

Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program

ACCESS

YEAR ONE ANNUAL REPORT

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Submitted by:

**JHPIEGO in collaboration with
Save the Children
Futures Group International
Academy for Educational Development
American College of Nurse-Midwives
Interchurch Medical Assistance**

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The logo for ACCESS, featuring the word "access" in a purple, lowercase, sans-serif font. The letter "a" is stylized with a small orange circle above it, and the "c" has a small orange circle to its right.

Access to clinical and community
maternal, neonatal and women's health services



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ABBREVIATIONS AND ACRONYMS

| | |
|--------|---|
| ACCESS | Access to Clinical and Community Maternal, Neonatal and Women’s Health Services |
| ACNM | American College of Nurse-Midwives |
| AED | Academy for Educational Development |
| AFRO | Regional Office for Africa |
| AMTSL | Active Management of the Third Stage of Labor |
| ANE | Asia Near East |
| ART | Antiretroviral |
| BASICS | Basic Support for Institutionalizing Child Survival |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| CAF | Choose A Future |
| CMT | Core Management Team |
| CORPS | Community Own Resource Persons |
| CT | Counseling and Testing |
| DRHT&S | District Reproductive Training and Supervision Teams |
| EARN | East and Southern Africa Roll Back Malaria Network |
| EMNC | Essential Maternal and Newborn Care |
| EmOC | Emergency Obstetric Care |
| FANC | Focused Antenatal Care |
| FBO | Faith-based Organization |
| FP | Family Planning |
| HHCC | Household-to-Hospital Continuum of Care |
| HNP | Healthy Newborn Partnership |
| IBP | International Best Practices |
| ICM | International Confederation of Midwives |
| IMA | Interchurch Medical Assistance |
| IP | Infection Prevention |
| IPT | Intermittent Preventive Treatment |
| IPTp | Intermittent Preventive Treatment during Pregnancy |
| IR | Intermediate Result |
| IRC | International Refugee Committee |
| ITN | Insecticide-treated (bed) Net |
| KMC | Kangaroo Mother Care |
| LAC | Latin America and Caribbean |
| M&E | Monitoring and Evaluation |
| MAC | Malaria Action Coalition |
| MCH | Maternal and Child Health |
| MIP | Malaria in Pregnancy |
| MIPESA | Malaria in Pregnancy East and Southern Africa Coalition |
| MNH | Maternal and Neonatal Health Program |
| MNPI | Maternal and Neonatal Program Index |
| MOH | Ministry of Health |
| MOHP | Ministry of Health and Population |
| MOPH | Ministry of Public Health |
| MPWG | Malaria in Pregnancy Working Group |
| NFE | Non-formal Education |
| NFHP | National Family Health Program |
| NGO | Nongovernmental Organization |
| PAC | Postabortion Care |

| | |
|--------|--|
| PAHO | Pan-American Health Organization |
| PEPFAR | President's Emergency Plan for HIV/AIDS Relief |
| PMNCH | Partnership for Maternal, Newborn and Child Health |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| POPHI | Prevention of Postpartum Hemorrhage Initiative |
| PPH | Postpartum Hemorrhage |
| PQI | Performance and Quality Improvement |
| PSMNH | Partnership for Safe Motherhood and Newborn Health |
| QAP | Quality Assurance Project |
| RAOPAG | West Africa Network against Malaria during Pregnancy |
| RBM | Roll Back Malaria |
| RH | Reproductive Health |
| SBA | Skilled Birth Attendance |
| SBM | Standards-based Management |
| SEARO | Regional Office for South-East Asia |
| SMA | Social Mobilization Advocacy |
| SMM | Safe Motherhood Model |
| SO | Strategic Objective |
| SP | Sulfadoxine-Pyrimethamine |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Testing |
| VDC | Village Development Committee |
| WHO | World Health Organization |
| WRA | White Ribbon Alliance |

I. SUMMARY OF ACHIEVEMENTS FOR YEAR ONE

The Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS) Program launched its mission to improve maternal and newborn health and survival in developing countries worldwide in July 2004, with program implementation beginning October 1, 2004. In its first year, ACCESS had three field-supported country programs; now—one year later—the Program has nine country programs, four Malaria Action Coalition (MAC) countries, and ongoing activities in another 16 countries worldwide. This rapid expansion of field-based programming reflects countries’ growing confidence and interest in ACCESS as they seek to reduce continued high rates of maternal and newborn mortality.

Over the past year, ACCESS has become increasingly recognized as a global leader for policy and advocacy, technical expertise, and implementing evidence-based interventions and approaches in maternal and newborn health. Because ACCESS is implemented through such a rich partnership¹, the Program has demonstrated the technical and programmatic expertise to both advocate for and support the full range of maternal and newborn health care interventions from the household to the referral level.

PROGRAMMATIC ACHIEVEMENTS

In Year One, the ACCESS Program made great strides toward achieving its expected outcomes. Key achievements are highlighted below:

- Improved enabling environment for safe motherhood and newborn health programming through global, regional, and national partnerships and alliances:
- ACCESS helped to ensure integration of maternal and newborn health into the recently launched Partnership for Maternal, Newborn and Child Health (PMNCH).
- ACCESS collaborated with the World Health Organization (WHO) in several ways, participating in the WHO Meeting on maternal and child health (MCH) in India and working with WHO/Regional Office for Africa (AFRO) and WHO/Regional Office for South-East Asia (SEARO) to support maternal and newborn health initiatives in their region.
- The Program’s work on global- and country-level advocacy of the *Lancet Neonatal Survival Series* is helping to place newborn health on the global agenda.
- ACCESS is a steering committee member of the Asia regional network—MotherNewBorNet—which collaborates with United States Agency for International Development (USAID) bilateral programs to strengthen community-based postpartum care.
- To influence policies and programs, ACCESS has also collaborated with other global partnerships, such as the International Confederation of Midwives (ICM) and the White Ribbon Alliance (WRA).
- In Africa, ACCESS initiated alliances with faith-based organizations (FBOs) in multiple countries to provide technical updates on focused antenatal care (FANC) and malaria in pregnancy (MIP).

¹ JHPIEGO implements the ACCESS Program in partnership with Save the Children, the Futures Group, AED, ACNM, and IMA.

- Increased informed demand and collective action for quality Essential Maternal and Newborn Care (EMNC) policies, programs, and investments at the global, national, and local levels:
- In Kenya, ACCESS developed a community orientation package on reproductive health (RH)/MIP that was used to train trainers who subsequently trained 146 community own resource persons (CORPS) in seven divisions—two divisions in Bondo, Makueni and three divisions in Kwale.
- In Cameroon, a Social Mobilization Strategy and Action Plan was developed. Ministry of Health (MOH) staff was updated in community mobilization and a group of 25 community mobilization trainers were trained.
- Improved EMNC policies, programs, and investments at the global, national, and local levels:
- ACCESS worked in both Tanzania and Haiti to develop evidence-based national service delivery guidelines for infection prevention (IP) and prevention of mother-to-child transmission of HIV (PMTCT), respectively.
- A regional workshop held in Tanzania on MIP for FBO and MOH representatives from five Malaria in Pregnancy East and Southern Africa Coalition (MIPESA) member countries in East Africa resulted in updated knowledge on FANC and MIP among participants.
- Also in Tanzania, a national curricular module for FANC for certificate-nurse midwifery schools was developed.
- In Burkina Faso, the MOH adopted a policy for intermittent preventive treatment (IPT) for prevention of MIP.
- Maternal and newborn policy initiatives in Nepal (skilled birth attendance [SBA] policy) and Afghanistan (the national safe motherhood strategy) were supported.
- ACCESS contributed to the Malaria Action Coalition (MAC) work on a regional level, supporting regional networks such as West Africa Network against Malaria during Pregnancy (RAOPAG) and MIPESA, including the compilation of a best practices report for MIPESA countries.
- In Latin America, ACCESS supported development of a regional strategy for newborn health.
- ACCESS reached a global audience through its fistula workshop and presentation on AMTSL (AMSTL) at the ICM triennial meeting in Brisbane, Australia, updating participants' knowledge of prevention of obstetric fistula and AMTSL.
- Tools, technical approaches, and services scaled up at national and local levels:
- ACCESS established FANC (including intermittent preventive treatment during pregnancy [IPTp] and syphilis screening) integrated with PMTCT services at 24 district hospitals in Tanzania. Clinical preceptors from all 21 certificate midwifery schools in Tanzania—representing 27 facilities used as clinical practice sites by students—were also trained.
- In Indonesia, Nepal, and Afghanistan, ACCESS provided support for community-based prevention of postpartum hemorrhage (PPH) using home-based delivery of misoprostol as part of its goal to introduce and scale up this successful approach in multiple countries. Based on technical discussions and advocacy workshops held by ACCESS, Afghanistan obtained Ministry of Health and Population (MOHP) approval for a PPH demonstration project.

- ACCESS further supported the work of the Prevention of Postpartum Hemorrhage Initiative (POPHI), a global USAID-funded project, by helping to distribute the PPH toolkit worldwide.
- Strengthened community, provider, and health systems capacity for improved EMNC service delivery:
- ACCESS supported trainings of providers and trainers from Haiti and Cameroon to strengthen the capacity to deliver EMNC services. Followup visits to trained EMNC providers in Cameroon showed that they had applied their new knowledge and skills on the job according to their action plans.

MANAGEMENT/ORGANIZATIONAL ACHIEVEMENTS

In Year One, ACCESS placed a great effort on laying a solid foundation for its future programming. This included strategic planning at the global and country level, raising awareness among international and national policymakers, establishing a strong organizational structure, and building a strong staff that reflects the program goals and partners' strengths. This systematic planning has set the stage for full-scale implementation of programs that will have a substantial impact on newborn health and survival worldwide. Some achievements include:

- **Defined Strategic Approach:** The ACCESS core management team (CMT) developed a unified vision, strategy, and technical approach for the Program, which core initiatives and field support programs have been designed to support.
- **Built Local Capacity:** As the Program has expanded into new countries (e.g., Afghanistan) and worked to establish field programs in other countries, a concerted effort was made to recruit and build the capacity of local staff for high-quality maternal and newborn programming.
- **Brought Together a Team of Experts:** ACCESS has assembled a team of staff that possesses the skills and experience necessary to meet the challenges of program expansion, management, and implementation. The ACCESS Partnership has seen changes in key staff in Year One, including the Program Director and the Monitoring and Evaluation (M&E) Director; a Faith-Based Coordinator was also recruited.
- **Expanded ACCESS Programming:** Despite changes in key staff, the ACCESS team responded to several new country programs and an associate award, receiving the ACCESS/Family Planning (FP) associate award in September 2005.

The next section of this report provides an overview of the ACCESS Program, including its strategic approach, results framework, and special technical areas. More detailed information is presented about the program results mentioned above, as well as other achievements. The results are organized by strategic objective (SO) and intermediate result (IR) for both core-funded and field-funded results. A discussion of programmatic challenges and opportunities follows the results section. To conclude the report, a financial summary is provided. Additional supporting information is included in several annexes.

II. PROGRAM OVERVIEW

STRATEGIC APPROACH

The ACCESS Program's strategy is based on a household-to-hospital continuum of care model that links the household, community-level health workers, peripheral health facilities, and the hospital in a systems approach to maternal and newborn care. The overall aim of this strategy is to expand coverage, access, and use of key maternal and newborn health services, making high-quality health services accessible as close to the home as possible.

The ACCESS approach to community intervention addresses key barriers to health care quality, access, and use, and seeks to promote appropriate household behaviors. ACCESS promotes interventions that are practical and affordable in preventing and managing the major causes of maternal and newborn illness and death. The Program's conceptual framework, illustrating which results will be achieved and how, is included in **Annex A**.

To implement its programs, ACCESS is working with national governments, FBOs, and USAID missions to: (a) improve the implementation of health programs catalyzing systemic change to improve maternal and newborn health and assure that these services reach poor and marginalized populations and involve women and men as full partners; (b) refine and replicate evidence-based, cost-effective community- and facility-based interventions or approaches that have proven successful on a small scale, but have yet to be adopted by other programs or partners; and (c) bring together the constituents, partners, and champions among policymakers, private-sector entities, civil society organizations, and community leaders to increase commitment and resources to ensure that maternal and newborn health figure more prominently in national health plans and programs, and to ensure a favorable environment conducive to and supportive of maternal and newborn health at local, national, and international levels.

As the USAID flagship program for maternal and neonatal health, ACCESS coordinates its activities and actively collaborates with organizations and other programs sharing a commitment to improving maternal and newborn health. Regular inter-organizational consultations between ACCESS and the relevant divisions of USAID and other organizations—such as the WHO (including its regional offices), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Roll Back Malaria (RBM), and the World Bank—are established through existing relationships.

In-country coordination for program implementation has involved regular consultations with host country counterparts, USAID and other donors, other cooperating agencies, and host country institutions. These include multilateral and bilateral donors, professional associations, community-based NGOs, FBOs, and educational institutions. The country teams also coordinated program activities with those of USAID bilateral programs and other cooperating agencies.

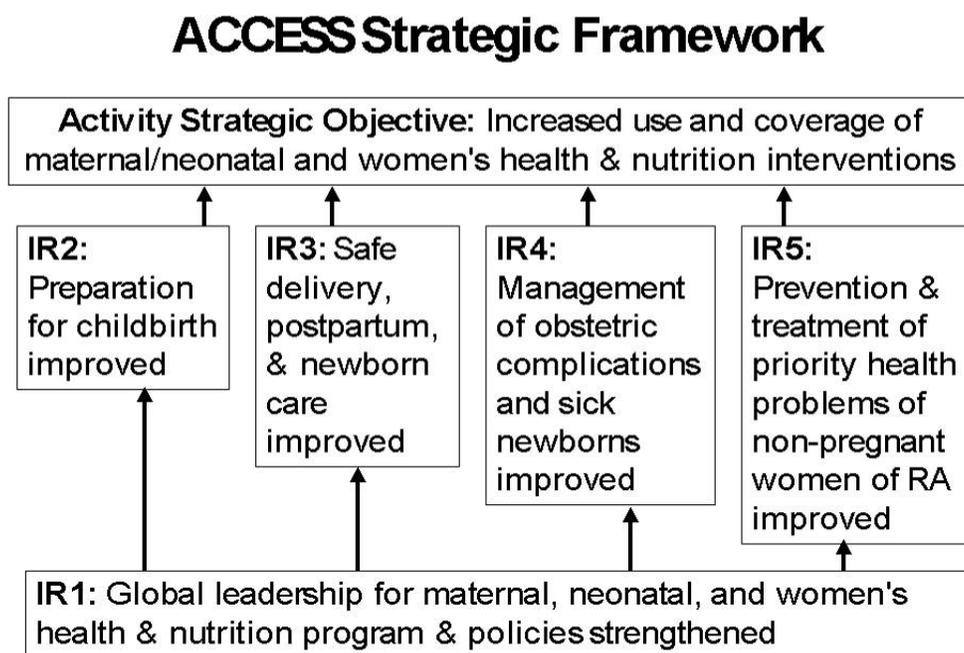
(For an overview of Program finances, see **Annex D**.)

ACCESS GLOBAL RESULTS FRAMEWORK

The ACCESS results framework (**Figure 1**) illustrates the results the Program aims to achieve globally, and includes outcomes under field programs as well as core global- and national-level advocacy. In addition to this framework, each significant ACCESS country-level program has an individually tailored results framework that has been approved by the corresponding USAID

Mission, and is linked to the Mission's strategic framework and the ACCESS strategic framework.² These country-level results frameworks are presented as annexes to this report and include updated status information.

Figure 1. ACCESS Strategic Framework



SPECIAL TECHNICAL AREAS

ACCESS received special earmark funding in Year One for activities in four technical areas: PPH; newborn health; prevention of MIP; and PMTCT. Below we describe the rationale for investing in these areas, a brief summary of accomplishments during Year One, and an overview of future plans.

Postpartum Hemorrhage

PPH continues to be the major cause of maternal mortality throughout the developing world. Uterine atony, responsible for most cases of PPH, can occur in otherwise normal births. In low-resource facilities, this can be prevented by the use of uterotonic agents given after the birth and through AMTSL; in home settings, prevention can be achieved through community-based distribution of misoprostol.

In Year One, ACCESS provided technical assistance to Afghanistan and Nepal and followup to Indonesia in the area of community-based distribution of misoprostol. As a result of advocacy by ACCESS, Afghanistan is currently preparing to conduct a pilot study on the use of misoprostol in the community. Nepal, through the USAID bilateral the National Family Health Program (NFHP), has begun implementation of a demonstration pilot to test the prevention of PPH at homebirth using misoprostol in Banke district with ACCESS technical assistance. ACCESS also produced a draft technical brief on prevention of PPH, and a PPH component for a USAID e-learning course.

² Minimum threshold for a separate M&E plan for ACCESS country-level activities is a funding level of at least \$300K. Other criteria may affect the decision regarding whether or not a country-level plan is necessary.

With respect to AMTSL, providers in Haiti (35 providers from 20 facilities) and Cameroon (20 providers from 15 facilities in Ngaoundere District) were trained in EMNC (including AMTSL) in 2005 and are now applying their skills on the job. In addition, the midwifery preservice education initiative being carried out by ACCESS, in collaboration with WHO/AFRO, in eight African countries includes an examination of AMTSL in the assessment tool being used.

In Year Two, ACCESS will continue to collaborate with organizations such as the USAID-funded POPPHI Program to ensure that the evidence-based knowledge and skills to apply these life-saving interventions are made available at all levels of the household-to-hospital continuum of care (HHCC) in each country in which it is working. Another Year Two priority will be sharing evidence-based knowledge, skills, and materials about the prevention and treatment of PPH to as wide an audience as possible. Thus, ACCESS, in concert with other collaborating organizations, will convene an Africa regional conference entitled “Preventing Mortality from PPH in Africa: Moving From Research to Practice”. Teams of policy-makers, providers, and community- and faith-based organizations from 10 to 15 countries will examine best practices, discuss strategies, and develop action plans aimed at the reduction of maternal mortality due to PPH in their settings. Two to four of these country teams will then be supported in their efforts to implement their plans. Over the life of the Program, ACCESS will aim to scale up PPH activities in one to two countries.

Newborn Health

Newborn health is an important technical area for the ACCESS Program, which receives special SO 2 funding for this work.

The majority of newborn deaths occur in the first 24 hours of life from birth asphyxia and birth injuries, infection, and prematurity. Most of these problems can be prevented or treated by skilled providers using simple measures that are suitable and affordable for low-technology settings throughout the HHCC, including: identification and treatment of obstructed labor in order to prevent obstetric fistula; prevention of PPH; and prevention and treatment of birth asphyxia and newborn infection. Skilled providers can also apply other means of preventing newborn complications including integration of programs aimed at PMTCT and prevention and case management of MIP throughout pregnancy, childbirth, and the postpartum and newborn periods. Thus, in order to achieve a decrease in morbidity and mortality for women and newborns, antenatal and postpartum care as well as basic emergency obstetrical and newborn care (BEmONC) must be accessible to them at all points along the continuum.

In Year One, ACCESS promoted global knowledge and awareness of emerging newborn health research through its support for disseminating findings from the *Lancet Neonatal Survival Series* in the U.S. and Indonesia, and through production of a draft technical brief on newborn health (currently under final review). In addition, ACCESS developed the first draft of a global training resource, a competency-based Kangaroo Mother Care (KMC) Training Manual, to teach health care workers at all levels how to care for low birth weight babies. Regionally, ACCESS helped to effect newborn care policy change in Latin America, where a regional strategy for newborn health developed with ACCESS assistance was approved by Guatemala, Bolivia, Paraguay, and the Dominican Republic. In Africa, ACCESS contributed to the preparation of the Africa region paper “Opportunities for Newborn Health”. In Asia, ACCESS co-financed the Nepal Neonatal forum meeting in April/May 2005.

Malaria in Pregnancy

African countries experience the heaviest burden of illnesses related to malaria during pregnancy. The devastating effects include maternal anemia, low birth weight, impaired child development and, all too often, maternal and infant mortality. With support from MAC, ACCESS is working to strengthen efforts to prevent MIP and reduce the burden of disease in Africa.

ACCESS took a global leadership role in spearheading the work of the RBM-Malaria in Pregnancy Working Group (MPWG) as well as guiding the work of two African regional malaria networks: East and Southern Africa Roll Back Malaria Network (EARN) and RAOPAG. A regional workshop was conducted on MIP for Islamic and Christian FBOs and MOH representatives from five MIPESA member countries in East Africa to update their knowledge on FANC and MIP, supervision, and the interaction between malaria and HIV. ACCESS also produced a draft technical brief on MIP, which is now under final review.

ACCESS carried out country-level MIP prevention efforts in Madagascar, Kenya, and Rwanda (see results section of this report), and MIP will continue to be a major thrust for the Program.

Prevention of Mother-to-Child Transmission of HIV

Vertical transmission of HIV is an increasingly serious health problem for newborns in both sub-Saharan Africa and parts of the Caribbean, and must be addressed through integrated service delivery. The platform of maternal and newborn health services offers an ideal entry point for PMTCT. ACCESS promotes PMTCT as a part of a comprehensive package of maternal health services for women in pregnancy. Because the integration of PMTCT into maternal and newborn health services is a relatively new idea, ACCESS is making an important contribution in this area.

In Year One, ACCESS achieved PMTCT-related results in Tanzania and Haiti. ACCESS established FANC (including IPTp and syphilis screening) integrated with PMTCT services at 24 district hospitals in Tanzania. An MCH-PMTCT Integration Conference sponsored by USAID and organized by ACCESS was held 6–7 December 2004 in Tanzania to launch coordination and collaboration among agencies working in PMTCT.

- In Haiti, ACCESS and the MOH revised and produced protocols, norms, and procedures for PMTCT (entitled *A Guide for the Prevention of Mother to Child Transmission*). ACCESS also adapted and translated a PMTCT learning package (based on the WHO package) for use in Haiti. In addition, ACCESS trained 43 Haitian policymakers, trainers, and service providers in Haiti in Voluntary Counseling and Testing (VCT)/PMTCT and conducted baseline PMTCT assessments at 4 facilities.

PMTCT will remain a focus of the Program as it allow for building on existing services and enables ACCESS to partner with USAID's Office of HIV/AIDS.

SUMMARY OF FIELD ACTIVITIES

A list of ACCESS field program funding levels for FY04 and a brief list of associated activities is included in **Table 1**.

Table 1. ACCESS Field Programs Program Year One: October 1, 2004 - September 30, 2005

| Country | Funding | Key Activities |
|--|---------|---|
| Haiti | \$1.5m | <ul style="list-style-type: none"> • Increased accessibility and use of PMTCT • Strengthened RH/postabortion care (PAC), FP, IP • Assess cervical cancer prevention |
| Tanzania | \$950k | <ul style="list-style-type: none"> • Integrated FANC and PMTCT • Preservice training in FANC • Dissemination of IP guidelines • Support to WRA |
| Nepal | \$200k | <ul style="list-style-type: none"> • Development of human resource strategy for SBAs and community-based maternal and newborn care |
| WARP | \$300k | <ul style="list-style-type: none"> • Development of EMNC providers in Cameroon • Training of community social mobilizers |
| MAC | \$770k | <ul style="list-style-type: none"> • Field support from Kenya, Madagascar, REDSO, Rwanda, and WARP • Coordination with MAC core funding |
| AFR/SD Bureau | \$200k | <ul style="list-style-type: none"> • Training of technical experts/facilitators for the implementation of the Africa Road Map • Preservice midwifery education |
| Asia Near East (ANE) Bureau | \$430k | <ul style="list-style-type: none"> • Support to WHO/SEARO • Country-level advocacy for Lancet series on neonatal health • Technical support to scaling up prevention of PPH for home births • Support community-based postpartum care MotherNewBorNet in Asia |
| Latin America & Caribbean (LAC) Bureau | \$50k | <ul style="list-style-type: none"> • Research and preparation of strategic document for newborn health with multiple stakeholders |
| Afghanistan | \$0 | <ul style="list-style-type: none"> • Support the Afghan Midwives Association • Maternal health policy review • Community based PPH study |
| Kenya | \$0 | <ul style="list-style-type: none"> • Design integrated PMTCT programs |

Complete results (for all IRs) for significant country and regional initiatives by country and initiative are included in **Annex C**.

III. PROGRAM RESULTS BY SO AND IR

This section of the report presents bulleted results for both core-funded and field support-funded activities organized by the ACCESS Global Results framework: the Activity Strategic Objective (SO) and the five associated IRs. For a complete list of core program outputs/deliverables produced in Year One by subactivity, please refer to the matrix in Annex B.

ACCESS SO: INCREASED USE AND COVERAGE OF MATERNAL/NEONATAL AND WOMEN'S HEALTH AND NUTRITION INTERVENTIONS

Over the past year, ACCESS increased coverage of quality maternal, newborn, and/or other health care services for women of reproductive age in Tanzania, Kenya, Haiti, Burkina Faso, and Cameroon³:

- In Tanzania, providers with strengthened focused antenatal care knowledge and skills gained through ACCESS-supported training events are now providing services at key district and sub-district level facilities in 18 of 21 regions (excluding Zanzibar and Pemba) in the country, representing 35 districts with an estimated combined total population of 1,367,319.⁴
- ACCESS worked to strengthen capacity within the MOH in family planning in Kenya, working in Nyeri, Homabay, and Nakuru districts, representing three different provinces (Nyanza, Central, and Rift Valley, respectively) and an estimated combined total population of 351,306.
- In Haiti, ACCESS supported delivery of PAC services at seven referral hospitals in six of nine departments covering an estimated 366,078 women of reproductive age.
- In Burkina Faso, ACCESS supported delivery of MIP services at six sites in Koupéla district, covering an estimated 4,407 women of reproductive age.
- In Cameroon, the ACCESS Program improved the availability of quality EMNC services in Ngaoundere district, with an estimated total population of 231,357.

IR 1: GLOBAL LEADERSHIP FOR MATERNAL, NEONATAL, AND WOMEN'S HEALTH AND NUTRITION PROGRAM AND POLICIES STRENGTHENED

During the past year, through global and national advocacy and strategic partnerships at global, regional, and national levels, ACCESS worked to build and expand existing resources and capacities, and extend maternal and newborn health activities beyond the reach of what ACCESS alone can do. ACCESS has been a voice to assure the integration of maternal and newborn health into the newly formed PMNCH. To influence policies and programs, ACCESS has collaborated with these global partnerships and others, such as the WHO/AFRO, WHO/SEARO, ICM, and WRA.

With respect to core-funded accomplishments under IR 1, an emphasis in Year One has been strengthening maternal and newborn policies and programs. This included adapting existing tools for EMNC, building strategic partnerships with nongovernmental organizations (NGOs) to further develop leadership and expand EMNC programming in Africa, and disseminating tools and

³ Population coverage estimates were drawn from data sources located at: www.gazeteer.com and www.census.gov.

⁴ This figure does not include estimates for the districts of Arumeru, Iramba, Serengeti, Karagwe, Rombo, Kilombero, Kwimba, Geita, Mbozi and Ilala, since data were not available. In addition, estimates for Dodoma, Songea, Iringa, Bukoba districts include the entire district rather than the part (rural or urban) where ACCESS is working as data for those sub areas were also not available.

materials that shared best practices and evidence-based interventions on maternal and newborn health (e.g., the *Index of Resources for Maternal and Newborn Care Programming*). In addition, ACCESS has supported the development of two USAID-sponsored e-learning mini-courses in global health fundamentals for technical officers and program managers: FANC and prevention of PPH.

Core-funded Results

- Index of tools and materials for maternal and newborn health—a compilation of technical resources and documents from organizations working in maternal and newborn health—disseminated to field offices.
- First drafts of technical briefs on newborn health, FANC, MIP, and prevention of PPH prepared and under final review.
- E-learning components on best practices in FANC and PPH prepared for USAID e-learning course.
- Participated in planning and development of the Africa region paper, *Opportunities for Newborn Health*.
- ACCESS website www.accesstohealth.org developed in Year One and launched in October 2005.
- A regional workshop on MIP for Islamic and Christian FBOs and MOH representatives from five MIPESA member countries in East Africa sponsored by ACCESS resulted in updated knowledge on FANC and MIP, supervision, and the interaction between malaria and HIV among the 28 participants. The workshop also included orientation to the HHCC approach. Country teams developed action plans that target the scale up of FANC/MIP through FBO groups. Participants are expected to play key roles in advocating for change and implementation of improved services in their countries.⁵
- Conducted fistula workshop and presented on AMTSL at ICM triennial meeting in Brisbane, Australia 24–28 July to update participants' knowledge and skills on prevention of obstetric fistula and AMTSL.
- Collaborated with the Partnership for Safe Motherhood and Newborn Health (PSMNH) in the WHO Global Meeting of heads of international organizations and leaders in maternal, child, and newborn health held in

Outcomes of ACCESS FBO Workshop Held in Tanzania in August 2005: Counseling and Testing in Malawi

We started the "opt-out" approach to HIV testing in our antenatal clinic at Mulanje Mission Hospital for the first time in September [previously it was "opt in"]. I first went to talk to the nurses in the clinic, then to talk to the lab technicians, and then to talk to the HIV counselors. Everyone seemed to agree that it would be a good idea. The best thing is that one of the young men who is a counselor thought it was a very good idea. He really tried to get over to the clinic and offer the counseling services. Ninety-six women accepted to be tested and 18 are positive. We are trying to offer continuing counseling and support to the positive ones, including Nevirapine. Up to this point we had only one or two women accepting to be tested a month. So Professor Dipo was right about "op-out". Also, two of the husbands of the positive women came in to talk to me. It is very hard to get men to come for testing even when they are sick in the hospital.

—Dr. Sue Makin, ob/gyn, Mulanje Mission Hospital, Malawi

⁵ The five countries represented include: Kenya, Malawi, Tanzania, Uganda, Zambia. Three participants were from the Christian Health Associations of the five select countries and from two from Islamic organizations: the Agha Khan Development Network (AKDN) and the Uganda Muslim Medical Bureau. In addition, one Ministry of Health representative from each of the five countries also participated.

Delhi, India, in April 2005, and supported participation of three people from Tanzania.

- Assisted with the advocacy launch in Washington, D.C. of the *Lancet Neonatal Survival Series* highlighting neonatal health and supported the country-level neonatal forums in Nepal and Indonesia that advocated the series.
- Developed the malaria and neonatal components of the Safe Motherhood Model (SMM); field testing to be done in Year Two.
- JHPIEGO served as the Secretariat for the RBM-MPWG, which provided global guidance to the RBM Secretariat on key issues to affect change for MIP including the use of IPT with sulfadoxine-pyrimethamine (SP) and the link between HIV and malaria.

Field Support-funded Results

ACCESS demonstrated leadership through its field-support funded work as well, influencing national policies in Afghanistan and Nepal; developing and disseminating service delivery guidelines in Tanzania; helping to implement the Africa Road Map; and initiating efforts to improve preservice midwifery education in Anglophone and Francophone Africa. Details are provided below. Complete results (for all IRs) for significant country and regional initiatives by country and initiative are included in **Annex C**.

Afghanistan

- As a result of advocacy efforts by ACCESS, the Ministry of Public Health (MOPH) of Afghanistan agreed to a demonstration project for community-based prevention of PPH (as modeled in Indonesia under MNH) and formed a technical advisory group to oversee the development and implementation of the project. As a result of attending the Asia regional advocacy workshop and visiting sites where the community-based prevention of PPH program is ongoing in Indonesia, the new Director for Reproductive Health (RH) at the MOPH, Dr. Rahela Kafeer, and Dr. Nazdana Pakhtiyal, a midwife and trainer from the International Refugee Committee (IRC), prepared to become strong advocates for the community-based prevention of PPH program.
- Obtained stakeholder consensus for a review of the national safe motherhood strategy in Afghanistan. The Maternal Newborn Program Index (MNPI) conducted in Afghanistan is to be used as a basis for reviewing and updating national safe motherhood and newborn health strategy. This included an analysis of various inputs by NGOs and the MOPH in the areas of maternal, newborn, and women's health by geographical area. Results are being compiled in a wall-sized matrix at the MOPH. National level policy-makers and stakeholders introduced to SMM (computerized version of MNPI) as a tool for policy making in Afghanistan.

Nepal

- Developed a strategy for "Improved SBA at the Community Level" in Nepal. This document contributed to the knowledge of the MOHP, USAID, and the national safe motherhood program. A draft policy on SBA is currently undergoing revision and approval by the MOHP. Subsequently, USAID asked ACCESS to prepare a two-year program that would strengthen SBA and improve access and coverage of community-based maternal and neonatal care.

Tanzania

- ACCESS, in collaboration with the MOH, finalized, printed, and disseminated the *National IP and Control Guidelines for Health Services* following a national, zonal, and regional stakeholders' workshop. The purpose of the guidelines is to ensure that all health care providers follow the same basic IP measures and safety precautions in their daily work. These guidelines have also been used as reference materials in training staff in the referral and selected district hospitals. Other partners, including John Snow, Inc., are using them in their training.
- ACCESS supported the WRA in Tanzania to encourage awareness and knowledge in the community of the importance of safe motherhood and birth planning. A meeting of the WRA was held in December 2004 to revitalize existing members as well as bring in new members. Agreement was reached to move ahead for effective action in terms of raising greater awareness in the communities about safe motherhood, acting as catalysts, and building alliances. Attendees recommended holding a stakeholders' workshop to reflect and address a wide range of issues as well as training partner organizations on birth preparedness and complication readiness, and giving highlights on best practices in Tanzania. The recommended mobilization and advocacy for maternal and newborn health workshop was held in July 2005 in Dar es Salaam. One of the purposes of the workshop was to help the WRA identify options for the future, including potential awareness-raising campaigns and advocacy actions. Participants suggested several ideas for new safe motherhood initiatives, including an action plan with a timeline.

Africa Regional

- Nine Anglophone and Francophone African countries⁶ have a total of 17 trained Africa Road Map facilitators—high-level physicians/medical professionals—ready to guide national-level policy makers to achieve Africa Road Map goals for Safe Motherhood in their respective countries. Technical assistance was provided to participants from Ethiopia and Tanzania and specific interventions identified.
- ACCESS provided technical guidance to East and West African malaria prevention networks, MIPESA and RAOPAG, respectively.

IR 2: PREPARATION FOR CHILDBIRTH IMPROVED

- A major intervention for reducing maternal and newborn deaths during childbirth is to improve the readiness of pregnant women, their families, communities, and health facilities staff to manage a clean and safe delivery. In Year One, ACCESS developed a technical paper that described the key maternal and newborn health interventions through a continuum of care from the household to the hospital. To facilitate the process of implementing the community component of this continuum in the field, ACCESS prepared a technical paper that identified the evidence base for home-base care for pregnant women, recent mothers, and newborns. To complement the community mobilization training manual *How to mobilize communities for health and social change* developed by JHU/Center for Communication Programs, work was initiated on an EMNC facilitator's guide. The two documents will assist country programs to improve the EMNC-related knowledge and skills of pregnant women, recent

⁶ Countries represented include: Ethiopia, Ghana, Tanzania, Zambia, Senegal, Niger, Burkina Faso, Guinea, and Mauritania

mothers, families, community members, community health workers, and health care providers.

- To support the integration of EMNC and PMTCT programs, an ACCESS technical team visited Kenya and Tanzania to work with MOH staff to design two demonstration projects. The Kenya project—developed in partnership with Boston University and AMKENI Project—has been put on hold due to lack of adequate funds to support its implementation⁷.

Core-funded Results

- First draft of technical paper, *Household-to-Hospital Continuum of Maternal and Newborn Care*, prepared and distributed for internal review; to be completed and printed in the first quarter of Year Two. A working group was established to guide the content of the paper.
- First draft of the EMNC facilitator's guide complete; to be finalized and printed in the first quarter of Year Two and ready for use during the implementation of the HHCC in Tanzania.
- First draft of technical paper *Guide for Home-Based Maternal and Newborn Care Programming* completed and under internal review.
- Standards-based management (SBM) approach and tool adapted and adopted in Tanzania and Madagascar for FANC including MIP. Program managers and supervisors in both countries were trained to use and implement this approach (see details in field section).
- Completed a followup survey on MIP in Koupéla, Burkina Faso and disseminated results to key stakeholders. The Burkina Faso pilot study results yielded that IPT led to a reduction in maternal anemia, peripheral parasitemia, and placental parasitemia. As a result, Burkina Faso officially adopted a countrywide MIP policy in February 2005 that includes IPT and insecticide-treated bed nets (ITNs) through FANC.



Photo: MNH standardization workshop at Hospital Justinien, Haiti: consultant Dr. Jean Mrony, course participant, Clinical Specialist Patricia Gomez.

Field Support-funded Results

Field support-funded projects in Afghanistan, Haiti, Kenya, Madagascar, Tanzania, Rwanda, Mali, including projects with funding from MAC, WARP and REDSO contributed results related to ACCESS global IR 2. Details are provided below.

Haiti

- Protocols, norms, and procedures for PMTCT in Haiti revised, produced, and presented to the MOH.⁸
- Forty-three policymakers, trainers, and service providers in Haiti trained in VCT/PMTCT at two 2-week VCT/PMTCT trainings in the Dominican Republic.
- PMTCT learning package adapted and translated of for use in Haiti.

⁷ The Kenya demonstration project may be revisited after USAID/Kenya awards its follow-on bilateral to the AMKENI Project.

⁸ This result and the following three results also contribute to ACCESS IR 3 but are only listed here.

- Conducted PMTCT facility assessments and developed preliminary implementation plans at HUEH, Isaie Jeanty, Jacmel, and Cap Haitien in Haiti.

Kenya

- ACCESS collaborated with the Division of RH and Division of Malaria Control on the development of a community orientation package on RH/MIP. A total of 77 newly trained public health officers and technicians, district health education officers, and representatives from civil society organizations from Bonso, Makeuni, and Kwale districts trained 146 CORPS. CORPS are considered to be opinion leaders and play a role in the broad dissemination of health messages within their communities (not only MIP but comprehensive RH). The CORPS followup in September 2005 revealed that most of the CORPS have held initial briefing meetings with community members and are planning additional meetings.

Madagascar

- Performance standards for FANC/MIP were developed and approved by the MOH/FP in Madagascar. Five health centers in Madagascar assessed their performance using the FANC/MIP performance standards and 28 actions were identified to reduce the gaps in service at the five sites. A total of 30 providers participated in the performance and quality improvement (PQI) analysis. The results from the evaluation of the five model sites provided the National Malaria Control Program with critical lessons that will be applied in further scale up of the MIP program.
- WHO/AFRO used the ACCESS MIP competency-based training materials and trainers developed in FY04 to scale up the program from 25 to 1,884 trained providers in 82 of the 94 district health systems located in malarial regions in Madagascar.
- Three trainers completed JHPIEGO's advanced training course, becoming candidate master trainers for MIP in Madagascar.
- ACCESS supported a national malaria meeting to discuss how to move forward with the prevention and control of malaria based on results from the PQI evaluation in Madagascar. Forty-five stakeholders from the National Malaria Control Program, Department of RH, UNICEF, UNFPA, and other leading organizations in the RBM network participated in the two-day meeting. The PQI assessments showed that two of the five model sites had neither SP nor ITNs, and that all sites had weak FANC. Meeting participants decided that the DRH and NMCP must work closer together to ensure that visits to followup training and subsequent supervisory visits take place on a much more timely basis. The MOH/FP also reviewed the distribution plan for SP and ITNs to ensure in the following year that both are distributed to health centers with trained providers. Meeting participants also determined that weak FANC will need to be handled through intensive supervisory visits and a facilitative supervision course is scheduled in the FY06 workplan.

Rwanda

- The "National Consensus Meeting for MIP: Nov. 2004" in Rwanda resulted in the national adoption of IPT for pregnant women and a plan of action to implement MIP services throughout the country.

- MIP training materials were adapted to the Rwandan policy, cultural, and systems context through a participatory approach. Forty-five national- and regional-level trainers who participated in ACCESS-supported training workshops have updated knowledge of FANC and MIP.

Tanzania

- An ACCESS-supported national workshop on integrating PMTCT within RH and MCH, held from 6–7 December, 2004, in Dar-es-Salaam, included discussions on current global concepts and generated dialogue and greater understanding among USAID Tanzania Health and Population Office partners and the roles that they could play in integration. Local and regional experiences were shared as were lessons learned on the integration of RH and PMTCT services. The critical programmatic elements for RH and PMTCT integration were also defined and discussed, and an attempt was made to identify gaps in geographical coverage (also funded with core).
- A total of 97 health facilities have strengthened capacity to deliver FANC as they were reached with FANC training (45 hospitals, 23 health centers, and 29 dispensaries). Twenty-four District/FBO hospitals with trainers developed by ACCESS conducted on-site training on FANC/MIP/SIP/IP. They linked with the 23 health centers and 29 dispensaries. The remaining 21 hospitals are the clinical training sites affiliated with certificate nurse-midwifery schools.
- ACCESS strengthened preservice education of certificate nurse-midwives in FANC in 21 schools (which graduate on average 33 students each per year). Forty-four tutors were trained in FANC, including the screening and management of malaria and syphilis in pregnancy. They also received preservice education training skills. Fifty clinical preceptors were trained from 27 health facilities, which are used for the students' clinical practice.
- Service providers at 45 district/FBO hospitals (24 PMTCT sites and 21 certificate midwifery preservice education training sites) were oriented to the SBM approach and assessment tool for FANC/PMTCT. ACCESS directly assisted providers in 7 sites to use the tool to assess the quality of their services and address gaps in an ongoing improvement process. The assessments led to the identification of performance gaps that needed to be addressed. The supervisors, administrators, and providers analyzed the causes of the gaps and identified and implemented appropriate interventions to correct specific gaps.
- Fifty-eight stakeholders participated in an ACCESS-supported coordination meeting held in July 2005 in Dar-es-Salaam in collaboration with the MOH under the chairmanship of the Head of Reproductive and Child Health Section. The meeting helped to establish a national coordination mechanism and to build consensus on how to address issues related to Reproductive and Child Health—including PMTCT—in Tanzania. A wide range of organizations attended from the private sector, civil society, international donors (UNICEF, WHO, UNFPA, USAID), collaborating agencies, and MOH national programs (PMTCT, NMCP).

Tanzania: Building Capacity for FANC

Anne, a provider at the Nyakahanga District Designated Hospital in the Lake Zone of Tanzania, reported that after she was trained as a trainer in FANC, she gained technical skills to provide FANC, training skills to train other providers in her facility, and communication skills. These skills gave her confidence to approach the District Medical Office to request that she be given a chance to join the district team of trainers to roll out FANC training in her district. (Nyakahanga is an FBO hospital under the management of the Evangelical Lutheran Church of Tanzania.) Anne said: "Before the training by ACCESS staff, I had no voice with the District supervisors. After the training, I gained confidence and approached the District Reproductive and Child Health

Mali

- Improved collaboration by stakeholders and strengthened leadership and networks to support activities for subsidized distribution, promotion, and use of ITNs, particularly to pregnant women.
- Drafted the “World Bank Support Project to Increase ITN Coverage in Mali” document. The project provides funding for 200,000 long-lasting ITNs for 2005.
- Developed supply plan for the purchase of drugs, laboratory reagents, insecticides, and computer materials as part of the Global Fund first proposal.
- Prepared the distribution document for 86,000 ITNs financed by the Netherlands.
- Prepared and submitted two funding proposals to the Global Fund: continuation document of the Global Fund first proposal (Round 1) for US \$227,826 total cost for 2006; drafting of the Mali proposal document for (round 5) for total cost of US \$7,500,000 over 5 years.
- Supported the data quality assessment of ITN distribution by Population Services International and NetMark.

Africa Regional

- Provided technical guidance and financial support to RAOPAG, enabling the network to continue to affect policy change and MIP program implementation in its member countries.
- A draft report of regional best practices and lessons learned from MIPESA countries was developed and presented in Blantyre, Malawi during the MIPESA Annual General Meeting in September 2005, and is being revised based on feedback received. MIPESA and RAOPAG both continue to affect implementation and scale up through regional support.

IR 3: SAFE DELIVERY, POSTPARTUM CARE, AND NEWBORN HEALTH IMPROVED

ACCESS works closely with POPPHI to disseminate the Prevention of PPH Toolkit, which includes a newly revised CD-ROM demonstrating AMTSL. Tracking information on dissemination shows that 293 toolkits and CD-ROMs were disseminated in Year One to individuals and organizations in 27 countries.

To disseminate information about the use of misoprostol in community-based services to prevent PPH, an article was submitted to the peer-reviewed British Medical Journal. In addition, a PPH training package and implementation guide are in the final stages of development. As a result of technical assistance from the ACCESS Program, both Nepal and Afghanistan developed plans for a pilot test of the prevention of PPH at homebirth intervention using misoprostol. The Nepal intervention received approval by the Nepal ethical review committee, USAID/Nepal and the MOH and is currently being implemented by the USAID bilateral in Banke district. This work will continue using Nepal field support funds through NFHP. The Afghanistan intervention is currently under review.

An important aspect of strengthening delivery, postpartum care, and newborn health is the use of evidence-based standards that guide providers, supervisors, and program planners in implementation of consistently high-quality care. To this end, the ACCESS Program has adapted approaches from JHPIEGO, Save the Children, and the Quality Assurance Project (QAP) to formulate a first draft of a guide that describes the PQI process and its use for maternal and newborn health.

Core-funded Results

- Finalization, printing, and distribution of CD-ROM describing AMTSL.
- In conjunction with POPPHI, dissemination of Prevention of PPH Toolkits.
- Submission of article to the British Medical Journal on community-based use of misoprostol.
- Final draft of community-based use of misoprostol training package and implementer's guide.
- Technical assistance on use of misoprostol in PPH prevention in Afghanistan, Indonesia, and Nepal.
- First draft of technical brief on evidence-based PQI process to assist countries in applying the process to improve delivery of maternal and newborn services.

Field Support-funded Results

Under I.R. 3, field-support funded results were achieved in four countries—Afghanistan, Haiti, Indonesia, Nepal—and regionally through WARP, ANE, and LAC funded activities. Please see the bullets below.

Afghanistan

- Supported Afghan Midwives Association, including the first annual meeting, election of four officers, and student-midwives poster competition and poster presentation.

Haiti

- SBM approach to PQI of PAC services implemented by six sites in Haiti. Gap analysis workshop conducted for participating sites. Quality improvement efforts initiated, contributing to achievement of compliance with international standards of care.
- Three facilities in Haiti with existing PAC services⁹ were developed as on-the-job training sites for PAC. Ten clinicians from these sites were trained to be able to provide inservice training at their sites and have plans to begin training in the next program year.
- Nine facilities in Haiti that reported PAC service delivery data during the period from January through September 2005 reported serving 449 PAC clients with emergency treatment¹⁰. Of these, 226 clients (50.3%) received FP counseling prior to leaving the facility. **Figure 1** shows the total PAC caseload at nine sites as well as the number of clients who received FP counseling prior to leaving the facility.
- Thirty-five providers in 20 sites in Haiti trained in EMNC. These sites will be supported by ACCESS under the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) as part of a PMTCT intervention.

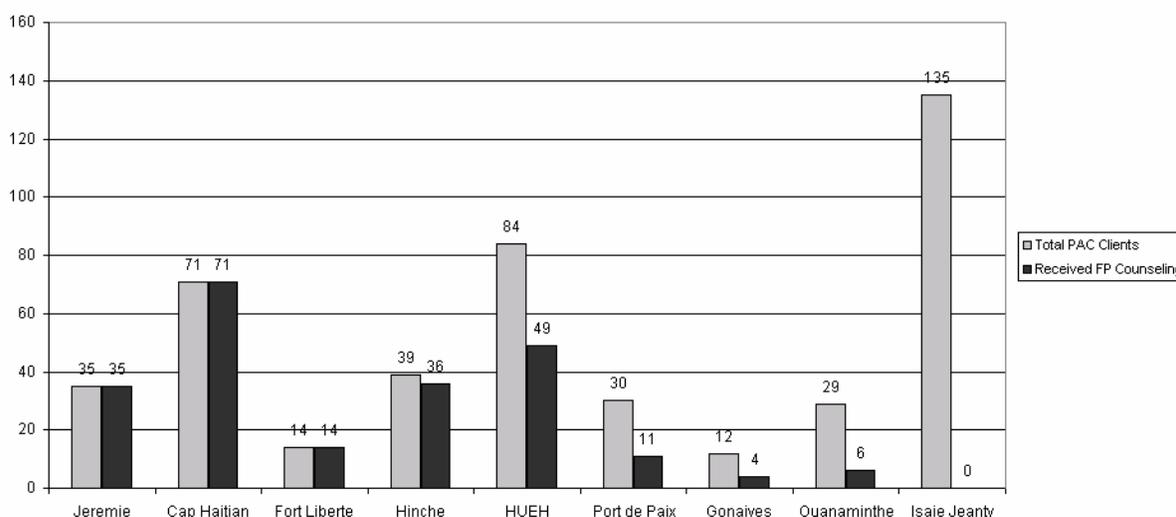


Photo: ACNM dinner to celebrate AMA President Pashtoon Azfar's (4th from left) receipt of the Bonnie Pederson International Midwife Award from the American College of Nurse-midwives, June 2005.

⁹ The three sites benefiting from OJT are: Justinien, Hinche, and Cayes.

¹⁰ Jeremie = 8 months; Cap Haitian = 7 months; Fort Liberte = 4 months; Hinche = 4 months; HUEH = 9 months; Port de Paix = 3 months; Gonaives = 3 months; Ouanaminthe = 7 months; Maternite Isaie Jeanty = 6 months.

Figure 1. Total PAC Caseload and Number Receiving FP Counseling at Nine Facilities (January to September 2005)¹¹



LAC

- ACCESS collaborated with partner organizations (Pan-American Health Organization [PAHO], Basic Support for Institutionalizing Child Survival [BASICS], and CORE) to define guidelines to develop a regional strategy for newborn care, based on a situation analysis of the region. The analysis included desk research on all LAC countries and visits to Guatemala, Bolivia, Paraguay, and the Dominican Republic. A concept paper of the regional strategy for newborn care was accepted by PAHO/W in September. The strategy document is being developed by Save the Children in close coordination with partners. A workshop to review the proposed document by the LAC countries has been planned for February 2006. The document will be submitted for ratification at the March 2006 PAHO meeting.

ANE

- Regional community-based postpartum care network for Asia, “MotherNewBorNet”, developed with ACCESS assistance. At the first regional meeting of MotherNewBorNet in April 2005, participants identified USAID bilateral programs in the Asia region that are positioned to develop a plan of action for future program planning with technical assistance from ACCESS and other partners. Cambodia was chosen as a key site for future ACCESS assistance.
- Collaborative agreement between ACCESS and WHO/SEARO developed to co-host a technical meeting on continuum of care for maternal and newborn health in Bangkok, Thailand for 11 SEARO countries as well as Pakistan, Afghanistan, Cambodia, and Vietnam in FY06.

Indonesia

- Lancet Series on Newborn Health launched in Indonesia. One hundred fifty key Indonesian stakeholders at the national, provincial, and district levels were updated on neonatal health at a meeting in Indonesia in September 2005 sponsored by the MOH, WHO, UNICEF,

¹¹ Six sites supported by ACCESS FY05 funding; HUEH, Gonaives, and Isaie Jeanty supported under a previous JHPIEGO project (Training in Reproductive Health).

USAID, and Save the Children, and supported by ACCESS and Perinasia. Participants provided feedback on a draft of the Indonesia National Neonatal Health Policy.

Nepal

- Technical assistance provided to the USAID bilateral, NFHP, for the prevention of PPH implementation plan for Banke district.

WARP/Cameroon

- Capacity of 20 providers from 2 provincial hospitals, 3 regional medical centers, and 10 health centers in the Ngaoundere District, Cameroon to deliver EMNC services increased¹². Followup visits to 14 of the 15 sites with trained EMNC providers showed that trained providers in each site applied their new knowledge and skills on the job according to their action plans. For example, among the 7 facilities with use of partograph in their action plans: 6 providers from 4 facilities demonstrated correct use of the partograph while 3 facilities either did not use the partograph or did so incorrectly but were assisted to begin doing so during followup visits. Of the 8 facilities where AMTSL was included as part of the action plan, 4 were found to be adequately practicing AMTSL, 1 was teaching AMTSL but not practicing it due to lack of deliveries in the followup period, and 3 had yet to sufficiently integrate AMTSL into their practice.

Strengthened Capacity to Deliver EMNC: Ngaoundere District, Cameroon

During the clinical followup visit to the Protestant hospital in Ngaoundere, the ACCESS clinical consultant was approached by the hospital's anesthesiologist with words of congratulations. He explained that he had been on vacation during the period of the EMNC training, but when he returned, he "noted many new behaviors by the staff in the delivery ward during emergency cesarean sections. It is after I mentioned this change that I was informed of the training."

A nurse at the facility recounted an experience that bolstered his confidence in the application of best practices (in EMNC). "I attended the delivery of a woman who arrived at the facility completely prepared with all the materials that she must have struggled to purchase. Surprised, I asked her how she knew to bring all these materials. She responded, 'It was you who counseled me during my last prenatal consultation to be prepared for the delivery.'"

- The Protestant hospital of Ngaoundere district in Cameroon was prepared and is currently functioning as a maternal and newborn clinical training site; it has been equipped with materials and anatomic models to support that function.
- Social Mobilization Strategy and Action Plan developed with community mobilizers from Ngaoundere District, Cameroon (April 2005) and implementation begun. Ten MOH staff from the Division of Family Health in Yaounde updated and orientated on social mobilization for maternal and newborn health. A core group of 25 community mobilization trainers from Ngaoundere District (June 2005) were trained and followed up and are now set to begin training community mobilization agents.

WARP/Mauritania

- Readiness for EmOC training assessed in Kaedi District, Mauritania and social mobilization tools prepared (August 2005).

¹² Participants in the 3-week EMNC technical update and clinical skills standardization course included 1 doctor, 8 state-certified nurses, 6 nurse-midwives, 2 general nurses, and 3 health aides.

IR 4: MANAGEMENT OF OBSTETRIC COMPLICATIONS AND SICK NEWBORNS IMPROVED

Too often in the Africa region, midwives are sent to facilities where they are the sole trained provider, but where they may not be allowed to carry out lifesaving interventions. This is due to prohibitory national statutes, because they do not possess the necessary competencies, or because supplies and equipment are not available. The Regional Midwifery Preservice Education Initiative was developed to scale up of the use of evidence-based emergency obstetrical and newborn care interventions in a sustainable way. With support from USAID's Africa Bureau (through Africa/SD) and in collaboration with WHO/AFRO, a series of activities, starting with the development of Road Map facilitators, has begun which will result in commitment at the national level for the expansion of midwifery practice as well as up-dated, evidence-based midwifery curricula that incorporate vital competencies to save the lives of mothers and newborns.

ACCESS incorporated neonatal and MIP components into the SMM to provide a tool that allows program managers to make strategic decisions about allocation and targeting resources to yield the best results in reducing maternal and neonatal mortality and morbidity. The new components of the model are now ready for field testing.

A first draft of a competency-based KMC training manual was developed, based on international standards, to teach health care workers of all levels how to care for low birth weight babies.

Core-funded Results

- KMC training manual adapted for use by developing countries worldwide at a meeting in June 2005. Draft manual completed, including information on feeding of low birth weight babies born to HIV infection mothers. Manual is currently in external and internal review.
- Revised MNPI questionnaire to include questions specific to neonatal interventions. Expanded SMM with a neonatal component and a report was prepared on its development.
- Regional workshop for adaptation of midwifery curricula/enabling environment assessment tool for midwifery educators from Ethiopia, Ghana, Malawi, and Tanzania carried out in conjunction with WHO/AFRO. As a result of the workshop, capacity to improve preservice midwifery education was strengthened in eight African countries¹³. Nineteen representatives were oriented in how to use a preservice midwifery education assessment tool and are now engaged in strengthening preservice midwifery education, a first step in a long-term activity that will lead to increased capacity of midwives to perform emergency obstetric care (EmOC). Preservice midwifery education assessments are in process in four countries—Ghana, Ethiopia, Malawi, and Tanzania—with ACCESS support. Workshop participants will present results and recommendations from their assessments to key stakeholders, with followup activities supported by ACCESS and WHO/AFRO next year.



Photo: Woman at health center in Morogoro region, Tanzania.

¹³ Ghana, Ethiopia, Tanzania, Malawi, the Gambia, Liberia, Nigeria and Sierra Leone.

IR 5: PREVENTION AND TREATMENT OF PRIORITY HEALTH PROBLEMS OF NON-PREGNANT WOMEN OF REPRODUCTIVE AGE IMPROVED (TARGETS OF OPPORTUNITY)

ACCESS supported the USAID goal of preventing obstetric fistula through providing small grants to four local organizations from Uganda, Nigeria, and Niger. These one-year grants were awarded in September 2005 and will support work in integrating fistula prevention into EMNC activities. Some of the organizations that were funded are countrywide networks; therefore, the grants go beyond supporting one organization in the country to support a network of organizations that provide outreach for women of reproductive age.

Core-funded Results

- Four grants awarded to organizations in Uganda, Nigeria, and Niger to support activities on the prevention and treatment of obstetric fistula.
- As a result of small grants procurement process, global database of organizations that provide outreach to women of reproductive age—from raising community awareness of obstetric fistula to training of midwives and social mobilization campaigns.

Field Support-funded Results

Summarized below are results under IR 5 achieved through field support-funded activities pertaining to FP in Kenya and RH awareness and decision making among adolescents in Nepal.

Kenya

- Fifteen national- and district-level trainers co-trained in FP with master trainers resulting in improved skills level among these national- and district-level trainers. These trainers are now ready to support the district reproductive training and supervision teams (DRHT&S) to cascade updates on international best practices (IBP) in FP and other RH issues within their districts.
- One hundred fifty-three service providers from 75 sites located in three districts (Nyeri, Homabay, and Nakuru) have updated skills in IBP in FP as a result of ACCESS training, including application of the new FP guidelines and the WHO eligibility criteria as applied to contraceptive use. The service providers were drawn from

Implementing Best Practices for FP in Kenya

Providers conveyed great thanks to the facilitators for the opportunity to participate in the updates. All participants had not received any FP updates in at least 3 years and at least for one participant it had been 20 years since his last update. This inconsistency with provider updates leads to lack of knowledge and capacity to delivery high-quality services. Service providers mentioned the fact that herbalists have played a partial role in discouraging clients from using FP methods. This has propagated rumors on some methods e.g., pills pile up in the stomach and so are dangerous for your health. With the lack of consistent refresher training it is not surprising that incorrect messages are sometimes taken for fact. As a result of the workshop/update, some providers attending the workshop are planning to go back to their communities and work with herbalists to convey correct messages.

One provider from Nakuru told JHPIEGO, "I feel so good when a client comes back and thanks me for getting a FP method". However, even with reports on client satisfaction with some of the FP methods, service providers feel the burden of having to travel on public transport and using personal resources to collect contraceptive supplies from the District stores, where they may often find few methods or none at all. While trainings are motivational and necessary for provider's knowledge and skills-systems must also be strengthened to ensure adequate supplies are available for providers to do their jobs.

MCH/FP clinics within hospitals, NGOs, and private clinics. For government health centers and dispensaries, in-charges who provide all out patient services including FP were trained. Providers are expected to update a minimum of five others. Each provider carried with them materials to assist them in reporting on their progress and a workplan that indicated the areas they identified as needing extra attention within their facilities in order to implement IBP. By the end of the activity, 765 providers will be updated through this cascade approach.

- Eighty-nine key administrators PHMT and DHMTs (PASCOS, PARTOs, PLTP, DASCOS, DLTP, district lab technicians) bought into the counseling and testing (CT) program and each district developed an action plan for the way forward for implementation of CT.
- The CT orientation package was presented and pre-tested and feedback is being incorporated into the final package.
- Sixty-four key administrators PHMT and DHMTs (PASCOS, PARTOs, PLTP, DASCOS, DLTP, and District Lab Technicians) bought into the antiretroviral (ARV) program through advocacy.
- Each district developed an action plan for the way forward for implementation of the ARV program.

Nepal

- Collaborated with CEDPA to support year two (1 April 2005 – 31 January 2006) of the “Building Demand for RH Awareness among Adolescent Girls in Conflict Affected Districts of Nepal” (BuD for RH) project. Highlights include:
- Choose A Future (CAF) Manual for Adolescent Girls used to orient a total of 96 adolescent girls groups (1,843 girls from 16 secondary schools), completing the discussion series in September 2005. The program covered 15 village development committees (VDCs) in 3 program districts. The girls still meet periodically and will be supported by the establishment of learning/resource centers in schools and communities in each program VDC.
- Adapted CAF manual for use with adolescent boys. Eighteen master trainers (IPs, managers, supervisors, project team of CEDPA/Nepal) were trained to use the CAF manual for discussion series with adolescent boys. One school in each program VDC has been selected for implementation of the discussion series for boys.
- Discussion of CAF held among out-of-school adolescent girls as a continuation from last year. A total of 1,155 out-of-school girls at 45 non-formal education (NFE) centers participated. All the girls passed the final examination of the NFE course (*Lalima* package developed by World Education). Of these girls, 45% (515) enrolled in formal schools either in grade 3 or 4. The remaining girls did not join the schools because they were too old for the grade where they would be eligible or for other socio-cultural reasons. Both school enrolled and un-enrolled adolescent girls are still meeting after completion of the course (NFE combined with literacy).
- Networking meetings for district- and local-level stakeholders (government organizations, NGOs, and community-based organizations) are taking place once a month to build an enabling environment for reproductive healthcare for adolescent girls. Village (15) and district level RH Coordination Committee meetings took place on a regular basis as well.

- An inter-district exchange visit program conducted for 36 adolescent girls from Mahottari and Udaypur to visit Baglung district in September 2005. This enabled them to: see the program in other program areas of other districts; share the experience of implementing the program in their areas; and share lessons learned in their individual lives, families, and communities.

VI. CHALLENGES AND OPPORTUNITIES

CHALLENGES

ACCESS is a global project that experienced strong growth and key staff changes within the first year. From a three-country program, ACCESS has matured into an effective global program that is currently responsive to Mission needs in more than 12 countries. This growth in new countries was accompanied by increased field support funding in existing countries. During this year, ACCESS replaced the Project Director and the Director for M&E, both key positions on the project. Keeping up with staff recruitment will remain a key challenge as we build new country programs and associate awards. Nevertheless, the team views this dynamic growth as a reflection of meeting a real demand from the field. The strong technical approach implemented through a highly motivated team of technical experts coming from a rich partnership under ACCESS bodes well for discovering new opportunities in the coming year.

Another challenge faced by a rapidly growing project is hiring in-country staff to manage country programs. ACCESS has developed tools and transition plans to devolve some of the authority to the field level, and to mentor local country directors and program managers to execute effective programs. Hiring new staff can be a lengthy process, but ACCESS hopes to convert this challenge into new opportunities to build in-country local capacity and develop sustainable programs.

The variability of Mission funding and changes in strategic direction can hamper the effectiveness of a global program. For instance, ACCESS was invited to work in Rwanda and hire an advisor for maternal and newborn health for the MOH. ACCESS staff proceeded to develop a job description, shortlist and interview candidates, and presented the top three candidates to the MOH and the Mission. However, the Mission decided to support a national expert chosen by the MOH and withdraw the funds they had indicated would be available to ACCESS under field support funds.

Finally, delay in receiving PEPFAR funding forced the postponement of activities in Kenya and Haiti.

OPPORTUNITIES

It is evident that many Missions are becoming interested in investing in maternal and neonatal health programs and the ACCESS Program has the strong technical approach, staff skills, and field presence through partner organizations to initiate and respond rapidly to Mission requests. With greater exposure to ACCESS resources, website, and results attained under the project, we see great opportunities ahead to expand ACCESS activities in new countries and strengthen activities in existing countries to make a difference in the lives of women and newborns around the world.

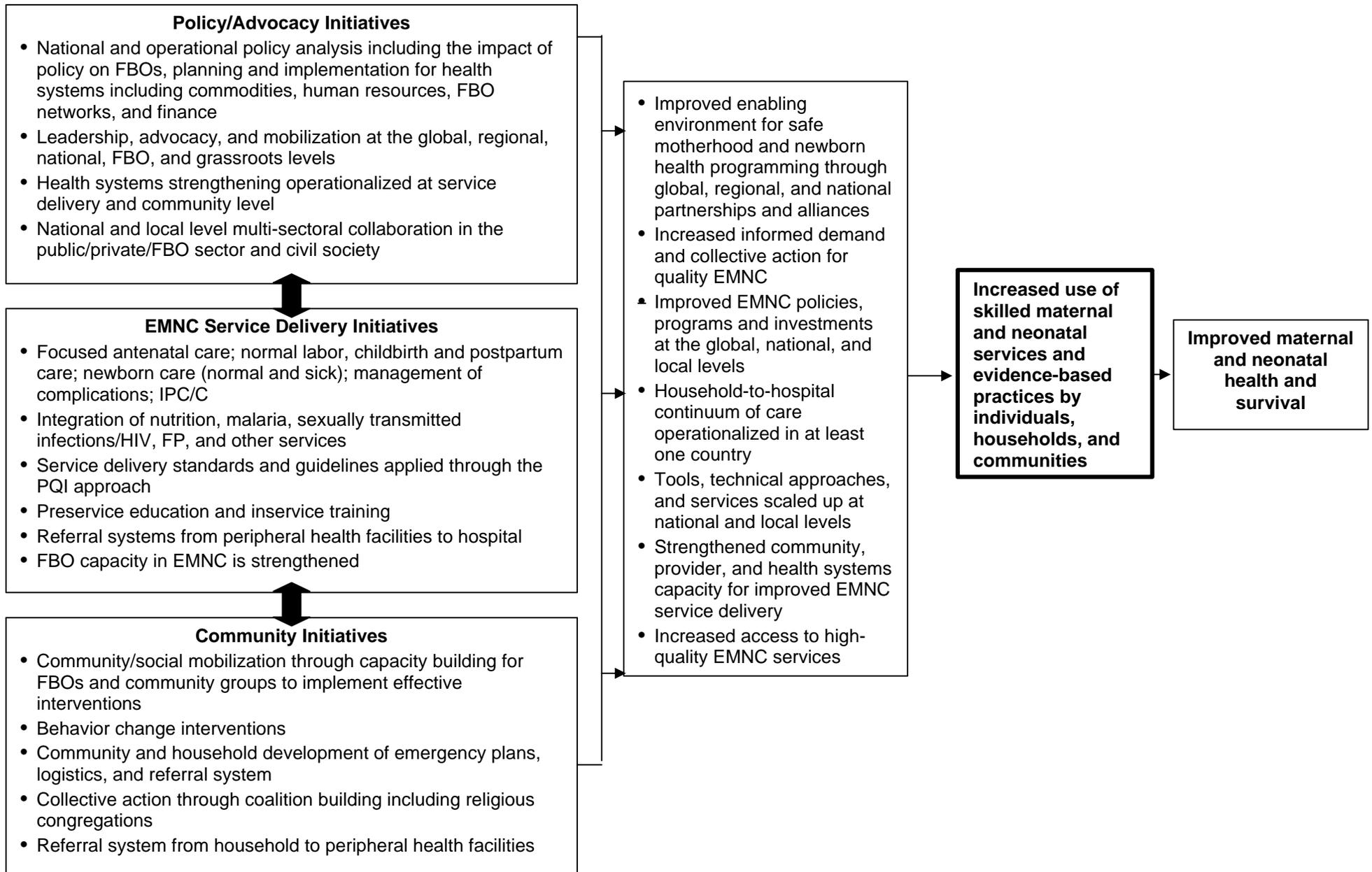
ACCESS will build on new initiatives undertaken in Year One. We anticipate that working with FBOs, supporting PPH programs in two countries, addressing PMTCT programs, and strengthening SBAs across several country programs will yield new opportunities to demonstrate results in these critical areas.

ANNEX A: CONCEPTUAL FRAMEWORK FOR ACCESS

Interventions

LOP Intermediate Outcomes

Impact



ANNEX B: CORE-FUNDED ACTIVITIES AND OUTPUTS MATRIX

| Core Activity | Major Programmatic Outputs/Deliverables Produced |
|---|---|
| IR 1: Global Leadership for Maternal, Neonatal, and Women’s Health and Nutrition Programs and Policies Strengthened | |
| 1.1 Global Networking and Partnerships | |
| 1.1.a The PSMNH and The Healthy Newborn Partnership (HNP) | <ul style="list-style-type: none"> • Participated in key global meetings with the PSMNH • WHO World Health meeting in Delhi attended by Tanzania delegation • “Opportunities for Newborn Health in Africa” report given technical input |
| 1.1.b Africa road map for safe motherhood and newborn health | <ul style="list-style-type: none"> • Africa Road Map Workshops for (1) Anglophone countries (Ethiopia, Ghana, Tanzania, Zambia, and Mozambique) and (2) Francophone countries (Senegal, Niger, Burkina Faso and Mauritania) • Planning for in-country support and followup to roll out Road Map activities |
| 1.1.c International Conference of Midwives | <ul style="list-style-type: none"> • Participated in triennial ICM meeting in Brisbane, Australia and facilitated a fistula workshop |
| 1.1.d The WRA | <ul style="list-style-type: none"> • Participated in the WRA Regional Workshop held in Bali, Indonesia in August 2005 |
| 1.1.e Partner coordination and collaboration | <ul style="list-style-type: none"> • Established contacts with FBOs and key stakeholders in ministries of health in Kenya, Malawi, Tanzania, Uganda, and Zambia • Workshop on MIP for Islamic and Christian representatives from five East African countries • Draft ACCESS strategy for accelerating FBO work in maternal and newborn health • Listserve on maternal and newborn health for FBOs |
| 1.1.f Country level advocacy to support Lancet series on newborn health | <ul style="list-style-type: none"> • Participated in the planning for the global launch of the Lancet series on neonatal health • Supported country-level advocacy efforts in Nepal and Indonesia, which included national forums on neonatal health during which Lancet neonatal series was presented in these meetings |
| 1.2 Health Care Financing and Policy | |
| 1.2.a Policy tools adapted and used | <ul style="list-style-type: none"> • Seminar on “Policy Tools for Maternal and Newborn Health” |
| 1.3 Dissemination of ACCESS Program Materials and Resources | |
| 1.3.a Website development and use | <ul style="list-style-type: none"> • Website (accesstohealth.org; accesstohealth.net) developed and launched in October 2005 |
| 1.3.b Materials disseminated to partners and alliances, donors, country level stakeholders, and USAID cooperating agencies, bilaterals, and other stakeholders working in maternal and newborn health | <ul style="list-style-type: none"> • Prepared an index of tools and materials for maternal and newborn health • Technical briefs on household-to-hospital continuum of care, newborn health, FANC, MIP, and prevention of PPH are in final review • E-learning components on FANC and PPH were prepared for USAID’s e-learning course |
| 1.4 Small Grants | <ul style="list-style-type: none"> • See IR 5 |
| 1.5 Technical Assistance to Strengthen Maternal, Newborn, and Women’s Health Services = Targets of Opportunity | <ul style="list-style-type: none"> • ACCESS provided technical assistance to support the development of a program on community-based safe motherhood and newborn health in Bangladesh. • ACCESS provided technical assistance to Zambia to prepare social mobilization program for HIV/AIDS. |

| Core Activity | Major Programmatic Outputs/Deliverables Produced |
|---|---|
| IR 2: Preparation for Childbirth Improved | |
| 2.1 Define the ACCESS Program Household-to-Hospital Package of EMNC Interventions | <ul style="list-style-type: none"> Working group established and guided the contents of technical paper. HHCC paper completed and at proofreading stage; printing will be completed by the third week of October |
| 2.2 Promote the Integration of EMNC and PMTCT | |
| 2.2.a Develop and evaluate integrated EMNC and PMTCT through health system in Gaza District, Mozambique | <ul style="list-style-type: none"> Planned to be done in three countries, including Mozambique, but was only done in Kenya and Tanzania |
| 2.2.b Conduct workshop on integration of EMNC and PMTCT in Tanzania with local partners, including WRA, faith based organizations, and others | <ul style="list-style-type: none"> Draft concept paper to strengthen maternal and newborn health and PMTCT through the household-to-hospital continuum of care approach MCH-PMTCT Integration Conference Dar es Salaam, Tanzania, December 2004 |
| 2.2.c Develop and evaluate integrated EMNC and PMTCT activities in health programs in Kenya and/or Ethiopia | <ul style="list-style-type: none"> Draft operations research proposal and work plan for joint ACCESS/Boston University activity in Kenya (to be considered for implementation at a later date) |
| 2.3 Implementation of “Home-Based Mother and Baby Care” Model | |
| 2.3.a Adapt the home-based model of care and document the process for implementation of a scaled-up program | <ul style="list-style-type: none"> Literature review on home-base care Working group established and guided the contents of the technical paper Draft home-based care technical paper in internal review |
| 2.4 Implementation of Social and Community Mobilization and Advocacy | <ul style="list-style-type: none"> Literature review and identification and collection of existing community mobilization tools |
| 2.5 MAC Activities | |
| 2.5.a Burkina Faso followup survey on MIP and dissemination of results to key stakeholders | <ul style="list-style-type: none"> Results of followup survey on MIP in Burkina Faso disseminated to key stakeholders; government adopted countrywide MIP policy that includes IPT and ITNs through FANC |
| 2.5.b Continued support of and participation in the RBM Partnership/MPWG | <ul style="list-style-type: none"> Technical assistance provided to coordinate RBM-MPWG efforts and mandate MPWG provided global guidance to the RBM Secretariat on key issues to affect change for MIP including the use of IPT with SP and the link between HIV and Malaria. |
| 2.5.c Technical support to the RBM Partnership and other malaria coalitions | <ul style="list-style-type: none"> “Advocacy and Focused Antenatal Care Efforts Strengthened” article for MIPESA newsletter Draft regional best practices and lessons learned report for MIPESA Technical assistance provided to RAOPAG’s proposal for the Global Fund RAOPAG brochure developed to assist with marketing the network to a wider audience of donors Assisted with planning, organizing, and facilitating RAOPAG annual partner meeting and workshop on MIP tools and resources |
| 2.5.d Support adaptation of PQI materials targeting integrated FANC including MIP, PMTCT and | <ul style="list-style-type: none"> SBM tool developed for FANC and MIP Base assessment conducted in Tanzania and Madagascar |

| Core Activity | Major Programmatic Outputs/Deliverables Produced |
|---|--|
| syphilis | <ul style="list-style-type: none"> Updated knowledge on FANC, MIP, the link between HIV and malaria, and the standards based management approach among 30 FBO technical experts from five countries |
| 2.5.e Support regional workshop in ESA for faith-based and other private service delivery organizations and MOH representatives to update knowledge on EMNC, including malaria during pregnancy and PMTCT | <ul style="list-style-type: none"> Regional workshop in ESA for FBO and MOH representatives; updated knowledge on FANC and MIP, supervision, and the interaction between malaria and HIV |
| 2.5.f Expand the SMM to include malaria | <ul style="list-style-type: none"> Testing of the model on hold until the new malaria and newborn components are added |
| 2.5.g Mali malaria insecticide treated nets advisor | <ul style="list-style-type: none"> Participated in workshop to better prepare PNLP agents for team work “World Bank Support Project to increase ITN coverage in Mali” document drafted Developed supply plan for the purchase of drugs, laboratory reagents, insecticides, and computer materials as part of the Global Fund first proposal Distribution document for 86,000 ITN drafted Two funding proposals to the Global Fund Organized two PNLP partners bimonthly meetings to share innovations and obstacles Survey to analyze situation of the use of SP in IPT to estimate needs for 2006 will be conducted Participated in press conference organized by PNLP about the various malaria control strategies recommended by the new policy guidelines Support the data quality assessment of ITN distribution |
| IR 3: Safe Delivery, Postpartum Care, and Newborn Health | |
| 3.1 Prevention of PPH | |
| 3.1.a Dissemination of resource materials and program tools | <ul style="list-style-type: none"> Finalization, printing, and distribution of CD-ROM describing AMTSL. In conjunction with POPPHI, dissemination of Prevention of PPH Toolkits. Article on community-based use of misoprostol submitted to the British Medical Journal. Finalization of training package and implementer’s guide on community-based use of misoprostol. First draft of technical brief on evidence-based PQI in process. |
| 3.1.b Technical support to countries as they introduce PPH prevention in homebirths through community education and community-based distribution of misoprostol | <ul style="list-style-type: none"> Plenary session presentation and participation in workshop on use of AMTSL at the ICM Triennial Congress, Brisbane, Australia. Technical support provided to Afghanistan, Indonesia, and Nepal to launch and/or solidify efforts to implement community-based programs using misoprostol. Afghanistan provided field support money for PPH work; therefore, ANE money was not needed and reprogrammed for the SEARO meeting in November 2004 and to support the new MotherNewBorNet. |
| 3.2 Strengthening skilled attendance through PQI | |
| 3.2.a Review and adapt the PQI tool package for EMNC facility and community care | <ul style="list-style-type: none"> Technical meeting on PQI to share approaches, materials, challenges, and lessons learned. Completed first draft of technical brief describing common approaches to evidence-based PQI for use in communities and facilities. |

| Core Activity | Major Programmatic Outputs/Deliverables Produced |
|--|---|
| IR 4: Management of Obstetric Complications and Sick Newborns Improved | |
| 4.1 Strengthening preservice midwifery education in EMNC | |
| 4.1.a Regional preservice midwifery education in selected African Anglophone countries | <ul style="list-style-type: none"> • Plenary presentation on EmONC in preservice and inservice education at the 3rd WHO/AFRO RH Task Force Meeting • Regional workshop, in conjunction with WHO/AFRO, to adapt midwifery curricula/enabling environment assessment tools and plan for future activities with participants from Ethiopia, Ghana, Malawi, and Tanzania |
| 4.2 Development and application of the resource allocation model | |
| 4.2.a Enhancement of resource allocation model, ALLOCATE, to include neonatal component | <ul style="list-style-type: none"> • Completed enhancement to the SMM, which is a component of the ALLOCATE model. |
| 4.3 Finalize training manual for KMC | <ul style="list-style-type: none"> • Established KMC working group and guided the contents of the training manual. • Completed draft KMC manual; currently being internally reviewed. |
| IR 5: Prevention and Treatment of Priority Health Problems of Non-pregnant Women of RH Age (Targets of Opportunity) | |
| 5.1 Support for the Prevention and Treatment of Obstetric Fistula | |
| 5.1.a Improve ability of health care providers to prevent and manage obstetric fistula | <ul style="list-style-type: none"> • Small grants mechanism, including criteria and proposal guidelines for grants to support NGOs and local midwifery associations working in the area of prevention of obstetric fistula • Grants awarded to four organizations in Africa • Database created of local organizations working in obstetric fistula |

ANNEX C: RESULTS FOR SIGNIFICANT COUNTRY AND REGIONAL INITIATIVES

ACCESS/Afghanistan Monitoring and Evaluation Framework

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Responsible Party | Progress to date (as of 9/30/05) |
|---|--|--|------------------------------|--|---|
| USAID/Afghanistan I.R. 3.1: Increase access of women and children under the age of five to quality basic health services, especially in the rural and underserved areas | | | | | |
| USAID/Afghanistan I.R. 3.1.1: Expand the access to quality Basic Package of Health Services (BPHS) | | | | | |
| Afghan Midwives Association (AMA) established with approved "Rules of the Association" | Yes/no measure | AMA meeting minutes, program records | Annual | AMA staff, ACNM and ICM representatives, JHPIEGO | Yes |
| AMA conducting productive Board of Director meetings | A productive meeting is one with a clear agenda and where business decisions are made. | AMA meeting minutes, program records | Annual | AMA staff | First planned in October |
| AMA continuing education guidelines developed | Yes/no measure | Continuing Education Guidelines, AMA records | One-time occurrence | AMA staff, ACNM | Planned for February 2006 |
| AMA action and business plans developed and being implemented | Yes/no measure. The business plan will include marketing and communication activities. | Business plan, Action Plans, AMA records, AMA follow up assessment | Semi-annual | AMA staff, ACNM, ICM and Futures Group | Planned for Oct. 2005 – Jan. 2006 |
| Feasibility assessment of the Maternity Waiting Home (MWH) in Badakhshan completed and findings shared with stakeholders | Yes/no measure. The assessment will examine cultural appropriateness, funding, community contribution, relationship to the community midwife program in Faizabad, etc. | MWH Feasibility assessment report, program records | Semi-annual | JHPIEGO | Planned for October 2005 – January 2006 |
| USAID/Afghanistan I.R. 3.1.2: Improve the capacity of individuals, families, and communities to protect their health | | | | | |
| Postpartum hemorrhage prevention implementation plan developed | Plan should be developed in collaboration with national-level stakeholders | PPH prevention implementation plan, program records | Annual | JHPIEGO | Proposal pending submission to MOPH TAG |
| PPH reduction Ministerial Advisory Group established | Yes/no measure | ACCESS Program records | Annual | MOPH, JHPIEGO | Yes |

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Responsible Party | Progress to date (as of 9/30/05) |
|--|--|---|------------------------------|---|---|
| Number of community-based workers trained to counsel pregnant women on birth planning including PPH reduction using misoprostol through ACCESS-supported training events | ACCESS-supported training events include ACCESS technical assistance, training materials, approved staff and/or funding. | JHPIEGO Training Information Monitoring System (TIMS) | Quarterly | Local NGOs, JHPIEGO | Planned for February 2006 |
| Number of healthcare workers trained to supervise the provision of misoprostol by community-based workers | | Training Information Monitoring System (TIMS) | Quarterly | Local NGOs, JHPIEGO | Planned for February 2006 |
| Number of pregnant women counseled on birth planning and provided with misoprostol through approved distribution channels | | Community-Based Worker logbook | Quarterly | Community-based worker CBW Supervisor Local NGOs | Planned to begin in March 2006 (ongoing from that time) |
| Number/% of women provided with misoprostol who report taking the drug according to standard | Routine use of misoprostol involves administration of the drug immediately following delivery of the baby and before delivery of the placenta. Unused packets will be collected. | Community-Based Worker logbook | Quarterly | Community-based worker CBW Supervisor Local NGOs | Planned to begin in March 2006 (ongoing from that time) |
| Number/% of women provided with misoprostol who report obtaining an emergency referral for a birth complication by type of complication | The number of emergency referrals for suspected PPH will be compared with the total number of emergency referrals. | Community-based Worker logbook | Quarterly | Community-based worker CBW Supervisor Local NGOs | March 2006 on |
| USAID/Afghanistan/REACH I.R. 3.1.3: Strengthen government health systems | | | | | |
| National Safe Motherhood Strategy developed | Yes/no measure. The strategy will include costing information and be operationalized by supporting a core safe motherhood committee. | Program records, Implementation plans | One time occurrence | ACCESS field staff Futures Group | Planned for February 2006 |
| Safe motherhood indicators | Part of the process to revise the | MOPH records and | Quarterly in | MOPH, | Planned to begin in March |

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Responsible Party | Progress to date (as of 9/30/05) |
|---|--|--|-------------------------------------|--------------------------|--|
| defined and tracked quarterly | national strategy is to define how progress will be measured and then track it. These indicators should be defined on/about December 2005 | data sources depending on how the indicators are defined | 2006 and beyond | ACCESS field staff | 2006 |
| Maternal and Neonatal Program Index Score | This is a composite index that rates the effort the government is applying to maternal and neonatal health services at the national level. Feasibility of using the MNPI measure at the provincial level will be explored. | MNPI assessment tool | Baseline and Followup | Futures Group | Baseline completed. Report in English printed and available in Baltimore, Washington (FG) and Kabul. |

ACCESS/AFRICA/SD MONITORING AND EVALUATION FRAMEWORK

| Indicator | ACCESS Activities | Program markers and targets | Status |
|--|--|--|---|
| Priority 1: Advocacy and Policy Results: Increased resources for maternal and newborn health programs at the country level Improved strategies and plans for maternal and newborn care at the country level | | | |
| - Number/% of target countries implementing the African Road Map | Training of Facilitators for implementing the Road Map | Facilitators trained in Road Map Small grants available for countries to adapt Road Map (through ACCESS core funds) | 17 Facilitators were trained in Road Map Small grants for further support were made to Ethiopia and Tanzania |
| Number/% of target countries with alliances (for safe motherhood) working at the country and sub-regional levels that mobilize stakeholders and decision-makers to actively support the Africa Road Map | Linking facilitators and country stakeholders to functioning WRA secretariats where applicable | WRA secretariats aware and supportive of Road Map efforts | This activity was not undertaken in FY05. |
| Priority 2: Dissemination of quality of care improvement approaches Results: Improved quality of integrated EMNC | | | |
| Number/% of target countries that used the WHO IMPAC standards and guidelines to update their midwifery curricula to reflect essential integrated maternal and newborn healthcare | Review of country policies and ability of midwives to apply IMPAC standards and guidelines | Country level preservice education and policies with respect to midwife practice assessed | Assessments were carried out in 8 countries (only 4 were directly supported by ACCESS) |
| Number/% of target countries that are using a performance and quality improvement approach (standards based management) at service delivery points affiliated with midwifery schools | Introduction of SBM (performance and quality improvement) in clinical facilities used for training of midwives | <ul style="list-style-type: none"> Service delivery points affiliated with midwifery schools using SBM | <ul style="list-style-type: none"> Program activities did not advance to this stage in FY05 |
| Number of countries with integrated EMNC training expertise | Integrated EMNC training for preservice midwifery education institutions | <ul style="list-style-type: none"> Tutors and clinical instructors trained in integrated EMNC | <ul style="list-style-type: none"> Training is planned for FY06 |
| Priority3: Development and dissemination of community and household approaches Results: ACCESS is not addressing this priority until Year 2.) Standard tools available to assess maternal and newborn health at household and community level Countries use formative research for programming community based approaches Skilled African researchers available to support country research | | | |
| Tools available | ACCESS will not be addressing | N/A | N/A |

| Indicator | ACCESS Activities | Program markers and targets | Status |
|---|--|--|---|
| | this until Year 2 | | |
| Number of countries using formative research | ACCESS is not contributing to this indicator | N/A | N/A |
| Number of researchers available | ACCESS is not contributing to this indicator | N/A | N/A |
| Priority 4: African regional and national capacity to implement programs Results: <i>African institutions actively engaged in supporting the implementation of the WHO/AFRO Road Map</i> <i>Linkages strengthened among African Institutions and networks to coordinate with each other and strengthen their leadership in MNH</i> <i>National-level capacity to implement safe motherhood programs improved</i> | | | |
| Number of trained African technical experts/facilitators supporting country road map planning | Training of technical experts/facilitators for implementing the Road Map | <ul style="list-style-type: none"> Estimated 50 facilitators trained | <ul style="list-style-type: none"> 17 facilitators trained (plus 2 who served as workshop co-facilitators) |
| Number of African institutions actively engaged in supporting the WHO/AFRO Road Map through participation in the implementation of guidelines and support for their distribution and use at the country level | Preservice education strengthening is a key component of the Road Map strategies. Those schools involved in this program will ultimately contribute to spreading the implementation of the Road Map (though not in Year 1) | <ul style="list-style-type: none"> 5 preservice midwifery schools and associated MOH/MOE decision-makers involved in implementing Road Map strategy | <ul style="list-style-type: none"> Representatives from preservice midwifery schools and MOH personnel from 8 countries were introduced to Africa Road Map |
| Number/% of target countries with human resource plans being implemented that include data driven strategies for deployment and retention of midwives, nurses, auxiliary nurses and other appropriate cadres of providers to both urban and rural areas | Assessment and dialogue on preservice midwifery education policies Introduction of competency-based training approaches and quality improvement methods in preservice midwifery education | <ul style="list-style-type: none"> 4-5 countries with action plan for applying IMPAC guidelines in preservice midwifery education and practice 4-5 midwifery schools with trained tutors and clinical instructors for EMNC | <ul style="list-style-type: none"> 4 Countries will be holding stakeholder meetings to develop action plans in FY06 EMNC training will take place in FY06 |

ACCESS/Haiti Monitoring and Evaluation Framework

| Indicator | Definition/Calculation | Data Source/Collection Method | Progress to Date (9/30/05) |
|--|---|--|-----------------------------------|
| USAID/Haiti IR2: Increased use of quality reproductive health services | | | |
| Haiti ACCESS Program Result: Reproductive health services strengthened in 13 departmental hospitals and 14 secondary health facilities, with focus on postabortion care, family planning, and infection prevention. | | | |
| Number of facilities with staff trained in the Standards Based Management Process applied to PAC | Standards Based Management is a process for improving performance of health facilities promoted by JHPIEGO. It can be applied to multiple health areas. | Program records/reports | 6 |
| Number of providers trained in PAC in the past year through ACCESS-supported training courses | ACCESS-supported training courses include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS PAC courses as recorded in program records. | Training participant tracking sheets and training database | NA |
| Number of qualified PAC On-the-Job (OJT) trainers developed in the past year | Qualified trainers included PAC-trained providers who successfully completed an ACCESS-supported Clinical Training Skills (CTS) or Advanced Clinical Training Skills (ATS) course for PAC OJT. | Training participant tracking sheets and training database | 10 |
| Number /%of PAC target facilities that achieved at least 40% of PAC SBM standards at followup assessment | <u>Numerator:</u> Number of PAC target facilities trained in SBM for PAC that achieved at least 40% of the standards <u>Denominator:</u> Total number of PAC target facilities trained in SBM for PAC | PAC SBM followup assessment | NA – Assessment not yet conducted |
| Number/% of PAC target facilities functioning as PAC OJT sites | “Functioning” PAC OJT sites must have at least one ACCESS-trained PAC trainer who is actively conducting PAC training and key supplies and equipment needed to conduct quality PAC OJT training | Program records/reports | 3 |
| Number/% of PAC clients at target facilities who received family planning counseling | <u>Numerator:</u> Number of PAC clients at PAC target facilities who received family planning counseling <u>Denominator:</u> Total number of PAC clients at PAC target facilities | PAC registers, Monthly PAC monitoring form, PAC database | 226/449 = 50.3% |

| Indicator | Definition/Calculation | Data Source/Collection Method | Progress to Date (9/30/05) |
|--|--|--|----------------------------------|
| Number/% of PAC clients at target facilities who received a family planning method | <p><u>Numerator</u>: Number of PAC clients at PAC target facilities who received a family planning method</p> <p><u>Denominator</u>: Total number of PAC clients at the PAC target facilities</p> | PAC registers, Monthly PAC monitoring form, PAC database | 68/449 = 15.1% |
| Number/% of PAC clients at target facilities who were referred for a family planning method outside of the PAC service delivery area | <p><u>Numerator</u>: Number of PAC clients at PAC target facilities who were referred for a family planning method outside of the PAC service delivery area</p> <p><u>Denominator</u>: Total number of PAC clients at the PAC target facilities</p> | PAC registers, Monthly PAC monitoring form, PAC database | Not collected |
| Number/% of PAC clients at target facilities who were referred for other reproductive health services | <p><u>Numerator</u>: Number of PAC clients at PAC target facilities who were referred for other reproductive health services</p> <p><u>Denominator</u>: Total number of PAC clients at the PAC target facilities</p> | PAC registers, Monthly PAC monitoring form, PAC database | Not collected |
| USAID/Haiti IR3: Reduced transmission of selected infectious diseases | | | |
| <i>Haiti ACCESS Program Result: Increased accessibility and use of PMTCT services.</i> | | | |
| Total number of health workers newly trained or retrained in the provision of PMTCT services according to national or international standards. | <p>Health workers include tutors, clinical preceptors, and providers. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff consistent with national or international standards for PMTCT.</p> <p>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.</p> <p>The number will be calculated as an annual count of persons satisfactorily completing ACCESS PMTCT courses as recorded in program records.</p> | Training participant tracking sheets and training database | 43 (22 physicians; 21 nurses) |
| Total number of target service outlets providing the minimum package of PMTCT services according to national or international standards. | <p>Number of target facilities providing the minimum package of PMTCT services according to national or international standards. Under PEPFAR, the minimum package is defined as:</p> <ul style="list-style-type: none"> -counseling and testing for pregnant women -ARV prophylaxis to prevent MTCT -Counseling and support for safe infant feeding practices -family planning counseling or referral | Program records/reports | NA |

| Indicator | Definition/Calculation | Data Source/Collection Method | Progress to Date (9/30/05) |
|--|--|---|----------------------------|
| Total number of pregnant women provided with PMTCT services at target facilities, including counseling and testing | Pregnant women include those attending ANC services and those delivering in the maternity at the PMTCT target facilities. | ANC registers, VCT registers, Maternity registers, CDC Global AIDS program database for Haiti, HMIS | NA |
| % of antenatal care clients at target facilities tested for HIV/AIDS | <p><u>Numerator</u>: Number of ANC clients at the target facilities tested for HIV/AIDS</p> <p><u>Denominator</u>: Total number of ANC clients at the target facilities</p> | ANC registers, VCT registers | NA |
| Number of PMTCT clients tested at target facilities who tested positive | PMTCT clients consist of all pregnant women who received PMTCT services | ANC registers, Maternity registers, CDC Global AIDS program database for Haiti | NA |
| Prevalence of HIV among PMTCT clients tested at target facilities | <p><u>Numerator</u>: Number of PMTCT clients at the target facilities tested for HIV/AIDS who tested positive</p> <p><u>Denominator</u>: Total number of PMTCT clients at the target facilities who were tested for HIV/AIDS</p> | ANC registers, Maternity registers, CDC Global AIDS program database for Haiti | NA |
| Number/% of antenatal clients at target facilities counseled about infant feeding options | <p><u>Numerator</u>: Number of antenatal clients at target facilities counseled about infant feeding options</p> <p><u>Denominator</u>: Number of all antenatal clients at target facilities</p> | ANC register, ANC client record review | NA |
| Number/% of HIV+ pregnant women at target facilities who received antiretroviral prophylaxis by type of prophylaxis | The types of ARV prophylaxis include AZT, NVP, and short-term tri-therapy. | ANC registers, Maternity registers, HMIS, CDC Global AIDS program database for Haiti | NA |
| Number/% of newborns with HIV+ mothers at target facilities who received antiretroviral prophylaxis by type of prophylaxis | The types of ARV prophylaxis include AZT and NVP. Prophylaxis should be received by the newborn within 72 hours after birth. | Maternity registers, HMIS, CDC Global AIDS program database for Haiti | NA |
| Number/% of maternity clients at target facilities who accepted a family planning method postpartum | <p><u>Numerator</u>: Number of maternity clients at target facilities who accepted a family planning method postpartum</p> <p><u>Denominator</u>: Number of all maternity clients at target facilities</p> | Maternity register, maternity client record review | Not collected |

ACCESS/Tanzania Monitoring and Evaluation Framework

| Indicator | Definitions and Calculation | Data source | Collection method/frequency | Responsible party | Baseline and target | Progress to date (as of 9/30/05) |
|--|--|---|--|--|---|--|
| <i>USAID/Tanzania Result (Health IR1): Communities empowered to practice key behaviors and use services for target health problems</i> <i>ACCESS Program Result: Partnerships initiated towards increasing community support for birth planning</i> | | | | | | |
| Number of community groups working with WRA that are aware of new evidence-based skills and practices for maternal and child health | <p>Community groups are organizations working to improve local conditions, e.g., the White Ribbon Alliance. Groups that agree to work with ACCESS will pursue increased knowledge of quality services through social mobilization, empowerment, and collective action strategies. Evidence-based MCH skills and practices will be informed by technical assistance from the ACCESS Program, international standards, and other stakeholders. The number will be calculated as an annual count of community groups with activities meeting the definition that are recorded in program documents.</p> | Program records | Records review to document community group activities; compiled annually | ACCESS, Muthoni Magu-Kariuki, TZ Program Manager | Baseline: 0 Target: 20 | 41 community groups (organizations working to improve local conditions and/or to pursue increased knowledge of quality services through social mobilization, empowerment, and collective action strategies) |
| <i>USAID/Tanzania Result (Health IR2): Family level access to target services increased</i> <i>ACCESS Program Result: National preservice/in-service curricula and actual practice (core competencies) reviewed/assessed</i> | | | | | | |
| Number of tutors, clinical preceptors, nurse-midwives who have been trained in the past year in focused ANC through ACCESS-supported training events | <p>Tutors, site preceptors, and nurse-midwives are defined according to local (Tanzania) categories of instructors and care providers. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS focused antenatal care courses as recorded in program records.</p> | Training database and/or other training records | Compiled from training database raw data annually | ACCESS, Muthoni Magu-Kariuki, TZ Program Manager | Baseline: 0 Target: 42 tutors 42 clinical preceptors 56 nurse-midwives | ? 44 tutors ? 50 clinical preceptors ? 208 midwives (48 of these nurse-midwives also trained as trainers) |

| Indicator | Definitions and Calculation | Data source | Collection method/frequency | Responsible party | Baseline and target | Progress to date (as of 9/30/05) |
|---|---|---|--|---|------------------------------------|--|
| <i>USAID/Tanzania Result (Health IR3): Sustainability reinforced for target health program ACCESS Program Result: National preservice/in-service curricula and actual practice (core competencies) reviewed/assessed (improved)</i> | | | | | | |
| Number of service delivery points with at least one nurse-midwife who has been trained within the past year in focused ANC through ACCESS-supported training events | Service delivery points are medical facilities where clinical care is provided for clients. Nurse-midwives are defined according to local (Tanzania) categories of care providers. Trained nurse-midwives are those who complete a focused ANC training event satisfactorily according to the criteria established for the course. The number will be calculated as an annual count of SDPs that have sent at least one person to an ACCESS-supported FANC course and who satisfactorily completed that training as recorded in program records. | Program records including training database and/or other training records | Training records reviewed to compile relevant information annually | ACCESS, Muthoni Magu-Kariuki, then TZ Program Manager | Baseline: 0 Target: 33sites | 97 SDP (21 preservice education hospitals; 24 PMTCT –hospitals; 23 Health centers; 29 dispensaries. |
| <i>USAID/Tanzania Result (HIV/AIDS IR2): Increased use of prevention-to-care products and services ACCESS Program Results: Integration of EMNC and PMTCT interventions strengthened; see also ACCESS IR 5, Targets of Opportunity</i> | | | | | | |
| Number of service delivery points providing integrated FANC and PMTCT services | Service delivery points are medical facilities where clinical care is provided for clients. The Prevention of Mother to Child Transmission package of services aims to prevent HIV+ transmission through the provision of ANC including a number of interventions. The provision of integrated ANC and PMTCT services at ACCESS target sites will be determined through follow-up and supportive supervisory review. | Program records | Records review to compile targeted SDPs that reach service provision goals | ACCESS, Muthoni Magu-Kariuki, then TZ Program Manager | Baseline: 0 Target: 33sites | 105 SDPs (30 hospitals, 36 health centers, 39 dispensaries) |

| Indicator | Definitions and Calculation | Data source | Collection method/frequency | Responsible party | Baseline and target | Progress to date (as of 9/30/05) |
|---|---|-----------------|--|---|--------------------------|---|
| Number of zonal and regional managers who have received the national IP guidelines through ACCESS-led dissemination | Zonal and regional managers are GOT employees responsible for health standards leadership for SDPs in their geographic areas. Receiving national infection-prevention guidelines will be accomplished through advocacy meetings. The number of managers receiving the guidelines will be calculated from the program records concerning attendance at these meetings. | Program records | Summary information will be compiled at the end of the reporting year. | ACCESS, Muthoni Magu-Kariuki, then TZ Program Manager | Baseline: 0 Target:40 | 26 managers (received the dissemination). (10 National, 16 regional/zonal) |

ACCESS/WARP Monitoring and Evaluation Framework

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Status |
|--|---|--|------------------------------|--|
| <i>WARP IR 5.1 Improved approaches to FP/RH, STI/HIV/AIDS and child survival services disseminated region wide</i> | | | | |
| <i>IR 5.1.B Number of AWARE-supported applications of promising and best practices in FP/RH, STI/HIV/AIDS, CS & ID</i> | | | | |
| <i>WARP IR 5.3 Increased capacity of regional institutions and networks</i> | | | | |
| <i>IR 5.3.A Number of AWARE-supported technical leadership institutions showing an improvement in institutional capacity</i> | | | | |
| ACCESS IR 3: Safe delivery, postpartum, and newborn care improved | | | | |
| Number of providers trained in EMNC in the past year through ACCESS-supported training courses | ACCESS-supported training courses include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS courses as recorded in program records. | Training participant tracking sheets and training database | Annual | 20 providers from 15 sites in Ngaoundere district in Cameroon were trained in EMNC |

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Status |
|---|--|--|--------------------------------|---|
| <p>% of providers trained in ACCESS-supported EMNC training courses competent in key EMNC skills 2 months after EMNC training</p> | <p><u>Numerator:</u> Number providers who completed an ACCESS-supported EMNC course who are competent in EMNC clinical skills 2 months after EMNC training</p> <p><u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC course</p> | <p>Clinical observations during training follow up site visits</p> | <p>2 months after training</p> | <ul style="list-style-type: none"> ● 14 out of the 15 sites were followed up. The provider from the 15th site was relocated shortly after the training. 4 out of the 20 providers were unavailable for follow-up. ● ● Of the eight facilities where AMTSL was included as part of their action plans, four were found to be adequately practicing AMTSL, one was teaching AMTSL but not practicing it due to lack of deliveries in the follow-up period, and three had yet to sufficiently integrate AMTSL into their practice. |
| <p>% of providers in ACCESS-supported EMNC training courses regularly using the partograph 2 months after training</p> | <p><u>Numerator:</u> Number of providers completed an ACCESS-supported EMNC course who used the partograph for at least 50% of deliveries conducted during the 2 months after the EMNC training</p> <p><u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC course</p> | <p>Review of service statistics and actual partographs during training follow up site visits</p> | <p>2 months after training</p> | <p>6 providers from 4 different sites demonstrated correct use of the partograph. 3 sites were either not using the partograph or doing so incorrectly. The remaining sites did not include the use of partograph in their action plans.</p> |

| Indicator | Definition/Calculation | Data Source/Collection Method | Frequency of Data Collection | Status |
|--|---|--|------------------------------|---|
| Number of targeted participants trained through Social Mobilization Advocacy (SMA) workshops in target countries | Targeted participants will be defined in the WARP implementation and management plan and identified through agreed processes through locally-coordinated efforts following the initial assessment. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS SMA courses as recorded in program records. | Training participant tracking sheets and training database | Annual | 25 participants from Ngaoundere district in Cameroon. |
| Number of trained Social Mobilization trainers reporting having conducted advocacy activities using auto diagnostic tools in the last 2 months | Trained SMAs are ACCESS-trained advocates through the workshops in targeted countries. Auto-diagnostic tools are a key focus of the training. | Program records/reports, completed auto diagnostic tools | 2 months after training | These activities will roll out in FY06. |

ANNEX D: ACCESS FUNDING OVERVIEW

HIDN BASELINE REPORT – 06/05, FY05

| | | | |
|------------------|--------|-----------------------------|------|
| Section I | | ACTIVAAAD LEVEL INFORMATION | |
| AAAD Title: | ACCESS | | |
| AAAD Number: | | | |
| Initial FY: | 2004 | Final FY: | 2009 |
| | | AAD End Date: _____ | |

| | | | |
|--------------------|---------------------|-----------------------------|---------------------|
| Section II | | ACTIVITY LEVEL INFORMATION | |
| Activity Title: | ACCESS Program | PRELIMINARY | CTO/TA: Nahed Matta |
| Activity Number: | | | |
| Contractor/Grant: | JHPIEGO Corporation | | |
| Award Date: | 7/27/2004 | End Date: | 7/27/2009 |
| Actual Start Date: | 10/1/2004 | DATE LAST MGT REVIEW: _____ | |

| | BUDGET / BUDGET AND FINANCIAL INFORMATION (\$000) | | | | | | FIELD SUPPORT | MAARDs | GRAND TOTAL |
|---|---|----------|---------|----------|---------|-------|---------------|--------|-------------|
| | Total | SO 1 POP | SO 2 MH | C O R E | | | | | |
| | | | SO 3 CS | SO 4 HIV | SO 5 ID | | | | |
| 1. Total Estimated Cost: | 75,000 | | | | | | | | 75,000 |
| 2. Cumulative Obligations (Thru 09/30/04): | 5,611 | 0 | 3,991 | 400 | 0 | 1,220 | 4,100 | 300 | 10,011 |
| 3. Obligated (FY 05): | 4,813 | 0 | 3,563 | 350 | 0 | 900 | 11,912 | 470 | 17,195 |
| 4. TOTAL Obligated todate (Thru 09/30/05): | 10,424 | 0 | 7,554 | 750 | 0 | 2,120 | 16,012 | 770 | 27,206 |
| 5. Cumulative Expenditures = (a) + (b), thru 09/30/05: | 3,564 | 0 | 2,576 | 302 | 0 | 686 | 4,080 | 576 | 8,220 |
| (a) Total Vouchered: PROJECTED | 3,564 | 0 | 2,576 | 302 | 0 | 686 | 4,080 | 576 | 8,220 |
| (b) Total Accruals: | 0 | 0 | | | 0 | | | 0 | 0 |
| 6. Pipeline (as of 09/30/05): | 6,860 | 0 | 4,978 | 448 | 0 | 1,434 | 11,932 | 194 | 18,986 |
| 7. Expended in Past Year = (a) + (b), 10/01/04–09/30/05: | 3,564 | 0 | 2,576 | 302 | 0 | 686 | 4,080 | 576 | 8,220 |
| (a) Total Vouchered: | 3,564 | 0 | 2,576 | 302 | 0 | 686 | 4,080 | 576 | 8,220 |
| (b) Total Accruals: | 0 | 0 | | | 0 | 0 | 0 | 0 | 0 |
| 8. Actual Monthly Burn Rate (10/01/04–09/30/05): | 297 | 0 | 215 | 25 | 0 | 57 | 340 | 64 | 685 |
| 9. Planned Expenditures Next 12 months (10/01/05–09/30/06): | 6,753 | 0 | 4,977 | 467 | 0 | 1,309 | 9,854 | 190 | 16,797 |
| 10. Planned Monthly Burn Rate (10/01/05–9/30/06): | 563 | 0 | 415 | 39 | 0 | 109 | 821 | 63 | 1,400 |
| 11. Months Funding After 09/30/05: | 12 | #DIV/0! | 12 | 12 | #DIV/0! | 13 | 15 | 3 | 14 |

* Cooperating agency/grantee/contractor to complete lines 5, 5a, 5b, 7, 7a, 7b and 9 only.

Shaded areas NOT be filled in by cooperating agency, grantee, or contractor.

All Core "SO columns" may not apply to you for reporting purposes.

**Projected Burnrates for semi-annual periods will be provided when 09/30/05 expenditures are finalized

NOTE: PY1 Core Workplan approved Jan 2005. Field approved Mar 05, with some exceptions. Actual Expenditures reflect that imp

NOTE: \$396,500 SO2 funding reserved per USAID/W for PY2 operations - funding in pipeline not programmed
NOTE: \$200,000 SO5 funding reserved for PY2/3 operations (ITN Advisor, multi-yr task)- funding in pipeline not programmed for PY2

Projections above are based on approved workplans as of 03/31/05.

Months Funding After 09/30/05-calc based on start-up burnrates. Delayed implementation reduced spending//
/Does not reflect notional spending pattern

ACCESS PROGRAM - Y1 ANNUAL IMPLEMENTATION PLAN

August 2004 - September 2005

Budget Distribution by Funding Type

| BUDGET | Year One FY04 Budget | Funding Type | | | | | | | | | | |
|---|----------------------------|--------------------|------------------|------------------|--------------------|------------------|----------------------------|------------------|---------------------------------------|------------------|---------------------------------------|-------------------------------------|
| | | SO2 General | SO2 Newborn | SO2 PPH | TOTAL SO2 | SO3 Newborn | SO5 Mali ITN Advisor | SO5 Malaria | TOTAL FUNDING before RESERVE | SO2 RESERVE | SO5 Mali ITN Advisor RESERVE | TOTAL FUNDING with RESERVE |
| CORE | | | | | | | | | | | | |
| IR 1. Global Leadership | | | | | | | | | | | | |
| TOTAL Activity 1. Global Networking and Partnerships | \$299,602 | \$269,602 | \$30,000 | | \$299,602 | | | | \$299,602 | | | \$299,602 |
| TOTAL Activity 2. Health Care Financing and Policy | \$147,275 | \$147,275 | | | \$147,275 | | | | \$147,275 | | | \$147,275 |
| TOTAL Activity 3. Dissemination of ACCESS Program Materials and Resources | \$86,195 | \$86,195 | | | \$86,195 | | | | \$86,195 | | | \$86,195 |
| TOTAL Activity 4. Small Grants | \$88,365 | \$88,365 | | | \$88,365 | | | | \$88,365 | | | \$88,365 |
| TOTAL Activity 5. Technical Assistance | \$90,000 | \$90,000 | | | \$90,000 | | | | \$90,000 | | | \$90,000 |
| TOTAL IR 1 Global Leadership | \$711,437 | \$681,437 | \$30,000 | | \$711,437 | | | | \$711,437 | | | \$711,437 |
| IR 2. Preparation for Childbirth Improved | | | | | | | | | | | | |
| TOTAL Activity 1. Finalize and standarize for ACCESS a household to hospital package | \$35,304 | | | | | \$35,304 | | | \$35,304 | | | \$35,304 |
| TOTAL Activity 2. Assure Integration of EMNC and PMTCT | \$203,724 | | \$203,724 | | \$203,724 | | | | \$203,724 | | | \$203,724 |
| TOTAL Activity 3. Implementation of Home Based Mother and Baby Care | \$253,902 | | | | \$253,902 | \$253,902 | | | \$253,902 | | | \$253,902 |
| TOTAL Activity 4. Implementation of Social/Community Mobilization | \$125,777 | \$125,777 | | | \$125,777 | | | | \$125,777 | | | \$125,777 |
| TOTAL Activity 5. MAC activities | \$920,000 | | | | \$920,000 | | | \$920,000 | \$920,000 | | | \$920,000 |
| TOTAL Activity 6. ITN Advisor | \$100,000 | | | | \$100,000 | | | \$100,000 | \$100,000 | | | \$100,000 |
| TOTAL IR 2. Preparation for Childbirth Improved | \$1,638,707 | \$125,777 | \$203,724 | | \$329,501 | \$289,206 | | \$920,000 | \$1,638,707 | | | \$1,638,707 |
| IR 3. Safe Delivery, Postpartum care, and newborn health improved | | | | | | | | | | | | |
| TOTAL Activity 1. Prevention of Post Partum Hemorrhage | \$193,995 | | | \$193,995 | \$193,995 | | | | \$193,995 | | | \$193,995 |
| TOTAL Activity 2. Strengthening skilled attendance through performance and quality in | \$82,501 | | | | \$82,501 | \$82,501 | | | \$82,501 | | | \$82,501 |
| TOTAL IR 3. Safe Delivery, Postpartum Care, and Newborn Health improved | \$276,496 | | | \$193,995 | \$193,995 | \$82,501 | | | \$276,496 | | | \$276,496 |
| IR 4. Management of obstetric complications and sick newborns improved | | | | | | | | | | | | |
| TOTAL Activity 1. Strengthen Pre-service Midwifery Education in EMNC | \$97,783 | \$81,507 | \$16,276 | | \$97,783 | | | | \$97,783 | | | \$97,783 |
| TOTAL Activity 2. Development and application of the resource allocation model | \$88,359 | \$88,359 | | | \$88,359 | | | | \$88,359 | | | \$88,359 |
| TOTAL Activity 3. Finalize training manual for Kangaroo Mother Care (KMC) | \$28,273 | | | | \$28,273 | \$28,273 | | | \$28,273 | | | \$28,273 |
| TOTAL IR 4. Management of obstetric complications and sick newborns improved | \$214,415 | \$169,866 | \$16,276 | | \$186,142 | \$28,273 | | | \$214,415 | | | \$214,415 |
| IR 5. Prevention and treatment of priority health problems of non-pregnant women of reproductive health age (Targets of Opportunity) | | | | | | | | | | | | |
| TOTAL Activity 1. Fistula Prevention | \$97,801 | \$97,801 | | | \$97,801 | | | | \$97,801 | | | \$97,801 |
| TOTAL IR 5. Prevention and treatment of priority health problems of non-pregnant women of reproductive health age (Targets of Opportunity) | \$97,801 | \$97,801 | | | \$97,801 | | | | \$97,801 | | | \$97,801 |
| Program Management | \$1,113,662 | \$1,113,662 | | | \$1,113,662 | | | | \$1,113,662 | | | \$1,113,662 |
| Quality and M&E | \$351,373 | \$351,373 | | | \$351,373 | | | | \$351,373 | | | \$351,373 |
| Pre-Workplan Approval - Start-up Costs | \$610,109 | \$610,109 | | | \$610,109 | | | | \$610,109 | | | \$610,109 |
| TOTAL CORE BUDGET | \$5,014,000 | \$3,150,025 | \$250,000 | \$193,995 | \$3,594,020 | \$399,980 | \$100,000 | \$920,000 | \$5,014,000 | | | \$5,014,000 |
| TOTAL CORE FUNDING BY TYPE | | \$3,150,000 | \$250,000 | \$194,000 | \$3,594,000 | \$400,000 | \$100,000 | \$920,000 | \$5,014,000 | \$396,500 | \$200,000 | \$5,410,500 |

ACCESS FUNDING TABLE
 1 October 2004 - 30 September 2006
 as of 12 October 2005

| Funding Type | Region / Country / Core FY05 Detail | TOTAL Funding Obligated FY04 for PY1 | Region / Country / Core FY05 Detail | Anticipated TOTAL Funding Obligation FY05 for PY2 |
|--|--|---|--|---|
| FIELD SUPPORT | ASIA | | | |
| | Afghanistan | \$0 | Afghanistan CSH1UNK: \$3,000,000 | \$3,000,000 |
| | Bangladesh | \$0 | Bangladesh CSH/CSMH: \$2,300,000 CSH/Pop: \$300,000 | \$2,600,000 |
| | Nepal CSMH: \$200,000 | \$200,000 | Nepal CSH/CSMH: \$880,000 CSH/CSMN: \$220,000 CSH/Pop: \$850,000 Mod 3: \$200,000 | \$2,150,000 |
| | ANE Bureau/SPOTS CSMH \$330,000 Pop \$100,000 | \$430,000 | ANE Bureau/SPOTS | \$0 |
| | TOTAL ASIA FIELD SUPPORT | \$630,000 | TOTAL ASIA FIELD SUPPORT | \$7,750,000 |
| | AFRICA | | | |
| | AFR/SD Pop \$100,000 HIV(CSH) \$100,000 | \$200,000 | AFR/SD CSH/CSMH: \$300,000 CSH/Malaria \$100,000 | \$400,000 |
| | Guinea | \$0 | Guinea CSH/CSMH: \$100,000 | \$100,000 |
| | West Africa Regional Program (WARP) | \$300,000 | Nigeria (pending) West Africa Regional Program (WARP) CSH/POP: \$300,000 | \$1,500,000 \$300,000 |
| | Tanzania CSMH: \$50,000 Inf \$100,000 HIV/GAI \$500,000 Malaria \$300,000 | \$950,000 | Tanzania CSH/CSMH: \$450,000 CSH/INF \$75,000 GAI/HIV (PEPFAR): \$500,000 CSH/Malaria \$600,000 | \$1,625,000 |
| | Zambia | | Kenya IBP: \$300,000 POP (IBP add on - PROPOSAL): \$250,000 in process Malaria (IBP add on - PROPOSAL): \$100,000 in process PEPFAR: \$200k + \$270k = \$470,000 | \$1,120,000 |
| | Zambia PEPFAR COP (pending) | | Zambia PEPFAR COP (pending) | 50,000 |
| | Subtotal Africa Field Support | \$1,450,000 | Subtotal Africa Field Support | \$5,095,000 |
| | Malaria Action Coalition (MAC) Field Support Kenya: Mal \$200,000 Madagascar: Mal \$225,000 Mali: Mal \$0 REDSOESA & GHAI: Mal \$100,000 Rwanda: Mal \$120,000 WARP: CSH/Malaria \$125,000 Total MAC Field Support \$770,000 | | Malaria Action Coalition (MAC) Field Support Kenya: Mal \$300,000 Madagascar: Mal \$150,000 Mali: Mal \$75,000 REDSO ESA & GHAI: Mal \$160,000 Rwanda: Mal \$0 WARP: CSH/Malaria \$0 Total MAC Field Support \$685,000 | |
| TOTAL AFRICA FIELD SUPPORT | \$2,220,000 | TOTAL AFRICA FIELD SUPPORT | \$5,780,000 | |
| LAC | | | | |
| LAC/RSD | \$50,000 | LAC/RSD (received as Core funds \$75k) | \$0 | |
| Haiti Population: \$1,350,000 CS/MH : \$150,000 | \$1,500,000 | Haiti GAI/HIV (PEPFAR): \$695,000 | \$695,000 | |
| TOTAL LAC FIELD SUPPORT | \$1,550,000 | TOTAL LAC FIELD SUPPORT | \$695,000 | |
| | | Other Field Funds - Heperian | \$357,000 | |
| TOTAL FIELD SUPPORT for PY05 | \$4,400,000 | TOTAL FIELD SUPPORT for PY06 | \$14,582,000 | |
| CORE | CORE FUNDING | | | |
| | SO2 - General Programming \$3,150,000 SO2 - Newborn \$250,000 SO2 - PPH \$194,000 SO2 Subtotal \$3,594,000 | | SO2 - General Programming \$3,038,305 SO2 - Newborn \$250,000 SO2 - PPH \$200,000 SO2 Subtotal \$3,488,305 | |
| | SO3 - Newborn \$400,000 | | SO3 - Newborn \$350,000 | |
| | | | LAC/RSD (received as Core GH/HIDN funds) \$75,000 | |
| | SO5 - Mali - ITN Mali (Obligation for Multi-Year Program) \$300,000 SO5 - Malaria Action Coalition (MAC) Malaria/Infectious \$920,000 | | SO5 - Mali - ITN Mali (Obligation for Multi-Year Program) \$0 SO5 - Malaria Action Coalition (MAC) Malaria/Infectious \$900,000 | |
| | TOTAL CORE funds obligated through Sept 05 (FY04 Funds for PY1 Ops) Core Funds Obligated for FY06 Programming | \$5,214,000 \$396,500 | TOTAL CORE funds to be obligated through Sept 06 (FY05 Funds for PY2 Ops) Core Funds Obligated for FY06 Programming | \$4,813,305 \$0 |
| TOTAL FUNDING OBLIGATION AS OF 31 December 2004 | \$10,010,500 | TOTAL ANTICIPATED FUNDING OBLIGATION as of 31 July 2005 (FY05 for PY2 Ops) | \$19,395,305 | |

\$29,405,805

12-Oct-05

Table 1. ACCESS PROGRAM CUMULATIVE FUNDING PROJECTIONS
as of 15 October 05

| CUMULATIVE FUNDING PROJECTIONS as of 15 October 2005 | Funding Type | | TOTAL |
|---|--------------------------|--------------------------|----------------------------------|
| | Core Initiatives | MAARD + Field Support | |
| 31 MAR 05 Beginning Balance (through Mod 2) | \$5,610,500 ¹ | \$4,400,000 | \$10,010,500 ² |
| New Funding to ACCESS Award | | | |
| Received Funding for PY2 Programming (through Mod 5) | \$4,813,305 | \$12,382,000 | \$17,195,305 |
| Current Cum Funding Available (through Mod 5) | \$10,423,805 | \$16,782,000 | \$27,205,805 ² |
| Anticipated Funding for PY2 Programming | \$0 | \$2,200,000 ³ | \$2,200,000 |
| TOTAL Received + Anticipated Funding for PY2/3 Ops | \$4,813,305 | \$14,582,000 | \$19,395,305 |
| TOTAL ACCESS Cum Funding Projected thru FY05 | \$10,423,805 | \$18,982,000 | \$29,405,805 |

ACCESS Program - FY05 ob for PY2
30-Sep-05

¹- Includes \$300k multi-year obligation for ITN advisor and \$396,500 SO2 obligation for PY2

²- Thru Mod 2

| | | |
|------------------------------|---------|--------------------|
| ³ - Anticipating: | Kenya | \$100,000 |
| | Kenya | \$250,000 |
| | Kenya | \$300,000 |
| | Zambia | \$50,000 |
| | Nigeria | \$1,500,000 |
| | | <u>\$2,200,000</u> |