East Africa Maternal, Newborn and Child Health Project

Supported by the Australia Africa Community Engagement Scheme (AACES)

APPLICANT ANGO DETAILS

Name	**World Vision Australia (WVA)**, together with: • World Vision Kenya • World Vision Rwanda • World Vision Tanzania; and • World Vision Uganda.
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APPLICANT DECLARATION

I, Graham Tardiff, do solemnly and sincerely declare that:

DEFINITIONS

In this declaration:

"**AusAID**" means the Australian Agency for International Development and represents the Commonwealth of Australia;

"**Applicant ANGO**" means the NGO or Consortium of NGOs making the Submission.

BASIS OF DECLARATION

I hold the position of Director of Policy and Programs of the Applicant ANGO and am duly authorised by the Applicant ANGO to make this declaration.

I make this declaration on behalf of the Applicant ANGO and on behalf of myself.

I declare as follows:

THE SUBMISSION

The Submission is accurate in every respect. In particular, I warrant that the information and certification included in each Submission is accurate, and that AusAID has the authority to make any inquiries regarding information or certification contained within this Submission.

I acknowledge that if the Applicant ANGO is found to have made false or misleading material claims or statements in the Submission or in this Applicant Declaration, AusAID may reject at any time any Submission lodged by or on behalf of the Applicant ANGO.

I acknowledge and agree to the matters specified in Clause 4 (AusAID's Rights) and Clause 5 (Applicant ANGO's Acknowledgement) of Section 1.

DECLARATION & SIGNATURE

The following undertaking must be made by an appropriately authorised officer of the Applicant ANGO or the lead Agency of a Consortium.

Graham Tardiff
Director of Policy and Programs

Date: 16 May 2011

Witness name:
Christine Latif, Grants Team Manager

Date: 16 May 2011

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List of acronyms

7-11	Seven-Eleven
AACES	Australia Africa Community Engagement Scheme
ADPs	Area Development Programs
ANCP	AusAID NGO Cooperation Program
ANGO	Australian NGOs
AU	Africa Union
AusAID	Australian Agency for International Development
CCC	Community Care Coalitions
CHN	Child Health Now
CHVs	Community Health Volunteers
CLTS	Community Led Total Sanitation
CV&A	Citizen, Voice and Action
DA	District Administrations
EAC	East Africa Community
EAMNCH	East Africa Maternal Newborn and Child
EMONC	Emergency Management of Obstetric and Newborn Care
HIS	Health Information Systems
HTSP	Healthy Timing and Spacing of Pregnancy
IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IYCF	Young Child Feeding
KAP	Knowledge, Attitude and Practices
LEAP	Learning through Evaluation Assessment and Planning
LMGs	Lead Mother's Groups
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICAH	Micronutrient and Health Program for Africa
MIP	Malaria treatment in Pregnancy
MMR	Maternal Mortality Rate
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCGs	Nutrition Care Groups
NGOs	Non-Governmental Organization

ORS	Oral Rehydration Solution
OSA	Organisational Self Assessment
PBF	Performance Based Finance
PD Hearth	Positive Deviance
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PLWHA	People Living With HIV and AIDS
PPTCT	Prevention of Parental to Child Transmission
PSGs	Parent Support Groups
TTC	Timed and Targeted Counselling
U 5MR	Under 5 (years) Mortality Rate
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VHTs	Village Health Teams
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation
WSC	Water Sanitation Committees
WV	World Vision
WVA	World Vision Australia

Executive summary

The East Africa Maternal Newborn and Child Health (EAMNCH) Project will improve maternal, newborn and child survival. This will be achieved through improved health system access, sustainable nutrition, and market diversity in selected communities in Kenya (Kilifi district), Rwanda (Gicumbi districts), Tanzania (Kilindi district) and Uganda (Kitgum district). This is a five year project (July 2011 – June 2016) with a total budget of $9 million.

The project will be implemented through a partnership led by World Vision Australia (WVA), involving World Vision (WV) National Offices in each country. Ministries of Health and other in-country partners will support the achievement of project outcomes improving the quality, supply, and community demand for Maternal Newborn and Child Health (MNCH) services; promoting the adoption of positive MNCH practices and contributing to a more favourable policy environment that facilitates MNCH improvements in Africa. This project also seeks to provide opportunities for the Australian public to better engage with development issues in Africa.

Maternal under-nutrition (caloric intake and essential micronutrients) contributes to the mortality rates of infants and children under five. This project includes focusing on the provision of essential nutrition for pregnant and lactating women, and addressing causal factors contributing to maternal and child under-nutrition[i] and will be conducted in collaboration with local communities, governments and other key social actors. Targeting the causes of under-nutrition for pregnant and lactating women will improve both these women's health outcomes, and foetal development. Low birth-weight children have increased short and long-term risks of infection and disease, so this approach will also contribute to reducing child and infant mortality in the target communities over the longer term. Interventions undertaken in this project seek to strengthen existing health systems and services - such as obstetric and antenatal care - to increase their accessibility and utilisation. Complimenting these activities, nutrition education will be undertaken together with market research to better understand the availability and utilisation of nutritious food, identifying links with nutrition outcomes and relevant areas for further interventions. These activities will, over the longer term, improve access to health services, increase nutritional awareness, and result in behaviour change that will reduce maternal and infant mortality and disability.

Ensuring government participation and commitment to MNCH improvements will be critical to project success and ensuring sustainable outcomes, but is a significant challenge given limited governmental resources and competing priorities. For this reason, the EAMNCH design has focused significantly on developing engagement and partnerships with key government stakeholders and demonstrating the benefits of best practice, whilst building demand for services at the community level so governments can be more informed by local issues and evidence.

Outline of the design process

The EAMNCH design process (October 2010- April 2011) drew together a multi-functional design team from across the WV partnership including: individuals from WVA and each WV implementing office; technical experts in MNCH, Nutrition, Disability, and Gender; individuals experienced in improving child health outcomes from WV's *Child Health Now* (CHN) campaign, and experienced program designers. The 'participatory design process' sought to ensure an integrated and sustainable approach to improving MNCH and Nutrition outcomes by building on existing and previous WV programming, the current evidence base in this sector and leveraging existing relationships in the health and food security sectors. The process included a joint design workshop in Uganda (January 2011) that provided a platform for further relationship-building and exploring the theory of change[ii] for each project location. Appropriate mechanisms for gender, disability, risk, power, sustainability and market analyses were developed by consensus at this workshop.

Extensive community consultation was undertaken across the four countries. Dedicated sub-teams in each country undertook in-depth consultations using participatory techniques with local communities, government structures, and other partners. Quantitative and qualitative data was gathered at provincial, district, sub-county and village levels. Data was disaggregated by gender and disability, and analysed to help ensure the specific needs of these vulnerable groups were appropriately considered. Focus groups –

including groups led by women and people with disabilities – were utilised to capture data on gender roles, barriers and enablers to health services access, control over resources, influence on market food availability and demand, and gender-specific recommendations.

During the design workshop, WV staff reflected on how the participatory process was empowering for those involved, and resulted in immediate and positive action. For example, in Tanzania some specific gaps in MNCH service delivery systems identified during the design consultation were immediately addressed by the local health authorities.

Utilising the 'Theory of Change''[iii] approach significantly benefitted the design process. The team focused on higher level outcomes and how best to achieve these; breaking away from less flexible processes more focused on needs and outputs. WV National Offices appreciated the 'Theory of Change" approach, and committed to applying this methodology in other relevant design processes in the future.

WV National Offices engaged with AACES partners in their countries to explore possibilities for program collaboration. In Kenya this has resulted in new 'non-traditional' collaborations and partnerships, including a Memorandum of Understanding (MOU) between WV Kenya, Action Aid, Plan and Marie Stopes.

Program staff from WV National Offices, together with WVA technical and programming specialists, critically examined models previously utilised by WV, seeking to improve the application of these to this project to improve both implementation and outcomes. This technique was also used to analyse cross-cutting issues such as gender and disability inclusion.

Another valuable lesson from the design process was that adequate financial and technical resourcing is essential to support the full exploration and understanding of contextual complexities for a project to achieve quality design of interventions and significant project outcomes. The provision of resourcing for the AACES design enabled a more rigorous approach, which is anticipated to result in stronger programming. It is recommended that AusAID continue to fund such design processes in the future. Lessons learned from the design process will continue to be built on throughout the life of this project.

Situation Analysis

1. Current experiences of communities, in particular vulnerable groups

The East African communities targeted in this project share common challenges including high maternal and infant mortality, seasonal food insecurity, poor nutrition, high incidence of waterborne diseases and poor sanitation. Selected statistics show high national rates of maternal and child mortality and malnutrition, as demonstrated by the following indicators.[iv,v,vi]

	Kenya	Rwanda	Uganda	Tanzania
MMR (per 100,000)	530	540	430	790
IMR (per 1,000)	55	70	79	68
U 5MR	84	111	128	108
The nutrition status of children under 5				
Stunting	35%	52%	35%	44%
Underweight	16%	15.80%	16%	17%
Wasting	7%	4.60%	7%	4%

Reliable district level data is difficult to obtain, illustrating weak health information systems (HIS). For this reason, data to benchmark indicators at the district level will be collected during a baseline exercise. Maternal under-nutrition is an underlying cause of infant and under-five child mortality, as well as maternal mortality and ill-health. Drawing from the country level design processes in the target communities there is typically poor maternal nutrition with high levels of anaemia, low birth weights, low rates of exclusive breastfeeding, and low knowledge and practice of good infant and young child feeding.

Analysis during the design process found that health centres are understaffed and staff are often poorly trained. In Uganda, up to 44% of clinics are understaffed.[vii] This resulting low quality of MNCH service

provision, often at a significant distance, with bad treatment of service users by health staff (especially for women with disabilities) discourages women from using the available MNCH services.

Connections between formal health systems and community level structures are weak. Community health structures such as Community Health Volunteers (CHVs) and Village Health Teams (VHTs) are undervalued by the formal system, and their poor resourcing results in a break-down in service delivery to households. Households have a low-level of health knowledge, particularly related to good nutrition and hygiene practices, and little awareness of available services. Some traditional practices, such as food taboos for pregnant women, were noted to undermine good nutrition practice or health service utilisation. Systemic gender inequalities in the communities restrict knowledge and control of resources and decision making for women's access to services. People with disabilities and those living with HIV and AIDS (PLWHA) face additional barriers to good MNCH; stigma and discrimination are significant barriers to health service access.

While government policies generally exist across the four countries for MNCH, nutrition and WASH, implementation of these has failed to fully reach the communities targeted in this project. For example, cadres of CHVs are trained by Ministries of Health to link community members with health services, but the CHVs are not well supported. Communication, referral and data collection is poor, and essential medicines are not always available; even when they are, they do not always get delivered to community level.

2. What gender equality considerations need to be addressed

Decision making power in the target communities generally rests with men, influencing women's choices about health care. This power relationship means that the option to appreciate and adopt good maternal and child health practices (including good nutrition and hygiene) is not always a woman's decision, but generally rests with the male head of household. In Uganda 51% of women deliver at home because men determine where women give birth, often basing the decision on their own mother's experiences[viii]. Access and control over household resources, including decisions about income and expenditure and what food will be grown, sold and eaten is also usually the domain of men. Women have limited access to information and so may not understand the importance of accessing health care during pregnancy. Women with a disability face further disadvantage as they generally have greater dependence on their husbands and others.

3. Strengths and opportunities for change and improvement

MNCH is a high development priority for the four governments, as indicated in current planning and policy documents. Tanzania is prioritising partnerships to achieve the Millennium Development Goals (MDGs) and the reduction of child and maternal mortality.[ix] In Kenya, MNCH service access and improving the nutrition status of pregnant and lactating women is directly supported in strategies focused on child survival and reproductive health.[x] Similarly, MNCH is supported in Uganda at national and district levels.[xi] Rwanda has developed a health system focused on primary health care (PHC), has CHVs, and includes good family planning policy supported by incentives.[xii] All four countries have ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), and have policies and/or laws to promote and protect the rights of people with a disability.

4. Existing services and assistance being offered already in these areas, including existing local government plans and activities and other donor programs.

WV has an existing presence in the four project areas within Area Development Programs (ADPs)[xiii] in Kenya, Rwanda and Tanzania and in existing grant-funded project areas in Uganda. These are long-term, multi-sector, integrated programs, which work at community level with local and national partners. The project will leverage and integrate with existing WV programs (including WASH and Food Security) and utilise WV infrastructure and staffing to implement activities[xiv]. Where possible, existing programs (including large grant funded projects) will be leveraged during the implementation of EAMNCH, e.g. UNICEF funded WASH programs in Rwanda. Kenya and Rwanda already have existing WASH programming at the project sites, so WASH will not be prioritised within the EAMNCH project at these sites. Also in Rwanda, Food Security is being funded by an alternative project, however, the project will ensure some integration for better nutrition outcomes.

WV has built good relationships with the communities and government (local and national). For example, in Rwanda and Uganda WV has signed a MoU with the Ministry of Health (MoH) outlining the specific roles it

will play in improving health programming in the areas of its operation. All local government District Development Plans incorporate MNCH services and, where relevant, this project will build upon existing programs in line with government policies eg CHVs to refer women to clinics for delivery. Rwanda has a well designed Community Health System where CHVs treat simple clinical cases and refer severe ones, e.g. CHVs test for malaria and administer first-line drugs. The CHVs are well motivated through cooperatives and free health insurance. This will significantly support project implementation.

Various NGOs support health systems by renovating or constructing health centres, supporting CHVs, providing clean birthing kits, mosquito nets and family planning services. This project will work with these NGOs to ensure no duplication of effort, and to leverage existing activities where relevant. For example, Marie Stopes will supply family planning services in Uganda, while WV will build community demand for these services. Large WASH projects exist in all four countries supported by various NGOs and the project will leverage or integrate where appropriate to provide access to potable water whilst the EAMNCH project focuses on sanitation and hygiene components of WASH. In all four countries, WV is a member of various interagency coordination mechanisms contributing to government plans, and streamlining MNCH programs.

5. Analysis of needs and gaps which could be addressed by additional external assistance (beyond what people can do for themselves and what is already being offered by government and others).

Based on extensive consultation undertaken as part of this project design, all four countries have common needs and gaps but with varying degrees of complexity that will require different entry points during implementation. Additional external assistance will address the following gaps:

i. ***Weak and inequitable health systems:*** Many women, including those with disabilities, do not access MNCH services because of how they are treated by health staff, many of whom do not have good client service attitudes. The staff lack critical knowledge of many MNCH issues, which is a further barrier to service. Governments in the four countries are unable to retain health staff in contemporary health service provision due to inadequate resources. In Kenya, this has been compounded by staff recruitment freezes. Tanzania lacks community-level personnel; only 46 CHVs work in the project area despite 204 being recommended.[xv]

ii. ***Weak capacity of community health structures***: In all four countries community health structures such as CHVs and VHTs exist, but function sub-optimally because they are not equipped to supply and demand good services for their communities and lack organisational skills. In Kenya, Tanzania and Uganda, the link between the community and the formal health structures is ill-defined and weak, exacerbating this problem. Rwanda lacks effective community engagement in their MNCH approach.

iii. ***Unreliable health information systems:*** Information systems are poor, and information - including the incidence of maternal and newborn death - does not flow well from communities to health facilities. In some settings VHT collected data is inaccurate, due to a lack of tools and skills. All data in Kenya is entered and transferred manually, creating opportunities for delays and errors; resulting data therefore cannot be used effectively in sub-county or district level planning. In other settings, recording of health information at village level does not occur as VHTs do not operate. Community members do not participate in determining the type of information that they need to keep or what they should access from the health facility, adding further complexity.

iv. ***Limited nutrition knowledge amongst women and their households***: Households grow food for themselves, however, this can be strengthened with appropriate techniques to increase production and storage. Limited nutrition knowledge, traditional practices and harmful gender norms are also causes of malnutrition and poor health outcomes among pregnant women and children under five. For example the rate of stunting rates in Rwandan target areas is up to 52.[xvi] Malnutrition needs to be addressed by building community knowledge and facilitating behaviour change for good nutrition.

v. ***Limited access to WASH services and facilities:*** There is low access to clean water and most households do not practice good hygiene. Washing hands with soap after visiting toilets is not a common practice. Additionally most households do not have pit latrines. The project area in Uganda has experienced ongoing Hepatitis E epidemics which can be fatal for pregnant women, so WASH will be prioritised.

vi. ***Environment that does not facilitate policy implementation:*** All four countries have MNCH related policies but implementation is weak. Community members and some village-level local government

staff are unaware of the policies. Implementation of reforms in Kenya has been politically-driven, and citizen participation is compromised for many reasons, including the lack of a framework to aid engagement.

Objectives

The overall project goal is to improve MNCH in selected districts in Kenya, Rwanda, Tanzania and Uganda. Improving MNCH is a priority for governments and target communities in each country. Governmental and community involvement, including the participation of women and men, will be critical to identifying strengths, needs and solutions that will contribute to realising project objectives. This project will contribute to achieving outcomes in three sectors - maternal, newborn and child health; food security; and WASH - all recognised AusAID priorities. The following outcomes will contribute to achieving the overall project goal:

1. Improved and equitable access to MNCH services

The project will ensure improved and equitable access to MNCH services by strengthening existing health systems through building both supply and demand of MNCH services at the facility and community level. The supply of services will be impacted by building the capacity of MoH staff through training in core MNCH clinical skills and improving the HIS, as well as improving the capacity of existing community health structures to provide health services. The program will also work with communities to explore and change behaviour, working towards increasing demand for equitable MNCH services. This will be achieved through awareness raising, building capacity within communities to plan change and strengthen community-based advocacy. These activities will support the development of a stronger health system with a continuum of care between households, community heath structures and existing formal health facilities.

2. Adoption of positive nutrition and WASH practices at community level leading to improved MNCH

During this project, activities undertaken with community groups – to build community knowledge on nutrition and explore harmful practices, including gender norms – will seek to change behaviour and achieve good household nutrition. Nutrition for women and children will be improved through increasing production and diversification of food and improved storage techniques. Good nutrition knowledge will influence women's decisions on the production and utilisation of food, which will impact local food markets and supply chains which will in turn increase the supply of more nutritious food. The project will work to build the capacity of communities to analyse food markets and supply chains. The project will also work with communities and the government to increase access to water and promote positive hygiene and sanitation practices in Tanzania and Uganda, as positive WASH practices contributes to improved MNCH.

3. Favourable policy environment for improved MNCH

The project will build community-based advocacy capacity using approaches such as Citizen, Voice and Action[xvii] (CV&A) to engage in discussion on policies and practices relating to a uniform CHVs system and Govt funding of PHC. The project will support communities to identify and prioritise their emerging advocacy issues that will be amplified by feeding into WV's CHN campaign - WV's platform for national and international advocacy work on MNCH, supporting advancement of MDGs 4 and 5. Intentional reflection and sharing on promising practices (e.g. Timed and Targeted Counselling and Positive Deviance Hearth) will contribute to improved policy delivery and learning.

4. AusAID's policy and practice on Africa Development is better informed

The program will meet with AusAID and work with both community and AACES partners in the first year of implementation to identify engagement and collaboration opportunities, including with other AusAID-funded programs. This collaboration will also identify policy issues and provide input to policy responses as they emerge from communities. The project will be intentional in its learning and present promising practices to AusAID for consideration in their own policy and practice activities. This will include exploring alternative practice relating to CHV support systems and the allocation of funds for in-country midwifery training.

5. Australian public is better informed on MNCH development issues in Africa

The program will work with other AACES and ANCP NGOs in the first year of implementation to explore how to best progress this objective. The program will convey the complexities of working in development and encourage members of the Australian community to explore this further. Community dialogues developed in CV&A will help convey stories that depict the reality of local MNCH issues, including the experiences of vulnerable women that resonate with the Australian community. WV has mechanisms to convey these stories to the Australian public to support their better understanding of development challenges in Africa, including the CHN campaign and the *One Just World* forums.

Project Strategy

1. The rationale for choosing to work in this location, with these people

The four project areas in Kenya, Rwanda, Tanzania and Uganda have been chosen because of the poor health outcomes in these countries, particularly related to MNCH and HIV&AIDS. They have weak health systems, characterised by inadequate governmental capacity to recruit, train and retain motivated health personnel. They experience inadequate medical supplies that affect delivery of quality health services, especially for rural populations. Some project areas (Kenya and Uganda) are areas of food insecurity and have had recent food distribution interventions. All four countries are within the East Africa Community (EAC) and have different MNCH practices. Lessons from the four countries will be used for MNCH policy dialogue and engagement with the EAC and Africa Union (AU) and more broadly.

WV is currently working in all four locations and so the project will build on and integrate with existing WV programming. Over the life of the project, the interventions will target 36,250 direct and 70,073 indirect beneficiaries (Kenya 5,209 and 10,143, Rwanda 15,520 and 24,939, Tanzania 9,921 and 22,291, Uganda 5,600 and 12,700). These will be made up of women of child bearing age and children under five (including people with a disability and those living with HIV). These are indicative figures, the actual numbers will be revised during baseline and implementation.

2. The way in which previous experience and lessons have informed this design.

World Vision's experience in implementing MNCH interventions such as *7-11*, Timed and Targeted Counselling (ttC), Positive Deviance (PD) Hearth, CHN and nutrition programs such as the Micronutrient and Health Program for Africa (MICAH)[xviii] has influenced the approach and activities for this project. WV has learnt that achieving maximum MNCH benefits for mothers and children requires the multi-factorial issues that compromise maternal health and nutrition to be addressed. These include access to essential health services, prevention of infection, good hygiene, access to clean water and sanitation, knowledge and attitudes about nutrition in pregnancy and child feeding, and the availability of and equity of access to nutritious food.

WV has also learnt that the lack of basic maternity care and emergency obstetric care before, during and after birth is a root cause of maternal mortality and disability in Africa. Pregnant women and new-born children are denied access to potentially life-saving interventions when a complication arises. It has been learnt that to work only on the supply side of MNCH services is unsustainable, hence this project's focus on improving both the supply and demand for health services. Women can influence what is produced and sold in markets based on their knowledge of good nutrition. Good nutrition requires food to be available, accessible and utilised. A market analysis to determine availability of nutritious food for pregnant/lactating women and their children will contribute to strengthening the demand and supply of nutritious foods at the market, as well as ensuring that men and women influence diet composition in their homes.

Addressing cultural and gender norms that dis-empower women is crucial to strengthening the enabling environment, so that men support women to be informed, make decisions and access the care they need. Sustainable development starts with transforming relationships. It requires strong partnerships with communities and other stakeholders to understand the causes of poverty, identify existing strengths and capacities that can be built upon and together, find solutions that enable communities to achieve outcomes such as improved health and nutrition. Approaches such CV&A, C-Change, Appreciative Inquiry and

organisational self-assessments that empower citizens to engage and organise themselves to achieve positive outcomes will be applied.

3. Why the proposed activities and approach are expected to lead to the intended outcomes

The EAMNCH project strategy focuses on using a strengths based approach, enabling all partners to understand, own, and participate in program objectives, for better programming into the future. The focus on policy issues and change for positive MNCH practices through building relationships both in Africa and Australia will create an environment conducive to sustainability. The project activities will lead to sustained MNCH because there is an integration of programming and advocacy for sustainability. This will lead to empowered community structures and systems including CHVs, VHTs, lead mothers groups (LMGs), Income Generating Activity (IGA) groups and men's groups that will ensure continued demand and supply of MNCH services. This has been demonstrated in reviews of the impact of Community Groups on MNCH services in WV's programming in East Africa[xix]. Advocacy interventions, together with the increased capacity of CHV and VHTs will contribute to increased demand at community level, improved engagement of the community members and strengthened capacity of MNCH service providers to be accountable and provide good services to citizens.

4. A description of how the project is situated within the wider work of the Australian NGO and its partners, including how it complements and contributes to NGO's broader program

The EAMNCH project will operate within existing WV ADPs in Kenya, Rwanda and Tanzania and in existing grant-funded project areas in Uganda. The project will leverage existing multi-sectoral programming, particularly around grant funded WASH and Food Security sectors, and resources including extensive existing community-level engagement in these areas. There will also be an intention to ensure best practice programming is utilised in WV's wider programming.

The project has adopted a strength based approach[xx] in working with marginalised groups including: children, as the core focus of all WV programming; women; the elderly; people with disability; and other local groups. The strength-based approach will add value to project outcomes by focusing on empowerment and not service delivery. For example the EAMNCH project will ensure that the capacity of MoH staff and other partners is developed to continue to conduct project activities and sustain outcomes. WV will not only work at a local level but will continue to forge strong national and international partnerships to advance knowledge-sharing and learning from this project, and improve MNCH practice and policy more broadly. This will include partnerships with UNICEF in Rwanda, the WFP in Kenya and Tanzania, and other AACES partners to improve programming and act together on influencing policy.

CV&A is already being utilised by WV in Uganda, Kenya and Tanzania and this methodology will be extended to Rwanda. CV&A will contribute to achieving project outcomes by working on both the demand and supply sides of MNCH services. The project will utilise the stories of community strengths and needs emerging through CV&A to feed into national and international policy debates including the CHN campaign. Sectoral expertise will also be utilised within WV, for example WV Tanzania and Uganda have significant programming focused on food security and this expertise will be shared across the other countries of the EAMNCH project.

The EAMNCH project aligns with WV's global *CHN* advocacy campaign singularly focused on reducing preventable deaths of children under five. In Africa, WVA is supporting CHN initiatives in Kenya where interventions involve both direct engagement with policy makers and mobilising and coordinating influential individuals and organisations to share information, policy, strategy and campaign activities. The AACES funding will ensure that WVA extends its support for CHN initiatives to Rwanda, Tanzania and Uganda. In addition to policy influence, CHN initiatives through the EAMNCH project will focus on ensuring that mothers and children are well-nourished, protected from infection and disease and have access to essential healthcare through the promotion of five inexpensive solutions: bed nets, oral rehydration, promoting exclusive breast-feeding, skilled attendants at birth and immunisation programs.

The EAMNCH project fits within the MDG-aligned *7-11*[xxi] initiative that focuses WV's global MNCH strategy on child-centred Primary Health Care. The *7-11* initiative targets the prenatal period to the first two years of life to ensure that children start life with a foundation of good health and nutrition. The EAMNCH project

will therefore sustainably achieve its objectives by focusing on seven key maternal and eleven child health interventions that are evidence-based and low-cost interventions that have worked in similar projects in conjunction with community health needs and the local PHC system. Inherent in the *7-11* approach is the intentional use of various development models such as C-Change, CV&A, Prevention of Parental to Child Transmission (PPTCT) [xxii], that have been shown to be effective in health programming.

5. The way in which this project will engage with AusAID and contribute to other AusAID supported work in Africa, and how AusAID's other work will contribute to this project

The EAMNCH project will be implemented in a region of ongoing priority and growth for AusAID. There will be increased dialogue with AusAID to understand specific AusAID priorities for Africa and where there are opportunities for synergy. The project provides opportunities for AusAID to expand its reach to Rwanda and advances MDGs 4, 5 and 6, for which all target countries are off-track. This project compliments AusAID's MNCH Initiative by working at the household and community level. Local data and voices captured during various stages of the project will inform AusAID's engagement with Africa on MNCH promising practices. Where possible, this project will leverage WV's existing engagement with government, as well as develop strategic alliances with other key stakeholders within the AACES program. These activities, as well as in other WV programming, will provide opportunities to promote and link with the Australia Africa Partnerships Facility (for MNCH, Food Security, WASH and Scholarships Program), which WVA and its partners will actively engage with through the AusAID Posts and program providers. The project will provide information to AusAID and WVA which can be used to inform the Australian public on the support they are giving for improved maternal and child health in Africa and improve community engagement with international aid and Australia's involvement in this sector.

6. The way in which the project will leverage change beyond the Australian program.

Extended outcomes will be realised because the project will work in concert with host governments and other development partners at local and national levels as it is one component of a larger integrated development program in each of the districts. The project aims to reduce poverty through improving sustainable livelihoods, WASH, community based disaster management, gender equity and the active participation of men and women in development processes.

Major activities

Activities described below are an aggregate of country level projects, with all four countries contributing to each outcome. However, not all outputs will be implemented in all countries due to existing contexts. Activities will also vary at country level due to different operating contexts and will not be implemented in all countries at the same time[xxiii]. Activities will be implemented within existing WV program sites, utilising existing structures and staffing which will allow for phasing in and scaling up and scaling down of activities[xxiv].

AACES Objective One: Marginalised people have sustainable access to the services[xxv] they require

Project Outcome 1: Improved and equitable access to MNCH services

This program objective supports AACES Objective 1 by focusing on improving the ability of health systems to deliver basic MNCH services, particularly for the most vulnerable groups in target communities. This will be done by improving both supply of and demand for services to ensure quantity and quality of services. This objective will be achieved through the following outputs and contributing activities:

Output 1.1: Increased capacity of Ministry of Health staff to deliver equitable services: At the health facility level, activities will include initiatives that refresh existing staff skills and build new knowledge of best practice for MNCH and nutrition. Capacity building for health facility staff will include clinical skills that directly impact on the quality of care: Infant and Young Child Feeding (IYCF); maternal nutrition; Malaria treatment in Pregnancy (MIP): Integrated Management of Childhood Illness (IMCI) and Emergency Management of Obstetric and Newborn Care (EMONC). For more sustainable change, the program will work with MoH at provincial and national levels to influence health staff curricula in areas of clinical practice, management, and interpersonal skills including equitable and accessible services for marginalised groups.

Activities aimed at management and leadership skills will focus on service provision with health facility management committees and a focus on innovation to improve Health Information Systems (HIS).

Output 1.2: Increased capacity of community structures to sustainably deliver health services at the household level: The project will network with and strengthen existing community health structures including CHVs, , VHTs, and other relevant groups such as nutrition care groups (NCGs), LMGs, parent support groups (PSGs), water sanitation committees (WSCs), disabled people's organisations (DPOs) and organisations for PLWHA. A number of these structures and groups will be strengthened through Organisational Self Assessment (OSA), training and mentoring. Linkages between health facility staff and community health structures are a key element of this design. MoH staff will be facilitated to supervise, mentor and support CHVs. This linkage will lead to better care, a better referral system, and improved flow of information and data from the community to the health facility and back to the community. This will include community groups facilitating the registration of births and deaths, a fundamental human right, through Community Based Registers. Relevant data showing the impact of improved service utilisation will be shared with the community to reinforce behaviour change.

Output 1.3: Increased community demand of health services: Underutilisation of health services can lead to poor quality services or cessation of service delivery. This project will promote household behaviour change to ensure communities demand services to improve utilisation and encourage the supply of quality services. Approaches focused on increasing community knowledge and understanding of barriers, attitudes and practice which impact on community access to MNCH services, will be used. This project will also use CV&A methodology to mobilise communities to form action plans with MNCH service providers for better quality services. This will ultimately lead to increased improved care of mothers and children and demand for and trust of the health system.

Through ttC, CHVs will counsel household members on MNCH messages and promote utilisation of antenatal, birthing, post-natal and child health care. The repeat household visits that comprise ttC will enable follow up on prevention messaging and exploring barriers to accessing care. Issues will include antenatal care, improved maternal nutrition, Healthy Timing and Spacing of Pregnancy (HTSP), child immunisation, use of mosquito nets and PPTCT. This approach will help ensure child survival through promoting care-seeking behaviours and access to curative care, as well as life saving actions in the home such as use of Oral Rehydration Solution (ORS) and zinc during diarrhoea. ttC will complement and integrate with CHVs and clinics' community outreach services by mobilising mothers and children to access these outreach services. As ttC is carried out in the household, the approach will increase support to those with limited access to centre-based services, including mothers with disabilities, mothers who are HIV positive, and the poorest mothers.

When visiting households and sharing information about *7-11* interventions in Uganda, VHT members will also discuss teen pregnancies and the health impacts of adolescent motherhood upon children, given the disproportionate representation of child mothers in maternal deaths. Men's influence over women's and children's access to health care will also be a core focus. Male CHVs will motivate other men to support women's access to care and to MNCH health services through C-Change. Traditional and socially constructed beliefs and practices which are harmful to health of women and children, as well as other vulnerable groups, will be identified, explored and agreement sought on alternative approaches.

Health messages will also be disseminated through community radio and talkback programs, and utilisation of health services will be further promoted through Community Care Coalitions (CCCs) that will encourage community members to seek Voluntary Counselling and Testing (VCT) and PPTCT services and provide follow up support.

Through CV&A community gatherings, the program will work with health service users and providers to identify gaps in services such as stock-outs of drugs, attitudes to clients (particularly excluded groups like women with disabilities and PLWHA) and housing for health centre staff. Advocacy initiatives focused on increasing access to health services will give some emphasis to exploring transport options and improving road conditions, for example, roads being graded after wet season by council. Other planned activities

include exploring options for community based transport with social protection/community insurance plans eg motorbike ambulances in Tanzania.

Project Outcome 2: Adoption of positive nutrition and WASH practices at community level leading to improved MNCH

This objective will ensure that women and children in target communities have sustainable access to good quality food and water, which are essential for good nutrition and health. Activities contributing to this objective focus on community capacity to produce and acquire nutritious food, increasing knowledge and behaviour change around food utilisation and hygiene practices.

Output 2.1: Improved knowledge of communities on good nutrition practices and health rights: The project will support community groups to increase knowledge and behaviour around good nutrition practices. WV will work with community health structures and groups such as NCGs, LMGs, PSGs and key stakeholders in identifying nutritional deficits and targeting response interventions; increasing household knowledge on maintaining diet requirements during pregnancy and lactation, exclusive breastfeeding and weaning foods; and other MNCH interventions to community leaders and households. Support for changing attitudes and practice will be provided through ttC of pregnant and lactating women and their husbands/partners, conducted by VHTs and NCGs comprised of local male and female farmers, and through implementing PD Hearth which will improve Knowledge, Attitude and Practices (KAP) at the same time as rehabilitating moderately malnourished children. C-Change will be used for community education and behaviour change for men and women, to make maternal and child nutrition a priority and to tackle nutrition related taboos and beliefs.

Output 2.2: Improved food nutrition for women and children: The program will increase production, accessibility and utilisation of nutritious foods. The project will work with the Ministries of Agriculture, to strengthen existing farmers' groups (that include many women of child bearing age and PLWHA) and support kitchen gardeners, to increase production of nutritious food that is diverse and drought tolerant, for use in the home and sale through farmer field-days. Small livestock production through revolving loan schemes, with a concomitant increase in knowledge and demand for animal protein during pregnancy and weaning, will contribute to reducing anaemia. Affordable and appropriate-technology post harvest and food storage techniques will be facilitated. Farmers' Groups will be supported to form NCGs to undertake community capacity activities related to MNCH, including training on the dietary requirements of pregnant and lactating women, and healthy foetal and infant growth. The project will also promote the use of technologies that enhance production and marketing information. Women's impact on production and marketing decisions at the household level will be investigated to inform empowering education and advocacy messages; women in Africa are often highly involved in farm management, selling goods in the market, and food purchases. Land ownership is often an issue underlying food security; therefore advocacy will be undertaken at all levels (community, national, regional and international levels) for protection and empowerment of smallholder farmers.

Output 2.3 Improved access to markets: Analysis of food markets (and the supply chain) through participatory farmer research teams will highlight market problems (supply, demand and price issues) related to nutritious food. This will inform production and value chain interventions to improve the availability, quality and affordability of nutritious food, leading to improved nutrition. Following an in-depth analysis of production, supply and market issues, the project will work with government and community groups, including women, to build their capacity to do market analysis. NCGs will be supported to undertake participatory market analysis in their local markets and will be linked with National Agricultural Advisory Services. This approach is new for WV and is a research opportunity which will be commenced in Tanzania and scaled up over the program's duration, if appropriate.

Output 2.4: Reduced under-five mortality from disease through hygiene promotion and increased access to clean water: The project will build the capacity of community groups to ensure better WASH practice and infrastructure. Interventions will protect health through ensuring safe management of excreta and the use of secondary barriers such as hand-washing with soap. The construction and use of accessible, safe and hygienic latrines/toilets and other sanitation facilities for men, women and children will be promoted

through community groups, e.g. VHTs, WSCs, and PSGs. WSCs will be supported to implement government WASH policy. Using CV&A, the project will raise community capacity to advocate for improved WASH services. The project will leverage other funding sources (ADP and grants) to gain access to infrastructure for clean water including boreholes, in under-serviced areas. Changed hygiene behaviours will be achieved through supporting local level government to deliver training to VHTs in implementation and monitoring of Participatory Hygiene and Sanitation Transformation (PHAST) and Community Led Total Sanitation (CLTS) methodologies. VHTs will be supported to roll-out these methodologies at community level to WSCs and PSGs. Water harvesting for kitchen gardens will reinforce food security.

Project Outcome 3: Favourable policy environment for improved MNCH

The project objective will be achieved through integrating programming interventions with advocacy approaches as a practice that will increase access to sustainable services in the communities where the program is working.

Output 3.1: Build community advocacy capacity: The project will work with communities to: increase information accessibility and transparency; strengthen their voice through education and empowerment; provide opportunity for dialogue; and promote power holders to be accountable. The program will build community advocacy capacity using approaches such as CV&A. As issues emerge through this organic approach, driven by community priorities, community voices will be amplified by feeding into CHN, WV's campaign platform for advocacy work on MNCH at national and international levels. Intentional reflection and sharing on promising practices (such as ttC and PD Hearth) will also contribute to improved policy delivery and learning.

Output 3.2: Sharing promising practices: Best practice case studies will be compiled (reports, documentaries etc) to inform policy delivery. The program will particularly focus on promising practice around markets influencing the nutrition of women and the remuneration of CHVs. Inherent in the M&E framework will be the use of innovative tools such as mobile phones for community level data entry and information sharing. WV will utilise its Sector Learning Centres in the region, to coordinate research with external institutions for specific examination of MNCH promising practice. This learning will influence WV's future MNCH programming and external duty bearers to influence MNCH policies.

Output 3.3: Dialogue on relevant national policies and practices: The policy issues to be raised during this project will be determined through CV&A and C-Change interventions when communities prioritise their own MCNH challenges. CHN is World Vision's platform for Advocacy work on MNCH; work in local projects is clearly linked to national and international engagement. CHN will use data and stories collected through CV&A to inform national, regional and international levels for engagement with policy makers and relevant governments, regional and multinational bodies. There will also be contribution to the development of innovative and appropriate gender sensitive and inclusive public health policies and activities in East Africa. WV will work closely with the MoH and Agriculture, District Administrations (DA), UNICEF, WHO, WFP and other agencies working on nutrition, to develop strategies for improved nutrition and to support the implementation of existing national nutrition strategies. Key advocacy and influencing approaches will include profiling success stories and issues from the project through formal (TV, Movies, Newspaper, Forums and publications) and informal (Internet, Mobile phone) channels.

Partnerships with key stakeholders - including NGO partners, communities, policy makers and practitioners – will facilitate greater understanding of MNCH, community health practices, health issues, and priorities for men and women.

AACES Objective Two: AusAID policy and programs in Africa are strengthened particularly in their ability to target and serve the needs of marginalised people

Project Outcome 4: AusAID's policy and practice on Africa Development is better informed

Output 4.1: Promising practices shared with other AusAID programs in Africa: In collaboration with other AACES partners and utilising good programming practice around Performance Based Finance (PBF) for health workers, the project will demonstrate to AusAID that CHVs are central to delivering many health services to communities, yet despite often being poor themselves, they are not adequately compensated. Furthermore,

NGOs that work through CHVs are not consistent in their approach to their remuneration which can lead to competition between NGOs and negatively affect sustainability. It is expected that AusAID Africa Health program will work in concert with the AACES program to influence host Governments to find collaborative systems to support CHVs.

Building on evidence from the effect on increased capacity of health staff in the delivery of quality services the project will influence AusAID to increase its funding allocation for in-country midwifery and nurse training. During the first year of the project, there will also be meetings with AusAID to understand specific AusAID priorities relating to policies and programming in Africa, to articulate how the project will contribute further to these.

AACES Objective Three: Increased opportunity for the Australian public to be informed about development issues[xxvi] in Africa

Project Outcome 5: Australian public is better informed on MNCH development issues in Africa

Output 5.1: Increased opportunities for the Australian community to engage in the Africa development agenda: The EAMNCH project will share its learnings with a wider audience of the Australian public, to explain the complexities of development practice and MNCH needs. During the first year of implementation, different public segments of the Australian community will be identified and thereafter reached using appropriate existing community engagement methods. Wherever possible, the resilience and resourcefulness of East African communities will be highlighted rather than the negative stereotypes often presented to Australians.

WVA will work with AACES and other ANGO partners (e.g. those collaborating on One just World, MICAH Challenge, CHN and Make Poverty History) to explore opportunities over the first year of the program. WV contributions to these partnerships could include hosting forums, producing publications and existing Australian networks such as WV youth network V-Generation, churches and school partnerships.

Monitoring and evaluation

The core of the M&E approach will utilise WV's established LEAP framework (Learning through Evaluation Assessment and Planning) with some innovative additions where possible. WV will seek to build upon already existing community and Government M&E structures (formal & informal) in informing best practice and raising issues through strength based advocacy approaches. Key selected indicators that will show contribution to the realisation of the project goal will be monitored at village and facility levels. These will include, but not be limited to the following:

Selected Indicator	Data Collection Method	Frequency	Responsible
Goal: Improved maternal, newborn and child health in selected districts in Kenya, Rwanda, Tanzania and Uganda - % reduction in infant and < 5 child mortality - % reduction in children aged 6 – 59 months who are stunted - % reduction in anaemia in pregnant women - % increase in number of women delivered by a skilled birth attendant	District Health data, Household survey, WV STEP reports[xxvii], Birth registers	Annually	CHV, VHT
Outcome 1: Improved and equitable access to MNCH services *(AACES Objective 1)* - % increase in children 0-59 months who received age appropriate immunization - % increase in men and women using family planning - % increase of women (including those with a disability) indicating that they are treated with respect by health staff - Reduced cost and time to obtain basic EMNOC - % increase in women receiving 4 quality ante-natal visits	Health facility Data, Focus Group Discussions, MSC with video stories, Market survey for contraception methods	Semi-Annually	CHV, VHT

Outcome 2: **Adoption of positive nutrition and WASH practices at community level leading to improved MNCH** *(AACES Objective 1)* - % WRA who practiced WHO minimum standards for IYCF (includes giving colostrum, EBF, complimentary feeding, correct time and amount) - % WRA eating adequate and balanced diet - % increase in households that wash hands with soap after visiting the toilet	MSC with video stories HH Food survey, Food market survey Focus Group Discussions, PD Hearth Registers, Village Hygiene Maps	Semi-Annually	CHV, VHT, Nutrition groups WASH groups
Outcome 3: Favourable policy environment for improved MNCH *(AACES Objective 1)* - % increase in civil society groups that demand better MNCH services - # districts receiving increased health resources going to primary health care - # of CV&A groups implementing local action plans	Focus Group Discussions Key Informants, Review of District budgets	Semi-Annually	CHV, VHT, CHN campaign team
Outcome 4: *AusAID's policy and practice on Africa Development is better informed* *(AACES Objective 2)* - increase in dialogue with AusAID regarding funding allocation for in-country midwifery and nurse training to Africa - # of inputs into AusAID policy and frameworks for Africa	Key Informants, Review of AusAID publications	Semi-Annually	Project staff, WVA Africa team and Grants team
Outcome 5: *Australian public is better informed on MNCH development issues in Africa* *(AACES Objective 3)* - % increase in number of people involved in CHN campaign - % of WV articles containing MNCH messages in the media	CHN Database by action, WV media archives	Semi-Annually	CHN team, WV media team
Output level Indicators - Increased number of women practising exclusive breastfeeding - # of villages with functioning nutrition groups dedicated to improving and preventing child malnutrition PD Hearth groups - # of women who sell and buy produce from local markets based on their need for nutritious foods - # of HH with hand-washing facilities at latrine - # of civil society groups that demand better MNCH services - # of AusAID staff participating in WV-organised meetings - # of One Just World events that have an Africa focus	Targeted Sample Survey, Key Informants, Community mapping, Focus Group Discussions	Monthly and Semi-Annually as appropriate	Health Facility Staff, Project team, CHN team, CHV,VHT, WASH committees

The community members including women will actively participate in tracking key MNCH indicators at both community and health facility level that will allow monitoring at a project level. Data collection will integrate with the existing health facility data so that where data exists for measuring the project performance, no additional collection will be done. Analysis of the data will be done so it will become usable to community groups. In addition to the qualitative data collection methods, the community will be trained to track stories related to the key indicators through a simple filming methodology that allows greater insight into project performance and direction. The change stories that will be captured by the community and project staff will play a critical role in policy influence interventions.

Through qualitative methods such as community forums and focus group discussions, community members including women, people with disability, children and the elderly, will participate in indicator benchmarking and monitoring implementation. They will continue to feed into the adjustment of yearly Detailed Implementation Plans and to inform decisions around project management. The project has been intentional in integrating M&E activities with its implementation strategy. For example, through our participatory and advocacy approaches we will mobilise the most vulnerable groups through CV&A to feed into existing M&E structures.

CHN and CV&A will also play a crucial role in monitoring the flow of increased MNCH resources and funding reaching these project areas. In partnership with other actors, the information and stories gathered (words and films) will be used to advocate for policy change and enactment at National, Regional and Global levels, including in Australia. The EAMNCH project will, in the second year, establish a webpage[xxviii] where communities, project staff and other stakeholders will feed in their comments and reflections through short films, SMS, and email where applicable. The stories will capture the complexity of development issues and will be used to inform and engage the Australian community. Stories will show the relationship between poverty and MNCH issues and how this further impacts on women and people with a disability. Further explanation on the project M&E plans are in Annexe 3.

Risks

Project risk analysis will be continuously updated throughout the project cycle. Major risks (contextual, design and implementation) identified with local communities and partners include (see Annex 4):

- ***Emerging and competing government priorities*** resulting in MNCH being given low priority leading to low budget allocation to MNCH services which has direct negative effect to the sustainability of the project.
- ***Political instability in relation to elections and their outcomes*****:** elections will occur in all four countries during the life of the project. Violence that may result after elections may have negative effect on implementation and deliverables of the project.
- ***Climate instability*** **(prolonged droughts and floods):** the project areas likely to be affected by this risk are in Uganda and Kenya. These are drought and flood prone areas.
- ***High attrition of trained health workers due to transfers and seeking new employment in urban areas*****.** Trained health personnel are sought after by different organizations and health facilities.
- ***Complexity of delivering programming across four countries*****:** Implementing a multi-sector and multi-country program is complex and can lead to inconsistencies in implementation leading to lowered program outcomes.
- ***De-motivated CHVs due to varying forms of incentives offered by different organisations and increasing workload*****.** These may affect the commitment of volunteers based on what they perceive to be good incentives.
- ***Project partners may not fulfil expectations due to competing priorities.*** Despite MOUs and other agreements, partners may opt to shift their commitments away from the project.

Sustainability and Transition/Exit strategy

Sustainability and transition strategy of the project has been imbedded in its approach. At the end of the EAMNCH project, due to its approach, there will be empowered community structures and systems including CHVs, VHTs, PSGs, IGA groups, WSCs, NCGs, farmers' groups and men's groups so that the demand for improved nutrition, MNCH and WASH will continue. Health facility staff will be better trained to deliver clinical services within an improved facility structure and system. The project will lead to better functioning Local Government Authorities and partners, ensuring a sustainable supply of MNCH services to communities. Policies that reflect the issues and needs identified at community level will lead to improved MNCH. A growing number of Australians will have a deeper awareness and understanding of development issues in Africa, particularly around MNCH and will be able to appropriately engage.

Advocacy approaches are crucial for sustainability. The sustainability strategy of this project includes working with existing health structures and systems where the project will provide inputs in the initial three years of the project and that will be reviewed at the mid-term evaluation. During these initial years, the project will demonstrate preventative MNCH practices such as ttC and IMCI to improve child survival, and malnutrition rehabilitative/curative practices such as PD Hearth. This demonstration of promising practices coupled with CV&A efforts will lead to governments and other partners appreciating and thereafter supporting them as models integral to their MNCH services. The CV&A approach and community conversations will mobilise and strengthen the capacity of community groups to demand MNCH services and improve their relationships

with service providers. The capacity enhancement of MNCH service providers at local, regional and national levels will ensure that they can effectively meet the community demand beyond the project's duration. The sustainability strategy also emphasises the changing roles of different stakeholders in the life of project: WV may take the lead in the initial years of the project, but its role will intentionally transition to that of a facilitator with the community, government local structures and other partners assuming the leading roles (with full awareness of how difficult this can be to achieve). As the project is being implemented in existing WV ADPs and project sites, programming will be integrated within the ADPs and so will continue to be implemented on completion of the EAMNCH project. Furthermore, there will be ongoing support to the Government and key partner relationships.

The strategy for building sustainability has included engaging and involving stakeholders, community groups and local structures in generating the ideas within this design; they have been central in charting the course of the project. They will remain critically involved throughout project implementation, monitoring and evaluation as part of their ownership of project interventions and outcomes. Capacity building at household level will lead to continued practise of good health and nutrition behaviours that will ensure good health and survival for pregnant and lactating mothers and their children.

Combined with the approach of integrating advocacy with programming, the project's community based M&E framework will enable community members, local government authorities and other partners to monitor project outcomes (including progress towards sustainability) and make relevant decisions. Semi-annual reflection meetings with community groups and stakeholders will ensure that the sustainability strategy is effectively managed and monitored.

The exit plan of this project includes working with ADPs and local government decentralised authorities in all project stages so that they will incorporate project activities into their annual plans. Formal agreements have been made with local health authorities in all four countries. Project assets will be handed over to the partners who will continue working in the area after the project is completed.

AusAID Policy Requirements

All EAMNCH project work will contribute to the sustained wellbeing of children within families and communities, especially the most vulnerable. In pursuing this impact, WV will be advancing relevant international conventions including the Convention on the Rights of the Child, Convention on Elimination of all forms of Discrimination Against Women and the Convention on the Rights of Persons with Disabilities. All these are embedded within AusAID policies.

Child Protection: Child protection is critical to fulfilling child rights and achieving WV's 'Child Wellbeing Outcomes', especially that children are 'cared for, protected and participating'. WV will actively incorporate child protection activities across the project, to identify child protection issues and address any risks. WV is an AusAID accredited agency with a Child Protection Category 3 compliance standard and it ensures that partner organisations also comply appropriately.

Environment: All project environmental impacts will continuously be monitored during implementation in accordance with the Environmental Protection & Biodiversity Act. As an unstable climate has been identified as a risk, food security interventions will focus on disaster risk reduction and promotion of drought tolerant crops. The project will ensure partners test the quality of water from boreholes to mitigate any negative effects on people and physical environment.

Inclusive Development: In line with the principle of 'Nothing about Us without Us', the EAMNCH project will continue to work with people with disabilities, DPOs and social service providers across the four countries to address attitudinal, institutional and physical barriers faced by people with a disability in accessing good nutrition, MNCH and WASH services. Activities include training caregivers, enhancing accessibility of services and providing leadership to policy initiatives. This will increase the decision-making of people with disabilities, improve quality of life, and ensure social inclusion.

All four countries have a high prevalence of HIV. As such, the EAMNCH project prioritises PPTCT and working with PLWHA on access to nutritious foods. CCCs will be trained to provide effective support to orphans and vulnerable children.

Gender: Women and men have been involved in indentifying the issues to be addressed in this project. Through gender analysis in all four countries, interventions have been developed to address underlying gender inequalities, improve women's leadership in decision-making, and ensure women's equitable access to health services. The project acknowledges the role of men in decision making and will ensure that men and boys are engaged through C-Change, ttC at the household level and the involvement of men in NCGs with direct links to farmers groups, to influence decisions in a positive way for men and women.

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[i] For example, anaemia, helminth and other infections

[ii] During the workshop the team explored "the change that we want to see, how we are going to get there, and what assumptions we are making".

[iii] See Annex 7 EAMNCH Project Map which informs the Theory of Change

[iv] Trends in Maternal Mortality: 1990 – 2008 Estimates developed by WHO, UNICEF, UNFPA and The World Bank

[v] Levels & Trends in Child Mortality Report 2010 Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation

[vi] Kenya - DHS 2008. Rwanda - Comprehensive Food Security and Vulnerability Assessment, 2009. Uganda – DHS, 2006. Tanzania – Country Profile: Maternal, Newborn and Child Survival UNICEF, March 2010

[vii] Kitgum District Development Plan, Uganda 2008 - 9

[viii] Masaka Care Support and Treatment Project for PLWHA, World Vision 2010

[ix] Tanzania Third Health Sector Strategic Plan 2009-2015

[x] Child Survival and Development Strategy (2008-2015) and the Reproductive Health Strategy (2009-2015), Kenya

[xi] Uganda National Development Plan (2010/11-2014/15), the Health Sector Strategic Plan and the Kitgum District Local Government Approved 3-Year Development Plan 2009-2011,

[xii] Rwanda Health Sector Strategic Plan 2009 - 2012

[xiii] See Annex 6

[xiv] See Annex 8

[xv] Kilindi District Health Plan, 2010 Tanzania

[xvi] Rwanda Comprehensive Food Security and Vulnerability Analysis and Nutrition Survey in 2009

[xvii] See Annex 6

[xviii] See Annex 6

[xix] World Vision Uganda Citizen voice and Action, Case Study Report, 2010

[xx] World Vision through its Integrated Programming Model (IPM) is using Strength Based Approach and partnership is all its projects.

[xxi] See Annex 6

[xxii] See Annex 6

[xxiii] See Annex 1 and 1B

[xxiv] See Annex 8

[xxv] For this program there is particular interest in services provided for food security, maternal and child health and water and sanitation. However provision of other services as required by people should also be included as the outcomes for this objective.

[xxvi] Some further consideration about central messages to be undertaken as part of implementation phase

[xxvii] WV Registered Child Management database

[xxviii] This will be similar to the style of the Ushahidi website – an interactive, community based approach http://ushahidi.com/

Annex 1: 1 Year Detailed Implementation Plan

AACES Country level Objective 1 - Uganda

East Africa Maternal and Child Health Project

World Vision

	Summary of objectives	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Project Goal	To improve maternal and child health in Lagoro and Mucwini sub-counties, Kitgum District, by June 2016												
AACES Objective 1	*Marginalised people have sustainable access to the services they require*												
Outcome 1	**Improved and equitable access to MNCH services**												
Output 1.1	**Increased capacity of Ministry of Health staff to deliver equitable services**												
Activity 1.1.1	Recruit, orientate and train staff												
Activity 1.1.2	Facilitate District health specialists to mentor 24 staff and volunteers in 2 health centers III in areas like interpersonal skills, how to treat women with disabilities, and counsel pregnant teenagers, supervision of staff and VHTs												
Activity 1.1.3	Facilitate 2 health centres III to carry out quarterly community outreaches on ANC and PNC, immunization and growth monitoring												
Activity 1.1.4	Facilitate District Biostatistian to mentor staff in 2 health centers III, 1 health center II and VHTs in collecting and analysing health data and do data validation												
Activity 1.1.5	Print and disseminate treatment and service delivery guidelines/charts for health facilities												
Activity 1.1.6	Engage with MoH on the curriculum for health workers (year 2)												
Output 1.2	**Increased capacity of community structures to sustainably deliver health services at the household level.**												
Activity 1.2.1	Conduct mapping of VHTs in 6 parishes in 2 sub-counties; their location, training they had, quality of their services												
Activity 1.2.2	Follow up with the Government on their plans to train all VHTs in Kitgum and if needed lobby with District to train VHTs without basic training												
Activity 1.2.3	Provide 85 VHTs (In 6 parishes) with basic tool kit, as recommended by MoH												
Activity 1.2.4	Support review quarterly meetings with VHTs for data collection and technical assistance												
Activity 1.2.5	Facilitate training of 30 (1 per village) pregnant and lactating women (including women with disabilities) as TOTs in MCH issues like exclusive breast feeding, use of ORS and mosquito nets, immunization, ANC and PNC services, birth and death registration												
Activity 1.2.6	Support TOTs to form 30 Parent Support Groups (PSGs) consisting of 10 pregnant and lactating women (including those with disabilities) and their husbands and share MCH issues in monthly meetings												
Activity 1.2.7	Train MoH and WVU staff as TOT's in Timed and Targeted Counseling (ttC) (year 2)												
Activity 1.2.8	Train VHTs in ttC (year 2)												
Activity 1.2.9	Support VHTs to conduct ttC (year 2)												
Output 1.3	**Increased community demand for health services**												
Activity 1.3.1	Orient staff and community in 'stepping stones' methodology												
Activity 1.3.1	Facilitate 6 VHTS to conduct monthly community conversations, using 'stepping stones' on issues like HTSP, early marriage and gender issues related to MCH with community members and clan leaders (including those with disabilities)												
Activity 1.3.2	Facilitate 6 (NUMAT) peer educators to conduct monthly community conversations using 'stepping stone' with child headed households on HTSP, early marriage and gender issues related to MCH												
Activity 1.3.3	Facilitate CVA TOTs to sensitize 6 parishes in the health policy, food bill and water and sanitation policies												
Activity 1.3.4	Organize bi-annual CVA Community gatherings with community members (including those with disabilities) in 2 subcounties to improve the quality of services offered												
Activity 1.3.5	Facilitate CHN shuttle to strengthen CVA activities in the communities												
Activity1.3.6	Organize bi-annual CVA subcounty dialogues (2) to improve the quality of services offered												
Activity 1.3.7	Organize bi-annual CVA district dialogues to improve the quality of services offered												
Activity 1.3.8	Produce and disseminate IEC materials of rights of mothers and children to MCH												
Activity 1.3.9	Organize bi-monthly radio programs about ANC, PNC and other available MCH services as well as project level data												
Activity1.3.10	Organize sensitization meetings with communities in 6 parishes about community based transport systems, including for people with disabilities (year 2)												

Outcome 2	**Adoption of positive nutrition and WASH practices at community level leading to improved MNCH**													
Output 2.1	**Improved knowledge of communities on health rights and good nutrition practices**													
Activity 2.1.1	Facilitate training of 40 VHTs in PD hearth													
Activity 2.1.2	Facilitate 40 VHTs to conduct PD hearth													
Activity 2.1.3	Train 40 VHTs as TOTs in Infant and Young Child Feeding (IYCF) practices and nutrition for pregnant women													
Activity 2.1.4	Provide 40 VHTs with IEC materials on nutrition, to share with PSGs													
Activity 2.1.5	Facilitate 40 VHTs to share IYCF and nutrition information with 30 PSGs													
Activity 2.1.6	Support 40 VHTS to monitor the PSG in the application of the learned knowledge													
Activity 2.1.7	Through CVA meetings build capacity of PSGs and other community members in 6 parishes to advocate for food supplements by HC, protection of farmers rights, encouragement of small scale producers to produce biofortified food													
Output 2.2	**Improved nutrition for women and children**													
Activity 2.2.1	Analyse with 30 PSG leaders gaps in the production and preservation of nutritious foods													
Activity 2.2.2	Establish 30 PSG demonstration and learning plots													
Activity 2.2.3	Facilitate Agricultural specialists to conduct TOT of 60 PSG leaders/members in the indicated areas of gaps (production and post harvest crop management, including crop preservation)													
Activity 2.2.4	Support National Research Organisation (NARO) to provide biofortified agricultural planting material for demonstration fields of PSGs (year 2)													
Activity 2.2.5	Provide small livestock and poultry to 30 PSGs as revolving fund													
Activity 2.2.6	Facilitate Veterinary specialists to conduct TOT of 60 PSG leaders in livestock keeping													
Activity 2.2.7	Facilitate Agricultural and Veterinary specialists to conduct follow up visits of PSGs													
Output 2.3	**Improved access to markets**													
Activity 2.3.1	Conduct food market and value chain market analysis, with regards to the availiability of nutritious foods													
Activity 2.3.2	Conduct sensitization meetings for 30 PSGs on the importance of consuming nutritious (biofortified) food													
Activity 2.3.3	Facilitate 6 VHTs and 6 peer educators to conduct community conversations on gender issues related to access of nutritious foods													
Output 2.4	**Reduced under-five mortality from disease through hygiene promotion and access to safe water**													
Activity 2.4.1	Train 40 VHTs and 30 local leaders as TOTs in PHAST (year 2)													
Activity 2.4.2	Facilitate 40VHTS and 30 local leaders to roll out PHAST and CLTS with the 30 PSGs and other community members in 6 parishes (year 2)													
Activity 2.4.3	Disseminate IEC materials on hygiene and sanitation to VHTs, Water Source Committees and community members (year 2)													
Activity 2.4.4	Through CVA meetings build capacity of community members and Water Source Committees in 6 parishes to advocate for more boreholes and water sources in the community (year 2)													
Outcome 3	**Favorable policy environment for improved MNCH**													
Output 3.1	**Community advocacy capacity built**													
Activity 3.1.1	Training of staff , VHTs, Peer educators in local level advocacy(CVA approach)													
Activity 3.1.2	Orient 6 VHTs and 6 (NUMAT) peer educators - persons with disabilities included- on the use of the community conversations/stepping stones approach (4 per parish)													
Activity 3.1.3	Facilitate training of PSGs in OSA and OD (year 2)													
Output 3.2	**Sharing promising practices**													
Activity 3.2.1	Quarterly project review meetings with Project Management Committee, community representatives, partners, WV staff,													
Activity 3.2.2	Annual WV AACES lessons learned meetings with representatives from WV Kenya, Tanzania, Rwanda and Uganda													
Activity 3.2.3	Participate in regional reflection meetings, with AusAID and AACES partners													
Activity 3.2.4	Compilation of best practice case studies to inform policy delivery (year 2)													
Activity 3.2.5	Through WV Sector Learning Centres coordinate research with external institutions for specific examination of MNCH promising practices (year 2)													
Output 3.3	**Dialogue held on relevant national policies and practices**													
Activity 3.3.1	Lobby at district and national level for improved support to health facilities II and III (through CHN campaign and sharing in networks and working group meetings)													
Activity 3.3.2	Advocate for identified issues (through CVA) at national level, through networks, working groups, CHN campaign and other means													
Activity 3.3.3	Work with MOH to develop a National VHT motivation strategy													
Activity 3.3.4	Engage with AACES partners and other NGOs on the importance of a standardized VHT motivation strategy and encourage them to adopt it (year 2)													
Activity 3.3.5	Meet with AACES partners on a quarterly basis to discuss and plan for joint policy dialogue activities													

Annex 1: 1 Year Detailed Implementation Plan

AACES Country level Objective 1 - Tanzania

East Africa Maternal and Child Health Project

World Vision

	Summary of objectives	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Project Goal (evaluation)	Improved Maternal Nutrition and Child Health in selected Communities in Kilindi District												
AACES Objective 1	*Marginalised people have sustainable access to the services they require*												
Outcome 1	**Improved and equitable access to MNCH services**												
Output 1.1	**Increased capacity of Ministry of Health staff to deliver equitable services**												
Activity 1.1.1	Recruit, orientate and train staff												
Activity 1.1.2	Facilitate training of Health workers in IMCI, IYCF, EMONC and 7-11 intervention packages.												
Activity 1.1.3	Facilitate health workers to conduct MNCH services analysis and mapping of gaps at health facility level.												
Activity 1.1.4	Facilitate training of volunteer community health workers to enable them collect relevant information within their villages.												
Activity 1.1.5	Promote use of mobile phone-based technology to strengthen data collection, referral and follow-up of pregnant women and ill children.(Year 2)												
Activity 1.1.6	Strengthen supportive supervision and development of technical capability of health workers at health facility and district levels												
Activity 1.1.7	Partner with Ministry of Health and Social Welfare and other NGOs and Health institutions to review/develop user-friendly Protocols for antenatal care, postnatal care, newborn and childcare, EmOC, Family Planning and Nutrition.												
Activity 1.1.8	Sensitize Council Health Management Team to plan and integrated health train and supervision of Basic emergency obstetric and neonatal care in Comprehensive Council Health Plan. (Year 2)												
Activity 1.1.9	Collaborate with University institutions/NGOs in delivering health and management information systems (HMIS) courses for Health workers (year 2)												
Output 1.2	**Increased capacity of community structures to sustainably deliver health services at the household level.**												
Activity 1.2.1	Develop and disseminate messages and tools to support VHWs & CBDs implement ttC on 7-11 and ENA at household level.												
Activity 1.2.2	Facilitate community mobilization in mapping issues affecting delivery of maternal, newborn and health services at community level.												
Activity 1.2.3	Facilitate communities to develop action plans to address and monitor maternal, newborn and child health issues.												
Activity 1.2.4	Build capacities of ward and village health committees in organizational self-assessment.												
Activity 1.2.5	Facilitate community through organizational self assessment to appreciate strengths, resources and opportunities to utilize in establishing and managing community resources for emergency transport of pregnant women, newborns and sick children.												
Activity 1.2.6	Promote use of motorbike ambulance to strengthen household to health facility referral (Year 2 if appropriate)												
Activity 1.2.7	Facilitate training of VHWs, village health committees and village leaders on emergency and response preparedness plans (Year 2)												
Activity 1.2.8	Facilitate establishment of village birth and death registers												
Activity 1.2.9	Facilitate Training of c-IMCI Trainer of Trainers and roll-out of c-IMCI.												
Output 1.3	**Increased community demand for health services**												
Activity 1.3.1	Facilitate implementation of community conversations about family planning, maternal and child nutrition and health care, Prevention of Parent to Child Transmission (PPTCT), early marriages and teenage pregnancies.												
Activity 1.3.2	Build and nurture partnership with communities, CBOs, Faith Based Organization and NGOs to advocate to the government to develop incentives for skilled health workers working in rural areas.												
Activity 1.3.3	Facilitate CVA on data use for Health planning at community and district level												
Activity 1.3.4	Facilitate training of volunteer community health workers to enable them collect relevant information within their villages.												
Outcome 2	**Adoption of positive nutrition and WASH practices at community level leading to improved MNCH**												
Output 2.1	**Improved knowledge of communities on health rights and good nutrition practices**												
Activity 2.1.1	Facilitate training to influential individuals (fathers, senior women) in families to support optimal breastfeeding and complementary feeding practices.												
Activity 2.1.2	Conduct cooking demonstrations to parents/ caregivers groups on proper preparation of nutrient-dense complementary foods.												
Activity 2.1.3	Train RCH staff and health facility staff to be counsellors on IYCF												
Activity 2.1.4	Conduct gender awareness sessions to address women's workload and Exclusive Breastfeeding for 6 months.												
Activity 2.1.5	Train VHWs, volunteers and conduct Positive deviance/Hearth sessions in communities with underweight prevalence equal to or >30% (Year 2)												
Activity 2.1.6	Train village health committees and nutrition groups to mobilized local food resources to support rehabilitation of underweight children where prevalence <30% (Year 2)												
Activity 2.1.7	Facilitate formation of men's club promoting men involvement in maternal and child care, nutritional needs of pregnant women & lactating mothers and young children.												
Activity 2.1.8	Facilitate training to married men on optimal breastfeeding and complementary feeding practices												

Activity 2.1.9	Promote use of lifecycle approach to deliver critical messages that empower both men and women at different stages of their lives.													
Activity 2.1.10	Facilitate community conversations to enhance communication between men and women on issues of sexuality, Reproductive health and their joint responsibilities in MCH.													
Activity 2.1.11	Provide integrated reproductive health education to young people on family planning, gender relations, STDs and HIV/AIDS and sexual abuse.													
Activity 2.1.12	Facilitate community sensitization on utilization of RCH services (Develop Radio and Campaign programs).													
Activity 2.1.13	Establish/strengthen home distribution and supervision mechanism of iron supplement to pregnant women using VHWs and CBDs.(Year 2)													
Activity 2.1.14	Support Vitamin A Supplementation campaign in the targeted communities													
Activity 2.1.15	Facilitate availability of Vitamin A Capsules at health facilities in the targeted district (Provide logistic support to distribute and supervise availability of supplies)													
Activity 2.1.16	Create awareness on importance of Vitamin A supplements to lactating mothers and under- five children in the targeted district.													
Activity 2.1.17	Establish/strengthen monitoring system on use of iodized salt at HH level (Year 2)													
Activity 2.1.18	Train Village, Ward and district official on importance and monitoring of salt iodization and reinforcing iodization policy. (Year 2)													
Output 2.2	**Improved nutrition for women and children**													
Activity 2.2.1	Facilitate situation analysis of post harvest loss and existing gaps on post harvest loss management among small farmers.													
Activity 2.2.2	Develop and distribute training packages on post harvest loss management.													
Activity 2.2.3	Promote appropriate technologies suitable for post harvest processing and storage of agricultural products.													
Activity 2.2.4	Facilitate community sensitization and awareness on establishment of community cereal banks.													
Activity 2.2.5	Promoting smallholders farmers participation in Farmers' associations													
Activity 2.2.6	Build Capacity of small farmers to produce and market agricultural products (Year 2)													
Activity 2.2.7	Strengthen technical and institutional capacity of local government to give small farmers better access extension services.													
Activity 2.2.8	Support capacity building of farmers and farmers' organizations													
Activity 2.2.9	Facilitate formation and strengthening of farmer's groups and community banks.													
Output 2.3	**Improved access to markets**													
Activity 2.3.1	Facilitate markets and value chain analysis and study of women's roles in production and marketing													
Activity 2.3.2	Facilitate creation of business linkages between farmers and the large private sector by improving information on market opportunities, value addition and entrepreneurial skills. (Year 2)													
Activity 2.3.3	Promote the commercial village approach and pro poor market innovations (Year 2)													
Output 2.4	**Reduced under-five mortality from disease through hygiene promotion and access to safe water**													
Activity 2.4.1	Support rehabilitation/improvement of water supply systems. (Year 2)													
Activity 2.4.2	Facilitate community participation in establishment of water committees in each village for maintenance and expansion of water supply systems.													
Activity 2.4.3	Facilitate Citizen Voice and Action (CVA) session at village, ward and district level.													
Activity 2.4.4	Facilitate communities to use Strength based approaches to plan, implement and maintain water projects.													
Activity 2.4.5	Facilitate implementation of community scorecard for monitoring government activities and plans related to WASH.													
Activity 2.4.6	Conduct Hygiene Workshops promoting hand washing to women of childbearing, school children and married couples.													
Activity 2.4.7	Facilitate Hands on training workshops for community-led total sanitation (Year 2)													
Activity 2.4.8	Promote appropriate, cost-effective sanitation and hygiene technologies at household level. (Year 2)													
Activity 2.4.9	Facilitate communities using participatory approaches to identify sanitation and hygiene problems in their area, solutions to their problems, monitoring and evaluation change in sanitation facilities and behaviour. (year 2)													
Outcome 3	**Favorable policy environment for improved MNCH**													
Output 3.1	**Community advocacy capacity built**													
Activity 3.1.1	Build capacity of communities to employ CVA and Community Scorecard to monitor and evaluate performance of government health facility and health workers.													
Activity 3.1.2	Work with District Medical office to plan and implement Performance Based Financing (PBF) to VHWs around ttC for 7-11. (year 2)													
Output 3.2	**Sharing promising practices**													
Activity 3.2.1	Gather evidence (stats and stories) and produce reports (physical and digital) from CVA at local level to be used at National and International level.													
Output 3.3	**Dialogue held on relevant national policies and practices**													
Activity 3.3.1	Document evidence and community stories to be shared in local, national, regional and international fora for policy change and advocacy.													
Activity 3.3.2	Profiling stories and issues through formal (TV, Movies, Newspaper, Forums) and informal (Internet, Mobile phone) channels to engage individuals and institutions on MCH issues to act													

Appendix 1: 1 Year Detailed Implementation Plan

AACES Country level Objective 1

East Africa Maternal and Child Health Project

Rwanda

	Summary of objectives	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Project Goal	Improved maternal, newborn and child health												
AACES Objective 1	*Marginalised people have sustainable access to the services they require*												
Outcome 1	**Improved and equitable access to MNCH services**												
Output 1.1	**Increased capacity of Ministry of Health staff to deliver equitable services**												
Activity 1.1.1	Recruit, orientate and train staff												
Activity 1.1.2	Facilitate MoH to conduct health customer care training for health facilities staff												
Activity 1.1.3	Organise reflection meetings on MNCH policy												
Activity 1.1.4	Multiply and distribute existing algorithm and on Malnutrition management, STI management , family planning and intestinal parisites.												
Activity 1.1.5	Facilitate MoH to conduct IMC refresh training for HF staff												
Activity 1.1.6	Identify and train HF staff on ONEC models												
Activity 1.1.7	Faciliate HF staff training on Family planning												
Activity 1.1.8	Facilitate HF trained staff to conduct Family planning counselling												
Output 1.2	**Increased capacity of community structures to sustainably deliver health services at the household level.**												
Activity 1.2.1	Advocate for CHWs training curriculum and materials and guidelines tailored to their literacy levels and experience												
Activity 1.2.2	Provide CHWs with MCH printed materials, equipments, supplies and a reliable supply chain												
Activity 1.2.3	Strengthen referral procedures and following up referred cases												
Activity 1.2.4	Strengthen integrated reporting systems with clear feedback loops												
Activity 1.2.5	Support Performance Based Financing objectives to motivate Community Health Workers with incentives based on high performance												
Activity 1.2.6	Enhance behaviour change by creating a better environment for CHWs to play their role of "community health communicators" for change												
Activity 1.2.7	Lobby for a CHW pocket guide with technical information on major community level interventions (Year 2)												
Activity 1.2.8	Facilitate CHWs, to effectively play their role in project catchment area												
Activity 1.2.9	Support performance based monitoring of health centres												
Activity 1.2.10	Work with government to develop an MCH scorecard to rate performance of health facilities												
Activity 1.2.11	Train CHWs on Timed, Targeted Counseling approach (TTC)												
Activity 1.2.12	Facilitate promotion of TTC within health centres												
Activity 1.2.13	Sensitisation of communities on family planning												
Activity 1.2.14	Promotion and greater involvement of men in family planning												
Activity 1.2.15	Facilitate CHWs to conduct Family planning counselling												
Activity 1.2.16	Facilitate transport of couples/men/women to attend Family planning programs												
Output 1.3	**Increased community demand for health services**												
Activity 1.3.1	Support theatre for development (including music dance and drama)												
Activity 1.3.2	Develop radio messages (Year 2)												
Activity 1.3.3	Organise community conversations, dialogue and appreciation days												
Activity 1.3.4	Facilitate CHW to conduct community mobilisation during maternal health week												
Outcome 2	**Adoption of positive nutrition and WASH practices at community level leading to improved MNCH**												
Output 2.1	**Improved knowledge of communities on health rights and good nutrition practices**												
Activity 2.1.1	Extend PD Hearth sessions to include 9-12 girl and maternal nutrition												
Activity 2.1.2	Screen for acute malnutrition and support referral system												
Activity 2.1.3	Support Health workers to conduct Nutrition counselling for prevention (Include IYCF counseilling)												
Activity 2.1.4	Facilitate couples to attend Prenuptial family planning counselling and follow up												
Activity 2.1.5	Facilitate CHWs to conduct Children growth monitoring												
Outcome 3	**Favorable policy environment for improved MNCH**												
Output 3.1	**Community advocacy capacity built**												
Activity 3.1.1	Sensitise the community on the existing MNCH policies & their rights												
Activity 3.1.2	Train community groups to identify and on advocacy for MCH issues												
Activity 3.1.3	Organise dialogue platforms between the national MCH desk and the communities												
Output 3.2	**Sharing promising practices**												
Activity 3.2.1	Partner with the MoH and local university to conduct research and inform policy development and implementation.												
Activity 3.2.2	Partner with other players to organise the annual MCH conference (Once a year)												
Output 3.3	**Dialogue held on relevant national policies and practices**												
Activity 3.3.1	Support the media, civil society and private sector organizations to engage in MCH												
Activity 3.3.2	Partner with MoH on the launch for CHN Campaign												
Activity 3.3.3	Facilitate CHN campaigns within operational areas												
Activity 3.3.4	Work with MoH to develop a standard curriculum and reference materials for training of CHW												
Activity 3.3.5	Support accountability and transparency administration throughout the health system												

Appendix 1: 1 Year Detailed Implementation Plan

AACES Country level Objective 1 - Kenya

East Africa Maternal and Child Health Project

World Vision

	Summary of objectives	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Project Goal	*Improve Maternal and Child Health*												
AACES Objective 1	*Marginalised people have sustainable access to the services they require*												
Outcome 1	**Improved and equitable access to MNCH services**												
Output 1.1	**Increased capacity of Ministry of Health staff to deliver equitable services**												
Activity 1.1.1	Recruit, orientate and train staff												
Activity 1.1.2	Support the MOH to disseminate the Community Strategy approach to community.												
Activity 1.1.3	Support the MOH to mentor and support the Cus (year 2)												
Activity 1.1.4	Support DHMT to conduct quarterly reviews with health facility incharges												
Activity 1.1.5	Develop and support a follow up mechanisms by CHWs for pregnant and lactating mothers.												
Activity 1.1.6	Develop a referral system (in collaboration with MOH and community).												
Activity 1.1.7	Support health staff to include DHMT to reach community level for support supervision and support of existing referral and linkage systems												
Activity 1.1.8	Conduct joint community activities with HIV&AIDs groups to integrate MCH in their interventions (PMTCT)												
Output 1.2	**Increased capacity of community structures to sustainably deliver health services at the household level.**												
Activity 1.2.1	Support /Facilitate CHWs to conduct monthly community level interventions on behaviour change as per each community unit action plans												
Activity 1.2.2	Purchase and replenish CHW kits (250)												
Activity 1.2.3	Develop and support an effective motivational model (Year 2)												
Activity 1.2.4	Mobilize Community health committees for each CU												
Activity 1.2.5	Train CHW using the MOH community strategy Curriculum on preventive and promotive care												
Activity 1.2.6	Train CHW on additional MCH capacities on IYCF and maternal nutrition												
Activity 1.2.7	Train CHW on Integrated Management of Childhood Illnesses and Malaria In Pregnancy (to be combined in the 1.2.1 training)												
Activity 1.2.8	Facilitate CHEW to conduct mentorship and support supervision to CHWs												
Activity 1.2.9	Facilitate CHC monthly meetings to review progress and consolidate data for HMIS												
Activity 1.2.10	Support CHW to plan for community interventions and education on PD hearth, MIP, ANC, immunization and other MCHN interventions based on community needs												
Activity 1.2.11	Support quarterly meeting for CHC, CHEW and CHWs												
Activity 1.2.12	Build the capacity of level 1, 2, 3 & 4 health management committees on leadership and management												
Activity 1.2.13	Train Health staff to include CHEWs on timed and targeted counseling (ttc)												
Activity 1.2.14	Train health staff to include CHEW on PD/Hearth												
Activity 1.2.15	Orient CHW on OCB, C-Change and CVA models												
Output 1.3	**Increased community demand for health services**												
Activity 1.3.1	Support CHW to conduct other rights activities to include dissemination and linkage for child registration to be integrated in MCHN community activities												
Activity 1.3.2	Support CVA link to CHN through NO advocacy and collection of local stories												
Outcome 2	**Adoption of positive nutrition and WASH practices at community level leading to improved MNCH**												
Output 2.1	**Improved knowledge of communities on health rights and good nutrition**												
Activity 2.1.1	Conduct sensitisation meetings for MOH and Communities on child malnutrition,												
Activity 2.1.2	Train the CHWs from community pockets with malnutrition to understand PD/Hearth initiative												
Activity 2.1.3	Support the CHW to coordinate the Implementation of atleast 1 PD Hearth sessions												
Activity 2.1.4	Support the CHEWs to orient CHWs on TTC to improve on MIP management, ANC attendance, skilled birth attendant utilization, child immunization an dother identified needs												
Activity 2.1.5	Support the CHWs to implement activities on positive behaviour and practice at household level according to the assigned households												
Activity 2.1.6	Support CHWs to conduct community dialogues using c-change methodology on Safe motherhood,Nutrition, and other areas requiring behaviour change												
Activity 2.1.7	Participate and Support MOH to conduct National initiatives like Malezi Bora weeks,World malaria day,Africa Nutrition day andWorld Breastfeeding week.												
Activity 2.1.8	Support community integrated outreach forums (7- 11 interventions - ANC,Nutrition,FP,Immunization,Micro nutrient supplementation,health n Nutrition education etc).												
Activity 2.1.9	Support MOH to conduct Verbal Autopsy on maternal deaths & use data/information for programming. Year 2)												

Output 2.2	**Improved nutrition for women and children**												
Activity 2.2.1	Promote and support adoption of On-Farm Rain Water Harvesting (RWH) Technologies (sunken bed, lined water ponds and Zaypits) for households (Mobilization in the first year)												
Activity 2.2.2	Establishment of Kitchen Gardens utilizing organic farming practices to grow vegetables…..												
Activity 2.2.3	Promote the production of highly nutritious drought tolerant crops (mobilization planned for first year)												
Activity 2.2.4	Build the capacity of farmer groups on Post harvest management (hermetic storage, metallic grain storage) and utilization of Farm Produce (Year 2)												
Activity 2.2.5	Promotion of high value tree crops (Year 2)												
Activity 2.2.6	Promote Improvement of local Poultry through introduction of improved breeds for eggs and meat (Year 2)												
Activity 2.2.7	Promote improvement of local goats through introduction of dual purpose (milk and Meat) Galla Goats (Year 2)												
Activity 2.2.8	Conduct training on improved livestock husbandry												
Activity 2.2.9	Promote Growing of high value crops under green house / drip irrigation conditions for maximum productivity (10 green house units). (Year 2)												
Activity 2.2.10	Train farmers groups on greenhouse production technologies.(Year 2)												
Activity 2.2.11	Participate and support Agriculture Extension activities (Farmer Field Days, Exposure tours) (Year 2)												
Output 2.3	**Improved access to markets**												
Activity 2.3.1	Provision of market linkages for farm produce (Year 2)												
Activity 2.3.2	Undertake market analysis in Bamba division (Year 2)												
Activity 2.3.3	Train Farmers on conducting market analysis (Year 2)												
Activity 2.3.4	Facilitate MOA to support farmers to support farmers to conduct market analysis (Year 2)												
Outcome 3	**Favorable policy environment for improved MNCH**												
Output 3.1	**Community advocacy capacity built**												
Activity 3.1.1	Train health facility management committees (levels1,2 &3) on advocacy skills												
Activity 3.1.2	Train community groups on CVA methodology with focus on maternal and newborn health (CVA teams,CHWs,CHCs)												
Activity 3.1.3	Train / Empower community groups in resource mobilization (Year 2)												
Activity 3.1.4	Facilitate interface meeting between health service providers and health management committees												
Output 3.2	**Sharing promising practices**												
Activity 3.2.1	Organise and conduct lesson sharing forums/field visit exchanges for trained health management committees & other stakeholders. (Year 2)												
Activity 3.2.2	Liaise with Learning Centre to identify Research partners												
Activity 3.2.3	Train IPA staff and community groups on documentation - elemtary Filmimg & photography												
Output 3.3	**Dialogue held on relevant national policies and practices**												
Activity 3.3.1	Organize and conduct consultative meetings with relevant committees managing devolved funds at the constituency/district/local authority levels (Year 2)												
Activity 3.3.2	Conduct a rapid analysis of health related projects supported by devolved funds in the district and their contribution to healthcare service delivery												
Activity 3.3.3	Production of IEC materials												
Activity 3.3.4	Organize a district level conference on devolved funds and child and maternal health (Year 2)												
Activity 3.3.5	Sensitize communities on the operation mechanisms of the existing devolved funds and their roles												
Activity 3.3.6	Empower community groups to monitor health related projects and support their participation in local development processes												
Activity 3.3.7	Support National level advocacy to influence health staff curriculum (Year 2/3)												
Activity 3.3.8	Organise field visits with the media to regularly highlight the health situation in the district and document contribution of the devolved funds in dealing with the health problems (Year 2)												

Annex 1: 1 Year Detailed Implementation Plan

AACES Project level DIP

East Africa Maternal and Child Health Project

World Vision

	Summary of objectives	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Project Goal	*To improve MNCH in selected districts in Kenya, Rwanda, Tanzania and Uganda*												
AACES Objective 1	*Marginalised people have sustainable access to the services they require*												
Outcome 1	**Improved and equitable access to MNCH services**												
Outcome 2	**Adoption of positive nutrition and WASH practices at community level leading to improved MNCH**												
Outcome 3	**Favorable policy environment for improved MNCH**												
Activity 1	Support and conduct baseline surveys across all national offices												
Activity 2	Support and conduct market analysis in Uganda and Tanzania												
Activity 3	Undertake orientation and training of national level staff												
Activity 4	Meetings with AusAID to clarify specific priorities for Africa and where the EAMNCH project will contribute to them (include opportunities with Australia Africa Partnership Facility and Scholarship program)												
Activity 5	Organise a reflection and learning event												
AACES Objective 2	*AusAID policy and programs in Africa are strengthened, particularly in their ability to target and serve the needs of marginalised people*												
Outcome 4	**Engage AusAID on Africa Development Policy and Practice**												
Activity 1	Conduct continuos documentations of the innovations on mobile phone monitoring and CHW motivational package												
Activity 2	Publish lessons learnt on the net and other media												
Activity 3	Participate in AusAID related forums to share the promising practices												
Activity 4	Invite other ausaid program to annual reflection meetings												
Activity 5	Organise AusAID visits to project sites												
Activity 6	Partner with ministry of health and local universities to identify research opportunities												
Activity 7	Contribute to white papers and draft policies												
Activity 8	Engage with AACES partners on common policy issues												
Activity 9	Enagage with AusAID Canberra, Nairobi and Pretoria including on CHV remuneration, midwife crisis campaign												
AACES Objective 3	*Increased opportunity for the Australian public to be informed about development issues in Africa*												
Outcome 5	**Engage Australian public on MNCH development issues in Africa**												
Activity 1	Devlop WV's community engagement strategy around AACES												
Activity 2	Engage with AACES partners on common issues												
Activity 3	Initiate regular documentaries of the project interventions and shared through the WVA One Just World forums												
Activity 4	Hold joint documentations with Child Health Now Campaign project												

Annex 1B: AACES DIP Narrative

The project implementation will adopt a strength based approach so that in all a countries World Vision will be seeking to build on the existing health systems, structures and practices. Focus will also be on building the capacities of the community and the health facilities.

The project design document is an aggregation of country level projects, where countries will contribute to all outcomes. However, outputs will vary across countries – reflecting different operating contexts. For example WASH programming is already occurring at both the Kenya and Rwanda sites so will not be a priority for the EAMNCH project in these countries. In Rwanda Food Security programming is being funded by an existing project, which the EAMNCH project will integrate with to achieve better nutrition outcomes. Outputs shared across countries do not necessarily have the same contributing activities. This again reflects the varied contexts of the project sites, as does the different timing for implementation of activities across countries.

Country level DIPs only include AACES Objective 1 (Outcomes 1, 2 and 3). AACES Objectives 2 and 3 (Outcomes 4 and 5) are referred to in the project level DIP.

The DIPs have been extracted from a multi-year design and so some activities have been included that will not commence until Year 2. This is why some of the activities in the Year 1 DIPs appear blank. Activities that will not commence in Year 1 have been included in the Year 1 DIPs to ensure consistency between the DIPs and logframes.

The project level design document has universally referred to Community Health Volunteers (CHVs) and Village Health Teams (VHTs), while the country level DIPs have used context specific terminology.

Implementation of project activities will be on an incremental pace in the sense that each National Office will start will less project implementation sites. New sites that have already been identified will be added based on learning drawn from sites already implementing. This will require close monitoring by National Offices with support from World Vision Australia and the Regional Office.

Annex 3: Monitoring and Evaluation Plan

Approach

The project M&E system will be based on existing WV processes under LEAP (Learning through Evaluation Assessment and Planning[1]). The M&E plans for this project are aligned with World Vision's Child Health Now campaign and other wider policy influence initiatives. The evidence to be gathered through field level monitoring will feed into these higher level campaigns and policy dialogues. The M&E plans include opportunities for the community (particularly vulnerable groups such as children, women and people with a disability) to voice their issues and challenges. Data collection will integrate with the existing health facility data so that where data exist for measuring the project performance, no additional collection will be done. The data will be analysed so that the information becomes usable to community groups. The project M&E process will also ensure that feedback on policy and practice outcomes will be shared back to the community. The project M&E has included selected MNCH indicators and key World Vision Child Well Being Outcome (CWBO) Compendium indicators[2] depending on country contexts.

The project M&E approach is based on five key principles:

- M&E is core to inform our work, show best practice and support advocacy
- Feedback on project impact should be sought from multiple sources for triangulation. Primary data will only be collected where it does not already exit.
- Inclusive M&E collected by a range of groups (Community Health Volunteers CHVs, Village Health Teams VHTs, Citizen Voice and Action CV&A Groups) helps adjust targets appropriately over time
- Increase accountability to communities, stakeholders and partners
- Build upon and strengthening existing health information at local health facilities is key for sustainable community access to health services.

Project's key M&E components:

Baselines: These will be conducted at the beginning of the project implementation to establish key indicator values and to refine the indicators (including numbers of beneficiaries) in all four respective project areas. Gaps in beneficiary groups and specific indicators that might be identified during baseline measurements will lead to adjusting of the targeting approach and the indicators. The baseline will be conducted at the project and national level, using a mixture of quantitative and qualitative methods including household surveys, market analysis, change stories (that will be captured on short videos) and focus group discussions. Each country will conduct its own baseline but not concurrently because in some cases, the same person will lead the baseline survey in more than one country. Baseline data will provide the point of reference when assessing how the national interventions are informing national advocacy efforts. At a national level, working closely with the Child Health Now (CHN) Team, the project will make a baseline assessment of the current MNCH situation including global MNCH commitments, policy and expenditure. From this we will be able to see over time if the AACES work is impacting upon the national discourse in relation to MNCH and vice-versa. The baseline will also be an opportunity for building the capacity of CHVs in data collection, so that they continue to gather credible data for the duration of the project.

Continuous Monitoring: The continuous project monitoring will be done through quantitative and qualitative methods and will be based on these key elements:

(a) A focus on monitoring ***processes,*** assessed as key achievements in progress towards achieving the project outcomes and objectives, this will be linked with the ongoing project management

[1] LEAP is World Vision's DM&E framework that is applied in World Vision programming globally
[2] World Vision has an aggregated set of child wellbeing indicators to guide programming

system (eg. monthly activity review & planning process), and will employ data for decision-making.

(b) An emphasis on the ***simplicity, quality and timeliness*** of the collection, analysis, documentation, dissemination and application of information essential for:

- Project-level and multi-country planning and management;
- Government (district and province) collation, analysis and use of district information for long-term planning, evaluation, and policy development;
- a system of tracking effectiveness of the project process:- progress in reaching indicators, achieving core milestones and improving skills in the management and technical quality of MNCH
- a focus on monitoring trends in the MNCH issues in the district, as well as coverage and utilisation of services aimed at addressing these issues.

In each country project CHVs, community members including VHTs, health workers and project staff will be involved in continuous monitoring of activities, output and outcome level indicators to provide information on progress towards objectives, in order to inform project implementation and highlight any areas that require adjustments to the approach. Each community group including VHTs will have registers where they will record on progress towards each indicator. They will also have a video camera to capture change stories. The information from the community groups will be analysed and aggregated at project area level. This information will then be pulled together to form a EAMNCH project contribution to the overall AACES outcome areas. Thus at EAMNCH level, the M&E will seek to gather evidence towards the achievement of the agreed AACES outcome areas. Information from the continuous monitoring will significantly inform the agenda for the annual progress reviews that will take place in each country and at the EAMNCH project level.

Mid-term program evaluation: We will conduct a mid-term evaluation and reflection in the third year of implementation to assess project performance and draw lessons to inform the remaining project period. This will be done by measuring the key indicators and collecting change stories using film in each project area. Based on the findings, a selection of documentaries capturing best practices will be made to share with other communities and the broader development sector including the Australian public; and to influence AusAID's policy and practice around midwifery training. The mid-term review will also be used by WV to contribute to the discussions of progress towards attaining MDGs 4 & 5 in East Africa. Just like baselines, the mid-term evaluation will use both quantitative and qualitative methods and will not be conducted concurrently because the same evaluator will lead the evaluations in all four countries.

End of program evaluation: The end of program evaluation will measure progress and impact against key indicators established in the baseline using both quantitative and qualitative methods. This will show us what has changed over time and why it has changed. The evaluation will be conducted in the 5th year. From this evaluation a shorter public report will be generated to share the experience, impacts and learnings of our work under AACES. This will be shared through various methods including a final international forum on MNCH. Both the mid-term and end of program evaluations will also be part of wider AACES program assessments.

Lessons learnt, Reviews and Reflections meetings: Annual project level review meetings will be held where key community stakeholders, in-country AACES partners, other AusAID Africa Programs and selected NO representatives will reflect on the project performance. This will include the change stories including those in film. Representatives from the four countries will also meet once a year to assess the whole EAMNCH project. The result of these reflections will inform the AACES lessons learnt forums to be organised by AusAID. In addition, this will inform the next years Detailed Implementation Plan (DIP).

Reports

Several reports will be generated during the lifecycle of the program to ensure accountability, transparency and learning. These will be done at quarterly, half-yearly and yearly intervals as follows:

Quarterly financial reports: Financial reports will be generated quarterly for accountability and tracking against progress and expenditure of activities.

Semi-annual narrative reports: The narrative reports will be based upon WV's semi-annual LEAP reporting and will include the AACES outcome areas. In addition to the normal written narrative reports, short films will be made asking community members key questions around key MNCH indicators to assess progress and challenges. The tracking against indicators will tell us what is happening and the film approach will tell us why it is happening. The films (10 for each project area per half year) are to be uploaded to the narrative reports as attachments under existing web-based solutions. The narrative report will include information from key stakeholders. These will range from household to facility level including CHVs, CV&A groups, Disabled Peoples Organisations (DPOs) and women's groups. The information gathered through films and tracking against key indicators, as well as impact upon the most vulnerable will be used in the advocacy and engagement work at local, national, regional and global levels under the work of CV&A and CHN.

Monitoring visits

Project monitoring visits will be done by the EAMNCH Project Manager and WVA Country Program Managers and Advisors at least once a year. It is expected that AACES partners will also visit project sites for cross learning. WV's East Africa Health and Nutrition team will also visit the project to monitor progress.

External research

Relevant WV East Africa Learning Centres (Health and Nutrition – Kenya; Food Security and Climate Change – Tanzania; Advocacy - Uganda) will identify emerging MNCH research opportunities through participation in the M&E processes. WV Australia will identify and link Australia universities and relevant research bodies to the research opportunities.

Feedback loops

Whilst the formal M&E processes provide the program with a grounded and structured M&E process, the project will also engage a more organic feedback system through a number of innovative approaches. These will help WV gauge our progress in impacting MNCH in the project areas. These will be done in relation to context specific available mechanisms and may include:

Community radio talk shows: Whilst radio will be used to disseminate MNCH information it will also be used as a way of gauging community opinions and behaviours at any one time. This may be done through talkback radio segments that provide incentives to call in (e.g. free to air phone calls, family greetings).

SMS competitions: There may be opportunity to send SMS questions to community members and ask for their responses. The incentives to do this may vary but should not affect quality feedback.

Community led/driven documentaries: A film approach may be used where community members (including children, women, people with a disability) are trained in simple film making to tell their story in relation to certain issues. These may be shared at local, national and regional forums to improve learning and raise the voice of these groups.

Participatory theatre and debates: By using participatory theatre within the Project areas it will increase community discussion, build capacity as well as bring out key reflections on what is happening and how the East African MNCH Program is impacting upon the community.

Roles, responsibilities, data collection and use

Who collect data	What type of data	Where is shared and when
WV and Project staff (CWB facilitators, health project officers at local level, child sponsorship, sector specialty coordinators at NO)	Tracking against activity, output and outcome level at project and broader outcomes at NO and RO level as well as key indicator tracking	Lessons learned to sector specialist (NO,RO) – annually Stakeholders forums- annually Text messages to community leaders- quarterly Competitions on Radio – semi annually International forums – when and where appropriate (1 – 2 over the life of the project)
Government staff and structure (CHVs, VHT, Health facilities)	CHVs, VHT - community health status, HHs status e.g TTC Health facilities- key indicators, service provision, HIS	
Civil societies (CV&A Committees)	Service provision	
CBOs - (DPOs, women groups, men groups)	Measure impact to most vulnerable and best practices respectively	
Children Households	Measure impacts to community and involvement	

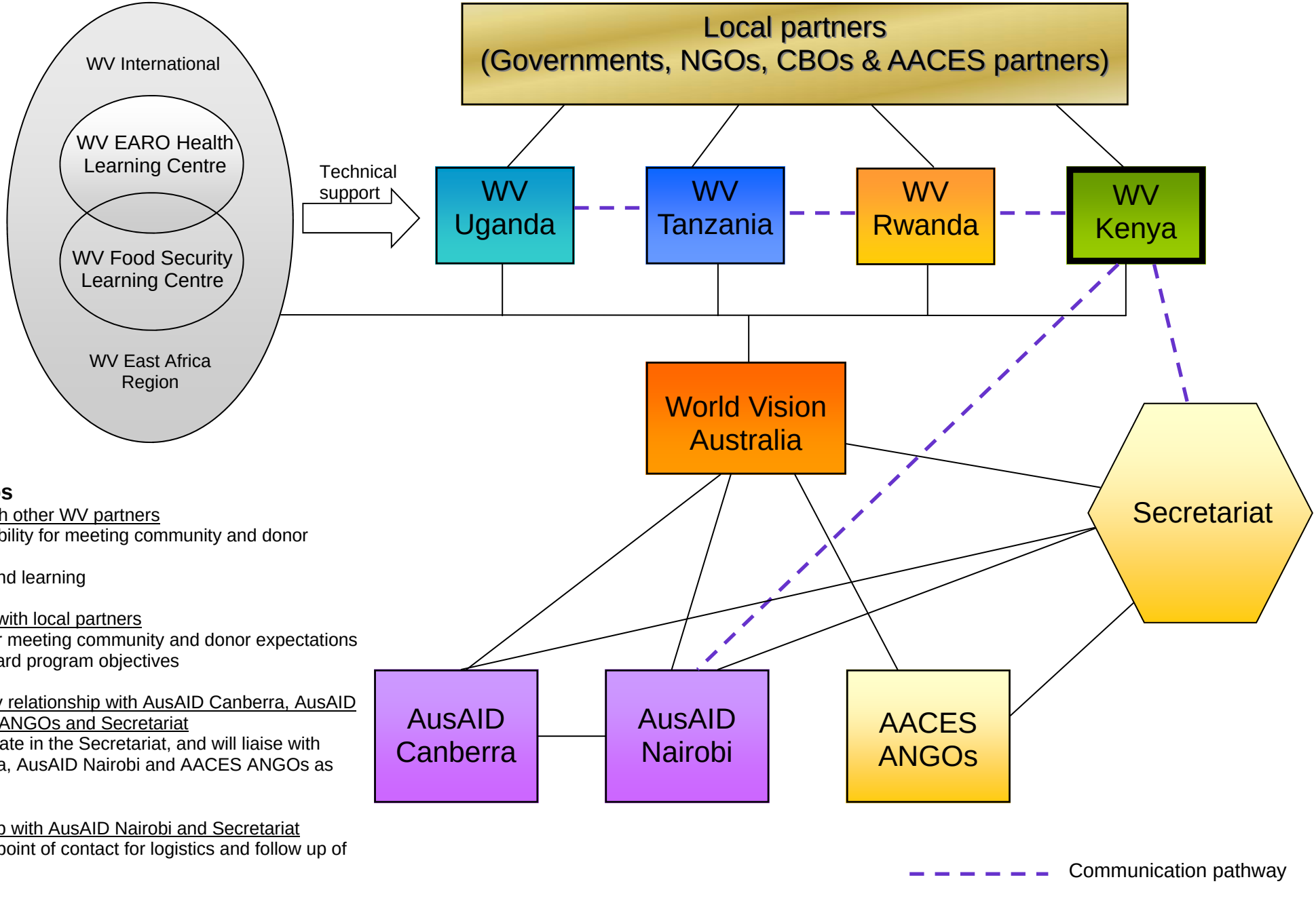
Annex 4: Risk Matrix

Risks	Potential Impact on the project	Likelihood (1-5 where 1=very low 5=very high)	Impact (1-5 where 1=very low 5=very high)	Risk (likelihood X Impact)	Management Strategy (for Risks rated 5 and above)	Responsibility	Is the risk assessed through the M&E System? Y/N
Contextual Risks							
Emerging and competing government priorities result in MNCH being given low priority	Prioritisation of MNCH services in the district will be low affecting sustainability of the project interventions	3	4	12	- Train Village Health Teams Governments (local, district, national) to prioritise MNCH interventions in their comprehensive health plan - Engage and dialogue with Governments and East Africa Parliament,– bilaterally and as part of an inter-agency coalition- on budget planning. - Showcase promising and best practice around MNCH programming	Project Manager, Health and Nutrition Manager, CH N Manager	Y
Political instability due to impending elections	Shut down of socio-economical activities including negative effect on implementation and deliverables of the project	2	4	8	- Monitor early warnings - Engage and dialogue with Governments,– bilaterally and as part of an inter-agency coalition	Security and Risk Managers in National Officers, Project Manager	N
Climate instability (prolonged drought; floods)	Attendance for and rendering of MNCH services will be low	3	3	9	- Engage with government leaders for emergency preparedness plan and environmental protection policy to be in place and implemented. - Climate mitigation and adaptation initiatives implemented in each program area e.g. Drought tolerant crops	Project Manager, Food Security and Climate Change Learning Centre Advisor	Y
Communities not appreciating strengths based approach when accustomed to service delivery	Slow to change behaviour resulting in a negative effect on implementation and deliverables of the project	2	3	6	- Set clear expectations and continue to engage with communities and partners, ensuring their ownership of the project	Project Manager	Y
High attrition of	Delayed realisation of	3	3	9	- Engage with the government on staff	Project Manager,	Y

Risks	Potential Impact on the project	Likelihood (1-5 where 1=very low 5=very high)	Impact (1-5 where 1=very low 5=very high)	Risk (likelihood X Impact)	Management Strategy (for Risks rated 5 and above)	Responsibility	Is the risk assessed through the M&E System? Y/N
trained health workers due to transfers and seeking new employment	expected quality MNCH services				retention strategy/measures - Programming will directly address factors that affect staff motivation e.g. training, staffing levels, community appreciation	Health Manager	
Design and Implementation risks							
Complexity of delivering programming across four countries	Inconsistencies in implementation leading to lowered program outcomes	3	4	12	- Training of staff in evidence based programming models - Support from WV Learning Centres - Utilisation of WV management and monitoring systems - Periodic regional reflection meetings	Program Manager, Heath and Nutrition Learning Centre Advisor, Health Managers	Y
Government may not fulfil expectations due to competing priorities	Lowered program outcomes	3	4	12	- Build demand for services at the community level so governments can be more informed by local issues and evidence - Engage and dialogue with Governments and East Africa Parliament,– bilaterally and as part of an inter-agency coalition - Showcase promising and best practice around MNCH programming	Project Manager, Health and Nutrition Manager, CHN Manager	Y
Project partners may not fulfil expectations due to competing priorities	Lowered program outcomes	3	4	12	- Set clear expectations and sign MOUs. - Continue to engage dialogue and reflect with partners,	Project Manager	Y
Attitude and behaviour change needed from men to support improved MNCH is not realised.	Lowered program outcomes and potential for conflict at household level	2	4	8	- Include men and boys in all programming including ttC, C-Change, farmers groups - Working closely with local leadership to encourage men's participation and commitment to the program	Project Manager, Gender Advisor	Y

Risks	Potential Impact on the project	Likelihood (1-5 where 1=very low 5=very high)	Impact (1-5 where 1=very low 5=very high)	Risk (likelihood X Impact)	Management Strategy (for Risks rated 5 and above)	Responsibility	Is the risk assessed through the M&E System? Y/N
Low motivation amongst CHV due to varying incentive offered by different organisations.	Delayed implementation impacting program outcomes	3	4	16	- Engage and dialogue with Governments,– bilaterally and as part of an inter-agency coalition – on harmonisation of incentives	Project manager, CHN Manager	Y
Poor road infrastructure networks.	Limited accessibility of communities to access health services and markets for nutritious food	3	3	9	- Engage with Governments around road infrastructure	Project Manager	Y
Sensitivity of Governments on collection of anthropometric data	Difficulty in establishing baseline and measuring performance of project	2	4	8	- Engage and involve Government staff on data collection	Project Manager, Health Manager	Y

Annex 5: Relationship Chart



Key relationships

WVA relationship with other WV partners

- Mutual accountability for meeting community and donor expectations
- Joint reflection and learning

WV NO relationship with local partners

- Accountability for meeting community and donor expectations and working toward program objectives

WVA has the primary relationship with AusAID Canberra, AusAID Nairobi, AACES ANGOs and Secretariat

- WVA will participate in the Secretariat, and will liaise with AusAID Canberra, AusAID Nairobi and AACES ANGOs as needed

WVK and relationship with AusAID Nairobi and Secretariat

- WVK will be the point of contact for logistics and follow up of ongoing issues.

Annex 6: Program models utilized by World Vision

The WV Program models that will be applied in the East Africa maternal Newborn and Child Health project will include:

Citizen Voice and Action (CV&A): An approach that aims to increase dialogue between ordinary citizens and the organisations that provides services to the public. It also aims to improve accountability from the administrative and political sections of government (both local and national) in order to improve the delivery of services to the public. The approach seeks to empower communities to influence the quality, efficiency and accountability of public services.

Seven-Eleven (*7-11*): WV's platform for delivering health programs through a series of cost effective, preventative interventions drawn from the global evidence base that address the primary causes of maternal, newborn and child malnutrition, illnesses and death. WV works with communities to raise awareness of and increase the knowledge and demand for the supply of services around 7 key interventions focused on the mother and 11 key interventions focused on children under the age of two. The *7-11* interventions include the following:

Targets	Pregnant Women: -9 months	Children: 0-24 months
Core Interventions	Adequate diet	Appropriate breastfeeding
	Iron/folate supplements	Essential Newborn Care
	Tetanus toxoid immunisation	Hand washing
	Malaria prevention & intermittent preventative treatment	Appropriate complementary feeding (6-24 months)
	Healthy timing & spacing of delivery	Adequate iron
	De-worming	Vitamin A supplementation
	Facilitate access to maternal health service: antenatal and postnatal care, skilled birth attendance, prevention of Mother to Child Transmission, HIV/STI screening	Oral Re-Hydration Therapy/Zinc
		Care seeking for fever
		Full immunisation for age
		Malaria prevention
		De-worming (+12 months)

PD Hearth: A positive deviance (PD) approach to good nutrition. The model utilises families in communities that have managed to raise well-nourished children and identify what they are doing differently to support change for those families with under-nourished children. The practices may include identifying local food to improve nutrient density, proactive child feeding and/or positive hygiene practices, which are taught in a behaviour change program (Hearth).

Prevention of Parent to Child Transmission (PPTCT): This model aims to build the value of PPTCT services in order to create demand for services and to support adherence after delivery. This is done through context specific mother/father support groups to build awareness and confidence of HIV positive people to learn more to help them make difficult decisions.

Diet Diversification/Modification Approach: A food-based nutrition approach to addressing malnutrition, which encompasses a variety of models. Diversifying the types of food produced and eaten results in higher-quality diets and contributes to healthier families. The models used are dependent on the assessed nutritional need as well as the context, for example, a combination of promoting small animal production, food preparation methods, home gardens, storing or preservation of foods. WV's programming has been informed by numerous programs, such as MICAH (Ethiopia, Ghana, Malawi, Senegal, Tanzania), ENHANCE (Malawi), Essential Nutrition Package ENP (Kenya, Rwanda, Zambia, Zimbabwe, Tanzania, Mali, Malawi).

C-CHANGE: WV's brand of the UNDP's Community Conversations methodology used in Africa. The methodology has been effective in raising awareness of the underlying social norms and traditional practices driving the HIV epidemic. Its application is not limited to HIV, as it is a context-neutral process of facilitation and empowerment that can be used to generate community discussion and action planning on any topic(s) of concern to the community including primary healthcare, nutrition.

Area Development Program (ADP): An ADP is WV's primary development model which is a multi-sector community development program. ADPs operate in contiguous geographical areas, large enough to have some micro-regional impact, yet small enough to make a major impact on selected communities. At the centre of the ADP model is a long term commitment from WV to partner with communities to ensure community ownership and participation. Through participatory and civil society strengthening strategies, community organisations, families and individuals share in project leadership and activities from the start. A typical ADP will be a 15 year commitment and could include a health, education, food security and WASH projects. The number of ADPs within each country varies, depending on country size and capacity. Progress towards meeting the ADP's goals is evaluated every five years, and its design and future is then reassessed.

Timed and targeted counselling (ttC): A Child Health Worker approach to extending PHC counselling to the household level. The important distinction and expectation of ttC is that this counselling is targeted to households that have specific needs, at specific times. This is an evidence based, behaviour change model that has been proven to have specific impact. To achieve this, CHVs make a series of visits to households when women become pregnant and through the child's infancy or longer, organising all the *7-11* messages into message sets to be communicated at the most appropriate times, using a counselling and dialogue-based approach.

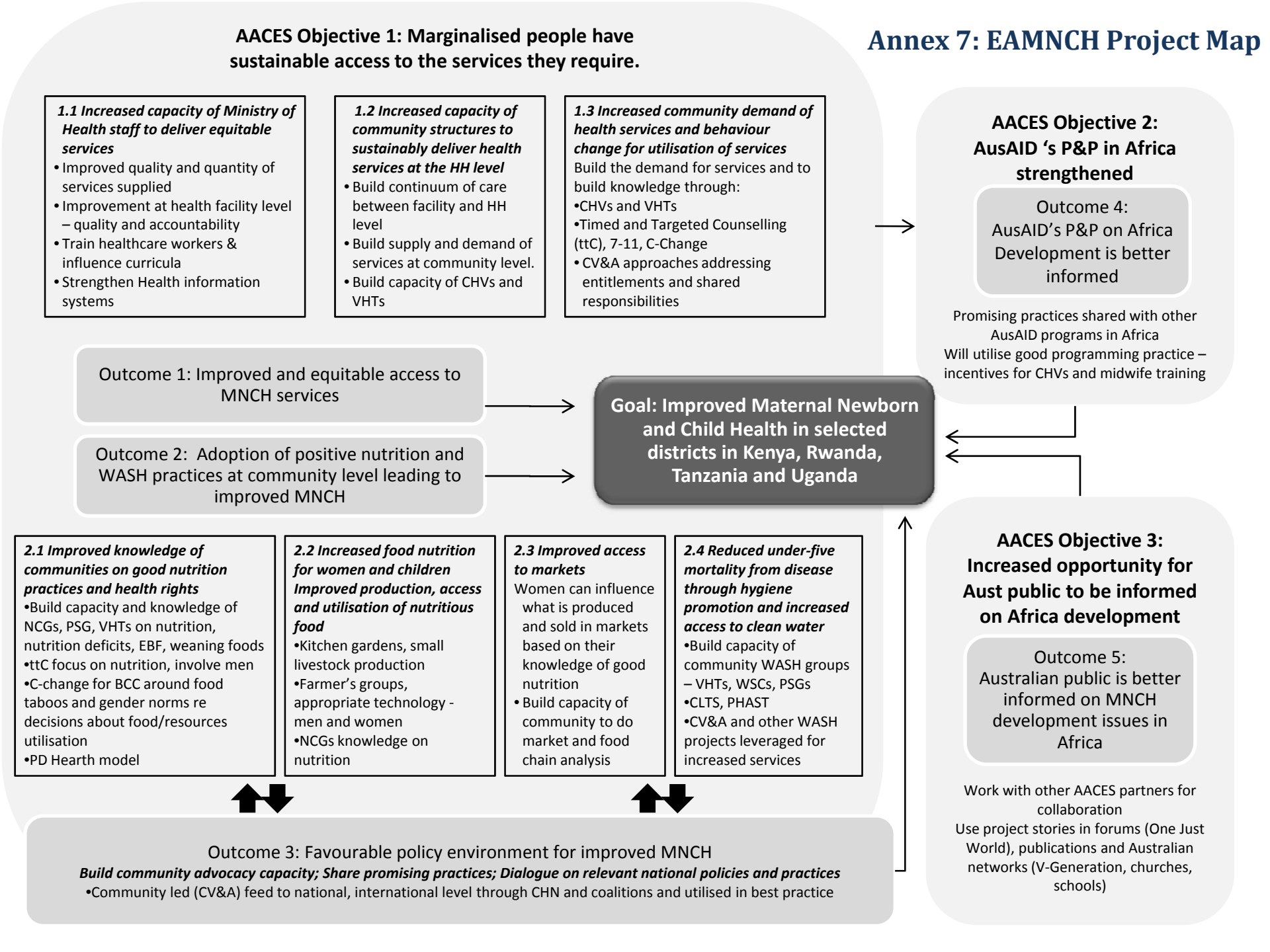
Healthy Timing and Spacing of Pregnancy (HTSP): Is using family planning to ensure an adequate time interval (3 – 5 years) between the previous birth and beginning of the next pregnancy for a woman.

Child Health Now (CHN): Child Health Now is a global WV campaign contributing to the growing global movement calling for urgent action to save mothers and their children from preventable deaths. We are already working closely with a range of other coalitions, charitable organisations, foundations and associations that, like us, believe that every child deserves a chance to live life in all its fullness regardless of where they were born. Through our own work and our work with others we will press governments to prioritise addressing the basic health needs of poor children and women. Greater support and priority needs to be given to proven, low-cost preventative measures, including good food, clean water and sanitation, as well as seeing families and communities as the most important contributors to health care intervention in a child's life. An important distinctive of the CHN campaign is that it is substantially bottom-up in all our engagements to mobilise affected communities. The success of the campaign rests in its ability to create chains of accountability that stretch from the community upwards. A key role for World Vision is to provide a platform for the voice of the communities to represent their concerns before a national and international audience.

As a result of this campaign, we hope to achieve a significant reduction in maternal, newborn and child mortality, particularly in the poorest and most marginal regions and countries in the world. To accomplish this we press governments to make child, newborn and maternal health a priority by:

- **Creating national plans to achieve MDG 4** - National governments must adopt clear, time bound and costed health plans focused on tackling the direct and indirect causes of child deaths in their country.
- **Providing a full and timely donor response to support national plans** - The world's richest countries must ensure all countries with a national plan committed to achieving MDG 4 are provided with the financial and technical resources to implement their plans.
- **Ensuring access and addressing neglected diseases** – Both donor and recipient governments must work together to remove the economic and social barriers to equal access to health care for women and children. These governments must also collaborate to address pneumonia and diarrhoea in their national plans.
- **Developing and implementing a comprehensive monitoring and accountability system for activities designed to achieve MDG 4.** To ensure the implementation and effectiveness of these plans.

Annex 7: EAMNCH Project Map



Annex 8: Management Plan

National Offices

WV National Offices (NOs) are responsible for project implementation. NO structures comprise centralised high level technical expertise and financial and administrative functions, and provide decentralised DM&E support through Zonal Clusters. Zonal Clusters in turn provide technical, financial and administrative support to Area Development Programs and projects. Each NO (Kenya, Uganda, Tanzania and Rwanda) will appoint a Project Manager to oversee implementation at the project site. The project manager will liaise with NO Head Office personnel identified to both provide oversight of the project and facilitate linkages to other project sites. The Project Manager in Kenya will also support the liaison with AusAID post and the Secretariat in Nairobi.

Where the project will implement within an ADP site, the project activities will be integrated with ADP planning. In this way the EAMNCH project will be leveraging both existing complementary projects and ADP staff. Being able to draw on existing project outputs and staffing will facilitate scaling the EAMNCH project up and down as needed.

At all levels – NO, Zonal Cluster, ADP/project level – relevant WV and EAMNCH Project Staff are responsible for supporting and managing project performance and value add of partners including local and national government representatives, participating NGOs, CBOs and community groups. Memoranda of Understanding will be developed with project partners to clarify expectations and responsibilities.

WV East Africa Regional Office

WV East Africa Regional Office including its Learning Centres, Grant Management and Project Management units will provide additional technical expertise support in health, food security, and advocacy and in project management to EAMNCH Project staff. In addition, NOs have technical specialists in health, agriculture and WASH who will contribute to management, monitoring and training components of the project.

Child Health Now

Management structures to implement WV's Child Health Now campaign are embedded in the NO structures. As this project will leverage the goals common to WV's Child Health Now campaign, the advocacy component of the EAMNCH project will also be supported by existing Child Health Now staff and structures.

World Vision Australia (WVA)

As lead partner who is responsible for the delivery of the project, WVA will appoint a Program Advisor who will be responsible for coordinating project implementation in all four countries. WVA will monitor project performance and learning in each country, and coordinate sharing of learning across countries (with WVK providing logistical support). WVA will participate in all annual reviews, receive and review reports and ensure that any deviations identified are addressed in a timely manner.

WVA will provide technical, DME and financial management support to all four countries and will ensure that project management needs are met and supported with additional funds if this is required. WVA will also be responsible for submitting financial and narrative reports to AusAID.