A social protection initiative (SURE-P) is established to improve the lives of the most vulnerable populations (pregnant women and children under the age of five years old)

1. Reduce maternal mortality ratio from current 584/100,000 to 320/100,000 live births in target communities
2. Reduce neonatal mortality ratio from current 9/1000 to 7/1000 live births in target communities
3. Increase percentage of pregnant women receiving focused ANC by 52% from current baseline coverage figures in target communities
4. Increase percentage of skilled birth attendance by 63% from current baseline figures in target communities
5. Increase postnatal care attendance within 2 days of birth by 63% from current baseline figures in target communities
6. Increase family planning attendance by 26% from current baseline figures in target communities

### Situation

1. Recruitment, training and deployment of 2,000 midwives, 1000 CHWs & 9,000 VHWs
2. CCT to pregnant women in rural areas
3. CCT to CORPs i.e. VHWs & TBAs who accompany pregnant women to facilities
4. Activation/orientation of Ward development committees (WDCs)
5. Improved supplies
6. Infrastructural upgrades of 500 PHC facilities & 125 referral general hospital and mobile clinic vans and boats
7. Testing technology-based reporting mechanisms (MADEX)-
8. Referral general hospital and mobile clinic vans and boats
9. Run bi-annual refresher courses for VHWs
10. Conduct quarterly review meetings

### Outputs

1. Community leaders sensitized
2. 2,000 midwives, 1,000 CHWs and 9,000 VHWs trained at any one time at full utilization of training model. (State Output)
3. Training courses organized to train VHWs
4. Course content was on KHHPs
5. 2 refresher courses run annually for VHWs
6. 4 x quarterly review meetings held annually with KAP of VHWs reinforced.

### Activities

1. Conduct advocacy & sensitization meetings with community leaders at ward level for recruiting VHWs
2. Select VHWs from within their resident communities to ensure maximal acceptance.
3. Organize training courses as 1 class per ward to train VHWs at community level.
4. CHWs to conduct 1 week training for VHWs on Key Household practices (KHHs) & provide VHWs with kits for their role.
5. Run bi-annual refresher courses for VHWs
6. Conduct quarterly review meetings at which supervisors (JCHEWs & CHEWs) will also reinforce knowledge/skills of VHWs
7. Recruitment, training and deployment of HRH & payment of CCT to clients/ CORPS.

### Inputs

1. Documents review e.g. report of recruitment & deployment of HRH
2. IDIs with heads of facilities on deployment of HRH & payment of CCT to clients/ CORPS.
3. FGDs with VHWs
4. Documents review (training & refresher training reports).
5. Documents review (report of quarterly meetings)

### Short-Term

1. Enhanced community participation in SURE-P project.
2. Improved knowledge, skills and competence of VHWs
3. VHWs complement roles of midwives and CHEWs by working in community.

### Intermediate

1. Community participation and ownership facilitate achievement of SURE-P objectives.
2. Increased home visits by VHWs lead to improved utilization of ANC services.
3. Increased trained birth attendance and post-natal care attendance.
4. Increased uptake of family planning.

### Long-Term

1. Reduced maternal mortality
2. Reduced neonatal mortality
Situation by 2015

Inputs

Activities

Outputs

Outcomes — Impact

7. Adequate numbers of midwives and CHWs recruited and deployed based on local targets agreed with SURE-P.
8. Adequate numbers of midwives and CHWs trained as per local targets set by SURE-P.
9. 4 x quarterly training review meetings held & KAP of VHWs reinforced.
10. Midwives and CHWs receive monthly allowances.
11. CHWs & midwives provided housing and security in community.

Short-Term

4. Improved knowledge, skills and competence of midwives & CHWs.
5. Improved quality/standard of training attained.
6. Enhanced job satisfaction for midwives & CHWs.

Intermediate

1. Increased effectiveness and efficiency of midwives and CHWs & of health facilities.
2. Improved performance by midwives and CHWs.
3. Increased skilled birth attendance.
4. Improved quality of services.

Long-Term

1. Reduced maternal mortality ratio.
2. Reduced neonatal mortality ratio.

Data

3. Documents review and physical inspection to verify availability and adequacy of supplies i.e. drugs, consumables and equipment.
4. Documents review of infrastructural upgrades.
5. IDIs with heads of facilities to verify whether CCT payment mechanisms were piloted e.g. check existence of: • CCT trend register & personal health cards of CCT beneficiaries • Mobile payment system • Payment through the bank
6. Suggestions are welcome on data for testing MADEX.

Data

3. Documents review of staff recruitment, deployment and remuneration via SURE-P.
4. IDIs with heads of facilities to verify staff recruited/deployed.
5. Documents review (training & refresher training reports).
6. Documents review (report of quarterly meetings).
7. FGDs with midwives & CHWs on perceptions of trainings & quarterly meetings.
8. FGDs with midwives & CHWs to verify whether they are provided with housing, security etc.
10. Inspection of houses.

Data

4. IDIs with project implementers about quality of training.
5. FGDs with midwives & CHWs to ask about job satisfaction.

Data

1. Review HMIS data of health facilities for data on skilled birth attendance.
2. For efficiency and effectiveness: IDIs with heads of facilities to verify availability of HW. Availability HW at the point of supportive supervision. No of deliveries, No of ANC visits.
3. For HRH performance: Pre-Sure P productivity vs. during SURE-P OR productivity of SURE-P site and non-SURE-P site over the same period.
4. For quality of MCH services: Client satisfaction exit survey.

Data

1. National data sources e.g. NDHS (national demographic and health survey).
2. Verbal autopsy with WDCs.
**Situation**

**Target metrics by 2015**

**Inputs**

**Activities**

**Outputs**

**Outcomes — Impact**

**Short-Term**

1. Increased №s of skilled delivery at health facilities and even at home
2. Increased early identification of risk factors/emergencies for referrals to general hospitals.
3. Increased referral of complications from PHCs to general hospitals.

**Intermediate**

1. Improved efficiency of health system to facilitate achievement of MDGs 4, 5, and 6

**B) Supply of Kits**

12. Supply midwives & CHWs with outreach kit to provide handy tools for skilled delivery even at home

**C) Strengthen PHC facilities**

13. 500 facilities to cluster around 125 general hospitals for prompt referral
14. Upgrade 500 PHC facilities, 125 general hospitals, mobile clinics vans and boats
15. Procure standard basic health packages to ensure

**Long-Term**

1. Reduced maternal mortality ratio
2. Reduced neonatal mortality ratio

**Data**

11. Document review to verify supply of outreach kits to midwives and CHWs.
12. IDIs with SURE-P programme manager about cost of kit supplied to CHWs/VHWs; cost of facility upgrades.
13. Records review and IDIs with heads of facilities to verify upgrade of facilities
14. Records review to verify cost of supplies, commodities and equipment.

10. IDIs with CHWs & midwives about supply of outreach kits.
11. Inspection visits to facilities to verify that clustering of facilities promote prompt referral
12. Visit facilities to inspect infrastructural upgrade. Visit facilities to inspect availability of appropriate supplies/equipment for quality MCH services

6. Documents review i.e. HMIS data of skilled deliveries in health facilities and at home.
7. Documents review i.e. HMIS data of trend of identification of risk factors & complications.
8. Documents review of HMIS and registers of general hospitals (receiving centres for the referral of complications from PHCs).

4. Suggestions are welcome Re: data for efficiency of health system in achieving MDGs

1. State and national data sources e.g. NDHS (national demographic and health survey)
2. Verbal autopsy with WDCs
1. Review HMIS data and registers of MCH for clients addresses
2. IDIs with heads of facilities to verify trend of access to MCH services.
3. IDIs and exit interviews with service users.
4. Document review of annual reports of trend of coverage of MCH services following SURE-P programme implementation.

**DEMAND COMPONENT**

**A) CCT**

16. WDCs are trained to identify CCT beneficiaries
17. More pregnant women mobilized to use MCH services in target communities.
18. Beneficiaries are paid CCT as incentive for using MCH services.
19. VHWs and TBAs paid CCT for mobilizing clients and ensuring service utilization.
20. A verifiable CCT payment system is in place (Bank, mobile transfer etc.)

**Short-Term**

10. Improved identification of CCT beneficiaries.
11. Equitable access to quality MCH services both at health facilities and via home visits.
12. Improved satisfaction of beneficiaries with MCH services.

**Intermediate**

1. Increased coverage of MCH services.
2. Increased utilization of MCH services by pregnant women (ANC, skilled birth, post-natal care and immunization).

**Long-Term**

1. Reduced maternal mortality ratio
2. Reduced neonatal mortality ratio

**Situation**

1. State and national data sources e.g. NDHS (national demographic and health survey)
2. Verbal autopsy with WDCs

**Targetmetrics by 2015**

**Outputs**

9. Review HMIS data and registers of MCH for clients addresses
10. IDIs with heads of facilities to verify trend of access to MCH services.
11. FGDs and exit interviews to assess client satisfaction with services.
12. IDIs with VHWs/ TBAs on coverage of MCH services and home visits.
13. FGDs with family members about access to services.

**Activities**

1. Review training report of WDCs
2. Facility HMIS data of use of MCH services
3. Review facility CCT trend register & personal health cards of CCT beneficiaries
4. IDI and exit interviews with pregnant women
5. Review facility MCH registers for trend of coverage of services e.g. increased client registration.
6. IDIs with heads of facilities to assess changes in service utilization.
7. IDIs and exit interviews with service users.
8. Document review of annual reports of trend of coverage of MCH services following SURE-P programme implementation.

**Inputs**

15. Review facility CCT trend register & personal health cards of CCT beneficiaries
14. VHWs and TBAs paid CCT for mobilizing clients and ensuring service utilization.

**Outputs**

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**Inputs**

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14. VHWs and TBAs paid CCT for mobilizing clients and ensuring service utilization.
Situation → Targetmetrics by 2015 → Inputs → Activities → Outputs → Outcomes — Impact

Data

CCT
15. IDIs with community leaders to verify training of WDCs
16. IDIs with heads of facilities and inspect means of verification of CCT payments.
17. Documents review of CCT payment to pregnant women, VHWs and TBAs
18. IDIs with heads of facilities to ascertain bank and mobile payment of CCT.

COST (SUPPLY SIDE)
1. Cost of recruiting, deploying and training midwives, CHWs and VHWs.
2. Cost of drugs, consumables and equipment supplied to health facilities.
3. Cost of infrastructural upgrade, transport etc.

COST (DEMAND SIDE)
1. Cost to the programme of implementing CCT.
2. Cost of administration of programme.
3. Cost to households of accessing and obtaining services e.g. cost of obtaining ANC, skilled birth attendance, and postnatal services

17. FGDs with CHWs and VHWs/TBAs on remunerations
18. Documents review of HRH remunerations
19. IDIs and exit interviews with pregnant women about cost of obtaining MCH services
20. FGDs with family members about cost of obtaining MCH services
21. Suggestions are welcome Re: data for a verifiable CCT payment system