Maternal and Child Health Integrated Program (MCHIP)
Zimbabwe

Associate Award

Program Year 2
Implementation Plan

January 1, 2015 – December 2015

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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
ACS	antenatal corticosteroids
ACSM	advocacy, communication, and social mobilization
ACT	artemisin-based combination therapy
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
CAC	Community Action Cycle
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
CD	Country Director
cEmONC	Comprehensive Emergency Obstetrical and Newborn Care
CH	child health
CM	community mobilization
CS	child survival
CSS	child survival strategy
CTC	clinical training centers
DFID	United Kingdom Department for International Development
DHE	District Health Executive
DHIS	District Health Information Software
DHS	Demographic and Health Survey
DQA/DQS	data quality self-assessment/data quality survey
ECA	environmental compliance assessments
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EHT	extension health workers
EmONC	Emergency Obstetrical and Newborn Care
ENC	Essential Newborn Care
EPI	Expanded Program on Immunization
ETAT	Emergency Triage Assessment and Treatment
F&A	finance and administration
FH	family health
FP	family planning
HBB	Helping Babies Breathe
HF	health facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTF	Health Transition Fund
ICC	Inter-Agency Coordinating Committee
iCCM	integrated Community Case Management
IEC	Information and Education Campaign
IIP	Immunization in Practice
IMAM	integrated management of acute malnutrition
IMNCI	Integrated Management of Newborn and Childhood Illness
IPV	inactivated polio vaccine
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

MICS	Multiple Indicator Cluster Survey
MIP	Malaria in Practice
MNCH	maternal, newborn, and child health
MNH	Maternal and newborn health
MOHCC	(Zimbabwe's) Ministry of Health and Child Care (Formerly MoHCW)
MPCMA	Maternal, Perinatal and Child Death Notification and Audit
MPMA	Maternal and Perinatal Mortality Audits
MSD	measles second dose
NH	newborn health
NIHFA	National Integrated Health Facility Assessment
NITAG	National Immunization Technical Working Group
NMCP	National Malaria Control Programme
OJT	on-the-job training
OPHID	Organization for Public Health Interventions and Development
OR	operations research
OSDV	onsite data verifications
PCV 13	Pneumococcal Conjugate vaccine
PDQ	Partnership-Defined Quality
PE/E	pre-eclampsia, eclampsia
PPH	postpartum hemorrhage
PMP	Performance Monitoring Plan
PMTCT	prevention of mother-to-child transmission of HIV
PNC	postnatal care
PPFP	postpartum family planning
PPIUD	postpartum intrauterine device
PQI	performance quality improvement
PHE	Provincial Health Executive
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
RMNCH	reproductive, maternal, newborn, and child health
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
TBD	to be determined
TOR	terms of reference
TOT	training of trainers
TSS	train, supply, and support
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
Zim Asset	Zimbabwe Associate for Sustainable Socio-Economic Transformation
ZICOM	Zimbabwe Confederation of Midwives

INTRODUCTION

Overview

This Project Year 2 (PY2) Workplan describes the strategies and activities that will support implementation of the MCHIP/Zimbabwe Associate Award (AA) for the period January 1, 2015 to December 31, 2015. These strategies and activities were selected based on an analysis of the current country context; country priorities in maternal, newborn, and child health (MNCH); experiences and lessons learned during PY1; consultation with the Zimbabwe Ministry of Health and Child Care (MOHCC), as well as the United States Agency for International Development (USAID)/Zimbabwe Mission; and an acknowledgement of developments in global and national MNCH policy, programming, and implementation best practices over the past year.

Programming constraints

This workplan re-submission is presented with substantial budget cuts to program activities, personnel, and short-term technical assistance (STTA), due to PY2 funding constraints. It reflects rigorous consultations with the Mission Agreement Officer's Representative in December 2014, following the team's original, draft workplan submission.

The original Best and Finals budget for PY2 under the MCHIP/Zimbabwe AA was approximately $5.8 million. Actual PY2 funding available is substantially less: the project will receive $3.175 million in new Mission funding for PY2. Unfortunately, this is not sufficient, even with an anticipated PY1 pipeline of about $343,000. The MCHIP/Zimbabwe AA is no longer positioned to provide the contractually mandated level of technical support to the MOHCC that would be needed to advance its national agenda and support the implementation of key MNCH activities in Manicaland province. If additional funding is unlikely following USAID's review of this revised and re-submitted workplan, the project requests that the AA's contractual scope of work and expected results be realigned with the new funding levels for PY2 and PY3.

PROGRAM GOAL, OBJECTIVES, AND APPROACH

The **vision** of the MCHIP/Zimbabwe AA is to significantly contribute to accelerated and sustainable improvement in MNCH in Zimbabwe through scaling up of evidence-based, high-impact, and 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 to scale up and roll out evidence-based, high-impact interventions that will reduce maternal, newborn, and child morbidity and mortality and contribute to the attainment of Millennium Development Goals (MDGs) 1c, 4, 5, and 6 in Zimbabwe.

The first year of this AA was one rich in achievements. At the national level, this included supporting the MOHCC in finalizing the National Quality Improvement (QI) Policy and Strategy, revising the National Reproductive Health (RH) Policy, finalizing the National Nutrition Strategy, facilitating the MOHCC's national adoption of the Emergency Triage Assessment and Treatment (ETAT) approach and clinical training package for postpartum family planning (PPFP), and supporting the national introduction of rotavirus vaccine. The project team participated in and even co-hosted numerous MNCH-related Steering Committee and Technical Working Group meetings at the national level, including the Reproductive Health (RH) Steering Committee, Child Survival (CS) TWG, Nutrition TWG and Immunization Inter-Agency Coordinating Committee (ICC), and National Immunization Technical Advisory Group (NITAG).

The MCHIP/Zimbabwe AA also had a fruitful year championing QI efforts at the provincial, district, and community levels. This included completing a baseline Quality of Care (QoC) assessment in all seven districts in Manicaland province and supporting 36 health facilities and numerous communities in Manicaland to develop and implement their QI plans—which now also include an immunization component and a refined child health component. As part of the project's learning agenda, selected components of the community performance quality improvement (cPQI) approach that was developed and tested during the earlier MCHIP program were also refined and further expanded. Moreover, key, evidence-based approaches in MNCH service delivery were sustained (e.g., Reaching Every District, or RED) and/or scaled up (e.g., Kangaroo Mother Care, or KMC) in all seven districts in Manicaland.

Strengthening local capacity to promote and deliver MNCH services has been another priority area of technical assistance for the project. In PY1, 120 health workers were trained on various aspects of MNCH, from IMNCI to infant and young child nutrition and feeding (IYCF), and the team contributed technically to a new set of health worker guidelines on family planning (FP) and postpartum intrauterine device (IUD). Community-level achievements included revision of the Village Health Worker (VHW) job aids and improved access to key MNCH services through an increased number of VHWs, nurse aids, and SHMs trained on integrated community case management (iCCM) and other interventions. The team also completed a rigorous CSO mapping exercise and selection process, thereby laying the groundwork for the proposed community partnership activities that should be managed through CSO subawards in PY2.

Improving the cost-effectiveness of programming

Much of the MCHIP/Zimbabwe AA's work relies heavily on training health care workers and imparting both knowledge and practical skills. This emphasis on training is often quite costly. In response, the project team has made great efforts to be innovative and forward thinking, and to change the mindsets of other colleagues on how trainings could and/or should be conducted in Zimbabwe. MCHIP has been quite proactive in improving not only the way that training is done, to make it more user friendly and more likely for long-term skills transfer and utilization, but also to do so in a more cost-effective way. These cost-control measures also foster transparency and sustainability of future trainings and improve their ownership by the MOHCC.

The MCHIP/Zimbabwe AA now supports more trainings that are non-hotel based, as well as non-residential trainings and workshops. One such example of this is the MCHIP-supported refurbishment of MOHCC facilities that are now used for trainings; not only are these trainings less expensive, but they also allow for more participation from these facilities and greater MOHCC ownership. The project team has also increasingly held project trainings in our own offices (as opposed to offsite), which has greatly reduced conferencing costs. In

PY2—particularly given our increased budget constraints with respect to PY1—we will continue to explore ways to improve supportive supervision, post-training follow-up, and mentorship for more lasting skills transfer.

The MCHIP/Zimbabwe AA has also implemented creative cost control measures by co-locating project staff within MOHCC office space (which has also facilitated coordination and collaboration). Combining planned administrative support trips with workshops, conferences, and field support visits has been another effective cost-control measure sustained by the project. With procurements, which are always in line with USAID rules and regulations, we have also been successful in further negotiating prices for goods and services such as conferencing and accommodation packages. Lastly, in effort to address often highly variable vendor pricing, we have routinely solicited more vendor quotes than the number required for each threshold procurement value.

The project team has both increasingly implemented *whole-site* orientations for SBM-R and further integrated our supportive supervision visits to look at facilities and services more holistically, rather than by technical intervention. These measures were deliberately taken to work smarter and more efficiently, and to respond to a direct criticism from the Provincial Medical Director's (PMD's) office these trainings, while important, were keeping staff out of the office for too long. In relation to this, The MCHIP/Zimbabwe AA will continue to seek more practical, hands-on, non-hotel based trainings, use existing facilities for training (e.g., Sakubva Hospital, for KMC trainings) and improve our efforts to deliver and/or support blended learning activities. In PY2, the project will also further efforts to leverage with other funding mechanisms, such as the HTF/RBF, to advocate for their cost share of certain trainings, procurement, and MOHCC learning exchange visits.

In PY1, the project's **objectives** were as follows:

1. To 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. To 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. To strengthen the capacity of civil society organizations (CSOs) to implement MNCH activities and manage US Government (USG) funding.

In PY2, Objective 3 has been redefined to reflect severe funding constraints, which have necessitated a substantially reduced scope of work and the project's ability to directly partner with only one CSO. This re-defined Objective 3 is as follows:

3. REVISED: To strengthen the capacity of Civil Society Organizations (CSOs) to effectively implement MNCH activities.

The MCHIP/Zimbabwe AA will build on its successful experience over the past four years (three under the previous MCHIP award, and one under the current, follow-on AA) and will consolidate 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, particularly those where implementation has not started or is lagging; 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 and will take deliberate steps to mitigate the underlying causes of excess maternal, newborn, and child mortality, with an emphasis on reversing the malaria burden and collaborating with other partners to address the effects of malnutrition and HIV/AIDS.

Within the limitations of available funding, the project will expand its geographic reach, continue to prioritize improved service provision at high-volume health facilities, and engage civil society organizations (CSOs) to

complement its own and the Government of Zimbabwe's community-based initiatives. At the same time, the MCHIP/Zimbabwe AA team will continue to complement and will share time with the JSI Research and Training Institute-supported immunization activities in Matabeleland North and South provinces, which have been made possible by a two-year grant from the ELMA Vaccines & Immunization Foundation. The ELMA grant is also entering its second year.

While the MCHIP/Zimbabwe AA's contributions to health outcomes are expected to manifest fully by the end of 2016, the project has in the meantime identified milestones and intermediate achievements to be reached by end of PY2. These mid-term results, the strategies used to attain them, and the basis for prioritizing them are detailed in the implementation matrices below, which are in turn organized according to project objectives and then specific packages of interventions and deliverables.

In the following sections, we present the MCHIP/Zimbabwe AA's project approach, rationale for proposed PY2 strategies and activities, implementation framework, monitoring and evaluation (M&E) plan, management plan, and project indicator matrix.

EXPECTED RESULTS AND ACTIVITIES BY OBJECTIVE

Below we provide a summary of expected life-of-project results for the MCHIP/Zimbabwe AA; review PY1 achievements; propose results we expect to achieve in PY2; and articulate detailed activities and tasks proposed under each of the above objectives.

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

Objective 1: Life of Project Results	PY1 Key Achievements	PY2 Expected Results
• National MNCH policies, strategies, guidelines and tools developed/finalized with MCHIP support.	• National QI Policy and Strategy finalized with MCHIP technical and financial support. • National RH policy revised with substantive input from MCHIP. The launch of the RH policy was postponed to allow for alignment to the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset) and the planned revision of the National Health Policy and Strategy. • National Nutrition Strategy finalized by the Nutrition TWG, with MCHIP support. • Emergency Triage Assessment and Treatment (ETAT) adopted as a national strategy and part of national policy to improve child health outcomes, with MCHIP's advocacy. The initial training of health providers/potential trainers is scheduled for early 2015.	• QI policy and strategy disseminated and reflected in plans for MNCH departments. • National Nutrition Strategy launched and disseminated with MCHIP contribution. • National ETAT guidelines and tools adapted and printed, and a national pool of ETAT trainers and mentors trained; lessons learned in implementing ETAT in the Zimbabwean context documented to contribute to national rollout and refinement of ETAT. • VHW training manual revised in line with new malaria treatment guidelines, and to incorporate updated diarrhea, pneumonia, and malnutrition case management guidelines.
• MNCH program coordination, planning, and monitoring strengthened through MCHIP support for national steering committees/Technical Working Groups (TWGs), and 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.	• Coordination of MNCH activities and support for MNCH social mobilization and advocacy events improved with MCHIP's support, through the successful commemoration of national/international health days. • Technical contributions made by MCHIP through participation in and co-hosting of various MNCH planning and coordination activities and progress reviews under the auspices of the RH Steering Committee, MNH TWG, Child Survival (CS) TWG, Nutrition TWG, the ICC and National Immunization Technical Advisory Group (NITAG), H4+, Health Transition Fund (HTF)/Results Based Financing (RBF), Health Management Information Systems (HMIS) TWG, PMI, Behavior Change Communication (BCC)/Community Mobilization (CM) TWG, and others. • New MOHCC Child Health Deputy Director selected, with participation on interview panel by World Health Organization (WHO), United Nations Children's Fund (UNICEF), MCHIP, and MOHCC. • Village health worker (VHW) job aids reviewed and updated, with other partners working to improve community MNCH and strengthen VHW service provision.	• Partners (e.g., HTF, H4+, UN,) and national resources increasingly leveraged to support MNCH trainings. • Partner coordination forums meeting regularly, MNCH plans developed, and regular MNCH program/strategy reviews conducted. • National Child Survival and Development Strategy reviewed, revised, and completed with MOHCC and partners. • National IMNCI policy and chart booklet updated based on new WHO pneumonia treatment guidelines.
• MNCH pre-service education (PSE) curricula for nurses, doctors and other health professionals improved through inclusion/updating of content on Basic Emergency	• 120 health providers trained on MNCH (20 on BEmONC/HBB, 20 on IMNCI, 20 on IYCF, 20 on KMC, 20 on Immunization in Practice (IIP), and 20 on iCCM) in clinical training courses using current evidence on CBT. • Reviews of various training curricula supported at national level. National University of Science and Technology and Africa University engaged by	• Capacity-building innovations, such as blended learning approaches and targeted mentorship, tested and supported to improve the competencies of health providers (beyond the use of traditional off-site, group-based clinical trainings, which tend to compromise service delivery).

Objective 1: Life of Project Results	PY1 Key Achievements	PY2 Expected Results
Obstetrical and Newborn Care (BEmONC), Helping Babies Breathe (HBB), Integrated Management of Newborn and Childhood Illness (IMNCI), maternal nutrition, Infant and Young Child Feeding (IYCF) and immunization, as well as skills strengthening of instructors in Competency Based Training (CBT).	MCHIP in developing scopes of work for technical support; these scopes are now being implemented.	• VHW job aids finalized, launched, and disseminated for wider use. • Curriculum review processes supported and the adoption of CBT principles sustained. Key MNCH components improved in the final versions of these curricula.
• Greater focus on resources and commodities available for malaria in pregnancy (MIP), maternal and child nutrition, pneumonia and diarrhea case management, prevention of mother-to-child transmission of HIV (PMTCT), and postpartum family planning (PPFP)/postpartum intrauterine device (PPIUD) interventions through collaboration with partners/donors supporting antenatal care (ANC) and postnatal care (PNC) programming.	• FP/PPIUD training guidelines completed with other partners, who will then support their national rollout. • Selected components of cPQI approach tested and refined by MCHIP. • Facility and community QI plans implemented, with resources and support leveraged from MCHIP and other MNCH partners. • QI plans developed by 36 health facilities in follow-up to MCHIP-supported baseline assessments.	• Promising cPQI components, such as MNCH registers and SS approaches, adopted for scale-up. • Other promising MNCH tools and approaches taken or being taken to scale, with support from MCHIP and other MNCH partners.
• Strategic information systems strengthened through improvements to the national HMIS, inclusion of quality and community indicators within the HMIS, and revitalization of the maternal and perinatal mortality audit (MPMA) system nationally.	• TrainSMART, a database for capturing in-service trainings hosted on a web-based platform, set up with MCHIP's technical input into indicators and data collection tools. • Advocacy for the integration of community indicators onto the District Health Information Software (DHIS) platform sustained. Technical support provided by MCHIP during national HMIS strategy reviews, and for development of national RMNCH Balanced Score Card. • MPMA guidelines finalized. • Maternal and perinatal death notification forms drafted (for future uploading onto an electronic platform for piloting in Manicaland and H4+ districts). •	• TrainSMART rolled out to Manicaland, and database information used to develop and implement provincial and district training plans. • Community module on the DHIS-2 platform developed and tested in Manicaland with MCHIP's support. • First meeting of National MPMA Committee held, and national MPMA report produced with MCHIP technical assistance. • Electronic format for maternal and perinatal death notification forms field tested in Manicaland, and findings analyzed, together with results from the H4+ districts. •
• New MNCH approaches and tools explored, lessons learned documented, and best practices	• Rotavirus vaccine successfully launched nationally, with MCHIP's substantial support during planning and rollout. • Planning for national introduction of Measles/Rubella (MR) vaccine second	• Rotavirus vaccine post-introduction evaluation (PIE) conducted with MCHIP's technical support. • Inactivated polio vaccine (IPV) vaccine successfully introduced

Objective 1: Life of Project Results	PY1 Key Achievements	PY2 Expected Results
shared with MNCH stakeholders.	dose completed with MCHIP's technical support. • Immunization activities in Matabeleland North and South successfully launched, and vaccine store in Mashonaland East constructed and turned over to Province with ELMA Foundation funding. • Technical and financial support provided for the development and adoption of national training of trainer (TOT) guidelines for BEmONC in-service trainings. • Advocacy for the development of national scale-up plans for antenatal corticosteroids (ACS) successfully conducted. • All MCHIP Program Learning activities completed (report drafts and/or manuscripts now at different stages of development and/or are seeking publication). • IMNCI patient registers field tested and nationally adopted. • National guidelines on the rational use of blood and blood products for MNH developed and adopted.	nationally. • Measles second dose introduced nationally with MCHIP's support. • Plans finalized to document lessons learned from implementing a solar powered cold chain system in ELMA-supported districts (Future: Lessons documented and findings used to improve cold chain maintenance nationwide.) • BEmONC TOT guide used to support national TOT and each province with a team of trainers by early 2015. • New evidence on ACS use in MNH synthesized and used to revise national plans. • IMNCI patient registers adopted for use beyond Manicaland • MCHIP program learning agenda used to influence the development and implementation of a national and Manicaland MNCH program learning and research agenda. • National guidelines on rational use of blood and blood products for Maternal and newborn health adopted nationally.

Strategy

After a decade of decline, Zimbabwe has seen significant improvement over the past five years in national socio-economic indicators. This improvement coincided with remarkable political stability during the era of the Government of National Unity, which was disbanded when new elections were held in 2013. Family and community livelihoods as well as performance of the social services sector had started to improve in tandem with improvements in the broader national macro-economic environment. The rate of national economic growth was above 5% per annum, no major health services disturbances were reported, and the 2014 MICS validated positive trends for most of the RMNCH indicators. For example, significantly more pregnant women were delivering at health facilities with skilled attendance (skilled birth attendance rose to 80 percent), the proportion of children surviving to their 5th birthday also increased (U5 mortality declined by 10 percentage points to 75 per 1000 live births), and more children were reached with immunization services (Coverage for all main antigens rose to above 80 percent). There remained some gaps especially in neonatal mortality, which rose from 25 to 29 deaths per 1000 live births, as well as in the quality of care provided at the health facilities, with only 51.8 percent of pregnant women having BP, urine and blood checked during ANC; and only 13.8 percent, 14.1 percent and 34.3 percent of sick children with diarrhea, fever, and ARI being managed according to national standards of care, respectively. Unfortunately, 2014 coincided with a reversal of the country's socio-economic gains; there were widespread political protests, the national economic growth rate tumbled by over 50 percentage points, industries closed down, and there were repeated strikes by the health workforce.

During the first nine months of implementation (PY 1), under Objective 1, the MCHIP/Zimbabwe AA's support to the MOHCC was targeted at strengthening the policy environment and forging partnerships to improve the quality of care at the health facility and community levels, as well as working through VHWs to positively influence care-seeking behaviors of pregnant women, children and their families and improve access to community-based malaria and diarrhea treatment and pneumonia referral. MCHIP worked through various technical and coordination working groups to advocate for, revise, update and develop specific RMNCH policies and strategies and to improve the content and reach of VHW services.

In PY2, the MCHIP/Zimbabwe AA will work with partners, notably UN agencies, HTF, RBF, and similar mechanisms to sustain the gains in increasing the availability and quality of RMNCH services along and across the continuum of care. Specifically, MCHIP will support development and review of priority RMNCH policies, plans and packages; advocate to expand the community reach of VHWs; advocate for the adoption and scale up of interventions like the Baby Friendly Hospital Initiative (BFHI), ETAT, ECEB, HMS, HBB and KMC; and continue to plan at national level for the introduction of measles second dose (MSD) and Inactivated Polio (IPV) vaccines. The project will also build on lessons learnt in Manicaland province to support the development and implementation of a program learning agenda that includes testing innovative platforms for reaching communities and delivering health services (i.e., mobile and electronic platforms); more cost effective approaches to building competencies of service providers; and improving the design, population, and use of health information systems and tools. In terms of addressing underlying and key determinants of health, although MCHIP does not anticipate receiving dedicated nutrition, family planning or HIV funding, the Project will work with the MOHCC working groups to raise awareness and leverage support to address these important causes of maternal, newborn, and child death.

Specifically for nutrition, the recent 2012 National Micronutrient Survey conducted in Zimbabwe reports that 30 percent of children under five years of age are stunted, and that there has been no improvement in this indicator since the 2010/11 Demographics and Health Survey (DHS), when it was 32 percent. Zimbabwe joined the Scaling Up Nutrition Initiative in June of 2011 and has prioritized nutrition in the National Food and Nutrition Security Policy, which was led by the Food and Nutrition Council (FNC), and which continues to convene multi-sector stakeholders. MCHIP supported the MOHCC's national nutrition review, the design of an implementation matrix for the National Food and Nutrition Security Policy, the development of the National Nutrition Strategy, and a review of the Infant and Young Child Feeding (IYCF) program and IYCF formative research. At the level of nutrition implementation, the MCHIP/Zimbabwe AA also supported nationwide IYCF training in MCHIP-supported districts. The project plans to continue its nutrition support to the MOHCC's Nutrition Unit, Nutrition Cluster, IYCF Steering Committee, and national-level Technical Advisory Group (TAG). National-level technical advisory support will be provided to finalize guidelines for micronutrient supplementation for women and children, as well as national food fortification guidelines. The

project will also contribute to the dissemination of the National Nutrition Strategy and its launch in 2015, as well as the scale-up of BFHI accreditation through continued support to Mutare and Chimanimani districts, where this initiative is at an advanced stage. For HIV and family planning, the MCHIP/Zimbabwe AA will continue to engage with the PPF and other partners supporting the operationalization of pediatric antiretroviral therapy (ART), Option B+, and FP/PPFP guidelines.

Below we present our rationale for the selected strategies, specific activities, and how we will implement those various activities targeted at reversing the negative health outcomes and sustaining the positive gains from the previous years of support to the MOHCC.

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
Activity 1.1 Support the development and rollout of national policies, strategies, guidelines and tools							
1.1.1	**<u>Implementation of RMNH plans</u>:** In PY1, MCHIP supported the development and review of a national RH policy which sought to codify important programmatic advances since the last RH policy was developed more than 10 years ago, and to cover issues that were not included in the National MNH Roadmap. One notable gap in the various RHMH policies and strategies available was the absence of a clearly defined implementation matrix/plan. In PY2, MCHIP will support the alignment of RMNH strategies with the post-2015 agenda and the development of plans to facilitate the monitoring and evaluation of these plans.	a) Participate in the development and leveraging of funds for implementation of the 2015 National Annual MNH implementation Plan	X	X	X	X	• One National MNH 2015 Implementation Plan finalized • Government of Zimbabwe and partner commitments in place in support of MNH plans
		b) Support 2 of the review meetings for the National Annual MNH Implementation Plan	X		X		• 2 review meetings supported, with actionable recommendations documented for follow-up
1.1.2	**<u>Behavior Change Communication (BCC), including national advocacy around priority topics</u>:** In PY2, MCHIP will support the MOHCC Health Promotion Unit to further develop and fill gaps in the integrated RMNCH package of job aids and BCC packages for VHWs and health facilities. Currently, VHW counselling cards have weak content on important MNCH themes like malaria, essential care for every newborn baby, and KMC, and MIYCF feeding and/or messages and images have not been adapted to the current Zimbabwean context. Population Services International (PSI) has developed malaria counselling	a) Provide technical support for various MNCH days, and contribute financially to the commemoration of at least 1 MNCH-related national health day, with a priority given to increasing community and male engagement in those events	X	X	X	X	• Undetermined number of national Health Days supported technically • 1 Health Day commemorated with project technical and financial contribution

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	cards, but they are not integrated into 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 diarrhoea treatment and may need to be strengthened with messages about feeding children during and after illness. MCHIP will also work at the national level, with the Health Promotion Unit, to ensure that the Health Promotion content of the new National Health Strategy is adequately reflected.	b) Contribute in TWG and sub-groups working to the development of a VHW toolkit		X	X	X	• MNCH content reflected in job aids for health providers and VHWs
1.1.3	**QI Strategy and MNCH quality of care standards**: In 2013, MCHIP worked with the MOHCC's Quality Assurance Unit to develop and gain consensus on the national QA/AI policy, which has now been approved. In PY2 of the AA, MCHIP will support the launch and implementation of the QI policy and strategy.	a) Support the launch and implementation of the QI policy and strategy	X	X	X	X	• National QI policy and strategy finalized, launched, and in reflected in plans for MNCH departments
1.1.4	**National Nutrition Strategy printed and launched**: MCHIP has been working through the Nutrition TWG to support implementation of the National Food and Nutrition Security Policy, which was developed by the Food and Nutrition Council and launched by the President of Zimbabwe. MCHIP supported implementation of the Policy as a member of the Nutrition TWG, under the MOHCC Nutrition Unit, which had been tasked with developing a National Nutrition Strategy and M&E Framework. In PY2, MCHIP will support the MOHCC in printing and launching the Strategy.	a) Support the launch and country-level dissemination of the National Nutrition Strategy	X				• National Nutrition Strategy launched, and in use by MOHCC

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
1.1.5	**Child Health - Emergency Triaging and Treatment (ETAT):** The MOHCC's plan for child health (CH) 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. In PY1, MCHIP supported the development of the training guide for ETAT. In PY2, MCHIP will work through the Child Survival TWG, under the leadership of the Directorate of Family Health (DFH) of the MOHCC, to adapt the WHO ETAT training package and co-fund a national TOT and introduction of the training package in Manicaland.	a) Participate in the WHO/ UNICEF- funded TOT in ETAT and advocate for at least 3 trainers from Manicaland to be enrolled in the national course.	X				• ETAT CBT completed by at least 3 national trainers from Manicaland, and ETAT rolled out in Manicaland by the trainers
		b) Work with UNICEF to support MOHCC to strengthen the CH commodity forecasting and distribution chain system for ETAT commodities, by advocating for partner secondment of logistician to DFH	X	X	X	X	• ETAT commodity forecasting and supply chain strengthened through the CSTWG and related platforms
1.1.6	**Malaria Community Case Management (MCCM):** Based on the new malaria treatment guidelines, in PY2 MCHIP will work through the National Malaria Control Programme (NMCP)/PMI to support finalization of the MCCM training package to reflect iCCM protocols and include the new malaria treatment guidelines.	a) Work with PMI partners to support the NMCP to finalize the MCCM package	X				• MCCM training package revised and printed
		b) Support the dissemination of study findings highlighting the need to strengthen MCCM in the context of Malaria in Practice (MIP) in Manicaland via different forums, including by sharing study findings on MCM in Mutasa	X	X			• Mutasa MCM study findings disseminated and used to raise awareness and support from stakeholders to cover the identified gaps.
Activity 1.2 Strengthen MNCH program coordination, planning and monitoring, and leveraging of other available MNCH funds							
1.2.1	**Coordination and leveraging of partner resources:** A number of MNCH policies and strategies will end in 2015, as they were aligned to the MDG agenda. In PY2, MCHIP will support the initiatives of key national	a) Participate in existing steering committees and technical working groups	X	X	X	X	• Key and strategy reviews informed by technical evidence and MCHIP program learning

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	MNCH TWGs and steering committees (RH SC, CSTWG, FP TWG, Malaria, IYCF, PMTCT Partnership Forum, ICC/National Immunization Technical Advisory Group, Health Cluster, Nutrition Cluster, QA/QI, HMIS, others) to review and finalize these policies and strategies. Priority policies and strategies include the Essential Drugs List for Zimbabwe (EDLIZ), RH Policy, RMNCH/CS Strategy, RMNCH Commodity Security Strategy, and the National HMIS strategy. MCHIP will advocate for promising MNCH approaches: During the first 3 years, MCHIP developed a number of innovations with promise. In PY2, the tools, guidelines, and reports from these learning activities, for their potential use in other settings, will be finalized and shared with the MOHCC and partners. Among the most promising approaches are Standards Based Management and Recognition (SBM-R) for improving CH services; the IMNCI assess, classify and treatment tool; and CBT in BeMONC. MCHIP will advocate for their further scale-up and adoption as appropriate with the national Steering Committees (SCs) and TWGs, Provincial and District	b) Advocate for revision of national policies and implementation plans to facilitate RMNCH implementation	X	X	X	X	• Advocacy plan completed and used to inform national MNCH plans and priorities
		c) Advocate for the appointment of an RMNCH logistician to the DFH	X	X	X	X	• Partner support leveraged for a logistician in the DFH
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							
1.3.1	**<u>Blended learning approaches for CBT in MNCH:</u>** MCHIP is championing a CBT approach to BEmONC, HBB, IMNCI, ETAT, and other training programs, and in PY2 will support the development of a CBT TOT guide for use in all clinical trainings. In PY1, MCHIP successfully advocated for and provided technical support to restructure national clinical training approaches towards a CBT model (e.g., supported standardized clinical training model/curricula, post-training follow-up (PTFU), SS, and on-the-job training	a) Contribute to national MNCH TOTs in EmONC, ENC, ECEB, KMC, and other selected topics while testing blended learning approaches	X	X	X	X	• Blended learning tested in Manicaland and lessons learned shared during TWG meetings
		b) Support the MOHCC to track trained personnel using TrainSMART clinical training information system	X	X	X	X	• National clinical training information system generating regular reports

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	(OJT)) as a way of influencing the implementation of in-service MNCH training and SS. In PY2, MCHIP will support the adoption of blended learning approaches in scaling up provider competencies in the cited areas, and will advocate for partners to adopt the same.	c) Contribute to the standardization of integrated SS tools that can be used for RMNCH program and health service delivery improvement, and advocate for harmonization of funding modalities for RMNCH	X	X	X	X	• SS tools extensively tested and improved based on field experience
1.3.2	**Pre-service MNCH education:** MCHIP has been providing 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 so that graduates are deployed with the requisite competencies to effectively and sustainably deliver MNCH services. In PY2, MCHIP will provide technical support to the MOHCC to improve MNCH pre-service education, with a focus on curriculum review, CBT approaches, and blended learning.	a) Provide technical support for the inclusion/updating of MNCH technical content (e.g., EmONC, PPFP, PPIUCD, IMNCI, HBB, IYCF, BFHI, Integrated Management of Acute Malnutrition (IMAM), EPI) and CBT approach in pre-service curricula for midwives, nurses, doctors , extension health workers (EHTs) for MCCM, and others as needed, during curriculum review opportunities	X	X	X	X	• New MNCH training content and approaches included in pre-service MNCH education
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	**BFHI scale-up**: BFHI is a global initiative which aims to give every baby the best start in life by creating a health care environment that supports breastfeeding as a norm. The initiative includes a global assessment and accreditation scheme that recognizes the achievements of health facilities whose practices support breastfeeding, and encourages health facilities with less than optimal practices to improve. In PY1, MCHIP supported training of health workers in BFHI in Mutare and Chimanimani. MCHIP also supported pre-assessments for 5 admitting hospitals. These hospitals will be assessed in PY2 for accreditation.	Support MOHCC Nutrition Department to conduct final BFHI assessments for 3 hospitals	X	X			• 3 hospitals certified in BFHI

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
1.4.2	**Antenatal corticosteroids:** Some evidence emerged towards the end of PY1 to suggest the possibility of negative outcomes associated with the use of ACSs in particular contexts. This has generated a lot of conversation around the scale-up of ACS and USAID's instruction that its funding will not be used to promote ACS use below the district hospital level until and unless this is recommended by WHO. In PY2, MCHIP will support platforms for further discussion on the issues raised and the review of guidelines as may be agreed on before proceeding with the provision of technical support for the possible rollout of ACS in the management of pre-term birth below the district hospital level.	a) Support MOHCC review of national guidelines on ACS use	X	X			• Guidelines on the scale-up of ACS updated in alignment with current evidence, and with international and national positions • Updated guidelines on the appropriate use of ACS in place
		b) Support the updating of plans to improve the appropriate use of ACS (including a plan for reorienting health workers, and for corresponding commodity security		X	X		
1.4.3	**KMC support for central hospitals:** A significant proportion of all LBW babies delivered in the country are actually managed at the central hospital level (Parirenyatwa, Harare Central Hospital, Chitungwiza, Mpilo Central Hospital, and United Bulawayo Hospitals, since expectant mothers exhibiting complications associated with preterm/LBW deliveries are referred to these facilities for obstetric care and end up delivering there. In PY2, MCHIP will continue with the SS activities to compliment efforts initiated in PY1. Financial support for the originally planned KMC training and procurement has been removed from this workplan revision, however, these inputs are still considered very important. As such, MCHIP will work with the MOHCC, management of the different hospitals and other partners in an attempt to leverage resources for formal KMC training and supplies.	a) Facilitate quarterly SS visits to central hospital KMC units and work to leverage other resources for formal training of hospital staff and KMC supplies	X	X	X	X	• SS provided for quality KMC services
1.4.4	**Maternal, Perinatal and Child Death Notification and Audit (MPCMA)**: MCHIP has been a key partner in the revising and revitalizing the MPMA process at the national level. In PY2, MCHIP will continue to support	a) Advocate for the appointment of a National MPMA Committee and support the Committee to meet at least once, along with				X	• 1 national MPMA review meeting conducted

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	the national MPMA information system, including through national MPMA committee meetings, database maintenance, production of national MPMA reports, and introduction and scale-up of an electronic system for maternal and perinatal death notifications. MCHIP will also support the orientation of provincial focal persons on the recently finalized guidelines of conducting verbal autopsy and on how to perform child death audits.	H4+ partners					
		b) Working with H4+ partners, contribute to a national assessment of the feasibility and effectiveness of the electronic maternal and perinatal death notification system		X	X	X	• Electronic maternal/perinatal death notification system tested in 1 province
1.4.5	**Advocate for promising approaches**: Share findings from baseline assessment in Manicaland, past program learning activities in Zimbabwe and studies elsewhere and advocate with MOHCC and others for adoption of promising approaches. During the first three years, MCHIP developed and tested a number of innovations that appear to have promise. Under the AA, the reports of these studies and the guidelines and tools for their uptake in other settings will be finalized and shared with MOHCC and partners. Among the most promising approaches are: 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 the 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 the course of its work with the national SCs and TWGs, the PHEs and DHEs and amongst the partners.	a) Support the dissemination of findings from past program learning activities	X	X	X	X	• Program Learning reports and findings shared at national level
		b) Advocate for the adoption/scale-up of successful approaches through participation in SCs and TWGs, and by disseminating findings	X	X	X	X	• Promising MCHIP tools/approaches adopted at the national level and/or by other partners
Activity 1.5 Strengthen national systems for the collection and use of strategic MNCH information							
1.5.1	**National HMIS – Indicators and community information system**: The MOHCC rolled out the DHIS2 in all provinces in October 2012. The system was piloted in Manicaland, and lessons learned from this	a) Support the full integration of indicators measuring quality of MNCH care and coverage into the DHIS2		X			• MNCH quality indicators added to national HMIS

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	rollout were instrumental to scale-up. The MOHCC and other partners have begun revising and updating indicators to include the community indicators generated by VHWs and others. The KMC registers introduced by MCHIP in 2013 were vital in improving the documentation of LBW babies receiving KMC. However, continued advocacy at the national and provincial levels is needed to ensure the integration of data on LBW babies receiving KMC into the routine HMIS.	b) Support the creation and use of standard dashboards in DHIS2			X		• Standard dashboards created and used to support utilization of data in DHIS2
		c) Provide technical support in the integration of the community health information system into the national HMIS		X	X	X	• Community health indicators integrated into DHIS 2
		d) Participate in regular HMIS planning and review activities	X	X	X	X	• Contributions made to HMIS related activities
1.5.2	**Advocate for and disseminate learnings and findings from promising approaches**: Since 2010, the MCHIP project set out to implement learning activities on 13 topics, which were later narrowed down to 6 topics: SBM-R, cPQI, oxytocin potency, zinc distribution, RED, and HBB PTFU. The SBM-R study was fully implemented, incorporated into MCHIP's global SBM-R study manuscript, and submitted for publication in a peer-reviewed journal. These learning activities were implemented to generate new knowledge and information on selected evidence- based, high-impact interventions. At the end of MCHIP and PY1 of the AA, these activities were at different stages of implementation. In PY2 of the AA, MCHIP will ensure that results from the remaining five studies are shared with stakeholders.	a) Support documentation, reporting and dissemination of findings from past program learning studies:	X	X			• Program Learning reports and findings from five program learning studies shared at national level
		b) Finalize and submit at least 3 study manuscripts for publication in peer-reviewed publications	X	X			• 3 manuscripts/abstracts submitted for publication in peer-reviewed publications
1.5.3	**New learning agenda and routine data collection**: In PY1 of the AA, MCHIP identified priority topics for further study to be implemented in PY2. These topics include a baseline assessment of KMC service delivery, strengthening referrals between VHWs and health facilities using SMS, a cost-benefit analysis of cold chain in routine immunization (RI) (funded by ELMA Foundation), and operations research on key drivers of cross-border malaria transmission study (PMI-funded).	a) Obtain local and secondary institutional IRB approval and implement learning activities as proposed	X	X	X	X	• IRB approvals in place and learning activities underway

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
1.5.4	**Contribute to national studies and surveys**: MCHIP will provide technical support for a PMI-funded malaria cross-border operations research activity which USAID/Zimbabwe requested MCHIP to conduct during PY2. The team is also expected to support the next Zimbabwe Demographic and Health Survey (DHS) in 2015.	a) Contribute to/lead malaria cross-border operations research activity and ZDHS, per guidance from USAID/Zimbabwe	X	X	X	X	• Malaria cross-border study designed and initiated

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

Objective 2: Life of Project Results	PY1 Key Achievements	PY2 Expected Results
• Number of health facilities satisfying criteria for QI standards (SBM-R) for MNCH increased. • Number of health facilities and VHWs implementing SBM-R in MNCH increased.	• Baseline Quality of Care (QoC) and QI for MNCH completed in all 7 districts in Manicaland province. • 36 MCHIP-supported sites (health facilities) in Manicaland implementing the revised version of SBM-R, which now also includes immunization and a refined CH component	• 18 health facilities meeting 80 percent of MNCH QI standards. • QI institutionalized in 36 health facilities, and capacity of health providers to support QI initiatives strengthening
• Cause-specific mortality rates for MNCH cases reduced in MCHIP-supported health facilities and communities.	• Maternal, newborn, and child mortality indicators reduced for all MCHIP-supported 36 health facilities in PY1 compared to baseline.	• Cause-specific mortality rates for MNCH cases reduced in MCHIP-supported health facilities and communities sustained and documented.
• Number of health workers and VHWs trained in MNCH increased.	• 100% coverage achieved in VHW trainings in MNCH in selected communities. • All targeted nurse aides and SHMs trained in MCCM.	• 50 health workers, 50 nurse aids, 50SHMs, and 50VHWs trained on cMNCH and at least 80% of them received SS.
• Rotavirus vaccine introduced in Manicaland (7 districts).	• Rotavirus vaccine introduced with MCHIP's support.	• PIE for rotavirus vaccine completed and MR introduced in Manicaland and Matabeleland North and South.
• Immunization coverage in Manicaland increased.	• Coverage for all antigens in Manicaland increased with MCHIP's technical support.	• Increased coverage for all antigens in Manicaland sustained and improved.
• Essential Newborn Care (ENC) coverage of all newborns increased.	• Performance on selected indicators for ENC in Manicaland increased.	• ENC coverage for all newborns in Manicaland increased.
• Number of eligible newborns receiving HBB, KMC, and IMNCI increased.	• KMC services expanded to all 7 districts in Manicaland.	• Coverage for HBB, KMC, and IMNCI increased in Manicaland province.
• Survival rates for newborns managed with KMC, IMNCI, and HBB improved.	• Health outcomes for MNCH have begun to improve in target districts.	• Improvements in survival rates for newborns sustained in Manicaland province.
• Number of districts with costed implementation plans increased.	• Number of health facilities and communities reached with MNCH packages increased in target districts, including more health facilities implementing QI plans.	• Number of districts implementing costed MNCH plans increased.
• Number of districts conducting MPMAs increased.		• Number of districts conducting MPCMAs using national guidelines increased.
• Number of VHWs satisfying set criteria for managing MNCH cases increased.		• Number of VHWs, nurse aids, and SHMs reaching set criteria for QI in MNCH increased.
• Institutional deliveries increased.		• Institutional deliveries in target districts increased.

Objective 2: Life of Project Results	PY1 Key Achievements	PY2 Expected Results
• Timeliness, completeness, and quality of MNCH data increased in Manicaland province.	• Quality of MNCH data from facilities and communities improved with MCHIP-supported capacity building initiatives in recording and reporting data.	• Quality of MNCH data improved in target districts.
• Number of pregnant women and newborns receiving at least one home visit according to national schedule increased.	• Number of health facilities and communities documenting improvements in coverage of key MNCH interventions increased.	• Coverage of home visits to pregnant women, newborns, and sick children increased.
• Coverage of key prevention and treatment interventions for MH increased, including MIP, maternal nutrition, pre-eclampsia/eclampsia (PE/E), postpartum hemorrhage (PPH), obstructed labor, and sepsis. • Number of women and newborns who received core MNH package (preventive treatments in ANC, active management of the third stage of labor (AMTSL) with use of partograph and delayed cord clamping, and EmONC) increased.		• Prevention and treatment coverage of key MNCH interventions increased in target districts.
• PPFP coverage improved.	• Clinical training package for PPFP completed with MCHIP support, adopted as the national approach to scale up PPFP, and partner resources leveraged to take PPFP to scale.	
• Coverage of sick children who receive correct treatment, appropriate care, and follow-up improved.	• Number of sick children being managed correctly increased with the use of innovative tools like the ACT register for CH and the cPQI register.	• Number of sick children being managed correctly continues to increase in MCHIP-supported communities.
• Number of households that report receiving MNCH BCC messages increased. • Number of individuals and families adopting and supporting key household practices and MNCH health-seeking behaviors increased.	• PMI resources used to strengthen the platform for adopting wider MNCH initiatives, including zinc use at community level.	• Increased adoption of community key household practices in target districts.
• Capacity of communities and sub-groups to plan for and support MNCH services strengthened.	• Community reach with key interventions improved, with an increased number of VHWs, nurse aids, and SHMs trained on MCCM and other iCCM initiatives.	• Number of communities and sub-groups mobilized and utilizing MNCH services increased.
• Coverage for community MNCH intervention packages improved, including home visits for MNC, MCCM, early referral for sick children, and home care for sick children, according to IMNCI.	• Community and health facility baseline surveys completed. QI plans developed and implemented, with indication of gains in MNCH indicators.	• Number of target populations reached by selected MNCH interventions increased.

Strategy

MCHIP was originally called upon in 2009 to support the MOHCC in Manicaland province, which had demonstrated the worst RMNCH performance indicators of all provinces across Zimbabwe. Under this follow-on AA, the project continues to help advance strategic RMNCH approaches to reversing negative health outcomes, documenting lessons learned, and generating programming information for use at the national level to effectively roll out interventions at scale. PY1 AA activities sought to sustain and build on lessons learned during MCHIP, while refining implementation approaches for impact at scale. MCHIP deliberately aimed to support RI in all seven districts in Manicaland and to improve coverage for all antigens; focused on testing and building a QoC platform in two focus districts, Mutare and Chimanimani; and cultivated strong relationships with DHEs and PHEs as a platform for reaching the whole province with high-impact, evidence-based interventions under the follow-on AA.

Data from the 2014 MICS suggests that Manicaland has benefitted from this approach. Skilled attendance at delivery, institutional delivery, postnatal care, management of sick children, the adoption of positive health behaviors, and immunization coverage rates have all significantly improved since 2009. However, persistent gaps are still being reported in the quality of RMNCH care, performance on nutrition and newborn indicators, documentation and reporting on RMNCH health events, ECEB and KMC coverage, and DHE stewardship beyond the two project-supported focus districts. As such, most activities supported during PY1 were meant to establish relationships with DHEs and further assess the provision and quality of services in Manicaland's five remaining districts.

In PY2, the AA team in Manicaland will work with DHEs, the PHE, and other partners to help address the gaps in service access and quality identified during PY1. Specifically, the project will: provide intense support for the rollout and institutionalization of the SBM-R QoC improvement approach and revision of clinical training, mentorship, and SS approaches; consolidate the implementation of RED by rolling out IIP training for the frontline health workers responsible for providing vaccination services; support the provincial rollout of vaccines that are scheduled for introduction, including MSD, rubella, and IPV; support the rollout of new, nationally adopted interventions like ETAT, ECEB, MHS, and the use of mobile and electronic platforms for data management; expand the scope and content of maternal, perinatal, child, and EPI audits and reviews; continue to support the consolidation of KMC, HBB, BEmONC, and IMNCI, with a focus on 36 priority, high-volume health facilities; strengthen other interventions aimed at reducing maternal, newborn, and child mortality, like CEmONC, ETAT, MIYCF, and NUVI; build the capacity of district, facility, provincial, and community workers to better document and report on project lessons and data; and expand the coverage of community-based RMNCH activities to at least one more district. The activities related to each of these strategies are presented in the implementation matrix below.

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			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 all 7 districts of Manicaland province							
2.1.1	**Quality of Care Improvement for MNCH:** MCHIP will continue to support the rollout and integration of QoC improvement approaches in Manicaland province, prioritizing 36 high-volume sites in all 7 districts. In PY2, MCHIP will implement SBM-R Modules 2 and 3 and integrate SBM-R with other QoC improvement approaches also being implemented in the province. **Comments**: In PY1 of the AA, the project expanded its support to 25 new, high-volume (deliveries) facilities in 5 scale-up districts, and retained 10 facilities of the original 17 in Mutare and Chimanimani (plus Manicaland Provincial Hospital). The focus of project support in PY2 will be to improve 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 4 of 5 sites selected in each of the 7 districts, the MNH QI approach will focus on prevention, early detection, and prompt initial management, including early referral of PPH, complicated malaria in pregnancy, severe PE/E, birth asphyxia, and severe prematurity/LBW. In at least 1 referral site in each of the 7 districts, additional support will be provided for ETAT, including strengthening monitoring and capacity for C/S of these emergencies (emphasizing the first 24 hours after admission/referral).	a) Refine QI tools and SS processes to harmonize SBM-R with RBF and other QI processes	X	X	X	X	• Refined and integrated QI tools and processes updated to support SBM-R implementation
		b) Work with SBM-R champions at the provincial/district levels in Mutare and Chimanimani to expand their capacity for advocacy and mentorship, and to be effective hosts for learning visits	X				• 12 SBM-R champions trained in advocacy and mentorship
		c) Conduct trainings for QI support teams (champions and DHE members). Train teams to conduct SBM-R SS in order to lead and eventually take over SBM-R implementation in the 36 sites	X	X			• 7 QI support teams formed and trained in QI mentorship in all 7 districts in Manicaland
		d) Disseminate baseline SBM-R assessment findings to stakeholders at different forums	X	X			• SBM-R baseline assessment findings disseminated to key stakeholders
		e) Implement QI action plans for 36 hospitals and high-volume sites through SBM-R Modules 2 and 3, and through minor procurements, minor refurbishments, clinical attachments, and the reorganization of services	X	X	X	X	• Evidence-based facility QI action plans implemented at 36 SBM-R sites on schedule, with 60% of facilities satisfying annual targets for MNH/QI
		f) Support MOHCC to carry out SS for MNCH QoC improvement to all 36 SBM-R sites	X	X	X	X	• 3 SBM-R SS visits conducted to each of 36 SBM-R sites

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		g) Support a needs assessment for CEmONC services in 3 secondary level health facilities through minor procurements for the refurbishment of operating theatres	X	X			• Contributions to refurbishments made
		h) Strengthen blood transfusion services for MNH (SS for blood coupon system, minor procurements and refurbishments to set up blood banks in 3 health facilities earmarked for upgrade to CEmONC status)	X	X			• 3 hospitals considered for CEmONC status
		i) Support mentorship activities for CEmONC (mentor site visits and OJT, exchange visits, and attachments, including showcasing DHIS2 dashboards)	X	X	X	X	• 3 secondary level health facilities upgraded and considered for CEmONC activities.
		j) Technically support the MOHCC to establish a provincial RMNCH stakeholders' planning and coordination platform, and to host quarterly review meetings	X	X	X	X	• Provincial RMNCH planning and coordination forum established and quarterly review meetings held
		k) Participate in regular review meetings with each of meetings of the 7 DHEs	X	X	X	X	• Participate in 1 RMNCH review meeting supported in each of Manicaland's 7 districts
		l) Facilitate orientations to MPMA guidelines and revised maternal and perinatal notification system for health workers at secondary-level SBM-R sites (hospitals): ▪ Support facility-based MPMAs and use findings to update	X	X	X	X	• 7 districts and provincial hospital in Manicaland conducting MPMAs to audit all facility-based maternal and perinatal deaths using current guidelines and using findings to improve MNCH QI plans

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		SBM-R QI action plans. ▪ Support monthly MPMA meetings at MPH ▪ Support quarterly provincial MPMA meetings ▪ Provide technical support for monthly provincial MPM committee meeting ▪ Provide support for provincial committee SS/follow-up visits to districts and facilities (one district per quarter) ▪ Roll out verbal autopsy activities in one learning district using new guidelines ▪ Orient members from the 7 DHEs on conducting verbal autopsies					
Activity 2.2: Scale up high-impact interventions for MNH							
2.2.1	**<u>HBB, KMC, and ECEB scale-up:</u>** **Geographic area:** All health facilities in the 7 districts for HBB, and high-volume sites for KMC in the 7 districts **Package:** ECEB, KMC, and HBB TSS **Comments:** Prematurity/LBW and neonatal birth asphyxia are the leading causes of neonatal deaths in Manicaland. KMC and HBB are 2 effective interventions to reduce these deaths, yet coverage with these low-cost interventions at the facility level in Manicaland remains low. In PY1, MCHIP scaled up its support from the original 8 KMC units in the 2 learning districts by training 40 health workers from the other 5 districts and refurbishing 6 additional facilities in the 5	a) Support cascading of HBB trainings through OJT province-wide, and support facilities to establish newborn corners	X	X	X	X	• At least 2 nurses trained on HBB, and PTFU received at each facility in the province • Functional newborn corners established in all 36 SBM-R sites
		b) Supply new SBM-R sites with at least 1 HBB training simulator each for ongoing OJT	X	X			• 25 HBB simulators supplied to facilities in the 5 remaining districts and in use for ongoing OJT
		c) Orient providers on ECEB, prioritizing the 36 sites receiving intensive MCHIP support		X	X	X	• 36 sites implementing ECEB
		d) Support the MOHCC to provide SS to the 6 MCHIP-supported KMC units	X	X	X	X	• Quarterly SS conducted in the 14 MCHIP-supported KMC units in 7 districts

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	districts. **Strategy**: In PY2, MCHIP will support rollout of the ECEB package, both vertically and in an integrated manner, through continued support to DHEs and district trainers. Roll out HBB/CBT in all the 7 districts, with a strong emphasis on OJT, and by supplying training simulators, refurbishing newborn corners, and SS.	e) Provide OJT for health workers on KMC		X	X	X	• OJT on KMC provided to 125 health workers at all functional KMC sites.
		f) Procure KMC commodities for the establishment/revitalization of 6 new KMC units in 5 scale-up districts in Manicaland		X	X	X	• 6 KMC units revitalized in 5 districts (e.g., minor refurbishments, procurement of commodities)
		g) Advance 3 areas of learning in in KMC: ▪ Strengthen post-discharge linkages between the KMC unit, referring PHC center, and VHWs in Chimanimani ▪ Track outcomes of KMC babies at 6 weeks via EPI's 6-week post-natal visit ▪ Follow up KMC graduates at community level for survival determinants (quantitative), community practices, and attitudes (qualitative)					• 6 week post-partum outcomes of LBW babies documented • Strategies and outcomes to improve linkages between KMC units, referring sites, and VHWs documented • Learning activity on KMC graduates underway
2.2.2	**<u>Competency-based clinical training in BEmONC:</u>** **Geographic area**: Province wide **Comments:** In PY1, MCHIP successfully supported the development and finalization of the new CBT BEmONC TOT guidelines at the national level, as well as national- level TOTs attended by representatives from Manicaland province. The provincial MOHCC received a lot of partner support for BEmONC training, which resulting in province-wide coverage with every facility having at least one trained cadre on board. Distribution is uneven, however, with some districts receiving less support than others, with the high mobility of trained nurses. **Strategy**: In PY2, MCHIP will support the orientation of existing trainers in Manicaland on the newly developed	a) Advocate for and support the use of the TrainSMART Clinical Training Information System at the provincial/district level, focusing on BEmONC for learning	X	X	X	X	• Provincial MOHCC using TrainSMART to document BEmONC clinical training information, with MCHIP's support
		b) Support MOHCC to strengthen BEmONC CBT in pre-service education at 2 training sites in Manicaland	X	X	X		• Tutors and preceptors at 2 midwifery pre-service education sites oriented on BEmONC CBT and implementing the approach to midwifery students
		c) Program Learning: Pilot the training of modular aspects of BEmONC (e.g. partograph) using blended learning techniques in selected district(s)	X	X	X	X	• Training of modular aspects of BEMONC conducted using innovative blended learning approaches; lessons learned documented

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	CBT TOT guidelines. MCHIP will support the MOHCC at the provincial and district levels to implement a Clinical Training Information System for BEmONC. MCHIP will also leverage support from the HTF to revitalize midwifery training, working with nursing and midwifery training institutions and the DNS, to explore the use of the SBM-R approach, BEmONC, and other evidence-based approaches in PSE at 2 sites in Manicaland.						
Activity 2.3 Support MoHCC to scale up interventions for reducing childhood illnesses in Manicaland province							
2.3.1	**IMNCI:** **Geographic area**: First-line health facilities in all 7 districts of Manicaland **Package**: IMNCI capacity building for health workers **Strategy**: MCHIP will contribute to scaling up IMNCI SS through activities that build the capacity of health workers; leverage resources to provide technical support for IMNCI training and QoC to manage sick children for all remaining health workers at the primary care level, including on delivering messages on feeding during and after illness; disseminate and support the use of job aids and registers that facilitate care and SS; strengthen the capacity of DHEs and PHEs to plan for and roll out IMNCI, with minimal external support. Over the past 3 years, MCHIP has supported the training of nurses at regional health centers in IMNCI. Secondary-level health facilities are also being used as primary health care facilities for their catchment population, but coverage for IMNCI at this level is very low. The HTF was rolled out in Manicaland in recent years, but some districts still have only one nurse trained at the health facility—which is not adequate. In PY2, MCHIP will advocate for more IMNCI trainings	a) Conduct quarterly SS visits	X	X	X	X	• Quarterly SS visits conducted to all 36 health facilities
		b) Advocate and work with PHE and DHEs to leverage other resources to increase the coverage of IMNCI-trained health workers, particularly in outpatient services of SBM-R supported facilities.	X	X	X	X	• Increased coverage of IMNCI-trained health workers in SBM-R supported facilities.

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	with other donor funding to address this gap, while directing MCHIP efforts to SS						
2.3.2	**ETAT for managing complicated/severe childhood illnesses:** **Geographic area**: 1 secondary level hospital in each of the 7 districts **Package**: Facility based ETAT for childhood illnesses **Strategy**: Support to IMNCI will be complemented with ETAT, which seeks to ensure that children maximally benefit from 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.	a) Support provincial training for 30 nurses and doctors in ETAT+		X			• 30 doctors & nurses trained in ETAT+
		b) Support selected health workers to conduct mentorship visits to all MCHIP-supported ETAT facilities		X	X	X	• Each district referral facility receives at least 1 mentorship visit per quarter
		c) Print and distribute job aids and stationery to support ETAT implementation for 7 ETAT implementation sites b) Orient health workers on how to use ETAT job aids		X	X		• ETAT job aids and stationary available at 7 ETAT implementation sites • Health workers using ETAT job aids
		d) Support ETAT sites to re-organize CH services, improve client flow, and document experiences		X	X	X	• Sick children triaged and client flow Improved at 7 ETAT sites
2.3.3	**New Program Learning Agenda:** Develop and begin implementing a new nationally relevant learning agenda. In PY2, MCHIP's CH team will finalize and implement a study protocol on ETAT.	a) Support data collection during implementation of the ETAT study protocol	X	X	X	X	• ETAT study protocol finalized and implemented
2.3.4	**Nutrition:** **Geographic area**: Mutare and Chimanimani for nutrition, and 7 district level hospitals **Package**: Malnutrition **Strategy:** MCHIP will support province-wide scale-up of initiatives to address the underlying causes of childhood morbidity and mortality, with a focus on preventing and mitigating the effects of malnutrition on U5 mortality. For malnutrition, the project will support BFHI activities introduced in Chimanimani and Mutare districts and conduct SS. MCHIP will work with	a) Support BFHI SS for 8 hospitals in Mutare and Chimanimani	X	X	X	X	• 8 hospitals visited for SS once every 4 months
		b) Support 2 districts (Mutare and Chimanimani) towards process to receive BFHI certification	X	X	X	X	• 2 districts in Manicaland province (Mutare and Chimanimani) considered for certification in in BFHI

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	health facility staff in 2 districts to recognize and appropriately treat acute malnutrition with nutritional supplements. MCHIP will again work with supply experts to determine why these specialty products are not available and how to solve the problem.						
Activity 2.4 Work at the community level to positively influence behavior change, strengthen the continuum of MNCH care, improve MNCH service provision, and promote the adoption of key MNCH household practices							
2.4.1	**Community MNCH and MCCM:** **Geographic area: All 7 districts for MCCM and 3 districts for cMNCH.** Intense support in Chimanimani, phased introduction of intense support to Mutasa district, and improved community health information registers. **Package:** MCCM and integrated cMNCH through VHWs **Strategy:** The project has provided technical and financial support for VHW, SHM, and nurse aid trainings in MCCM; with the revised MCCM guidelines, refresher trainings will be needed for all those formerly trained in MCCM. The project has also been providing intense support to selected VHWs in Chimanimani as part of testing a QI approach for MNCH at the community level. This will include focusing on improving documentation and reporting systems and strengthening SS. In PY2, intense support will be given to 150 VHWs in to Mutasa district, and to all VHWs in Chimanimani. Community MNCH registers will be rolled out to improve the tracking of all other MNCH activities in these districts, with a priority on 5 districts where malaria is endemic.	a) 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
		b) Support the rollout of cHMIS registers and other data collection tools province-wide	X	X	X		• cHMIS rolled out in Manicaland province
		c) Introduce cPQI (intense SS, minor procurements, cHMIS) in Mutasa district	X	X			• PQI introduced in Mutasa district
		d) Using revised MCCM guidelines, provide refresher trainings to 1400 VHWs, 90 SHM, 150 nurse aids, and 20 supervisors		X	X	X	• Refresher trainings for 1400 VHWs, 90 SHMs, 150 nurse aids, and 20 supervisors provided
Activity 2.5 Reposition health information systems, mortality audits, and data for decision-making for improved local health systems performance							
2.5.1	**<u>Improving HMIS/M&E capacity at the provincial and district levels</u>:** **Geographic area**: Province wide	a) Support the MOHCC to conduct quarterly onsite data verifications (OSDV) and	X	X	X	X	• Quarterly OSDV and ECAs conducted and results used for program improvement

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	Package: HMIS, program learning, M&E, MPMA **Strategy**: This activity will focus on the following areas, namely Improving HMIS/M&E capacity at the provincial and district level, supporting PHEs and DHEs to conduct regular planning and review meetings, including maternal and perinatal mortality audits. 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 and use of data at higher levels through capacity development (trainings/PTFU/OJT/SS) of PHE/DHE/health workers in Manicaland in data generation and use in 7 districts to fully use the DHIS2 platform. The project will also support quarterly onsite data verifications and ECAs, building the capacity of the PHEs and DHEs to develop action plans to mitigate the negative environmental effects. For MPMA and program review and planning meetings at the provincial and district levels, the project will work through existing PHT, DHT, partner forums, and immunization review meetings.	environmental compliance assessments (ECAs)					
		b) Support Manicaland health workers through PTFU/OJT/SS on data generation, analysis, and use in 7 districts	X	X	X	X	• DHEs/PHEs/PHIOs/7 district health information officers (DHIOs) and 200 health workers supported in data generation, analysis, and utilization
		c) Support PHEs and DHEs to conduct regular provincial- and district-level planning, review, and partner coordination meetings	X			X	• 2 provincial planning/review meetings supported
		d) Support the MOHCC to conduct regular integrated MNCH DQAs and use findings to improve program performance	X			X	• Two Integrated MNCH DQAs conducted, and findings used to improve program performance
		e) Support PHEs and DHEs to pilot an electronic system for the notification of maternal and perinatal deaths	X	X	X	X	• Electronic system for notification of maternal and perinatal deaths piloted in Manicaland, and results used for national rollout of the system
		f) Provide technical support and participate in midline evaluation (to be conducted by USAID)		X	X		• External midline evaluation conducted and results disseminated
Activity 2.6. Support routine immunization activities and the introduction of new vaccines in Manicaland province							
2.6.1	**<u>Immunization:</u>** **Geographic area**: 7 districts **Package**: RED, IIP, NVI, and Vitamin A supplementation **Strategy**: The project will continue supporting 2 key aspects of immunization: RI, through the RED approach, and new vaccine introduction. MCHIP will	a) Train 20 nurses on IIP training combined with EPI micro-planning, and support district MOHCC facilitators to conduct IIP PTFU/SS of health workers in their respective districts in Manicaland	X	X	X	X	• 20nurses trained on IIP and providing high-quality care during RI

	ACTIVITY	TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	also support nationwide introduction of IPV and MSD vaccine by assisting the province with pre- and post-introductory activities in 2015, and will begin to work with CSO partners to increase community demand for immunization. This could facilitate the participation of religious groups that have traditionally rejected immunization and other modern health services.	b) Continue to support Manicaland PHEs and DHEs in EPI system strengthening activities (e.g., RED, IIP, SS, DQA) targeted to poor performing and districts facilities	X	X	X	X	• Quarterly SS provided to all districts with poor indicators
		c) Provide technical and financial support to the 7 districts in Manicaland for the African Vaccination and other social mobilization and accelerated outreach activities, including National Immunization Days	X	X			• 3 social mobilization events supported
		d) Support biannual provincial EPI review meetings and incorporate mid-level management modular training in the EPI review meetings	X			X	• 2 EPI meetings and EPI plans developed and reviewed
		e) Support the training of 8 cold chain technicians to support the 7 districts	X				• 8 cold chain technicians trained
		f) Support the introduction of IPV and MR in Manicaland province	X	X			• IPV and MR successfully introduced in Manicaland

Objective 3: Strengthen the capacity of CSOs to effectively implement MNCH activities

Objective 3: Life of Project Results	PY1 Achievements	PY2 Expected Results
• Number of local CSOs in Manicaland with the capacity to design, implement, and monitor community MNCH programs increased. • Increased number of target communities reached with MNCH information. • Number of target communities implementing activities to improve use of key MNCH services increased. • Community level support and household behaviors strengthened • Community-level recognition of danger signs of illness and early care seeking improved. • Participation of pregnant women during the antenatal period (through women-to-women groups, grandmother/grandfather support) increased. • Number of birth plans increased and knowledge of maternal and newborn danger signs improved among families, including husbands, grandmothers/grandfathers, and women. • Exclusive breastfeeding (via mothers support groups model) improved.	• CSO mapping completed. • CSO selection process conducted and shortlist of potential CSOs to be engaged developed. • Capacity of MCHIP team to support CSO engagement and facilitate community mobilization activities strengthened. • CSO Capacity Building Coordinator identified (but no plans to recruit this position in PY2, due to funding constraints) • Tools for CSO selection, engagement, and capacity building reviewed, updated, and finalized.	• MCHIP Supported CSOs strengthening their focus on RMNCH activities • Organizational and technical assessments undertaken with chosen CSO. • MCHIP supported CSO Board and SMTs with improved knowledge of USG compliance requirements, and adopting these as the CSO best practice. • CSO improved organizational policies that are documented, understood, accessible, and used by staff. • CSO Board with improved knowledge of and actively supporting expansion of the RMNCH agenda. • MCHIP supported CSO implementing costed strategic plan linked to resource mobilization plans. • MCHIP supported CSO with more efficient, effective, and supportive financial management and operational systems. • CSO developed functional Community Mobilization Teams set up and operational plans. • CSO trained in phases of the Community Action Cycle (CAC) and CAC implementation begun. • CSO with Community Core Group established and working with CSO to develop individual plans of action

Strategy

CSO engagement is an important ingredient in the MCHIP/Zimbabwe AA's expansion of community MNCH work to strategic districts and communities to further complement our SBM-R work at the facility level. MCHIP plans to engage a CSO to further their ability and engagement in a variety of activities, such as improving community and household MNCH knowledge, practice, and care-seeking behaviors; engaging community committees in the definition of quality and monitoring of MNCH services; stimulating demand and increasing service utilization; and supplementing the training, supervision, and support provided by health facilities for their VHWs.

The MCHIP/Zimbabwe AA team will work in direct partnership with a selected local CSO as a way to expand the reach and impact of the MCHIP/Zimbabwe AA's support to the MOHCC in Manicaland, and to strengthen a critically important segment of the broader health system. The project will directly build and/or strengthen local civil society leadership to design, plan, implement, monitor, and evaluate MNCH-related programming at the community level, in 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.

In PY2, the MCHIP/Zimbabwe AA will work with the MOHCC, Manicaland PHE, DHEs, and the CSO to further define the role that this CSO will be asked to play in provincial MNCH improvement efforts. Due to severe funding constraints, the project will begin working with only one CSO to implement a portion of the project's community and family mobilization strategy, rather than the two to three originally planned,.

After the project's initial mapping of the relevant CSOs, and the project's assessment of the selected CSO capacity to contribute to the MOHCC's and MCHIP's life of project results, this one purposively selected CSO partner will be engaged to participate with project staff in expanding specific community MNCH activities described under Objective 2. The MCHIP/Zimbabwe AA will work with this CSO partner to finalize their scope of work and develop a workplan and budget before non-competitively awarding this partner a one-year sub-agreement. The CSO will work closely with MCHIP project staff and MCHIP project staff will mentor CSO staff to build their technical and organizational capacity to implement MNCH activities.

Throughout this partnership with the CSO, we will compile and use lessons learned to refine the CSO engagement plan, processes, and tools to further improve their ability to positively influence and deliver quality MNCH services at the community level. In line with the other MCHIP objectives, much of our support to the chosen CSO will be in the form of technical assistance and smaller, more informal on-the-job training sessions, rather than the large scale trainings of the project's recent past. The MCHIP/Zimbabwe AA, through our highly skilled staff, plan to provide as much support in terms of organizational and technical capacity building as we can, given our restrictive budget. Among other capacity building efforts, we will ensure that they have the systems and the knowledge to manage our sub-agreement, in accordance to USG rules and regulations. We will seek to build further synergies in what the CSO is already doing, their comparative advantages and what is best suited to complement other aspects of MCHIP's work.

ACTIVITY		TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
Activity 3.1. Support the Board and senior management to strengthen the CSO's governance systems and structure, and to articulate and advocate for the RMNCH agenda internally and externally							
3.1.1	**Launch of CSO subaward:** In PY1 of the AA, MCHIP finalized its selection process for the CSO. This CSO partnership will aim to increase knowledge, improve practices, and promote positive attitudes on specific elements of MNCH by families and communities through the implementation of community mobilization and empowerment strategies.	a) Finalize and sign subaward	X				• CSO subaward in place • Board fully understands and actively supports CSO expansion of the RMNCH agenda • Provincial and district mobilization teams in place • Board members are champions of RMNCH among their networks • Board and SMT are more knowledgeable of USG compliance requirements and have adopted these as best practice for this CSO
		b) Provide CSO with agreed-upon funding for community mobilization and PDQ activities	X				
		c) Develop and finalize workplan and budget (technical, finance and admin.)	X	X			
		d) Finalize organizational and technical capacity assessment tools and conduct assessments	X	X			
		e) Conduct a workshop to introduce the context for RMNCH interventions, Government of Zimbabwe priorities and framework, and health impact accomplished to-date vs. MDG targets	X	X			
		f) Conduct 1-day post-award conference to appraise CSO on specific USG administrative and financial management regulations	X	X			
		g) Provide opportunities for greater exposure to key stakeholders in the RMNCH space				X	
3.1.2	**CSO organizational capacity building**: Through the subaward process, MCHIP will support CSO to cultivate organizational systems and structures for the sustainable implementation of RMNCH activities.	a) Assist in formulation/finalization of operational policies and procedures, finance and human resource manuals, contracts and grants manuals, etc.	X	X			• Organizational policies documented, understood, accessible, and operationalized by staff • Costed strategic plan linked to resource mobilization plan developed
		b) Convene quarterly review meetings with CSO to promote accountability and support		X	X	X	
		c) Support CSO SMT and Board in pursuing new funding opportunities for RMNCH programs				X	

ACTIVITY		TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
3.1.3	**Building CSO organizational and management capacity**: In PY2, MCHIP will work closely with CSO to strengthen staff capacity to effectively perform their respective functions, implement best practices in organizational management, and understand USG rules and regulations governing the management of their subaward from MCHIP	a) Conduct quarterly post-award compliance and support reviews (desk reviews, site visits)			X	X	• Post-award compliance review visits conducted • CSO managing their subgrant in line with USG rules and regulations and MCHIP standards
		b) Support monthly, 2-hour forum for CSO finance managers and contracts and grants officers meet to share experience and challenges with MCHIP F/A staff	X	X	X	X	
		c) Provide periodic, 1-hour trainings on specific organizational management topics	X	X	X	X	
Activity 3.2 Work with the MOHCC and CSO to support improved MNCH in Manicaland							
3.2.1	**Improving demand for and access to RMNCH services via CSO** In Manicaland province, MCHIP will support the development of annual provincial and district-level community mobilization plans that will identify areas of CSO geographic focus in order to increase community RMNCH outreach and systems support. The project will also work to strengthen the capacity of CSOs to mobilize and empower individuals, families, and communities to engage in collective action for improved demand for, and access to, quality services and improved RMNCH practices.	a) Hold 1-day orientation for PHE and DHEs on the Community Action Cycle (CAC) and Partnership Defined Quality (PDQ) approach to community mobilization, and identify key stakeholders to form the Community Mobilization Team support team	X				• Provincial and district Community Mobilization Team support team constituted and supporting CSO MNCH activities • CSO staff and DHEs trained and applying the CAC
		b) Train and support CSO to implement the CAC and other key mobilization approaches	X				
		c) Develop and apply CSO Technical Capacity Assessment	X				• Community 'core groups' implementing *a least one* activity from their RMNCH community action plan • CSO able to mobilize communities to engage women in child-bearing age, pregnant women, fathers, and post-partum women for improved RMNCH practice • VHW training and support scaled up in selected RMNCH modules via CSO • 170 VHWs trained in cRMNCH, including cIYCF and KMC, by CSOs in Mutare and Chimanimani
		d) Convene a one-day meeting with provincial and district health partners to develop a community mobilization plan (framework for working with CSO)	X				
		e) Work directly with the CSO to develop their community mobilization plan (framework for community engagement), and harmonize and simplify tools for application at the community level	X	X			
		f) Conduct a 3-day RMNCH training for the CSO Board/ SMT, relevant technical staff and Community Mobilization Team to provide an overview of MNCH issues and share		X			

ACTIVITY		TASK	JANUARY-DECEMBER 2015				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		MNCH knowledge, attitudes, and practices (KAP) baseline results.					
		g) Conduct regular CSO mentoring and structured learning visits			X		
		h) Strengthen the capacity of CSO RMNCH 'core groups' at the community level				X	
Activity 3.3 Support CSO to work with communities and health facility workers to improve the quality of RMNCH services at the health facility							
3.3.1	**Strengthening links between health facility and community levels**: In PY2, MCHIP will develop the capacity of CSO to implement the PDQ process with health facilities and communities.	a) Support a 'phased-in' training approach, consisting of 3 trainings and mentoring for the CSO, as part of the PDQ process	X	X			• QI teams organized, with members from the communities and health workers meeting regularly with a jointly develop action plan • Health workers and communities working together for improved quality of MNCH services
		b) Support CSO to implement the PDQ process			X		• CSO able to improve linkages between community and facilities to ensure RMNCH service quality

MONITORING AND EVALUATION

The MCHIP/Zimbabwe AA will continue to ensure that monitoring and evaluation (M&E) is core to project management, monitoring, problem-solving, and learning. The existing national health information system (NHMIS) will provide a platform for the generation of most of the project's routine monitoring activities.

Over the last four years—under MCHIP, and now under the AA—MCHIP's activities in Zimbabwe have focused 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. A Performance Monitoring Plan (PMP) was also developed and updated to ensure accountability for and tracking of project performance. Four MCHIP staff members now have access to the DHIS2 and will use this database to extract service statistics data for further analysis, utilisation, and reporting. Apart from using data for internal decision making and accountability, the project team will also work to build the capacity of provincial, district, and health facility staff in data management, including around the development and use of standard dashboards.

The main objective of M&E and HMIS activities is to improve the quality, availability, and timely use of health information for internal and external decision-making and learning. As in PY1 of the AA, in PY2 the MCHIP/Zimbabwe AA will ensure that M&E activities are reflected in all three project objectives. These activities include but are not limited to participating in the national HMIS Steering Committee and providing technical support for the revision of the national Health Information strategy; support provincial- and district-level Health Information Officers (HIOs) to develop and use standard dashboards and conduct SS (during which they will mentor and assist health workers in collecting and managing their data); support the MOHCC at the provincial and district level to conduct ODFs and ECAs; produce quarterly reports for submission to USAID; produce quarterly feedback reports; build the capacity of selected CSOs in data management and reporting; and support the technical team to implement program learning agenda activities as planned.

In PY2, the project team will revise its PMP to include updated targets; produce quarterly, semi-annual, and annual reports for submission to USAID; produce and share quarterly feedback reports with the district teams; develop and/or finalize learning activity plans, protocols, databases, reports, and manuscripts; conduct quarterly ODF and ECAs in all seven districts of Manicaland and share reports with key stakeholders at the district, provincial, and national level; conduct quarterly SS visits to each project-supported health facility in all seven districts of Manicaland; and provide technical support to the MOHCC in provided in revising the National Health Information Strategy. Please see the PMP below for a comprehensive list of project indicators and targets for PY2.

In addition to the formal learning agenda and special studies described under the Learning Agenda section below, the MCHIP/Zimbabwe AA will collect a wealth of information on quality of care, community participation, capacity building, and other topics during the course of project implementation. Although these are not presented as formal learning topics, it is our intent to rigorously analyze this rich program dataset as part of our ongoing M&E activities.

LEARNING AGENDA

Activity Number (per the activity matrix under each Objective above)	Learning question(s)? Why important?/objectives	Principle Investigator, Co-Investigators	Methodology (i.e., will this be a special study or will it be answered through data from monitoring and documentation from reports?)	Status, incl. IRB Approvals	Need for external support? Type? Timing?
Completion of MCHIP Program Learning Agenda					
1.5.2	**cPQI study:** To assess the effectiveness of a performance and quality improvement approach for MNCH services provided by VHWs at community level	Edhina Chiwawa	This was a before and after control study of the VHW performance	Abstract submitted to Global Health Science and Practice as a field action study	• Finalizing the manuscript • Submitting for publication
1.5.2	**Oxytocin study:**To assess potency of Oxytocin in use in the public sector, at selected points along the distribution system, and in labor wards in Zimbabwe	Hillary Chiguvare	This was a special study that collected data on the potency of Oxytocin in the institutions.	Consolidating comments into final manuscript	• Finalizing the manuscript • Submitting for publication
1.5.2	**Zinc study:** To evaluate the case management practices of HWs in managing children under five years who presented with diarrhoea at HFs in Chimanimani district	Leocardia Mangwanya	This was a retrospective study using routine programmatic data from the registers	Abstract submitted to Global Health Science and Practice as a field action study	• Finalizing the manuscript for publication as Field Action Report
1.5.2	**RED documentation:** To document the contribution of the RED approach in improving routine immunization coverage in Manicaland	Adelaide Shearley	This used routine programmatic data from the registers	Abstract submitted to Global Health Science and Practice as a field action study	• Finalizing the manuscript for publication as Field Action Report
1.5.2	**HBB post-training follow-up:** To compare the effectiveness of different strategies for improving knowledge and skills retention following HBB in-service training	Fishiwe Chiyaka	This was a cohort study with separate data collection from routine programmatic data	Report is being finalized with home office support	• Finalizing the study report for dissemination in country and posting on MCSP website

Activity Number (per the activity matrix under each Objective above)	Learning question(s)? Why important?/objectives	Principle Investigator, Co-Investigators	Methodology (i.e., will this be a special study or will it be answered through data from monitoring and documentation from reports?)	Status, incl. IRB Approvals	Need for external support? Type? Timing?
New Learning Agenda for the MCHIP/Zimbabwe Associate Award					
1.5.3	**KMC baseline:** To assess hospital based KMC service delivery in six secondary health facilities in Manicaland province.	Rose Kambarami	This is a descriptive, cross-sectional study	Awaiting both local and secondary IRB approval	• IRB submission • Analysis & report writing
1.5.3	**Strengthen referrals between community (via VHWs) and health facilities using SMS:** This is a cell phone-mediated (SMS) system, that includes a counter-referral note effective in strengthening the VHW referral system in Mutasa	Edhina Chiwawa, Frank Chikhata, John Mandisarisa	*Quantitative:* Routine aggregate data on referral outcomes *Qualitative:* Client and provider interviews (key informant interviews, focus group discussions on feasibility and acceptability) to collect information on acceptability (clients) and feasibility (providers)	Awaiting both local and secondary IRB approval, still in planning stages	• Protocol development • IRB submission • Analysis & report writing
1.5.3	**Cost-benefit analysis of cold chain *(ELMA project-funded)*:** What is the cost-benefit of using solar powered refrigerators as compared to gas/electricity refrigerators?	Adelaide Shearley, Rose Kambarami, John Mandisarisa	The study will be both quantitative and qualitative. The quantitative element has to do with the costing and cost-benefit analysis. The qualitative element has to do with the acceptability among health staff of solar power versus gas/electric refrigerators	Awaiting both local and secondary IRB approval, still in planning stages	• Protocol development • IRB submission • Analysis and report writing
1.5.3	**ETAT:** 1. Are U5 sick children being managed according to the ETAT+ protocol by health providers? **2.** Does the implementation of ETAT Plus lead to improved child health outcomes?	Rose Kambarami, MOHCC Paediatrician, John Mandisarisa	Mixed quantitative and qualitative methods. The quantitative potion will focus on then provider performance in managing sick children using ETAT+. The qualitative, descriptive, cross-sectional evaluations will focus on provider views on barriers and on facilitator views on implementing ETAT+	Awaiting both local and secondary IRB approval, still in planning stages	• Protocol development • IRB submission • Analysis and report writing

Activity Number (per the activity matrix under each Objective above)	Learning question(s)? Why important?/objectives	Principle Investigator, Co-Investigators	Methodology (i.e., will this be a special study or will it be answered through data from monitoring and documentation from reports?)	Status, incl. IRB Approvals	Need for external support? Type? Timing?
1.5.3	**Drivers of malaria cross-border study:** Scope to be determined with guidance from PMI team in country	Rose Kambarami, John Mandisarisa	To be determined	Awaiting both local and secondary IRB approval, still in planning stages	• Protocol development • IRB approval • Data collection, collation, and cleaning

MONITORING, EVALUATION, RESEARCH, AND INNOVATION

ACTIVITY		TASKS	JANUARY–DECEMBER 2015				OUTPUTS
			Q1	Q2	Q3	Q4	
Activity 1.4 Promote the scale-up of high impact interventions on existing MNCH service delivery platforms to improve efficiency and increase coverage							
1.4.4	**Maternal Perinatal Death Notification and Audit (MPMA)**: MCHIP provided technical assistance in the revision of the MPMA guidelines and forms. In order to improve the reporting of death notifications and audits, in PY2 MCHIP will support the introduction of an electronic system for maternal and perinatal death notifications.	a) Support 1 national MPMA meeting			X		• 1 national MPMA review meeting conducted
		b) Provide technical support for the national assessment of the feasibility and effectiveness of the electronic maternal and perinatal death notification system	X	X	X		• Electronic maternal/perinatal death notification system tested in 1 province
Activity 1.5 Strengthen national systems for collection and use of strategic MNCH information							
1.5.1	**National HMIS – Indicators and community information system**: The MOHCC rolled out the DHIS 2.0 in all provinces in October 2012. This system was piloted in Manicaland, and lessons learned during the pilot were instrumental during the rollout process. Engagement with MOHCC and other partners has begun in revising and updating the indicators to include the community indicators generated by VHWs and others. The KMC registers introduced by MCHIP in 2013 were vital in improving the documentation of LBW babies receiving KMC. However, advocacy work will continue to be carried out at national and provincial levels so that the data on LBW babies receiving KMC is integrated into the routine HMIS. MCHP will also experiment in Manicaland the transmission of community data by VHWs via cell phones.	a) Support the full integration of indicators measuring the quality of MNCH care and coverage into the DHIS2		X			• MNCH quality indicators added to national HMIS (quality of care, community based interventions, etc.)
		b) Provide technical support in the integration of the community health information system into national HMIS		X	X	X	• Community health indicators integrated into DHIS2
		c) Participate in regular HMIS planning and review activities	X	X	X	X	• Contributions made to HMIS-related activities
		d) Implement a study on cell phone-mediated data collection and reporting system	X	X	X	X	• Study on cell phone-mediated data collection and reporting by VHWs underway.

ACTIVITY		TASKS	JANUARY–DECEMBER 2015				OUTPUTS
			Q1	Q2	Q3	Q4	
1.5.2	**Advocate for promising approaches**: 13 studies were selected during the previous MCHIP award; these were later narrowed down to six and these were as follows: • SBM-R study • cPQI • Oxtocyn potency study • Zinc study • RED study • HBB post training follow up study The SBM-R study was fully implemented (manuscript was developed for publishing in peer review journals) and incorporated into a global SBM-R study under MCHIP. These studies were implemented in order to generate new knowledge and information on selected evidence based high impact interventions. At the end of the project ("MCHIP 1") and PY1 of the AA, the studies were at different stages of implementation. In PY2, MCHIP will ensure that the remaining five studies are fully implemented and results shared with stakeholders.	e) Support the documentation, reporting, and dissemination of findings from past program learning studies the following studies:	X	X			Program Learning reports and findings from five program learning studies shared at national level
		f) cPQI study: Finalize manuscript and submit for publication	X	X			• cPQI study submitted for peer-reviewed publication
		g) Oxytocyn study: Finalize report and disseminate nationally	X	X			• Oxytocin study findings disseminated nationally
		h) Zinc study: Finalize manuscript and submit for publication as Field Action Report	X	X			• Zinc study published
		i) RED study: Finalize manuscript and submit for publication as Field Action Report	X	X			• RED study published
		j) HBB PTFU study: Finalize report and disseminate nationally	X	X			• HBB PTFU report finalized and disseminated in country
1.5.3	**New Learning Agenda**: In PY1 of the AA, MCHIP identified priority topics for further study. These will be implemented in PY2.	a) KMC baseline: To assess hospital based KMC service delivery in six secondary health facilities in Manicaland province.	X	X	X	X	• IRB approval in place and study underway
		b) Strengthen referral between VHW and health facilities using SMS: IRB approval, data collection collation, and cleaning	X	X	X	X	• IRB approval in place and study underway
		c) ETAT: IRB approval, data collection, collation and cleaning	X	X	X	X	• IRB approval in place and study underway

ACTIVITY		TASKS	JANUARY–DECEMBER 2015				OUTPUTS
			Q1	Q2	Q3	Q4	
	In PY2, the project will also supporting national-level surveys (e.g., ZDHS) and other research activities, such as a PMI-funded malaria cross-border study.	d) Cost-benefit analysis of cold chain (ELMA project-funded): What is the cost-benefit of using solar powered refrigerators as compared to gas/electricity refrigerators?	X	X	X	X	• Protocol drafted, IRB reviews underway, technical support from health economist to be coordinated
		e) Drivers of malaria study (PMI funding): Protocol development , IRB approval, data collection, collation and cleaning	X	X	X	X	• Contributions to other national MNCH survey(s) made
Activity 2.4 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							
2.4.1	**<u>Community MNCH:</u>** **Package**: Integrated cMNCH through VHWs 2). **Geographic area**: Intense support in Chimanimani, phased introduction of intense support to Mutasa district, and improved community health information registers. **Strategy**: The project has been providing intense support to selected VHWs in Chimanimani as part of testing a QI approach for MNCH at community level focusing on improving documentation and reporting systems and strengthening SS. In PY2, intense support will be given to 150 VHWs in Mutasa and to all VHWs in Chimanimani. Community MNCH registers will be rolled out to improve tracking of all other MNCH activities taking place in these districts, with a priority on 5 districts where malaria is endemic.	a) Disseminate cPQI pilot findings (at the provincial level) and adapt the cPQI package of activities for scale-up in Mutasa district	X	X	X		• cPQI Findings shared with Provincial MOHCC
		b) Support the rollout of cHMIS registers and other data collection tools province-wide	X	X	X		• cHMIS rolled out in Manicaland province
		Introduce cPQI (intense SS, minor procurements, cHMIS) to Mutasa district	X	X			• cPQI introduced in Mutasa district
Activity 2.5 Reposition health information systems, mortality audits and data for decision-making for improved local health systems performance							
2.5.1	**Package**: HMIS, Program learning, M&E, MPMA **Geographic area**: Province wide	a) Support the MOHCC to conduct quarterly OSDVs and ECAs	X	X	X	X	• Quarterly OSDVs and ECAs conducted and results used for program improvement.

ACTIVITY		TASKS	JANUARY–DECEMBER 2015				OUTPUTS
			Q1	Q2	Q3	Q4	
	Strategy: This activity will focus on improving HMIS/M&E capacity at the provincial/district level, and supporting the PHE/DHEs to conduct regular planning and review meetings, including MPMAs. For HMIS, MCHIP will continue with current efforts to improve local capacity for generating quality data, using 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 DHIS2 platform. The project will also support quarterly onsite data verifications and environmental compliance assessments, building the capacity of PHEs/DHEs to develop action plans to mitigate negative environmental effects. For MPMA and program review and planning meetings at provincial and district levels, the project will work through existing PHT, DHT, partner forums, and immunization review meetings.	b) Support Manicaland health workers 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
		c) Support the PHE/DHEs to conduct regular provincial/district level planning, review and partner coordination meetings	X			X	• 2 provincial planning/review meeting supported
		d) Support the MOHCC to conduct regular integrated MNCH data quality self-assessments and use findings to improve program performance	X			X	• 2 integrated MNCH DQAs conducted and findings used to improve program performance
		e) Support PHE/DHEs to pilot electronic system for notification of maternal and perinatal deaths	X	X	X	X	• Electronic system for notification of maternal and perinatal deaths piloted in Manicaland and results used for national roll out of the system.
		f) Provide technical support and participate in midline external project evaluation (to be conducted by USAID)		X	X		• Midline evaluation conducted and results disseminated

INDICATOR MATRIX

Note: PY1 achievements are reported through the end of September 2014 unless otherwise stated. October 2014 data in the DHIS2 is currently being sanitized.

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
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	254/100,000 live births (data from the 36 SBM-R supported HFs)	Reduce baseline MMR by 5%	**23/100,000** live births (data from 36 SBM-R supported sites covering period April – September 2014)	Reduce baseline MMR by 10%	Fewer deaths occurred during the reporting period
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	33/1,000 total births (data from the 36 SBM-R supported HFs)	22/1,000 total births	**31/1,000** total births (data from 36 SBM-R supported sites covering period April – Sep 2014)	20/1,000 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 (data from the 36 SBM-R supported HFs)	Reduce baseline U5 mortality by 5%	**15.9/1,000** live births 242/15,262 (data from 36 SBM-R supported sites covering period April – September 2014)	Reduce baseline U5 mortality by 10%	
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	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	2 (67%) • BeMONC TOT trainers package • Guidelines for Maternal and Perinatal Death Audits	9 • RMNCH Policy/Strategy reviewed • QI policy and strategy finalised • VHW training	

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
	• Training packages				QA/QI strategy, and National HMIS strategy) Guidelines Training packages: 2 (National MNH TOT training package, and PPFP/PPIUCD Training Package)		manual (MCCM training package) reviewed • VHW job aides finalised • National Child Survival Strategy reviewed • National IMNCI policy and chart booklet updated • MNCH Training curricula reviewed in line with CBT approach • MNCH pre-service curricula reviewed • ACS guidelines updated	
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,	2 • MICS (further analysis for the final report will be supports beginning Oct. 2014), • Baseline assessment	4 • ZDHS • Rotavirus PIE • Evaluation of blended learning approach • Electronic death	Studies under the Program Learning are listed separately in Learning table

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
						for the AA	notification system piloted in Manicaland	
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)	47 HCWs trained to train VHWs in MCCM (the 47 HCWs trained as trainers for VHW MCCM trainings were not part of the PY1 target)	ETAT: 30 (national)	Of the 200 targeted for BEmONC and ETAT no trainings were done during the period under reporting
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	Total: **1,882** BEmONC: 210 HBB: 42(OJT) IMNCI: 160 IYCF:60 BFHI: 120 IMAM:30 ETAT: 60 MCCM: 1200 VHWs, nurse aides and EHTs in total	Total: **2,222** Rotavirus introduction: 490 MCCM: 1,464 VHWs and 138 nurse aides IYCF: 30 (50%) HCWs IMNCI: 100(63%) HCWs	Total**: 2,940** HBB: 564 (OJT) ETAT: 30 SBM-R advocacy and mentorship:12 QI mentorship: 28 CEmONC: 18 (clinical attachment) IIP: 20 Verbal Autopsy: 30 Data Management: 20 Cold Chain Management: 8 cMNCH: 300 VHWs MCCM refresher: 1,400 VHWs, 90 SHMs, 150 Nurse Aides and 20	Rotavirus introduction trainings were not part of the initial target

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
							supervisors Induction workshop for CSO staff: 30 Community Action Cycle: 30	
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 36 SBM-R supported HFs in the seven 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: 8% of 36 HFs achieving at least 60% of MNH Standards (Labour and Delivery) CH: TBD by Q4 of PY1	MNH: 60% (N=36) CH: 60% (N=35)	
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 36 SBM-R supported HFs in the seven districts Denominator: Total number of expected annual pregnancies for in 36 SBM-R supported HFs in the seven districts	Program records; census data; service statistics	Quarterly	69% (data from the 7 districts of Manicaland)	75%	70% 48,005/68,745 (provincial level data covering the period Jan-Sep 2014) **11,402** (data from the 36 SBM-R health facilities covering the period April –Sep. 2014)	80%	The denominator for the 36 SBM-R health facilities is yet to be obtained. The baseline will be calculated for the 36 HFs once the denominators are obtained.
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 36 SBM-R supported HFs in the seven districts Denominator: Total number of pregnant women receiving first ANC visit in 36	Program records; census data; service statistics	Quarterly	34% (data from 36 SBM-R supported HFs)	40%	37% 2,270/6,168 (data from 36 SBM-R supported HFs starting from April to Sep. 2014)	40%	The targets for PY1 and PY2 revised based on data on the 36 SBM-R HFs

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
	SBM-R supported HFs in the seven districts							
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 attendants (TBAs) and Nurse Aides (NAs). Number of institutional deliveries will be used as proxy.	HMIS/service statistics	Quarterly	25,242 (data from the 36 SBM-R supported HFs) (Jan – Dec 2013)	27,766 (36 SBM-R supported HFs target)	18,398 (66%)	20,000 (36 SBM-R supported HFs)	The data is from 22 HFs for the period Jan.–Mar. is from the 22 HFs and 36 HFs from Apr. to Sep. 2014
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% (SBM-R supported HF)	90%	**92.8%** 20,095/21,635	95% (36 SBM-R supported health facilities)	The data under the achievement column is from 22 SBM-R HFs for the period Jan.-Mar. 2014 and from 36 SBM-R supported HFs from Apr. to Sep. 2014
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	94% (data from the 7 districts in Manicaland)	95% (7 districts in Manicaland)	98.4% 40,577/41,238 (data from the seven districts in Manicaland)	98% (7 districts in Manicaland)	

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
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	83% (data from the 7 districts in Manicaland)	95% (7 districts in Manicaland)	**98.3%** 40,517/41,238 (data from the 7 districts in Manicaland)	98% (7 districts in Manicaland)	
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 Denominator: Number of children less than 12 months in MCHIP supported districts	HMIS/service statistics	Quarterly	0%	70% (7 districts in Manicaland)	89% 12,253/13,746 (data from 7 districts in Manicaland covering the period Jul-Sep 2014	80% (7 districts in Manicaland)	
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	94% (data from the 7 districts in Manicaland)	95% (7 districts in Manicaland)	**99.7%** 41,113/41,238 (data from 7 districts in Manicaland)	98% (7 districts in Manicaland)	

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
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	16,448 (extrapolated data from the36 SBM-R supported health facilities)	15,626 (36 SBM-R supported health facilities)	10,193	14,803 (36 SBM-R supported health facilities)	The data under the achievement column is from 22 SBM-R HFs for the period Jan.-Mar. 2014 and from 36 SBM-R supported HFs from Apr.- Sep. 2014
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	6,446 (data from 36 SBM-R supported HFs)	TBD (to be updated during after Q4 of PY1)	6,819	10,000 (36 SBM-R supported health facilities)	The data under the achievement column is from 22 SBM-R HFs for the period Jan.-Mar. 2014 and from 36 SBM-R supported HFs from Apr.- Sep. 2014

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
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 36 SBM-R supported HFs in the seven districts Proxy indicator: Number of cases of moderate and severe pneumonia reported on the T5	HMIS/service statistics or population-based survey (numerator)	Quarterly	29,379 (extrapolated data from the36 SBM-R supported health facilities) (Jan.–Dec. 2013)	27, 910 (36 SBM-R supported health facilities)	17,813	26,441 (36 SBM-R supported health facilities)	The data under the achievement column is from 22 SBM-R HFs for the period Jan-Mar 2014 and from 36 SBM-R supported HFs thereafter
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 after Q4 of PY1)	TBD (to be updated during after Q4 of PY1)	1,131 (data from SBM-R supports health facilities)	TBD (to be updated during after Q4 of PY1)	
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 (to be updated during after Q4 of PY1)	707	TBD (to be updated during after Q4 of PY1)	
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%	95%	**92%** 1,003/1,092	98% (from 36 SBM-R HFs)	The data under the achievement column is from 22 SBM-R HFs for the period Jan.-Mar. 2014 and from 36 SBM-R supported HFs thereafter

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
23. Number of KMC units established	Number of KMC units established in MCHIP supported districts	Program records	Annual	8	14	0	6	Assessments were done for 6 HFs. Trainings and procurements for the 6 HFs targeted for Q4, 2014.
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 2 districts, Mutare and Chimanimani)	40%	**33%** 536/1,607	40% (from 36 SBM-R HFs)	The data under the achievement column is from 22 SBM-R HFs for the period Jan.-Mar. 2014 and from 36 SBM-R supported HFs thereafter
Objective 3: Strengthen the capacity of Civil Society Organizations to effectively implement MNCH activities.								
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	0	1	This indicator will be tracked beginning in PY2
26. 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	0	1	This indicator will be tracked beginning in PY2
27. Number of CSOs with improved management	Number of CSOs with improvement over baseline in management and	CSO organizational capacity	Annual	0	0	0	1	This indicator will be

INDICATOR	DEFINITION AND DISAGGREGATIONS	DATA SOURCE /COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASELINE AS OF DECEMBER 2013 (TO BE UPDATED)	TARGET			NOTES
					PY1 TARGET	PY1 ACHIEVEMENTS TO DATE (JAN.-SEP. 2014)	PY2 TARGET	
and implementation of MNCH activities	implementation of MNCH activities	assessments (in technical MNCH areas)						tracked beginning in PY2

MANAGEMENT AND STAFFING

Management structure and systems

As with the preceding MCHIP award, JSI continues to be the lead implementing partner under the MCHIP/Zimbabwe AA. Per the terms of the leader award with USAID, Jhpiego serves as the contractual prime for formal correspondence and official notifications. Inquiries from the Mission regarding the achievement of targets, staff performance, and deliverable timeliness/quality will be directed to and responded to by Jhpiego, in close consultation with JSI, or by JSI with Jhpiego's authorization. Save the Children also continues to play a critical technical support role. Unfortunately, PATH has been reluctantly removed from the project budget due to sever funding constraints.

Consortium partners at both the local and headquarters levels are actively involved in project design, implementation of integrated programming, learning, and project reporting and monitoring. JSI provides three of the key personnel positions (Country Director, Deputy Country Director, and Finance and Administration [F&A] Manager). Together, these positions supervise the management of project offices and administration of all local activity costs. Jhpiego provides the project's Technical Director, who leads the project's QI initiatives particularly around maternal health and technically supports the advancement of the project's learning agenda. Save the Children provides technical leadership on newborn health and community mobilization, and JSI will continue to lead the project's work in CH, immunization, M&E and CSO capacity building.

All consortium partners will contribute to community-level and malaria activities. The first year of the AA was an incredibly productive one in terms of recruitment of key and other important positions: at the end of PY1, the project has staffed up, and nearly all positions have been filled. After over a year recruiting for a strong candidate for the Child Health Advisor position and several months of recruitment for the CSO Capacity Building Coordinator and finding excellent candidates for both position, we are disappointed that due to PY2 funding constraints, the project cannot hire either the CSO Capacity Building Coordinator or the Child Health Advisor at this time. The team had also planned to hire an Accounting Assistant to support the project's high volume of field accounts—particularly given that the project's finance staff also support the ELMA project—but this will no longer be possible in PY2. All three of these positions have been removed from the organogram below and the budget.

To date, the MCHIP/Zimbabwe AA's management and financial systems have proven effective in ensuring that the project runs smoothly and achieves results within its approved budget, timelines and USG rules and regulations. As with MCHIP, the follow-on award continues to be led by a highly experienced Senior Management Team (SMT)—which the Director of Innovations, Research, and M&E has now joined. This SMT, which includes five senior country staff, including all four key personnel, is responsible for providing consistent managerial support and oversight to all levels of the country team. The SMT, with support from MCHIP's headquarters, "sets the tone" for the project and ensures that systems are in place to foster a productive and empowering environment. The SMT closely monitors implementation and spending against approved plans and takes corrective action if performance and/or spending are not as expected. The group also manages all field-based human resource functions, including recruitment, staff capacity development, and performance appraisals.

Staffing plan

As illustrated in the staffing organogram below, MCHIP/Zimbabwe AA has selected a highly qualified and experienced team to manage this complex project and maximize the use of local expertise and high-level technical support. All staff positions, with the exception of only the Deputy Country Director, are filled by Zimbabweans, and all proposed technical and management staff are fluent in English and Shona. Selected staff salaries are cost shared with the aforementioned two-year grant from the ELMA Vaccines & Immunization Foundation (whose staff are also shown in the organogram).