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## **Maternal and Child Health Integrated Program (MCHIP) Zimbabwe**

Associate Award

Program Year 3  
Implementation Plan

January 1, 2016 – December 31, 2016

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## ACRONYMS AND ABBREVIATIONS

AA	Associate Award
ACS	Antenatal Corticosteroids
ACT	Artemisinin-Based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
AEFI	Adverse Effects Following Immunization
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ARK	Absolute Return for Kids
ART	Antiretroviral Therapy
AVW	Africa Vaccination Week
bCPAP	Bubble Continuous Positive Airway Pressure
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BFHI	Baby Friendly Hospital Initiative
bOPV	Bivalent Oral Polio Vaccine
CAC	Community Action Cycle
CBHW	Community-Based Health Worker
CH	Child Health
cMNCH	Community-Based Maternal, Newborn, And Child Health
CBT	Competency-Based Training
CTB	Community Childhood Tuberculosis
CCM	Community Case Management
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CG	Care Group
CM	Community Mobilization
cHMIS	Community Health Management Information System
CORDAID	Catholic Organization for Relief and Development Aid
cPQI	Community Performance And Quality Of Care Improvement
CS	Child Survival Strategy
C/S	Caesarean Section
CSS	Child Survival Strategy
CSO	Civil Society Organization
DFID	United Kingdom Department for International Development
DHE	District Health Executive
DHIO	District Health Information Officer
DHIS	District Health Information Software/System
DHS	Demographic and Health Survey
dIMNCI	Distance-learning Integrated Management of Newborn and Childhood Illnesses
DNO	District Nursing Officer
DOMCCP	Diocese of Mutare Community Care Programme
DSR	Death Surveillance and Response
DQA/DQS	Data Quality Assessment/Data Quality Survey
DQSA	Data Quality Self-Assessment
ECA	Environmental Compliance Assessments
ECEB	Essential Care for Every Baby
ECSB	Essential Care for Small Babies
ECMM	Environmental Compliance Monitoring and Mitigation
EDLIZ	Essential Drugs List in Zimbabwe
EGPAF	Elizabeth Glazier Paediatric AIDS Foundation
EHT	Environmental Health Technician
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
FNC	Food and Nutrition Council
FP	Family Planning
GOZ	Government of Zimbabwe
H4+	Joint Partnership of UN Agencies (UNFPA, UNAIDS, UNICEF, UN Women, WHO and the World Bank)
HBB	Helping Babies Breathe

HBS	Helping Babies Survive
HDF	Health Development Fund
HF	Health Facility
HIO	Health Information Officer
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMS	Helping Mothers Survive
HP	Health Promotion
HW	Health Worker
HTF	Health Transition Fund
ICC	Inter-Agency Coordinating Committee (for Immunization)
iCCM	Integrated Community Case Management
IEC	Information and Education Communication/Campaign
IIP	Immunization in Practice
IMAM	Integrated Management Of Acute Malnutrition
IMNCI	Integrated Management of Newborn and Childhood Illness
IPV	Inactivated Polio Vaccine
IRB	Institutional Review Board
IRC	International Rescue Committee
IYCF	Infant and Young Child Feeding
JSI	John Snow, Inc.
KAP	Knowledge, Attitudes And Beliefs
KMC	Kangaroo Mother Care
LBW	Low Birthweight
LLIN	Long Lasting Insecticide Treated Nets
M&E	Monitoring And Evaluation
MCCM	Malaria Community Case Management
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MDSR	Maternal Death Surveillance and Response
MEL	Monitoring, Evaluation and Learning
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MIP	Malaria in Pregnancy
MIS	Malaria Indicator Survey
MLM	Mid-Level Managers
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 Mortality Audit
MPDSR	Maternal and Perinatal Death Surveillance and Response
MPH	Mutare Provincial Hospital
MPMA	Maternal and Perinatal Mortality Audits
MR	Measles-Rubella
MSD	Measles Second Dose vaccine
NH/NBH	Newborn Health
NHMIS	National Health Management Information System
NIHFA	National Integrated Health Facility Assessment
NITAG	National Immunization Technical Advisory Group
NMCP	National Malaria Control Programme
NPEC	National Polio Expert Committee
NUVI	New and Underutilized Vaccine Initiative
OJT	On-The-Job Training
OPHID	Organization for Public Health Interventions and Development
OSDV	Onsite Data Verification
PCV 13	Pneumococcal Conjugate Vaccine
PDQ	Partnership-Defined Quality
PE/E	Pre-Eclampsia/Eclampsia
PIE	Post-Introduction Evaluation
PMI	President's Malaria Initiative
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
PSI	Population Services International
PSZ	Population Services Zimbabwe
PTFU	Post-Training Follow-Up
PY	Program Year
QA/QI	Quality Assurance/Quality Improvement
QIST	Quality Improvement Support Team
QoC	Quality Of Care
RBF	Results Based Financing
RED/REC	Reaching Every District/Reaching Every Child
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Newborn, And Child Health
SBCC	Social and Behavior Change Communication
SBM-R	Standards Based Management and Recognition
SHC	School Health Coordinator
SHM	School Health Master
SIA	Supplementary Immunization Activities
SDG	Sustainable Development Goal
SMT	Senior Management Team
SP	Sulphadoxine and Pyrimethamine
SS	Supportive Supervision
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TBD	To Be Determined
TrainSMART	Trainings, Monitoring and Reporting Tool
TOR	Terms Of Reference
tOPV	Trivalent Oral Polio Vaccine
TOT	Training Of Trainers
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
USG	United States Government
VHW	Village Health Worker
WHO	World Health Organization
Zim Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZEPI	Zimbabwe Expanded Program on Immunization
ZNFPC	Zimbabwe National Family Planning Council

## INTRODUCTION

### Overview

This Project Year 3 (PY3) Workplan describes the strategies and activities that will support implementation of the MCHIP/Zimbabwe Associate Award (AA) for the period January 1, 2016 to December 31, 2016, the final year of the project. USAID has assured the team of the Mission's interest in extending MCHIP past its current December 2016 end date, although at the time of submission of this workplan, a mechanism had not yet been decided or communicated to the MCHIP partners. Both Field Support buy-in to the Maternal and Child Survival Program (MCSP) and a no-cost extension for a period of time dictated by the remaining ceiling at the end of 2016 are possible. In this workplan, the project has planned for program close out by December 31, 2016, with implementation of AA field activities ending by September 30, 2016 to allow sufficient time for close out and simultaneous transition to a new mechanism.

The strategies and activities described in this workplan were selected based on an analysis of the current country context; evolving country priorities in maternal, newborn, and child health (MNCH); experiences and lessons learned during PY1 and PY2 of the AA; 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 of best practices over the past year.

## STRATEGIC APPROACHES

In response to the current maternal, newborn and child health situation in Zimbabwe, the project orients its technical programming around the following strategic approaches:

- **Improving quality of care at all levels of the health system** through rigorously and continually assessing, planning, implementing and evaluating MNCH care using the Standards-Based Management and Recognition (SBM-R) approach to quality improvement.
- **Strengthening health systems** by building capacity at all levels of the health sector and by increasing access to quality coverage with high impact, cost-effective, integrated MNCH interventions.
- **Establishing strategic partnerships** to implement high-impact interventions with the MOHCC in the lead and MCHIP and other partners engaged in joint programming and leveraging of funding through technical assistance to MNCH technical reviews, planning and activity implementation.
- **Empowering families and communities**, especially the poor and marginalized, to be able to meaningfully participate in planning, implementation, monitoring and evaluation of MNCH interventions, make informed decisions, and access quality services.
- **Advocating for policies** that promote the scale-up of MNCH resource mobilization and allocation towards interventions that lead to reductions in maternal, newborn and child mortality.
- **Using evidence-based planning, implementation and evaluation** to generate clear expected results, timelines, and benchmarks that strengthen existing health infrastructures; to effectively use data to inform policy, planning, and practice; and to prioritize continuous improvements in quality of care.

## GENERAL PRINCIPLES

The project's strategic technical approaches are also guided by the following general principles, which inform the day-to-day operation of the project:

- **Responsiveness to changes in the programming environment** – PY3 activities will be designed and implemented in line with changes in key national guiding documents, such as the National Health Strategy and the Child Health Strategy. The project will also align with changes in USAID programming, as described in the Country Development Cooperation Strategy, and the transition within the funding environment from the Health Transition Fund (HTF) to the Health Development Fund (HDF).
- **Strengthening human resources for health** – Much of the project's work focuses on strengthening human resources for health for improved quality of care provision. Since offsite training can be quite costly, the project team is continually thinking of new, innovative ways to build capacity and convince others of the user-friendliness, cost-effectiveness, and long-term impact of on-the-job training (OJT). Cost-control measures such as these also foster transparency and sustainability for future trainings and improve ownership by the MOHCC. In PY3, the program will continue to explore ways to improve supportive supervision (SS), post-training follow-up, and mentorship for more lasting skill transfers.
- **Integration** – The project will continue to operate in an integrated, collaborative way with the MOHCC by physically co-locating project staff within MOHCC office space and stimulating collaboration from within. In another form of integration, the project has combined planned administrative support trips with workshops, conferences, and field support visits to further reduce project costs. Finally, the project continues to advocate for and support an integrated package of MNCH SS, mentorship, OJT, and post training follow-up.
- **Filling gaps** – The project continues to identify and fill gaps in programming that lead to improvements in the quality of care provided at MCHIP-supported HFs. In an effort to address often highly variable vendor pricing, the project has routinely solicited more vendor quotes than the number required for each threshold procurement value and has successfully negotiated prices for goods and services that support quality improvement.
- **Leveraging** – The project will undertake environmental scoping exercises aimed at identifying and developing smart partnerships with other organizations to leverage resources in the delivery of high impact, evidence-based MNCH programs at the national, provincial, district and community level. These partnerships enable the project to gain from the comparative advantage of partner organizations, especially in areas where certain costs are unallowable by USAID rules and regulations.
- **Sustainability** – By ensuring local governance, ownership and custodianship of all interventions piloted and implemented in health facilities (HFs) and communities, the project builds sustainability into the high impact, evidence-based interventions that it supports.
- **Equity** – The project continues to focus on equitable access to evidence-based, high impact interventions by monitoring and tracking population groups that access interventions in the supported districts. The project achieves this through the collection of **sex** and age disaggregated data as well as data disaggregated by level of care. The project will pursue improvements in community health management information system (CHMIS) data collected on the DHIS 2.0 platform to understand geographical access to MNCH services at the community level. 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 (GOZ's) community-based initiatives. At the same time, the team will continue to complement and will cost-share 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 and will end in February 2016.

## PROGRAM GOAL AND OBJECTIVES

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 rollout evidence-based, high-impact interventions that will reduce maternal, newborn, and child morbidity and mortality and contribute to the attainment of **Sustainable Development Goal 3 (SDG 3)** in Zimbabwe.

The project's **objectives** are 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.

The first two years of this AA were 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 EPI guidelines and tools in light of new vaccine introduction (e.g. Rotavirus vaccine, Immunization in Practice [IIP] modules), developing a national Kangaroo Mother Care (KMC) training package, finalizing and launching the National Nutrition Strategy, reviewing the National HMIS Strategy, facilitating the MOHCC's national adaptation and adoption of the Emergency Triage Assessment and Treatment (ETAT) approach, and supporting the national introduction of Measles-Rubella (MR) and routine Measles second dose (MSD). To influence policy, the project team participated in and co-hosted numerous MNCH-related Technical Working Group (TWG) meetings at the national level, including the Reproductive Health (RH) Steering Committee, Child Survival (CS) TWG, Nutrition TWG, National Health Management Information System (NHMIS) TWG, 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 baseline surveys of Quality of Care (QoC), immunization coverage and community knowledge, attitudes and beliefs (KAP) in all seven districts in Manicaland province. The team also supported 36 high volume health facilities in Manicaland to develop and implement their QI plans – which for the first time also included an immunization component and a refined child health component. A significant achievement in PY2 was the establishment of facility and district quality improvement support teams (QIST) in all seven districts of Manicaland, where the program is working intensively with the Provincial Health Team to introduce standards-based QI methods in reproductive, maternal, neonatal and child health services as a way of institutionalizing QI in the MOHCC structures and processes and promoting sustainability for QI gains.

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 in Chimanimani, Mutare and Mutasa districts. Moreover, other 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), again in all seven districts in Manicaland. The project also successfully carried out a study of malaria in communities in Manicaland along the Zimbabwe–Mozambique border. The study was supported by the President's Malaria Initiative (PMI) to identify the key drivers of malaria transmission in this high prevalence region. Data collection and analysis were completed and findings presented to the Malaria National Control Program and working group in the fourth quarter of PY2.



Strengthening local capacity to promote and deliver MNCH services has been another priority area of technical assistance for the project. In PY1 and PY2, the project trained 4,822 health workers (HWs) on various aspects of MNCH, from Integrated Management of Newborn and Childhood Illness (IMNCI) to infant and young child nutrition and feeding (IYCF), and the team contributed technically to a new set of HW guidelines on family planning (FP) and postpartum intrauterine device (PPIUD) (*with non-United States Government funding*). 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 aides, and school health masters (SHMs) trained on integrated Community Case Management (iCCM) and other interventions. The team also completed a rigorous civil society organization (CSO) mapping, selection, and subawarding process. The project assisted the selected CSO, the Diocese of Mutare Community Care Program (DOMCCP), to carry out organizational and technical self-assessments, design a project M&E plan and reporting system, and initiate community partnership activities using the Community Action Cycle (CAC).

The project team has both increasingly implemented *whole-site* orientations for SBM-R and further tested and integrated SBM-R SS visits into routine SS visits in Manicaland province. These measures were deliberately taken to work smarter and more efficiently and effectively. The MCHIP/Zimbabwe AA will continue to use more practical, hands-on, non-hotel based trainings, use existing facilities for training (e.g., Sakubva Hospital for KMC trainings), and will improve efforts to deliver and/or support blended learning activities. In PY3, the project will also further efforts to leverage other resources, such as the Health Development Fund, or HDF (formerly the Health Transition Fund, or HTF), to advocate for key MNCH procurements, and MOHCC learning exchange visits.

The MCHIP/Zimbabwe AA will build on its successful experience over the past five years (three under the previous MCHIP award, and two 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 its promising work in 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.

While the MCHIP/Zimbabwe AA's life of project contributions to health outcomes are expected to be realized by the end of 2016, the project's achievements should be viewed in light of severe funding constraints over the life of the project. This year's funding level of \$3.3 million (inclusive of new funding and expected pipeline) is substantially less than the \$6 million that was originally envisioned in the AA agreement, and the overall funding level at the end of the project will only be \$9.65 million, or less than two-thirds of the original \$15 million. In response to these constraints, the project team has been proactive in identifying cost-control measures and in seeking out opportunities to generate cost share and leverage funding to enable to program to achieve 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. The strategies used to attain the life of project results 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 PY3 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 and PY2 achievements; propose results we expect to achieve in PY3; 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 and PY2 Key Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>National MNCH policies, strategies, guidelines and tools developed/finalized with MCHIP support.</li> </ul>	<ul style="list-style-type: none"> <li>National Child Survival Strategy (CSS) under development.</li> <li>National QI Policy and Strategy finalized with MCHIP technical and financial support.</li> <li>Contributed to the standardization of integrated SS tools that can be used for MNCH program and health service delivery improvement, and advocated for harmonization of funding modalities for MNCH.</li> <li>Supported the integration of Environmental Compliance Assessment tools into the HTF SS tools.</li> <li>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/Strategy.</li> <li>Developed, piloted, finalized, printed and disseminated national maternity booklets.</li> <li>National Nutrition Strategy finalized, launched and disseminated by the Nutrition TWG, with MCHIP support.</li> <li>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 completed. Initial adaptation of training materials done.</li> <li>Developed new malaria community case management (MCCM) training manuals for VHWs based on new treatment guidelines and incorporated updated diarrhea, pneumonia, and malnutrition case management guidelines.</li> <li>Technical and financial support provided for the development and adoption of national training of trainer (TOT) guidelines for Basic Emergency Obstetrical and Newborn Care (BEONC) in-service trainings.</li> </ul>	<ul style="list-style-type: none"> <li>Costed CSS finalized.</li> <li>QI policy printed.</li> <li>QI strategy disseminated.</li> <li>Improved and refined integrated SS tools that have more QI process elements for quality improvement and a focus beyond the numbers available.</li> <li>National ETAT guidelines and tools finalized, printed, and lessons learned in implementing ETAT in the Zimbabwean context documented.</li> <li>National level ETAT TOT conducted and a national pool of ETAT trainers and mentors available.</li> <li>MCCM VHW training manuals disseminated and rolled out for national training purposes.</li> </ul>

Objective 1: Life of Project Results	PY1 and PY2 Key Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>• MNCH program coordination, planning, and monitoring strengthened through MCHIP support for national steering committees/Technical Working Groups (TWGs), and review and planning meetings.</li> <li>• Availability of a competent MNCH workforce increased through strengthening of in-service and pre-service clinical training; rollout of a standardized, integrated SS protocol; and development and dissemination of MNCH job aids for HWs.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• New MOHCC Child Health Deputy Director selected, with participation on interview panel by MCHIP.</li> <li>• VHW job aids reviewed and updated, with other partners working to improve community MNCH and strengthen VHW service provision.</li> </ul>	<ul style="list-style-type: none"> <li>• Partners (e.g., HTF, H4+, UN,) and national resources increasingly leveraged.</li> <li>• Partner coordination forums supported.</li> <li>• MNCH plans developed, and regular MNCH program/strategy reviews conducted.</li> <li>• National IMNCI policy and chart booklet updated.</li> <li>• Community MNCH counselling cards and family health handbooks designed, piloted, finalized and disseminated for use by lead mothers/fathers.</li> </ul>
<ul style="list-style-type: none"> <li>• MNCH pre-service education (PSE) curricula for nurses, doctors and other health professionals improved through inclusion/updates of content on BEmONC, Helping Babies Breathe (HBB), IMNCI, maternal nutrition, IYCF and immunization, as well as skills strengthening of instructors in Competency Based Training (CBT).</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Reviews of various training curricula supported at national level.</li> <li>• National University of Science and Technology and Africa University engaged by MCHIP in developing scopes of work for technical support; these scopes are now being implemented.</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporation of BEmONC into <b>midwifery in-service training</b> supported.</li> </ul>
<ul style="list-style-type: none"> <li>• 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 other partners and donors (<i>non-USG</i>) supporting antenatal care (ANC) and postnatal care (PNC) programming.</li> </ul>	<ul style="list-style-type: none"> <li>• FP/PPIUD training guidelines completed (<i>this activity was supported by non-USG funding</i>) with the assistance of other partners, who will then support their national rollout.</li> <li>• Selected components of cPQI approach tested and refined by MCHIP.</li> <li>• Facility and community QI plans implemented, with resources and support leveraged from MCHIP and other MNCH partners.</li> <li>• QI plans developed by 36 HFs in follow-up to MCHIP-supported baseline assessments.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Through non-USG funding</i>, collaboration with UNFPA, The Zimbabwe National Family Planning Council (ZNFPC), and MOHCC to provide technical assistance for PPIUCD TOTs using training package conducted. <i>This activity will count towards cost-share requirements.</i></li> <li>• Promising community performance and quality improvement (cPQI) tools, such as MNCH registers and SS approaches, adopted for scale-up.</li> </ul>
<ul style="list-style-type: none"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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. <b>MCHIP uses the database to track all trained health care workers.</b></li> <li>• Advocacy for the integration of community indicators onto the District</li> </ul>	<ul style="list-style-type: none"> <li>• TrainSMART database in use in Manicaland Province, and database information used to develop and implement provincial and district training plans.</li> <li>• Community module on the DHIS 2.0 platform</li> </ul>

Objective 1: Life of Project Results	PY1 and PY2 Key Achievements	PY3 Expected Results
<p>nationally.</p>	<p>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.</p> <ul style="list-style-type: none"> <li>• MPMA guidelines finalized.</li> <li>• Maternal and perinatal mortality audit forms drafted in collaboration with H4+.</li> </ul>	<p>developed and tested in Manicaland with MCHIP's support.</p> <ul style="list-style-type: none"> <li>• Data use training conducted for the MPMA in collaboration with H4+ (dependent on the availability of training package).</li> </ul>
<ul style="list-style-type: none"> <li>• New MNCH approaches and tools explored, lessons learned documented, and best practices shared with MNCH stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>• Rotavirus vaccine successfully launched nationally, with MCHIP's substantial support during planning and rollout.</li> <li>• Rotavirus vaccine post-introduction evaluation (PIE) conducted with MCHIP's technical support.</li> <li>• Planning for and national introduction of Measles/Rubella (MR) vaccine second dose completed with MCHIP's technical support.</li> <li>• Provision of technical assistance and support to the pilot/demonstration of HPV in Matabeleland South.</li> <li>• BEmONC TOT guide used to support national TOT and each province with a team of trainers.</li> <li>• Development of adapted Adverse Event Following Immunization (AEFI) Guidelines.</li> <li>• Technical assistance in the development of the "switch" plan from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV).</li> <li>• Development of the Performance Framework for Monitoring Gavi-supported activities aligned to HDF immunization activities in Matabeleland North and South successfully undertaken, along with RED/REC training in all districts.</li> <li>• Vaccine store in Mashonaland East constructed and turned over to Province (with ELMA Vaccines and Immunization Foundation funding).</li> <li>• Advocacy for the development of national scale-up plans for antenatal corticosteroids (ACS) successfully conducted. National stakeholder meeting held to build consensus around new ANC global guidance and next steps for Zimbabwe.</li> <li>• All MCHIP program learning activities completed (report drafts and/or manuscripts now at different stages of development and/or are seeking publication).</li> <li>• IMNCI patient registers tool field tested and nationally adopted. National printing supported by UNICEF.</li> <li>• National guidelines on the rational use of blood and blood products for MNH developed and adopted.</li> </ul>	<ul style="list-style-type: none"> <li>• VHW job aids revised/updated to include TB, finalized, and disseminated for wider use.</li> <li>• IPV successfully introduced nationally.</li> <li>• Report on lessons learned from implementing a solar powered cold chain system in ELMA-supported districts available.</li> <li>• IMNCI registers rolled-out nationally through leveraging of resources to support printing and dissemination.</li> <li>• MCHIP program learning agenda used to influence the development and implementation of a national and Manicaland MNCH program learning and research agenda.</li> <li>• ACS national guidelines developed.</li> </ul>

## Strategy

During the first two years of implementation (PY1 and PY2), the MCHIP/Zimbabwe AA's support to the MOHCC under Objective 1 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. Over the two years, the MCHIP AA has 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 PY3, the MCHIP/Zimbabwe AA will work with partners – notably UN agencies, the HDF, RBF, and other similar mechanisms – to sustain gains in increasing the availability and quality of MNCH services along and across the continuum of care. Specifically, MCHIP will support the development and review of priority MNCH 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, Essential Care for Every Baby (ECEB), Helping Mothers Survive (HMS), HBB and KMC; and continue to plan at national level for the introduction of IPV. The project will also build on lessons learned 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.

With regards to nutrition, the recent 2012 National Micronutrient Survey conducted in Zimbabwe reports that 30 percent of children U5 are stunted, and that there has been virtually no improvement in this indicator since the 2010/11 Demographic and Health Survey (DHS), when it was 32 percent. Zimbabwe joined the Scaling Up Nutrition Initiative in June 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, the adoption and launch of the food fortification policy, and a review of the 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, 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 PMTCT Partnership Forum and other partners supporting the operationalization of pediatric antiretroviral therapy (ART), Option B+. In collaboration with UNFPA, ZNFPC, and MOHCC and with technical assistance from Jhpiego, PPIUCD TOTs will be conducted using the revised FP/PPFP training package. Since these activities are non-USG funded, the project will consider them as cost-share.

In PY3, the project will enter into a partnership with The International Union Against TB and Lung Disease (The Union) to fulfil an objective of the USAID-funded Challenge TB mechanism that focuses on improved access to quality, patient-centered care for TB, TB/HIV and multi-drug-resistant-TB services. Our partnership is designed to address the low awareness about TB in children within communities and by health care workers (HCW); inadequate HCW knowledge, skills, and resources for sample collection in young children; low implementation of TB prevention methods; and limited access to/use of diagnostic tools. Activities designed to address these challenges will feature a patient-centered care and treatment approach that intensifies TB case-finding for all risk groups by all care providers, including community health workers. In collaboration with The Union, MCHIP will pilot the community portion of this initiative in one district of Manicaland, focusing on intensified childhood TB case finding and referral to care. To do this, MCHIP will

conduct a TOT on Childhood TB case finding and case management and then follow up to support a cascading of the training to a broad group of HCWs in the selected district. MCHIP will also update and print 1,000 copies of the tools and registers needed for HCWs' use (i.e., outpatient registers, community registers, VHW training materials, and TB screening tools). Finally, MCHIP will provide technical assistance to bolster community engagement, orient 350 VHWs to the intervention package and conduct SS visits. The scope of MCHIP's work with The Union was determined after discussions with USAID, The Union, and MCHIP, and it was agreed that The Union would pay directly for the activities that MCHIP staff will carry out as part of the partnership.

In immunization in PY3, a key area of technical assistance to the MOHCC will involve support to introduce inactivated poliomyelitis vaccine (IPV) into the national routine immunization program and to support the "switch" from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV), in line with the global commitment to end tOPV use and as part of the global polio Endgame Plan. This work will entail participating with MOHCC counterparts and other ICC members in planning for the IPV introduction and tOPV to bOPV switch at national level, including revision of training materials, job aids, registers, reports and other tools; training trainers; and participation in vaccine launch at national level. In Manicaland, MCHIP staff will also participate in the training of HCWs and EPI focal points prior to vaccine introduction and they will monitor introduction through field supportive supervision visits. Ideally, MCHIP staff will also participate with other partners in the Post Introduction Evaluation of the new vaccine products during the possible follow-on program that is currently being discussed with USAID/Zimbabwe.

In the activity matrix below, we describe our strategy for consolidating and sustaining the gains from the previous years of support to the MOHCC and to continuing our efforts to create an enabling policy environment and the key partnerships that have already begun to improve the health outcomes for Zimbabwe's most vulnerable women, infants and young children.

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
<b>Activity 1.1 Support the development and rollout of national policies, strategies, guidelines and tools</b>							
1.1.1	Support the development and rollout of National MNCH policies, strategies, guidelines and tools	Leveraging of resources for printing and distribution of QI Policy	X	X			QI Policy printed
		Support and provide TA for review of national MNCH policies, strategies, guidelines and tools	X	X	X		Two MNCH policies and tools reviewed with MCHIP support
	Contribute in TWG and sub groups working to the development of a VHW toolkit	Develop and scale up peer-to-peer SS guidelines nationally, for improvement of QoC at community level	X	X			Peer-to-peer SS guidelines available and in use for the improvement of quality of care at community level
		Workshop for pre-testing of SS guidelines in Mutasa district		X			Materials are pretested and finalized
		Update/revise cMNCH tools and registers to include <b>Community Childhood Tuberculosis (CTB)</b>	X				cMNCH tools and registers updated to include childhood TB (CTB) and in use
		Print updated cMNCH tools and job aids that include CTB		x			1000 VHW cMNCH/CTB job aids and registers printed
		Print MNCH counselling cards for use by VHWs in Mutasa (danger signs)	X				200 copies printed
	Social and Behavior Change Communication (SBCC), including national advocacy around priority topics: In PY3, MCHIP will advocate through the MOHCC Health Promotion (HP) Unit to set up a national SBCC TWG for information sharing and development of integrated MNCH materials to fill in gaps at the health facility and community level	Engage the MOHCC national HP Unit in setting up of a national SBCC TWG and support quarterly SBCC TWG meetings	X	X	X		Documented minutes of four SBCC TWG meetings
		Develop, pre-test and re-print new MNCH materials	X	X	X		At least two new MNCH materials developed for HWs and community level

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Provide technical support to at least four social mobilisation events (including the International Day of Handwashing), and contribute financially to the commemoration of at least one MNCH-related national health day, with a priority given to increasing community and male engagement in those events	X	X	X		Technical support to at least four national Health Days  Technical and financial support to the commemoration of the international day of handwashing
1.1.2	Support review and planning of the 2016 National Annual MNCH Implementation Plans	Provide TA for review and development of National 2016 MNCH plans. Leverage resources for implementation of 2016 MNCH plans.	X				Two national Annual MNCH Implementation Plans developed with MCHIP support
1.1.3	National Child Survival Strategy (CSS) for 2016-2020 reviewed, revised, and completed with MOHCC and partners <i>(NB: The MOHSS drafted the CSS in PY2 with support from MCHIP and others in reviewing the previous strategy and in drafting the new one. MCHIP will continue to support the finalization of the CSS in PY3.)</i>	Support finalization of the CSS in line with the NHS	X				Costed CSS finalized with technical support from MCHIP and others
		Support development of the CSS Implementation Plan	X				Implementation Plan developed with MCHIP's support
		Support dissemination of the CSS	X	X			CSS disseminated
1.1.4	National ETAT guidelines and tools adapted and printed, and a national pool of ETAT trainers and mentors trained. Ongoing support with printing of the IMNCI registers.	Support National TOT on ETAT	X				30 national trainers complete ETAT competency-based training
		Support printing of ETAT manuals for trainings	X				36 participant and six facilitator manuals printed
		Support revision and printing of recommended ETAT job aids	X				Job aids available at ETAT implementation sites
		Support printing of IMNCI registers	X				IMNCI registers printed



	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
1.1.5	Contribute to national studies and surveys	Contribute to the Malaria Indicator Survey (MIS) and provide technical input to other national MNCH-related studies as appropriate	X	X	X		MIS completed with MCHIP support  Other national MNCH studies completed with MCHIP support
1.1.6	Provide TA in NITAG, ICC, National Polio Expert Committee (NPEC) and all National EPI Activities. Continue to provide TA to all national TWGs. Continue TA support for developing and updating guidelines and strategies (i.e., Zimbabwe EPI (ZEPI) data collection tools, including the ZEPI Register & Child Health Cards). Continue support for EPI review meetings.	Support revision to Child Health Card to include new vaccines	X				Child Health Card revised and distributed to all HFs by end of first quarter
		Support updating of ZEPI register and immunization data collection tools (T5, T6)	X				ZEPI register and EPI data collection tools updated for new vaccines
		Support two of the quarterly EPI review meetings	X		X		Two (2) EPI review meetings supported
		Support finalization and printing of the MR and MSD field guides	X				MR and MSD field guides produced and distributed to all HFs
		Support development of IPV and “switch” field guides	X	X			IPV and “switch” field guides developed
		Provide TA during national technical working groups (ICC and other TWGs)	X	X	X		TA support to MNCH TWGs documented
<b>Activity 1.2 Strengthen MNCH program coordination, planning and monitoring, and leveraging of other available MNCH funds</b>							
1.2.1	Strengthen MNCH program coordination, planning and monitoring, and leveraging of other available MNCH funds	Support key CH TWGs and participate in national coordination functions (e.g., CS TWG, malaria, IYCF, NHMIS, RH, CS, Nutrition, PMTCT Partnership Forum, National Nutrition NTWG meetings, etc.)	X	X	X		MNCH program coordination strengthened with MCHIP support

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
<b>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</b>							
1.3.1	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, SS, and the introduction of distance training approaches	Provide TA and support to national MNCH OJTs (BEmONC, post-training follow-up [PTFU] OJT/SS)	X	X	X		Availability of a competent MNCH workforce increased through strengthening of in-service clinical training; rollout of standardized, integrated protocols; development and dissemination of MNCH job aids for HWs; OJT; and mentorship.
		Provide TA and support review and development of new national training packages and guidelines for MNH	X	X	X		Two national training packages or guidelines reviewed and developed as needed
		Contribute to the final incorporation of BEmONC into midwifery pre-service curriculum	X	X	X		BEmONC integrated into preservice midwifery training
1.3.2	Support advocacy for incorporation of Helping Babies Survive (HBS) package (HBB, ECEB, Essential Care for Small Babies [ECSB]) <i>(NB: The curriculum update mainly involves tutors but has representation from other national stakeholders involved in in-service training.) (See Activity 1.4.1)</i>	Support awareness-raising and advocacy meeting for HBS .	X	X			Stakeholders oriented on HBS and advocating for its use
1.3.3	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	Support standardization of integrated SS quality tools	X	X	X		Standardized SS quality tools developed and available
<b>Activity 1.4 Promote the scale-up of high impact interventions on existing MNCH service delivery platforms to improve efficiency and increase coverage</b>							
1.4.1	Support adoption and scale up of HBS package (ECEB, ECSB) for in-service training	Support the adoption of HBS guidelines and tools into national level maternal and newborn health training manuals and tools	X				Advocacy meetings held at national level
		Support national orientation of	X	X			Provincial supervisors oriented to the (HBS)

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		provincial service providers on HBS package (ECEB, HBB, ECSB)					ECEB, HBB, ECSB
		Provide TA for SS at five central hospitals for ECSB	X	X			SS visits to five central hospitals conducted
1.4.2	Scale up of BFHI activities	Support national plans for BFHI pre-assessments	X	X	X		Hospital pre-assessment activities planned and dates communicated to provinces
		Support planning for final BFHI assessments		X			Final BFHI assessment activities planned and dates communicated to provinces
1.4.3	Support implementation of national EPI activities	Provide TA for TOT for IPV and “switch”	X				National IPV TOT supported
		Participate in the “switch” launch activities		X			“Switch” launch successfully held
		Participate in MR and IPV post-introduction evaluation (PIE)		X			MR and IPV PIE conducted
		Participate in and present on Zimbabwe’s achievements during the WHO-convened ‘Exchange of Best Practices Workshop on REC, Equity, and Integration of Child Survival Interventions’ regional workshop in Cape Town, South Africa	X				Meeting attended
<b>Activity 1.5 Strengthen national systems for the collection and use of strategic MNCH information</b>							
1.5.1	Collaborate with and support MOHCC and other partners to pilot and rollout an electronic Maternal Perinatal Mortality Audit (eMPMA) System	Participate and provide technical support in one stakeholder meeting to review the pilot findings	X				One stakeholder meeting held

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		In response to a request from MOHCC, provide TA to train health care workers in data use prior to rolling out the electronic system	X	X	X		Health care workers trained in data use with MCHIP technical support
		Support the development and use of standard dashboards that promote maternal death surveillance and response (MDSR)/maternal and perinatal surveillance and review (MPDSR) data utilization	X	X	X		Standard dashboards that promote MDSR/MPDSR data utilization available in selected facilities
1.5.2	Support the strengthening of the national HMIS	Provide technical support to integrate quality and NBH indicators into the DHIS 2.0	X	X	X		Quality indicators integrated into the DHIS 2.0 available
		Participate in national HMIS annual review and planning meeting	X				One national HMIS annual review and planning held
1.5.3	<b>Implementation Research:</b> Support and collaborate with MOHCC and other partners to conduct prospective malaria cross-border study in Manicaland as a follow-on to the PY2 cross-sectional malaria cross border study and based on the recommendations of the PMI MOP team as well as feedback from the Manicaland Provincial Health Team  <i>(NB: Dissemination to the Manicaland Provincial Health Team is planned for January 2016, and recommendations on specifications for the study from the PMI MOP team are also expected in January 2016.)</i>	Develop concept with PMI, USAID and National Malaria Control Program (NMCP)	X				Concept note developed with PMI, USAID and NMCP
		Develop full study protocol and associated materials (tools, training materials and job aides) and seek local and US based IRB review and approval	X				Study protocol developed and local and US based IRB approval obtained
		Implement the study		X			The malaria prospective study implemented (data collection, cleaning, analysis, report writing) and report available
		Develop and implement a dissemination plan			X		Study findings disseminated

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	<p><b>Landscape situational assessment of Malaria in Pregnancy (MIP) in selected areas in Zimbabwe:</b></p> <p>Control of malaria in pregnancy (MIP) was adopted as a national policy in 2004 for implementation in moderate to high-burden malaria transmission areas. The policy was a three-pronged approach that recommended IPTp with three doses of SP as the drug of choice; distribution and promotion of use of LLINs during pregnancy; and early and effective diagnosis and treatment of clinical malaria. Coverage rates for these interventions, however, are not known. This situational analysis will identify areas where further programming support for MIP is needed.</p>	Develop full study protocol and associated materials (tools, training materials and job aides), get IRB approval, implement and disseminate results	X				Protocol developed, approved, implemented and results disseminated
		Seek local and US based IRB review and approval	X				Local and US based IRB approval obtained
		Implement the assessment		X			Assessment implemented (data collection, cleaning, analysis, report writing) and report available
		Develop and implement a dissemination plan			X		Study findings disseminated
1.5.4	<p><b>Analysis of routine MNCH data:</b></p> <p>MCHIP has facilitated the development, piloting, and implementation of several MNCH data collection tools, processes and databases, including IMNCI, KMC, VHW and other registers and reports. The data generated are captured through the DHIS 2, other program-specific data flows and MCHIP's own monitoring and supervision reports. MCHIP uses data from all of these when preparing its quarterly and annual reports but analysis is primarily descriptive and focused on comparing achievements to targets in the PMP. In PY3, additional data capture and secondary analysis of existing datasets will form the basis of the program's implementation research. The program-specific questions to be answered will be formulated early in the PY, and an plan for the secondary analysis of the data will be developed with assistance from MCHIP home office. The purpose of this secondary analysis and additional data capture will be to inform MOHCC and stakeholder decision making and future USAID-supported program improvements.</p>	Develop a concept note and plan for secondary analysis of data from existing sources and share with MCHIP M&E team and USAID for review and input	X				Concept note and analysis plan developed, input received
		Finalize the analysis plan based on home office and USAID review; develop associated materials and tools, including a dissemination plan; seek local and US-based IRB exemption, if required		X			Final protocol and analysis plan developed; materials prepared; and, local and US IRB exemptions obtained
		Implement additional data capture and perform secondary data analysis, as planned;		X	X		Data compiled, cleaned and analyzed, and report prepared
		Implement the dissemination plan			X	X	Study findings disseminated

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
1.5.5	Support and collaborate with MOHCC and other partners to conduct a cost-benefit analysis of the cold chain ( <i>solar refrigerators funded by ELMA</i> ) in Matebeleland North and South. A protocol was developed and IRB approval was obtained in 2015. The solar refrigerators were installed in 104 HF's in 2015 and the study will commence six months after installation of the refrigerators.	Implement the study	X	X			The cost-benefit analysis of cold chain implemented (data collection, cleaning, analysis, report writing) in Mat. North and South and report available
		Develop and implement a dissemination plan		X	X		The study findings disseminated
1.5.6	Support the publications and dissemination of previous studies	Develop and finalize manuscript of cPQI study and submit to appropriate journal	X	X	X		cPQI study manuscript finalized and results disseminated
		Develop and finalize manuscript of RED implementation study and submit to appropriate journal	X	X	X		RED implementation study manuscript finalized and findings disseminated
		Develop and finalize manuscript of HBB skills retention study and submit to appropriate journal	X	X	X		HBB PTFU study manuscript finalized and results disseminated
		Develop and finalize manuscript of Oxytocin study and submit to appropriate journal	X	X	X		Oxytocin study manuscript finalized and results disseminated

**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 and PY2 Key Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>Cause-specific mortality rates for MNCH cases reduced in MCHIP-supported HF and communities.</li> </ul>	<ul style="list-style-type: none"> <li>Maternal, newborn, and child mortality indicators improved at all MCHIP-supported 36 HF in PY2 compared to baseline.</li> </ul>	<ul style="list-style-type: none"> <li>Further reductions in cause-specific mortality rates for MNCH cases in MCHIP-supported HF and communities achieved.</li> </ul>
<ul style="list-style-type: none"> <li>Number of HF satisfying criteria for QI standards (SBM-R) for MNCH increased.</li> </ul>	<ul style="list-style-type: none"> <li>Baseline and midterm assessment of MNCH QoC completed in all seven districts in Manicaland province.</li> <li>18 HF met 80% of immunization QI standards; 15 HF met 80% of child health QI standards; and six HF met 80% of MNH QI standards.</li> </ul>	<ul style="list-style-type: none"> <li>22/35 HF (63%) meeting 80% of QI standards for immunization and child health.</li> <li>12/36 HF (33%) meeting 80% of QI standards for MNH.</li> </ul>
<ul style="list-style-type: none"> <li>Number of HF and VHW implementing SBM-R in MNCH increased.</li> </ul>	<ul style="list-style-type: none"> <li>36 MCHIP-supported sites (HF) in Manicaland implementing integrated MNCH QI activities which now also include immunization and a refined CH component.</li> <li>Minor procurements supported in response to facility-based action plans informed by baseline assessment of MNCH QoC.</li> <li>Quality Improvement Support Teams (QIST) established and trained in the 36 sites.</li> <li>The Provincial Health Executive (PHE) incorporated SBM-R activities into their quarterly RBF SS routine.</li> </ul>	<ul style="list-style-type: none"> <li>QI approaches institutionalized in 36 HF, and capacity of health providers to support QI initiatives strengthened through the establishment and strengthening of QIST.</li> </ul>
<ul style="list-style-type: none"> <li>Number of HW and VHW trained in MNCH increased.</li> </ul>	<ul style="list-style-type: none"> <li>100% coverage of MNCH training for VHW in Mutasa and Chimanimani districts.</li> <li>All targeted VHW, nurse aides, and SHM in selected communities trained in MCM. 1,455 VHW and 115 SHM received refresher training following updating of malaria treatment guidelines.</li> <li>All HF in Manicaland province have at least one HW trained in BEmONC and IMNCI; 332 HW from all 36 MCHIP-supported sites received onsite or OJT for various newborn health HBS modules; 43 HW underwent group training in KMC; 163 HW trained in IIP; eight cold chain technicians received training with leveraging of TA provided by WHO.</li> </ul>	<ul style="list-style-type: none"> <li>Mop-up MCM training conducted for 600 VHW, 150 SHM, and 150 nurse aides from the seven districts and at least 30% of them received SS.</li> <li>60 HW and 350 VHW trained in CTB interventions during pilot in Mutasa district.</li> </ul>

Objective 2: Life of Project Results	PY1 and PY2 Key Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>Number of VHWs satisfying set criteria for managing MNCH cases increased.</li> </ul>	<ul style="list-style-type: none"> <li>On job orientation of District Health Executive (DHE) staff from seven districts and HWs from selected HF oriented on implementation of VHW SS visits.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened VHW SS practice among HWs and peer-to-peer supervisors in Mutasa and Chimanimani districts.</li> <li>cHMIS job aids and other data collection tools rolled out to two more districts in Manicaland province.</li> <li>Number of VHWs, nurse aides, and SHMs reaching set criteria for QI in MNCH increased.</li> </ul>
<ul style="list-style-type: none"> <li>Coverage of key prevention and treatment interventions for MH increased, including MIP, maternal nutrition, pre-eclampsia/eclampsia (PE/E), postpartum hemorrhage (PPH), obstructed labor, sepsis and PPFPP.</li> </ul>	<ul style="list-style-type: none"> <li>Contributed to the upgrading of two sites to CEmONC status through support for mentorship attachments and minor procurements.</li> </ul>	<ul style="list-style-type: none"> <li>Prevention and treatment coverage of key MNCH interventions increased in target districts.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>MCHIP supported modular OJT activities for HWs on various aspects of BEmONC including use of the partograph and HBB in all 36 supported sites.</li> </ul>	<ul style="list-style-type: none"> <li>Prevention and treatment coverage of key MNCH interventions increased in target districts.</li> </ul>
<ul style="list-style-type: none"> <li>Number of pregnant women and newborns receiving at least one home visit according to national schedule increased.</li> </ul>	<ul style="list-style-type: none"> <li>Number of HF and communities documenting improvements in coverage of key MNCH interventions increased.</li> </ul>	<ul style="list-style-type: none"> <li>Coverage of home visits to pregnant women, newborns, and sick children increased.</li> </ul>
<ul style="list-style-type: none"> <li>Institutional deliveries increased.</li> </ul>	<ul style="list-style-type: none"> <li>During the first three quarters of 2015, the Provincial MOHCC recorded institutional deliveries of 65% of all expected deliveries in the province.</li> </ul>	<ul style="list-style-type: none"> <li>Institutional deliveries increased in target districts.</li> </ul>
<ul style="list-style-type: none"> <li>Essential Newborn Care (ENC) coverage of all newborns increased.</li> </ul>	<ul style="list-style-type: none"> <li>Performance on selected indicators for ENC in Manicaland increased through OJT, SS, and support to QI processes.</li> <li>Heaters procured for labor wards and post-natal units in all 36 MCHIP-supported sites.</li> </ul>	<ul style="list-style-type: none"> <li>30/36 HFs have the capacity to provide Essential Newborn Care in Manicaland.</li> </ul>
<ul style="list-style-type: none"> <li>Number of eligible newborns receiving HBB, KMC, and IMNCI increased.</li> </ul>	<ul style="list-style-type: none"> <li>HBB rolled out to all 36 MCHIP-supported HFs in the seven districts in Manicaland.</li> <li>KMC being implemented in 32/36 MCHIP-supported HFs.</li> <li>Procurement of essential KMC supplies for the establishment or revamping of KMC programs in 23 new sites out of the 36 supported sites in Manicaland province.</li> </ul>	<ul style="list-style-type: none"> <li>30/36 MCHIP-supported HFs meeting 80% of QI standards for HBB.</li> <li>25/32 MCHIP-supported HFs meeting 80% of QI standards for KMC.</li> </ul>



Objective 2: Life of Project Results	PY1 and PY2 Key Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>Survival rates for newborns managed with KMC, IMNCI, and HBB improved.</li> </ul>	<ul style="list-style-type: none"> <li>Health outcomes for sick and low birth weight (LBW) newborns began to improve in target districts; 83% of babies born with asphyxia were successfully resuscitated in the 36 MCHIP-supported sites.</li> </ul>	<ul style="list-style-type: none"> <li>Improvements in survival rates for newborns <b>increased</b> in Manicaland province.</li> </ul>
<ul style="list-style-type: none"> <li>Number of districts conducting MPMA's increased.</li> </ul>	<ul style="list-style-type: none"> <li>Whole site orientation on MPMA's completed at seven district hospitals.</li> <li>TA provided for quarterly provincial MPMA meetings; financial support for which was leveraged from a UNFPA program.</li> </ul>	<ul style="list-style-type: none"> <li>Number of districts conducting MPMA meetings increased.</li> </ul>
<ul style="list-style-type: none"> <li>New vaccines introduced in all seven districts of Manicaland province.</li> </ul>	<ul style="list-style-type: none"> <li>Rotavirus vaccine, MR and MSD introduced with MCHIP's support.</li> </ul>	<ul style="list-style-type: none"> <li>PIE for new vaccines completed with MCHIP support.</li> </ul>
<ul style="list-style-type: none"> <li>Immunization coverage in Manicaland increased.</li> </ul>	<ul style="list-style-type: none"> <li>Coverage for all antigens in Manicaland increased with MCHIP's technical support.</li> <li>Supported EPI SS visits targeted at poorly performing districts.</li> <li>Supported pilot of integrated community child health tracking tool alongside community based Vitamin A administration.</li> </ul>	<ul style="list-style-type: none"> <li>Increased immunization coverage rates for all antigens in Manicaland sustained.</li> <li>IPV introduced and the "switch" from tOPV to bOPV supported.</li> </ul>
<ul style="list-style-type: none"> <li>Coverage of sick children who receive correct treatment, appropriate care, and follow-up improved.</li> </ul>	<ul style="list-style-type: none"> <li>Number of sick children being managed correctly increased with the use of innovative tools like the ACT register for CH and the cPQI register.</li> </ul>	<ul style="list-style-type: none"> <li>Increased coverage for sick children managed according to IMNCI, ETAT and IMAM guidelines.</li> </ul>
<ul style="list-style-type: none"> <li>Number of households that report receiving MNCH BCC messages increased AND number of individuals and families adopting and supporting key household practices and MNCH health-seeking behaviors increased.</li> </ul>	<ul style="list-style-type: none"> <li>PMI resources used to strengthen the platform for adopting wider MNCH initiatives, including zinc use at community level.</li> </ul>	<ul style="list-style-type: none"> <li>Increased adoption of community and key household practices in target districts.</li> </ul>
<ul style="list-style-type: none"> <li>Capacity of communities and sub-groups to plan for and support MNCH services strengthened.</li> </ul>	<ul style="list-style-type: none"> <li>Communities reached with key interventions improved, with an increased number of VHWs, nurse aides, and SHMs trained on MCCM and other iCCM initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>Number of communities and sub-groups mobilized and utilizing MNCH services increased.</li> </ul>
<ul style="list-style-type: none"> <li>Coverage for community MNCH intervention packages improved, including home visits for maternal and newborn care (MNC), MCCM, early referral for sick children, and home care for sick children, according to IMNCI.</li> </ul>	<ul style="list-style-type: none"> <li>Community and health facility baseline surveys completed. QI plans developed and implemented, with indication of improvements in MNCH indicators.</li> </ul>	<ul style="list-style-type: none"> <li>Number of target populations reached by selected MNCH interventions increased.</li> </ul>
<ul style="list-style-type: none"> <li>Timeliness, completeness, and quality of MNCH data increased in Manicaland province.</li> </ul>	<ul style="list-style-type: none"> <li>Quality of MNCH data from facilities and communities improved with MCHIP-supported capacity building initiatives in recording and reporting data.</li> </ul>	<ul style="list-style-type: none"> <li><b>Quality MNCH data reporting and use</b> improved in target districts.</li> </ul>

## 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. MCHIP deliberately aimed to: support routine immunization (RI) in all seven districts in Manicaland and improve coverage for all antigens; focus on testing and building a QoC platform in two focus districts, Mutare and Chimanimani; and cultivated strong relationships with DHEs and the PHE as a platform for reaching the whole province with high-impact, evidence-based interventions under the follow-on AA. Under this follow-on AA, the project continues to help advance strategic RMNCH approaches in order to reverse negative health outcomes, document lessons learned, and generate programming information for use at the national level to effectively rollout interventions at scale. In carrying out this mandate, the AA team in Manicaland works closely with DHEs, the PHE, and other partners to facilitate integration, coordination, collaboration and leveraging to maximize the outcomes of available resources. In PY1 of the AA, the project expanded its support to 25 new, high-volume (delivery) facilities in five scale-up districts, and retained 10 facilities of the original 17 in Mutare and Chimanimani (including the Provincial Hospital).

PY1 and PY2 AA activities sought to sustain and build on lessons learned during MCHIP, while refining implementation approaches for impact at scale. Data from the 2014 MICS suggests that Manicaland has benefitted from MCHIP's contribution, with indicators such as skilled attendance at delivery, institutional delivery, postnatal care, management of sick children, the adoption of positive health behaviors, and immunization coverage rates having all significantly improved since 2009. The major thrust in PY3 will be to consolidate the gains in MNCH outcomes achieved over the past five years of MCHIP and its follow-on AA program implementation. MCHIP will work on establishing sustainable structures and mechanisms that will allow the MOHCC in Manicaland province to continue to deliver of quality MNCH services, even in the eventuality of a reduced intensity of direct support from MCHIP in the future.

Results from a mid-term self-assessment of MNCH QoC standard achievements indicate a general improvement in scores compared to baseline in most of the 36 high volume MCHIP-supported HFs; however, persistent gaps are still reported in the quality of RMNCH care provided. In a bid to foster institutionalization of the QI program, MCHIP supported the establishment and training of 36 facility-based QISTs in PY2. In PY3, MCHIP will strengthen the functioning of this structure as it is strategically placed to take over the role of supporting regular and consistent SS and other in-house QoC improvement activities locally with minimal logistic/financial input. The project has also successfully established varying levels of DHE stewardship over the MNCH QoC initiative among the seven DHEs with the PHE actually having incorporated the use of the SBM-R checklists during their quarterly RBF SS visits. MCHIP will work on building the capacity of district level teams of managers and champions to carry out more of the supervisory activities for the QoC improvement initiatives with less direct technical or financial involvement from MCHIP.

With the emphasis on QI in the upcoming National Health Strategy (draft in progress), MCHIP is strategically placed through its learning experience to support the implementation of QI activities and to influence/inform adoption and scale up of some QoC improvement approaches beyond Manicaland province, especially in the context of transitioning into the next funding mechanism. However, the resource-intensive SBM-R approach taken with the 36 sites in Manicaland province with its off-site trainings and heavy reliance on regular external assessment and external SS may not **be easy to scale up as an unmodified package**. In efforts to expand coverage of the QI initiative, some district supervisors have distributed copies of checklists to non SBM-R sites for use as job aides and for carrying out peer assessments or in-house assessments. In one district, QISTs were constituted in nearby non-SBM-R sites and members were invited by the District Nursing Officer (DNO) to attend the formal QIST training event at one mission hospital.

Throughout the life of the project, significant improvement has been noted in maternal and child mortality, but similar gains have not been reflected in perinatal outcomes. In responding to this observation during PY2, MCHIP supported rollout of the ECEB package, both vertically and in an integrated manner, through continued support to DHEs. The project also supported an accelerated effort at OJT of HBB, KMC and a module on intrapartum monitoring to 332 HWs in the 36 supported sites. To consolidate the gains of this effort, in PY3 the project will continue to facilitate supply of training simulators as required, refurbish newborn care corners, and provide SS. While coverage for KMC increased with MCHIP support to the establishment or revival of

services in 29 HF by the end of PY2, data from the province indicates that prematurity has overtaken birth asphyxia as the main cause of death among newborns. In PY3, MCHIP will support the strengthening of the use of ACS according to ACS guidelines and support the use of newer, low cost bubble continuous positive airway pressure (bCPAP) technology at the provincial hospital for preterm newborns requiring ventilation support.

The Provincial MOHCC office has expressed the need for fewer interventions that remove the HW from their station as this contributes to diminished QoC for the patients and will sometimes not add value to the care they provide, with evidence of lack of adequate skills acquisition or retention in some cases. In PY3, MCHIP will continue its support for more OJT/on-site training activities which emphasize skills transfer through CBT methods. Specifically, MCHIP will focus on building the capacity of selected QISTs to plan for and coordinate in-house modular training programs. Furthermore, distance IMNCI (dIMNCI) training is being piloted in two districts outside Manicaland province with imminent plans for scale up. MCHIP intends to support training of facility-based supervisors who will in turn support the implementation of dIMNCI training activities at facility level.

Project support in PY3 will also continue to focus on improvement of province-wide capacity to manage obstetric, newborn and child health 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. This support will include strengthening monitoring and capacity for C/S as well as implementation of the Emergency, Triaging, Assessment and Treatment (ETAT) package. In the latter program, 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.

Despite the significant child mortality observed at the referral centers, child death audits have not been taking place. In PY3, MCHIP will support the introduction of a facility-based child death audit process embedded within the ETAT protocols. Lessons learned from this process in the ETAT sites will inform advocacy and discussion efforts at national level on adoption and incorporation of the child deaths piece into the existing Death Surveillance and Response (DSR) structures and systems which are currently limited to maternal and perinatal deaths (MPDSR). In PY1, MCHIP provided orientation to PHE, DHEs and facility managers on how to conduct MPMA according to the new national guidelines, and in PY2, the project supported the strengthening of MPMA by providing TA to whole site orientation on MPMA at the secondary level facilities in the province. Since then, the provincial MPMA meeting has been held consistently on a quarterly basis and institutions have generally adopted appropriate maternal death notification efforts and are carrying out maternal death audits regularly. In the latest quarterly provincial MOHCC report, this intervention has been credited for the observed 19 percent drop in maternal deaths, which from January to September 2015 fell to 47 compared to 58 during the same period in 2014. In PY3, MCHIP will continue its work towards expanding the scope and depth of the audit processes with an emphasis on strengthening the perinatal death notification and audit aspect, which institutions have not taken up as effectively as the maternal component.

In PY1 and PY2, the project supported efforts to consolidate the implementation of RED by rolling out IIP training for frontline health workers responsible for providing vaccination services. Support for the provincial rollout of new vaccines that are scheduled for introduction was also provided by MCHIP and will continue in PY3 as the nation introduces and rolls out IPV and embarks on the tOPV to bOPV “switch.” MCHIP will also continue to support regular targeted SS visits to facilities in districts with underperforming indicators. In PY2, MCHIP supported the successful pilot of an integrated community child health tracking tool alongside the administration of Vitamin A by VHWS in the community and scale up of this tool will be supported in PY3.

During the life of the project, the quality of MNCH data from facilities and communities has generally improved with MCHIP-supported capacity building initiatives in recording and reporting data. In PY3, MCHIP will continue to offer support targeted to districts that still exhibit challenges in data timeliness and completeness. The project will also support strengthening of data interpretation and utilization at point of generation and at district level as well as work on building the capacity of community, facility, district and provincial cadres to better document and report on project lessons and data.

In PY1 and PY2, community reach with key MNCH interventions improved significantly, with a province-wide effort to support training of VHWS, nurse aides, and SHMs in MCCM and iCCM. In PY3, MCHIP will support mop-up trainings for newly recruited VHWS, nurse aides, and SHMs in order to cover the gap in MCCM

coverage in high burden areas. One of the major focus areas of the project's community piece has been the integration of different programmatic areas into a single package in order to simplify the expectations on the community-based HW (CBHW) as well as tackling quality issues in a more holistic and coordinated manner. The MCCM training has also been integrated with cIMNCI, where the CBHW is also trained to assess, classify and treat or refer clients as appropriate. PMI resources for MCCM have been successfully used to strengthen the platform for adopting wider iCCM initiatives such as management of diarrhea with ORS and Zinc at community level. In PY3, MCHIP will support the incorporation of community-based screening for childhood TB, which will be piloted in Mutasa district of Manicaland province in partnership with the Challenge TB project, which is managed by the International Union Against TB and Lung Disease (The Union). While 25% of the child mortality observed in the Sub-Saharan region has been previously ascribed to acute pneumonia, it is now believed that some could be dying of undiagnosed TB. Malnourished children may also have TB. As a result, the pilot of the community tools for TB screening will be useful in establishing the burden of underdiagnosed TB in children and contribute to mortality reduction.

MCHIP has demonstrated improvements in the QoC provided by VHWs following the introduction of a community package (cPQI), which includes appropriate refresher training in MNCH, use of cHMIS tools and job aids, and VHW peer-to-peer SS and minor procurements. In PY3, MCHIP will continue to support expansion of the cPQI package in Mutasa district, while also supporting the coverage of one component of the package (cHMIS) in two more districts in the province.

The activities related to each of the strategies discussed above are presented in the implementation matrix below.

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
<b>Activity 2.1: Institutionalize a quality improvement and quality assurance approach for MNCH in all seven districts of Manicaland province</b>							
2.1.1	<b>Integrated Quality of Care improvement for MNCH:</b> MCHIP will continue to support the rollout of integrated QI approaches for MNCH in Manicaland Province. In PY3, MCHIP will implement Module 3 of the SBM-R process and support recognition for HFs achieving 80% of the MNCH set standards.	Conduct trainings for district level QI support teams (QISTs; champions and DHE members). Train teams to conduct QI SS in order to lead and eventually take over support for implementation of QI approaches in the 36 sites.	X				Seven QISTs formed and trained in QI mentorship in all seven districts in Manicaland
		Support QI (SBM-R) external assessments for the 36 supported HFs	X				External QI assessments conducted at 36HFs
		Support introduction of SBM-R Module 3 in 36 HFs and dissemination of self-assessment findings	X				HFs institutionalizing QI process and results disseminated
		Support HF based self-assessments and verification assessments for final recognition			X		All HFs meeting 80% of set MNCH performance standards recognized
		Support MOHCC to carry out regular SS for MNCH QoC improvement and support HF based QISTs in all 36 SBM-R sites (including targeted SS to non performing sites)	X	X	X		Quarterly integrated MNCH QI SS visits conducted to each of the 36 SBM-R sites
		Support benchmarking/exchange visits between HFs	X	X	X		Three benchmarking visits conducted for selected HFs from the seven districts
		Support the MOHCC to establish a provincial RMNCH stakeholders' planning and coordination platform, and to host periodic review meetings	X	X	X		Two provincial RMNCH stakeholders meetings conducted
<b>Activity 2.2: Support MOHCC to scale up high impact interventions for reducing maternal and newborn morbidity and mortality</b>							
2.2.1	<b>Strengthen the provision of quality CEmONC services:</b> MCHIP intends to support the MOHCC in its strategic efforts to upgrade two outstanding secondary facilities to CEmONC status. In addition, MCHIP will promote the use of a standard checklist for safe surgery.	Support short-term secondments for operating theatre staff to MPH to strengthen skills for providing CEmONC services.		X	X		Two additional hospitals offering CEmONC services
		Support procurement of surgical sundries (i.e., instruments for caesarean section packs) to facilitate the delivery of CEmONC services		X	X		Minor procurements to support CEMONC establishment done
		Support development, printing, distribution and use of checklist for safe surgery	X	X			Checklist for safe surgery developed and in use

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
2.2.2	Modular training for HWs on selected MH topics focusing on labor and delivery	Support targeted OJT/on-site/in-house training for selected MH modules (e.g., management of emergencies (P/EE, PPH) AMTSL and use of the partograph) at selected HF	X	X	X		OJT/OST conducted on identified gaps in targeted HF
		Support orientation of HWs on use of the maternity booklets through nurses meetings. Document lessons learnt and support its refinement.	X	X	X		Maternity booklet correctly used by nurses province wide
2.2.3	Increase Essential Newborn Care (ENC)/ECEB coverage for newborns	Facilitate OJT on ECEB, partograph use and MNH SBM-R checklists in 20 targeted SBM-R sites in two selected districts	X	X			At least two staff at each of the 20 SBM-R sites trained in ECEB
2.2.4	Improve survival rates for newborns managed with HBB	OJT/on-site training on HBB in 20 SBM-R sites	X	X	X		At least two nurses trained on HBB at 20 SBM-R sites
		Procurement of 20 HBB models for remaining SBM-R sites	X				20 HBB models procured and distributed
		SS for HBB	X	X	X		Three SS visits conducted for all 36 MCHIP-supported sites
2.2.5	<b>Increase coverage of interventions for preterm deliveries and low birth weight newborns and increased survival rates for small babies:</b> MCHIP will support use of antenatal corticosteroids (ACS), KMC sites and practice, and introduction of ventilation support with bCPAP	Strengthen use of ACS in line with Essential Drugs List in Zimbabwe (EDLIZ) recommendations	X	X	X		ACS used at secondary level HF for preterm labor
		Introduce and conduct ECSB OJT and SS for the whole package	X	X	X		200 HCWs reached with ECSB OJT. Three SS visits conducted for all 36 MCHIP-supported sites.
		Include ECSB implementation at lower level HF during SS visits	X	X	X		ECSB practiced at all levels of care at MCHIP-supported facilities
		Document and monitor newborn care and outcomes post-discharge from KMC	X	X			Post-discharge outcomes documented and analyzed and results used for program improvement
		Introduce bCPAP at Mutare Provincial Hospital (MPH) and document experience and learning	X	X	X		bCPAP machine in use at MPH
2.2.6	Strengthen implementation of MPMA meetings at provincial, district and institutional level and facilitate	Support use of MPMA guidelines for HWs at facility level with emphasis on carrying out perinatal audits	X	X	X		HF carrying out perinatal audits

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
	execution of emergent recommendations	Support two districts (Makoni and Buhera) and provide technical assistance to Chipinge and use findings to update the districts' QI action plan		X			Two district level MPMAs supported and findings used to improve MNCH QI plans
		Support one provincial MPMA meeting financially and provide technical support for the other meetings	X				One quarterly provincial MPMA meeting supported financially and technically
<b>Activity 2.3: Support MOHCC to scale up high impact interventions for reducing childhood morbidity and mortality in Manicaland province.</b>							
2.3.1	Scale-up the implementation of Emergency Triaging, Assessment and Treatment Plus (ETAT+) in Manicaland province	Refine ETAT QI tools/processes to include updated information on pneumonia management	X	X			Refined and user friendly QI tools and processes available to support CH QI implementation
		Support provincial training and PTFU for 60 nurses and doctors in ETAT+	X				60 HCWs trained and followed up
		Support ETAT sites to re-organize CH services, improve client flow, and document experiences	X	X	X		CH services at ETAT sites re-organized and experiences documented
		Orient HCWs on how to use ETAT job aids/tools	X	X			HCWs from 15 facilities implementing ETAT oriented on the job aids
		Support provision and use of ETAT job aids at the 15 facilities implementing ETAT	X	X	X		ETAT job aids and stationery available at 15 ETAT implementation sites; HCWs utilizing ETAT job aids
		Facilitate minor procurement of equipment and sundries to support ETAT implementation (e.g., pulse oximeters, oxygen concentrator, etc.)	X	X			Sundries and equipment to support ETAT implementation procured
		Support selected HCWs to conduct mentorship visits to all the ETAT facilities	X	X	X		Each district referral facility receives at least one mentorship visit per quarter
		Support targeted OJT/on-site/in-house training for ETAT		X	X		OJT conducted on identified gaps in targeted HFs
		Support child death audits in 15 ETAT sites with documentation of experiences and learning		X	X		Child death audit meetings carried out in 15 ETAT sites and experiences documented
2.3.2	Support for IMNCI Training, PTFU and OJT of IMNCI concepts	Support IMNCI training for 20 facility-based supervisors	X				20 supervisors trained and followed up
		Support training for 40 HCWs from Mutare City	X				40 HCWs trained

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Health department					
		Refine IMNCI QI tools/processes to include updated information on pneumonia management	X				Refined and user-friendly QI tools and processes available to support CH QI implementation
		Support targeted OJT/on-site/in-house training on IMNCI concepts in facilities where gaps have been noted in the management of the sick child	X	X	X		OJT conducted on identified gaps in targeted HF's
2.3.3	Support for BFHI activities in Manicaland province	Support BFHI final assessments for two hospitals in Mutare and one in Chimanimani by MOHCC Nutrition department ( <i>See also Objective 1</i> )	X	X			MOHCC Nutrition department supported to conduct BFHI final assessments for three hospitals (two in Mutare and one in Chimanimani), if not done by the end of PY2
		Support whole site OJT for three hospitals in Makoni district		X			HWs at three facilities in Makoni district oriented in BFHI and implementing BFHI activities
		Support BFHI pre-assessment activities for three hospitals in Makoni ( <i>See also Objective 1</i> )			X		National MOHCC Nutrition department supported to conduct pre-assessment of three hospitals in Makoni
		Continue to provide SS to strengthen BFHI activities in certified facilities	X	X	X		Baby friendly practices maintained in BFHI certified hospitals
<b>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</b>							
2.4.1	Support the rollout of cHMIS job aids and other data collection tools in two more districts of Manicaland Province	Train 350 VHWS from two new targeted districts in cHMIS		X	X		350 VHWS from Makoni and Nyanga trained in HMIS
		Print seed copies for VHWS from communities with high malaria burden		X			Copies printed and distributed to 15 HF's in two districts
2.4.2	In collaboration with The Union, pilot a Community Childhood Tuberculosis (CTB) intervention in Mutasa District	Support provincial and district sensitization meetings	X				Sensitization meetings done
		Conduct TOT for CTB using training package developed by consultant contracted by The Union	X				20 HW trainers (Environmental Health Technicians [EHTs], Nurses, Health Information Officers [HIOs], lab scientists, pharmacists) trained
		Cascade training to HWs	X				60 HWs trained



	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Provide SS post-training as part of regular SS to VHWs	X	X	X		SS provided as part of regular SS to VHWs
2.4.3	Introduce cPQI (intense SS, minor procurements, cHMIS) in Mutasa district and strengthen peer-to-peer SS in Chimanimani district	Train 20 VHWs in Mutasa district on peer-to-peer SS		X			20 VHW peer supervisors trained on peer-to-peer SS and in receipt of <b>post-training follow-up</b>
		Orientation of HWs in Mutasa district to VHW peer-to-peer SS		X			At least one HW from Mutasa district supported; HF oriented to the VHW SS guidelines and tools
		Support refresher cluster meetings for 20 peer supervisors from Chimanimani District	X				Four meetings held
		SS of the VHW peer supervisors in Chimanimani	X				20 VHWs supported
		Network and benchmark: identify best practices for MNCH and arrange "look and learn" visits	X				Two "look and learn" visits conducted
		Minor procurements for 150 VHWs in Mutasa (i.e., weighing scales, timers, thermometers, stationary, rain coats, tennis shoes, umbrellas, solar lamps, etc.)	X				Procurements for 150 VHWs completed
2.4.4	Provide mop-up MCCM trainings to VHWs, SHMs, and nurse aides	Refresher MCCM training for 600 VHWs, 150 SHMs, and 150 nurse aides	X	X	X		600 VHWs, 150 nurse aides and 150 SHC trained in MCCM
<b>Activity 2.5 Reposition health information systems, mortality audits, and data for decision-making for improved local health systems performance</b>							
2.5.1	Support the rollout of Community HMIS in high malaria burden districts in Manicaland	Support the rollout of cHMIS registers targeting high malaria burden districts		X	X		150 VHWs trained in cHMIS in high malaria burden districts; cHMIS rolled out in high malaria burden districts
		Support onsite data verification (OSDV) and environmental compliance assessment (ECA) targeting selected VHWs in Manicaland	X				One OSDV and ECA conducted targeting VHWs in selected HF
2.5.2	Strengthen data generation, analysis, and utilisation at provincial, district, and health facility levels	Support the MOHCC to conduct quarterly OSDVs and ECAs	X	X	X		Four OSDV and ECAs conducted in selected HF
		Support the MOHCC to conduct regular integrated MNCH data quality self-assessments and use findings to improve program performance		X			One provincial Data Quality Self-Assessment (DQSA) conducted in Manicaland and results shared

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Support the Provincial Health Information Officer (PHIO)/District Health Information Officers (DHIOs) to develop minimum DHIS 2.0 dashboard package	X	X			Minimum package of indicators for DHIS 2.0 dashboards developed
2.5.3	Support PHE/DHEs to pilot electronic system for notification of maternal and perinatal deaths	Support quarterly provincial audit meetings	X	X	X		Three provincial audit meetings held
		Conduct monitoring visits to selected HFs where the eMPMA is piloted	X		X		Two monitoring visits conducted and findings shared
<b>Activity 2.6: Support routine immunization activities and the introduction of new vaccines in Manicaland province</b>							
2.6.1	Support PHEs and DHEs in EPI system strengthening activities (e.g., RED, IIP, SS, DQS) and strengthen HW capacity in the provision of quality immunization services	Support provincial EPI review meetings half yearly	X		X		TA provided for at least two EPI Review meetings
		Support mid-level management (MLM) SS and M&E module training for EPI supervisors (integrated into bi-annual EPI review meetings)	X		X		Two MLM modular trainings supported
		Support SS visits to under-performing districts	X	X	X		Support at least one SS visits per quarter
		Support one peer supervisory visit for supervisors		X			One peer review SS visit supported
		Support introduction of Immunization Calendar for 290 facilities	X				Immunization calendar available in all HFs in Manicaland
2.6.2	Provide technical and financial support to the seven districts for the African Vaccination Week (AVW) and other supplementary immunization activities (SIAs)	Provide technical support for the development of the Provincial AVW implementation plan	X				Provincial AVW implementation plan developed
		Support social mobilization for the 6 <sup>th</sup> AVW	X	X			Social mobilization activities for the AVW supported
2.6.3	Support onsite refresher training for cold chain technicians from Manicaland province	Support follow-up OJT for district cold chain technicians	X	X	X		At least four district cold chain technicians supported with OJT
2.6.4	Support activities towards the introduction of new vaccines	Provide technical support for development of IPV introduction and tOPV-bOPV “switch” provincial plan	X				Provincial tOPV-bOPV “switch” plan developed and ready for use
		Provide technical support for IPV and “switch” training for HWs at district level	X	X			IPV and OPV “switch” training supported province-wide
		Support social mobilization for IPV and “switch” from tOPV to bOPV		X			Social mobilization events supported for tOPV to bOPV “switch”

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Continue to provide TA to the rollout of MR and MSD in the province	X	X			MR and MSD rollout strengthened in Manicaland province

### Objective 3: Strengthen the capacity of CSOs to implement MNCH activities and manage USG funding

Objective 3: Life of Project Results	PY1 and PY2 Achievements	PY3 Expected Results
<ul style="list-style-type: none"> <li>• Number of local CSOs in Manicaland with the capacity to design, implement, and monitor community MNCH programs increased.</li> <li>• Increased number of target communities reached with MNCH information.</li> <li>• Number of target communities implementing activities to improve use of key MNCH services increased.</li> <li>• Community level support and household behaviors strengthened.</li> <li>• Community-level recognition of danger signs of illness and early care seeking improved.</li> <li>• Participation of pregnant women during the antenatal period (through women-to-women groups, grandmother/grandfather support) increased.</li> <li>• Number of birth plans increased and knowledge of maternal and newborn danger signs improved among families, including husbands, grandmothers/grandfathers, and women.</li> <li>• Exclusive breastfeeding (via mothers support groups model) improved.</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity of MCHIP team to support CSO engagement and facilitate community mobilization activities strengthened.</li> <li>• CSO selection and engagement process finalized.</li> <li>• Organizational and technical capacity assessments undertaken with chosen CSO and capacity development plans in place.</li> <li>• CSO Board and Senior Management Team (SMT) oriented on USG compliance requirements.</li> <li>• CSO strengthened their focus on RMNCH activities and inclusion of RMNCH components into their 2016-2020 Strategic Plan.</li> <li>• CSO trained in the Community Action Cycle (CAC) and Care Group Model (CG) and implementation of both interventions begun.</li> <li>• SBCC materials for CSO interventions developed and finalized.</li> </ul>	<ul style="list-style-type: none"> <li>• CSO Board and SMT with improved knowledge of USG compliance requirements.</li> <li>• CSO Board has improved knowledge of and actively supports expansion of the RMNCH agenda.</li> <li>• Specific, targeted technical capacity building efforts with CSO improve their depth of understanding and ability to effectively support community RMNCH activities</li> <li>• CSO effectively implementing community RMNCH interventions to improve community knowledge of RMNCH issues and community uptake of good RMNCH household practices and care seeking behaviors</li> <li>• Increased number of communities implementing activities to improve use of RMNCH services.</li> <li>• Improved CSO organizational policies that are documented, understood, accessible, and used by staff.</li> <li>• CSO successfully managing USG funds and using efficient, effective, and supportive financial management and operational systems.</li> <li>• CSO implementing costed strategic plan linked to resource mobilization plans.</li> <li>• CSO M&amp;E capacity strengthened to document and report on project learning, experience and data.</li> </ul>

## Strategy

Under Objective 3, the MCHIP/Zimbabwe AA team committed to engage with Civil Society Organizations (CSOs) and to work with them in direct partnership as a way to expand the reach and impact of the project's support to the MOHCC in Manicaland and to strengthen the capacity of 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 an effort to empower community-led organizations to respond effectively to the health needs of their communities.

CSO engagement is an important ingredient in the MCHIP/Zimbabwe AA's expansion of community MNCH work to the strategic district and communities of Mutasa to further complement the QoC improvement work at the facility level. Activities under this objective build on the foundation of community-based work that was built during MCHIP programming (2011-2013) and which the AA continues to support under Objective 2. Due to severe funding constraints leading to significant budget cuts in PY2, the project began 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 for in the overall project design. It is important to note that the overall project was designed with a \$15 million budget, and in reality the budget for the three-year MCHIP AA award totaled just over \$9M, so adjustments were made.

In PY1, MCHIP underwent capacity building activities for the team to be able to support CSO engagement and facilitate community mobilization activities. In PY1, MCHIP embarked on a CSO mapping, assessment and selection exercise that led to the engagement of a CSO, The Diocese of Mutare Community Care Project (DOMCCP) in PY2. MCHIP worked closely with DOMCCP to develop a scope of work centered on expanding specific community MNCH activities and complementing life of project results described under Objective 2. MCHIP also sought to build further synergies with what the CSO was already doing, taking into consideration their comparative advantages and what was best suited to complement other aspects of MCHIP's work. The project worked with DOMCCP to develop a workplan, budget and M&E plan before non-competitively awarding this partner a one-year subagreement contract.

The aim of the RMNCH project implemented through DOMCCP is to facilitate community engagement in a variety of activities aimed at improving community and household RMNCH knowledge, practice and care seeking behaviours, thus increasing utilization of quality RMNCH services; mobilizing communities to own and respond to issues affecting RMNCH in their localities; as well as working with community committees in the definition of quality and monitoring of MNCH services. In PY2, following the signing of the award agreement, the CSO SMT and RMNCH project staff received an orientation on USG rules, regulations, and compliance issues, as well as USAID requirements for reporting and financial management. The wider DOMCCP establishment, including the SMT, were also oriented on RMNCH issues in general and given an overview of the RMNCH project's scope of work. The project also provided technical assistance in the review of the CSO's Strategic Plan, thus enabling the inclusion and emphasis on RMNCH in the organization's 2016-2020 strategy. In PY3, MCHIP will further support activities to improve the DOMCCP Board's knowledge of USG compliance requirements and foster their awareness and support for the RMNCH agenda.

In PY2, MCHIP facilitated the process of self-administered organizational and technical capacity assessments and these revealed gaps in the DOMCCP capacity, which were then used to inform the crafting of a relevant and responsive Capacity Development Plan to inform PY2 and PY3 MCHIP activities towards meeting Objective 3. To initiate the technical capacity building process for DOMCCP, the project facilitated a series of CBT training activities in RMNCH, the Community Action Cycle (CAC), and the Care Group (CG) Model. Although funds granted to DOMCCP can only support their activities in Mutasa, a strategic decision was made to train and involve all of their technical staff, so that their ability to implement quality cRMNCH activities in all six of the districts they support in Manicaland is strengthened.

DOMCCP initiated implementation of the CAC and CG Model in Mutasa district in PY2 with MCHIP offering PTFU support during the initial rollout of community level trainings for the CG Model and during the "organize" phase of the CAC. DOMCCP's workplan has them focused on reaching mothers and fathers with critical RMNCH information and promoting dialogue and action through the "Lead Mother and Lead Father" community CG Model. DOMCCP will focus their efforts for PY3 in support of the improved functioning of CGs. Where CGs

already exist, they will be revitalized, revamped and members further trained and equipped. DOMCCP and MCHIP are also developing critical tools and job aids (e.g., counselling cards) for CGs and a Family Health Handbook for individual level household use. Since DOMCCP's activities are focused on improving mothers' knowledge of danger signs during and after pregnancy and on improving health seeking behavior, it is expected that these activities will address and reduce the "first delay." DOMCCP will also address critical issues of sexual- and gender-based violence and will integrate these topics into trainings within their cRMNCH work. In addition, in order to mobilize communities to own and respond to issues affecting RMNCH in their localities, DOMCCP will work to strengthen Health Center Committees and community groups through the application of the CAC, which empowers communities to organize, explore, plan and act together. With DOMCCP's reach in the community as well as the community's involvement in understanding and identifying expectations and needs, MCHIP thinks that health seeking behaviour will increase, leading to improved MNCH health outcomes in Mutasa and greater community-ownership and sustainability for the gains.

One of the pertinent technical capacity areas requiring strengthening is the effective engagement of men in health issues, and especially in RMNCH issues. DOMCCP's self-assessments highlighted the need for periodic updates on new programs and trends affecting RMNCH programming, such as New and Underutilised Vaccines Initiative (NUVI), the introduction of the new child health card, and new malaria treatment guidelines. In addition, the assessment revealed a number of M&E, documentation, and information management issues that will need to be strengthened. In PY3, MCHIP will continue to work closely with DOMCCP staff to build their technical and organizational capacity to successfully implement RMNCH activities.

In line with the other MCHIP objectives, much of the project team's support will be in the form of technical assistance and smaller, more informal OJT sessions, rather than large scale trainings. Given the budget constraints, MCHIP will maximize the expertise of its own staff to provide the organizational and technical capacity building directly. This support will include regular SS and mentoring activities, including strengthening RMNCH programming, community mobilization, engagement with stakeholders, project M&E, and project documentation and dissemination of learning and experiences. Capacity building efforts will also include a focus on systems, skills and knowledge to manage the sub-agreement, in accordance with USG rules and regulations. The level and type of support that MCHIP will provide in PY3 will be more on-going and informal than the trainings that took place in PY2 (including an orientation to cRMNCH and technical trainings on various aspects of cRMNCH) and will occur during periodic meetings with MCHIP's technical team, during monitoring visits, during review and input into their periodic reporting (both financial and programmatic), and during quarterly F&A compliance meetings. MCHIP staff will also be present for many of DOMCCP's community mobilization efforts in order to provide on-going technical and programmatic support. Harare-based office staff will provide "business development support" in terms of working together with DOMCCP to identify new funding opportunities. It is important to note that DOMCCP has engaged with a variety of non-USG donors in the past, and MCHIP's USAID funds are DOMCCP's first USG funds, the project is cognizant of the challenges and opportunities this presents and are working with DOMCCP to manage these funds appropriately and effectively.

The subaward with DOMCCP was initiated in August 2015 and will end in August 2016. Towards the end of the implementation period for the DOMCCP award, MCHIP will support appropriate evaluation exercises to assess the progress made in knowledge acquisition and changes in household practices in communities where DOMCCP has been engaged. MCHIP will also support DOMCCP to appropriately close out activities and finances according to USG funding guidelines.

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
<b>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</b>							
3.1.1	Orient the CSO's Board on the internal and external RMNCH agenda and USG funding compliance issues	Conduct sessions with Board members to introduce the context for RMNCH interventions, GOZ priorities, and a framework and overview of USG compliance requirements	X	X			<ul style="list-style-type: none"> <li>Board fully understands and actively supports CSO expansion of the RMNCH agenda</li> <li>Board members are champions of RMNCH within their networks</li> <li>Board is more knowledgeable of USG compliance requirements and adopts these as best practices for the CSO</li> </ul>
		Disseminate RMNCH SBCC and IEC materials to Board members	X	X			
<b>Activity 3.2 Strengthen the capacity of the CSO to effectively support the implementation of community RMNCH interventions</b>							
3.2.1	<p><b>Increased number of target communities reached with MNCH information and target communities that have implemented activities to improve use of key MNCH services:</b> This should lead to increased community level support and uptake of recommended RMNCH household behaviors as well as improved knowledge on recognition of danger signs of illness and early care seeking.</p> <p>Regular SS, mentoring and monitoring visits will be conducted with the following objectives:</p> <ul style="list-style-type: none"> <li>Provide technical support and monitoring of phases of the CAC in selected wards</li> <li>Participation in CAC core group meetings</li> <li>Strengthen linkages between care groups and VHWs</li> <li>Provide technical support and monitoring of care group activities</li> </ul>	Conduct regular CSO mentoring and structured learning visits; technical support based on identified gaps and monitoring of field activities	X	X	X		<ul style="list-style-type: none"> <li>CSO capacity in cRMNCH programming strengthened through regular SS and mentoring visits</li> <li>Community 'core groups' implementing <i>a least one</i> activity from their RMNCH community action plan</li> <li>CSO able to mobilize communities to engage women of child-bearing age, pregnant women, fathers, and post-partum women for improved RMNCH practices</li> </ul>
		Support CSO distribution of RMNCH materials in target communities	X	X			<ul style="list-style-type: none"> <li>2,000 Family Health Handbooks distributed to households in Mutasa district</li> <li>250 Family Health Counseling Cards distributed to lead mothers/fathers in Mutasa district</li> </ul>

	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		Support activities to provide periodic updates on new programs and trends in RMNCH (e.g., NUVI, the new child health card, new malaria treatment guidelines)	X	X	X		CSO well informed of current RMNCH programs and using that knowledge to inform their community programs
		Facilitate participation of CSO technical staff in training on how to effectively engage men in health issues, especially RMNCH issues	X				CSO trained and effectively engaging men to participate in cRMNCH programs
		Convene quarterly review meetings with CSO to promote accountability and support	X	X	X		Three quarterly review meetings conducted with the CSO
		Provide opportunities for greater exposure to key stakeholders in the RMNCH space	X	X	X		CSO participating at forums with other key stakeholders in the RMNCH space
3.2.2	<b>Support CSO to work with communities and health facility workers to improve the quality of RMNCH services at the health facility:</b> Provide technical support for implementation and documentation of Partnership Defined Quality (PDQ) process at one facility	Support workshop to train the CSO in the PDQ process	X				One three-day training for PDQ conducted for the CSO and MOHCC colleagues
		Provide technical support and monitoring of phases of the PDQ	X	X	X		QI teams composed of members from the community and HWs meeting regularly with a jointly developed action plan  HWs and communities working together for improved quality of MNCH services
<b>Activity 3.3 Strengthen the CSO's capacity to successfully manage USG funds using efficient, effective, and supportive financial management and operational systems and improved organisational policies</b>							
3.3.1	Provide support for organizational and financial management capacity improvement for DOMCCP	Ongoing support with periodic targeted orientation and skills trainings in organizational and financial administration issues	X	X	X		CSO organisational and financial administration capacity improved
		Conduct quarterly post-award compliance and support review activities (administrative and technical desk reviews and site visits)	X	X	X		Three quarterly compliance visits conducted
		Conduct bi-monthly F&A support meetings	X	X	X		At least four bi-monthly F&A support meetings conducted
		Support CSO SMT and Board in pursuing	X	X	X		At least two new funding opportunities for



	ACTIVITY	TASK	JANUARY-DECEMBER 2016				PERFORMANCE TARGET
			Q1	Q2	Q3	Q4	
		new funding opportunities for RMNCH programs					RMNCH pursued by CSO with MCHIP support (proposals submitted)
<b>Activity 3.4 Support the strengthening of the CSO's M&amp;E systems and capacity to document, report and share experiences and project learning</b>							
3.4.1	Support establishment and strengthening of CSO's M&E system	Support CSO to develop an improved M&E system, including M&E Guidelines	X	X			Improved M&E system in place
		Conduct semi-annual data verification visits at CSO	X		X		Two data verifications conducted for CSO
		Facilitate centralization of data management system and provision of capacity building on how to consolidate data from different projects into a global/organisational system	X	X			Data management system for CSO centralized and staff consolidating data from different projects into global system
3.4.2	Strengthen CSO's capacity to document and share project experiences and successes	Provide orientation for CSO on processes to facilitate adequate documentation of community social networks, community resources, community capacities and success stories across their projects	X	X			CSO adequately documenting project experiences and successes and sharing using appropriate modalities
		Facilitate strengthening of CSO's capacity to increase the visibility of their community work through optimising the management of their website, other social media, relevant stakeholders' forums for presentation and/or publication	X				

## MONITORING, EVALUATION, RESEARCH AND INNOVATION

In PY3, the project will continue to ensure that monitoring and evaluation (M&E) is core to project management, monitoring, problem-solving, and learning. Most of the project's routine monitoring data will continue to be generated from the existing national health information system so that no parallel systems for data collection are created.

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 and PY2, in PY3 the AA team will ensure that M&E activities are integral to 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 piloting and rolling out of the electronic MPMA system; supporting provincial- and district-level Health Information Officers (HIOs) to develop and use standard dashboards; supporting the MOHCC at the provincial and district level to conduct OSDVs and Environmental Compliance Monitoring and Mitigation (ECMM); producing quarterly reports for submission to USAID; producing quarterly feedback reports; building the capacity of DOMCCP in data management and reporting; and supporting the technical team to implement program learning activities as planned.

In PY1 and PY2, the project team was instrumental in the revision of the core set of HMIS indicators and we supported the strengthening of the quality of data generated by health facilities by conducting quarterly OSDVs and providing OJT. ECMM was elevated to a higher level when the quarterly visits conducted by the team inspired several health facilities to use financial resources available to them from other sources (such as RBF and the HTF) to strengthen their own waste management and drug management systems. The team also successfully advocated for the inclusion of the environmental compliance monitoring tools into the HTF routine SS tools. Finally, the team successfully conducted baseline assessments that have been critical in informing the project's priority interventions and activities.

In PY3, the team has revised the PMP to include updated targets and will continue to produce quarterly, semi-annual and annual reports for submission to USAID. We will also produce and share quarterly feedback reports with the district teams; develop and/or finalize learning activity plans, protocols, databases, reports, and manuscripts; conduct quarterly OSDV and ECMM in all seven districts of Manicaland and share reports with key stakeholders at the district, provincial, and national level; and support the establishment and strengthening of DOMCCP's M&E system and conduct one OSDV for DOMCCP. The project team will also provide technical support to the MOHCC in piloting and rolling out the electronic MPMA system.

Part of the current MCHIP program learning agenda focuses on consolidating documentation and ensuring the dissemination of findings and lessons learned from previous studies and past project implementation. Looking forward, the learning agenda includes a collaborative prospective study involving PMI, MCHIP and the MOHCC that carries further the knowledge gained from the cross-sectional study on malaria conducted in PY2 along the Zimbabwean-Mozambican border. The analysis from both the cross-sectional and prospective studies will be used to inform malaria programming, and discussions are currently underway with PMI to narrow the focus of the follow-on prospective study in order to commence work on that activity and complete it before the AA close out. In addition to the prospective malaria cross-border study, a landscape analysis of MIP will be carried out in order to understand the magnitude of the MIP problem and the extent to which the national MIP program is addressing the burden of MIP. The focus of a separate learning question will be the impact of ETAT+ in the management of severe childhood illnesses. This question will compare health outcomes in chosen sites before and after ETAT+ implementation, shedding light on challenges and areas that may need to be addressed to strengthen MCHIP's programming in Manicaland and ETAT+ implementation in other parts of the country. All such research will feature robust data analysis and use in decision-making.

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	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?
<b>Completion of MCHIP Program Learning Agenda</b>					
1.5.2	<b>CPQI study:</b> To assess the effectiveness of a performance and quality improvement approach for MNCH services provided by VHWs at community level.	John Mandisarisa, Edhina Chiwawa, Hillary Chiguvare	This was a before and after control study of the VHW performance.	Re-analyzing data and re-drafting manuscript. Local IRB exemption obtained; <b>JSI IRB panel deferred to local IRB.</b>	<ul style="list-style-type: none"> <li>Re-draft manuscript based on PPT presented in Ghana and new data analysis.</li> </ul>
1.5.2	<b>Zinc study:</b> To evaluate the case management practices of HWs in managing children under five years who presented with diarrhoea at HFs in Chimanimani district.	John Mandisarisa, Leocardia Mangwanya	This was a retrospective study using routine programmatic data from the registers.	Write up study as a success story and include in donor report. <b>No Home Office IRB approval needed as this was determined to be public health practice, not research.</b>	<ul style="list-style-type: none"> <li>Secondary analysis of data.</li> <li>Home Office Child Health team to support.</li> </ul>
1.5.2	<b>RED documentation:</b> To document the contribution of the RED approach in improving routine immunization coverage in Manicaland.	Adelaide Shearley, John Mandisarisa, Rose Kambarami	This used routine programmatic data from the registers.	Gather further findings to present at WHO/IST Exchange of Best Practices Meeting in Cape Town in January 2016. Write up as a success story.	<ul style="list-style-type: none"> <li>Home Office Immunization Technical Advisor to work with in-country team.</li> </ul>
1.5.2	<b>HBB post-training follow-up:</b> To compare the effectiveness of different strategies for improving knowledge and skills retention following HBB in-service training.	John Mandisarisa, Fishiwe Chiyaka	This was a cohort study with separate data collection from routine programmatic data.	Re-visit manuscript draft and presentation given at MCHIP End of Project Close-Out event. Local IRB obtained. <b>Since information will only be disseminated locally and used to improve the program, Home Office IRB approval not required.</b>	<ul style="list-style-type: none"> <li>Finalize the study report for dissemination in country.</li> </ul>

Activity Number	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?
<b>New Learning Agenda for the MCHIP/Zimbabwe Associate Award</b>					
1.5.3	<b>KMC baseline:</b> To assess hospital-based KMC service delivery in six secondary HFs in Manicaland province.	John Mandisarisa, Rose Kambarami	This is a descriptive, cross-sectional study.	Include in Routine Data Analysis exemption given by local IRB.	<ul style="list-style-type: none"> <li>Analysis and report writing.</li> </ul>
1.5.3	<b>Cost-benefit analysis of cold chain (ELMA project-funded):</b> What is the cost-benefit of using solar powered refrigerators as compared to gas/electricity refrigerators?	John Mandisarisa, Adelaide Shearley, Rose Kambarami	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.	Local IRB exemption obtained. US IRB exemption obtained. Data collection starts in Jan 2016.	<ul style="list-style-type: none"> <li>Analysis and report writing.</li> </ul>
1.5.3	<b>ETAT:</b> Are US sick children being managed according to the ETAT+ protocol by health providers? Does the implementation of ETAT Plus lead to improved child health outcomes?	John Mandisarisa, Frank Chikhata, Leocadia Mangwanya, Florence Rondoza, Rose Kambarami	Mixed quantitative and qualitative methods. The quantitative portion will focus on 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+.	Local and secondary IRB approval needed, still in planning stages. (Will be part of routine data analysis.)	<ul style="list-style-type: none"> <li>Protocol development.</li> <li>IRB submissions.</li> <li>Analysis and report writing.</li> </ul>
1.5.3	<b>Prospective malaria cross-border study (PMI funded):</b> Scope to be determined with guidance from PMI team in-country.	John Mandisarisa, Frank Chikhata, Rose Kambarami	<b>Proposed scope focuses on mortality by following up with children captured through ETAT with verbal autopsy in community (awaiting PMI MOP Team's response to MCHIP's proposal for this prospective study).</b>	Will seek both local and secondary IRB approval, still in planning stages.	<ul style="list-style-type: none"> <li>Protocol development.</li> <li>IRB approval.</li> <li>Data analysis and report writing.</li> </ul>
1.5.3	<b>Landscape situational analysis of MIP (PMI funded):</b> Control of malaria in pregnancy (MIP) was adopted as a national policy in 2004 for implementation in moderate to high-burden malaria transmission areas. The policy was a three-pronged approach that recommended IPTp with three doses of SP as	John Mandisarisa, Frank Chikhata, Rose Kambarami	Desk review and national cross-sectional analysis to inform MIP programming.	Will seek local and US-based IRB. Still in planning stages.	<ul style="list-style-type: none"> <li>Review of protocol and tools.</li> <li>Facilitation of US-based IRB approval.</li> </ul>

Activity Number	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?
	the drug of choice; distribution and promotion of use of LLINs during pregnancy; and early and effective diagnosis and treatment of clinical malaria. Coverage rates for these interventions, however, are not known. This situational analysis will identify areas where further programming support for MIP is needed.				
1.5.3	<b>Secondary analysis of routine MNCH data:</b> From the beginning, MCHIP has facilitated the development, piloting, and implementation of several MNCH data collection tools, processes and databases. Analysis of this routine data forms the basis of the program's ongoing implementation research and use of data for decision making and future program improvements. See Activity 1.5.4 for additional description of this secondary analysis of existing HMIS and program-generated data.	John Mandisarisa, Frank Chikhata	<ol style="list-style-type: none"> <li>1. ETAT (outcomes within the first 24-48 hours of admission)</li> <li>2. MNH outcomes</li> <li>3. Community health outcomes (service utilisation, coverage, programme dose)</li> <li>4. KMC</li> <li>5. Mutasa cPQI</li> </ol>	Will seek umbrella IRB exemption in Zimbabwe.	<ul style="list-style-type: none"> <li>• Review of documents/manuscripts produced.</li> </ul>
1.5.3	<b><u>Process documentation of introduction of bCPAP</u></b>	John Mandisarisa, Elizabeth Dangaiso, Rose Kambarami	Key informant interviews, focus groups. What are issues in terms of operationalizing it? (Process documentation, lessons learned and effect on outcomes.)	Will seek local and US-based IRB. Still in planning stages.	<ul style="list-style-type: none"> <li>• Review of protocol and tools.</li> <li>• Facilitation of US-based IRB approval.</li> </ul>

## INDICATOR MATRIX

Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
1. Facility-based maternal mortality ratio	Number of facility-based maternal deaths, divided by the total number of facility-based live births in MCHIP-supported sites, multiplied by 100,000.	HMIS, facility records	Quarterly	254/100,000 live births (data from 36 SBM-R supported HFs)	241/100,000 live births (data from 36 SBM-R supported HFs)	229/100,000 live births	216/100,000 live births	The project is in line to achieve the PY3 target.
					208/100,000 live births (data from 36 SBM-R supported sites in Manicaland)	124/100,000 live births		
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-supported sites, multiplied by 1,000.	HMIS, facility records	Quarterly	33/1,000 total births (data from 36 SBM-R supported HFs)	22/1,000 total births	20/1,000 total births	19/1,000 total births	MCHIP will continue to support implementation of interventions such as KMC in hopes of achieving this target.
					31/1,000 total births (data from 36 SBM-R supported sites in Manicaland)	28/1,000 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	Reduce baseline U5 mortality by 5%	18/1,000 live births	15/1,000 live births	The project has achieved the annual target

Indicator	Definition and Disaggregations	Data Source/Collect on Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date (JAN.-SEP. 2015)</i>		
				36 SBM-R supported HFs)	14.3/1,000 live births (data from 36 SBM-R supported sites) Number of deaths: 400	16/1,000 live births Number of deaths: 259		Since achieving the original PY3 target of 16.6 by the end of PY2, the project has adjusted the PY3 target down to 15 to further reduce newborn mortality.
<b>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</b>								
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, and training packages.	Final documents; program records	Annual	12 (over life of current program)	6 <sup>1</sup> (see complete list in footnote)	9 <sup>2</sup> (see complete list in footnote)	MR and MSD field guides IPV field guides CSS	MNCH pre-service curricula yet to be reviewed and Antenatal corticosteroid guidelines are still to be finalized.
					11 (183%) <sup>3</sup> (see complete list in footnote)	7		

<sup>1</sup> **Indicator #4 – Breakdown of PY1 Targets:** Policies: 1 (National RH Policy); Strategies: 3 (National Nutrition Strategy, National QA/QI strategy, and National HMIS strategy); Guidelines/Training packages: 2 (National MNH TOT training package, and PFPF/PPIUCD Training Package).

<sup>2</sup> **Indicator #4 – Breakdown of PY2 Targets:** 1) RMNCH Policy/Strategy reviewed; 2) QI policy and strategy finalized 3) VHW training manual (MCCM training package) reviewed; 4) VHW job aides finalized; 5) National Child Survival Strategy reviewed; 6) National IMNCHI policy and chart booklet updated; 7) MNCH Training curricula reviewed in line with CBT approach; 8) MNCH pre-service curricula reviewed; and 9) Antenatal corticosteroid guidelines updated.

<sup>3</sup> **Indicator #4 – Breakdown of PY1 Achievements:** 1) QA/QI strategy; 2) Nutrition Strategy; 3) IYCF policy; 4) Adaptation of Antenatal corticosteroids guidelines in progress; 5) Family planning training package; 6) BEMONC TOT trainers package; 7) Guidelines for Maternal and Perinatal Death Audits; 8) Maternal and Neonatal health record; 9) Rotavirus vaccine field guide; 10) IIP Field Guide; and 11) IMNCHI registers.

Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date (JAN.-SEP. 2015)</i>		
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 include studies, OR, baseline, midline, and endline assessments.	Final documents; program records	Annual	10 (over life of current program)	MICS, ZDHS, EPI cluster survey	4 <sup>4</sup> (see complete list in footnote)	Malaria Indicator Survey	Evaluation of the blended learning approach was postponed.
					2 <sup>5</sup>	3 <sup>6</sup>		
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)	ETAT: 30 (national)	ETAT: 30 CTB: 20	National level training in ETAT was held and supported by UNICEF. The rollout of the trainings has been postponed to PY3.
					84 HCWs	46 HCWs trained to train VHWs in MCCM		
<b>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 HFs and in the community to support national-level scale-up plans.</b>								

<sup>4</sup> Indicator #5 – Breakdown of PY2 Targets: 1) ZDHS; 2) Rotavirus PIE; 3) Evaluation of blended learning approach; and 4) Electronic death notification system piloted in Manicaland.

<sup>5</sup> Indicator #5 – Breakdown of PY1 Achievements: 1) MICS (further analysis for the final report began Oct. 2014); and 2) Baseline assessment for the AA.

<sup>6</sup> Indicator #5 – Breakdown of PY2 Achievements: 1) ZDHS; 2) Rotavirus PIE; and 3) Electronic death notification system piloted in Manicaland.



Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
7. Number and percent of people trained in MNCH	<i>Numerator:</i> Number of people (HWs, VHWs) trained in MNCH/AA training packages with MCHIP support. <i>Denominator:</i> Number of people (HWs, VHWs) eligible for training. Disaggregated by type of person trained/cadre, gender, and type of training.	Training information records/monitoring system	Quarterly	2,547	Total: 1,882 <sup>7</sup> (see breakdown in footnote)	Total: 2,940 <sup>8</sup> (see breakdown in footnote)	Total: 1,540 <sup>9</sup> (see breakdown in footnote)	National level training in ETAT was held and supported by UNICEF. The rollout of the trainings has been postponed by the MOHCC to PY3.
					Total: 2,973 <sup>10</sup> (see breakdown in footnote)	Total: 2,508		
8. Percentage of project-supported facilities applying the SBM-R process that are achieving at least 80% of clinical standards	<i>Numerator:</i> Number of MCHIP-supported HF's applying the SBM-R process that are achieving at least 80% of clinical standards. <i>Denominator:</i> Total number of facilities in 36 SBM-R supported HF's in the 7	Program records; supervision visit reports	Annual	MNH: 76% (13/17 HF's) CH: 43% (9/21 HF's) (From Mutare and	MNH: 60% (N=30) CH: 60% (N=30)	MNH: 60% (N=36) CH: 60% (N=35)	MNH: 60% achieving at least 80% of standards (N=36) CH: 60% achieving at least 80% of standards (N=35)	

<sup>7</sup> **Indicator #7 – Breakdown of PY1 Target:** BEmONC: 210; HBB: 42(OJT); IMNCI: 160; IYCF:60; BFHI: 120; IMAM:30; ETAT: 60; MCCM: 1200 VHWs, nurse aides and EHTs in total

<sup>8</sup> **Indicator #7 – Breakdown of PY2 Target:** 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 SHCs, 150 nurse aides and 20 supervisors; Induction workshop for CSO staff: 30; Community Action Cycle: 30

<sup>9</sup> **Indicator #7 – Breakdown of PY3 Target:** ETAT: 60 HCWs; CTB: 60 HCWs; IMNCI: 20 supervisors and 40 HCWs; IMAM: 30 HCWs; ECEB: 40 HCWs; HBB: 40 HCWs; MCCM: 600 VHWs; 150 nurse aides and 150 SHCs; cHMIS: 350 VHWs

<sup>10</sup> **Indicator #7 – Breakdown of PY1 Achievements:** Rotavirus introduction: 490; MCCM: 1464 VHWs; MCM: 196 nurse aides and 51 school health masters; IYCF: 30 HCWs IMNCI: 100 HCWs; BFHI: 171 clinical staff, 216 support staff and 30 decision makers; IIP: 142 HCWs; KMC: 83 HCWs

Indicator	Definition and Disaggregations	Data Source/Collecti on Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
	districts.			Chimanimani districts)	MNH: 8% of 36 HF's achieving at least 60% of MNH Standards (Labour and Delivery)	MNH: 8/36 HF's achieving at least 80% CH: 15/35 HF's achieving at least 80% Immunisation: 18/35 HF's achieving at least 80%		
9. Percentage of pregnant women receiving at least 4 visits for reasons related to pregnancy	<i>Numerator:</i> Number of pregnant women receiving at 4 pregnancy-related visit in 36 SBM-R supported HF's in the seven districts <i>Denominator:</i> Total number of expected annual pregnancies for in 36 SBM-R supported HF's in the seven districts.	Program records; census data; service statistics	Quarterly	69% (data from 7 districts of Manicaland)	75%	80%	85%	The data on the expected number of pregnancies for PY3 was based on projected 2012 census figures and extrapolated to cover 36 HF's. The PY3 denominator was adjusted to reflect the partial year.
					22,204/22,998 = 97% (absolute number from 36 SBM-R supported HF's)	14,355/17,249 = 83% (absolute number from 36 SBM-R supported HF's)		
10. Number and percentage of pregnant women receiving intermittent preventive treatment for malaria	<i>Numerator:</i> Number of pregnant women at risk for malaria receiving at least 3 doses of SP to prevent	Program records; census data; service statistics	Quarterly	34% (data from 36 SBM-R supported	40%	40%	45%	

Indicator	Definition and Disaggregations	Data Source/Collect on Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date</i> (JAN.-SEP. 2015)		
	malaria during ANC visits in 36 SBM-R supported HFs in the seven districts. <i>Denominator:</i> Total number of pregnant women receiving first ANC visit in 36 SBM-R supported HFs in the seven districts.			HFs)	4,086/11,696 = 34.9% <i>(data from 26 SBM-R supported HFs in 5 malaria districts of Manicaland)</i>	4,738/12,252 = 38.7% <i>(data from 36 SBM-R supported HFs in 5 malaria districts of Manicaland)</i>		
11. Number of deliveries with a skilled birth attendant (SBA)	Number of deliveries with a SBA in MCHIP-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 36 SBM-R supported HFs) (Jan – Dec 2013)	27,766 (36 SBM-R supported HFs)	20,000 (36 SBM-R supported HFs)	24,000 (36 SBM-R supported HFs)	The project has surpassed the annual target of 20,000.
					29,853 <i>(data from 36 SBM-R supported HFs in 7 districts of Manicaland)</i>	22,159 <i>(data from 36 SBM-R supported HFs in 7 districts)</i>		
12. Percentage of women receiving a uterotonic during the third stage of labor immediately after birth	<i>Numerator:</i> Number of women giving birth who received a uterotonic during the third stage of labor in MCHIP facilities applying SBM-R. <i>Denominator:</i> total number of women giving vaginal birth in supported HFs applying SBM-R.	HMIS/service statistics	Quarterly	93.4% (SBM-R supported HF)	90%	95% (36 SBM-R supported HFs)	98% (36 SBM-R supported HFs)	The project has surpassed the annual target of 95% and every effort will be made to sustain this.
					21,049/22,564 = 93.3% <i>(data from 36 SBM-R supported HFs in 7 districts of Manicaland)</i>	21,615/22,159 = 97.5% <i>(data from 36 SBM-R supported HFs in 7 districts of Manicaland)</i>		

Indicator	Definition and Disaggregations	Data Source/Collect on Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
					(Apr-Dec 2014)			
13. Percentage of children less than 12 months of age who received DPT3/Penta 3 vaccination	<i>Numerator:</i> Number of children less than 12 months who received DPT3/Penta 3 in a given year in MCHIP-supported districts. <i>Denominator:</i> Number of children less than 12 months in MCHIP-supported districts. Disaggregated by gender.	HMIS/service statistics	Quarterly	94% (data from 7 districts in Manicaland)	95% (7 districts in Manicaland)	Manicaland: 98% Mat North: 95% Mat South: 95%	98% (7 districts in Manicaland)	The denominators are based on 2012 census projected figures. Achievements for PY2 are based on partial year reporting and will be updated in the PY2 Annual Report.
					53,673/54,984 = 97.6% (data from 7 districts in Manicaland)	Manicaland: 39,204/42,183 = 92.9% Mat North: 15,839/17,235 = 91.9% Mat South: 13,283/15,141 = 87.7%		
14. Percentage of children less than 12 months of age who received PCV 3 vaccination	<i>Numerator:</i> Number of children less than 12 months who received PCV 3 in a given year in MCHIP-supported districts. <i>Denominator:</i> Number of children less than 12 months in MCHIP-supported districts. Disaggregated by gender.	HMIS/service statistics	Quarterly	83% (data from 7 districts in Manicaland)	95% (7 districts in Manicaland)	Manicaland: 98% Mat North: 95% Mat South: 95%	98% (7 districts in Manicaland)	The denominators are based on 2012 census projected figures. Achievements for PY2 are based on partial year reporting and will be updated in the PY2 Annual Report.
					53,657/54,984 = 97.6% (data from 7 districts in Manicaland)	Manicaland: 39,159/42,183 = 92.8% Mat North: 15,988/17,235 = 92.8% Mat South: 12,647/15,141 = 83.5%		

Indicator	Definition and Disaggregations	Data Source/Collect on Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
15. Percentage of children less than 12 months of age who received rotavirus (second dose) vaccination	<i>Numerator:</i> Number of children less than 12 months who received rotavirus (second dose) vaccination in a given year in MCHIP-supported districts. <i>Denominator:</i> Number of children less than 12 months in MCHIP-supported districts.	HMIS/service statistics	Quarterly	0%	70% (7 districts in Manicaland)	Manicaland: 80% Mat North: 90% Mat South: 90%	98% (7 districts in Manicaland)	The denominators are based on 2012 census projected figures. Achievements for PY2 are based on partial year reporting and will be updated in the PY2 Annual Report.
					24,917/27,492 = 90.6% (data from 7 districts in Manicaland)	<i>Manicaland:</i> 38,127/42,183 = 90.3% <i>Mat North:</i> 15,051/17,235 = 87.3% <i>Mat South:</i> 12,880/15,141 = 85.1%		
16. Percentage of children less than 12 months of age who received measles vaccination	<i>Numerator:</i> Number of children less than 12 months who received measles vaccination in a given year in MCHIP-supported districts. <i>Denominator:</i> Number of children less than 12 months in MCHIP-supported districts. Disaggregated by gender.	HMIS/service statistics	Quarterly	94% (data from the 7 districts in Manicaland)	95% (7 districts in Manicaland)	Manicaland: 98% Mat North: 98% Mat South: 98%	98% (7 districts in Manicaland)	The denominators are based on 2012 census projected figures. Achievements for PY2 are based on partial year reporting and will be updated in the PY2 Annual Report.
					54,725/54,984=99.5% (data from 7 districts in Manicaland)	<i>Manicaland:</i> 39,335/42,183 = 93.2% <i>Mat North:</i> 15,344/17,235 = 89% <i>Mat South:</i> 12,899/15,141 = 85.2%		
17. Number of cases of child diarrhea treated with ORT and zinc	Number of cases of child diarrhea treated in MCHIP-supported districts with ORT and zinc supplements.	HMIS/service statistics or program records	Quarterly	16,448 (extrapolated data from 36 SBM-R)	15,626 (36 SBM-R supported HF)	14,803 (36 SBM-R supported HF)	14,803 (36 SBM-R supported HF)	"Cases of child diarrhea treated with ORT and zinc" means cases "with

Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date (JAN.-SEP. 2015)</i>		
	<i>Proxy indicator:</i> Number of cases of diarrhea reported on T5.			supported HF's)	14,610 <i>(data from 36 SBM-R supported sites in 7 districts)</i>	9,260 <i>(data from 36 SBM-R supported sites in 7 districts)</i>		dehydration" plus cases with "no dehydration" on the T5 form.
18. Number of confirmed cases of malaria in children U5 treated at HF's	Number of confirmed cases of malaria in children < 5 years treated at HF's.	HMIS/service statistics	Quarterly	6,446 (data from 36 SBM-R supported HF's)	9,000 (36 SBM-R supported HF's)	10,000 (36 SBM-R supported HF's)	10,000 (36 SBM-R supported HF's)	"Confirmed cases of malaria treated" refers to positive cases of malaria on the T5 form. <b>Malaria cases for the season have remained consistently lower than the previous season.</b>
				8,580 <i>(data from 36 SBM-R supported sites in 7 districts)</i>	2,566 <i>(data from 36 SBM-R supported sites in 7 districts)</i>			
19. Number of cases of child pneumonia treated with antibiotics by trained HW's	Number of cases of child pneumonia treated with antibiotics by trained HW's in 36 SBM-R supported HF's in the seven districts. <i>Proxy indicator:</i> 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 the 36 SBM-R supported HF's) (Jan.–Dec. 2013)	27,910 (36 SBM-R supported HF's)	26,441 (36 SBM-R supported HF's)	26,441 (36 SBM-R supported HF's)	"Cases treated" means "moderate (pneumonia)" plus "severe (pneumonia)" on the T5 form.
					24,078 <i>(data from 36 SBM-R supported sites in seven districts)</i>	16,306 <i>(data from 36 SBM-R supported sites in seven districts)</i>		
20. Number of sick children U5 referred to health facility by VHW's for	Number of cases in children < 5 detected and referred to health facility	HMIS/service statistics or population-	Quarterly	0 New indicator started to be	1,000	2,000	3,000	

Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date</i> (JAN.-SEP. 2015)		
further management	by VHWs in Chimanimani.	based survey (numerator)		tracked in 2014	1,668 <i>(data from SBM-R supported HFs)</i>	2,195 <i>(data from SBM-R supported HFs)</i>		
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-supported VHWs in MCHIP-supported sites.	HMIS/service statistics	Quarterly	1,477 (Data from 16 SBM-R supported HFs) (as of Nov. 2013)	1,500	1,800	2,000	The project will strengthen community health interventions in order to achieve the annual target.
					897 <i>(data from SBM-R supported HFs)</i>	976 <i>(data from SBM-R supported HFs)</i>		
22. Percentage of babies not breathing/crying at birth who were successfully resuscitated	<i>Numerator:</i> Number of babies successfully resuscitated from SBM-R supported facilities. <i>Denominator:</i> Number of babies not crying/breathing at birth from 30 SBM-R supported facilities.	Program records	Quarterly	91%	95%	98% (from 36 SBM-R HFs)	98% (from 36 SBM-R HFs)	The project will continue to strengthen the implementation of HBB.
					1,211/1,366 = 88.7% <i>(data from 36 SBM-R supported sites)</i> <i>(Apr-Dec 2014)</i>	1,015/1,221 = 83% <i>(data from 36 SBM-R supported sites)</i>		
23. Number of KMC units established	Number of KMC units established in MCHIP-supported districts.	Program records	Annual	8	14	6	0	The project realized that the demand for KMC services outweighed the targeted number of 6. Hence, the

Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					PY1 Achievements	PY2 Achievements to date (JAN.-SEP. 2015)		
					0	21		procurement of KMC supplies targeted all the district hospitals and most high volume sites. There are no plans to establish more KMC sites.
24. Percentage of LBW babies initiated on KMC	<i>Numerator:</i> Number of LBW babies provided KMC from SBM-R supported facilities <i>Denominator:</i> 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%	40% (from 36 SBM-R HFs)	50% (from 36 SBM-R HFs)	MCHIP will support the MOHCC to sustain this target.
					$692/1,949 = 35.5\%$ (data from 36 SBM-R supported HFs) (Apr-Dec 2014)	$921/1,952 = 47.2\%$ (data from 36 SBM-R supported HFs)		
<b>Objective 3: Strengthen the capacity of Civil Society Organizations to implement MNCH activities</b>								
25. Number of CSOs receiving funds from MCHIP to implement MNCH activities	Number of CSOs receiving funds from MCHIP to implement MNCH activities.	Internal CSO and MCHIP management system	Annual	0	0	1	1	
					0	1		
26. Number of CSOs receiving funds from MCHIP to implement MNCH activities	Number of CSOs receiving funds from MCHIP to implement MNCH activities.	Internal CSO and MCHIP management system	Annual	0	0	1	1	
					0	1		



Indicator	Definition and Disaggregations	Data Source/Collection Method	Frequency of Data Collection	Baseline as of December 2013	Targets and Achievements			Notes
					PY1 Target (JAN.-DEC. 2014)	PY2 Target (JAN.-DEC. 2015)	PY3 Target (JAN.-DEC. 2016)	
					<i>PY1 Achievements</i>	<i>PY2 Achievements to date (JAN.-SEP. 2015)</i>		
27. Number of CSOs with improved management and implementation of MNCH activities	Number of CSOs with improvement over baseline in management and implementation of MNCH activities.	CSO organizational capacity assessments (in technical MNCH areas)	Annual	0	0	1	1	This indicator will be tracked beginning in PY3.
					0	0		

## MANAGEMENT AND STAFFING

### Management structure

As the MCHIP country lead for the Zimbabwe AA, JSI leads the program's work in child health, immunization, M&E and CSO capacity building; manages project offices in Harare and Manicaland; administers all local activity costs; and provides three of the four key personnel positions on the AA team (Country Director [CD], Deputy Country Director [DCD], and Finance and Administration [F&A] Manager), as well as the program's Director of Innovations, Research and M&E, the Senior Immunization Advisor, a Child Health Technical Officer and the Provincial Team Leader, among others. Jhpiego is the MCHIP agreement's Prime for formal correspondence and official notifications and its technical lead for maternal health and quality improvement. Jhpiego provides the program's other key position--the Technical Director/Maternal Health Advisor who leads the project's QI initiatives, advances its maternal health agenda, and technically supports the advancement of its learning agenda--and the Clinical Training Officer who works across all technical areas. The third AA partner, Save the Children, continues to provide technical guidance in the areas of newborn health and community mobilization, and seconds three technical team members: the Newborn Health Technical Officer, the Communications/BCC Officer and the Manicaland-based Community Health Officer. All consortium partners contribute to community-level and malaria activities and are actively involved in project design, implementation of integrated programming, learning, and project reporting and monitoring.

The MCHIP Country Director, Deputy Country Director, Finance and Administration Manager, Technical Director and the Director of Innovations, Research and M&E comprise the project's senior management team (SMT). Together they provide consistent managerial support and oversight to all levels of the country team; direct program activities; manage relationships with the MOHCC and other partners; ensure that systems are in place to foster a productive and empowering environment; closely monitor implementation and spending against approved plans, and take corrective action if performance and/or spending are not as expected; with the headquarters team, "set the tone" for the project and ensure that it is linked to global technical priorities and initiatives; and oversee all field-based human resource functions, including recruitment, staff capacity development, and performance appraisals.

### Staffing

The MCHIP/Zimbabwe AA has a highly qualified and experienced team in place to manage this complex project and maximize the use of local expertise and high-level technical support. All staff positions, with the exception of 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). The current ELMA grant ends February 29<sup>th</sup>, 2016. Although efforts are underway to secure additional ELMA funding, for the purposes of this workplan it should be assumed that all MCHIP staff that support the ELMA project and thereby charge time to ELMA will revert back to spending 100 percent LOE on MCHIP as of March 1, 2016. The salaries of the Technical Director and Clinical Trainer/Coordinator will also be shared minimally with Jhpiego's UNFPA-funded FP/PPIUD project. These cost shares are all reflected in the budget for PY3.

There are currently two key staff positions that are vacant--the F&A Manager and the Technical Director/Maternal Health Advisor. The F&A Manager left the project in August 2015; since that time, his financial, administrative, and operational responsibilities have been shared by the DCD and the remaining F&A staff, which has ensured continued smooth operations of the project. For cost savings and staff development reasons, JSI will formally propose to split the key position into two mid-level, non-key positions--one for a Senior Finance Manager and the other a Senior Administrator--and to promote two mid-level staff members into these new positions. To make this possible, F&A oversight functions will be formally added to the Deputy Country Director's job description. MCSP will submit a formal request to the Agreement Officer to make this change to the project's Key Personnel positions after review of this workplan with the USAID AOR and Activity Manager.

The other vacant key position is that of the Technical Director/Maternal Health Advisor. This position was recently vacated and recruitment is on-going. The Director of Innovations, Research and M&E is acting in the

Technical Director role in the interim. With only one year left in the AA, it is proving difficult to attract a strong candidate for this important role. MCHIP will keep USAID informed about progress on the recruitment. We also look forward to official notification from USAID that the program will continue after December 2016 as a longer timeframe would make the position more attractive to strong candidates who are reluctant to leave their current positions for a one-year contract.

Finally, in recognition of the project's increasing role as a high quality technical assistance provider instead of a direct implementer, we are re-evaluating the current staffing pattern to ensure that the project is able to provide the highest levels of technical support possible. In this vein, in PY2, we had hoped to hire two important positions--a Child Health Advisor and a CSO Capacity Building Coordinator--but In spite of finding excellent candidates for both jobs, we were not able to hire for either of them due to funding constraints. In PY3, the project has again budgeted for a Child Health Advisor to ensure that critical CH activities, including the delayed ETAT introduction, will have a senior staff member assigned who has the ability to move them forward at national and provincial level. Again, although we will begin recruitment for the Child Health Advisor as soon as this workplan is approved, until we can guarantee candidates a timeframe of more than 12 months, we anticipate that it will be difficult to fill this role. (The CSO position will be revisited if the scope of work for the MCHIP continuation increases the role of CSO partners, as we hope it will.)