Maternal and Child Health Integrated Program

ZIMBABWE

Associate Award

Program Year 1
Implementation Plan
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ACRONYMS AND ABBREVIATIONS

AA	Associate Award
ACSM	Advocacy, Communication, and Social Mobilization
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ARK	Absolute Return for Kids
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetrical and Newborn Care
CB-MNCH	Community-based Maternal, Newborn, and Child Health
CBT	Competency-Based Training
CCM	Community Case Management
CCORE	(UNICEF-supported) Collaborating Centre for Operational Research and Evaluation
CH	Child Health
CS	Child Survival
CSS	Child Survival Strategy
C/S	Caesarian Section
CTC	Clinical Training Centers
DHE	District Health Executive
DHIS	District Health Information System
DFID	United Kingdom Department for International Development
DQA/DQS	Data Quality Assessment/ Data Quality Survey
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EmONC	Emergency Obstetrical and Newborn Care
ENC	Essential Newborn Care
EPI	Expanded Program on Immunization
ETAT	Emergency Triage and Treatment
F&A	Finance and Administration
FP	Family Planning
GoZ	Government of Zimbabwe
HBB	Helping Babies Breathe
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTF	Health Transition Fund
ICC	Immunization Interagency Coordinating Committee
IEC	Information and Education Campaign
IIP	Immunization in Practice
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Newborn and Childhood Illness
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
M&E	Monitoring and Evaluation
MCCM	Malaria Community Case Management
MCHIP	Maternal and Child Health Integrated Program
MH	Maternal Health
MIP	Malaria In Pregnancy

MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOHCC	(Zimbabwe's) Ministry of Health and Child Care (Formerly MOHCW)
MPMA	Maternal and Perinatal Mortality Audits
NH	Newborn Health
NIHFA	National Integrated Health Facility Assessment
NMCP	(Zimbabwe's) National Malaria Control Programme
OPHID	Organization for Public Health Interventions and Development
OR	Operations Research
PCV 13	Pneumococcal Conjugate vaccine
PE/E	Pre-eclampsia, eclampsia
PHE	Provincial Health Executive
PIE	Post-Introduction Evaluation
PMI	The President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUD	Postpartum IUD
PQI	Performance Quality Improvement
PSE	Pre-Service Education
PTFU	Post-Training Follow-Up
QA	Quality Assurance
QI	Quality Improvement
QoC	Quality of Care
RBF	Results Based Financing
RED/REC	Reaching Every District/Reaching Every Child
RH	Reproductive Health
RHC	Rural Health Center
SBM-R	Standards Based Management and Recognition
SC	Steering Committee
SIA	Supplementary Immunization Activities
SMT	Senior Management Team
SS	Supportive Supervision
STTA	Short-term Technical Assistance
TA	Technical Assistance
TBD	To Be Determined
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
VHW	Village Health Worker
WG	Working Group
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-related Hospitals
ZEPI	Zimbabwe's Expanded Programme on Immunisation
ZICOM	Zimbabwe Confederation of Midwives

INTRODUCTION

The Maternal and Child Health Integrated Program (MCHIP) in Zimbabwe was launched in 2010,with Field Support funding from USAID/Zimbabwe that was used to design and implement a three-year technical assistance program. The program's objectives were to support the Ministry of Health and Child Care(MOHCC) at the national level in developing and rolling out maternal and child health policies, strategies, guidelines, and training programs; to improve the quality of clinical care for women, infants, and young children in health facilities in Manicaland province; to build the capacity of Village Health Workers (VHWs) in providing maternal, newborn, and child health (MNCH) information and services in two districts of the same province; and to support the national immunization program (ZEPI) in increasing immunization coverage and introducing new life-saving vaccines countrywide.

During its first three years, MCHIP contributed to the development or updating of many different policies, strategies, guidelines and training packages with partners, including the Reproductive Health Policy, Emergency Obstetric and Newborn Care (EmONC) and Helping Babies Breathe (HBB) training packages, National Nutrition Strategy, Quality Assurance/Quality Improvement(QA/QI) Policy and Strategy, Malaria Community Case Management(MCCM) training package, Integrated Management of Newborn and Childhood Illnesses (IMNCI) training package revision, and others. In Manicaland province, MCHIP worked intensively with the Provincial Health Executive (PHE) and District Health Executives (DHEs) in Mutare and Chimanimani districts to introduce performance standards for maternal, newborn and child health and improve the quality of maternal, newborn and child health in 21 high volume health facilities using the Standards-Based Management and Recognition (SBM-R) approach. Other MCHIP achievements have included the development and roll out of the new MCCM training module and a community health information system (HIS) in communities with a high burden of malaria and the testing of a Community Performance and Quality Improvement (cPQI) strategy in Chimanimani district that includes peer-to-peer supervision, MNCH refresher training and MCCM training for VHWs and introduction of the community HIS mentioned above.

Another major national achievement during the first phase of MCHIP was the project's contribution, along with other partners, to the introduction of both pneumococcal and rotavirus vaccines. These two vaccines alone have the potential to greatly reduce the country's disease burden from two of the most common causes of infant and child mortality—pneumonia and diarrhea. Assistance was provided both at national level(to prepare for vaccine arrival and to launch, monitor and evaluate its introduction country wide) and in Manicaland province, where MCHIP supported vaccine introduction and strengthened the routine immunization (RI) platform by revitalizing the Reaching Every District (RED) approach. MCHIP's immunization support in Manicaland was to all seven districts.

MCHIP's Field Support-funded program in Zimbabwe will end in early May 2014, and the program's work will be continued, consolidated, and advanced under the new, three-year AA. This agreement was duly executed in January 2014 and will run through December 2016. Building on past achievements and lessons learned, this workplan describes in detail the strategies that will be supported in Program Year 1 (PY1 – December through January 2014) under the new MCHIP/Zimbabwe AA. The strategies in question were selected based on an analysis of the current country context, country priorities in MNCH, and acknowledgement of the support that other partners are expected to contribute to the Government of Zimbabwe (GoZ) during the implementation period.

There will be approximately four to five months of overlap between the current MCHIP Field Support-funded program and the follow-on AA. This period will be used to fully close out activities supported under the MCHIP Lead Award, and to strategically position and kick-start activities under the AA. A separate extension workplan has been submitted that describes transitional activities that will continue to be funded through early May 2014 using the remaining Field Support pipeline.

PROGRAM GOAL, OBJECTIVES, AND APPROACH

The MCHIP/Zimbabwe's vision is to significantly contribute to accelerated and sustainable improvement in MNCH in Zimbabwe through scaling up of evidence-based, high-impact, integrated public health interventions.

The goal of the MCHIP/Zimbabwe AA is to increase access to quality MNCH services and strengthen health services in Zimbabwe by supporting the MOHCC and contributing to the scale up and roll out of evidence-based, high-impact interventions that will reduce maternal, newborn, and child morbidity and mortality and contribute to the attainment of Millennium Development Goals (MDG) 1c, 4, 5 and 6.

The objectives of the MCHIP/Zimbabwe AA are to:

1. Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high impact maternal, newborn, and child health interventions;
2. Strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated maternal, newborn and child health services at health facilities and in the community to support national level scale-up plans; and
3. Strengthen the capacity of Civil Society Organizations (CSOs) to implement MNCH activities and manage USG funding.

During the first year of the AA, MCHIP will build on its successful experience over the past three years and re-double efforts to strengthen the capacity of the MOHCC to deliver high-quality MNCH services at scale. This will be done by supporting the finalization of key MNCH policies and strategies needed to create an enabling environment for program implementation; advocating for the adoption, revitalization, and scale up of selected high impact interventions whose implementation has not started or is lagging behind; working through national coordination platforms and leveraging other partner resources to strengthen the capacity of the MOHCC to implement MNCH interventions; and, strengthening information systems to improve accountability for high quality program delivery and use of data in making decisions.

The project will also expand the promising work on improving quality of care provided at health facilities and through community health workers, while taking deliberate steps to mitigate the underlying causes of excess maternal, newborn, child mortality. This will include an emphasis on reducing the detrimental effects of malaria in pregnancy (MIP), improving prevention at community level and providing community-based treatment for malaria, and collaborating with other partners to address the effects of malnutrition.

The project will expand the geographic focus of its support and continue to target interventions to those health facilities and communities where most of the preventable maternal, newborn and child deaths occur in Manicaland province. It will also go beyond Manicaland with additional resources from the ELMA Foundation (a project co-share activity) to cover Matabeleland North and South provinces with a standard package of immunization interventions and support for the introduction of Rotavirus vaccine and other new vaccines.

PROGRAM ACTIVITIES AND EXPECTED RESULTS

In the sections below, MCHIP identifies the intermediate results to be achieved by the end of PY1; presents these in the context of the Life-of-Project results; describes the strategies that will be employed to attain the PY 1 results; provides activity details, the geographic area of focus, and the collaborating partners for each of the main activities; and, lists the specific PY1 outputs/products by project objective.

OBJECTIVE 1: NATIONAL HEALTH POLICIES AND STRATEGIES

Objective 1: Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale -up of high-impact maternal, newborn and child health interventions

Life of Project Results	PY1 Results
• National MNCH policies, strategies, guidelines and tools developed/finalized with MCHIP support • MNCH program coordination, planning and monitoring strengthened through MCHIP support for national steering committees/technical working groups (TWGs), and national review and planning meetings • Availability of a competent MNCH workforce increased through strengthening of in-service and pre-service clinical training; rollout of a standardized, integrated supportive supervision (SS) protocol; and development and dissemination of MNCH job aids for health workers • MNCH pre-service education (PSE) curricula for nurses, doctors and other health professionals improved through inclusion/updating of content on basic EmONC, HBB, IMNCI, maternal nutrition, infant and young child feeding (IYCF) and immunization, as well as skills strengthening of instructors in competency-based training (CBT) approaches • Greater focus on and resources and commodities available for MIP, maternal and child nutrition, pneumonia and diarrhea case management, prevention of mother-to-child transmission (PMTCT), and postpartum family planning (PPFP)/postpartum IUD (PPIUD) interventions through collaboration with partners/donors supporting antenatal care (ANC) and postnatal care (PNC) programming • Strategic information systems strengthened	• National Reproductive Health Policy finalized and provinces oriented • National MNH 2014 Implementation Plan finalized and resourced • National Nutrition Strategy approved and launched • Emergency Triage and Treatment (ETAT) guidelines adapted and master trainers trained • 80 national trainers trained in MCCM, including environmental waste management standards • VHW toolkit (including behavior change communication (BCC) messages and counseling materials) enhanced and available. • World Health Days commemorated with MCHIP support • Rotavirus vaccine rolled out and achieving at least 60% coverage achieved in all provinces in PY1 • ELMA Foundation activities launched at national level and in Matabeleland North and South (cost-share) • National QI policy and strategy disseminated to all provinces • National MNCH Competency Based Training TOT Guide finalized and 100 national trainers trained • National clinical training database generating regular reports • Scale up plan for introduction of antenatal corticosteroids in place • HMIS indicators and community health information system components included in revised HMIS strategy • 20 provincial focal persons oriented on the revised maternal and perinatal notification system

Life of Project Results	PY1 Results
through improvements to the national HMIS, inclusion of quality and community indicators within the HMIS, and revitalization of the Maternal and Perinatal Mortality Audits (MPMA) system nationally • New MNCH approaches and tools explored, lessons learned documented and best practices shared with MNCH stakeholders	and MPMAs • Electronic Maternal Perinatal Death Notification system tested in one province • National guidelines for verbal autopsy finalized and 30 provincial focal points oriented • Promising MCHIP tools and approaches shared with and adopted at national level and by other partners • At least two new Program Learning studies with IRB approval and underway

MCHIP Zimbabwe will continue working to build the capacity of the MOHCC to deliver high-quality MNCH services. At the national level, this will be done by expanding the skilled workforce and strengthening institutional systems for long-term sustainability. Using a collaborative approach, MCHIP will strengthen the MOHCC's capacity to formulate, coordinate, roll out and monitor key MNCH interventions by: 1) providing technical and other support to MOHCC departments, steering committees and TWGs for the development and rollout of national policies, strategies guidelines and tools; 2) strengthening linkages between the MOHCC and key national MNCH partners; 3) increasing the pool of human resources with skills necessary to deliver high-quality services nationally; 4) supporting the availability and use of high-quality strategic health information for decision making; 5) supporting new and innovative approaches, tools and operations research, documenting lessons learned and sharing best practices; and 6) expanding the reach of interventions through integrated, multi-health themes and multi-sector approaches, particularly for nutrition, and partnering with Feed the Future partners to link health and other interventions to address the barriers to optimal nutrition.

The planned PY 1 activities, tasks, timeline and outputs under Objective 1 are described in the matrix below.

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
Activity 1.1 Support the development and rollout of national policies, strategies, guidelines and tools							
1.1.1	**Reproductive Health (RH) Policy and Plan**: Support the MOHCC in finalizing the national RH policy and developing the annual MNH plan. The national RH Policy is being developed under the leadership of the RH unit and input from RH TWG is being consolidated by a team of consultants before approval by the MOHCC. The policy codifies evidence-based best practices that are in the MNH Road Map but were not supported by policy until now. Once approved, MCHIP will co-fund printing and co-facilitate orientation to the new policy for provincial RH focal points. MCHIP will also participate in drafting the annual MNH plan and will advocate for sufficient resources. This includes the national plan for national implementation of PPIUCD/PPFP roll out.	Support the MOHCC in finalizing, printing and launching the RH policy		X	X		• Final RH policy • Provincial focal points oriented
		Participate in the development and the leveraging of funds for implementation of the 2014 national annual MNH plan		X	X	X	• MNH implementation plan for 2014 finalized • GoZ and partner commitments made in support of MNH plan
1.1.2	**Nutrition Strategy and Costed Implementation Plan**: MCHIP has been working through the Nutrition Cluster- a coordination mechanism- to support the development of national Food and Nutrition policy which was coordinated by the office of the President and Cabinet. The policy document was launched by the President of Zimbabwe, and now MCHIP is working under the MOHCC Nutrition Unit to support development of the national Nutrition policy, which will serve as the sectoral coordination policy document for the MOHCC. The development process, coordinated through the national Nutrition TWG, is at an advanced stage and awaits finalization and costing.	Support finalization, printing, launch and 1 national dissemination meeting of the national nutrition strategy		X	X		• National Nutrition Strategy finalized, launched and disseminated

	ACTIVITY	TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.1.3	**Child Health - Emergency Triaging and Treatment (ETAT):** The MOHCC's plan for child health calls for investing in ETAT to improve the care and survival of severely ill infants and children who present at health facilities. At present, IMNCI protocols are followed in these facilities, but they do not address the additional care or the emergency nature of the care that may be required to save the lives of these children. MCHIP will work through the Child survival TWG under the leadership of the Directorate of Family Health of the MOHCC to adapt the WHO ETAT training package and to co-facilitate training of master trainers at national level, while also introducing the package to Manicaland.	Contribute to the national adaptation of the ETAT service delivery guidelines and implementation plans		X	X		• Adapted ETAT service delivery guidelines • ETAT implementation plan with GoZ and partner commitments • 30 national master trainers trained on ETAT (including clinical orientation, post-training follow-up (PTFU), revision of HMIS tools and SS)
		Conduct National TOT in ETAT for 30 national-level master trainers			X		
1.1.4	**Malaria Community Case Management:** MCHIP has supported the MOHCC National Malaria Control Programme (NMCP) to develop the national MCCM training package and will be expanding MCCM training and community HIS in at least 5 of Manicaland's districts with PMI support. The malaria sharps waste management policy exists but it is not uniformly implemented. In particular, there are problems with procurement and availability of sharps boxes. MCHIP will help to document the current situation and then develop a strategy for addressing it with the programs. MCHIP will also co-facilitate a training workshop to increase the number of VHW trainers who can teach MCCM.	Assist MOHCC/NMCP to monitor compliance with safe disposal of MCCM medical waste by updating the supportive supervision checklist, monitoring the allocation of resources for sharp box procurement and other commodities, and the inclusion of safe disposal of medical waste in GoZ/partner plans		X	X	X	• 80 national trainers and supervisors updated on MCCM, including waste management and environmental compliance standards

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.1.5	**<u>Behavior Change Communications, including national advocacy around priority topics</u>:** Support the MOHCC Health Promotion Unit to further develop and fill gaps in the integrated reproductive, maternal, newborn and child health (RMNCH) package of job aids and BCC packages for VHWs and health facilities. At present, VHW counseling cards are missing content (malaria and kangaroo mother care (KMC)) and/or messages and images have not been adapted to Zimbabwe's reality. PSI has developed malaria counseling cards but they are not integrated with the standard VHW package. Health facilities have few BCC materials for CCM, and those they have are not up to date, i.e. they do not include zinc in diarrhea treatment. MCHIP will also work at national level with the Health Promotion Unit to ensure that the Health Promotion content of the new National Health Strategy includes a stronger MNCH focus than in the past. In collaboration with partners, co-sponsor the commemoration of national and international MNCH-related days and initiatives as a way to reach large populations with key messages.	Support the revision of VHW tool kit (counseling cards, job aids, BCC materials, registers) and support use of the tool kit in trainings and supportive supervision.		X	X		• Updated MNCH tool kit for use by VHWs
		Contribute to the commemoration of up to 5 MNCH related national world health days (Africa Vaccination Week (April 22-28, 2014), World Pneumonia Day (November 12, 2014), World Prematurity Day November 17, 2014), World Malaria Day (April 25, 2014), International Day of the Midwife (May 5, 2014)		X	X	X	• World Health Days commemorated with increased community and male engagement

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.1.6	**<u>Routine immunization and introduction of new vaccines</u>:** With other ICC partners, support ZEPI to launch and introduce rotavirus vaccine in all provinces (now expected to begin March 2014) and to continue national efforts to expand RED and strengthen other aspects of RI, including integration of immunization and other RMNCH services and refinement of policies on the allocation, installation and maintenance of solar cold chain equipment. MCHIP is working at national level with ZEPI and Immunization Interagency Coordinating Committee (ICC) partners on all aspects of the national immunization program, including GAVI reports and applications, etc. MCHIP partner JSI expects the award of the ELMA Foundation support that will be combined with USAID support to MCHIP to expand the project's support to two additional provinces—Matabeleland North and South. A major objective of the ELMA support is to transition from electric and gas cold chain equipment to solar powered units. National policies on solar equipment, specifications for procurement, allocation, installation and maintenance will be addressed with ELMA support at national level. The ELMA-funded project will be launched in Quarter 2 as an MCHIP cost-share activity.	With ZEPI and other members of the ICC, support the national launch and roll out of rotavirus vaccine countrywide		X	X	X	• Rotavirus vaccine successfully launched in all provinces • At least 80% coverage nationally with all antigens by end of 2014 (except Rota, which will not be introduced until mid-year) • Updated national integrated MNCH service delivery guidelines and tools • ELMA foundation supported EPI activities launched at national level and in Mat North and South • 2 Joint MOHCC/partner EPI SS and review meetings completed
		Support the MOHCC to conduct post-introduction evaluation (PIE) of rotavirus vaccine.			X	X	
		Launch ELMA Foundation support and work with ZEPI to refine national policies on the allocation, installation and maintenance of solar cold chain equipment		X	X	X	
		Support the development of national guidelines and tools to encourage greater integration of immunization and other MNCH services		X	X	X	
		Support national level joint MOHCC/partners EPI SS and review meetings		X	X	X	

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.1.7	**<u>QI Strategy and MNCH quality of care standards</u>**: In 2013, MCHIP worked with the MOHCC's Quality Assurance Unit to develop and gain consensus on the national QI policy, which has now been approved. In PY1 of the AA, MCHIP will support the dissemination of the policy and the orientation of national trainers to it, including support to national roll out of the new QI policy and strategy with focus on implementation of MNCH quality of care standards (incorporating patient safety).	Support the printing and launch of QI policy and strategy		X	X		• National QI policy and strategy printed, launched and disseminated
		Support two national level dissemination meetings of the QI policy and strategy			X	X	
Activity 1.2 Strengthen MNCH program coordination, planning and monitoring, and leveraging of other available MNCH funds							
1.2.1	**<u>Coordination and leveraging of partner resources</u>:** Participate in and support the initiatives of key national MNCH working groups (WGs) and steering committees (SCs) (i.e., RH SC, Child Survival TWG (CSTWG), Family Planning (FP) TWG, Malaria, IYCF, PMTCT Partnership Forum, ICC/National Immunization Technical Advisory Group, Health Cluster, Nutrition Cluster, QA/QI, HMIS, and others). MCHIP works through these SCs and TWGs to influence, develop, finalize and disseminate national MNCH policies, strategies, training programs, etc. described under 1.1 above.	Participate in existing steering committees and technical working groups	X	X	X	X	• National policies and strategies informed by technical evidence and MCHIP program learning
		Advocate for revision of national policies and implementation plans to facilitate RMNCH implementation (revision of Essential Drugs List for Zimbabwe (EDLIZ), Zinc use at community level, MNH commodity security, KMC scale up, community participation)	X	X	X	X	• Advocacy plan completed and used to inform national MNCH plans and priorities.
		Advocate for RMNH logistician in the RH Unit	X	X	X	X	

<table>
<tr><th rowspan="2" colspan="2">ACTIVITY</th><th rowspan="2">TASK</th><th colspan="4">TIMELINE
JAN. 2014-DEC. 2014</th><th rowspan="2">OUTPUTS/DELIVERABLES</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td colspan="8">Activity 1.3 Provide technical support to the MOHCC and partners at national level in building a competent MNCH workforce through improvements in pre-service and in-service training, supportive supervision, and the introduction of distance training approaches</td></tr>
<tr><td rowspan="6">1.3.1</td><td rowspan="6"><u>Competency-based training (CBT):</u> MCHIP is championing the CBT in BEmONC, HBB, IMNCI and other training programs and will offer support for the development of a CBT Trainer of Trainer (TOT) guide for use in all clinical training. In PY1, MCHIP will advocate and provide technical assistance (TA) for remodeling national clinical training approaches towards a CBT model (e.g., supporting standardized clinical training model/curricula, PTFU, SS, and on the job training (OJT)) as a way of influencing the implementation of <u>in-service MNCH training and supportive supervision</u>. Furthermore, MCHIP will support the training of master trainers and national/provincial trainers in skilled birth attendance, EmONC, Essential Newborn Care (ENC), MCCM and other topics, as requested by MOHCC through MNH TWG and monitor in-service training needs at national level in collaboration with UNICEF, UNFPA, Cordaid and other partners.</td><td>Support two stakeholder meetings on the development of MNH CBT TOT guide</td><td></td><td>X</td><td>X</td><td></td><td rowspan="2">• National MNCH CBT TOT guide finalized and in use</td></tr>
<tr><td>Support orientation of national trainers on the MNH CBT TOT guide</td><td></td><td>X</td><td>X</td><td></td></tr>
<tr><td>Support national MNCH TOTs inEmONC, ENC, KMC and other selected topics</td><td></td><td></td><td>X</td><td>X</td><td>• 100 national trainers trained</td></tr>
<tr><td>Support KMC activities, including minor refurbishments and trainings for central hospitals</td><td></td><td></td><td></td><td></td><td>• 50 Health workers from Central hospitals trained in KMC
• 2KMC units at central hospitals functional</td></tr>
<tr><td>Support the MOHCC to track trained personnel using a national clinical training information system – package provincial level (Obj. 2)</td><td></td><td>X</td><td>X</td><td>X</td><td>• National clinical training information system in place and generating regular reports</td></tr>
<tr><td>Provide TA in the standardization of integrated SS tools that can be used for MNCH program and health service delivery improvement</td><td>X</td><td>X</td><td>X</td><td></td><td>• SS tools that have been extensively tested and improved based on field experience</td></tr>
</table>

	ACTIVITY	TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.3.2	**<u>Pre-service MNCH education</u>:** MCHIP has provided support to strengthen in-service clinical trainings and has been exploring opportunities to ensure that the clinical training approaches and content are included in PSE to ensure that graduates are deployed with the requisite competencies for sustainable and effective service delivery. In PY1, MCHIP will provide technical support to the MOHCC to improve MNCH pre-service education with a focus on curriculum review.	Provide technical support for inclusion/updating of MNCH technical content (e.g., EmONC, IMNCI, HBB, IYCF, Baby Friendly Hospital Initiative (BFHI), Integrated Management of Acute Malnutrition (IMAM), EPI) and CBT approach in pre-service curricula for midwives, nurses, doctors and others, as needed, during curriculum review opportunities.		X	X	X	• Inclusion of new MNCH training content and CBT in at least one pre-service nurse training institution
Activity 1.4 Promote the scale up of high impact interventions on existing MNCH service delivery platforms to improve efficiency and increase coverage							
1.4.1	**<u>Antenatal Corticosteroids</u>:** Despite clear policy guidance on Antenatal Corticosteroids, they are rarely used beyond the central hospitals. MCHIP will advocate and provide technical support for the roll out of Antenatal Corticosteroids in the management of pre-term birth through supporting a stakeholder's forum to highlight key newborn intervention that are neglected and follow that with service delivery guidelines and job aids for use at decentralized levels of the health care.	Support a national stakeholders' advocacy workshop on roll out of Antenatal Corticosteroids		X	X		• Advocacy workshop conducted for stakeholders
		Develop a scale up plan for introduction of Antenatal Corticosteroids including plan for reorientation of health workers, commodity security (Betamethasone/Dexamethasone) and monitoring introduction		X			• Scale-up plan for introduction of Antenatal Corticosteroids in place

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		Work with MOHCC to develop, print and distribute service delivery protocols for Antenatal Corticosteroids		X	X	X	• Protocol on Antenatal Corticosteroids developed, printed and distributed to health facilities
Activity 1.5 Strengthen national systems for collection and use of strategic MNCH information							
1.5.1	**National HMIS – Indicators and community information system:** Zimbabwe is in the process of introducing District Health Information System (DHIS) II across the country. Initial testing of the new system was done in Manicaland and work is beginning now to update indicators, consider the inclusion of community indicators generated by VHWs and others, and make other improvements. MCHIP has introduced antenatal and KMC registers in health facilities and community registers and reports that are as much job aids as data collection tools for use by VHWs. Experiences and lessons learned in Manicaland will be shared at national level and the project will actively engage in DHIS revisions to improve the availability and use of critical RMNCH data in decision making at all levels, support the MOHCC HMIS Unit in HMIS planning, coordination, implementation and monitoring of national HMIS-related activities, and experiment in Manicaland with the transmission of community data via cell phones. Furthermore, MCHIP will collaborate with the World Bank to repeat the MNCH QoC study. Findings from this study will contribute to the evaluation of the national Results Based Financing (RBF) program, and to MNCH baselines for the MCHIP AA.	Advocate for inclusion of new indicators in the national HMIS (e.g., indicators measuring quality of MNCH care and coverage of newer evidence-based interventions)		X			• HMIS strategy revised with input from MCHIP • MNCH quality indicators added to national HMIS (quality of care, community based interventions, etc.) • Agreement to add community health indicators and data collection and flow to DHIS II • Collaborated with World Bank to complete MNCH quality of care (QoC) Assessment
		Support the integration of the community health information system into national HMIS.		X	X	X	
		Support and participate in regular HMIS planning and review activities and other revision to the national HMIS		X	X	X	
		Support the revision of the NHMIS Strategy and collaborate with World Bank in conducting MNCH QoC assessment		X	X		

	ACTIVITY	TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
1.5.2	**Maternal and Perinatal Death Notification and Audit (MPMA)**: MCHIP has been a key partner in the revision and revitalization of the MPMA process at national level. In PY1, MCHIP will support the national MPMA information system, including national MPMA committee meetings, database, revision of tools, production of national MPMA reports and introduction/scale up of an electronic system for maternal and perinatal death notifications	Support 1 national MPMA meeting			X		• 1 national MPMA review meeting conducted • Maternal and perinatal death notification forms and audit guides printed and distributed • 20 provincial focal persons oriented on the revised maternal and perinatal notification system and MPMAs • Electronic maternal/perinatal death notification system tested in 1 province • National guidelines for verbal autopsy finalized • 30 provincial focal persons oriented on verbal autopsy guidelines and tools
		Contribute to printing of final maternal and perinatal death notification forms		X	X		
		Support orientation of provincial focal persons on the revised maternal and perinatal notification system and MPMAs		X	X	X	
		Contribute to national assessment of feasibility and effectiveness of electronic maternal and perinatal death notification system.		X	X	X	
		Support printing of MPMA guidelines, maternal and perinatal death notifications and perinatal deaths reporting forms		X			
		Support finalization of national guidelines and tools on Verbal Autopsy		X	X		

	ACTIVITY	TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		Support orientation of 30 provincial focal points on the Verbal Autopsy guidelines and tools		X			
Activity 1.6: Introduce new approaches and tools, document lessons learned and share best MNCH practices							
1.6.1	**Advocate for promising approaches**: Share findings from past program learning activities in Zimbabwe, and from studies elsewhere and advocate with MOHCC and others for adoption of promising approaches. During the first three years, MCHIP developed and tested during implementation a number of innovations that show promise. Under the AA, the reports of these studies and guidelines and tools for their uptake in other settings will be finalized and shared with MOHCC and partners. Promising approaches include: SBM-R for improving MNH services; peer supervision of VHWs; new HIS tools (clinic registers that serve as job aids and data collection instruments, including KMC, ANC, and community HIS registers and C5); competency based training; and others. MCHIP will advocate for further scale-up and adoption of many of these in its work with national SCs and TWGs, PHEs and DHEs, and among partners.	Support dissemination of findings from past program learning pilots and studies	X	X			• Program Learning reports and findings shared at national level • Promising MCHIP tools/approaches adopted at national level and/or by other partners
		Advocate for the adoption/scale-up of successful approaches through participation in SCs and TWGs and by publishing findings	X	X	X		
1.6.2	**New Program Learning Agenda**: Develop and begin implementation of a new, nationally relevant program learning agenda. Early in PY 1, MCHIP will identify priority topics for further study and learning and prioritize these in consultation with USAID, the MOHCC and other stakeholders. At the time this workplan was prepared, potential topics for implementation research included: 1) a referral study to	Consult with MOHCC counterparts and other partners to identify priority research topics		X	X		• New PL agenda developed with stakeholder input • At least 2 new PL studies with IRB approval underway before end of PY1 • Contributions to other
		Contribute to the implementation of at least three research studies with MOHCC and partners to investigate priority topics			X	X	

ACTIVITY		TASK	TIMELINE JAN. 2014-DEC. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	document and track labor & delivery (L&D) utilization patterns, incentives and barriers; 2) further modification and testing of community HIS tools and use of cell phones to transmit community data; 3) testing of a simplified quality improvement approach and of ETAT in primary and secondary health facilities; 4) alternative training and other capacity building approaches.	Contribute to national MNCH research plans (e.g., Multiple Indicator Cluster Survey (MICS), coverage surveys, etc.); disseminate and use findings	X	X	X	X	national MNCH research studies • Research and innovation incorporated in national MNHC/HMIS implementation plans

OBJECTIVE 2: FACILITY AND COMMUNITY MNCH CARE

Objective 2:Strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated maternal, newborn and child health services at health facilities and in the community to support national level scale-up plans

Life of Project Results	PY1 Results
• Increased number of health facilities (HFs) satisfying criteria for QI standards (SBM-R) in MNCH • Increased number of HFs and VHWs implementing SBM-R in MNCH • Reduced cause-specific mortality rates for MNCH cases in supported HFs and supported communities • Increased number of health workers and VHWs trained in MNCH • Rotavirus antigen introduced in Manicaland (seven districts) and in Matebeleland South (Mat South) • Increased immunization coverage in Manicaland and Mat South for all antigens • Increased ENC coverage of all newborns • Increased number of eligible newborns receiving HBB, KMC and IMNCI • Improved survival rates for newborns managed with KMC, IMNCI, and HBB • Increased number of districts with costed implementation plans • Increased number of districts conducting MPMAs • Increased number of VHWs satisfying set criteria for managing MNCH cases • Increased institutional deliveries • Increased timeliness, completeness and quality of MNCH data in the province • Increased number of pregnant women and newborns receiving at least one home visit according to national schedule • Increased coverage of key prevention and treatment interventions for maternal health, including MIP, maternal nutrition, pre-eclampsia/eclampsia, PPH, obstructed labor and sepsis • Increased number of women and newborns who received core MNH package (preventive treatments in ANC, active management of the third stage of labor with use of partograph and delayed cord clamping, and EmONC) • Improved coverage of PPFP • Improved coverage of sick children who receive correct treatment, appropriate care and follow-up • Increased number of households that report receiving MNCH BCC messages • Increased number of individuals and families adopting	• 60% of facilities satisfying set criteria for quality improvement standards (SBM-R) in MNCH • 7 districts implementing quality improvement activities (SBM-R) in MNCH • 60% of all HWs and VHWs trained in MNCH in target districts/facilities • Rotavirus antigen vaccine introduced in Manicaland with USAID support • Immunization coverage in Manicaland increased to above 60% for Rotavirus vaccine and 80% for all other antigens • KMC, HBB and BEmONC scaled up to all 7 districts in Manicaland • 7 districts in Manicaland implementing costed MNCH plans and holding regular review meetings • 7 districts in Manicaland conducting MPMA and using findings to improve MNCH plans • Increased timeliness, completeness, and quality of MNCH data in the province • Increased number of pregnant women, newborns and children receiving quality MNCH care • Maternal, newborn, and child cause specific mortality rates reduced in the 7 districts • 7 districts managing sick children according to IMNCI/ETAT at 80% of target facilities • Coverage for MIP and MCCM increased in the 5 malaria priority district of Manicaland • All VHWs in Chimanimani receiving MCHIP support showing improved performance • C-PQI approach adapted and introduction begun in Mutasa district • 250 VHWs trained in key household and family practices • Communities, families and individuals in MCHIP-supported districts of Manicaland receiving messages about key household health practices • Baselines for selected project interventions conducted • Two integrated MNCH DQAs conducted and

Life of Project Results	PY1 Results
and supporting key household practices and health-seeking behavior for MNCH • Improved capacity of communities and sub-groups to plan for and support MNCH services • Improved coverage for community MNCH intervention packages for MNCH, including home visits for MNC, MCCM, early referral for sick children and home care for sick children according to IMNCI	findings used to improve project performance • PHE/DHE data quality improved through training and continuous support • MPMA information system developed and in use at provincial/district level

MCHIP has been supporting the MOHCC to strengthen its capacity to manage common causes of maternal, newborn and child morbidity and mortality in Manicaland, with intense focus in Mutare and Chimanimani districts for all interventions except immunization, which has been supported province-wide. Lessons learnt over the past three years will be used to refine the package of MNCH activities and the expansion plan for impact at scale under the AA.

In PY1, MCHIP will continue supporting these interventions through scaling up the following key strategies:

- Quality Improvement activities for MNH: Expanding beyond Mutare and Chimanimani, MCHIP will target high volume sites in all 7 districts with a package of interventions with the potential to reduce maternal and newborn deaths.
- Scaling up other MNH interventions with impact on mortality: The project will aim for province-wide coverage of KMC, HBB and BEmONC services and maternal perinatal mortality audits.
- For child health: The project will aim for province-wide coverage with IMNCI; will expand the IMNCI platform to include ETAT; will introduce rotavirus vaccine; will continue scaling up RI through the RED approach; will use ELMA funding to expand its immunization support to Matabeleland North and South; and will address malnutrition.
- Malaria prevention and case management: The project will work in the 5 malaria endemic districts to strengthen prompt and effective treatment at community level and support MIP at the health facility level through QI interventions.
- Community MNCH: MCHIP will continue supporting the VHWs in Mutare and Chimanimani that it has worked with over the last two years. The project will also expand and intensify it support to VHWs in Chimanimani during PY 1 to include all health facilities and villages. Successful elements of the c-PQI will also be adapted and introduced in a phased manner in a third district—Mutasa—during PY1. MCHIP also intends to begin working with the PHE and other partners in PY1 to introduce two promising elements of the cPQI approach province-wide: cHMIS and MCCM.

The detailed expansion and coverage plans are presented in the following matrix.

	ACTIVITY	TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
Activity 2.1 : Institutionalize a quality improvement and quality assurance approach (SBM-R and SBM-R-like activities) for MNCH in Mutare and Chimanimani and scale up to 5 remaining districts							
2.1.1	**<u>Quality of Care (QoC) Improvement for MNH</u>** MCHIP has been supporting the roll out of QoC improvement approaches in Manicaland with promising results. This work will continue for MNH and CH, which are at different stages of implementation. **Geographic area:** 21 high volume sites in all 7 districts **Package**: QI in the management of obstetric and newborn complications/emergencies **Strategy**: 1) Consolidate SBM-R implementation in Mutare and Chimanimani and 2) expand to 5 remaining districts. Since 2010, MCHIP QI approaches emphasized prevention, early detection, and pre-referral stabilization of obstetric and newborn emergencies at 17 sites in Mutare and Chimanimani. In PY1 of the AA, MCHIP will expand to 20 new high volume (deliveries) facilities in the remaining 5 districts in Manicaland with a focus on	Refine SBM-R tools/processes to focus on obstetric and newborn emergencies		X	X	X	• Refined and user friendly QI tools and processes available to support SBM-R implementation
		Conduct refresher trainings for QI Support Teams (22 individuals, including DHEs) in Mutare and Chimanimani on SBM-R supportive supervision to lead and eventually take over SBM-R implementation in the 17 existing MNH and 21 CH-supported sites		X			• 22 HWs able to support QI activities in Mutare and Chimanimani with minimal external technical support
		Introduce, conduct baseline assessments, and develop QI action plans for 21 hospitals and high-volume sites (4–5 sites per district) through SBM-R Modules 1 and 2		X	X		• Quality of care gaps in managing obstetric and newborn emergencies documented and used to develop evidence based QI action plans

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	improving district wide capacity to manage obstetric and newborn emergencies beyond initial stabilization to include emergency triaging and continued/definitive treatment for the period covering 24 hours of admission to a health facility where indicated. At 3 out of the 4 sites selected in each of the 7 districts (including 6 in Mutare and Chimanimani), MNH QI approach will be simplified and refined to focus on prevention, early detection, and prompt initial management (including early referral where indicated) of PPH, complicated MIP, severe pre-eclampsia/eclampsia (PE/E), birth asphyxia, and severe prematurity/low birth weight (LBW). At 1 referral site in each of the 7 districts, additional support will be provided for EMAT (including strengthening monitoring and capacity for caesarean sections (C/S)) of these emergencies emphasizing the first 24 hours of admission/receiving referrals.	Support DHEs and facility managers to monitor and strengthen capacity for C/S, including documenting lessons learnt in strengthening C/S		X	X	X	• C/S coverage improves by 20% over baseline and lessons learnt in strengthening C/S used to advocate for scale up of CEmOC in Manicaland
		Support facility-based MPMA at SBM-R sites and use findings to update SBM-R QI action plans		X	X	X	• All facility-based maternal and perinatal deaths audited according to national guidelines and findings included in facility wide QI action plans
		Implement facility-based QI action plans at 21 health facilities (SS, minor procurements, minor refurbishments, clinical attachments, reorganization of services)and conduct recognition ceremony for MNH		X	X	X	• All facility-based QI action plans implemented on schedule with 80% of facilities satisfying annual targets for MNH/QI
2.1.2	**Quality of Care Improvement for CH:** **Geographic area**: 21 high volume sites in all 7 districts **Package:** Quality of Care improvement for IMNCI **Strategy**: For CH/SBM-R, MCHIP will use lessons learnt in implementing QI for	Refine IMNCI and ETAT QI tools/processes (to include updated information on rotavirus vaccine, fever, malnutrition and HIV management, and EPI)	X				• Refined and user friendly QI tools and processes available to support CH SBM-R implementation

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	IMNCI at 22 health facilities in Mutare and Chimanimani to refine the tools and further adapt the IMNCI QI approach for province-wide targeting 3-5 health facilities that manage sick children in each district. The focus on IMNCI will also be reviewed to address the unacceptable child mortality.	Introduce, conduct baseline assessments and develop QI action plans for 21 high-volume sites (3–5 sites per district) through SBM-R Modules 1 and 2		X	X		• Quality of care gaps in managing sick children emergencies documented and used to develop evidence based QI action plans at 21 HFs with findings used to inform province-wide scale-up CH intervention plans
		Implement QI action plans for CH in all the 7 districts with intense focus on 21 high volume sites (SS, minor procurements, minor refurbishments, clinical attachments, and reorganization of services) for IMNCI and ETAT		X	X	X	• Facility-based QI action plans implemented on schedule with 80% of the 21 facilities satisfying annual targets for CH/QI
2.1.3.	**<u>For improvement of both MNH and CH Quality of Care</u>** **Geographic area**: as described above for CH and MNH **Strategy**: The project will use lessons learnt and capacity built in Mutare and Chimanimani to support rapid scale up and institutionalization of the QI for both MNH and CH in the remaining 5 districts and redefine the intervention package to have impact on mortality.	Work with SBM-R Champions at provincial/district levels in Mutare and Chimanimani to expand their capacity for advocacy, mentorship and to be effective hosts for benchmarking/learning visits		X	X	X	• 12 SBM-R champions trained in advocacy and mentorship

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		Use existing QISTs/Champions in Mutare and Chimanimani to identify Champions in the 5 new districts, in preparation for district-led SBM-R implementation		X	X	X	• Quality Improvement Support Teams established in 7 districts and provincial hospital
		Work with DHEs to develop their capacity to document and share lessons learned in SBM-R implementation	X	X	X	X	• DHEs documenting and sharing lessons learnt in SBM-R implementation
		Conduct recognition ceremony for facilities satisfying MNCH QI standards.				X	• Recognition event held and all the participating HFs satisfying criteria for recognition for both CH and MNH recognized
Activity 2.2: Scaling up high impact interventions for MNH.							
2.2.1	<u>**HBB and KMC scale-up**</u> **Geographic area:** All health facilities in the 7 districts for HBB, and high volume sites for KMC in all the 7 districts **Strategy**: Prematurity/LBW and neonatal birth asphyxia are the leading causes of neonatal deaths in Manicaland. KMC and HBB are two effective interventions to reduce these deaths. Yet coverage with these low cost interventions at facility	Support cascading of HBB trainings as needed province-wide and supporting facilities to establish newborn corners	X	X	X	X	• At least 2 nurses trained on HBB and received PTFU at each facility in the province.
		Supply 50 MNH SBM-R sites with at least 1 HBB training simulator each for ongoing OJT		X	X		• 50 HBB simulators supplied in the 5 remaining districts

	ACTIVITY	TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	level in Manicaland is low. In PY1, MCHIP will harness the capacity building support provided to the province since 2011 to rapidly scale up these two interventions. **<u>For Province wide scale up of HBB</u>**: MCHIP will continue to support the DHEs and district trainers in rolling out HBB/CBT in all the 7 districts. For Province wide scale up of KMC: In Mutare and Chimanimani, MCHIP will continue to capacity build the DHEs to provide SS to the 8 KMC units while expanding to 20 additional HFs selected for MNH QI activities in the remaining 5 districts through minimal refurbishment, furnishings, and provision of supplies, supportive supervision and bench-marking visits, and KMC trainings based on district-level KMC scale-up.	Support the MOHCC to provide supportive supervision to existing 8 KMC units in Mutare and Chimanimani	X	X	X	X	• Quarterly SS to the 8 KMC units in Mutare and Chimanimani conducted
		Support training of 40 HWs on KMC and procure KMC commodities for establishment/revitalization of at least 1 new KMC unit in each of the 5 remaining districts in Manicaland		X	X		• 6 KMC units revitalized in the remaining 5 districts (minor refurbishments, procurement of commodities)
		Establish and implement *Community Care Group* model supporting community KMC at 1 high volume HF and document lessons learnt			X	X	• 1 Community Care Group for KMC functional at 1 HF
2.2.2	**<u>Competency based clinical training in EmONC</u>** **Geographic area**: Province wide **Strategy**: At provincial and district level, MCHIP will work with partners to support training of additional 30 provincial (4-6 per district in Manicaland) trainers, and at least 100 additional health workers targeting high volume sites in an integrated package of essential and emergency MNH care.	Leverage funds from partners to support BEmONC TOT for 40 HWs and 210 BEmONC providers at provincial and the remaining 5 districts in Manicaland		X	X		• 40 BEmONC trainers trained and supported to train • 210 HWs in BEmONC with MCHIP Support
		Advocate for and support use of a BEmONC Clinical Training Information	X	X	X	X	• Provincial/ District BEMONC clinical training information system developed and

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	MCHIP will work through partnership forums to support MOHCC at provincial and district level to implement a Clinical Training Information System and leverage support from the Health Transition Fund (HTF) to revitalize midwifery training, working with Nursing and Midwifery training institutions and the DNS to explore the use of the SBM-R approach in PSE at 2 sites in Manicaland.	System at provincial/district level					in use with MCHIP support
		Support MOHCC to strengthen BEmONC CBT in pre-service education at 2 sites in Manicaland			X	X	• Tutors and Preceptors at 2 midwifery pre-service education sites oriented on BEmONC CBT and implementing the approach to midwifery students.
Activity 2.3.Support MoHCCto scale up interventions for reducing childhood illnesses in the province							
2.3.1.	**IMNCI** **Geographic area**: All first line health facilities in the 7 districts **Package**: IMNCI capacity building for HWs **Strategy**: MCHIP will contribute to scaling up of IMNCI through activities that build capacity of HWs; leverage resources and provide technical support for IMNCI training and quality of care for managing sick children for all remaining health workers at primary care level (RHC, PHC) in the two learning districts; disseminate and support use of job aids and registers that facilitate care and SS; and strengthen capacity of DHEs/PHE to plan for and roll out IMNCI with minimal external support.	Support IMNCI trainings of HWs in 7 districts including PTFU and SS		X	X	X	• 200 HWs trained in IMNCI in 7 districts
		Support training of 20 IMNCI provincial supervisors		X			• 20 provincial supervisors trained in IMNCI
		Support quarterly SS for HWs in all PHC facilities in 7 districts		X	X	X	• Quarterly IMNCI SS visits conducted to all 7 districts.
		Support MOHCC to carry out a rapid assessment of current oral rehydration therapy (ORT) corner functionality in Mutare/Chimanimani		X			• Rapid assessment on ORT functionality done

	ACTIVITY	TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		Support MOHCC to scale up zinc utilization		X	X	X	• Zinc/ORS use in managing diarrhea improved in all the 7 districts
2.3.2.	**<u>ETAT for managing complicated/severe childhood illnesses</u>** **Geographic area**: 1 Secondary level hospital in each of the 7 districts **Package**: Facility based ETAT for childhood illnesses **Strategy**: The support to IMNCI will be complemented with ETAT which seeks to ensure that children maximally benefit from the treatment available in the districts. Sick children will be triaged according to the urgency with which they should receive care and those that need treatment beyond IMNCI are referred to institutions where advanced and follow-on care has been strengthened.	Work with USAID/DELIVER and other partners to support MOHCC to strengthen CH commodity forecasting and distribution chain system		X	X		• CH commodity forecasting and supply chain strengthened
		Support Provincial training for 30 nurses and doctors in ETAT				X	• 30 doctors & nurses trained in ETAT
		Support selected HCWs to conduct mentorship visits to all the facilities implementing ETAT		X	X	X	• Each district referral facility receives at least 1 mentorship visit per quarter
		Print and distribute job aids and stationery to support ETAT implementation for 7 ETAT implementation sites		X	X	X	• ETAT job aids and stationary available at 7 ETAT implementation sites
		Support ETAT sites to re-organize CH services, improve client flow and document experiences.		X	X		• Improved client flow at ETAT sites

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
2.3.3.	**Malnutrition** **Geographic area**: Mutare and Chimanimani for Nutrition **Package**: For malnutrition, the project will expand the BFHI activities introduced in Chimanimani to the remaining 6 districts, provide intensive support to Chimanimani and Mutare through the training of HWs in IYCF and encourage screening of every child under 5 who comes to a facility or outreach site for up-to-date Vitamin A supplementation. MCHIP will work with health facility staff in the 2 districts to recognize and appropriately treat acute malnutrition with nutritional supplements and will, again, work with supply experts to determine why these specialty products are not available and how to solve the problem.	Support training of Senior managers in improvement of Child Health programming from Manicaland		X			• 30 senior managers trained in CH programming
		Support training in WHO growth standards in Mutare and Chimanimani districts		X	X		• 60 HWs trained in WHO growth standards
		Support IYCF mop up training for 60 HWs in Mutare and Chimanimani		X	X		• 60 HWs trained in IYCF
		Support IMAM training for 30HWs from admitting hospitals				X	• 30 HWs trained in IMAM
		Support BFHI mop up training for 120 HWs in Mutare and Chimanimani and support facilities to receive BFHI certification			X		• 120 HWs trained in BFHI

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
Activity 2.4Support the MOHCC's introduction of rotavirus vaccine nationally, continue strengthening the routine immunization system in Manicaland							
	Immunization: **Geographic area**: 7 districts **Package**: RED, NUVI, and Vit A supplementation **Strategy**: The project will continue supporting 2 key aspects of immunization, namely RI through RED approach and the introduction of new vaccines. MCHIP will intensify assistance provided to nationwide introduction of rotavirus vaccine by assisting the province with pre- and post-introductory activities in 2014 building on the support provided towards RED scale up; will work with counterparts to develop and test guidelines for integrating other MNCH services on the immunization outreach platform; and will begin to work with CSO partners to increase community demand for immunization and understand how religious groups that have traditionally rejected immunization and other modern health services might be more able to use them.	Continue to support Immunization In Practice (IIP) and PTFU/SS of health workers in 7 districts of Manicaland		X	X	*X*	• Post training follow up and SS for IIP conducted in the 7 districts
		Continue to support Manicaland PHE/DHEs in routine EPI system strengthening activities (e.g., RED Micro planning and mapping, SS, HMIS support, immunization coverage surveys, data quality surveys (DQS))	X	X	X	X	• At least 4 quarterly SS visits conducted (prioritizing poor performing districts) and 7 provincial cluster meetings focusing on updating of RED micro-plans supported
		Support revitalization of the integrated community EPI register with other partners		X	X	X	• Standard Community EPI register revitalized and in use
		Support semi-annual provincial EPI review meetings, routine outreach, etc.)		X		X	• 2 EPI review meetings supported
		Support rotavirus vaccine introduction activities in Manicaland (e.g., training of	X	X	X	X	• Rotavirus vaccine successfully introduced in the Province and integrated into the

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		trainers/training for HWs, HMIS support, adverse event following immunization (AEFI) surveillance and reporting, community mobilization, etc.)					routine immunization program
		Mobilize communities to utilize immunization services.	X	X	X	X	• Health Center Committees, Community Care Groups and CSOs supporting rotavirus roll-out and other changes in vaccination schedules
Activity 2.5Expand support for malaria activities to all malaria-prone areas in Manicaland, through direct assistance and leveraged funds from other malaria partners							
	Malaria Case Management **Geographic area**: Mutare, Chimanimani, Mutasa, Nyanga, Chipinge **Package**: Integrated Community Case Management **Strategy**: MCHIP will expand its current integrated community case management approach by expanding the iCCM/MCCM/MNCH activities to other areas of the province by using the capacity gap analysis survey conducted by the NMCP in the province to identify	Support development of provincial and district MCM/MCCM implementation plans by PHE/DHEs in 5 priority districts	X	X			• Provincial and district plans developed and implemented
		Support trainings of nurses, EHTs and Nurse Aids, school health masters in MCM/MCCM	X	X	X		• 1200 VHWs, nurse aides and EHTs in total trained in MCM/MCCM in Chipinge, Mutasa, Nyanga, Mutare and Chimanimani)

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	priority areas where Nurse Aids, School health Masters and VHWs will be trained. The project will also partner with other organizations that are already working on MNCH/malaria prevention in the targeted areas to add malaria treatment to their community-based services and use these platforms to disseminate the use of the community case management registers and related supportive supervision job aids. The project team will work with DHEs and the PHE Manicaland to ensure that there are adequate supplies of safety boxes and bags and proper disposal of RDT waste (sharps, blood) at community level in areas with partners, support the partners; and work with DELIVER to ensure product availability.	c) Support training of 40 provincial trainers on Malaria Case Management including safe disposal of medical waste	X	X			• 40 VHW Trainers trained and competent to support MCM/MCCM
		d) Advocate for strengthened health care waste management	X	X	X		• Improved stock status for MCM/MCCM commodities and medicines in the province
		e) Print and disseminate job aids and registers for MCCM to all the 5 priority districts		X	X	X	• Integrated MNCH/MCCM registers available in 5 priority districts
Activity 2.6. Work at community level to positively influence behavior change, strengthen the continuum of MNCH care, improve MNCH service provision and promote adoption of key MNCH household practices							
	Community MNCH **Package**: Integrated cMNCH through VHWs **Geographic area**: Intense support in Chimanimani, phased introduction of intense support to Mutasa district, and	Expand Peer-to Peer based SS, support minor procurements and roll out cHMIS to cover all VHWs in Chimanimani.		X	X	X	• All VHWs in Chimanimani providing care according to cMNCH protocol

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	improved community health information registers and forms in the remaining 5 **Strategy**: The project has been providing intense support to selected VHWs in Chimanimani as part of testing a quality improvement approach for MNCH at community level focusing on improving documentation and reporting systems and strengthening supportive supervision. Beyond this intense support, the project has been assisting all other VHWs in Mutare and Chimanimani mainly through replenishing their VHW Kits. In PY1, the intense support will be expanded to all VHWs in Chimanimani and later in the year the same package will be introduced to Mutasa district. In the remaining 5 districts, the community MNCH registers will be rolled out to improve tracking all other MNCH activities taking place in these districts with priority to 5 districts where malaria is endemic.	Support the roll out of the integrated MNCH/malaria/nutrition cHMIS (registers and other data collection tools) province wide with priority to 5 RBM		X	X	X	• cHMIS rolled out in Manicaland Province
		Disseminate cPQI pilot findings (at provincial level) and adapt the cPQI package of activities for scale up in Mutasa district	X	X	X		• cPQI Findings shared with Provincial MOHCC and cHMIS rolled out in a phased approach to Mutasa district in PY1
		Support two day trainings of 250 VHWs on 17 key household province wide		X	X	X	• 250 VHWs trained in 17 key household and family practices
		Introduce PQI (intense SS, minor procurements, cHMIS) to Mutasa district				X	

ACTIVITY	TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
		Q1	Q2	Q3	Q4	
Activity 2.7. Reposition health information systems, mortality audits and data for decision-making for improved local health systems performance						
<u>**Health Information Systems/M&E**</u> **Package**: HMIS, Program learning, M&E, MPMA **Geographic area**: Province wide **Strategy**: This activity will focus on 3 main areas, namely Improving HMIS/M&E capacity at the provincial/district level, supporting the PHE/DHEs to conduct regular planning and review meetings, including Maternal and Perinatal Mortality Audits, and institutionalizing Research, innovation and program learning in provincial and district plans.For HMIS, MCHIP will continue with current efforts to improve local capacity for generating quality data, using the data for decision making, and support reporting/notification and use of data at higher levels through capacity development (trainings/PTFU/OJT/SS) of Manicaland PHE/DHE/health workers in data generation and utilization in 7 districts to fully utilize the DHIS 2 platform. The project will also support piloting of community indicators in	Conduct baselines for future evaluations (i.e., RED/immunization coverage surveys, SBM-R in new districts and others as needed)	X	X			• Baselines for selected interventions conducted
	Support Manicaland HCWs through trainings/PTFU/OJT/SS) on, data generation, analysis and utilization in 7 districts	X	X	X	X	• DHEs/PHEs/PHIOs/7 DHIOs and 200 health workers supported in data generation, analysis and utilization
	Support the PHE/DHEs to conduct regular provincial/district level planning, review and partner coordination meetings				X	• 2 Provincial planning/review meeting supported
	Support the MOHCC to conduct regular integrated MNCH data quality assessments and use findings to improve program performance		X		X	• Two Integrated MNCH data quality assessments conducted and findings used to improve program performance

ACTIVITY		TASK	TIMELINE Jan. 2014-Dec. 2014				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
	district-level activities and reporting of community data up the HMIS chain and support documentation of experiences piloting cHMIS activities to support advocacy and scale up efforts initially in 5 RBM districts. For MPMA and program review and planning meetings at provincial and district levels, the project will work through existing PHT, DHT, partner forums, Immunization Review Meetings	Support piloting of community indicators in district-level activities, reporting of community data up the HMIS chain, and documentation of experiences piloting cHMIS activities to support advocacy and scale-up efforts		X	X	X	• Action plan developed for the adoption of selected community indicators and a mechanism for transmitting community generated data piloted in Manicaland
		Support PHE/DHEs to strengthen the MPMA system, including review meetings, databases, production of provincial MPMA reports, and piloting of electronic notification of maternal and perinatal deaths	X	X	X		• MPMA information system developed and in use at provincial/district level

OBJECTIVE 3:CSO CAPACITY BUILDING

Objective 3: Strengthen the capacity of Civil Society Organizations (CSOs) to implement MNCH activities and manage USG funding

Life of Project Results (Outcomes)	PY 1 Results (Outputs/Deliverables)
• Increased number of local CSOs in Manicaland with the capacity to design, implement and monitor community MNCH programs • Increased number of local CSOs in Manicaland with the capacity to handle USG funds responsibly (i.e., comply with standard USG operating procedures and financial regulations • Increased number of target communities reached with MNCH information • Increased number of target communities that have implemented activities to improve use of key MNCH services • Increased community level support and household behaviors • Increased recognition of danger signs of illness and early care seeking • Participation of pregnant women during the antenatal period (through women-to-women groups, grandmother/grandfather support) • Increased number of birth plans and increased knowledge of maternal and newborn danger signs by families, including husbands, grandmothers/grandfathers and women • Improved exclusive breastfeeding (mothers support groups model)	• Proposed CSO engagement plan developed with PHE, DHEs and other partners in Manicaland (including proposed CSO scope(s) of work, selection criteria, selection process, templates for subawards, budgets and financial reports, tools for organizational assessment and strengthening, among others) • At least one CSO selected, awarded subagreement and implementing agreed upon scope or scopes of work • Lessons learned by and with CSO(s), DHE and communities captured and used to refine CSO engagement plan for PY 2-3 • CSO engagement plan ready for implementation across districts in PY2-3

MCHIP Zimbabwe will work in direct partnership with local NGOs/CSOs as a way of both expanding the reach and impact of MCHIP's support of the MOHCC in Manicaland, and strengthening a critically important segment of the broader health system. MCHIP will build and/or strengthen local civil society leadership to design, plan, implement, monitor, and evaluate MNCH-related programming at the community level, in an effort to empower community-led organizations to respond effectively to the health needs of their communities. Activities under this objective will build on the foundation of community-based work that MCHIP has laid over the past three years.

CSO engagement is an important ingredient in MCHIP's expansion of community MNCH work to other districts and communities. CSOs could be engaged in a variety of activities, such as improving community and household MNCH knowledge, practice and care seeking; engaging community committees in monitoring the of quality of MNCH services; stimulating demand and increasing utilization of services; and supplementing the training, supervision and support provided by health facilities for their VHWs.

In PY1, MCHIP will:

1) Work with the MOHCC, Manicaland PHE, DHEs and CSOs to define the roles that CSOs will be asked to play in provincial MNCH improvement efforts;
2) Develop a CSO engagement plan (including guidelines and tools for procurement, subagreement management and CSO capacity building)that will be ready for roll out in PY2;
3) Purposively select and begin working with one to two CSOs in PY1 to implement a portion of the project's community and family mobilization strategy; and
4) Initiate a competitive CSO procurement process for award of subagreements early in PY2.

After MCHIP's initial mapping of CSOs and the project's assessment of CSO capacity to contribute to the MOHCC's and MCHIP's Life of Project results, 1-2 CSO partners will be selected to participate with MCHIP staff in expansion of specific community MNCH activities described under Objective 2. MCHIP will work with these first CSO partners to finalize their scopes of work, and to develop workplans and budgets before awarding one-year, sole source subagreements. These first CSOs will be treated as members of the extended MCHIP team. MCHIP will work directly with them to build their technical and managerial capacity and will compile and use lessons learned to refine its CSO engagement plan, processes and tools. The goal is to have a final CSO engagement plan and tools that can be rolled out in support of all seven districts in PY2.

	ACTIVITY TITLE/DESCRIPTION	TASKS	TIMELINE (JAN. 2014-DEC. 2014)				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
Activity 3.1 Work with the MOHCC, the National Association of NGOs, and other partners to identify and engage CSOs to support improved MNCH in Manicaland							
3.1.1	**Develop CSO engagement plan**: An MCHIP framework for mobilizing communities and families to improve MNCH is in draft. In PY1, MCHIP will develop terms of reference for CSO engagement in the implementation of its community strategy in consultation with the PHE and DHEs in Manicaland. Other elements of the CSO engagement plan will include the CSO selection criteria; guidelines for competitive selection of CSO partners; templates for solicitations, proposals, budgets, subagreements, reports and other required documentation; and tools for assessing and strengthening CSO capacity, among others. All of these will be compiled and will serve as MCHIP's draft CSO engagement plan in PY1.	Finalize MCHIP's strategy for mobilizing communities and families	X	X			• Internal document to guide MCHIP's community work, including engagement of CSOs finalized
		Identify CSO roles and responsibilities with MOHCC/Manicaland and other partners		X			• Clear guidance provided from MOHCC and NANGO on the role and scope of CSOs in community health
		Draft guidelines for CSO selection and subagreements, including templates and tools for CSO competitive procurement, proposals, budgets, subagreements, reports, and other documentation		X	X	X	• Detailed implementation plan guidelines and tools developed for competitive selection of CSOs, award and management of CSO subagreements, CSO reporting, etc.
		Adapt tools for assessing and strengthening CSO capacity in strategic planning and program design, technical MNCH issues, budgeting, financial and HR management, M&E and reporting, and other areas as needed			X	X	• Tools for CSO capacity strengthening adapted and ready for us (STTA - JSI Capacity Building Center)

	ACTIVITY TITLE/DESCRIPTION	TASKS	TIMELINE (JAN. 2014-DEC. 2014)				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		Finalize CSO engagement plan (guidelines, templates and tools) after use with first CSOs in PY 1 (see 3.1.2 below)				X	• CSO engagement plan, guidelines and templates finalized
		Develop plan for competitive selection of CSOs to support community health activities across Manicaland in PY 2 and PY 3			X	X	• Plan for competitive selection of CSOs in places in place • CSO tender or tenders issued
3.1.2	**Test CSO participation in PY1**: MCHIP will select 1-2 CSOs to participate in the implementation of its community health strategy in PY1. The CSO or CSOs in PY1 will be selected to increase specific elements of community and family mobilization in MNCH improvement and to help in refining the project's CSO engagement plan	Conduct a mapping exercise of existing CSOs in Manicaland community expansion sites (organizational profile, program and staffing portfolio)	X	X			• Completed inventory of CSOs and inventory report produced
		Identify one or more CSOs with presence in expansion sites and determine their interest in working with MCHIP and their organizational capacity	X	X			• Organizational Capacity Assessment conducted with 3 CSOs and feedback provided
		Work with selected CSO(s) and affected DHE(s) to develop detailed workplan(s) and budgets		X	X		• 1-2 CSOs ready to begin implementation
		Develop and implement plans for strengthening the selected CSO(s) technically, managerially, financially		X	X	X	• CSO-specific capacity building plans implemented
		Process sole source sub-agreement(s) for implementation in year one			X		• 1-2 one-year CSO sub-agreements awarded

	ACTIVITY TITLE/DESCRIPTION	TASKS	TIMELINE (JAN. 2014-DEC. 2014)				OUTPUTS/DELIVERABLES
			Q1	Q2	Q3	Q4	
		CSOs implement approved workplans/subagreements			X	X	• Activities carried out by CSO as defined in subagreements
		Interviews with CSOs, DHEs, HFs, and communities to capture lessons learned and refine CSO engagement plan				X	• Report and recommendations for final CSO engagement plan
3.1.3	**Begin CSO procurement for PYs 2 &3**: Initiate competitive selection of additional CSOs as partners in the project's community and family mobilization strategy	Finalize scopes of work for CSO engagement in PY2/3 and publish tender				X	• Tender published • PY2 CSO selection, start-up, and subagreements initiated

MONITORING AND EVALUATION

The MCHIP/Zimbabwe AA team will approach Monitoring & Evaluation (M&E) as a core management, project monitoring, problem-solving, and learning activity and will operate to the maximum degree possible within the MOHCC's existing health management information system (HMIS).

MCHIP/Zimbabwe's activities since 2010 set the foundation for the project's M&E strategy by focusing on district, provincial, and national-level coordination and capacity-building, and on establishing the necessary systems and tools to guide and manage project data collection and analysis. This includes the development of the formal Performance Monitoring Plan (PMP), databases that will be used to store and analyze project data, and M&E capacity-building that is required at each level to ensure timely, complete, and high quality project data.

Situation Update

The availability of timely, accurate, reliable, and relevant routine health information remains a significant challenge in Zimbabwe. Resource constraints (human, financial, and technical) continue to pose challenges at all levels of the health system (national, provincial, district, and facility) that result in the unavailability of health-related information needed by policy makers, program managers, facility staff, donors, and other stakeholders. Data collection, reporting, analysis, and use are still problematic and coordination of HMIS activities at all levels is limited. As in previous years, inconsistent supply and use of data collection forms and registers, limited communication between levels of the health information unit, and other inadequate support systems (including limited supportive supervision of health information staff) all serve to compromise the ability of health personnel to record, report, and use high quality data. Manicaland is not immune to these challenges.

PY1 Performance Targets

Internal:
- MCHIP PMP updated with revised targets
- One internal MCHIP M&E retreat conducted
- 4 quarterly reports produced and submitted to MCHIP headquarters and USAID mission
- 4 quarterly feedback reports shared with the district teams
- 2 newsletters produced and shared with stakeholders (MOHCW and other partners)
- Learning agenda plan, protocols, and databases finalized and reports/findings disseminated

External:
- 4 quarterly data verification exercises conducted in all 7 districts of Manicaland and reports shared with stakeholders
- Quarterly supportive supervision visits conducted to each of the MCHIP-supported HFs in the seven districts.

Key Activities and Tasks for PY1

The objective of M&E and HMIS activities is to improve the quality, availability, and timely usage of health information for internal and external decision-making and learning. In PY1, MCHIP will build on previous years' activities and will continue to support the MOHCC at national, provincial, and district levels in the areas of M&E and HMIS. In PY1, MCHIP's key activities and tasks under the M&E objective include:

M&E 1: Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high-impact MNCH health interventions. MCHIP will continue to participate in the national HMIS Steering Committee and work towards supporting the finalization of a national HMIS Implementation Plan. MCHIP will continue to explore additional ways to support national-level coordination functions and activities. At the provincial and district levels, MCHIP will build on HMIS-related training investments made since the beginning of MCHIP by supporting provincial and district-level Health Information Officers (HIOs) to conduct

supportive supervision during which they will mentor and assist HWs in their data collection and management duties. In addition to providing support for mentoring and supportive supervision, MCHIP will also assist the MOHCC to conduct quarterly data verification activities in implementation sites. Data verification activities will be aimed at engaging HWs in the examination of data being collected at their facilities and discussions about how data collection, reporting, analysis, and use can be improved. Findings from data verification activities can then be used to target supportive supervision visits and highlight areas needing extra support.

M&E 2: Strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated MNCH services at HFs and in the community to support national-level scale-up plans: MCHIP/Zimbabwe will actively monitor its progress through the collection of routine internal and external project data, and regularly report on its progress to stakeholders within and outside of the project. The project's guiding M&E-related document is its PMP, which is based on experience gained since the beginning of MCHIP. As in previous years, continual efforts will be made in Y1 to orient and train MCHIP staff and stakeholders on data issues relevant to the project as well as data issues relevant to effective monitoring and decision-making within the health system. In addition, MCHIP staff will work on other activities such as the production of quarterly feedback reports and semi-annual project newsletters to sensitize and build capacity among MCHIP staff and project partners/stakeholders in M&E and other areas.

M&E 3: Strengthen the capacity of CSOs to implement MNCH activities and manage U.S. Government (USG) funding. MCHIP will monitor and document lessons learnt in the engagement and subsequent working with CSOs to understand how effective the relationship will be in reaching key Zimbabwean sub-populations like the apostolic religious sects in Manicaland with health promotion and demand generation activities. Efforts will be made to document the effectiveness and impact of MCHIP-supported activities on improving health behaviors and health outcomes among these groups.

For a comprehensive list of project indicators and targets for PY1, as well as for the life of project,, please refer to Annex 1: Performance Monitoring Plan (PMP).

ANNEX 1: PERFORMANCE MONITORING PLAN (PMP)

(Please see separate file)

ANNEX 2: BRANDING & MARKING PLAN

(Please see separate file)

ANNEX 3: ENVIRONMENTAL MITIGATION & MONITORING (EMMP)

(Please see separate file)

ANNEX 4: BUDGET SUMMARY

(Please see separate file)

ANNEX 5: BUDGET NOTES

(Please see separate files: 5a) Jhpiego, 5b) John Snow, Inc., and 5c) Save the Children)

ANNEX 6: BUDGET CHECKLIST

(Please see separate file)

Maternal and Child Health Integrated Program

ZIMBABWE

Associate Award

Performance Monitoring Plan (PMP)

January 2014 - December 2016

Revised and re-submitted to:

United States Agency for International Development

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Submitted by:

Jhpiego in collaboration with

John Snow, Inc.

Save the Children

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ACRONYMS AND ABBREVIATIONS

AA	Associate Award
ACSM	Advocacy, Communication, and Social Mobilization
AMTSL	Active Management of the Third Stage of Labor
ARK	Absolute Return for Kids
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetrical and Newborn Care
CB-MNCH	Community-based Maternal, Newborn, and Child Health
CCM	Community Case Management
CCORE	(UNICEF-supported) Collaborating Centre for Operational Research and Evaluation
CD	Country Director
CH	Child Health
CS	Child Survival
CSS	Child Survival Strategy
CTC	Clinical Training Centers
DFID	United Kingdom Department for International Development
DQA/DQS	Data Quality Assessment/ Data Quality Survey
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EmONC	Emergency Obstetrical and Newborn Care
ENC	Essential newborn care
EPI	Expanded Program on Immunization
F&A	Finance and Administration
FP	Family Planning
HBB	Helping Babies Breathe
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTF	Health Transition Fund
ICC	Immunization Interagency Coordinating Committee
IEC	Information and Education Campaign
IIP	Immunization in Practice
IMNCI	Integrated Management of Newborn and Childhood Illness
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
M&E	Monitoring and Evaluation
MCCM	Malaria Community Case Management
MCHIP	Maternal and Child Health Integrated Program
MH	Maternal Health
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOHCC	(Zimbabwe's) Ministry of Health and Child Care (Formerly MOHCC)
MPMA	Maternal and Perinatal Mortality Audits
NH	Newborn Health
NIHFA	National Integrated Health Facility Assessment
OPD	Outpatient Department
OPHID	Organization for Public Health Interventions and Development
OR	Operations Research
PCV 13	Pneumococcal Conjugate vaccine
PE/E	Pre-eclampsia, eclampsia
PHC	Primary Health Care
PMP	Performance Monitoring Plan

PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPFP	Postpartum Family Planning
PQI	Performance Quality Improvement
PTFU	Post-Training Follow-Up
Q	Quarter
QA	Quality Assurance
QI	Quality Improvement
QOC	Quality of Care
RBF	Results Based Financing
RED/REC	Reaching Every District/Reaching Every Child
RH	Reproductive Health
RHC	Rural Health Center
SBM-R	Standards Based Management and Recognition
SIA	Supplementary Immunization Activities
SMT	Senior Management Team
SS	Supportive Supervision
STTA	Short-term Technical Assistance
TA	Technical Assistance
TB	Tuberculosis
TBD	To Be Determined
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
U5	Under 5 Years Old
USAID	United States Agency for International Development
VHW	Village Health Worker
WG	Working Group
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-related Hospitals
ZICOM	Zimbabwe Confederation of Midwives

SECTION 1: INTRODUCTION

1.1 BACKGROUND

The Maternal and Child Health Integrated Program (MCHIP) in Zimbabwe has been supporting the Ministry of Health and Child Care (MOHCC) to improve the quality of Maternal, Newborn and Child Health (MNCH) care services through the implementation of evidence-based, high-impact interventions since October 2010. These interventions were carried out in Manicaland province, with intensive support in the districts of Mutare and Chimanimani. For the next three years, under a new Associate Award (AA), MCHIP/Zimbabwe will continue to provide support to MOHCC, with a focus on Manicaland province. The project will expand program activities in a geographically-targeted and thematic-specific approach in order to achieve province-wide impact by the end of the project. Identification of new districts have been based primarily on mortality trends, the case load distribution patterns, partnerships mix and the potential to build on existing opportunities like the World Bank-funded Results-Based Financing Program (RBF). To expand the coverage of maternal and newborn interventions, MCHIP proposes a two-pronged approach: 1) an intense quality of care improvement intervention, based on the SBM-R approach, targeting at least four high-volume health facilities in each district, focusing on CEmONC/HBB; and 2) going beyond the high-volume sites with support for clinical training, supportive supervision and procurement to address the gaps identified at the lower level sites, which are the main source of the complicated cases, focusing on essential obstetric and newborn care (including KMC) to improve the capacity for early detection, stabilization and pre-referral treatment of cases. For child health and community-based interventions, the project will work towards district-wide scale-up in the current two districts in Year 1, and expansion to at least one other district by Year 2, with the aim of achieving district-wide coverage in three districts by Year 3. (*Refer to the Implementation Plan for a detailed description of the expansion plan.)*

1.1.1 Project Description

Vision

The MCHIP/Zimbabwe AA's vision is to significantly contribute to accelerated and sustainable improvement in maternal, newborn, and child health in Zimbabwe through scaling up evidence-based, high impact, integrated public health interventions.

Goal

The MCHIP/Zimbabwe AA's goal is to increase access to high-quality MNCH services and strengthen health services in Zimbabwe by supporting the MOHCC and contributing to the scale-up and rollout of evidence-based, high-impact interventions that will reduce maternal, newborn and child morbidity and mortality and malnutrition and support progress towards the attainment of MDGs 4 and 5.

Objectives

MCHIP/Zimbabwe's objectives are to:

1. Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high-impact MNCH health interventions;
2. Strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated MNCH services at health facilities (HFs) and in the community to support national-level scale-up plans; and
3. Strengthen the capacity of civil society organizations (CSOs) to implement MNCH activities and manage U.S. Government (USG) funding.

Technical Approach and Strategies

Approach/Guiding Principles

The MCHIP/Zimbabwe Associate Award will build on the experience, successes and lessons learned to date. Apart from that innovations and evidence-based practices will be incorporated, not forgetting continued emphasis on building local capacity and sustainability across every activity. In implementing this project MCHIP Zimbabwe will be guided by the following principles:

a) **Promoting women, girls and gender equity:** At the national level, as a member of the Health Transition Fund (HTF) Steering Committee, and through the MNCH working groups, the MCHIP Zimbabwe AA will advocate for rapid rollout of HTF plans to abolish user fees for MCH services. MCHIP will expand the coverage of quality improvement (QI) activities to new districts to equip health workers to deliver evidence-based, integrated services that are humanistic, respectful and client-centered. At the community level, MCHIP will work with VHWs and CSOs to engage Manicaland communities in dialogue around issues such as utilization of health services among women (apostolic and other) and children, empowerment issues within families, and early marriage and early pregnancy. Equity will be measured by the proportion of children accessing immunization services by religious group. MCHIP will also support the PHE to convene and strengthen provincial partner meetings with other USAID-funded and non-USAID-funded projects in Manicaland and PHTs. These meetings will give partners the opportunity to advocate for integrating relevant issues (e.g., gender-based violence, family planning (FP) and cervical cancer prevention and services) within provincial and district implementation plans and budgets.

b) **Encouraging country ownership and investing in in-country plans:** Throughout the first award, MCHIP focused exclusively on providing technical and other support for MOHCC structures and government-led programs, policies and initiatives, believing that doing so would result in greater country ownership, empowerment and sustainability of achievements. The MCHIP/Zimbabwe AA will continue this approach and will invest in in-country initiatives and plans, including providing leadership to develop them, as requested by the MOHCC. At provincial and district levels, MCHIP will continue to foster country ownership by providing support to activities identified and prioritized by the Provincial Health Executives (PHEs)/District Health Executives (DHEs), in the areas of strategic planning, coordination, program implementation, health information systems and M&E. MCHIP will also assist the MOHCC to engage with global initiatives and emerging best practices. In addition, by identifying and building the capacity of local CSOs in MNCH project management, MCHIP will foster further community participation that will ensure sustainability and local ownership of MNCH activities.

c) **Increasing impact through strategic coordination and integration while strengthening and leveraging other efforts/partners:** Since the project began in early 2011, MCHIP has built a solid foundation of relationships with MOHCC counterparts and other key MNCH stakeholders such as UNICEF, WHO, the United Nations Population Fund (UNFPA), Ark Zimbabwe, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the Organization for Public Health Interventions and Development (OPHID), the White Ribbon Alliance (WRA) and others. As a result, MCHIP has a seat at the table for MNCH-related policymaking, strategy formation, guideline development and program planning/coordination. Under the MCHIP/Zimbabwe AA, and as illustrated in Annex I, we will use these relationships to leverage the efforts and resources of other partners and initiatives such as HTF, ISP and the Global Fund. MCHIP will engage in strategic dialogue with the MOHCC, donors and technical partners at the national level to influence the national technical agenda and will garner buy-in for scale-up of MCHIP/AA-supported approaches. At provincial and district levels, MCHIP will focus on providing technical assistance to the MOHCC and will seek to leverage partner resources to amplify its technical reach.

d) **Improving metrics and monitoring and evaluation (M&E):** The MCHIP/Zimbabwe AA will continue to provide technical assistance to the MOHCC in its efforts to strengthen the health management information systems (HMIS) at all levels. Specifically, MCHIP will support the MOHCC by working in three strategic areas: 1) HMIS design, 2) HMIS performance and infrastructure and 3) data quality and use in decision-making. Working through the national HMIS Steering Committee and Technical Working Groups (TWGs), the Global Fund-supported information systems strengthening initiatives, the Results-Based

Financing scheme and other MNCH TWGs, MCHIP will advocate for the inclusion of key quality of MNCH care indicators in national and partner indicator matrices as well as for strengthening and integrating the community HMIS with the national HMIS. MCHIP will also work with ZIMHISP and other partners in supporting the national rollout of performance improvement related to the DHIS. MCHIP will also test the use of other innovations, such as the use of mobile phones for HMIS data collection. In addition, MCHIP will work with various partners at all levels(as illustrated in Annex I)to support the use of health management information for decision-making through targeted support to maternal and perinatal mortality audits (MPMAs), program implementation and review meetings, data quality audits, operations research and piloting innovative approaches to streamline and standardize the HMIS.

e) **Promoting research and innovation:** MCHIP will continue to prioritize research, innovation and learning as a key project focus and use results from studies to refine its implementation design and advocate for the adoption and scale-up of successful approaches.

f) **Engaging and building the capacity of civil society:** Under the MCHIP Zimbabwe AA, MCHIP will partner selectively with local CSOs in order to: 1) reach culturally and geographically hard-to-reach communities with a more complete package of evidence-based MNCH services and behavior change messages; 2) address important socio-economic and gender-based factors that contribute to poor maternal, newborn and child health outcomes; and 3) influence local decisions—community, household, health facility decisions—that can affect the availability and acceptability of MNCH services among vulnerable population groups. Our goal is for CSO sub-awardees to be able to design and implement locally appropriate strategies that increase the population's demand for—and their access to and use of—MNCH information and services over time. MCHIP will work with the MOHCC and the National Association of NGOs to review the national BCC strategy and ensure that MNCH, malaria and gender-related issues that limit access to care for women and children are addressed through a common set of messages and materials that all CSOs can use. In Manicaland Province, MCHIP will support the development of annual provincial-level integrated implementation plans and will work with the MOHCC to develop scopes of work that address BCC needs in areas such as community MNCH, malaria and gender. MCHIP will then use these scopes of work to identify CSO partners that could be engaged to help reach population groups and geographic areas that are not currently being reached through the traditional health services. In the area of community MNCH, possible CSO partners in Manicaland include the Community Working Group on Health (CWGH), OPHID, FACT Mutare, Jekesa Pfungwa, the White Ribbon Alliance, and Plan. Possible partners in the areas of community mobilization/sensitization for early malaria care seeking behavior may include CWGH, Tsuro dze Chimanimani, PSI and Padare. Possible partners to address gender issues that affect access to care for mothers and children may include Padare, UDACIZA, CWGH, Jekesa Pfungwa, WRA, FACT and the Musasa Project. Scopes of work for CSO involvement will be need-based and will include specific, doable actions and clear deliverables in all cases. MCHIP will support CSO capacity building, CSO-led program implementation and CSO-led program monitoring and evaluation.

g) **Building sustainability through health systems strengthening:** MCHIP/Zimbabwe currently supports four of WHO's six health systems strengthening building blocks (i.e., health service delivery, health workforce, health information systems, and health leadership and governance; the two remaining HSS building blocks being support for essential medicines and health system financing) and will maintain support for these pillars under the MCHIP/Zimbabwe AA. In addition, MCHIP will focus on building the capacity of CSOs to create demand for HF services and manage high-quality MNCH-related activities at community level. MCHIP believes that working with CSOs and existing community structures will build awareness and demand for MNCH services and will lead to greater sustainability of project results, since these resources will remain in place beyond the life of the AA.

h) **Committing to Quality Improvement (QI):** The program's continued commitment to QI will be reflected in MCHIP's focus on:
   a. Raising the national profile on quality and the concept of "going beyond the numbers";
   b. Catalyzing individual and institutional change processes at all levels of the public health system;
   c. Supporting a comprehensive "whole site" improvement model and integrating services;
   d. Supporting scale-up of CBT approaches;

e. Strengthening the HMIS and MPMA system so stakeholders are better able to collect, analyze and use data for improvement of program performance; and
f. Advocating for the incorporation of indicators measuring quality (not just quantity) into the national HMIS, as well as in major initiatives like the HTF and RBF. By taking advantage of curriculum reviews and further strengthening PSE, quality will also be ensured for new health workers entering the system.

i) **Leveraging resources:** The number of donors providing MNCH funding has increased since 2010. A core strategy will be to work closely with the MOHCC and HTF donors to leverage resources for district-wide activities. The HTF is helping to revitalize MNCH services, provide essential medicines, support health service staffing (e.g., retention scheme, training and supervision), and assist with policy and national health financing systems. Leveraging resources and partners will be critical to the expansion of MNCH activities into additional districts. MCHIP will also build upon achievements supported by the USG in the areas of preventing mother-to-child transmission of HIV (PMTCT), HIV prevention, tuberculosis (TB), malaria, nutrition and FP programs. MCHIP, working closely with implementing partners such as OPHID, EGPAF, Ark Zimbabwe, Catholic Organization for Relief and Development Aid (CordAid)/World Bank, UNICEF, UNFPA, the Zimbabwe National Family Planning Council (ZNFPC) and others, will identify their comparative advantages in strengthening different technical MNCH components of health service delivery.

j) **Geographic focus:** In addition to supporting the MOHCC at the national level with MNCH-related policy and guidelines development through TWGs, MCHIP/Zimbabwe activities to date have focused on Manicaland Province, with an intensive level of support in Mutare and Chimanimani districts. Under the AA, the team will expand program activities in a geographically targeted and thematic-specific approach in order to achieve province-wide impact by the end of the project. Identification of new districts will be based primarily on maternal and newborn mortality trends, case load distribution patterns, partnership opportunities and the potential to build on existing opportunities (e.g., the World Bank-funded Results-Based Financing Program [RBF], which works in 18 districts in Zimbabwe). In order to build sustainability and ensure that MCHIP staff members are not overstretched, MCHIP will utilize lessons learned in Mutare and Chimanimani. In the last three years MCHIP, working with DHEs, has been implementing Standards-Based Management and Recognition (SBM-R) modules in 17 to 22 facilities using the SBM-R modular training strategy across all facilities simultaneously. This effort is capacitating facility staff to conduct self-assessments, peer assessments, and gap analysis, and to develop and implement action plans for MNCH improvement. Moving forward, under the AA, working with PHEs, the program plans to take a provincial approach to implementing SBM-R (i.e., module one training will be conducted for all 21 facilities in the five districts simultaneously); the rest of the modules be conducted in the same way. For rapid scale-up of interventions, the MCHIP/Zimbabwe AA will support the training of national and provincial trainers, who subsequently cascade trainings and post-training follow-up (PTFU) to provinces. Supportive supervision sustains these gains. Furthermore, because procurement and facility refurbishment support is being funded through HTF and RBF, MCHIP is proposing different expansion approaches for its maternal and newborn health (MNH) and child health (CH)/malaria work:

For **Maternal and Neonatal Health**, the following three key issues were noted in the current districts:

1. All maternal and newborn deaths reported in the past three years in a district were from just two high-volume sites in that district;
2. A significant number of the complicated cases were referrals-in from outside the district; and
3. The poor quality of health care, prior to referral for higher-level treatment, adversely affects final health outcomes. MCHIP, therefore, proposes a two-pronged approach to scaling up MNH activities in the province. First, an intense quality of care improvement intervention, based on the SBM-R approach, will target four high-volume health facilities in each district, focusing on Community Emergency Obstetrical and Newborn Care (CEmONC)/Helping Babies Breathe (HBB). Second, support will be provided to lower level sites for clinical training, supportive supervision and procurement to address the gaps identified at these sites, which are the main sources of complicated cases. Support

for these sites will focus on essential obstetric and newborn care including Kangaroo Mother Care (KMC) to improve capacity for early detection, stabilization and pre-referral treatment of cases. For CEmONC, HTF is procuring blood for use by health facilities through a coupon system, and MCHIP plans to support strengthening health facilities' capacity to conduct care and support through short-term clinical attachments of doctors and nurse anesthetists to provincial or central hospitals to demonstrate best practices.

For Child Health, in order to save infant and child lives from the major killers after the newborn period, capacity—at the lower primary health care (PHC) level, and in the communities around them—must be improved so that preventive interventions can be delivered and sick children can be properly assessed and treated. To date, our work in Chimanimani and Mutare has focused on too few PHCs and communities to make a significant difference in child survival; therefore, we are proposing to expand to additional PHCs in the same districts before adding one to three additional districts in PYs 2 and 3. The province-wide approach to immunization adopted under the current MCHIP Zimbabwe program will be consolidated under the AA by focusing on supporting successful introduction of new vaccines and strengthening Reaching Every District (RED) implementation. Additional resources will be mobilized during the life of the project from partners like the ELMA Vaccines & Immunization Foundation to expand immunization activities to two new provinces.

As more intensive support begins in new districts, a transition plan for a "less intensive" phase of support for Mutare and Chimanimani will be drawn up in collaboration with the DHE team and the provincial health team. "Less intensive" support is likely to consist of providing joint supervision and supporting monitoring activities, rather than focusing on training and acquiring equipment or refurbishing clinics. To ensure a responsible transition, MCHIP will include the following in its transition plan: 1) an assessment of the MOHCC's capacity to sustain the results achieved in Mutare and Chimanimani; and 2) a determination of how best to phase out support.

15. **Equity –focused programming:** MCHIP Zimbabwe will promote equitable access to health services. A six-step process, as outlined below, will be used to identify and reach the most disadvantaged within the disadvantaged geographical region. We will compare health outcomes over time between the disadvantaged and advantaged groups. The RED strategy will aim to achieve this.

    The following Six-Step Check process will be followed:

    a) Understanding the equity issues
        - identifying inequities in health outcomes and the magnitude of the differences:- Who are these children that suffer/die from vaccine preventable diseases and How many are they?
        - and understanding underlying issues and barriers to universal immunisation:- Is it a problem of geographic access, race, occupation, gender, religion, education or socio economic status?

    b) Identifying the disadvantaged groups on which to focus: Using community linkages to identify these groups, VHWs head counts as well as EPI Registers.

    c) Deciding what the EPI Programme can manage to change: Adopting approaches that best suit the hard-to-reach populations.

    d) Defining equity goals, objectives and the "reaching every child" (REC) goal: Mapping out, quantifying setting targets to reach the unreached.

    e) Defining equity strategies and activities of reaching the unreached: Dialogue with influential Traditional, Religious and Political leaders. MCHIP to explore working with Union for Development of Apostolic Churches in Zimbabwe, Africa (UDACIZA). Also engaging the Apostolic youths through UDACIZA to serve as agents for change. Advocating for Apostolic faith VHWs.

    f) Developing equity-focused M&E to capture the percentage of apostolic children, as an underserved population, who received all basic immunizations.

16. Gender Mainstreaming

Under the MCHIP/Zimbabwe AA, the project team continues to recognize that women are at a disadvantage at the household, community, and societal levels. Within the household, women have more limited access to and influence over resources and household decisions. Outside the household, women often have more limited access to communal resources, are under-represented in public decision-making bodies; have limited bargaining power in markets (such as the labor market), and often lack opportunities to improve their socioeconomic position. These dynamics contribute to the increasing maternal morbidity and mortality in Zimbabwe. Efforts to reduce gender inequality, including through increased male engagement, will be enhanced in all intervention areas to increase access to MNCH services. Where possible, the project will ensure that training indicators are disaggregated by gender, and aim to assess how project interventions affect males and females differently.

1.2 PURPOSE OF THE PMP

This Performance Monitoring Plan (PMP) will guide the collection and management of information in monitoring and evaluating the performance of the MCHIP/Zimbabwe AA project. The guiding document for this PMP will be the MCHIP/Zimbabwe Associate Award—which is in line with the Zimbabwe Health Strategy 2010–2015 and National Health Information Strategy 2009-2014—and MCHIP/Zimbabwe AA annual workplans. The PMP identifies a key set of program performance indicators that will be used to monitor and evaluate the project's progress in achieving its intended objectives over the next three years. For each indicator, the PMP defines the source of data, method of data collection, frequency and schedule of data collection, and the person(s) responsible for data collection.

The PMP is a tool to be used by the team to help ensure that data collection and analysis are timely and useful to the MCHIP/Zimbabwe AA, USAID, in-country project counterparts, and the global MCHIP program. The PMP will be used to report progress against set targets, and to facilitate regular review and adjustment of project strategies and activities as needed.

1.2.1 Key Monitoring and Evaluation Questions to Be Addressed

The project indicators and evaluation plans highlighted in this PMP will enable the MCHIP/Zimbabwe AA to address fundamental questions around monitoring and measuring the success of the project and its intended impact.

Key M&E questions include the following:

1. Is the MCHIP/Zimbabwe AA helping to strengthen the capacity of the MOHCC at the national level to formulate evidence-based national health policies, strategies, and programs to enhance scale-up of high-impact MNCH health interventions?
2. Is MCHIP Zimbabwe helping to strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated MNCH services at HFs and in the community to support national-level scale-up plans; and
    - Is the MCHIP/Zimbabwe AA increasing access to and use of evidence-based MNCH-FP interventions?
    - Is the MCHIP/Zimbabwe AA improving the quality of care in MNCH-FP service provision?
    - How effective has MCHIP's model for supportive supervision (SS) been at improving health worker performance and how can the SS approach be made more sustainable?
3. Is MCHIP Zimbabwe strengthening the capacity of CSOs to implement MNCH activities and manage U.S. Government (USG) funding?
    - How effective have MCHIP/Zimbabwe AA and its CSO partners been in reaching key Zimbabwean sub-populations like the apostolic religious sects in Manicaland with health promotion and demand generation activities?
    - What interventions were particularly effective and not so effective?

- What impact have MCHIP/Zimbabwe AA-supported activities had on improving health behaviors and health outcomes among these groups?

4. Is the MCHIP/Zimbabwe AA helping to reduce maternal, neonatal and child deaths in supported districts?
5. Can the MCHIP/Zimbabwe AA's learnings be shared and used to improve programming throughout the country?

1.3 GUIDING PRINCIPLES OF THE PMP

The PMP is an important tool for managing and documenting project performance. It enables timely and consistent collection of comparable performance data, which allows the MCHIP/Zimbabwe AA team to make informed project management decisions. The following are principles governing this PMP:

a) **A tool for self-assessment:** This PMP has been developed to enable the MCHIP/Zimbabwe AA team to actively and systematically assess its contribution to MOHCC MNCH results and take corrective action when necessary. At its core are practical tools such as indicator reference sheets and a performance management task schedule.

b) **Performance-informed decision-making:** The PMP is meant to inform management decisions. The chosen indicators will provide data to answer the key M&E questions highlighted above, under Section 1.2.1. Project data will provide information on the effectiveness of activities in advancing the project's four major objectives.

c) **Transparency:** To increase transparency, indicator and data quality assessments will be conducted wherever possible, and any known limitations documented in the PMP. Efforts will be made to ensure that intermediate results and project outcomes can reasonably be attributed to MCHIP efforts.

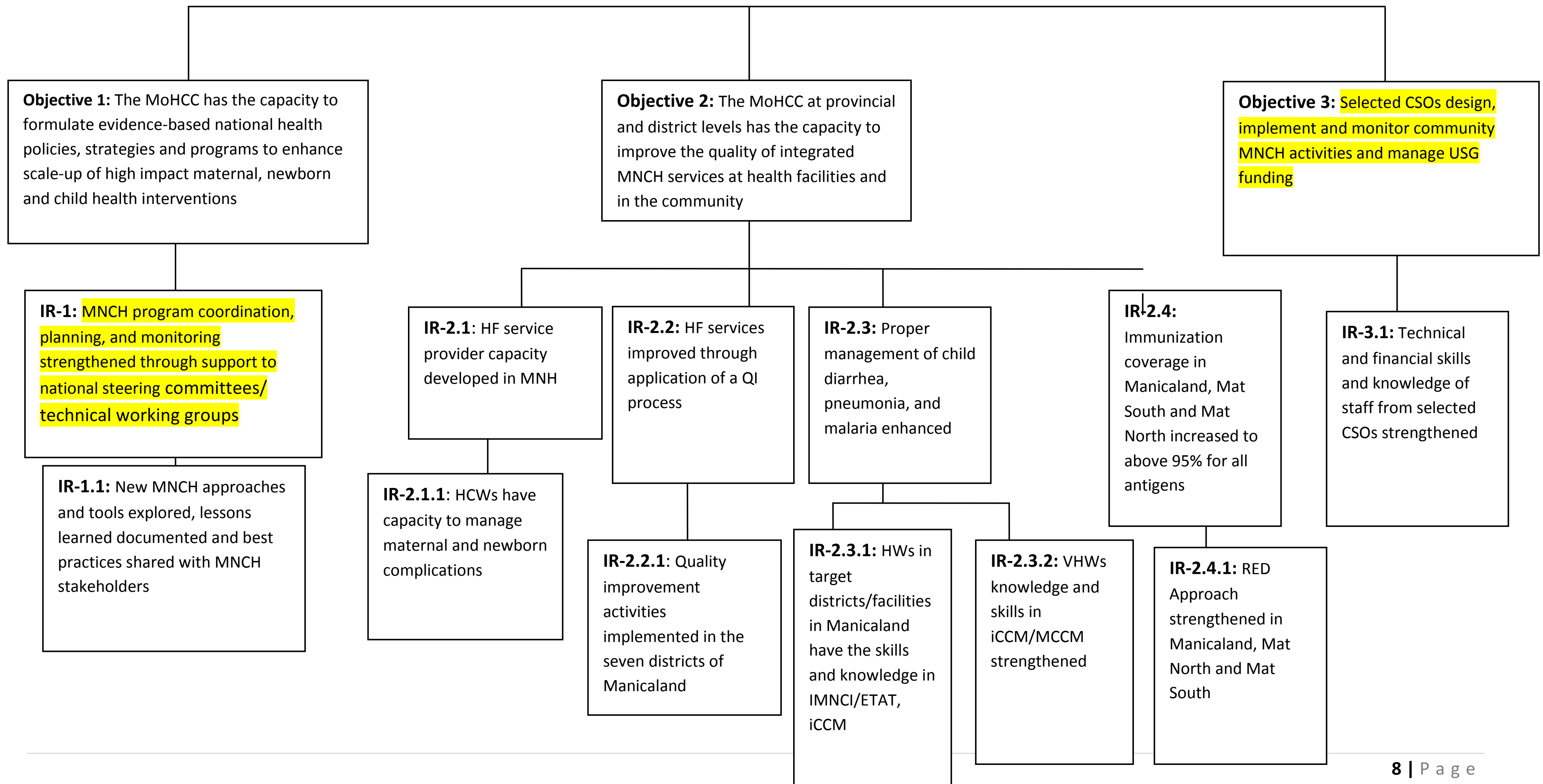
d) **Economy of effort:** When selecting indicators, efforts have been made to streamline and minimize the burden of data collection and reporting on project staff and counterparts. As such, efforts have been made to utilize data and data sources that are already being collected and/or used by MOHCC, with a few additions. In addition, the principle of "management usefulness" was applied to ensure that only data that will be useful for decision-making will be collected.

e) **Avoiding parallel systems:** The MCHIP/Zimbabwe AA's main priority is to provide support to the MOHCC and avoid creating parallel systems that cannot be sustained after the project has been completed. Efforts will be made wherever possible to avoid creating parallel data collection systems except where necessary, focusing instead on strengthening and using the existing HMIS.

SECTION 2: RESULTS FRAMEWORK

As outlined above, the MCHIP/Zimbabwe AA project has articulated three major project objectives that contribute to the overall project goal of national-level reductions in maternal, newborn, and child mortality. Each objective is supported by one or more intermediate results, which are supported in turn by lower-tier intermediate results. Achievements made towards intermediate results lead to achievements toward the major objectives, which in turn contribute to national-level impact. These relationships are depicted below, in the project's Results Framework.

2.1 GRAPHICAL REPRESENTATION: MCHIP/ZIMBABWE AA RESULTS FRAMEWORK



2.2 PERFORMANCE INDICATORS

Thirty-three project indicators have been identified to help monitor the performance of the MCHIP/Zimbabwe AA. These are organized into four groups, which correspond to the three project objectives and goal. Some of these indicators also align with/are the same as those used in monitoring the Zimbabwe National MNCH Program. A detailed explanation of the indicators is included in Section 4.2, "Indicator Reference Sheets."

2.2.1 Criteria for Selecting Indicators

The purpose of the proposed project indicators, which have been determined in consultation with USAID, the MOHCC, and key partners, is to support effectiveness and efficiency throughout the processes of planning, implementation, monitoring, reporting and evaluation—in other words, over the full spectrum of project implementation. All MCHIP/Zimbabwe AA indicators are in line with national MOHCC MNCH indicators, USAID indicators, and/or global MCHIP indicators. MCHIP/Zimbabwe AA indicators are described in the Indicators Table below, under Section 4.

2.2.2 Target Setting

Most project targets for PY1 are derived from the endline project results of the previous (and overlapping) MCHIP/Zimbabwe award. Selected project targets are based on national statistics (e.g., MOHCC, MIMS, or DHS data) or district-level data (e.g., district census data). All MCHIP/Zimbabwe AA targets have been set to monitor improvements in quality and/or utilization of services, and not just increases in the project's geographical coverage. Targets for PY2 and PY3 have been set based on average annual achievements under the previous MCHIP/Zimbabwe award as well (per the Indicators and Targets table below, under Section 4). These are subject to change, depending on factors such as project performance and changes in the operating environment. As such, targets will be reviewed accordingly on an annual basis.

2.3 CRITICAL ASSUMPTIONS

The MCHIP/Zimbabwe AA project has made some critical assumptions in setting the proposed project targets. These including the assumption that the MOHCC will continue to be a committed partner in providing the human, financial, and material resources required for a functioning health delivery system. The HTF is moreover assumed to be available until the end of the MCHIP/Zimbabwe AA implementation period, so that critical resources are available to help bolster the morale of Zimbabwean health workers. It is assumed that mothers and pregnant women will continue to have confidence in the national health system and will value antenatal care (ANC), as well as delivery, postnatal, and CH services. The economic and political environment in the country is also assumed to remain stable.

SECTION 3: MANAGING FOR RESULTS

3.1 COLLECTING PERFORMANCE DATA

3.1.1 Primary Data Collection Tools

The MCHIP/Zimbabwe AA will rely on MOHCC primary data collection tools to collect MNCH/FP data. However, where data collection tools do not currently exist or are not currently being used routinely, efforts will be made, in consultation with the MOHCC, to develop supplementary tools, incorporate additional variables on existing tools, and/or revitalize tools currently out of use, in order to ensure the availability of data needed by the project. Primary data collection tools to be used include ANC registers; outpatient department (OPD) registers; delivery registers; T3/T5/T6 tally sheets, the DHIS, and others. For community-level activities, the MCHIP/Zimbabwe AA will also rely on community health worker (CHW)-based tools such as village health worker (VHW) registers. Efforts will be made to ensure that the community MNCH data is incorporated into the routine HMIS.

3.1.2 Levels of Performance Data

- **Process (input and output)** indicators refer to useful data for ongoing, continuous management of activities by the MCHIP team. For example, indicators on numbers of support and supervisory visits conducted are output indicators. These indicators generally provide more operational data than results-oriented data. Process data will therefore be used to assess project and counterpart/partner performance and address operational issues. These indicators are primarily drawn from the agreements and work plans agreed upon by the MCHIP/Zimbabwe AA and its implementing partners. Data on activities will be found mainly in internal activity reports.

- **Outcome** indicators refer to project results that pertain to service quality, changes in behaviour and intervention coverage. Outcome indicators selected by MCHIP directly correspond to the objectives and IRs laid out in the Results Framework and also serve as the basis for performance reporting to USAID/Zimbabwe and there is a reasonable expectation that improvements in these indicators could be attributed to MCHIP/Zimbabwe AA interventions.

- **Goal (impact)** indictors measure results pertaining to morbidity, mortality, and quality of life and are at a higher level than the MCHIP/Zimbabwe AA's intermediate objectives, at the program goal level. Two high-level indicators will be tracked for project-supported facilities. These indicators are sometimes indicators of development results that are influenced by multiple factors, such as other partners' contributions and government action, and hence cannot necessarily be directly attributed to project activities.

3.2 PROCESSING AND ANALYZING PERFORMANCE DATA

The MCHIP/Zimbabwe AA's national M&E Unit, headed by the Director Innovations, Research, and M&E, will be responsible for consolidating and analyzing project data sets. This will help to assess project performance and reveal any project-related challenges. Data will be analyzed against set targets, comparing results for the quarter against results from previous quarters, and against annual targets. Quarterly and annual performance results will be reviewed against targets, and justifications for not meeting or exceeding targets will be provided.

Project coverage will also be analyzed at the health facility and population levels to determine access to and utilization of MNCH services by women and children in the project's target areas.

3.2.1 Data Management

An internal project monitoring database was developed under the previous MCHIP/Zimbabwe award. We will continue to use this database to manage and analyze routine data under the AA. The project team will help strengthen country staff capacity at lower levels to manage and analyze local datasets.

3.2.2 Project Monitoring and Training Databases

In collaboration with partners such as ITECH, MCHIP will be using a national training monitoring database to be managed by MOHCC. This database will be used to establish trends in staff attrition over time, and to better inform future training needs. Under the previous MCHIP/Zimbabwe award, an internal training database was developed to track the number of health workers trained by type, location, cadre, and gender. As the AA project team now awaits rollout of the national training database, this internal training database will be used in the meantime to track trainings supported by the project.

3.2.3 Reviewing Performance Information

To help make effective management decisions, the MCHIP team will hold internal quarterly performance and annual internal performance reviews. Depending on the results of these reviews, the MCHIP team may decide to adjust its activities and/or approaches. The following will be reviewed during these performance reviews:

- Progress toward achievement of objectives and expectations regarding future results achievement;
- Evidence that outputs of activities are adequately supporting the relevant IRs and ultimately contributing to the achievement of the objectives;
- Adequacy of inputs for producing activity outputs and efficiency of processes leading to outputs;
- Status and timeliness of input mobilization efforts;
- Status of critical assumptions and causal relationships defined in the results framework, along with the related implications for performance towards objectives and IRs;
- Pipeline levels and future resource requirements; and
- MCHIP team effectiveness and adequacy of staffing.

In addition to these internal reviews, the MCHIP/Zimbabwe AA team will conduct external district reviews (quarterly and annually) that will engage stakeholders and partners in reviewing progress, and in discussing issues influencing project implementation and achievement of results. To the extent possible, and to maximize efficiencies, the project will prioritize conducting these external district review meetings along with existing quarterly review meetings conducted by the District Health Teams. Conducting joint district review meetings will enable improved planning, coordination, communication, and district-level implementation.

The following table describes internal and external performance reviews:

Type of review	Frequency	Purpose
Performance reviews (internal)	Quarterly	Allows the project team to discuss and assess progress towards results internally, and to plan for future quarters.
Performance reviews (with other partners excluding CSOs)	Quarterly	Allows the project team to discuss and assess progress towards results with external implementing partners and stakeholders, and to plan for future quarters.
Annual performance review (internal)	Annually	Strategic reviews – assess progress towards results, and draft annual workplans internally.
Annual performance review (with external partners)	Annually	Strategic review – assess and discuss progress towards results externally, and disseminate/discuss draft annual workplans (including joint workplans where possible) with external implementing partners and stakeholders.
Quarterly planning and review meetings with selected CSOs	Quarterly	Allows the project team to review and plan together with selected CSOs.

3.2.4 Annual Target Setting

To ensure program activities remain relevant and in line with national interests, project targets will be set annually. Changes to performance targets will be based on an annual review of project successes and challenges, and changes will be submitted to USAID in writing.

Targets may be influenced by many different factors, including:

- Trends in program performance;
- Increases in geographic coverage of the programme;

- Increases in service uptake through improved client tracking and access to services;
- Improvements in M&E system and data reporting;
- Changes in external factors; socio-economic and political factors that affect delivery of MNCH services.

3.3 REVIEWING AND UPDATING THE PMP

This PMP is a living document that will be used to guide MCHIP/Zimbabwe's overall monitoring and evaluation processes. Consequently, the plan will be reviewed on an annual basis during MCHIP's annual review meetings as well as will be referred to during quarterly performance review meetings. As new developments take place within the national MNCH programme and/or new indicators and targets incorporated, the PMP will be altered accordingly. Any changes will be communicated to USAID in writing.

3.4 REPORTING PERFORMANCE RESULTS

Project monitoring is a continuous process to assess whether the project is being implemented as planned, and the extent to which progress is being made towards achieving intended results. The sections below detail various methods of reporting performance results for the MCHIP/Zimbabwe AA.

3.4.1 Monthly Progress Reporting (District Team/MOHCC)

The MCHIP/Zimbabwe AA will abide by MOHCC monthly reporting structures and requirements. This is crucial to avoiding the unnecessary creation of parallel reporting systems by the MCHIP/Zimbabwe AA project. The project does not directly implement health service provision activities but provides support and technical input to MOHCC to deliver MNCH services, requiring primary data collection and aggregation to be done by MOHCC health workers at the health facility/site level. The project will use health registers and tally sheets developed by the national HMIS (and other ad hoc registers used at the facility level if needed).

While efforts to strengthen the HMIS are considered and/or developed, and to support preparation of project reports, MCHIP/Zimbabwe AA District Teams will help collect data from project-supported health facilities when necessary (using standardized tools that were developed under the previous MCHIP/Zimbabwe award; these tools will be reviewed to incorporate additional indicators), and submit these data to the national MCHIP/Zimbabwe AA office for analysis and reporting. Though efforts will be made to keep this level of intervention to a minimum, these efforts may be necessary to keep data flowing, as the current HMIS may not be able to provide real-time data needed by the project.

3.4.2 Training Workshop Reports

All training activities will be captured using a standard training workshop report form which was developed under the previous MCHIP/Zimbabwe award. Upon adopting the national training system under the AA, the project team will adjust the training workshop report form accordingly. This form will act as the primary data source for all indicators on training activities. For trainings that will be conducted by partners on behalf of the MCHIP/Zimbabwe AA, completed forms will be submitted to the project team soon after training has been conducted. Likewise for project-conducted trainings, completed forms will be submitted to the M&E Unit soon after training. Detailed narrative workshop reports will be submitted later to provide qualitative information on training processes. In order to assess knowledge and skills transfer, each training workshop will be accompanied by pre- and post-tests. In addition, each training workshop will be evaluated using standard evaluation forms. Timely participant feedback is critical to ensuring that future trainings are effectively and efficiently delivered.

3.4.3 District Review Reports (District Team/MOHCC)

District review meetings will be held on a quarterly basis to take stock of project implementation and inform future planning and implementation. These district review meetings will be held with MOHCC site-level implementers to review project progress, appraise each other on project challenges and new policy developments. To the extent possible, and to maximize efficiencies, the MCHIP/Zimbabwe AA will prioritize conducting these external district review meetings along with existing quarterly review meetings conducted

by the District Health Teams and district partners. Conducting joint district review meetings will enable improved planning, coordination, communication, and district-level implementation.

At the beginning of each project year, MCHIP/Zimbabwe AA District Teams will conduct district planning meetings with key partners and stakeholders to review progress against targets, develop district level annual plans, and revisit and/or revise targets as needed to inform district-level quarterly plans.

District review reports will be complied and shared with the project's national office, to ensure that all project staff members are kept continually abreast of project status and dynamics.

3.4.4 USAID Quarterly Reports (MCHIP/Zimbabwe AA)

The overall responsibility of monitoring project implementation and reporting project achievements and challenges to USAID will lie with the MCHIP/Zimbabwe AA national office (with contributions from the Washington, DC-based country support team). Reports will be submitted to USAID/Washington and USAID/Zimbabwe on a quarterly basis and shared with other stakeholders as appropriate.

3.4.5 Annual Reports (MCHIP/Zimbabwe AA)

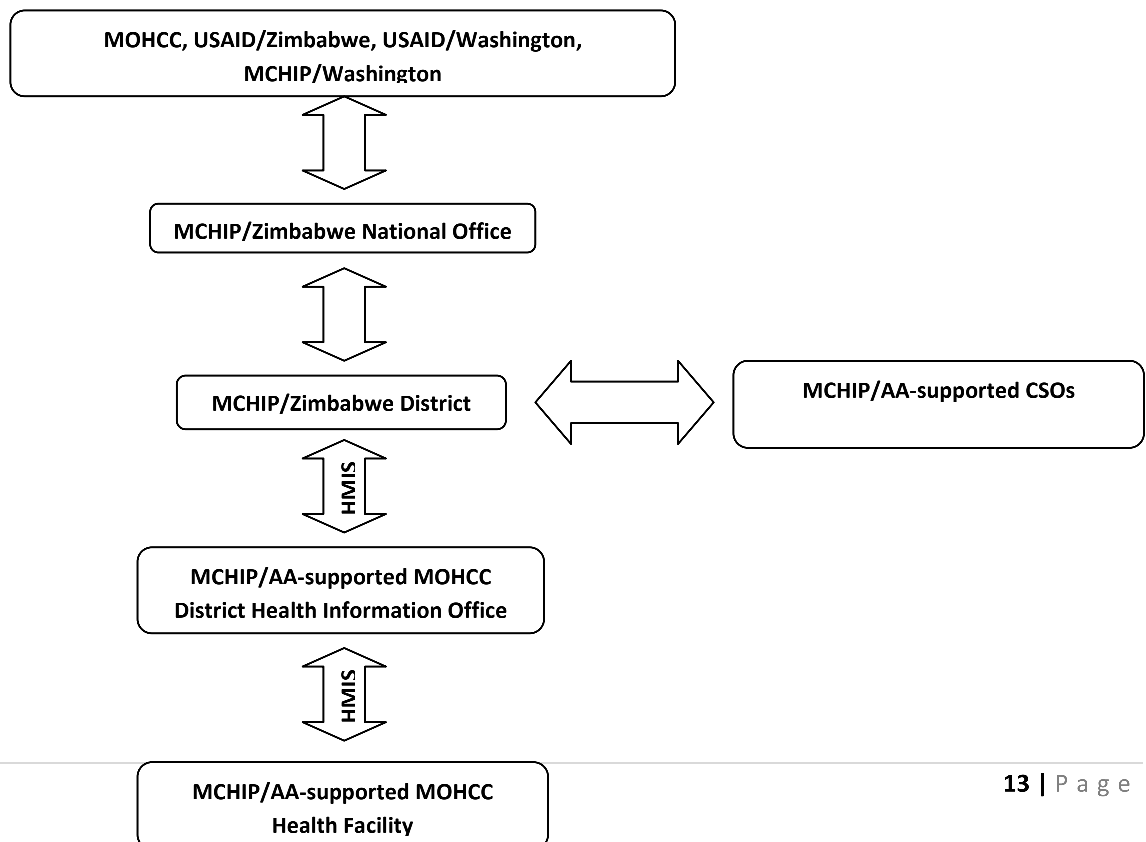
Annual reports will be compiled to review progress against annual work plans and targets and highlight successes and challenges in the overall project, providing justification for any under-performance or explanation of exceptional project achievements. Annual reports will be submitted to MOHCC and the USAID/Zimbabwe AA. MCHIP/Washington will also prepare a global annual report that compiles information across all MCHIP country programs and summarizes core-funded achievements. This report will be submitted to USAID/Washington.

3.4.6 Data Flow and Management

Timely communication of data to all relevant stakeholders is essential to ensuring effective monitoring of project implementation. This section details systems in place to ensure consistent communication.

The diagram below highlights how data flows to and from the implementing sites (e.g., MCHIP/Zimbabwe AA-supported health facilities through the HMIS, other sources such as VHWs) up and down various stakeholder channels.

Data Flow within the MCHIP/Zimbabwe AA Project



3.5 ASSESSING DATA QUALITY

Reliable, high-quality data is critical to ensuring meaningful analysis, reporting, and decision making. The MCHIP/Zimbabwe AA will assess the quality of data according to the following data quality standards (which are in line with USAID data quality standards):

- **Validity:** Efforts will be made to ensure that the collected data clearly, directly, and adequately represent the results they intend to measure.
- **Reliability:** Data collection methods will be the same over time, so as not to interfere with efforts to judge performance progress accurately.
- **Timeliness:** Data collection for reporting to USAID and other key stakeholders will be done consistently every quarter to ensure evidence-based decisions.
- **Precision:** Reported data will be checked for accuracy before analysed and shared with key stakeholders.
- **Integrity:** Mechanisms will be in place to reduce the possibility of data manipulation for political or personal reasons. This is admittedly difficult to assess, but it will remain an issue to keep in mind when setting up the systems to collect and review data.

The MCHIP/Zimbabwe AA will strive for high data quality at two levels (i.e., internally and externally). The table below include illustrative examples of procedures to be established for internal, project-level data collection, and on how MCHIP will help strengthen the national HMIS (externally). Examples of systems to be established by the project include:

Procedure	Internal	External
Data will be collected using standard data collection tools	MCHIP/Zimbabwe AA will develop a series of data collection tools and databases	MCHIP/Zimbabwe AA will support partners to use national HMIS data collection tools
Data will be collected by qualified personnel and personnel are properly supervised	Data collection supervised by MCHIP/Zimbabwe AA M&E Unit	MCHIP/Zimbabwe AA will support health facility workers and other partners (VHWs) to use appropriate data collection tools
Mechanisms will be put in place to prevent unauthorized changes to the data	MCHIP/Zimbabwe AA will ensure databases are password protected and access will limited to few staff	MCHIP/Zimbabwe AA will support MOHCC to strengthen existing HMIS security systems
Source documents, i.e., primary data collection tools will be maintained and readily available	MCHIP/Zimbabwe AA will store all primary data collection records onsite	MCHIP/Zimbabwe AA will support MOHCC to strengthen existing primary data collection storage systems

To ensure that all site level activities are effectively monitored, and as part of data quality control efforts, the MCHIP/Zimbabwe AA district team with assistance from the M&E Officer at national level will carry out routine site visits at least once every quarter. This does not mean that each site will be visited once every quarter; rather, site visits will be conducted every quarter ensuring that all sites will have been covered by the end of the year. The main objective of these visits will be to verify reported data against primary data sources and assess general project implementation at the site level against project standards and national guidelines. Aside from routine data verification visits, formal and structured data quality assessments will also be conducted to verify the quality of reported data for key indicators at selected sites; assess the ability of data management systems to collect, manage and report quality data; and implement corrective measures with action plans for strengthening the data management and reporting system and improving data quality.

The project team will monitor the number of site visits conducted per site per quarter. A tool has been developed to track the number of visits to individual sites throughout the year. The table below describes how the project team will assess data quality throughout the life of the project.

Monitoring Activity	Purpose	Frequency	Responsible Party
Site support visit	General site support; assess implementation of project activities, data collection and reporting, availability of MNCH medical supplies, client flow, training needs, etc.	Every quarter	MCHIP District team MOHCC District Office
Site data verification	Review data reports against primary data sources (i.e., data collection tools at health facility level)	Every quarter	MCHIP National Office USAID/Zimbabwe MCHIP District team MOHCC District Office
Site compliance visits	Monitor for compliance at site level with regard to various USG regulations (e.g., family planning regulations, environmental compliance*) and report issues to USAID	Twice per year	USAID/Zimbabwe
Data Quality Assessments	Verify the quality of reported data, assess ability of data management systems to collect, manage and report quality data	Every year	USAID/Zimbabwe
Site data verification (at prime partner and HF levels)	Verify the quality of reported data, assess ability of data management systems to collect, manage and report quality data	Every 3 years	USAID/Zimbabwe

** For more information on the MCHIP/Zimbabwe AA's Environmental Mitigation and Monitoring Plan (EMMP), please refer to the EMMP document.*

3.6 CONDUCTING EVALUATIONS AND SPECIAL STUDIES, INCLUDING OPERATIONS RESEARCH

To inform the program design, and determine key outcomes, a pre-post population-based household survey and facility survey will be conducted, after obtaining Institutional Review Board approval, to examine coverage and quality of key MNCH interventions promoted by the program. The project will explore the possibility of using LQAS in a step-wedge design comparing districts in which intervention activities have begun with districts in which activities have not yet begun. A smaller mid-line will be conducted on key indicators. The endline household and facility surveys will take place in the last half of implementation. Baseline values for selected MNCH indicators will be obtained through collection of data from the HMIS for the selected districts and province(s).

In conjunction with the MCHIP/Zimbabwe AA team, USAID will draft clear terms of reference for an external evalution to be conducted toward the end of project implementation, in PY3.

3.7 PERFORMANCE MANAGEMENT TASK SCHEDULE

The following table outlines the timeline associated with various M&E-related activities:

Performance Management Tasks and Indicators	PY1				PY2				PY3				Notes
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Collecting Performance Data													
1. Facility-based maternal mortality ratio	X	X	X	X	X	X	X	X	X	X	X	X	
2. Facility-based early neonatal and intrapartum mortality rate	X	X	X	X	X	X	X	X	X	X	X	X	
3. Facility – based U5 mortality	X	X	X	X	X	X	X	X	X	X	X	X	

Performance Management Tasks and Indicators	PY1				PY2				PY3				Notes
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Objective 1: Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high impact maternal, newborn and child health interventions.													
4. Number of national policies/guidelines/ protocols/strategies developed with MCHIP support				X				X				X	
5. Number of MNCH/FP evaluations/reviews conducted, with findings shared with stakeholders				X				X				X	
6. Number of trainers trained in MNCH	X	X	X	X	X	X	X	X	X	X	X	X	
Objective 2: Strengthen the capacity of the MOHCC at Provincial and District levels to improve the quality of integrated maternal, newborn and child health services at health facilities and in the community to support national-level scale-up plans.													
7. Number and percentage of people trained in MNCH	X	X	X	X	X	X	X	X	X	X	X	X	
8. Number and percentage of project-supported health facilities applying the SBM-R process for MNCH interventions that are achieving at least 80% of clinical standards				X				X				X	
9. Number and percentage of pregnant women receiving at least 4 visits for reasons related to pregnancy	X	X	X	X	X	X	X	X	X	X	X	X	
10. Number and percentage of pregnant women receiving intermittent preventive treatment for malaria	X	X	X	X	X	X	X	X	X	X	X	X	
11. Number of deliveries with a skilled birth attendant (SBA)	X	X	X	X	X	X	X	X	X	X	X	X	
12. Percentage of women receiving a uterotonic during the third stage of labor immediately after birth	X	X	X	X	X	X	X	X	X	X	X	X	
13. Number and percentage of children less than 12 months of age who received DPT3/Penta 3 vaccination	X	X	X	X	X	X	X	X	X	X	X	X	
14. Number and percentage of children less than 12 months of age who received PCV 3 vaccination	X	X	X	X	X	X	X	X	X	X	X	X	

Performance Management Tasks and Indicators	PY1				PY2				PY3				Notes
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
15. Number and percentage of children less than 12 months of age who received rotavirus (second dose) vaccination	X	X	X	X	X	X	X	X	X	X	X	X	
16. Number and percentage of children less than 12 months of age who received measles vaccination	X	X	X	X	X	X	X	X	X	X	X	X	
17. Number of cases of child diarrhea treated with ORT and zinc	X	X	X	X	X	X	X	X	X	X	X	X	
18. Number of confirmed cases of malaria in children < 5 years treated at HFs	X	X	X	X	X	X	X	X	X	X	X	X	
19. Number of cases of child pneumonia treated with antibiotics by trained health workers	X	X	X	X	X	X	X	X	X	X	X	X	
20. Number of cases in children < 5 detected and referred to health facility by village health workers	X	X	X	X	X	X	X	X	X	X	X	X	
21. Number of mothers receiving a postnatal care home visit within the first 3 days of delivery	X	X	X	X	X	X	X	X	X	X	X	X	

Performance Management Tasks and Indicators	PY1				PY2				PY3				Notes
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
22. Percentage of babies not breathing/crying at birth who were successfully resuscitated	X	X	X	X	X	X	X	X	X	X	X	X	
23. Number of KMC units established				X				X				X	
24. Percentage of LBW babies initiated on KMC	X	X	X	X	X	X	X	X	X	X	X	X	
Objective 3: Strengthen the capacity of civil society organizations to implement MNCH activities and manage USG funding.													
25. Number of CSOs receiving funds from MCHIP/Zimbabwe AA to implement MNCH activities								X				X	
26. Number of CSOs with improved management of funding and implementing MNCH activities								X				X	
27. % of program implementation targets met by CSOs								X				X	
Conduct Evaluations and Special Studies													
End of Project Evaluation									X	X	X		
Operations Research and other studies													
Review Performance Data													
Quarterly Performance review (MCHIP internal)	X	X	X	X	X	X	X	X	X	X	X	X	
Quarterly Performance review (with External Partners)	X	X	X	X	X	X	X	X	X	X	X	X	
Annual review (MCHIP internal)					X			X				X	
Report Performance Results													
Monthly Progress Reporting	X	X	X	X	X	X	X	X	X	X	X	X	
District Review Reports	X	X	X	X	X	X	X	X	X	X	X	X	
USAID Quarterly Reports	X	X	X	X	X	X	X	X	X	X	X	X	
Assess Data Quality													
Data Verification Visits	X	X	X	X	X	X	X	X	X	X	X	X	
Data Quality Assessments				X			X				X		
Monitoring for Compliance													
Compliance site visits (FP, environmental) as part of routine supervision	X	X	X	X	X	X	X	X	X	X	X	X	
Review and Update PMP													
Review PMP and update if necessary				X				X				X	

SECTION 4: INDICATOR ANNEXES

4.1 INDICATOR TABLE AND THREE-YEAR PERFORMANCE TARGETS

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
1. Facility-based maternal mortality ratio	Number of facility-based maternal deaths, divided by the total number of facility-based live births in MCHIP/AA-supported sites, multiplied by 100,000	HMIS, facility records	Quarterly	TBD (to be updated in Q2 of PY1)	Reduce baseline MMR by 5%	Reduce baseline MMR by 10%	Reduce baseline maternal mortality rate by 15%	
2. Facility-based early neonatal and intrapartum mortality rate	Total Number of facility-based fresh stillbirths and early neonatal deaths within 7 days of delivery, divided by total number of facility-based births in MCHIP/AA-supported sites, multiplied by 1,000	HMIS, facility records	Quarterly	24/1,000 total births (data from the seven districts of Manicaland)	22/1,000 total births	20/1,000 total births	19/1,000 total births	
3. Facility-based U5 mortality rate	Number of deaths in children aged less than 5 years	HMIS, facility records	Quarterly	19.5/1000 live births (to be verified/ updated in Q2 of PY1)	Reduce baseline U5 mortality by 5%	Reduce baseline U5 mortality by 10%	Reduce baseline U5 mortality by 15%	
Objective 1: Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high impact maternal, newborn and child health interventions.								
4. Number of national policies/guidelines/ protocols/strategies developed with MCHIP support	Number of national policies, regulations, strategy documents developed or revised with MCHIP support Disaggregated by: • Policies • Strategies • Guidelines • Training packages	Final documents; program records	Annual	12 (over life of current program)	Policies: (National Reproductive health policy - currently in draft form) Strategies – 3 (National Nutrition Strategy, National QA/QI strategy, and National HMIS strategy)	TBD	TBD	To attach a policy tracking template

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
					Guidelines Training packages – 2 (National MNH TOT training package, and PPFP/PPIUCD Training Package)			
5. Number of MNCH/FP evaluations/reviews conducted, with findings shared with stakeholders	Number of evaluations and reviews conducted to gather information relevant for a particular program or activity to improve knowledge or understanding about the program/MNCH Evaluations will include studies, OR, baseline assessments, midline assessments, and endline assessments	Final documents; program records	Annual	10 (over life of current program)	MICS, ZDHS, EPI cluster survey,	TBD	TBD	To attach a surveys/ studies tracking template
6. Number of trainers trained in MNCH	Number of people trained as trainers in MNCH interventions, disaggregated by type of training and gender	Training information records/monitoring system	Quarterly	839	BEmONC: 100 (national) ETAT: 100 (national)	BEmONC: 100 (national) ETAT: 20 (national)	BEmONC: 100 (national) ETAT: 20 (national)	
Objective 2: Strengthen the capacity of the MOHCC at Provincial and District levels to improve the quality of integrated maternal, newborn and child health services at health facilities and in the community to support national-level scale-up plans.								
7. Number and percent of people trained in MNCH	Numerator: Number of people (health workers, VHWs) trained in MNCH/AA training packages with MCHIP/AA support. Denominator: Number of people (health workers, VHWs) eligible for training. To be disaggregated by type of person trained/cadre, gender, and type of training	Training information records/ monitoring system	Quarterly	2,547	BEmONC: 210 HBB: 42(OJT) IMNCI: 160 IYCF:60 BFHI: 120 IMAM:30 ETAT: 60 MCCM: 1200 VHWs, nurse aides and EHTs in total	BEmONC: 30 HBB: 42 (OJT) IMNCI: 30 ETAT: 30 MCCM:60	BEmONC:30 HBB: 42 ETAT: 30 MCCM:30	

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
8. Percentage of project-supported facilities applying the SBM-R process that are achieving at least 80% of clinical standards	Numerator: Number of MCHIP/AA-supported health facilities applying the SBM-R process that are achieving at least 80% of clinical standards Denominator: Total number of facilities in MCHIP/AA-supported districts	Program records; supervision visit reports	Annual	MNH: 76% (13/17 HFs) CH: 43% (9/21 HFs) (from Mutare and Chimanimani districts)	MNH: 60% (N=30) CH: 60% (N=30)	MNH: 70% (N=30) CH: 70% (N=30)	MNH: 80% (N=30) CH: 80% (N=30)	
9. Percentage of pregnant women receiving at least 4 visits for reasons related to pregnancy	Numerator: Number of pregnant women receiving at 4 pregnancy-related visit in MCHIP/AA-supported districts Denominator: Total number of expected annual pregnancies for MCHIP/AA-supported districts	Program records; census data; service statistics	Quarterly	69% (data from the 7 districts of Manicaland)	75%	80%	80%	
10. Number and percentage of pregnant women receiving intermittent preventive treatment for malaria	Numerator: Number of pregnant women at risk for malaria receiving at least 3 doses of SP to prevent malaria during ANC visits in 5 MCHIP/AA-supported districts (Chimanimani, Chipinge, Mutare, Mutasa, and Nyanga) Denominator: Total number of pregnant women receiving first ANC visit in 5 MCHIP/AA-supported districts (Chimanimani, Chipinge, Mutare, Mutasa, and Nyanga)	Program records; census data; service statistics	Quarterly	57% (data from 5 districts: Chimanimani, Chipinge, Mutasa, Mutare, and Nyanga)	60%	70%	80%	
11. Number of deliveries with a skilled birth attendant (SBA)	Number of deliveries with a SBA in MCHIP/AA-supported districts. SBA includes: Medically trained doctor, nurse or midwife. It does NOT include traditional birth	HMIS/service statistics	Quarterly	43,057 (data from the seven districts of Manicaland) (Jan – Dec 2013)	47,363	49,516	51,668	

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
	attendants (TBAs) and Nurse Aides (NAs). Number of institutional deliveries will be used as proxy.							
12. Percentage of women receiving a uterotonic during the third stage of labor immediately after birth	Numerator: Number of women giving birth who received a uterotonic during the third stage of labor in MCHIP/AA facilities applying SBM-R Denominator: total number of women giving vaginal birth in supported HFs applying SBM-R.	HMIS/service statistics	Quarterly	93.4% (to be verified/updated in Q2 of PY1)	90%	95%	95%	
13. Percentage of children less than 12 months of age who received DPT3/ Penta 3 vaccination	Numerator: Number of children less than 12 months who received DPT3/Penta 3 in a given year in MCHIP/AA-supported districts Denominator: Number of children less than 12 months in MCHIP/AA-supported districts Disaggregated by gender	HMIS/service statistics	Quarterly	Manicaland: 94% Mat North: 80% (ZDHS 2010/11) Mat South: 83% (ZDHS 2010/11)	Manicaland: 95% Mat North: 95% Mat South: 95%	Manicaland: 95% Mat North: 95% Mat South: 95%	Manicaland: 95% Mat North: 95% Mat South: 95%	
14. Percentage of children less than 12 months of age who received PCV 3 vaccination	Numerator: Number of children less than 12 months who received PCV 3 in a given year in MCHIP/AA-supported districts Denominator: Number of children less than 12 months in MCHIP/AA-supported districts Disaggregated by gender	HMIS/service statistics	Quarterly	Manicaland: 83% Mat North: TBD Mat South: TBD	Manicaland: 95% Mat North: 95% Mat South: 95%	Manicaland: 95% Mat North: 95% Mat South: 95%	Manicaland: 95% Mat North: 95% Mat South: 95%	
15. Percentage of children less than 12 months of age who received rotavirus (second dose) vaccination	Numerator: Number of children less than 12 months who who received rotavirus (second dose) vaccination in a given year in MCHIP/AA-supported districts	HMIS/service statistics	Quarterly	0%	Manicaland:70% Mat North:70% Mat South:70%	Manicaland:80% Mat North:80% Mat South:80%	Manicaland:90% Mat North:90% Mat South:90%	

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
	Denominator: Number of children less than 12 months in MCHIP supported districts							
16. Percentage of children less than 12 months of age who received measles vaccination	Numerator: Number of children less than 12 months who received measles vaccination in a given year in MCHIP/AA-supported districts Denominator: Number of children less than 12 months in MCHIP/AA-supported districts Disaggregated by gender	HMIS/service statistics	Quarterly	Manicaland: 94% Mat North: 91% (ZHDS 2010/11) Mat South: 85% (ZDHS 2010/11)	Manicaland:95% Mat North: 95% Mat South: 90%	Manicaland:95% Mat North: 95% Mat South: 90%	Manicaland:95% Mat North: 95% Mat South: 90%	
17. Number of cases of child diarrhea treated with ORT and zinc	Number of cases of child diarrhea treated in MCHIP/AA-supported districts with oral rehydration therapy (ORT) and zinc supplements Proxy indicator: Number of cases of diarrhea reported on T5	HMIS/service statistics or program records	Quarterly	58,745 (data from the seven districts of Manicaland) (Jan – Dec 2013)	55,808	52,868	49,933	
18. Number of confirmed cases of malaria in children U5 treated at HFs	Number of confirmed cases of malaria in children < 5 years treated at HFs	HMIS/service statistics	Quarterly	TBD (to be updated during Q2 of PY1)	TBD	TBD	TBD	
19. Number of cases of child pneumonia treated with antibiotics by trained health workers	Number of cases of child pneumonia treated with antibiotics by trained health workers in MCHIP/AA-supported districts Proxy indicator: Number of cases of moderate and severe pneumonia reported on the T5	HMIS/service statistics or population-based survey (numerator)	Quarterly	122,411 (data from the seven districts of Manicaland) (Jan – Dec 2013)	116,290	110,170	104,049	

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
20. Number of sick children U5 referred to health facility by VHWs for further management	Number of cases in children < 5 detected and referred to health facility by VHWs in Chimanimani	HMIS/service statistics or population-based survey (numerator)	Quarterly	TBD (to be updated during PY1)	TBD (Chimanimani)	TBD (Chimanimani and Mutasa)	TBD (Chimanimani, Mutasa, Chipinge)	
21. Number of mothers receiving a postnatal care home visit within the first 3 days of delivery	Number of mothers visited within the first 3 days of life by MCHIP/AA-supported VHWs in MCHIP/AA-supported sites	HMIS/service statistics	Quarterly	1,477 (Data from 16 SBM-R supported HFs) (as of Nov 2013)	TBD (Chimanimani)	TBD (Chimanimani and Mutasa)	TBD (Chimanimani, Mutasa, Chipinge)	
22. Percentage of babies not breathing/crying at birth who were successfully resuscitated	Numerator: Number of babies successfully resuscitated from SBM-R supported facilities Denominator: Number of babies not crying/breathing at birth from 30 SBM-R supported facilities	Program records	Quarterly	91% (to be verified/ updated in Q2 of PY1)	Mutare and Chimanimani: 95% Other 5 districts: 80%	Mutare and Chimanimani: 98% Other 5 districts:90%	Mutare and Chimanimani: 98% Other 5 districts:90%	
23. Number of KMC units established	Number of KMC units established in MCHIP supported districts	Program records	Annual	8	14	20	25	
24. Percentage of LBW babies initiated on KMC	Numerator: Number of LBW babies provided KMC from SBM-R supported facilities Denominator: Number of LBW babies from SBM-R supported facilities	HMIS/service statistics/KMC register	Quarterly (T9)	22% (data from the two districts – Mutare and Chimanimani)	Mutare and Chimanimani: 40% Other 5 districts: 20%	Mutare and Chimanimani: 60% Other 5 districts: 40%	Mutare and Chimanimani: 60% Other 5 districts: 60%	
Objective 3: Strengthen the capacity of Civil Society Organizations to implement MNCH activities and manage USG funding.								
25. Number of CSOs receiving funds from MCHIP/AA to implement MNCH activities	Number of CSOs receiving funds from MCHIP to implement MNCH activities	Internal CSO and MCHIP management system	Annual	0	0	2	2	This indicator will be tracked beginning in PY2

Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	Baseline As of Dec. 2013 (to be updated)	Targets			Notes
					PY1	PY2	PY3	
26. Number of CSOs with improved management of funding and implementing MNCH activities	Number of CSOs with improvement over baseline in management of funding and implementing MNCH activities	CSO organizational capacity assessments (in technical MNCH and financial management areas)	Annual	0	0	1	1	This indicator will be tracked beginning in PY2
27. % of project implementation targets met by CSOs	Numerator: Number of program implementation targets met by CSOs Denominator: Number of CSO-implementation targets	Program records	Annual	0	0	60%	80%	This indicator will be tracked beginning in PY2

4.2 INDICATOR REFERENCE SHEETS

Performance Indicator Reference Sheet
Indicator 1: Facility-based maternal mortality ratio
DESCRIPTION
Precise Definition(s): According to WHO, a maternal death refers to a female death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy **Numerator =** Number of facility-based maternal deaths from MCHIP/AA-supported districts. **Denominator** = Total number of facility-based live births in MCHIP/AA-supported districts. **Correction Factor =** (Numerator/Denominator)*100,000
Unit of measurement: Ratio
Disaggregated by: N/A
Justification: Maternal mortality is a sensitive measure of health system strength, access to quality care and coverage of effective interventions to prevent maternal deaths. The MMR represents the risk associated with each pregnancy and is also a useful barometer of social and economic conditions such as women's and girls' access to education, equality, and political commitment to health and development. One of the ultimate objectives of MCHIP/AA's quality improvement and capacity building activities at the facility level is to decrease the occurrence of maternal deaths.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Delivery Registers and T5 (tally sheet) , HMIS (T5)
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Descriptive, trends analysis
Presentation of data: Charts, diagrams
Reporting of data: Quarterly report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 2: Intrapartum and early newborn death rate at MCHIP/AA- supported facilities
DESCRIPTION
Precise Definition(s): The proportion of births that result in early neonatal death or an intrapartum death (fresh stillbirth) in MCHIP/AA-supported facilities. Numerator = The sum of intrapartum and early neonatal deaths within the first seven days of delivery occurring in the facility during a specific period Denominator = is the total number of births in the facility during the same period. Rate =(Numerator/Denominator)*100
Unit of measurement: Percentage
Disaggregated by: N/A
Justification: This indicator has been proposed to shed light on the quality of intrapartum care for foetuses and newborns delivered at facilities.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Delivery Registers , and T5 (tally sheet), HMIS (T5)
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Descriptive, trends analysis
Presentation of data: Charts, diagrams
Reporting of data: Quarterly Report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 3: Facility-based under 5 mortality rate in MCHIP/AA-supported facilities
DESCRIPTION
Precise Definition(s): The proportion of children under 5 years who die in MCHIP/AA-supported facilities. Numerator = The sum of deaths of children under 5 years Denominator = the total number of children under 5 years in MCHIP/AA-supported facilities Rate =(Numerator/Denominator)*1000
Unit of measurement: Rate
Disaggregated by: N/A
Justification: This indicator has been proposed to shed light on the quality of child health care
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Hospital Patient records
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): This indicator is currently not being collected routinely and the T9 has since been revived and integrated into the DHIS 2.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Descriptive
Presentation of data: charts, diagrams
Reporting of data: Quarterly Report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 4: Number of national policies/guidelines/protocols/strategies developed with MCHIP/AA support
DESCRIPTION
Precise Definition(s): This refers to the number of national policies, regulations, strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCHIP/AA support to improve access to and use of high impact MNCH services, including FP. When reporting these will be disaggregated by: • Policies • Strategies • Guidelines • Training packages
Unit of measurement: Number
Disaggregated by: type of documents produced
Justification: National policies/guidelines/protocols/strategies are pivotal for the sustainability of programs and for use and access of services. This is an OP indicator and MCHIP Global Indicator
PLAN FOR DATA COLLECTION
Data Collection method: Annual reports
Data Source: MCHIP Project Report
Frequency of Data collection: Annually
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Descriptive
Presentation of data: Presentation of draft and final policies/guidelines/protocols/strategies to the Mission (USAID). A policy tracking template indicating the different stages of development of those documents (policies, strategies, guidelines, etc) will also be attached the reports sent to USAID.
Reporting of data: Annual Report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 5: Number of MNCH/FP evaluations/reviews conducted with findings shared with stakeholders.
DESCRIPTION
Precise Definition(s): Number of evaluations and reviews conducted to gather information relevant for a particular program or activity to improve knowledge or understanding about the program/MNCH. Evaluations will include studies, operations researches, baseline assessments, midline assessments, and endline assessments.
Unit of measurement: Number
Disaggregated by: type of evaluations/reviews
Justification: Evaluations/reviews are crucial for improving program implementation.
PLAN FOR DATA COLLECTION
Data Collection method: Annual reports
Data Source: MCHIP Project Report
Frequency of Data collection: Annually
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Descriptive
Presentation of data: Presentation of evaluations/reviews reports to the Mission (USAID). As part of annual reports survey and studies tracking tool will be attached
Reporting of data: Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 6: Number of trainers trained in MNCH
DESCRIPTION
Precise Definition(s): Number of trainers trained in training methodology and the national MNCH training package.
Unit of measurement: Number (Count)
Disaggregated by: Type of training, sex, geographical area, and cadre
Justification: This indicator will be used to quantify MCHIP support for building local capacity for delivering MNCH services (ANC, Labour and Delivery, EmONC, Postnatal care and newborn complications, management of childhood illnesses and training methodology).
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Training Reports, attendance register
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count, i.e. quantitative analysis.
Presentation of data: templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 7: Number and percent of people trained in MNCH
DESCRIPTION
Precise Definition(s): Numerator: Number of people (health workers, VHWs) trained in MNCH training packages with MCHIP/AA support. Denominator: Number of people (health workers, VHWs) eligible for project-supported training
Unit of measurement: Number (Count)
Disaggregated by: type of training
Justification: This indicator will be used to quantify MCHIP/AA support for building local capacity for delivering MNCH services
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Training Reports, attendance register
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count, i.e. quantitative analysis.
Presentation of data: Templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 8: Percentage of project-supported facilities applying the SBM-R process that are achieving at least 80% of clinical standards
DESCRIPTION
Precise Definition(s): Numerator: Number of MCHIP/AA-supported facilities applying the SBM-R process that are achieving at least 80% of clinical standards. Denominator: Total number of MCHIP/AA-supported HFs applying the SBM-R process
Unit of measurement: Percent
Disaggregated by: Geographical area, facility type, type of standard met (MNH, CH and diarrhea and pneumonia (subsets of CH) and AMTSL)
Justification: Measures the quality of care exhibited by the facilities
PLAN FOR DATA COLLECTION
Data Collection method: Annual Reports
Data Source: SBM-R Assessment
Frequency of Data collection: Annual
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Percent
Presentation of data: templates, diagram, charts, and narrative report.
Reporting of data: Annual Reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 9: Percentage of pregnant women receiving at least four visits for reasons related to pregnancy
DESCRIPTION
Precise Definition(s): Numerator: Number of pregnant women receiving at least four pregnancy-related visit in MCHIP/AA-supported districts Denominator: Total number of expected annual pregnancies for MCHIP/AA-supported districts
Unit of measurement: Percentage
Disaggregated by: Geographical area, facility type
Justification:
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Facility Level ANC Registers, T5
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any):
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Percentage
Presentation of data: templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 10: Percentage of pregnant women receiving intermittent preventive treatment for malaria
DESCRIPTION
Precise Definition(s): Numerator: Number of pregnant women at risk for malaria receiving at least two doses of SP to prevent malaria during ANC visits in 5 MCHIP/AA-supported districts (Chimanimani, Chipinge, Mutare, Mutasa and Nyanga) Denominator: Total number of pregnant women receiving first ANC visit in 5 MCHIP/AA-supported districts (Chimanimani, Chipinge, Mutare, Mutasa and Nyanga)
Unit of measurement: Percentage
Disaggregated by: Geographical area, type of facility
Justification: Malaria is one of the leading causes of maternal deaths. Thus prevention of malaria in pregnancy is crucial.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: HMIS (T5)
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): none
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Percent
Presentation of data: Templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 11: Number of deliveries with a skilled birth attendant (SBA)
DESCRIPTION
Precise Definition(s): Number of deliveries with a skilled birth attendant (SBA). SBA includes medically trained doctor, nurse, or midwife. It does NOT include traditional birth attendants (TBA) and Nurse Aids (NAs). This is an OP and MCHIP Global Indicator. The number of institutional deliveries will be used as proxy to this indicator.
Unit of measurement: Number (Count)
Disaggregated by: Geographical area**,** facility type
Justification: Deliveries that take place in the absence of skilled birth attendant are usually at risk of increased maternal and infant mortality
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Facility Level Delivery Register , HMIS (T5)
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count
Presentation of data: Templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 12: Percentage of women receiving a uterotonic during the third stage of labor immediately after birth
DESCRIPTION
Precise Definition(s): Numerator **=** Number of women giving birth who received a uterotonic during the third stage of labor in MCHIP/AA-supported facilities Denominator = Number of women giving birth in MCHIP supported facilities Proportion = (Numerator/Denominator)*100
Unit of measurement: Percent
Disaggregated by: Geographical area (district), facility type.
Justification: Giving uterotonic is one way of improving maternal health as most cases of maternal death are experienced during the third stage of labor
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports
Data Source: Facility Level Delivery registers
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): No current tallying on uterotonic use in facilities. The MCHIP/Zimbabwe AA will develop a new tally sheet and train facility staff on how to use it or devise other ways of collecting this data.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Percent
Presentation of data: Templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 13: Percentage of children less than 12 months of age who received Penta 3 through MCHIP/AA-supported facilities
DESCRIPTION
Precise Definition(s): Numerator = Number of children less than 12 months who received Penta 3 in MCHIP/AA- supported facilities. Denominator = Number of children less than 12 months in MCHIP/AA-supported districts Percentage = (Numerator/Denominator)*100
Unit of measurement: Percent
Disaggregated by: sex, geographical area, facility type
Justification: Penta 3 coverage can be used as a proxy for full immunization coverage in countries with established immunization programs. Child immunization is one of the most cost-effective program interventions to reduce under-five mortality.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports.
Data Source: EPI registers, T6 (tally sheet) and District Profiles.
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count; trend analysis over time. A drop in numbers may indicate potential problems, while a rise in trend will indicate progress. A plateau may also still indicate progress.
Presentation of data: list, chart, diagram disaggregated by geographical area, and sex.
Reporting of data: Annual and Quarterly reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 14: Percentage of children less than 12 months of age who received PCV 3 vaccination
DESCRIPTION
Precise Definition(s): Numerator = Number of children less than 12 months who received PCV 3 in MCHIP/AA-supported facilities. Denominator = Number of children less than 12 months in MCHIP/AA-supported districts Percentage = (Numerator/Denominator)*100
Unit of measurement: Percent
Disaggregated by: sex, geographical area, facility type
Justification: Child immunization is one of the most cost-effective program interventions to reduce under-five mortality.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports.
Data Source: EPI registers, T6 (tally sheet) and District Profiles.
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count; trend analysis over time. A drop in numbers may indicate potential problems, while a rise in trend will indicate progress. A plateau may also still indicate progress.
Presentation of data: List, chart, diagram disaggregated by geographical area, and sex.
Reporting of data: Annual and Quarterly reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): **May 2014**

Performance Indicator Reference Sheet
Indicator 15: Percentage of children less than 12 months of age who received rotavirus (second dose) vaccination
DESCRIPTION
Precise Definition(s): Numerator = Number of children less than 12 months who received rotavirus (second dose) vaccination in MCHIP/AA-supported facilities. Denominator = Number of children less than 12 months in MCHIP/AA-supported districts Percentage = (Numerator/Denominator)*100
Unit of measurement: Percent
Disaggregated by: sex, geographical area, facility type
Justification: Child immunization is one of the most cost-effective program interventions to reduce under-five mortality.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports.
Data Source: EPI registers, T6 (tally sheet) and District Profiles.
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count; trend analysis over time. A drop in numbers may indicate potential problems, while a rise in trend will indicate progress. A plateau may also still indicate progress.
Presentation of data: list, chart, diagram disaggregated by geographical area, and sex.
Reporting of data: Annual and Quarterly reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 16: Percentage of children less than 12 months of age who received measles vaccination
DESCRIPTION
Precise Definition(s): Numerator = Number of children less than 12 months who received measles vaccination in MCHIP/AA-supported facilities Denominator = Number of children less than 12 months in MCHIP/AA-supported districts Percentage = (Numerator/Denominator)*100
Unit of measurement: Percent
Disaggregated by: sex, geographical area, facility type
Justification: Measles coverage can be used as a proxy for full immunization coverage (primary course completion) and utilisation in countries with established immunization programs. Child immunization is one of the most cost-effective program interventions to reduce under-five mortality
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly reports.
Data Source: EPI registers, T6 (tally sheet) and District Profiles.
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count; trend analysis over time. A drop in numbers may indicate potential problems, while a rise in trend will indicate progress. A plateau may also still indicate progress.
Presentation of data: List, chart, diagram disaggregated by geographical area, and sex.
Reporting of data: Annual and Quarterly reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 17: Number of cases of child diarrhea treated with ORT and zinc
DESCRIPTION
Precise Definition(s): Number of cases of diarrhea treated in children <5 years of age through MCHIP/AA-supported facilities with ORT and Zinc supplements. Treatment here implies having been screened, counselled and given a prescription for ORT and Zinc. We are only including OPD cases. This is an OP and MCHIP Global indicator. Since this indicator is not currently reported through the T5, a proxy indicator, "Number of cases of diarrhea in children <5 years of age" report on T5 will be used.
Unit of measurement: Number (Count)
Disaggregated by: Geographical area, treatment type, facility type, and sex.
Justification: Proper management of child diarrhea is crucial in reducing child mortality.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Outpatient registers (T12), T5
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): The current tally sheet (T3) only indicates cases managed: for diarrhoea with or without dehydration**.** However "managed" does not indicate treatment prescribed or given. Thus whether a child was given ORT and Zinc cannot be determined given the information collected in any tally sheet. The only place where this data is available is the OPD register, which is not summarised. The MCHIP/Zimbabwe AA will use a proxy indicator as highlighted above. However assessments of the zinc prescription patterns will be held half-yearly in the SBM-R supported health facilities.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count; trend analysis over time. A drop in numbers may indicate potential impact showing that child diarrhoea has been contained, while a rise in trend my indicate problem. A plateau may also still indicate progress
Presentation of data: List, chart, diagram disaggregated by geographical area, and sex
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 18: Number of confirmed cases of malaria in children < 5 years treated at HFs
DESCRIPTION
Precise Definition(s): Number of cases of malaria treated in children <5 years of age in MCHIP/AA-supported facilities. This indicator is designed to measure the quality of treatment for cases of malaria diagnosed in MCHIP supported health facilities. We are only including OPD cases. This is an OP and MCHIP Global Indicator.
Unit of measurement: Number (Count)
Disaggregated by: Geographical area, facility type, and sex
Justification: Malaria is one of the killer diseases among children and it's management is very critical to reduce child mortality
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Outpatient registers and T3 (tally sheet), T5
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any):
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count; trend analysis over time. A drop in numbers may indicate potential impact showing that child malaria has been contained, while a rise in trend my indicate problem. A plateau may also still indicate progress
Presentation of data: List, chart, diagram disaggregated by geographical area, and sex
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 19: Number of cases of child pneumonia treated with antibiotics by trained health workers
DESCRIPTION
Precise Definition(s): Number of cases of pneumonia treated in children <5 years of age with antibiotics in MCHIP/AA-supported facilities. Antibiotics are not given by community health workers. We are only including OPD cases. This is an OP and MCHIP Global Indicator. This following proxy indicator, "Number of cases of moderate and severe pneumonia reported on the T5" will be used.
Unit of measurement: Number (Count)
Disaggregated by: geographical area, sex, facility type
Justification: Pneumonia is one of the killer diseases among children and it's management is very critical to reduce child mortality
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Outpatient registers , T3 form, T5
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): The current tally sheet (T3) indicates pneumonia cases by severity: mild; moderate; and severe. Mild (coughs and cold) will not be treated with antibiotics where moderate and severe pneumonia is treated with antibiotics**.** Therefore we will only be counting cases with moderate and severe pneumonia from the T5.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count; trend analysis over time. A drop in numbers may indicate potential impact showing that child pneumonia has been contained, while a rise in trend my indicate problem. A plateau may also still indicate progress.
Presentation of data: List, chart, diagram disaggregated by geographical area, and sex
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 20: Number of sick children <5 referred to health facility by VHWs for further management
DESCRIPTION
Precise Definition(s): Number of cases in children < 5 detected and referred to health facility by village health workers in Chimanimani
Unit of measurement: Number (Count)
Disaggregated by: Geographical area, facility type and age.
Justification: Early health seeking behaviour is crucial in ensuring that cases are managed properly while they are not yet complicated. As such, VHWs play a crucial role in detecting childhood illnesses early and refer the caregivers for further management at health facilities.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: VHW referral form, C5 form from VHWs
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: descriptive, trends analysis
Presentation of data: templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 21: Number of mothers receiving a postnatal care home visit within the first 3 days of delivery
DESCRIPTION
Precise Definition(s): Number of mothers visited by VHWs within the first 3 days of delivery in MCHIP/AA-supported districts.
Unit of measurement: Number (Count)
Disaggregated by: Geographical area
Justification: Newborns need proper health care services and it is critical for them to be attended by community based health worker especially if delivered at home so that if there are any danger signs for both or either the mother or baby they can be referred to the health facilities for further management.
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: VHW registers
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): This indicator depends on VHW register information, which currently is not formally transmitted through the HMIS.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count
Presentation of data: list, chart, diagram disaggregated by geographical area
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 22: Percentage of babies not breathing/crying at birth who were successfully resuscitated
DESCRIPTION
Precise Definition(s): Numerator: Number of babies successfully resuscitated from SBM-R supported facilities **Denominator:** Number of babies not crying/breathing at birth from 30 SBM-R supported facilities
Unit of measurement: Percent
Disaggregated by: Geographical area
Justification:
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Delivery registers
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): This indicator is not currently transmitted through the HMIS; hence data collection and reporting will be for the SBM-R supported sites only.
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: percent
Presentation of data: list, chart, diagram, disaggregated by geographical area
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): **May 2014**

Performance Indicator Reference Sheet
Indicator 23: Number of KMC units established
DESCRIPTION
Precise Definition(s): Number of KMC units established in MCHIP/AA-supported districts
Unit of measurement: Number (Count)
Disaggregated by: Geographical area.
Justification:
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: Program records
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any):
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count; trend analysis over time.
Presentation of data: list, chart, diagram, disaggregated by geographical area
Reporting of data: Quarterly and Annual reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 24: Percentage of LBW babies initiated on KMC at SBM-R-supported facilities
DESCRIPTION
Precise Definition(s): Numerator = Number of LBW newborns in MCHIP supported facilities receiving KMC services Denominator = Number of LBW newborns admitted to MCHIP supported facilities Percentage =(Numerator/Denominator)*100 LBW newborns are newborns with weight at delivery less than 2.5kg. KMC is a method of care for preterm infants which is initiated in a health facility and is primarily comprised of the following: • early, continuous and prolonged skin-to-skin contact between the mother and the baby; • exclusive breastfeeding
Unit of measurement: Percent
Disaggregated by: Geographical area
Justification: KMC improves health of LBW newborns
PLAN FOR DATA COLLECTION
Data Collection method: Quarterly Reports
Data Source: KMC register, T5(for the denominator)
Frequency of Data collection: Quarterly
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): The data for the enumerator is not currently being reported through the HMIS and hence data collection and reporting will be limited to the SBM-R supported health facilities
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: percent
Presentation of data: templates, diagram, charts, and narrative report.
Reporting of data: Quarterly and Annual Reports
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 25: Number of CSOs receiving funds from MCHIP/AA to implement MNCH activities
DESCRIPTION
Precise Definition(s): Number of CSOs with staff trained in financial and technical components
Unit of measurement: Number (Count)
Disaggregated by: none
Justification: In response to USAID Forward, the MCHIP/Zimbabwe AA is expected to capacity-build and work with CSOs in delivering MNCH services in the districts. Working with CSOs and other community-based structures improves service delivery and promotes sustainability of MCHIP/AA-supported interventions long after the life of the project. Sub-granting to CSOs provides a basis for measuring CSOs for both financial management and accountability for program results. The project will fund CSOs that demonstrate promising approaches to potential scale-up of MNCH services throughout the community.
PLAN FOR DATA COLLECTION
Data Collection method: Annual reports.
Data Source: Program records
Frequency of Data collection: Annual
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: count
Presentation of data: List, chart
Reporting of data: Annual reports.
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 26: Number of CSOs with improved management of funding and implementing MNCH activities
DESCRIPTION
Precise Definition(s): Number of CSOs with improvement in management of funding and implementing MNCH activities
Unit of measurement: Number (Count)
Disaggregated by: none
Justification: In response to USAID Forward, the MCHIP/Zimbabwe AA is expected to capacity-build and work with CSOs in delivering MNCH services in the districts. Working with CSOs and other community-based structures improves service delivery and promotes sustainability of MCHIP supported interventions long after the life of the project. Training, coaching and mentorship are important capacity-building approaches to ensure CSOs demonstrate improvement in accountability for both resources and results. Measurement of improvement based on established standards gives credibility to recommendations given to the CSOs at the end of the engagement period.
PLAN FOR DATA COLLECTION
Data Collection method: Annual reports
Data Source: Program records
Frequency of Data collection: Annual
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count
Presentation of data: List, chart
Reporting of data: Annual report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

Performance Indicator Reference Sheet
Indicator 27: % of project implementation targets met by CSOs
DESCRIPTION
Precise Definition(s): Numerator: Number of project implementation targets met by CSOs Denominator: Number of CSO-implementation targets
Unit of measurement: Percent
Disaggregated by: none
Justification: Working with CSOs and other community-based structures improves service delivery and promotes sustainability of MCHIP/AA-supported interventions long after the life of the project. Performance measurements justifies whether CSOs are managing the sub-agreements well. They are used together with financial monitoring activities such as expenditure analyses to judge whether the CSO is managing the sub-award well.
PLAN FOR DATA COLLECTION
Data Collection method: Annual reports
Data Source: Program records
Frequency of Data collection: Annual
Individual responsible at project: Country Director
Individual responsible for providing data to USAID: Director, Innovations, Research, M&E/M&E Officer
DATA QUALITY ISSUES
Known data limitations and significance (if any): None
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data analysis: Count
Presentation of data: List, chart
Reporting of data: Annual report
OTHER NOTES
Notes on baselines/targets: TBD
SHEET LAST UPDATED ON(DATE): May 2014

BRANDING STRATEGY

POSITIONING

Intended Program Name
The MCHIP/Zimbabwe team requests the name "MCHIP Zimbabwe Associate Award" pending final USAID approval.

Project Logo
The MCHIP/Zimbabwe team will continue to co-brand/mark materials with the USAID identity and MCHIP logo as agreed under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00,0 [09-AWD-010 (USAID-MCHIP): Modification 1]. See page 7.

Language and Translation
USAID materials will remain in English at all times. The tagline "From the American people" may be translated into local language. The local-language tagline will be set in a typeface that matches the brandmark as closely as possible (2.8 USAID Graphics Standards Manual).

Program Branding
In addition to the USAID identity and MCHIP logo, the MCHIP/Zimbabwe team would like to include a line below the logos that states, "MCHIP Zimbabwe Associate Award" This line will adhere to USAID's clear space rule (2.9 USAID Graphics Standards Manual).

TYPES OF BRANDING AND MARKING

As an associate award, the project is subject to co-branding.

Co-Branding/Marking: Used when a product, publication or event is positioned as from USAID and a program implementing partner. It applies when another organization has contributed funding and/or the Mission or Zimbabwe Agreement Officer Representative (AOR) otherwise agrees that there is a compelling rationale to co-brand. The design varies as appropriate, though the USAID logo should be of equivalent size and prominence as other partner logos. The design will include the MCHIP logo and, "MCHIP Zimbabwe Associate Award" as described in the Program Branding section above. USAID approval is required for co-branding of all products produced 100% with USAID funds. USAID approval is not required to co-brand products produced with joint funding from other organizations, assuming the funding contributed is not a token amount.

ACKNOWLEDGMENTS

Direct Involvement from the Zimbabwe Government Ministries
The MCHIP/Zimbabwe team understands that USAID accepts co-branding with government ministries and may, in fact, at times request that a government ministry be acknowledged with greater prominence than USAID. The level of participation in the departments and ministries will be determined in concert with relevant stakeholders upon award.

Involvement from Other In-Country Partners
When working with in-country partners and grassroots organizations, recognizing contributions of partners through co-branding is essential for building local capacity, increasing in-country ownership and validating project activities or findings, and highlighting the ways in which the U.S. Government works collaboratively with others.

MARKING PLAN

The MCHIP/Zimbabwe team will mark all Program and activity sites, Program deliverables, events and commodities funded by USAID except those that are non-deliverable items for internal Program use, e.g., Program offices, vehicles. Whenever permanent marking is impossible, e.g., events that take place inside a hotel, a temporary service center, etc., removable or temporary marking will be used. For example:

What Will Be Marked	Type of Marking	Level of Marking	Marking Materials	When Marked	Where Marked
Program and Activity Sites					
Training sites, orientation sites and service delivery sites	Co-branding/ co-marking	In at least one location at all sites. In cases where it is physically, financially, legally or culturally impractical to mark the site, printed materials will be distributed that detail USAID involvement and, when possible, USAID involvement will be acknowledged orally.	Materials will depend on site and type of signage required.	On or before commencement of program activity	Depending on acceptability due to the location of the event, signage may be placed outside the facility or meeting room or in another appropriately visible place.
Administrative					
Folders, note cards, invitations	Co-branding/ co-marking	All items	Printed ink	Will be made part of design from program award	As appropriate
Program-related stationery (letterhead, memos, fax sheets)	Co-branding/ co-marking	All items	Printed ink	Will be made part of design from program award	As appropriate
Business cards	MCHIP logo, program name and “USAID Grantee”	All items	Printed ink	Will be made part of design from program award	As appropriate
Technical Assistance, Studies, Reports, A/V Productions, Media, etc.					
Briefing papers, memoranda, and policy recommendations	Co-branding/ co-marking	All items	Printed ink	In all instances	On the cover or first page

What Will Be Marked	Type of Marking	Level of Marking	Marking Materials	When Marked	Where Marked
Electronic media, e.g., CD-ROM, video, DVD, Web cast, podcast, PowerPoint presentation, etc.	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	In all instances	For items distributed with a cover or case, the identity may appear both on the case and on the item. For broadcast media, the identity will be incorporated into the presentation, e.g., splash screen for CD-ROM, opening credits for video. Videos will be 403 compliant.
Traditional media, (e.g., radio, television, phone, etc.)	Co-branding/ co-marking	All occurrences for television. For radio spots and phone messages, the tagline "made possible by USAID: From the American people".	Materials will be determined on a case-by-case basis but will be consistent with the medium in question.	In all instances	When broadcast via television, the USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Flyers, fact sheets, materials for site visits	Co-branding/ co-marking	All items	Printed ink or other material depending on item	In all instances	On the cover or first page
Press releases, media advisories	Co-branding/ co-marking	All items	Printed ink or other material depending on item	In all instances	As appropriate
Job Aids					
Technical reports, studies and analyses	Co-branding/ co-marking	All items	Printed ink	In all instances	On the cover or first page
Training materials and manuals	Co-branding/ co-marking	All items	Printed ink	In all instances	On the cover or first page
Events					
Exhibitions, fairs, workshops, information dissemination meetings, training courses, conferences, seminars, press conferences	Co-branding/ co-marking	Minimum 1 occurrence per event	Materials will depend on site and type of signage required.	On or prior to the date of the event, depending on in-country circumstances	Depending on acceptability due to the location of the event, signage may be placed outside the facility or meeting room or in another appropriately visible place.
Invitations for information dissemination or similar meetings	Co-branding/ co-marking	All items	If printed invitation, printed ink; if e-mailed, will follow marking for program emails	In all instances	If printed, on the invitation itself; if emailed, in the body of the message

What Will Be Marked	Type of Marking	Level of Marking	Marking Materials	When Marked	Where Marked
Program promotional materials	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	In all instances	As appropriate
Commodities					
Equipment and supplies	Co-branding/ co-marking	All equipment and supplies (as defined by USAID) that may be marked and are not covered by one or more presumptive exceptions	Stickers or paint (brush or stencil) depending on the item, or other method	Upon purchase or acquisition	As appropriate
Program Deliverables					
Reports, including quarterly, mid-term and final	Co-branding/ co-marking	All items	Printed ink	From 1st report due date	As appropriate
Information, education and communication (IEC) materials such as t-shirts, caps, brochures and posters	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	IEC products are developed on a case-by-case basis.	As appropriate
Health learning materials (HLM) such as brochures, pamphlets and instructional workbooks	Co-branding/co-marking	All items	Materials will be determined on a case-by-case basis.	Materials are produced at various times during a project's life.	On the cover or first page
Tools/training manuals	Co-branding/co-marking	All items	Materials will be determined on a case-by-case basis.	Training manuals are developed at the beginning of a project and on a case-by-case basis.	On the cover or first page
Mobile health units	Co-branding/co-marking	All units	To be determined based on financial consequence of various marking methods (paint, stickers, etc.).	Before deployment of the vehicle	Exterior: The USAID identity will appear in the same location and of an equivalent or greater size than other logos. Interior: Marking where practicable with the same stipulations as exterior marking.

PROGRAM DELIVERABLES THAT WILL NOT BE MARKED

In cases where deliverables are not marked, USAID's contribution may be acknowledged either in the text or verbally at relevant meetings and events.

DELIVERABLE THAT WILL NOT BE MARKED	RATIONALE
Any program communication or material produced under the award covered by one or more Presumptive Exceptions.	While the MCHIP/Zimbabwe team is happy to fulfill the requirement to submit two copies of all program and communications materials produced under the award to the Zimbabwe AOR and one copy to the DEC, the Team believes that it would not be cost-effective to retroactively mark materials produced without marking under any of the Presumptive Exceptions that may be granted.

Waivers: The MCHIP/Zimbabwe team may request a waiver of the Branding Strategy or of the marking requirements of this provision, in whole or in part, for each program, project, activity, public communication or commodity, or, in exceptional circumstances, for a region or country, when USAID-required marking would pose compelling political, safety or security concerns, or when marking would have an adverse impact in the cooperating country. The MCHIP/Zimbabwe team will submit the request through the Zimbabwe AOR with the understanding that final approval must be granted by the Principal Officer (PO). In the event that the request for a waiver is denied, the MCHIP/Zimbabwe team understands that it has the right to appeal the denial to the PO's Cognizant Assistant Administrator.

PRESUMPTIVE EXCEPTIONS

The MCHIP/Zimbabwe team would like to request the following Presumptive Exceptions and follows the text of each Exemption with the Team's rationale for the request:

Presumptive Exception (i): USAID marking requirements may not apply if they would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials, such as election monitoring or ballots, and voter information literature; political party support or public policy advocacy or reform; independent media, such as television and radio broadcasts, newspaper articles and editorials; and public service announcements or public opinion polls and surveys (22 C.F.R. 226.91(h)(i)).

Presumptive Exception (ii): USAID marking requirements may not apply if they would diminish the credibility of audits, reports, analyses, studies or policy recommendations whose data or findings must be seen as independent (22 C.F.R. 226.91(h)(ii)).

Presumptive Exception (iii): USAID marking requirements may not apply if they would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements or other communications better positioned as "by" or "from" a cooperating country ministry or government official (22 C.F.R. 226.91(h)(iii)).

Presumptive Exception (iv): USAID marking requirements may not apply if they would impair the functionality of an item, such as sterilized equipment or spare parts (22 C.F.R. 226.91(h)(iv)).

Presumptive Exception (v): USAID marking requirements may not apply if they would incur substantial costs or be impractical, such as items too small or otherwise unsuited for individual marking, such as food in bulk (22 C.F.R. 226.91(h)(v)).

Presumptive Exception (vi): USAID marking requirements may not apply if they would offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bedpans or similar commodities (22 C.F.R. 226.91(h)(vi)).

FLOW-DOWN TO SUBRECIPIENTS AND SUBCONTRACTORS

Subrecipients

The MCHIP/Zimbabwe team accepts that all subawards will be marked with the following disclaimer:

> "As a condition of receipt of this subaward, marking with the USAID Identity of a size and prominence equivalent to or greater than the recipient's, subrecipient's, other donor's or third party's is required. In the event the recipient chooses not to require marking with its own identity or logo by the subrecipient, USAID may, at its discretion, require marking by the subrecipient with the USAID Identity."

MARKING OF PUBLIC COMMUNICATIONS

The MCHIP/Zimbabwe team agrees that any USAID-funded public communications as defined in 22 C.F.R. 226.2, for which the content has not been approved by USAID, will contain the following disclaimer:

"This study/report/audio/visual/other information/media product (specify) was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader GHS-A-00-08-00002-00, under the Associates Cooperative Agreement AID-613-LA-14-00002. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government."

SUBMISSION OF PROGRAM AND COMMUNICATIONS MATERIALS

The MCHIP/Zimbabwe team will provide the Zimbabwe AOR or other USAID personnel designated in the cooperative agreement with two copies of all program and communications materials produced under the award. In addition, the Team will submit either one electronic or one hard copy of all final documents to USAID's Development Experience Clearinghouse (DEC).

Leader with Associates Cooperative Agreement
GHS-A-00-08-00002-00 [09-AWD-010 (USAID-MCHIP): Modification 1

BRANDING STRATEGY AND MARKING PLAN

The purpose of this document is to demonstrate that the JHPIEGO -led Maternal and Child Health Integrated Program (MCHIP) Team completely accepts USAID's Branding Strategy and Marking Plan provisions. JHPIEGO is willing to work with USAID toward its goal of ensuring that program beneficiaries, stakeholders, and host-country citizens know that the aid being provided is from the American people as a demonstration of solidarity and commitment toward improving the lives of people in the countries that benefit from MCHIP. In submitting this proposed Branding Strategy and Marking Plan, the MCHIP Team agrees to adhere to all applicable provisions of 22 CFR 226.91 and ADS 320 as revised on 8 January 2007.

The proposed Branding Strategy and Marking Plan were developed with consideration for the needs of potential beneficiaries of the MCHIP Program and respect for USAID goals. MCHIP will substantially help reduce maternal, neonatal, and child mortality in 30 focus countries and the MCHIP Team envisions that all 68 Millennium Development Goal (MDG) Countdown countries will benefit from the tools, reports, publications, and technical knowledge developed and produced over the life of the Program. Given the geographic reach and technical and programmatic scope of MCHIP, the communications strategy undertaken will be marked by creativity and flexibility. In all presence- and non-presence impacted countries, the MCHIP Team will take into consideration literacy rates, income levels, rural or urban settings, and the impact of prior programs when developing communications.

The MCHIP Team's goal is the seamless integration of the Agency's marking provisions with a successful program, thereby ensuring that the Agency, and thus the American people, will be associated with the decreased maternal, infant, and child mortality and improved health and well-being that are the goals of the Program. In order to fulfill this goal, the MCHIP Team will ensure the complete agreement of the Branding Strategy and Marking Plan by the Program Director, Dr. Koki Agarwal, who will confirm consistent adherence to the plan by the MCHIP Team, and will solicit input and feedback from USAID Missions and in-country stakeholders.

The MCHIP Team understands that this proposed Branding Strategy and Marking Plan may be reviewed and renegotiated by the Agreement Office prior to award, and is committed to facilitating that process. The following information may change based on the goals of USAID or the conditions in MCHIP focus countries at the time of award. Estimated costs for executing this proposed Marking Plan have been included in the MCHIP Team's cost submission.

BRANDING STRATEGY

POSITIONING

Intended Program Name
The MCHIP Team has kept the program name chosen by USAID. MCHIP will come to represent the pinnacle of high-impact, evidence-based maternal, neonatal, and child health (MNCH) programming.

Language and Translation
Due to the vast geographic scope of MCHIP, decisions on language and translation will have to be made on a case-by-case basis with individual country missions and stakeholders. As a rule, MCHIP will use local languages to produce written materials and will use an approved translation of the USAID tagline. In instances where materials are destined to be used in more than one country, they may be produced in English.

Program Logo
A final determination on Program logo needs will be made with the Agreement Office.

TYPES OF BRANDING AND MARKING

As a Leader with Associates Award, the Program is subject to co-branding/marking.

Co-Branding/Marking: Used when a product, publication, or event is positioned as coming from USAID and a program-implementing partner. It applies when another organization has contributed funding and/or the Mission or CTO otherwise agrees that there is a compelling rationale to co-brand. The design varies, as appropriate, though the program sub-brand should be of equivalent size and prominence as other partner logos. USAID approval is required for co-branding of all products produced with 100 percent of USAID funds. USAID approval is not required to co-brand products produced with joint funding from other organizations, assuming the funding contributed is not a token amount.

PROGRAM COMMUNICATIONS AND PUBLICITY

Primary and Secondary Audiences
The Program seeks to serve varied populations to substantially help reduce maternal, neonatal, and child mortality in 30 countries, contributing to an accelerated progress toward achieving MDG 4 and 5 targets. The following illustrative list is based on the interventions described in the MCHIP Team's response to this procurement and may change based on conditions at the time of award:

Primary Audiences:	***Secondary Audiences:***
In-country policymakers	Community members
In-country healthcare providers	Men
Pregnant women	Healthcare facility staff
Women of reproductive age	Civil Society

Communications and Program Materials
The MCHIP Team intends to market the Program through information sessions; kick-off meetings, including stakeholders from government, private sector, and community groups; training materials; brochures; pamphlets; and other mechanisms to be determined in concert with in-country stakeholders.

Main Program Messages
One of the mainstays of the approach developed by the MCHIP Team is the Program's delivery of consistent health care messages. Upon award, the Team will develop a communications plan that will be specific, targeted, and memorable and will address MNCH. During the development of this plan, the Team will introduce the idea of incorporating USAID's primary message—aid "from the American people"—into the narrative of program materials. Some sample program messages are provided below:

Program Messages
Communities, households, and individuals are not only recipients of health services but are an integral part of implementation of health services
In-country policymakers should know that MCHIP is an opportunity for them to help them achieve their Millennium Development Goals
The combined results of several donors working together, under the Ministry of Health (MOH) leadership, can exceed the sum of individual partners' investments
Opportunities must be strategically focused to achieve large-scale MNCH impact and maximize the number of maternal, newborn, and child lives saved

Public Promotion of Program
Part of the development of a communications plan will involve the determination of how to publicly launch and promote the Program. Lessons learned from the publicizing of other similar programs will inform this process. The MCHIP Team understands that incorporating the message, "USAID from the American People" and displaying the USAID identity are required at media releases, press conferences, public events, and similar promotions opportunities.

Other Methods of Increasing Awareness of the Support of the American People
As the full communications plan is developed, all opportunities to increase the awareness of the in-country public and Program beneficiaries of the fact that USAID support is provided by the American people will be maximized.

Acknowledgments

Direct Involvement from Government Ministries
The MCHIP Team understands that USAID accepts co-branding with government ministries and may, in fact, at times request that a government ministry be acknowledged with greater prominence than USAID. The level of participation in the Program of government departments and ministries will be determined in concert with relevant stakeholders upon award or when appropriate.

Logo or Identity of Other Groups

The MCHIP Team may choose to include the logo or identity of JHPIEGO, its major partners, or any sub awardee on program materials and related communications. The decision to include other logos will be made by the Program Director on a case-by-case basis. Any of the logos or identities may receive the same prominence as USAID's.

MARKING UNDER ASSISTANCE INSTRUMENTS

The MCHIP Team will mark all Program and activity sites, Program deliverables, events and commodities funded by USAID except those that are non-deliverable items for internal Program use, e.g., team offices, vehicles, and those covered by one or more presumptive exceptions. Whenever permanent marking is impossible, e.g., events that take place inside a hotel, a temporary service center, etc., removable or temporary marking will be used. For example:

WHAT WILL BE MARKED	TYPE OF MARKING	LEVEL OF MARKING	MARKING MATERIALS	WHEN MARKED	WHERE MARKED
Program and Activity Sites					
Training sites, orientation sites, and service delivery sites	Co-branding/ co-marking	In at least one location at all sites. In cases where it is physically, financially, legally, or culturally impractical to mark the site, printed materials will be distributed that detail USAID involvement and, when possible, USAID involvement will be acknowledged orally.	Materials will depend on site and type of signage required.	On or before commencement of program activity.	Depending on acceptability due to the location of the event, signage may be placed outside the facility or meeting room or in another appropriately visible place.
Administrative					
Folders, note cards, invitations	Co-branding/ co-marking	All items	Printed ink	Will be made part of design from program award	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Program-related stationery	Co-branding/co-marking	All items	Printed ink	Will be made part of design from program award	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.

WHAT WILL BE MARKED	TYPE OF MARKING	LEVEL OF MARKING	MARKING MATERIALS	WHEN MARKED	WHERE MARKED
Program-related e-mails (other than daily correspondence)	Co-branding/ co-marking	In all cases when practicable, USAID identity will not be used in cases of plain text e-mails or where message size may compromise message delivery. In those cases, USAID involvement will be recognized in text.	Electronic identity or plain text mention	Will be made part of e-mail template from program award. Will apply to e-mails initiated by the Program and not replies or forwarded messages.	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Program-related e-mails (daily correspondence)	Co-branding/ co-marking	Since plain text messages may frequently be used in daily correspondence, the USAID identity will not be used on a daily basis. Rather, USAID involvement will be acknowledged and the tagline "From the American People" used.	Plain electronic text	Will be made part of e-mail template from program award. Will apply to e-mails initiated by the Program and not replies or forwarded messages.	The USAID acknowledgment will appear in the same location and be of an equivalent or greater font size as other acknowledgments.
Technical Assistance, Studies, Reports, A/V Productions, Media, tc.					
Briefing papers, memoranda, and policy recommendations	Co-branding/ co-marking	All items	Printed ink	In all instances	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Electronic and traditional media, e.g., CD-ROM, video, DVD, webcast, podcast, PowerPoint presentation, e-newsletter, etc.	Co-branding/ co-marking	All items. For items that are distributed with a cover or case, the identity may appear both on the case and on the item. For broadcast media, the identity will be incorporated into the presentation, e.g., splash screen for CD-ROM, opening credits for video, etc.	Materials will be determined on a case-by-case basis.	In all instances	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.

WHAT WILL BE MARKED	TYPE OF MARKING	LEVEL OF MARKING	MARKING MATERIALS	WHEN MARKED	WHERE MARKED
Flyers, fact sheets, materials for site visits	Co-branding/ co-marking	All items	Printed ink or other material depending on item	In all instances	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Job aids					
Technical reports, studies and analyses	Co-branding/ co-marking	All items	Printed ink	In all instances	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Training materials and manuals	Co-branding/ co-marking	All items	Printed ink	In all instances	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Events					
Exhibitions, fairs, workshops, information dissemination meetings, training courses, conferences, seminars, press conferences	Co-branding/ co-marking	Minimum one occurrence per event	Materials will depend on site and type of signage required	On or prior to the date of the event, depending on in-country cir-cumstances	Depending on acceptability due to the location of the event, signage may be placed outside the facility or meeting room or in another appropriately visible place.
Invitations for information dissemination or similar meetings	Co-branding/ co-marking	All items	If printed invitation, printed ink; if e-mailed, will follow marking for program emails	In all instances	If printed, on the invitation itself. If e-mailed, in the body of the message.
Program promotional materials	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	In all instances	Where marking is possible, the USAID identity will appear in the same location and be of an equivalent or greater size than other logos.

WHAT WILL BE MARKED	TYPE OF MARKING	LEVEL OF MARKING	MARKING MATERIALS	WHEN MARKED	WHERE MARKED
Commodities					
Equipment and supplies	Co-branding/ co-marking	All equipment and supplies (as defined by USAID) that may be marked and are not covered by one or more presumptive exceptions.	Stickers or paint (brush or stencil) depending on the item, or other method	Upon purchase or acquisition	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Program Deliverables					
Reports, including quarterly, mid-term, and final	Co-branding/ co-marking	All items	Printed ink	From first report due date	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Information, education and communication (IEC) materials such as t-shirts, caps, brochures, and posters	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	IEC products are developed on a case-by-case basis.	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Health learning materials (HLM) such as brochures, pamphlets, and instructional workbooks	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	Materials are produced at various times during the life of a project.	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.
Tools/training manuals	Co-branding/ co-marking	All items	Materials will be determined on a case-by-case basis.	Training manuals are developed at the beginning of a project, and on a case-by-case basis.	The USAID identity will appear in the same location and be of an equivalent or greater size than other logos.

WHAT WILL BE MARKED	TYPE OF MARKING	LEVEL OF MARKING	MARKING MATERIALS	WHEN MARKED	WHERE MARKED
Mobile health units	Co-branding/ co-marking	All units	To be determined based on financial conse-quence of various marking methods (paint, stickers, etc.)	Before deploy-ment of the vehicle	Exterior: The USAID identity will appear in the same location and of an equivalent or greater size than other logos. Interior: marking where practicable with the same stipulations as exterior marking.

PROGRAM DELIVERABLES THAT WILL NOT BE MARKED

In cases where deliverables are not marked, USAID's contribution may be acknowledged either in the text or verbally at relevant meetings and events.

DELIVERABLES THAT WILL NOT BE MARKED	RATIONALE
Organizations' policies, strategies, plans, and guidelines or other materials positioned as being from a local partner	Upon request of a host-country government or Mission, the MCHIP Team may be requested to refrain from marking certain materials for which, though not covered by one or more presumptive exceptions, there is a desire to position as being from a local partner.
Any program communication or material produced under the award covered by one or more Presumptive Exceptions.	While the MCHIP Team is pleased to fulfill the requirement to submit two copies of all program and communications materials produced under the award to the CTO and one copy to USAID's Development Experience Clearinghouse, The MCHIP Team believes that it would not be cost-effective to retroactively mark materials produced without marking under any of the Presumptive Exceptions that may be granted.
Any materials that, after pre-testing, are determined to have a greater impact among target individuals if they are left unmarked.	In close consultation with local governments and stakeholders, the MCHIP Team will examine pre-testing results for all materials. If suggested by the pre-testing results and with the agreement of the government and stakeholders, the MCHIP Team may refrain from marking certain items.

Waivers: The MCHIP Team may request a waiver of the Marking Plan or of its requirements, in whole or in part, for each program, project, activity, public communication or commodity, or, in exceptional circumstances, for a region or country, when USAID-required marking would pose compelling political, safety or security concerns, or when marking would have an adverse impact in the cooperating country. The MCHIP Team will submit the request through the Cognizant Technical Officer with the understanding that final approval must be granted by the Principal

Officer (PO). In the event that the request for a waiver is denied, the MCHIP Team understands that it has the right to appeal the denial to the PO's cognizant Assistant Administrator.

PRESUMPTIVE EXCEPTIONS

The MCHIP Team would like to request the following Presumptive Exceptions and follows the text of each Exemption with its rationale for the request:

Presumptive Exception (i): USAID marking requirements may not apply if they would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials, such as election monitoring or ballots, and voter information literature; political party support or public policy advocacy or reform; independent media, such as television and radio broadcasts, newspaper articles and editorials; and public service announcements or public opinion polls and surveys (22 C.F.R. 226.91(h)(1)).

Rationale: All of the MCHIP Team's key personnel are well-respected within the international health care community. At any time, any one of them may be asked to share their MNCH expertise by the government of an MCHIP presence- or non-presence country either through producing materials or appearing in a public forum. This type of communication is intrinsically neutral because its purpose is to share public health expertise for the betterment of the consumers of that communication. In consultation with the relevant presence- or non-presence-country MOH, the relevant USAID mission, and the Agreement Office, the determination of whether any member of the MCHIP Team would produce writings, including scientific articles, A/V materials, or appear in a public forum in the capacity of a leading authority not affiliated with USAID would be thoroughly negotiated on a case-by-case basis.

Presumptive Exception (ii): USAID marking requirements may not apply if they would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent (22 C.F.R. 226.91(h)(2)).

Rationale: As described in the rationale for the request of Presumptive Exception (i), at the behest of an MCHIP presence- or non-presence country government, members of the MCHIP Team may be requested to write or appear in their capacity of international experts as opposed to members of the Program. In those instances, an exception may be requested.

Presumptive Exception (iii): USAID marking requirements may not apply if they would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as "by" or "from" a cooperating country ministry or government official (22 C.F.R. 226.91(h)(3)).

Rationale: In consultation with the appropriate MOH and the Agreement Office, the MCHIP Team will determine whether or not any of the materials produced under this Program fall into the category of laws, regulations or other that the host-country government would prefer not be marked.
Presumptive Exception (iv): USAID marking requirements may not apply if they would impair the functionality of an item, such as sterilized equipment or spare parts (22 C.F.R. 226.91(h)(4)).

Rationale: As part of the proposed Program, the MCHIP team may build the capacity of local institutions to provide high-impact MNCH interventions. Many of the materials required at local service delivery sites, such as bandages, gloves, scissors, bleach and/or washcloths, would be impossible to mark because of the way in which they are used and the fact that many of them are

sterile or individually wrapped for cleanliness. In addition, the Program may provide other sterile health care tools and materials to service providers.

Presumptive Exception (v): USAID marking requirements may not apply if they would incur substantial costs or be impractical, such as items too small or otherwise unsuited for individual marking, such as food in bulk (22 C.F.R. 226.91(h)(5)).

Rationale: In building the capacity of individual service delivery sites, the MCHIP Team may purchase computer software; information technology consumables, such as CDs, DVDs, or other; memory; and other items required to render computers provided to build site capacity wholly functional. Marking these items would be a laborious process and the fact that they are consumables would mean that very few in the target audience would benefit from it.

Presumptive Exception (vi): USAID marking requirements may not apply if they would offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities (22 C.F.R. 226.91(h)(6)).

Rationale: In building the capacity of local institutions, the MCHIP team may provide anatomical procedure dummies on which to train. These dummies may consist of replicas of the human body or body parts and the MCHIP Team believes that it would be inappropriate to mark these or any similar items.

FLOW-DOWN TO SUBRECIPIENTS AND SUBCONTRACTORS

Sub recipients

JHPIEGO accepts that all sub awards will be marked with the following disclaimer:
"As a condition of receipt of this sub award, marking with the USAID identity of a size and prominence equivalent to or greater than the recipient's, sub recipient's, other donor's or third party's is required. In the event the recipient chooses not to require marking with its own identity or logo by the sub recipient, USAID may, at its discretion, require marking by the sub recipient with the USAID identity."

Subcontractors

JHPIEGO accepts that subcontracts granted under this Leader with Associates Award would be subject to exclusive USAID branding per the requirements for acquisitions.

MARKING OF PUBLIC COMMUNICATIONS

The MCHIP Team agrees that any USAID-funded public communications as defined in 22 C.F.R. 226.2, for which the content has not been approved by USAID, will contain the following disclaimer:
"This study/report/audio/visual/other information/media product (specify) is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

SUBMISSION OF PROGRAM AND COMMUNICATIONS MATERIALS

The MCHIP Team will provide the Cognizant Technical Officer (CTO) or other USAID personnel designated in the award document with two copies of all program and

communications materials produced under the award. In addition, the team will submit either one electronic or one hard copy of all final documents to USAID's Development Experience Clearinghouse.

III. Except as specifically amended herein, all other terms and conditions remain unchanged and in full force. "

END OF MODIFICATION

Maternal and Child Health Integrated Program (MCHIP)

ZIMBABWE

Associate Award

Environmental Mitigation and Monitoring Plan (EMMP)

January 2014 – December 2016

Revised and Re-submitted to
United States Agency for International Development
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Submitted by:
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Broad Branch Associates
Population Services International

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ACRONYMS AND ABBREVIATIONS

AA	Associate Award
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetrical and Newborn Care
cHMIS	Community Health Management Information Systems
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CSO	Civil Society Organization
DHE	District Health Executive
EMA	(Zimbabwe's) Environmental Management Agency
EMMP	Environmental Mitigation and Monitoring Plan
ETAT	Emergency Triage and Assessment
HBB	Helping Babies Breathe
IEE	Initial Environmental Examination
IMNCI	Integrated Management of Newborn and Childhood Illness
KMC	Kangaroo Mother Care
MCHIP	Maternal and Child Health Integrated Program
MCCM	Malaria Community Case Management
MGD	Millennium Development Goal
MIP	Malaria In Pregnancy
MNCH	Maternal, Newborn and Child Health
MOHCC	(Zimbabwe's) Ministry of Health Child Welfare (formerly MOHCC)
PHE	Provincial Health Executive
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSA	Public Service Announcement
PQI	Performance Quality Improvement
QI	Quality Improvement
RBF	Results-Based Financing
RED	Reaching Every District
RI	Routine Immunization
SBM-R	Standards-Based Management and Recognition
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group
USG	United States Government
VCT	Voluntary Counselling and Testing
VHW	Volunteer Health Worker

SECTION 1: INTRODUCTION

1.1 Background

MCHIP Zimbabwe has been supporting the Ministry of Health and Child Care (MOHCC) to improve the quality of Maternal, Newborn and Child Health (MNCH) care services through implementing evidence-based high impact interventions since October 2010. Interventions have been carried out in Manicaland province with intensive support in Mutare and Chimanimani, which were the pilot districts. Lessons learned in implementing interventions there have been critical in national MNCH programming.

Over the next three years, MCHIP/Zimbabwe Associate Award (AA) program will continue to provide support to the MOHCC at the national level with MNCH-related policy and guidelines development facilitated through Technical Working Groups (TWGs). In addition, MCHIP/Zimbabwe AA activities will continue to be focused in Manicaland province, with an intensive level of support in Mutare and Chimanimani districts. The MCHIP/Zimbabwe AA will expand program activities in a geographically targeted and thematic approach in order to achieve province-wide impacts by the end of three years. Identification of new districts will be based primarily on such factors as: mortality trends; case load distribution patterns; partnerships; and the potential to build on existing opportunities like the World Bank-funded Results-Based Financing Program (RBF).

To expand the coverage of **maternal** and **newborn** interventions, the MCHIP/Zimbabwe AA proposes a two-pronged approach to scaling up activities:

1) An intensive quality of care improvement intervention, based on the Standards-Based Management and Recognition (SBM-R) approach, which will target four high-volume health facilities in each district and will focus on Comprehensive Emergency Obstetric and Newborn Care (CEmONC) and Helping Babies Breathe (HBB); and
2) Support for clinical training, supportive supervision, and procurement beyond the high-volume sites; addressing gaps identified at the lower level sites (which are the main sources of complicated cases); and focusing on essential obstetric and newborn care, including Kangaroo Mother Care (KMC), to improve the capacity for early detection, stabilization and pre-referral treatment of cases.

For **child health** and **community-based** interventions, the project will work towards district-wide scale-up in the current two districts in Program Year 1 (PY1) and expansion to at least one other district by PY2, with the aim of achieving district-wide coverage in three districts by PY3.

Monitoring and evaluating the progress and achievements of the program is a key priority for the MCHIP/Zimbabwe AA. As such, it is a of central importance for the MCHIP/Zimbabwe AA to ensure that no harm is rendered to people or the environment in the implementation of program activities, and that interventions are planned with environmental safety and preservation in mind. This Environmental Mitigation and Monitoring Plan (EMMP), read in conjunction with the program's Performance Monitoring Plan (PMP), outlines how the MCHIP/Zimbabwe AA plans to systematically incorporate environmental mitigation interventions into its work; monitor for compliance; and report on these activities over the next three years.

1.2 Government of Zimbabwe Environmental Policies and Procedures

In 2002, the Parliament and President of Zimbabwe enacted the Environmental Management Act, establishing the national Environmental Management Agency (EMA), the National Environment Council and an Environmental Fund. The Act also establishes an Environmental Minister, tasked with several duties, one of which is to appoint the appropriate experts and representatives to a National Environmental Council, which reports to the Minister with environmental policy recommendations and advice. Furthermore, the Act tasks the EMA with the following important duties:

> *"IV.10. (a) to formulate quality standards on air, water, soil, noise, vibration, radiation, and waste management; (b) to assist and participate in any matter pertaining to the management of the environment; and in particular – (vi) to regulate, monitor, review and approve environmental impact assessments, (viii) to make model by-laws to establish measures for the management of the environment within the jurisdiction of the local authorities and (xiv) to carry out periodic environment audits of any projects…for the purpose of ensuring that their implementation complies with the requirements of this act."*[1]

Regarding environmental impact assessments, the law stipulates that such an assessment and accompanying report must be carried out for a series of types of projects found in section 146 of the Act.

The process established by the Zimbabwean Environmental Management Act of 2002 is quite similar to the compliance examination process as laid out in USAID regulation 22 CFR 216. Both USAID's and Zimbabwe's environmental policies aim to protect and preserve the environment through a proper identification of potentially adverse impacts from proposed project activities (based on a clearly established environmental impact assessment) as well as through the rigorous application and implementation of appropriate mitigation measures. Consequently, both USAID regulation 22 CFR 216 and Zimbabwe's Environmental Management Act are fully compatible, and this EMMP is consistent with both.

1.3 MCHIP/Zimbabwe AA Program Description

Vision

The MCHIP/Zimbabwe AA's vision is to significantly contribute to accelerated and sustainable improvement in maternal, newborn, and child health in Zimbabwe through scaling up of evidence-based, high impact, integrated public health interventions.

Goal

The MCHIP/Zimbabwe AA's goal is to increase access to high-quality MNCH services and strengthen health services in Zimbabwe by supporting the MOHCC and contributing to the scale-up and roll-out of evidence-based, high-impact interventions that will reduce maternal, newborn and child morbidity and mortality and malnutrition and support progress towards the attainment of Millennium Development Goals (MDGs) 4 and 5.

[1] Government of Zimbabwe 2002. Environmental Management Act (Chapter 20:27). Government Printers, Harare, Zimbabwe.

Objectives

Objective 1: Strengthen the capacity of the MOHCC at the national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high-impact MNCH health interventions.

Strategic Approach & Key Activities:

The MCHIP/Zimbabwe AA will continue to build the capacity of the MOHCC to deliver high-quality MNCH services. At the national level, this will be done by expanding the skilled workforce and strengthening institutional systems for long-term sustainability. Using a collaborative approach, the MCHIP/Zimbabwe AA will strengthen the MOHCC's capacity to formulate, coordinate, roll out and monitor key MNCH interventions by:

- Providing technical and other support to MOHCC departments, steering committees and TWGs for the development and roll-out of national policies, strategies, guidelines and tools;
- Strengthening linkages between the MOHCC and key national MNCH partners;
- Increasing the pool of human resources with skills necessary to deliver high-quality services nationally;
- Supporting the availability and use of high-quality strategic health information for decision making;
- Supporting new and innovative approaches, tools and operations research, documenting lessons learned, and sharing best practices; and
- Expanding the reach of interventions through integrated, multi-health themes and multi-sector approaches, particularly for nutrition, and partnering with Feed the Future partners to link health and other interventions to address the barriers to optimal nutrition.

Objective 2: Strengthen the capacity of the MOHCC at provincial and district level to improve the quality of integrated MNCH services at health facilities and in the community to support national level scale-up plans.

Strategic Approach & Key Activities:

- Quality Improvement activities for MNH will include expansion beyond Mutare and Chimanimani districts to target high volume sites in all seven districts with a package of interventions with the potential to reduce maternal and newborn deaths;
- Scale-up coverage for KMC, HBB, BEmONC services, and mortality audits to the entire province;
- Child health activities will include province-wide coverage for Integrated Management of Newborn and Childhood Illness (IMNCI); the introduction of the Rotavirus vaccine; the scale-up of Routine Immunization (RI) through the Reaching Every District (RED); the use of ELMA Foundation funding to expand immunization activities to Matabeleland North and South; and to expand the IMNCI platform to include Emergency Triage and Assessment (ETAT) and to address HIV and malnutrition;
- Mitigating the effects of malaria by strengthening prompt and effective treatment at the community level, while supporting malaria in pregnancy (MIP) at the health facility level through Quality Improvement (QI) interventions in the five malaria districts; and

- Expanding on the support provided to Volunteer Health Workers (VHWs) in Mutare and Chimanimani to intensify the geographical coverage of MNCH care provided by VHWs to all villages in Chimanimani; province-wide scale-up of promising components of the Performance Quality Improvement (PQI) approach, with a focus on community Health Management Information Systems (cHMIS); and providing intensive support to Mutasa district through a phased approach.

Objective 3: Strengthen the capacity of Civil Society Organizations (CSOs) to implement MNCH activities and manage U.S. Government (USG) funding.

Strategic Approach & Key Activities:

- Work with the MOHCC, Manicaland Provincial Health Executive (PHE), District Health Executives (DHEs) and CSOs to define the roles that CSOs will be asked to play in provincial MNCH improvement efforts;
- Develop a CSO engagement plan (including guidelines and tools for procurement, sub agreement management and CSO capacity building) that will be ready for roll-out in PY2;
- Select and begin working with 1 to 2 CSOs in PY1 to implement a portion of the project's community and family mobilization strategy; and
- Initiate a competitive CSO procurement process for the award of subagreements early in PY2.

1.4 Purpose and Scope of the EMMP

This Environmental Mitigation and Monitoring Plan (EMMP) covers planned activities under the MCHIP/Zimbabwe AA. The EMMP will be used for the collection and management of information in mitigating adverse effects to the environment as a result of implementing MCHIP activities. To the extent possible, the procedures outlined below adhere to Zimbabwe's and USAID's environmental policies. Activities implemented by the MCHIP/Zimbabwe AA will be modified according to the guidance presented in this document to the extent feasible, and as determined by project staff. Any significant changes in project activities or in the project environment will result in amendments to the EMMP to be submitted with future annual workplans.

SECTION 2: "CATEGORICAL EXCLUSION" OF MCHIP/ZIMBABWE AA ACTIVITIES

Activities	Effects on natural or physical environment	Determination and Regulations 216 action required
Categorical Exclusion		
• Project/ Program Management • Developing sound monitoring and evaluation techniques that report on impact and not just outcomes • Ensuring the sustainability of funded initiatives • Miscellaneous durable goods – i.e., a stove or refrigerator for a clinic or hospital	No adverse effect on the natural or physical environment	**Categorical Exclusion** per 22 CFR 216.2 (c) (1) (i)
• Technical assistance, education, training programs except to the extent that such programs include activities directly affecting the environment • Financial, accounting, management and other	No adverse effect on the natural or physical environment	**Categorical Exclusion** per 22 CFR 216.2 (c) (2)(i)

Activities	Effects on natural or physical environment	Determination and Regulations 216 action required
capacity building activities • Community mobilization/ organization efforts • Funding CSOs to monitor activities • Training for preparing grant proposals		
• Analyses, studies, workshops and meetings	No adverse effect on the natural or physical environment	**Categorical Exclusion** per 22 CFR 216.2(c) (2)(iii)
• Document and information transfer • Public outreach campaigns, including the development of print or other media • Discussion panel(s) on television or radio • Public service announcement s (PSAs) for television or radio	No adverse effect on the natural or physical environment distinctive	**Categorical Exclusion** per 22 CFR 216.2 (c) (2)(v)
• Activities that will develop the capabilities of CSOs to engage in planning	No adverse effect on the natural or physical environment	**Categorical Exclusion** per CFR 216.2(c) (2) (xiv)

SECTION 3: ACTIVITIES FALLING UNDER "NEGATIVE DETERMINATION WITH CONDITIONS" CATEGORY

There are three classes of activities implemented by MCHIP Zimbabwe that fall within the "Negative Environmental Determination with Conditions" category. These activities are as follows:

1. **Management of public health commodities** (i.e., laboratory reagents, drugs and supplies)

2. **Management and disposal of hazardous medical waste** (both at health facilities and in the community). The following are activity areas of focus under this category:
   a. **Immunization**
      i. Expanded Program on Immunization (EPI) and IMCI interventions; and
      ii. Other immunization and vaccination services that directly or indirectly result in generation and disposal of bio-hazardous health care waste.
   b. **Antenatal Care (ANC)**
      i. Support (direct or indirect) for blood testing, screening, or treatment for HIV, sexually transmitted infections (STIs), and tuberculosis (TB) which may occur as part of voluntary counselling and testing (VCT), ANC, or prevention of mother-to-child transmission (PMTCT) programs, e.g.:
         1. VCT and PMTCT services at clinical/treatment sites;
         2. VCT and PMTCT at primary health care and ANC clinics;
         3. STI screening, prevention, and treatment services; and
         4. TB screening conducted as part of VCT, ANC, and PMTCT activities.

   c. **Labor and Delivery**
      i. Support MOHCC in the safe disposal of medical waste generated as result of labor and delivery, including:
         1. Sharps generated from medical injections, canulae, blades, broken vials, etc.; and

2. Contaminated swabs, gloves, and other disposable utilities.
3. Biological waste such as spilt blood, placentas, and other human tissues (still births, etc.)

d. **Malaria Community Case Management**

i. Support for community-based management of malaria through:

1. The safe disposal of medical waste generated by rapid diagnostic tests; and
2. Management of occupational exposure to blood (needle pricks, cuts, etc.) as appropriate.

3. **Blood testing, screening or treatment for HIV, STIs, and TB,** which may occur as part of VCT, ANC or PMTCT programs; training of health care professionals in AIDS services; testing of human subjects; laboratory support which results in waste; clinical research; and purchase and use of drugs for treatment purposes.

Please see **Annex 1** for the potential impact, mitigation measures and monitoring indicators for ensuring environmental compliance.

SECTION 4: GENERAL ENVIRONMENTAL AWARENESS-RAISING ACTIVITIES

MCHIP/Zimbabwe AA staff will seek opportunities to provide technical assistance and capacity building to MOHCC and its partners in environmental protection and mitigation issues. For example, in MCHIP/Zimbabwe AA-supported sites, attention will be paid to how facilities are managing and disposing of hazardous medical waste. MCHIP/Zimbabwe AA staff will seek to ensure that medical waste management and disposal topics are included in project trainings, quality improvement activities, and supportive supervision visits, as appropriate. As suggested by the USAID Initial Environmental Examination (IEE), dissemination messages may include the following guidance:

- Sharps should be collected together and stored in puncture-proof, impermeable and tamperproof containers with fitted covers. If plastic or metal containers are unavailable, then containers made of dense cardboard are recommended.
- Highly infectious waste should be immediately sterilized by autoclaving.
- Onsite collection of waste should be handled at frequent intervals, and an adequate supply of fresh collection bags/containers should be available.
- Waste should be stored in an accessible room with adequate space and protection from sunlight. In any area that produces hazardous waste, three bins should be used to collect different types of waste and a separate container for sharps should be available.
- For hazardous and highly hazardous waste, the use of double packaging is recommended.
- To make waste collection easier, hospital, clinic or facility personnel should be trained to sort the waste they produce.
- Incinerators should be available, maintained, and functional so that medical waste is not disposed of improperly.
- Incineration of the following types of health care waste should be avoided: pressurized gas containers, large amounts of reactive chemical waste, silver salts and photographic or radiographic wastes, halogenated plastics, and waste with high mercury or cadmium content (e.g. thermometers and batteries).

In addition, as part of the MCHIP/Zimbabwe AA's regular activities, the project will seek opportunities to:

- Incorporate messages and standards regarding the environmental implications of health care programs (e.g., proper medical waste management, blood safety, etc.) into its health care messages, training protocols, and supervision checklists;
- Work with its implementing partners and other collaborating agencies to ensure, to the extent possible, that MCHIP/Zimbabwe AA-supported facilities and program operations have adequate procedures and capacities in place to properly handle, label, treat, store, transport, and dispose of blood, needles, and other medical waste; and
- Work with its implementing partners and other collaborating agencies to ensure, to the extent possible, that MCHIP/Zimbabwe AA-supported facilities use "environmentally friendly" equipment (e.g., chlorofluorocarbon (CFC)-free refrigerators for storage of vaccines).

SECTION 5: MITIGATION, MONITORING AND REPORTING

In terms of mitigation, monitoring and reporting of environmental compliance activities, the MCHIP/ Zimbabwe AA commits to:

- Incorporate environmental compliance issues into regular supportive supervision and monitoring visits;
- Include environmental compliance issues into regular trainings supported by the MCHIP/Zimbabwe AA. A module on environmental compliance will be developed and integrated into trainings packages;
- Report on the status of environmental mitigation and monitoring measures implemented in quarterly program reports; and
- Complete an annual environmental mitigation and monitoring report of activities undertaken (unless specified otherwise), to be submitted to the AOTR by the end of September each year;
- Ensure the availability and use of HIV post-exposure prophylaxis (PEP) training, guidelines and kits in all program-supported health facilities.

ANNEX 1: ENVIRONMENTAL MITIGATION & MONITORING PLAN (EMMP) FOR MCHIP/ZIMBABWE AA: JANUARY 2014-DECEMBER 2016

Activity	Recommended Determination	Mitigation Measures	Monitoring Indicators	Monitoring Frequency	Responsibility
Management of public health commodities (i.e., laboratory reagents and supplies, insecticide treated bed nets, and water purification products)	Negative Determination with Conditions	Store products according to information provided on the manufacturers safety data sheet All expired drugs should be disposed; work with the MOHCC on all aspects of essential medicine supply chain management Ensure that all new or used reagents are disposed in a way that does not pollute the environment Ensure that disposal that involves burning pharmaceuticals and plastic medical supplies (including expired or used reagents) at low temperatures or in open containers does not result in release of toxic pollutants Ensure that there are sufficient controls to	**Presence or absence of commodities stored according to Manufacturer's information instructions** **Presence or absence of expired drugs on the shelves** **All medical supplies have clear disposal instructions** **All expired and used medical supplies should be disposed according to given guidelines as below:** - ***Medical supplies*: Incinerated by the hospitals/health facilities in which MCHIP/Zimbabwe AA is working on MNCH activities, and by MOHCC staff responsible for waste management, to ensure that collection and incineration of the waste collected is occurring on a daily basis.** **Adherence to policies ensuring that**	Monthly Quarterly reporting	MCHIP/Zimbabwe AA and MOHCC staff

		prevent drugs beyond their expiry date from being diverted for resale in the general public	**expired drugs are destroyed and expired medicines are returned to the pharmacy or to the hospitals in which MCHIP/Zimbabwe AA is working, or to NatPharm directly, who will incinerate expired drugs**		
Management and disposal of hazardous medical waste	Negative Determination with Conditions	Sharps should be collected together and stored in puncture-proof, impermeable and tamperproof containers with fitted covers or one made of dense cardboard are recommended Highly infectious waste should be immediately sterilized by autoclaving Onsite collection and storage of waste should be handled as follows: • Waste is collected daily • All bins are emptied daily or when full and waste in bags is stored in a separate room • Waste is stored for no longer than **2 days** • The waste handler should weigh the amount of waste generated and keep a record in a log book • Organic waste should be disposed of daily A supply chain system for sharp containers and waste bags in three colours is in place	**Presence/absence of puncture proof containers with covers or dense cardboard boxes. These will be disposed of once the containers are ¾ filled with sharps** **Number of disposed sharps containers used after the team returns from outreach and from VHWs** **Sterilized highly infectious waste through autoclaving** **Empty bins at start of every day** **Presence/absence of a waste storage room** **Presence/absence of waste not older than 2 days** **Presence/absence of a waste log book** **Presence/absence of three types of bins.**	Monthly Quarterly reporting	MCHIP and MOHCC staff

		and supplies are delivered on a three month basis. A system for emergency supplies is in place. Waste should be stored in a room with adequate space and protection from sunlight. In any area that produces hazardous waste, three types of closed bins should be used to collect different types of waste and a separate container for sharps (puncture-proof, impermeable and tamper-proof containers with fitted covers or one made of dense cardboard) should be available**.** Bin liners in three different colours to separate waste should be available at all sites. **Clear colour coding of waste bags as follows:** **Yellow:** Safety boxes for sharps (needles, syringes, blades, broken glass, lancets, scissors, ampoules, catheters, slides, pops, and waste bins with papers, pharmaceutical packaging, infusion bags, plastic bottles, and big broken glass **Red:** Wet infectious materials (Blood, body tissues (foreskins), fluids (discharges), urine, and specimens (stool, sputum, placenta, wet dressings, blood bags) **Blue/black:** Non-infectious materials (food, fruit, and other food remains)	**No stock outs of waste bins and sharp containers in the last three months. Sufficient supplies of waste bins and sharp containers for three months at site.** **Presence/absence of a waste storage room at the site.** **Presence or absence of yellow, red and blue/black containers for different types of waste**		

		To make waste collection easier, clinic or lab personnel should be trained on waste management during the initial MNCH trainings and refresher courses should be organised annually. The site manager or a nurse supervisor should be tasked with ensuring that waste management is implemented according to standard guidelines. Internal quality assurance visits will be organised by MCHIP/MOHCC on a quarterly basis and eternal quality assurance visits will be organised annually. Incineration of placentas according to the protocols and guidelines of the hospitals or health care facilities where deliveries are carried out; or by contractors specializing in waste management and incineration.	**Record of personnel trained on waste management on annual basis.** **Record of placentas transported for incineration at government hospital incinerators**		
Blood testing, screening, or treatment for HIV, STIs, and TB which may occur as part of VCT, ANC, PMTCT, or malaria community case management (MCCM)	Negative Determination with Conditions	Sharps should be collected together and stored in puncture-proof, impermeable and tamperproof containers with fitted covers or one made of dense cardboard Highly infectious waste should be immediately sterilized by autoclaving Onsite collection and storage of waste should be handled as follows: • Waste is collected daily • All bins are emptied daily or when full and waste in bags is stored in a separate room • Waste is stored for no longer than **2 days** • The waste handler should weigh the	**Presence or absence of puncture proof containers** **Record of infectious waste sterilised by autoclaving** **Record of waste collected according to the set guidelines** **Records of waste managed in the community by VHWs**	Monthly Quarterly reporting	MCHIP/Zimbabwe AA and MOHCC staff

		amount of waste generated and keep a record in a log book • Organic waste should be disposed of daily			
		Undertake quarterly internal and annual external audits and consultations with implementing partners, periodic assessments of the environmental impacts of ongoing activities, and associated mitigation and monitoring measures.	**Compliance reports completed and shared with USAID**		
		Quality assurance assessments must be carried out and field monitoring conducted at random or at representative health care facilities, laboratories, VCT clinics and VHW homesteads.	**Quality Assurance assessments reports completed and shared with USAID every quarter**		