describe each CSH intervention and the activities that will be implemented to achieve the project objectives. 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. Cross-reference to the BC strategy description where appropriate.

In addition to a description of activities to be carried out and how they will be carried out, please also address the following under each intervention area (as applicable).

a. Quality Assurance

- i. Discuss MOH policies, strategies and/or case management policies or current services for each intervention.
- ii. Describe intervention-specific quality assurance activities, referring to those components of the quality assurance strategy identified in Section 3, Program Strategy. 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.
- iii. Discuss the availability of health-related products-drugs, vaccines, micronutrients, equipment, etc.
 - What commodities/services are essential to the success of the intervention?

- Discuss how reliable the supply of essential commodities/services 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-dependant” activities and approaches to overcome these constraints.
- 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).

b. Access to services

- i. Using the barriers to access (e.g. cost for services, distance to facilities, and transportation) discussed earlier in the program site section, describe how the project will address access to quality services.
- ii. Discuss how the project will increase equitable access to and use of services by under-served and disadvantaged groups, including situations where there is gender inequality.

5. Program Monitoring and Evaluation Plan

- a. 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 community-based data will complement facility-based data and vice versa.
- b. The following points may be addressed in a table, and will be updated to serve through the life of the project. **Note:** A sample M&E template is provided in ATTACHMENT F.
 - i. List the results-based objectives for selected child survival and health interventions;
 - ii. Define indicators used to measure program objectives/results and method(s) of measurement;
 - iii. Identify the targets that will be used to measure progress toward sustained health outcomes. Setting a realistic target requires a solid indicator and good baseline data. Project targets are often set based upon a "benchmark", which is the best level of performance on the indicator that a district, region, province or country has been able to achieve, or on international set targets (e.g. Roll Back Malaria targets for malaria control.) Extensive consultation is required with various partners, governmental and non-government organizations, and the general public (community) to establish realistic and achievable targets. An example of a target would be increase exclusive breastfeeding from 20% to 40% in the project area by the end of the 5 year project. The higher the target is set, the more resources the project (grantee, partners, communities...) will need to allocate to activities

linked to this target. Please see the M&E TRM for more information.

When establishing targets, consider the following:

- The context in which the project is working. What do recent trends suggest for each indicator? Consult DHS or local statistics.
- The level of effort proposed. For example, if a project is devoting 10% to immunization, it probably cannot move that indicator a great extent.
- Baseline levels of indicators. How much movement is possible? In general, it is more difficult (takes more resources) to move up from 80%, than to move up from 20%.
- Targets should not be close to baseline values; i.e. they should fall outside of the baseline value's confidence interval.
- Setting targets is a consensus-building activity and should include representatives from all project partners.
- It may be worthwhile to set a high target to act as a rallying point for project partners, even if it probably will not be achieved.

- iv. Describe how the data will be collected by including sources of data (e.g., facility-based records, household surveys, rosters, etc.), who will collect the data, and frequency of collection.
- c. Describe how data quality will be ensured, including how data collection will be supervised.
 - d. Describe the monitoring tools and methods which will be used (such as PRA, PLA, other participatory methods, LQAS, ISA, QA, cohort analysis, others), the tools developed by the project (if any), who will develop the tools, and who will field test the tools and produce them. Monitoring data generally consist of a subset of indicators from the M&E plan, which are measured on a regular basis. Many monitoring indicators measure processes, inputs, and outputs; however, grantees may not want to wait until evaluation time to assess the project's progress toward results. In this case, a few outcome-level indicators may be measured on a regular basis, using a method like LQAS, or through a review of MOH data, if they feed into project results. Grantees should plan to include monitoring data in annual reports.
 - e. Describe how the data will be collected by complementing the information in the table with descriptions of the following:
 - i. Process to determine the population denominator and how eligible women, children, newborns and others will enter and participate in the program.
 - ii. How program staff (including that of the grantee and partners) and beneficiaries will participate in data collection.
 - f. 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, grantee's home office and the larger NGO/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.

- g. 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.
- h. Describe how M&E skills of local staff and partners will be assessed and strengthened.
- i. Describe what aspects of the M&E system may be sustained by the community after the project is completed.
- j. Discuss operations research ideas that will be carried out during the program and how this operations research may further contribute to the project activities.
- k. Clearly identify the CSHGP Program Results that this project will contribute to, including indicators and data sources that will be used to report on the project's contributions to the CSHGP Program Results. (see Attachment G for an overview of the CSHGP Results Framework).
- l. Clearly identify the USAID Mission Program Results that this project will contribute to, including indicators and data sources that will be used to report on the project's contributions to the Mission strategy. Please also discuss the method used to communicate these contributions to the Mission.
- m. For TB programs, keep the following in mind:
 - Internationally recognized indicators and standardized reporting, monitoring and evaluation tools and criteria (e.g. reporting forms, cohort analysis) have been established by WHO and should be used.
 - The development or strengthening of the TB information and monitoring/evaluation system should not be done independently of the MOH system.
- o. Evaluation plan: Propose a plan and identify dates for the project mid-term and final evaluations. Once the plan is approved with the DIP, this will be the program's evaluation plan. Propose the optimal month in which to carry out the evaluations, taking into account conditions in country (e.g. seasons, local/religious holidays) and the project timeline. It is strongly recommended that the HQ backstop participate as a member of the Mid-term and Final Evaluation teams, so that (s)he is well positioned to assist the project team to address any recommendations that may emerge.

Note: A sample M&E template is provided in ATTACHMENT F.

6. Program Management

Provide an overall discussion of the management structure for this program, at the US headquarters, within the field program, and with partners at all levels. Include the responsibilities of all principle organizations and staff involved, reporting relationships, authority and decision-making processes, and lines of communication within and between each of these organizations. Please include an organogram indicating relationships and communication with key stakeholders of the project (i.e. the grantee at various levels, MOH, USAID Mission and local partners). For bundled programs, please indicate communication between grantee and partners at HQ and field levels.

In an annex, please provide an updated organizational chart that outlines the project staffing structure indicating roles and responsibilities, lines of authority and level of effort. Please also include mention of the linkage with the HQ technical backstop for the program.

Discuss how the U.S. headquarters will ensure transfer of skills, information, technical assistance/updates, and lessons learned with the field program. Also discuss exchanges between the field and headquarters.

Discuss any technical assistance and training needs and how these needs will be addressed over the life of the project (i.e. consultants hired, topics covered, etc).

Discuss how workers will be supervised, by whom, and how competency will be measured and improved – if not previously discussed in the Organizational Development Section.

Include the resumes/CVs of key grantee headquarters and in-country program staff in an annex, if these have changed from the application and include any job descriptions for vacancies. Discuss backstopping responsibilities for headquarters staff, including how many site visits will be made each year, how long, and the monitoring tools that the organization will use.

7. Organizational Development (required for Entry/ New Partner grantees; optional for other grantees)

The CSHGP is interested in documenting not only the technical results of the projects it funds, but also the capacity development that new partners experience from participating as grantees. CSHGP grantees not only contribute to population-level health outcomes and development of local capacities in country, but also to the capacities of their primary implementing partners (e.g., grantees) to carry out similar programs for other donors and in other settings. For grantee organizations new to the CSHGP, please use the questions below to guide a discussion of how the project will track changes in the grantee organization's capacity over the life of the grant.

- Discuss the grantee's present capacity to both implement and provide backstop support for this project; refer to a recent assessment, or plans to conduct a capacity assessment. Consider capacity to include such areas as technical knowledge and skills, human resource management, organizational learning, financial resource management, administrative infrastructure and procedures, and management practices and governance.
- Describe any plans the grantee organization has for strengthening its capacity in any of these areas over the life of the grant. What tools/measures will be used to demonstrate that the organization's capacity has increased as a result of implementing this grant.
- Indicate which project indicators will be tracked to evaluate organizational development and capacity building.
- Technical Assistance Plan: Provide plans for technical assistance for the life of the program to support areas requiring development. Identify the planned sources of technical assistance for specific interventions or other components of the program.

8. Training Plan

Include a table that lists the types or topics of trainings to be provided, the technical resources that will be used to conduct the training (material and personnel), the approximate timing of each training, and who will be trained. Cross-reference with the BC plan, if appropriate.

9. Work Plan

The table should facilitate easy monitoring of specific project activities. USAID believes that the work plan is a working document, for use as a tool throughout the implementation of the project. The grantee may use its organization's table format; however, it should include detailed information on the activities planned, the timeframe for implementation of the activities and the personnel responsible. A sample work plan template is provided in ATTACHMENT H. Status of these activities is to be reported in Annual Reports.

In addition to the table, a narrative can be provided if the grantee thinks that this provides additional information or clarity.

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. ***Map of project area***
4. ***Reports of baseline assessments:*** For each baseline assessment conducted, include a description of the methods employed, and copies of questionnaires, survey instruments and other tools used during the baseline assessment.
5. ***Agreements:*** Memoranda of Understanding, agreements, or Terms of Reference signed with other organizations.
6. ***Organizational Chart/Management plan***
7. ***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 project staff.
8. ***Training and Technical Guidelines:*** Include copies of any relevant curriculum, training modules, MOH guidelines that support technical intervention areas and activities.
9. ***Other Annexes:*** (as necessary)

ATTACHMENT A

Child Survival and Health Grants Program USAID/GH/HIDN FY 2006 Detailed Implementation Plan (DIP) Review Draft Agenda

- 1. Introductions & orientation to the DIP review process**
- 2. Presentation by the grantee (15 minutes)**
 - A brief overview of the project and/or baseline data
 - Important developments since the start of the program
 - Any important issues not addressed in the DIP
 - Responses to reviewer's comments/feedback
- 3. Discussion of critical issues prioritized and led by the CSHGP team, including clarifications, comments and suggestions of reviewers. Due to time constraints:**
 - Each issue will be raised/summarized by CTO/TA
 - Reviewers will provide input/comments/feedback
 - Grantee will have an opportunity to respond
- 4. Summary of Issues**
- 5. DIP Decision/Negotiation of final DIP submission**

ATTACHMENT B

Rapid CATCH Indicator Table

PLEASE NOTE: the Rapid Catch is currently being updated. Grantees will be notified when the revised CATCH is posted (sometime before December, 2006).

ATTACHMENT C

FY 2006 RFA List of Key Interventions

(illustrative examples of activities are also provided).

- **Immunization**: Strengthening routine immunization; expanding coverage and assessment; improving surveillance methods; improving quality and safety of products; support of Six+ immunization (DPT, BCG, Measles); support of polio vaccination programs; strengthening the cold chain.
- **Nutrition**: Improving knowledge of child nutrition; promoting food security and nutrition; improving maternal nutrition practices; promoting appropriate infant and young child feeding; promoting Essential Nutrition Actions.
- **Micronutrients**: Expanding access to Iodine, Iron, and/or Zinc supplementation; provision of iron supplementation for anemia; increasing intake of micronutrient-rich foods; promotion of micronutrient-fortified products.
- **Vitamin A**: Improve coverage and supplementation of Vitamin A for children under 5; increasing intake of Vitamin A-rich foods; promoting Vitamin A-fortified foods; integrating Vitamin A supplementation with expanded program for immunization (EPI) activities.
- **Breastfeeding**: Promotion of immediate and exclusive breastfeeding; increasing knowledge and utilization of breastfeeding techniques; forming community-level breastfeeding support groups for negotiating behavior change; improving hospital policies and practices through the Baby-Friendly Hospital Initiative.
- **Control of Diarrheal Disease**: Improving family and community practices including hand washing, transport and storage of drinking water; improving Diarrhea Case Management and reinvigorating ORT practices through inclusion of zinc treatment with the new low-osmolarity ORS; promotion of point of use treatment (POU) of water; hygiene promotion and improving water and sanitation technologies, strengthening of supportive enabling environments to reduce the incidence of diarrheal disease.
- **Pneumonia Case Management**: Ensuring adequate access to pneumonia case management; promoting prompt recognition and care seeking from appropriate providers; promoting Community Case Management of Pneumonia.
- **Prevention and Treatment of Malaria**: Prevention and treatment in pregnant women (IPT); expanding use of insecticide treated bednets (ITNs); improving Malaria Case Management; promotion of ACTs; supporting environmental control approaches, including indoor residual spraying.

- **Maternal and Newborn Care**: Improving access to focused antenatal care, including birth preparedness and complication-readiness planning; promoting skilled attendants for birth; improving access to quality postpartum care; improving skills of providers; promoting active management of third stage of labor; promotion of clean delivery and essential newborn care practices; where access to skilled care is difficult, implementation of the Home-Based Life Saving Skills (HBLSS) strategy.
 - **Child Spacing**: Promotion of child spacing; support of pre and/or post natal service integration; promotion of optimal birth spacing of 3-5 years. **Note**: Child spacing interventions should be part of an integrated Maternal and Newborn Care program, and not as stand-alone interventions or programs.
 - **Childhood Injury Prevention**: Assessing burden and improving surveillance injury-related morbidity and mortality; integration of injury prevention messages with IMCI key messages (i.e. messages related to drowning, road traffic injuries, falls, poisoning, burns, etc); demonstrating effectiveness of interventions to reduce the incidence of childhood injury.
 - **HIV/AIDS**: Expanding access to comprehensive prevention and care activities; prevention of Mother to Child Transmission (PMTCT); support for orphans and other vulnerable children affected by HIV/AIDS. **Note**: HIV/AIDS interventions may be proposed at up to a 30% level of effort and under the Entry/New Partner, Standard and Tuberculosis funding categories, must be relevant to the program context and intervention mix, and demonstrate that there is an unmet need in the target area.
- Family Planning (FP)**: Increasing the use of FP through increased knowledge and interest in family planning; improving the quality of family planning services in facilities and in the community; increasing access to family planning services in communities; improving social and policy environment for family planning services and positive reproductive health behaviors. Programs will develop strategies to ensure an adequate consistent supply of contraceptives. **Note**: The FP intervention may be proposed at 100% level of effort in the FP funding category or at a 30% level of effort under the Entry/New Partner and Standard funding categories as part of an integrated Maternal and Child Health program.
- **Tuberculosis**: Advocating for political commitment; improving diagnosis by direct smear microscopy; ensuring that DOTS programs are carried out appropriately including provision of DOTS training for health care workers; improving monitoring and evaluating systems. **Note**: Tuberculosis programs may only be proposed under the Tuberculosis funding category.

ATTACHMENT D

Tuberculosis Indicator Guidance

In tuberculosis prevention and control the primary target population is infectious adults with a heavy emphasis placed on the successful completion of treatment. Therefore the current Rapid CATCH and KPC Survey modules are not appropriate for TB programs. 100% TB programs will not be required to conduct the Rapid CATCH and KPC Surveys. However grants that contain a TB component as part of an integrated Child Survival Program will be required to conduct the Rapid CATCH and KPC Survey.

All programs containing a TB component are required to report on the standard TB indicator “Treatment Success Rate,” defined as follows:

Numerator: Number of new smear-positive pulmonary TB cases registered in a specified period that were cured plus the number that completed treatment

Denominator: Total number of new smear-positive pulmonary TB cases registered in the same period

Programs that are not directly addressing this indicator will need to coordinate with the appropriate counterparts at the National TB Program to obtain this data for the project area. The grantee should also report the local case notification rate, as the case detection rate will not be reported at anything other than the national level.

Case Notification Rate

Denominator: Total population in the specified area

Numerator: Number of new smear-positive pulmonary TB cases reported
X 100,000

Additionally, grantees **should** include other indicators that reflect the various components of the proposed TB project as well as provide the entire cohort analysis for the project’s coverage area as background. Guidance on indicator selection for the standard components of the DOTS Strategy can be found in the “Compendium of Indicators for Monitoring and Evaluating National TB Programs (WHO/HTM/TB/2004.344). This is available at http://www.stoptb.org/wg/advocacy_communication/assets/documents/Compendium%20of%20Indicators%20for%20Monitoring%20and%20Evaluating%20NTP.pdf#search=%22tuberculosis%20indicator%20compendium%22

The Compendium of Indicators does not include indicators for TB programs that have a BCC component that educates the public on the general signs and symptoms of TB. For programs containing such a component the following indicators should be used in conjunction with other indicators that reflect the project objectives:

Proportion of population who are aware that cough and fever are symptoms of TB

Denominator: Total # of people surveyed

Numerator: # of people who correctly identified *both* cough and fever as symptoms of TB

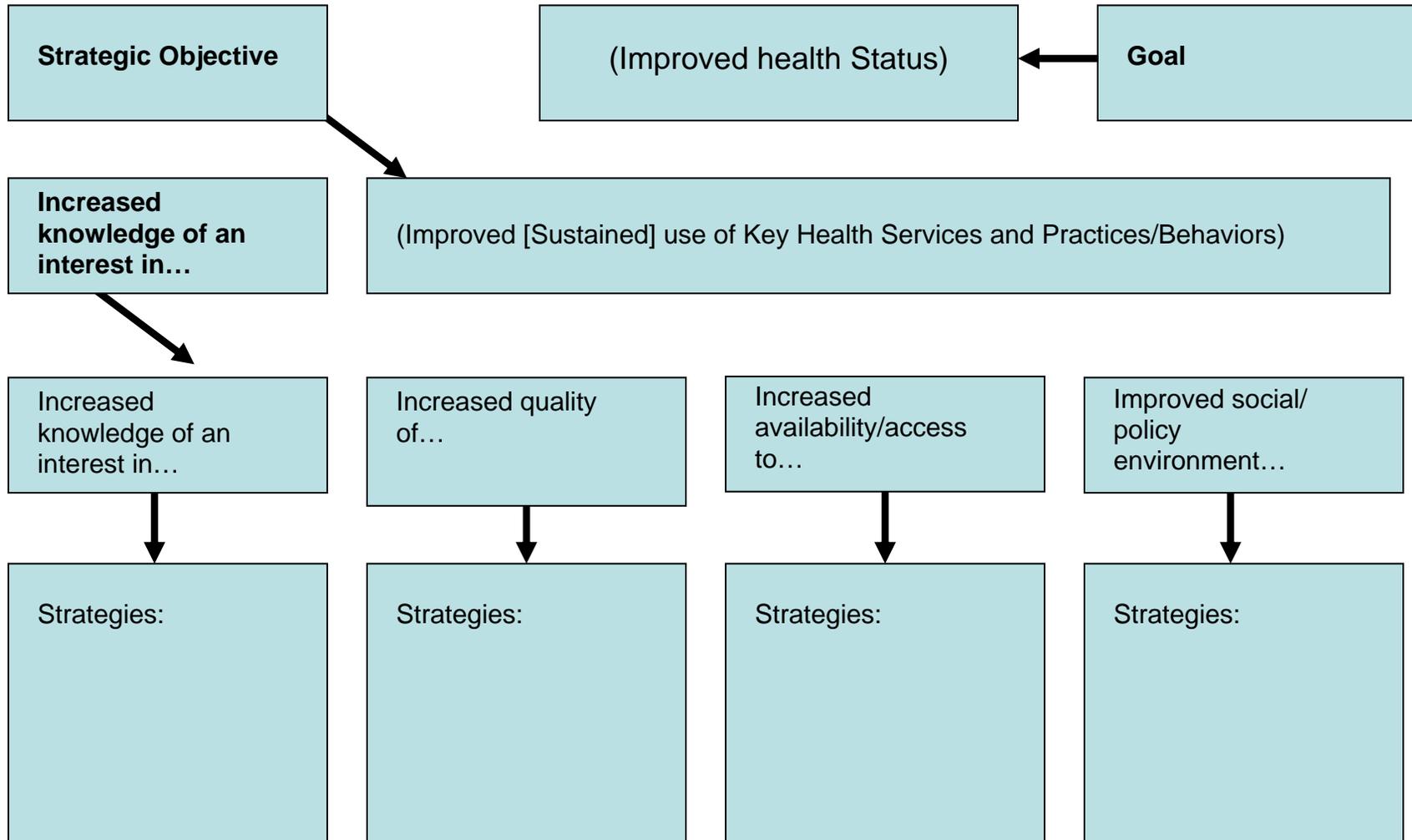
Proportion of population who know that TB is a curable disease

Denominator: Total # of people surveyed

Numerator: # of people who correctly answered that TB is a curable disease

ATTACHMENT E

Sample Results Framework



ATTACHMENT F
SAMPLE M&E PLAN TEMPLATE

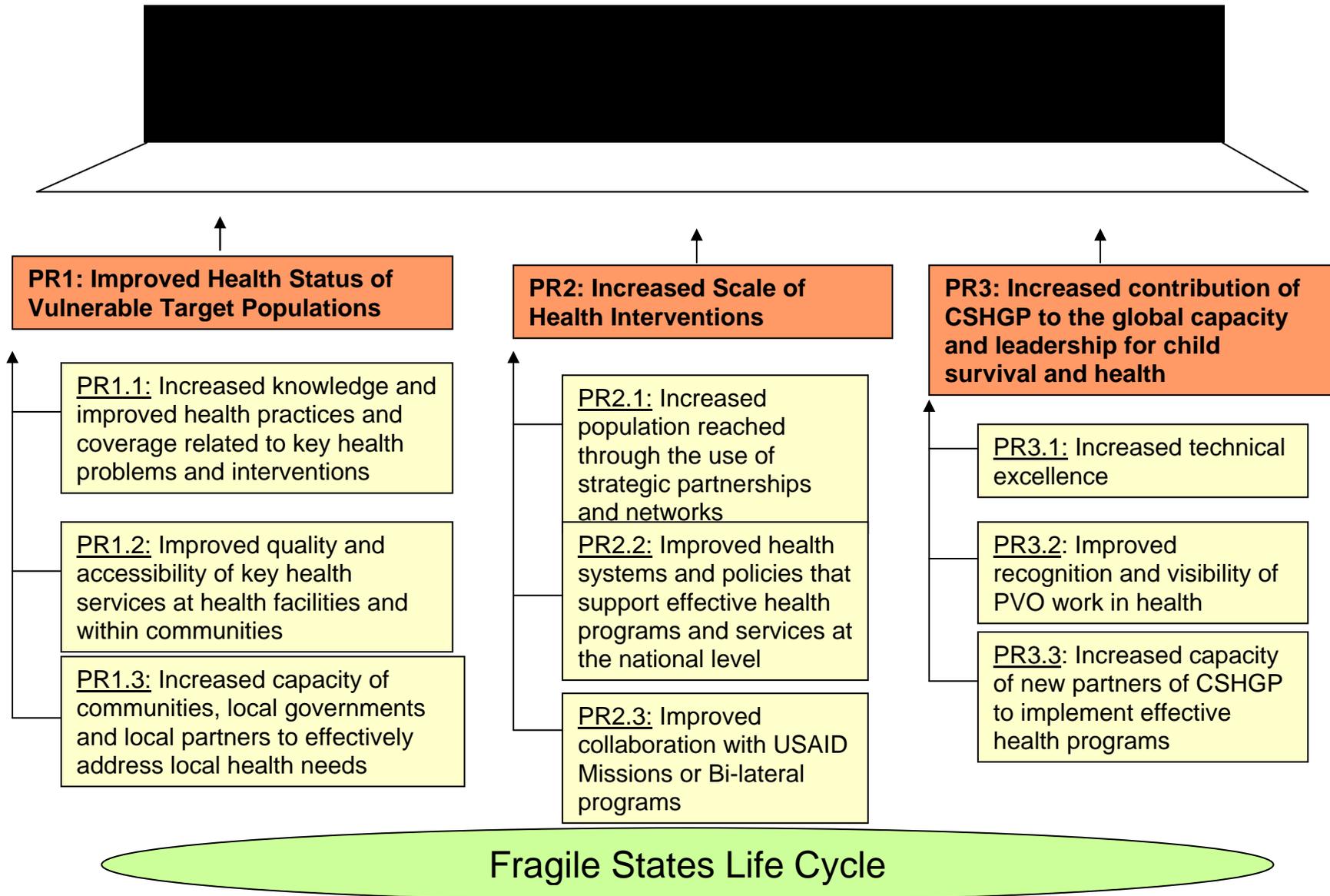
Objective/ Result	Indicators (by technical intervention or cross-cutting)	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
Objective/ Result 1					
Objective/ Result 2					
Objective/ Result 3					

Notes:

- Indicator:** (Sample wording) % of mothers who received two Tetanus toxoid injections (card confirmed) before the birth of the youngest child less than 24 months.
- Source of data:** Example: survey of mothers, health card of child
- Method of data collection:** Indicate how data was/will be collected.
- Frequency:** Indicate how often data will be collected throughout life of project.
- Baseline Value:** % or # at baseline.
- EOP Target:** End of Project % or # collected at final evaluation.

NOTE: Grantees are advised to design objectives and indicators comparable to internationally accepted standards. See the KPC 2000 Modules and Technical Reference Materials for internationally recognized and standardized indicators.

ATTACHMENT G CSHGP Performance Management Plan



ATTACHMENT H

SAMPLE WORK PLAN TEMPLATE

Major Activities	Year 1		Year 2				Etc.	Personnel
	Q3	Q4	Q1	Q2	Q3	Q4		
Activity	x	x						Staff
Activity	x							Staff
Activity			x	x				Staff
Activity				x	x			Staff
Activity						x	x	Staff
Activity		x	x					Staff
Activity	x							Staff
Activity			x	x	x	x	x	Staff
Activity							x	Staff
Activity	x	x	x	x				Staff
Activity				x	x			Staff
Activity		x						Staff
Activity	x	x	x	x	x	x	x	Staff

ATTACHMENT I

BC STRATEGY EXAMPLE

SBC Strategy Example: Iron/Folate

Broad behavior change goal: Improve maternal health practices

Specific behavioral objective: pregnant women should consume the recommended amount of iron/folate

Summary of strategy: This project will improve maternal health practices by increasing iron/folate consumption among pregnant women. Pregnant women's behavior will be changed by increasing education about the benefits of iron/folate, changing attitudes toward taking iron/folate, and improving the supply management of iron/folate. Education and attitude will be addressed through radio messages and dramas performed by mothers' support groups, and training for mothers' support groups, CHWs, and health facility staff to improve counseling skills regarding iron/folate. The supply will be improved by linking district health centers to provincial administration through improved record keeping and communication.

Channels of Communication:

Radio messages will be delivered by local DJs. The project has a standing partnership with a local station. Approximately 85% of the population has a radio at home, and all health centers have radios. The messages are based on national messages, though adapted for local context (local language). Messages will be tested through pre-and post-tests with a random audience selection. CHWs will carry out an oral pre-and post-test.

Dramas will be performed by mothers' support groups, which currently perform dramas in villages and at health centers on various topics. The messages will be the same as the radio messages. Oral pre- and post-tests will be conducted with the audience.

Interpersonal communication includes counseling given by health facility staff, CHWs, and mothers' support groups.

BEHAVE Framework

Priority and Supporting Groups	Behavior	Key Factors	Activities
Pregnant women	Take iron/folate tablets	Barriers: taste, supply Facilitators: desire for healthy outcome; more energy	Radio messages, drama groups, training for health workers and support groups, improving supply management

Priority and Supporting Groups	Behavior	Key Factors	Activities
Family members	Encourage pregnant women to take iron/folate tablets	Barriers: lack of knowledge Facilitators: desire for healthy outcome	Radio messages; training for health workers
Indicators: % pregnant women taking recommended amount of iron/folate % family members reporting correct information about iron/folate			
Health workers	Counsel pregnant women regarding iron/folate tablets	Barriers: lack of time; lack of knowledge; lack of supply Facilitators: desire to perform job well; desire to improve outcomes	Training in counseling, improved supportive supervision, improved record keeping forms, monthly record keeping contest
Indicators: % records indicating counseling regarding iron/folate % health workers that can correctly state information about iron/folate			

Behavior change indicators will be monitored and evaluated in accordance with the project's M&E plan (see M&E section, p. XX)

Monitoring table

Priority Group	Awareness	Knowledge	Attitudes/ skills	Trial	Behavioral maintenance
Pregnant women	Pregnant women are counseled about iron/folate during prenatal visits; radio messages broadcast 3 times each day; mothers' groups perform drama once each week	KPC survey, FGDs, and client exit interviews indicate that women know the benefits of taking iron/folate	Health facility records indicate that an appropriate amount of iron/folate is distributed; FGDs and client exit interviews indicate if women are planning to take the tablets	Reported increase in consumption at mid-term; reduced cases of anemia at mid-term	Consistent or increased amount of iron/folate distributed (in proportion to number of pregnant women counseled); consistent reported consumption; consistently reduced cases of anemia

ATTACHMENT J

Beneficiary Calculation Guidelines for the Child Survival and Health Grants Program

Beneficiary population numbers help reviewers determine if proposals target a reasonable number of people in relation to the project area and proposed interventions. Beneficiary population numbers are also used to calculate cost per beneficiary. For its annual portfolio review, CSHGP must report on the total number of beneficiaries reached by all the grants during the year and the total number of beneficiaries reached by the program since its inception in 1985. Grantees need to know the number of beneficiaries in order to plan activities on a yearly basis and over the life of the project. This document contains recommended guidance to help applicants report correct and standardized beneficiary numbers.

Definition: a beneficiary is an individual who directly or indirectly benefits from programmatic efforts

Guidance:

- Applicants must provide information on beneficiary population based on the population in the geographic area (or areas) of the project *at the beginning of the project*.

- Applicants must state the source of population numbers for the project area, the date when this information was collected and information as to whether or not these numbers were determined by official projections. For example did they perform a census of the project area or did they use an official source. How did they determine the percent of total population for women of reproductive age and children under 5 (broken down by age categories)? The following are links to official sites for population figures:
 - CENSUS BUREAU SITE: <http://www.census.gov/ipc/www/idbsum.htm>
 - UNICEF: <http://childinfo.org/>

- The age ranges for beneficiary population numbers and the type of beneficiaries vary among projects because the CSHGP covers a wide variety of intervention areas (e.g. immunization, nutrition, malaria, maternal and newborn care, HIV/AIDS). Applicants must provide a strong justification for the direct and indirect beneficiaries they are reporting in the proposal. [Please note that children under five must be disaggregated in the following categories: under 12 months, 12-23 months, 24-59 months.]

Illustration of Beneficiary Calculation for Project X:

Intervention areas: Immunization, Nutrition/Breastfeeding, Vitamin A, ARI, CDD, Malaria, MNC, Child Spacing.

Explanation of calculation: Numbers are calculated before the initiation of the project. The project X team calculated infants 0-11 and children 12-23 months based on DHMT guidance that

stated that each of these age groups represented 4% of the total population. This means that children in the 0-23 month age range represents 8% of the total population.

Beneficiary Population Numbers for Project X:

Beneficiary Population	Number
Infants: 0-11 months	5,193
Children: 12-23 months	5,193
Children: 24-59 months	15,580
Children 0-59 months	25,966
Women 15-49 years	28,561
Total Population	129,830