United States Agency for International Development
Bureau for Global Health
Office of Health, Infectious Disease, and Nutrition
USAID/GH/HIDN

Guidance for
Detailed Implementation Plans (DIPs)
For Child Survival and Health Grants
FY 2008

Child Survival and Health Grants Program

Revised October 2007

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I. INTRODUCTION/PURPOSE

The Detailed Implementation Plan (DIP) is an important tool for USAID and partners. It will be used by the CSHGP team to monitor progress in program implementation. It will serve as the working document for the grantee's field project staff, guiding day-to-day implementation and achievement of stated targets and results. **Grantees are committed to fulfill the approved DIP.**

The guidance provided in this document serves to assist those grantees awarded cooperative agreements as a result of the FY 2007 Child Survival and Health Grants Program RFA, in drafting DIPs. The due date for the final DIP is **April 11, 2008.** Grantees will receive written feedback on their DIP on or before May 23, 2008. Feedback will be discussed at the Child Survival and Health Grants Program's Mini-University during the week of June 2—6, 2008. At the Mini-University, the CSHGP will approve the DIP or request the grantee to make specific revisions before formal approval is granted.

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

At the time of the DIP submission, a grantee may request to change the selection of interventions and implementation strategies from what was proposed in the original Cooperative Agreement, only with a clear and sufficient justification for the changes. Grantees considering a major change in the Project Objectives and Indicators, Intervention Mix (including LOE), Specific Activities, Location of Project, Project Population, Local Partner, and Budget should first consult with the Cognizant Technical Officer (CTO) before submitting a request for a change in the DIP. All CTO assignments are noted on Country Reports, which are available at www.childsurvival.com.

Any further changes in the program description after the DIP has been approved, including changes to the Project Objectives and Indicators, Intervention Mix (including LOE), Specific Activities, Location of Project, Project Population, Local Partner, and Budget, must be proposed to and approved by the CTO and the USAID Agreement Officer prior to implementing the changes.

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

What's New in the DIP Guidelines?

- Intervention-specific section has been rolled into Program Description
- Removed full behavior change strategy
- Removed summary of baseline assessments from the official document (moved to annexes)
- Removed Description of DIP Preparation process from official documents (moved to annexes)
- Overall streamlining and simplification

II. DIP PREPARATION AND REVIEW PROCESS

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

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

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

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

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

DIP Review Process

Grantees will participate in a face-to-face DIP review process as part of an integrated technical workshop or "Child Survival and Health Mini-University." The Mini University provides technical updates as well as exposure to other CSHGP grantees and their partners. The Mini-University event is **tentatively set for June 2 - 6, 2008** and is usually scheduled to follow the annual Global Health Council meeting (planned for May 27 - 30, 2008 in Washington, DC).

In preparation for the Mini-University and DIP review, grantees are required to submit their final **DIP to USAID by April 11, 2008.** The DIP will be reviewed by the CSHGP team and technical

experts who will provide comments and feedback to DIP writers the week before the Mini-University.

Topic areas for the Mini-University sessions are identified based on an analysis of the interventions and strategies included in the FY 2008 funded applications. Grantees may also suggest additional relevant technical areas of interest to be addressed by sending ideas to csts@orcmacro.com, with the title "Mini-University Suggestions". Technical updates, presentations and agendas from past Mini-Universities are available at http://www.childsurvival.com/documents/workshops_1.cfm.

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

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

Grantees who are preparing a DIP for 2008 will be expected to participate in the following activities at the Mini-University:

- Presentation of their Detailed Implementation Plan at the DIP review meetings. These meetings are attended by CSHGP staff, individuals who have reviewed the grantee's DIP, and others who are interested in learning more about the project. Guidelines for preparing these presentations are included in ATTACHMENT A of this document. Grantees will be contacted in April 2007 by a representative from the CSTS+ project to schedule the specific day on which the DIP review meeting will occur during the Mini-University event.

- Peer review of one other DIP in this cohort of grantees. This responsibility will include review of the assigned DIP during the month of May, submission of written comments by May 23, and participation in the corresponding DIP presentation at the Mini-University. Peer reviewers are matched with DIPs for programs that have similar interventions or will be operating in similar countries/regions, and believe that the peer review process is often the first step in building long-term, in-country collaborative relationships between grantees.

- In some cases, grantees may be asked to participate in a panel discussion on a specific topic or cross cutting theme related to their grant or to their organization's experience in a specific area. Panel topics are normally confirmed in mid-April. Grantees will be contacted by a CSTS+ representative in early May 2008 if they will be requested to contribute to a panel discussion.

Grantees are strongly encouraged to send at least one headquarters staff member (i.e., the HQ Technical Backstop), the field-based project manager, and a local partner, to the extent that this is feasible, to the Mini-University for the full five days of the event. If a grantee has not budgeted for this level of participation, budget realignment may be necessary and will be supported by the CSHGP CTO. All sessions will be conducted in English, so grantees should take this into consideration when selecting their team. Please register grantee participants by April 18th at www.childsurvival.com.

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

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

III. SUBMISSION INSTRUCTIONS

1. Submission of Drafts of Critical DIP Components to CSTS+ for feedback before the DIP due date

CSTS+ staff will be assigned to check in with the HQ backstop of each DIP writing organization. DIP writers are strongly encouraged to consult with CSTS+ on the design of baseline surveys. In addition, it is strongly recommended that DIP writers consult CSTS+ to obtain input, refine, and effectively present the following information to facilitate DIP approval: Preliminary results from baseline surveys; the project Results Framework, Objectives, Targets, and Strategies; and Workplan. The timeline for reviews of these critical pieces can be negotiated with CSTS+. **Please note that grantees may consult with CSTS+ at any time about any DIP component.**

2. General formatting instructions

On the DIP cover page, please include the following: name of grantee, project location (country and district), cooperative agreement number, project beginning and ending dates, date of DIP submission, and (on the cover or on the next page) the names (including consultants) and positions of all those involved in writing and editing the DIP.

Include in the attachments of the DIP other relevant aspects of the project that may not be covered in the DIP Guidance. Please include enough detail so that the intervention is clear. This will enable reviewers to provide meaningful feedback. Keep in mind that reviewers of the DIP will not have read the original project application; therefore, the DIP should be considered as a stand-alone document for this DIP review process.

Limit annexes to those that are essential to understand the program (See Section V). All annexes should be in English or accompanied with a translation. One annex should include a copy of the jointly developed and signed agreements, which clearly delineate the roles and responsibilities of each partner.

Use a 12-point font that is clearly legible.

3. Submit a Final DIP to GH/HIDN/CSHGP, CSTS+ and the USAID Mission on or before April 11, 2008

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

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

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

Failure to submit a DIP on time to USAID could result in a material failure, as described in 22 CFR 226.61. If there are circumstances beyond the grantee's control that have had an impact on the ability to complete the DIP on time, please contact the CSHGP Technical Advisor or CTO (identified on Country Reports on www.childsurvival.com).

Address DIP to—

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

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

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

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

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

In accordance with the USAID AUTOMATED DIRECTIVES SYSTEM (ADS) 540.5.2, grantees are required to submit one electronic copy of the Final Approved DIP to the USAID/PPC/CDIE Development Experience Clearinghouse (DEC) within one month of final approval by the CTO. Not only is this a USAID requirement, but it also aides stakeholders in accessing important project documentation. Please include the Cooperative Agreement number on the electronic DIP submission. Electronic documents can be sent as e-mail attachments to docsubmit@dec.cdie.org. Grantees must copy the CTO on the email submission. For complete information on submitting documents to the DEC, see http://www.dec.org/submit.

IV. DIP GUIDANCE

The following sections should be included in the DIP.

A. Executive Summary

The Executive Summary from each DIP is used by GH/HIDN as an informational document for decision-makers, Congress, public inquiries, the press and others. Therefore, this section should contain the information that the grantee believes best represents its program. The executive summary is limited to two pages and should briefly include all the following:

- Program location, including name(s) of district(s).
- Problem statement.
- Estimated project population, broken down by children under five and women of reproductive age. Disaggregate children under five in the following categories: under 12 months, 12-23 months, 24-59 months. Please see Attachment J for guidance in reporting the project population. For TB, estimate the population that will be covered by DOTS and the estimated number of TB cases in the area.
- Program goals, objectives/results and major strategies.
- A break down of the estimated level of effort devoted to each intervention using the list of interventions in Section I of the FY 2007 RFA. (e.g., immunization – 30%, control of diarrhea disease – 45% and pneumonia case management – 25%.) This list is also included in ATTACHMENT C.
- Indicate any proposed Operations Research for the project. Include partners, budget, and timeframe for the research.
- Local partners involved in program implementation, including roles and responsibilities.
- The category of the original CSHGP application (entry, standard, or TB).
- The start and end dates.
- The level of funding.
- Name and position of the local USAID Mission representative with whom the program has been thoroughly discussed.
- Main writers of the document.
- Contact person at grantee organization's headquarters for the program.

B. CSHGP Data Form

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

It includes key contact information for the project; a project description, including a description of the project area; information on key project partners and subgrantees; information on key project strategies and activities within each intervention area; information on project beneficiaries; and the template for reporting on the Rapid CATCH indicators with standard definitions.

The form can be found at http://www.childsurvival.com/projects/dipform/login.cfm. A password has been assigned to each grantee in order to access and enter project information (and can be used to access all child survival projects for a given organization). To obtain a password, please contact the CSTS+ Project directly at (301) 572-0823, or send an email to csts@macrointernational.com. Detailed information on completing the form is available through individual 'Help File' links.

Include a copy of this form in the DIP, after the Executive Summary.

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

TB Programs should refer to ATTACHMENT D for guidance on indicator selection. Note: Rapid CATCH indicators do not apply to grants awarded under the TB Category.

C. Revisions (from the original application)

Describe the changes made in the DIP from the proposed application, if applicable. The Detailed Implementation Plan should be in line with what was proposed in the application. If there are changes in the program description (including goals and objectives), site, additions or deletions of child survival or health interventions, please state these changes and describe the rationale for any changes between the corresponding sections in the Cooperative Agreement and those discussed in the DIP. Include in the discussion any responses to proposal review comments and, if applicable, final evaluation recommendations (may cross-reference to annex).

D. Budget

Submit the final budget on Forms 424 and 424A as well as a full, detailed budget. Include a supporting narrative explaining the costs in each category.

E. Detailed Implementation Plan

The Detailed Implementation Plan document should be comprehensive enough to allow the reviewer to have a strong understanding of the program context. The DIP document is a

valuable tool that will aid in project decision-making and will be referred to during critical milestones in projects by the CSHGP team, other USAID stakeholders, as well as the project management team.

If a topic in the DIP Guidelines does not apply to the program, please indicate this. If the program has not yet obtained sufficient information to fully describe an element, then describe plans to obtain this information. Based on the original proposal and a more in-depth analysis/assessment of the health situation at the project site, the DIP should include the following information:

1. Program Site Information

This information expands on that provided in the application.

a. Please include in an annex, a legible map showing the location of the program impact area(s) relative to other regions of the country, and the program area itself. To the extent possible, label towns, existing hospitals, health centers, clinics, and/or health posts.

b. State the estimated total population living in the geographical area covered by the project and provide a breakdown by age and sex. Provide the number of 0-59 month old children and women 15-49 year old and disaggregate children under five in the following categories: under 12 months, 12-23 months, 24-59 months. See Attachment J for guidance, and include an explanation of the calculation, based on the example provided. For TB, estimate the population that will be covered by DOTS and the estimated number of TB cases in the area. Describe any differences between the population proposed in the original application and the population now targeted in this DIP.

c. Provide an overview of the current health status of the target population by citing the leading causes of under-five morbidity and mortality and maternal morbidity and mortality. Please cite sources of data. Provide the most recent disease surveillance data available (i.e. from local HMIS) for the program area, and discuss the quality of the data, including the completeness of reporting. Refer to data collected during project baseline assessments as well as data from secondary sources, if appropriate.

   Include the baseline survey report(s) including the survey questionnaire(s) in an annex to the DIP.

d. Describe other factors that influence health. This may include, but is not limited to:

   - Economic characteristics of the population such as: the general economy of the community and the nature and location of family members' work.

   - Social characteristics such as: religion, different ethnic groups, female literacy, the status of women

   - Cultural beliefs and practices and influential decision-makers and community networks relevant to promoting key family and community practices.

- Any potential geographic, economic, political, educational, and cultural constraints to child survival activities which are unique to this location.

e. Discuss the current status and overall quality of health care services in the site, including existing services (i.e. those of grantee organization, other U.S. NGOs/PVOs, the MOH, local NGOs, the private commercial sector, and traditional health providers, any USAID Mission programs), where people currently seek care, the current level of access, barriers to access (e.g. cost for services, distance to facilities, and transportation), client-health worker interaction, standard case management and availability of drugs. Include a table outlining resources per sub-area, e.g. a list of all health facilities with staffing levels, how many CHWs per village, etc. Refer to information gleaned from project baseline assessments and data from secondary sources, as appropriate.

f. For baseline assessments still to be completed, discuss the timeline for these and how the project will use the results to inform project planning. Examples of baseline assessments may include, but are not limited to, a census, a health facility assessment, national TB review/assessment, a TB cohort analysis, an organization and/or partner capacity assessment and any complementary qualitative research.

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

g. Include a discussion of any programming priorities identified and/or confirmed as a result of the findings from the baseline assessments and what implications these may have for selected child survival and health interventions, budget, staffing, etc. This should be a summarizing statement and should emphasize the main health problems, priority groups, priorities and challenges, and indicate which aspects the project will address. It may be helpful to display this information in a table.

h. Briefly describe other projects in which the organization is engaged in the same geographic area. This discussion may include health and non-health sector interventions.

   Describe health sector programs that other agencies are implementing in the same geographic area which may provide an opportunity for partnering and to ensure there is no duplication of effort. This includes a discussion of relevant programming of the USAID Mission, the proposed local partner, other NGOs, and global initiatives.

i. Discuss plans to include ongoing USAID Mission input throughout proposed project implementation. This may include mechanisms of continued collaboration with the bilateral, regular meetings with Mission staff, and plans to include their participation throughout project implementation.

2. Program Description

a. Based on the baseline assessments, and the grantee's original proposal, describe the **overall strategy** for implementing the program. Present a results framework that clearly represents the program's expected results and overall objectives, and briefly describe the project

strategy for achieving these results (e.g., through the C- IMCI strategy; through a strategy based on mobilization of cadres of community health volunteers; through a strategy to effect policy changes at the national level). Please see ATTACHMENT E for an example of a results framework.

b. Following the results framework, explain how the project will address issues of quality, access, equity, and sustainability at the various levels of intervention (e.g., community, facility, etc). If the strategies used to address these issues are cross-cutting (i.e. an overarching behavior change strategy or community mobilization strategy), explain them once only; do not copy and paste multiple times. If these strategies are best described by intervention area, include this information in the next section (D.2.c.) only. The descriptions should explicitly refer to project activities included in the workplan. Grantees are expected to have conducted qualitative research to inform these strategies. If this is not the case, then describe plans to conduct this research. If the BEHAVE Framework is used, include it in an annex, not in the text.

c. Apart from the overall strategy, describe, by technical area (malaria, pneumonia, MNH, etc.) the objectives and expected results (including targets) and how each result will be achieved. Briefly describe specific activities to achieve each result, e.g. training CHWs, mother support groups, etc.

d. Describe the local partner's role and responsibilities in the project. In an attachment, include a MOU for each of the cooperating governmental and/or other organizations with which the project will establish a formal relationship. The MOU must outline the specific role of each of the cooperating governmental and/or other organizations with which the project will establish a formal relationship.

e. Present a detailed workplan that is organized chronologically by activity. See Attachment H for a sample. Per the sample in the Annex, this workplan should identify which result(s) each activity supports. Organizations are welcome to add a "comments" column to the workplan in order to provide additional information on the purpose or scope of the activity. This workplan should be user-friendly so that the project team can use it to manage the project. All activities in the workplan should be included in the appropriate column of the M&E table (see M&E section for a description of this table). You may be asked detailed questions about activities and rationale if information is not provided.

3. Program Monitoring and Evaluation Plan

a. Describe how the project will set up or strengthen a M&E system that will fulfill project requirements and strengthen the local partner to better manage local health information.

b. The following points should be addressed in a table, and will be updated to serve through the life of the project. Note: A sample M&E template is provided in ATTACHMENT F.

   i. List the results-based objectives for selected child survival and health interventions.

ii. Define indicators used to measure program objectives/results and method(s) of measurement. Many of these indicators will be collected through a population-level baseline survey using the KPC 2000+ Survey Tools and Field Guide which includes the Rapid CATCH, and is available on line at: http://www.childsurvival.com/kpc2000/kpc2000.cfm.

iii. Identify the targets that will be used to measure progress toward sustained health outcomes. Setting a realistic target requires a solid indicator and good baseline data. Project targets are often set based upon a "benchmark", which is the best level of performance on the indicator that a district, region, province or country has been able to achieve, or on international set targets (e.g. Roll Back Malaria targets for malaria control.) Extensive consultation is required with various partners, governmental and non-government organizations, and the general public (community) to establish realistic and achievable targets. An example of a target would be increase exclusive breastfeeding from 20% to 40% in the project area by the end of the 5 year project. The higher the target is set, the more resources the project (grantee, partners, communities…) will need to allocate to activities linked to this target. Please see the M&E TRM for more information.

When establishing targets, consider the following:

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

iv. Describe how the data will be collected by including sources of data (e.g., facility-based records, household surveys, rosters, etc.), who will collect the data, and frequency of collection. Monitoring data generally consist of a subset of indicators from the M&E plan, which are measured on a regular basis. Many monitoring indicators measure processes, inputs, and outputs; however, grantees may not want to wait until evaluation time to assess the project's progress toward results. In this case, a few outcome-level indicators may be measured on a regular basis, using a method like LQAS, or through a

review of MOH data, if they feed into project results. Grantees should plan to include monitoring data in annual reports. At final evaluation, all programs are required to collect data on indicators relevant to their program objectives and activities, including all Rapid CATCH indicators. Collection of quantitative data at the Mid-term evaluation, in order to monitor progress on objectives, is optional. Describe how and by whom data will be analyzed and used to monitor program progress, improve program processes and program performance.

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

   For grantees implementing Tuberculosis programs, specific TB indicators are required for collection at baseline and final evaluations.

   USAID/GH/HIDN will use these data for results reporting and to examine trends across the CSHGP portfolio of child survival and health grants. In addition, USAID will use this information to assess program models and progress, reach, and effectiveness of programming, essential to ensuring continued support for CSHGP from Congress and tracking changes in maternal, newborn, and child health and TB. **Grantee programs will not be held accountable for achieving progress on indicators for which they have not proposed specific interventions.**

d. Describe how results will be shared and used with the stakeholders and partners (e.g., district level health officials, MOH authorities, grantee's home office and the larger NGO/PVO community). Specify how results may be used for advocacy in-country or internationally. Discuss how the community/beneficiaries will use the data and benefit from it.

e. If Operations Research is planned, state the rationale for the research, objective(s) and expected outcome(s), timing, budget, partnerships, plans to disseminate/utilize research findings, how research findings will be shared and with whom. Provide protocol as an annex. Include updates on progress in annual reports.

f. Clearly identify indicators and data sources that will be used to report on the project's contributions to the CSHGP Program Results. (see Attachment G for an overview of the CSHGP Results Framework).

g. Clearly identify the USAID Mission Program Results that this project will contribute to, including indicators and data sources that will be used to report on the project's contributions to the Mission strategy. Please also discuss the method used to communicate these contributions to the Mission.

h. Evaluation plan: Propose a plan and identify dates for the project mid-term and final evaluations. Once the plan is approved with the DIP, this will be the program's evaluation plan. Propose the optimal month in which to carry out the evaluations, taking into account conditions in country (e.g. seasons, local/religious holidays) and the project timeline. It is strongly recommended that the HQ backstop participate as a member of the Mid-term and Final Evaluation teams, so that (s)he is well positioned to assist the project team to address any recommendations that may emerge.

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

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

i. For TB programs, keep the following in mind:

- Internationally recognized indicators and standardized reporting, monitoring and evaluation tools and criteria (e.g. reporting forms, cohort analysis) have been established by WHO and should be used.

- The development or strengthening of the TB information and monitoring/evaluation system should not be done independently of the MOH system.

4. Program Management

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

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

b. Discuss how staff will be supervised, by whom, and how competency will be measured and improved—if not discussed in the Organizational Development Section.

c. Include the resumes/CVs of key grantee headquarters and in-country program staff in an annex, if these have changed from the application and include any job descriptions for vacancies. Discuss backstopping responsibilities for headquarters staff, including how many

site visits will be made each year, how long, and the monitoring tools that the organization will use.

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

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

- Discuss the grantee's present capacity to both implement and provide backstop support for this project; refer to a recent assessment, or plans to conduct a capacity assessment. Consider capacity to include such areas as technical knowledge and skills, human resource management, organizational learning, financial resource management, administrative infrastructure and procedures, and management practices and governance.

- Describe any plans the grantee organization has for strengthening its capacity in any of these areas over the life of the grant. What tools/measures will be used to demonstrate that the organization's capacity has increased as a result of implementing this grant.

- Indicate which project indicators will be tracked to evaluate organizational development and capacity building.

- Technical Assistance Plan: Provide plans for technical assistance for the life of the program to support areas requiring development. Identify the planned sources of technical assistance for specific interventions or other components of the program.

V. ANNEXES

1. ***Response to Application Debriefing:*** Discuss the weaknesses identified in the debriefing package summary score-sheet and external reviewer comments, and how they will be addressed in the program. Attach a copy of the summary score sheet and the external reviewer comments in this Annex.

2. ***Response to Final Evaluation Recommendations (if applicable):*** If this project is following one that has recently been completed by the same grantee in the same project area, describe how the program is addressing each of the recommendations made in the final evaluation. Reference the section of the DIP that addresses each recommendation.

3. ***Map of project area***

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

5. ***Reports of baseline assessments:*** For each baseline assessment conducted, include a description of the methods employed, and copies of questionnaires, survey instruments and other tools used during the baseline assessment.

6. ***Behavior Change Strategy (optional):*** Include a detailed BC strategy, following the guidance in Attachment K.

7. ***Agreements:*** Memoranda of Understanding, agreements, or Terms of Reference signed with other organizations.

8. ***Organizational Chart/Management plan***

9. ***Resumes/CVs and job descriptions of key personnel at HQ and in the field:*** (if different from application). Also, include the current hiring status of all project staff.

10. ***Other Annexes:*** (as necessary)

ATTACHMENT A

Child Survival and Health Grants Program
USAID/GH/HIDN
FY 2008 Detailed Implementation Plan (DIP) Review
Draft Agenda

1. Introductions & orientation to the DIP review process

2. Presentation by the grantee (15 minutes)

   - A brief overview of the project and/or baseline data
   - Important developments since the start of the program
   - Any important issues not addressed in the DIP
   - Responses to reviewer's comments/feedback

3. Discussion of critical issues prioritized and led by the CSHGP team, including clarifications, comments and suggestions of reviewers. Due to time constraints:

   - Each issue will be raised/summarized by CTO/TA
   - Reviewers will provide input/comments/feedback
   - Grantee will have an opportunity to respond

4. Summary of Issues

5. DIP Decision/Negotiation of final DIP submission

ATTACHMENT B

Rapid CATCH Indicator Table

Check www.childsurvival.com for the latest Rapid Catch Indicator information.

ATTACHMENT C

List of CSHGP-Supported Interventions (illustrative examples of activities are also provided)

Within the Foreign Assistance Framework, the Child Survival and Health Grants Program contributes to the Investing in People objective and its supporting elements and sub-elements, i.e. TB, MCH, Malaria. Technical interventions that support these elements are outlined below. All technical guidance and relevant tools for implementing these interventions (e.g. TRMs and the MAMAN framework) can be found on http://www.childsurvival.com.

Immunization: Strengthening routine immunization (DPT, BCG, Measles); expanding coverage and assessment; improving surveillance methods; improving quality and safety of products; strengthening the cold chain; support of polio vaccination programs.

Vitamin A/Micronutrients: Improving coverage and supplementation of vitamin A for children under 5; increasing intake of vitamin A-rich foods; promoting vitamin A fortified foods; integrating vitamin A supplementation with expanded program for immunization (EPI) activities; expanding access to iodine and iron supplementation; provision of iron supplementation for anemia (particularly for pregnant women); increasing intake of micronutrient-rich foods; promotion of micronutrient fortified products.

Infant and Young Child Feeding: Promoting appropriate infant and young child feeding (including appropriate complementary feeding); improving maternal nutrition practices; promotion of immediate and exclusive breastfeeding; increasing knowledge and utilization of breastfeeding techniques; forming community-level breastfeeding support groups for negotiating behavior change; improving hospital policies and practices through the Baby-Friendly Hospital Initiative.

Control of Diarrheal Disease: Expanding access to zinc supplementation; inclusion of zinc treatment with the new low-osmolarity ORS to improve Diarrhea Case Management for children; reinvigorating ORT practices; improving family and community practices including hand washing, transport and storage of drinking water; promotion of point-of-use treatment (POU) of water; hygiene promotion and improving water and sanitation technologies; strengthening of supportive enabling environments to reduce the incidence of diarrheal disease. Improve recognition and appropriate treatment of diarrheal disease at the facility level.

Pneumonia Case Management: Ensuring adequate access to pneumonia case management which includes facility- and community-based treatment; promoting prompt recognition and care seeking from appropriate providers.

Prevention and Treatment of Malaria: Promoting intermittent preventive treatment in pregnant women (IPT); expanding ownership and use of insecticide treated bednets (ITNs), with emphasis on long-lasting nets (LLINs); improving malaria case management at the facility and community levels; promoting care-taker recognition of fever in children under five and prompt care-seeking behavior; applications should not include activities related to indoor residual

spraying (IRS). In PMI countries (Angola, Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal Tanzania, Uganda and Zambia) CSHGP projects should be implemented in collaboration with PMI efforts and priorities in country, which are based on close planning with National Malaria Control Programs (NMCPs) (see PMI website at www.fightingmalaria.gov for more information). In all countries, projects should be consistent with NMCP strategies and approaches.

Maternal and Newborn Care: Improving birth preparedness and complication-readiness planning; access to focused antenatal care (including promotion of optimal birth spacing of 3-5 years); promotion of tetanus toxoid immunization; promoting skilled attendants for birth and improving skills of providers; promotion of clean delivery and infection control; employ appropriate household- and community-based strategies where access to skilled care is difficult, including referral; promoting active management of third stage of labor; improving access to quality postpartum care and appropriate postpartum messaging (including promotion of optimal birth spacing of 3-5 years); promoting essential newborn care practices, including identification and treatment of neonatal infection and complications, resuscitation, thermal stabilization, cord care and immediate and exclusive breastfeeding; promoting special care of premature and low birth weight infants.

HIV/AIDS: Prevention of Mother to Child Transmission (PMTCT); increasing community knowledge of HIV/STI transmission; expanding access to comprehensive prevention and care activities; promotion of voluntary counseling and testing.

Childhood Injury Prevention: Assessing burden and improving surveillance of injury-related morbidity and mortality; integration of injury prevention messages with IMCI key messages (i.e. messages related to drowning, road traffic injuries, falls, poisons, burns, etc.); demonstrating effectiveness of interventions to reduce the incidence of childhood injury.

Tuberculosis: Advocating for political commitment; improving detection and diagnosis using quality-assured bacteriology and standardized treatment with supervision and patient support; ensuring a reliable drug supply and management system; improving monitoring and evaluating systems through host country strategic information systems; improving management of TB/HIV co-infection; addressing multi-drug resistant TB; and providing care and support to people with TB. Care and support includes community participation in TB care and prevention, advocacy, communication and social mobilization, patient charter for TB care, enablers to help patients adhere to treatment, and engagement of civil society organizations.

ATTACHMENT D

Tuberculosis Indicator Guidance

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

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

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

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

Case Notification Rate

> **Denominator:** Total population in the specified area
> **Numerator:** Number of new smear-positive pulmonary TB cases reported
> X 100,000

Additionally, grantees **should** include other indicators that reflect the various components of the proposed TB project as well as provide the entire cohort analysis for the project's coverage area as background. Guidance on indicator selection for the standard components of the DOTS Strategy can be found in the "Compendium of Indicators for Monitoring and Evaluating National TB Programs (WHO/HTM/TB/2004.344). This is available at

http://www.stoptb.org/wg/advocacy_communication/assets/documents/Compendium%20of%20Indicators%20for%20Monitoring%20and%20Evaluating%20NTP.pdf#search=%22tuberculosis%20indicator%20compendium%22

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

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

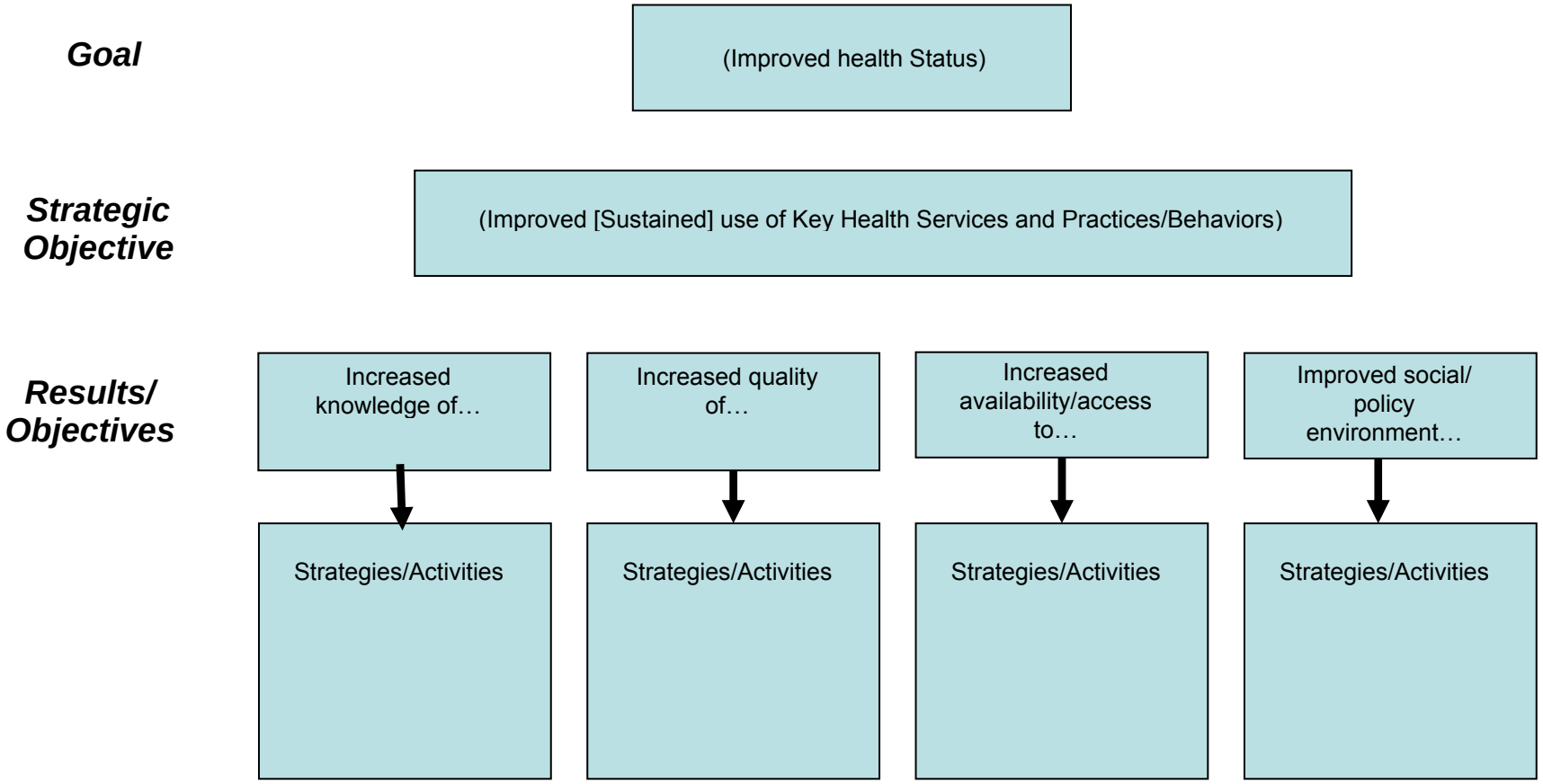
Denominator: Total # of people surveyed
Numerator: # of people who correctly identified both cough and fever as symptoms of TB

Proportion of population who know that TB is a curable disease

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

ATTACHMENT E

Sample Results Framework



ATTACHMENT F

Sample M&E Plan Template

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

Notes:

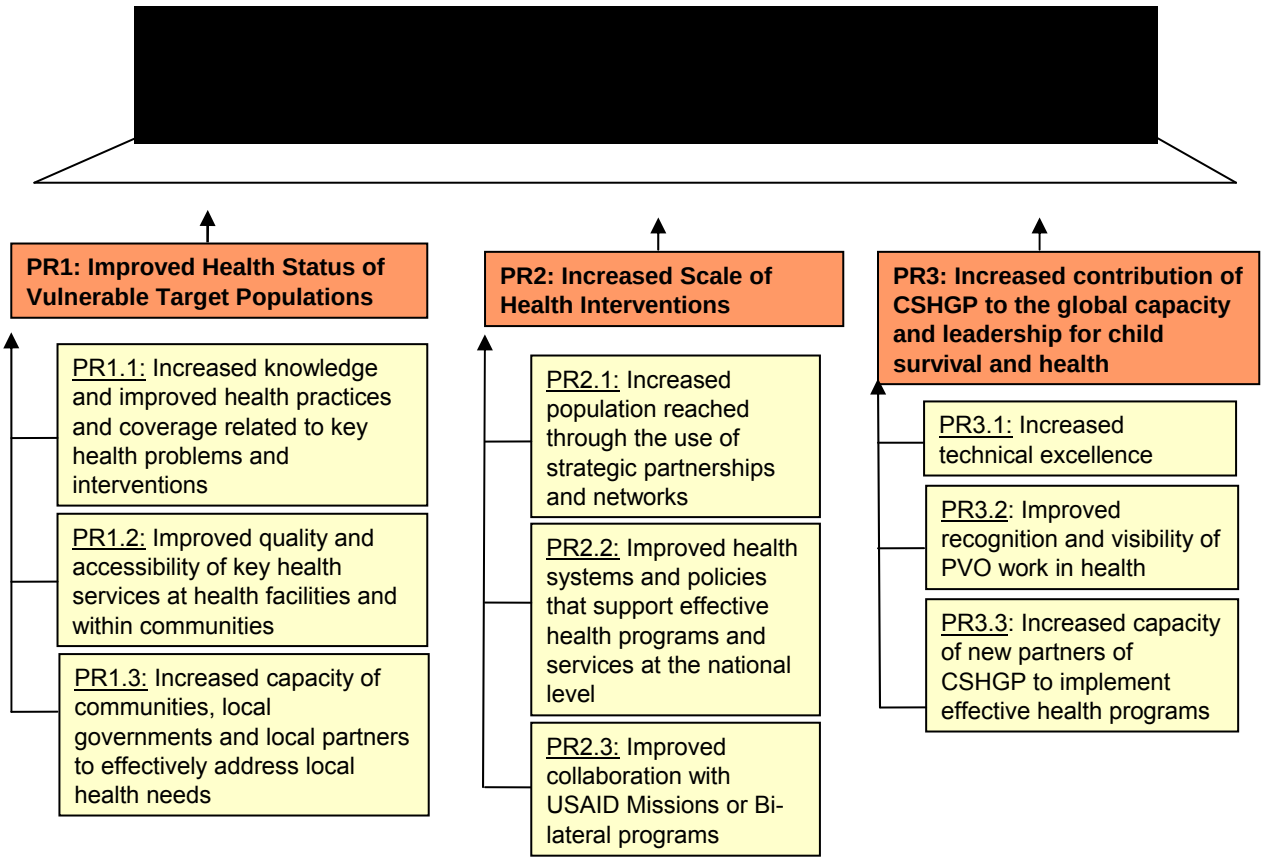
Indicator: (Sample wording) % of mothers who received two Tetanus toxoid injections (card confirmed) before the birth of the youngest child less than 24 months.

Source of data: Example: survey of mothers, health card of child
Method of data collection: Indicate how data was/will be collected.
Frequency: Indicate how often data will be collected throughout life of project.

Baseline Value:	% or # at baseline.
EOP Target:	End of Project % or # collected at final evaluation.
Related Activities:	List by name only the activities that support each objective or result. (Detailed information about activities should be included in the workplan or an accompanying narrative.)

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

CSHGP Performance Management Plan



ATTACHMENT H

Sample Work Plan Template

Result	Major Activities	Year 1		Year 2				Etc.	Personnel	Comments
		Q3	Q4	Q1	Q2	Q3	Q4			
	Activity Include a brief description that includes a reference to the related intervention area(s)	x	x						Staff position responsible	
	Activity	x							Staff	
	Activity	x	x	x	x				Staff	
	Activity	x	x	x	x	x			Staff	
	Activity	x	x	x					Staff	
	Activity		x	x					Staff	
	Activity		x	x	x				Staff	
	Activity			x	x	x	x	x	Staff	
	Activity			x	x	x	x	x	Staff	
	Activity			x	x	x			Staff	
	Activity				x	x			Staff	
	Activity				x	x	x		Staff	
	Activity				x	x	x	x	Staff	

ATTACHMENT J

Project Population Calculation Guidelines for the Child Survival and Health Grants Program

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

The project population figure consists of all people covered by services in the project area.

Guidance:

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

- Projects must state the source of population numbers for the project area, the date when this information was collected and information as to whether or not these numbers were determined by official projections. For example did they perform a census of the project area or did they use an official source? How did they determine the percent of total population for women of reproductive age and children under 5 (broken down by age categories)? The following are links to official sites for population figures:

  - CENSUS BUREAU SITE: http://www.census.gov/ipc/www/idbsum.htm
  - UNICEF: http://childinfo.org/

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

Illustration of Project Population Calculation for Project X—

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

- **Explanation of calculation:** Numbers are calculated before the initiation of the project. The project X team calculated infants 0-11 and children 12-23 months based on DHMT guidance that stated that each of these age groups represented 4% of the total population. This means that children in the 0-23 month age range represents 8% of the total population.

Direct Beneficiary Population Numbers for Project X:

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

ATTACHMENT K

Behavior Change Strategy Guidance (Optional)

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

1. Broad behavior change goals and objectives that correspond with overall project health objectives and a summary of the Behavior Change Strategy of the project.

2. A description of how the strategy will be operationalized, e.g. with communication, describe the channels that will be used; if materials will be developed by the project, or adapted from existing materials (name source); how messages will be selected and tested; etc. Please also indicate mechanisms to involve relevant stakeholders in the decision-making process and any plans for capacity building of partners for implementing the BC strategy. For training, describe who will conduct the training and who will attend; which curricula will be used; etc. There may be other aspects of operationalizing the strategy that are not listed here.

3. A table (BEHAVE Framework) with columns listing the Priority and Supporting Groups, Behaviors, Key Factors, and Activities (see the BC TRM for reference). Include all levels that the project is working at to change behavior (i.e. community, health facility). List indicators for evaluating progress in behavior change at the bottom of each section.

4. A description of how behavior change will be monitored and evaluated. In terms of process monitoring, state what incremental progress looks like for each target behavior and audience in each of the following phases: awareness, knowledge, attitudes/skills, trial, and behavioral maintenance. It may be useful to create a table to display that information. Also, describe how and how often indicators will be measured, who will review the data, and how the information will be used for project decision making (cross-reference to an updated project M&E plan, if appropriate).

See the example below.

SBC Strategy Example: Iron/Folate

Broad behavior change goal: Improve maternal health practices

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

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

will be improved by linking district health centers to provincial administration through improved record keeping and communication.

Channels of Communication:

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

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

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

BEHAVE Framework

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

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

Monitoring Table

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