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

# ACCESS

## YEAR TWO
## ANNUAL REPORT

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access
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 |
| AMA | Afghan Midwives Association |
| AMTSL | Active Management of the Third Stage of Labor |
| ANC | Antenatal Care |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| AWARE-RH | Action for West Africa Region-Reproductive Health |
| BASICS | Basic Support for Institutionalizing Child Survival |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| CDC | Centers for Disease Control and Prevention |
| CMT | Core Management Team |
| CORE | The Child Survival Collaborations and Resources Group |
| CORP | Community-Owned Resource Person |
| CT | Counseling and Testing |
| EMNC | Essential Maternal and Newborn Care |
| EmOC | Emergency Obstetric Care |
| EmONC | Emergency Obstetric and Newborn Care |
| FANC | Focused Antenatal Care |
| FBO | Faith-Based Organization |
| FP | Family Planning |
| FCHV | Female Community Health Volunteer |
| HB-PNC | Home Based Post-Natal Care |
| HHCC | Household-to-Hospital Continuum of Care |
| HIDN | Health, Infectious Diseases and Nutrition |
| HNP | Healthy Newborn Partnership |
| HUEH | National University Hospital of Haiti |
| ICM | International Confederation of Midwives |
| IP | Infection Prevention |
| IPT | Intermittent Preventive Treatment |
| IR | Intermediate Result |
| ITN | Insecticide-Treated (bed) Net |
| KMC | Kangaroo Mother Care |
| LAC | Latin America and Caribbean |
| LBW | Low Birth Weight |
| LGA | Local Government Areas |
| LRP | Learning Resource Package |
| M&E | Monitoring and Evaluation |
| MAC | Malaria Action Coalition |
| MCH | Maternal and Child Health |
| MIJ | Maternité Isaïe Jeanty |

| | |
|---|---|
| MIP | Malaria in Pregnancy |
| MIPESA | Malaria in Pregnancy East and Southern Africa Coalition |
| MNH | Maternal and Neonatal Health |
| MNCH | Maternal, Neonatal and Child Health |
| MNPI | Maternal and Neonatal Program Index |
| MOH | Ministry of Health |
| MOPH | Ministry of Public Health |
| MPWG | Malaria in Pregnancy Working Group |
| NFHP | Nepal Family Health Program |
| NGO | Nongovernmental Organization |
| NMCP | National Malaria Control Program |
| NSMP | National Safe Motherhood Program |
| OJT | On-the-Job Training |
| PAC | Postabortion Care |
| PAHO | Pan American Health Organization |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PMNCH | Partnership for Maternal, Newborn and Child Health |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| POPPHI | Prevention of Postpartum Hemorrhage Initiative |
| PPH | Postpartum Hemorrhage |
| PQI | Performance and Quality Improvement |
| PY | Program Year |
| RAOPAG | West Africa Network against Malaria during Pregnancy |
| RBM | Roll Back Malaria |
| RH | Reproductive Health |
| SBA | Skilled Birth Attendance/Attendant |
| SBM-R | Standards-Based Management and Recognition |
| SMA | Social Mobilization Advocacy |
| SMM | Safe Motherhood Model |
| SO | Strategic Objective |
| SP | Sulfadoxine-Pyrimethamine |
| TIMS© | Training Information Monitoring System |
| TT | Tetanus Toxoid |
| 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 |
| WHO/AFRO | WHO/Regional Office for Africa |
| WHO/SEARO | WHO/Regional Office for South-East Asia |
| WRA | White Ribbon Alliance |

# I. Introduction

This report presents detailed information on the achievements of the Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program over the period of 1 October 2005 to 30 September 2006. ACCESS is a five-year, $75 million, Leader with Associate award to JHPIEGO and Save the Children, Academy of Educational Development, American College of Nurse Midwives, Constella Futures, and Inter Church Medical Assistance. The Program's start date was July 2004. As of October 2006 the total amount of core funds obligated is approximately $14.6 million including SO 2, SO 3, and SO 5. The total amount for field support and MAARDS is about $28 million. The total core and field obligation is $42.6 million, including FY 06. The ACCESS program is active in 14 countries. Large programs are located in Bangladesh, Afghanistan, Nepal, Haiti, Tanzania, Kenya and Nigeria (average annual $1-$3 million). ACCESS-FP Associate Award (AA) was approved with $20 million ceiling and ACCESS/Afghanistan for $20 million. Cambodia AA was negotiated for $1.8 million.

The second section of this report, entitled "Program Results by HIDN Results Pathways," is structured around the four results pathways—developed by the United States Agency for International Development (USAID) Office of Health, Infectious Diseases and Nutrition (HIDN)—that pertain to the ACCESS Program: 1) Antenatal Care (ANC); 2) Skilled Birth Attendance (SBA); 3) Postpartum Hemorrhage (PPH); and 4) Newborn. These results pathways are designed to help Cooperating Agencies focus their efforts on key maternal and child health (MCH) areas and interventions in order to maximize results. These four pathways are linked with, and complementary to, the ACCESS Program's five intermediate results (IRs).[1] All ACCESS program results summarized in the narrative are categorized under one of these four results pathways. However, many results are crosscutting and contribute to more than one results pathway. In the case of crosscutting results, the result has been placed under the pathway to which it contributes the most; other relevant pathways are referenced.

Following the results narrative, this report presents program coverage achieved by ACCESS clinical and community interventions in a matrix format. Next, the report describes the challenges the Program has faced over this reporting period and the solutions applied to overcome them.

Finally, in addition to the narrative presentation of results, this document captures results achieved at the global, country and regional levels through a "status update" for indicators included in the Program's global, country and regional monitoring and evaluation frameworks. These frameworks are included in Annexes C and D. An update on core activities completed to date for this fiscal year is included in Annex A.

## Summary of Major Results and Activities

During its second year of operation, ACCESS evolved into a mature program and is now able to present wide-ranging global results in international leadership, capacity building, demand

[1] The HIDN office recently identified five core indicators for MNH programs: tetanus toxoid protection at birth; skilled birth attendance; active management of the third stage of labor (for facility-based programs and where skilled birth attendants conduct home deliveries); postpartum visits made by appropriately trained health workers to mothers and newborns delivered in facilities or at home within three days of birth; essential newborn care (composite indicator: clean cord care, thermal care [immediate drying and wrapping] and immediate and exclusive breastfeeding)

generation and service delivery in maternal and newborn health. All results fall under USAID's maternal and child health (MCH) program element. Core funds (100%) contribute to four of the five maternal and child health results pathways. The fifth pathway pertains to obstetric fistula.

Highlights of the key results include the following:

## SKILLED BIRTH CARE PATHWAY

**Core funds**

- Developed a policy module and a technical document on: Saving the Lives of Women and Newborns: "Home and Community-based Health Care for Mothers and Newborns."
- White Ribbon Alliance (WRA) capacity-building workshop focusing on SBA s was conducted in India for national secretariat representatives from 14 countries
- Work on-going with faith-based organizations (FBOs) in Tanzania to map and improve their maternal and newborn health services.

**Regional: AFR/SD and Core Funds**

- Conducted with WHO/AFRO an assessment and a three-week technical update and clinical skills standardization course (including active management of the third stage of labor, or AMTSL, and use of the partograph) in Ghana for Ghana, Ethiopia, Malawi, Tanzania and Nigeria (field funds) midwifery educators.
- Five Lusophone countries (Mozambique, Angola, Guinea Bissau, Cape Verde and Sao Tome) have a total of 24 trained Africa Road Map facilitators to guide national level policy makers to achieve Safe Motherhood goals.

**Regional: West Africa Funds**

- In Mauritania and Cameroon, ACCESS strengthened MNH clinical skills for 13 and 20 providers in Kaedi and Tibati districts, respectively and sixteen providers from four countries (Cameroon, Mauritania, Niger and Togo) received clinical training skills.

**Field Support Funds**

- In Nigeria, ACCESS initiated a $3 million program in two states, Kano and Zamfara, for integrated community and facility-based essential maternal and newborn care (EMNC) interventions. The ACCESS program will reach four local government areas (LGAs), with a population of 962,473, in the first year.
- In Afghanistan, ACCESS supported national policy initiatives related to SBA.. ACCESS also conducted a comprehensive review of the maternal and newborn health situation in Afghanistan using the Safe Motherhood Model, resulting in the development of a new five-year national MNH strategy and building the capacity of the Afghan Midwives Association. A new Associate ward was approved and will expand MNH activities.
- In Nepal, assisted in developing a generic SBA Learning Resources Package and conducted a study on factors influencing utilization of skilled providers in remote areas..
- WRA Tanzania held a successful workshop where MOH and other organizations committed to addressing issues surrounding safe motherhood and human resources for health.

## ANTENATAL CARE PATHWAY

### Core Funds

- Collaborated with the World Health Organization (WHO)/Geneva to develop a curriculum for front-line health providers on the prevention of mother-to-child transmission of HIV (PMTCT), and a guide for implementation of prevention of malaria in pregnancy (MIP) programs.

### Core MAC Funds

- Supported the West Africa Network against Malaria during Pregnancy (RAOPAG) secretariat to develop the network's 2006 action plan and a four-year strategic plan, which will be used to advocate for support of the network.
- Worked with WHO to finalize the Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition report on the experiences of the five MIPESA countries in adopting and implementing MIP policies and interventions.
- Participated in the Roll Back Malaria (RBM) Partnership's malaria in pregnancy working group (MIP WG) meeting. Participants revised the group's action plan to support the RBM strategy and approach for scaling up MIP programming for sustainable impact (MAC & AFR/SD).
- ACCESS and WHO/AFRO conducted an orientation workshop on the prevention and control of MIP and PMTCT as part of FANC for 27 participants from six African countries.
- In Abuja, Nigeria, ACCESS conducted an integrated workshop for FANC/MIP, including supervision and sensitization to the link between HIV and malaria. Now 28 RBM and reproductive health coordinators from 15 states have the capacity to use the performance and quality improvement (PQI) process for FANC as a platform for MIP and PMTCT.
- FBOs from two countries—Kenya and Tanzania—were awarded small grants for FANC/MIP work.
- ACCESS is supporting FBOs in Uganda to strengthen focused ANC and MIP services with MAC core, AFR/SD and REDSO funds.
- In Burkina Faso, a total of 114 providers from 49 facilities in five districts of one health region have been trained in FANC and MIP, and job aids are in use at all sites. An estimated total population of 3,849,335 is now covered by clinical sites offering improved FANC and MIP services.

### Field Support Funds

- In Tanzania, 201 providers and 90 trainers from 21 districts in four regions were trained in FANC and are now providing services at key district and sub-district level facilities. FANC/MIP services are now in 62 of 128 districts in 18 of 21 regions of the country covering a total population of 18,542,012. A total of 56 facilities with ACCESS-trained providers reported improved service delivery data on the provision of FANC/MIP services. Per (DHS): 52.1% for the first dose of IPT (IPT1) and 21.7% for the second dose (IPT2) among all ANC clients surveyed by the DHS compared with 65% IPT1 and 44% IPT 2 at ACCESS facilities. Tetanus toxoid (two doses) was 70%.
- In Kenya, ACESSS trained 26 trainers ready to facilitate nation-wide scale-up of FANC/MIP. In addition, a total of 94 service providers and 171 community-owned resource persons (CORPs) in three malaria endemic districts (Makueni, Kwale and Bondo) were orientated to all aspects of community reproductive health.
- In Haiti, ACCESS trained 312 providers at 40 sites in PMTCT, VCT, rapid testing and infant feeding and continuing in 18 sites. Twelve sites reported service statistic data for this period:

83% of ANC clients (n=11,271) received PMTCT counseling (pretest) and 88% of pregnant women counseled about PMTCT were tested for HIV, with a prevalence rate of 4.3%. And 97% of newborns with HIV+ mothers (n=85) delivering at the facility received antiretrovirals.

## PREVENTION OF POSTPARTUM HEMORRHAGE PATHWAY

**Core Funds**

- A PanAfrican conference to address Postpartum Hemorrhage in Africa was attended by about 200 participants from 22 African countries and other countries. Plans to address this problem have been initiated in several countries such as Uganda, Rwanda and Kenya.
- ACCESS awarded seven local organizations in six countries in Africa small grants in support of their expansion of country-level PPH activities (Madagascar, Kenya, Ethiopia, Burkina Faso, Mali, and DR Congo).
- ACCESS supported the work of POPPHI by helping to distribute worldwide a Prevention of PPH Toolkit, which includes a CD-ROM demonstrating AMTSL.
- In Cambodia, an initial support to a national partners' meeting and a design of a program addressing maternal and neonatal health issues resulted in the Mission funding a three-year associate award to address PPH, newborn care and midwifery education and to scale up SBA.

**Field Support Funds**

- Nepal and Afghanistan are conducting pilot tests of the prevention of postpartum hemorrhage (PPH) at homebirth intervention using misoprostol. About 88% of women who were registered in the community received misoprostol in Nepal.

**NEONATAL CARE PATHWAY**

**Core Funds**

- Completed a draft of a global training resource, the competency-based Kangaroo Mother Care (KMC) Training Manual.
- ACCESS staff co-authored with global and African technical leaders the regional report "Opportunities for African Newborns".
- Developed two new USAID-sponsored e-learning mini-courses, one on Essential Newborn Care.

**Regional: ANE Funds**

- In Asia, ACCESS collaborated with WHO/SEARO to conduct a regional workshop on the Continuum of Care for Maternal and Newborn Health .
- Supported WHO/SEARO to hold a regional training on newborn health in Bangladesh (ANE funds).

**Field Support Funds**

- In Bangladesh, a program to scale up community maternal and newborn health interventions is being implemented in Sylhet district. It will cover seven sub-districts with a population of 1,443,841.

- In Nepal, ACCESS has been working closely with the National Family Health Program (NFHP) to implement a comprehensive community-based maternal and newborn care (CBMNC) program in the Kanchanpur district of Nepal. Also developed a draft low birth weight (LBW) neonatal care and management training manual in Nepali.

## Expanded Program Reach for ACCESS

Large MNH programs started last year in Bangladesh and Nigeria. ACCESS also launched new initiatives in India and South Africa and has prepared a proposal for an associate award in Cambodia. New Associate Awards under the ACCESS Program—ACCESS-FP and an associate award in Afghanistan—also commenced activities during this time.

In the coming year, the Safe Birth Africa Initiative will be implemented in Rwanda ($650K-1M) and project design work has been initiated. Malawi and Ghana are possible additional countries to scale up maternal newborn health (MNH) activities in the future. Strategic activities planned for FY07 include:

- An evaluation of the ACCESS Program is planned by USAID for the last quarter of FY 07.
- Programs in Bangladesh (MN-community), Nigeria (EOC), Afghanistan (PPH and SBA), Nepal (LBW), Haiti (PMTCT-PAC &FP), Kenya (PPH-VCT) will be expanded and in South Africa (HIV/AIDS guidelines) initiated.
- In Tanzania, scaling up of FANC by training 1,800 providers in 400 facilities and expanding to an additional 10 districts reaching about 60 % of the total districts.
- In Cambodia, ACCESS will implement a program to strengthen PPH, newborn health and SBA activities.
- In India, pilot testing of MOH plan to improve SBA skills and increase their utilization is underway.
- In Malawi, a safe motherhood program that includes promoting AMTSL and newborn health care will be initiated.
- In Ghana, a program to improve SBA training and coverage.

# II. Program Results by HIDN Results Pathways

## A. Antenatal Care Results Pathway

### CORE-FUNDED RESULTS

**Expanding Access to FANC through FBO Networks in Africa**

ACCESS continues to work with FBO partners to scale up EMNC through local FBOs in Africa using core MAC funds. As a follow-on to the August 2005 FANC/MIP workshop for FBO and MOH representatives, ACCESS initiated a program to enable participating FBOs from Kenya, Malawi, Tanzania, Uganda, and Zambia to strengthen and/or scale up specific interventions in maternal and newborn health activities. FBOs from four countries submitted EMNC proposals; three proposals—from Kenya and Tanzania—received ACCESS funding. Another outcome of this workshop was the production and distribution of FANC job aids to all 256 health units affiliated with the Uganda Protestant Medical Bureau (UPMB). ACCESS is supporting FBOs in Uganda to strengthen focused ANC and MIP services using a mix of core MAC funds, AFR/SD funds and MAC REDSO funds. This six-month project, which began in June 2006, has already resulted in an assessment of FANC/MIP at five health facilities in Kasese District, and a draft of FANC clinical training materials and community training materials. These materials have been pre-tested among faith-based providers and will be adopted nationally to roll out focused ANC with MIP[2].

**FBO FANC Workshop: UPMB Takes Action**

Grace Nakazibwe, Uganda Protestant Medical Bureau representative to the FBO workshop on FANC, was determined to share her newly updated knowledge about FANC with all the providers in UPMB-affiliated units in Uganda. She found a quick and effective way of accomplishing her goal: she convinced UPMB leadership to produce and disseminate a job aid as well as an information booklet on FANC. These materials have since been distributed to several hundred midwives and other providers.

**Sharing Evidence-Based MNH Knowledge to Improve Services**

ACCESS has completed technical briefs on focused antenatal care, malaria in pregnancy and essential newborn care, which present evidence-based approaches for strengthening ANC programs. To complement the community mobilization training manual *How to Mobilize Communities for Health and Social Change*, developed by JHU/CCP, ACCESS developed a companion facilitator's guide. The two documents will assist country programs in improving the EMNC-related knowledge and skills of pregnant women, recent mothers, families, community members, community health workers and health care providers. The guide, entitled *Community Mobilization for Maternal and Newborn Health*, is currently being adapted for field-testing in Nigeria and Bangladesh and will support capacity building of NGOs, FBOs, ministries and others to generate public and private sector dialogue that leads to effective community-driven solutions to EMNC service use. A related technical brief highlighting program results, especially health outcomes, following the implementation of specific community mobilization approaches has also been completed and is being printed. This document will be used for advocacy with stakeholders to promote the strengthening of community mobilization activities in EMNC programs in PY3. In addition, downloads from the ACCESS website since its launch in October

[2] This project is co-funded with ACCESS/MAC core funds and USAID AFR/SD funds.

2005 have increased monthly, including more than 3,000 downloads of the HHCC report. To date, the site has seen 6,727 unique visitors.

**Addressing Malaria in Pregnancy through the Malaria Action Coalition**

ACCESS collaborated with Malaria Action Coalition (MAC) partners to develop the *Malaria in Pregnancy Implementation Guide*—which is currently undergoing external review—to serve as a tool countries can use to initiate the implementation process, or strengthen the existing implementation process, for MIP prevention and control. ACCESS is revising the Malaria Resource Package developed in 2003 to incorporate updated information on MIP and to include the implementation guide. ACCESS also worked with WHO to finalize the Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition report on the experiences of the five MIPESA countries in adopting and implementing MIP policies and interventions. Highlighting best practices and lessons learned, the report is intended to inform implementation and scale-up of MIP interventions in other African countries, and has been disseminated widely to policymakers, program planners, donors and partners in the sub-region.

ACCESS also provided support using MAC core funds to the West Africa Network against Malaria during Pregnancy (RAOPAG) Secretariat to develop the network's 2006 action plan and a four-year strategic plan, which will be used to advocate for support of the network. ACCESS is supporting the network to develop a database of MIP information that will be available on the RAOPAG website to share experiences among member countries, further encouraging the scale-up of MIP at the national level.

In April 2006, ACCESS participated in the Roll Back Malaria (RBM) Partnership's malaria in pregnancy working group (MIP WG) meeting. Participants revised the group's action plan to support the RBM strategy and approach for scaling up MIP programming for sustainable impact. Technical updates and program experiences related to MIP prevention and control were shared. Meeting outcomes included the commitment to reinforce ANC as a platform for MIP services, an agreement on the need to strengthen regional networks, and an understanding of the key issues affecting scale up and how to address these challenges. The country presentations from Uganda, Benin, Equatorial Guinea and Nigeria all suggested that they have integrated the ANC approach for delivering MIP services. Participants reiterated that there is a continued need to work with the RH divisions to enable MIP activities to be rolled out by the implementers of the RH programs. ACCESS also helped develop and provide input to the final WHO/RBM/MIP monitoring and evaluation (M&E) guidance.

ACCESS worked to build capacity in FANC/MIP in multiple countries. ACCESS and WHO/AFRO conducted an orientation workshop on the prevention and control of MIP and PMTCT as part of FANC for 27 participants from six African countries.[3] Participants defined the desired performance concerning collaboration between the National Malaria Control Program and the National Reproductive Health Program and developed action plans to overcome barriers to this collaboration. In February 2006 in Abuja, Nigeria, ACCESS conducted an integrated workshop for FANC/MIP, including supervision and sensitization to the link between HIV and malaria. As a result of their participation in this workshop, 28 RBM and reproductive health coordinators from 15 states now have the capacity to use the performance and quality improvement (PQI) process for FANC as a platform for MIP and PMTCT. Participants developed action plans targeting FANC,

[3] Countries included: The Gambia, Sierra Leone, Liberia, Uganda, Nigeria and Ghana.

MIP and PMTCT activities for the 15 states they represented at the workshop. In Burkina Faso, ACCESS, in collaboration with the National Malaria Control Program and Division of Reproductive Health, adapted MIP training materials and job aids for service providers. A total of 114 providers from 49 facilities in five districts of one health region have been trained in FANC and MIP, and job aids are in use at all sites. Approximately 50% (57/117) of the trained providers have been evaluated post training at their clinical sites. Supervisors reported an increase in the provision of MIP services and reduction in severe malaria cases compared to the prior reporting period. The remaining providers will be supervised by district teams who have been involved in this process. As a result, an estimated population of 3,849,335 are now covered by clinical sites offering improved FANC and MIP services. A remaining challenge is the availability of SP, which is not free, and ITNs, which are difficult for women in rural areas to obtain.

### Understanding the Financial Barriers to Health Service Utilization

ACCESS prepared a draft literature review and economic framework to address the financial and economic barriers and improve access to and utilization of maternal health services for the poor.[4] The results of this project will improve the utilization of antenatal, intrapartum and newborn care by decreasing the barriers to accessing these services. This in turn will increase the number of women who deliver with an SBA. In addition, planning of the project has resulted in a potential leveraging of ACCESS' work toward reaching the most vulnerable populations. Discussions with researchers from the MEASURE Evaluation program and the follow-on to the Policy II Project, who are also examining the issue of equity in FP/RH, have created an opportunity for cross-project learning and coordination of research.

## FIELD SUPPORT-FUNDED RESULTS

### Tanzania

In Tanzania, ACCESS is establishing FANC and MIP as part of routine maternal and child health services through inservice and preservice training and quality improvement interventions. ACCESS is working with the Ministry of Health and Social Welfare (MOHSW), Zonal Training Centers, service providers, collaborating agents and other partners to review and update the FANC Orientation Package, which is the standard MOHSW document for training service providers. A Facilitator's Guide was also drafted to standardize and make uniform the methodology for training on FANC. The document, which was integrated into Orientation Package for inservice FANC trainings and the preservice curriculum, will be available to National Trainers, Zonal, Regional, District RCH Coordinators and other trainers of FANC upon finalization.

Using a cascade strategy for inservice training in FANC/MIP, ACCESS trained 90 trainers and 201 providers. ACCESS trained approximately two providers at two hospitals in each district of the four target regions in both clinical and training skills (not all districts nominated two trainers for the FANC training), for a total of 90 trainers from 21 districts. These trainers subsequently trained 201 providers based at their own facilities as well as those from linked health centers and dispensaries from 21 districts in the four regions of Morogoro (6 districts), Kagera (6 districts), Dar es Salaam (3 districts) and Pwani (6 districts).

[4] This will be discussed with USAID in November.

ACCESS also updated trainers from five districts in the Arusha region on FANC[5], and 17 trainers from the Center for the Enhancement of Effective Malaria Interventions (CEEMI). The CEEMI trainers are engaged in the process of training a cadre of District Malaria/Integrated Management of Childhood Illness Focal Persons (DMIFPs), who will work to coordinate malaria prevention and control activities in each district. ACCESS, in collaboration with CEEMI, carried out an assessment to review the performance of DMIFPs to inform training and other strategies to address any perceived gaps in their work.

**Improving Infection Prevention and Control in Tanzania**

Sister Stephania Kamwanda is the Matron at the Cardinal Rugabwa Ukonga Hospital in Dar-es-Salaam, Tanzania and was trained in FANC and standards-based quality assurance by ACCESS. She and others at her facility used the standards-based quality assurance assessment tool and identified gaps in meeting infection prevention standards, particularly the failure (of providers) to wash hands after attending each client in the room where mothers and children receive immunizations. When the gaps were discussed with the quality assurance team at the hospital, the nurse working at the station explained how she wasted time walking next door to wash her hands. The quality assurance team then decided to create a washing station. They bought a 20-liter pale and inserted a tap on the side so that the nurse can get running water from the pale. The nurse working in the injection room is very happy with this change and she explained: *"I used to walk to the next room to wash my hands after examining each client. I wasted a lot of time walking back and forth from this room to the sink next door. I think that I also disturbed the doctor next door because he would be examining a client then I would walk in and he would have to stop or I would have to wait until he finished, thus wasting time and disturbing the client' s privacy. Now I can wash my hands without any problems." Sister Kamwanda feels that the hospital has improved infection prevention practices, and buckets with taps have been placed in other rooms where there is no sink and water for handwashing.*

Commitment and support for ACCESS' inservice and preservice capacity-building activities was achieved through a series of advocacy meetings held with stakeholders. In the four regions where ACCESS supported inservice FANC training, the program held meetings with key stakeholders in the MOHSW and hospitals. Similar advocacy meetings for preservice stakeholders were held with principals of the 15 Diploma Nurse-Midwifery schools and hospital administrators from hospitals where the students go for clinical practice. Also as part of the program's advocacy efforts, ACCESS made a presentation on FANC and MNH issues at the regional African conference for gynecologists and obstetricians in Dar-es-Salaam in an effort to advocate for FANC and to gain support from gynecologists and other stakeholders.

ACCESS continued to build capacity in preservice midwifery education as well this year, strengthening the teaching and curriculum development skills of 22 tutors and three facilitators in 15 Diploma nurse-midwifery schools. Training in FANC also targeted 33 facility-based clinical preceptors. The preceptors were strengthened with technical knowledge in FANC as well as preservice education teaching skills. ACCESS also reviewed both the FANC curriculum for pre-service schools and reviewed and adapted the existing FANC Resource Learning Package.

As part of the Program's quality-assurance work, ACCESS facilitated assessments at facilities with trained FANC/MIP providers through application of a standards-based quality assurance approach.

[5] These districts have not been counted in ACCESS coverage because CEDHA is responsible for training in FANC in the Arusha region.

These standards may apply to such areas as: information; education and communication; infection prevention (IP); management systems; and human, pharmacy and laboratory resources. To date, 64 facilities (39 hospitals, 14 health centers and 11 dispensaries) have conducted baseline assessments using the standards-based quality assurance tool—59 facilities during this reporting period. The first follow-up assessments were completed by 15 facilities this year, most of which were conducted with MOH or district level support, independent of ACCESS. The second follow-up assessments were completed by four facilities, and a third follow-up assessment by one facility. Mean and median performance scores at baseline and follow up are presented in **Table 1** below. Scores by facility are presented in Annex B.

**Table 1: Tanzania FANC/MIP Baseline and Follow-Up Assessment Standards-Based Quality Assurance Assessment Scores (Percentages)**

| ITEM | MEAN | MEDIAN | RANGE |
|---|---|---|---|
| Baseline Assessment Score (N = 64) | 42.1 | 40.5 | 15 to 84 |
| 1st Follow-Up Assessment Score (N = 15) | 60.8 | 60.9 | 38 to 85 |
| 2nd Follow-Up Assessment Score (N = 4) | 62.6 | 56.5 | 46 to 91.3 |
| 3rd Follow-Up Assessment Score (N = 1) | 54.3 | 54.3 | N/A |

As can be seen in Table 1, mean and median scores for the facilities increased substantially between baseline and the first follow-up assessment. This increase is due to steps taken by the facilities themselves to identify and address gaps in the quality of FANC/MIP services. For example, tremendous improvements across all five assessment areas[6] were found in both Monduli Hospital and Peramiho Hospital during the first follow-up assessment, with Peramiho achieving over 80% of the total standards, the target percentage for quality services. In Muheza Hospital, a few IP techniques were improved such as the use of paper towels, appropriate storage of cleaning materials, and reorganization of the reproductive and child health clinic space to keep it neat and clean, which helped the facility to achieve 100% of the IP standards at the first follow-up assessment. In general, most facilities scored high in the area of IP at the first follow up, as the use of bleach (Jik) for disinfection and proper hand washing increased.

The weakest areas of performance were related to management systems and information, education and communication. Many facilities do not have culturally appropriate materials in Kiswahili on maternal and newborn health visibly displayed in the waiting room and service delivery areas. Most facilities lacked written, updated procedures for treatment of malaria, syphilis and other relevant ailments, and job descriptions for ANC providers. Information from the recordkeeping system is generally not analyzed for decision-making purposes. Furthermore, formal ways for obtaining clients' opinions about services were often absent. A lack of drugs, particularly ferrous sulphate 200 mg (tablets) and folic acid 5 mg (tablets), and of RPR kits was noted at many facilities. SP is lacking in FBO-affiliated facilities. Selian Hospital, for example, had not given SP for the last nine months. In most facilities, there are also difficult gaps that are a challenge to continued success, such as the inability to conduct laboratory work at the ANC clinic, with all samples needing to be sent to the main hospital. Each facility has an action plan to address its specific performance gaps.

[6] Assessment areas include: FANC; information, education and communication; infection prevention; management systems; and human, pharmacy and laboratory resources.

Fifty-six facilities in Tanzania with trained FANC service providers, including hospitals, health centers and dispensaries, reported FANC/MIP services statistics during this reporting period. See **Table 2a** below for a summary of service delivery statistics.

**Table 2a: FANC/MIP Service Statistics for ACCESS Tanzania (October 2005–September 2006, for 56 Facilities)**

| SERVICE | NUMBER OF ANC CLIENTS RECEIVING SERVICE | PERCENT OF 1ST VISIT ANC CLIENTS (N = 29,070) RECEIVING SERVICE |
|---|---|---|
| IPT 1 | 18,841 | 65%* |
| IPT 2 | 12,669 | 44%* |
| Tetanus Toxoid (two doses) | 20,362 | 70% |
| Iron | 48,579 | 167%** |

* Fifteen facilities had a stock-out of SP at some point between October 2005 and September 2006.
**The percentage exceeds 100% because some facilities give iron to both 1st ANC visit clients and return clients.

The table above demonstrates that IPT uptake by ANC clients at facilities with ANC providers trained through ACCESS-supported training events is higher than among ANC clients in the general population, as measured by the most recent Demographic Health Survey (DHS): 52.1% for the first dose of IPT (IPT1) and 21.7% for the second dose (IPT2) among all ANC clients surveyed by the DHS) compared with 65% IPT1 and 44% IPT at ACCESS facilities (see Table 2a below). Fifteen facilities included in this analysis (26.8%) experienced stock-outs of SP at least once during this reporting period for a mean number of 62 days per facility.

**Table 2b: Tanzania MIP Coverage From Demographic Health Survey 2004-2005**

| MIP SERVICE | POPULATION-BASED COVERAGE FOR ALL WOMEN WHO ATTENDED ANC |
|---|---|
| IPT 1 | 52.1% |
| IPT 2 | 21.7% |

ACCESS worked with key MOHSW stakeholders from the Health Services Inspectorate Unit and others to adapt the current national Tanzania Infection Prevention guidelines, developed with technical assistance from ACCESS in FY 05, into an "Infection Prevention pocket guide" during a four-day workshop held in March. The document has been translated into Kiswahili and 500 copies of the English version will be printed in October and 2000 copies of the Kiswahili version will be printed in November and both will be disseminated in December.

## Madagascar/MAC

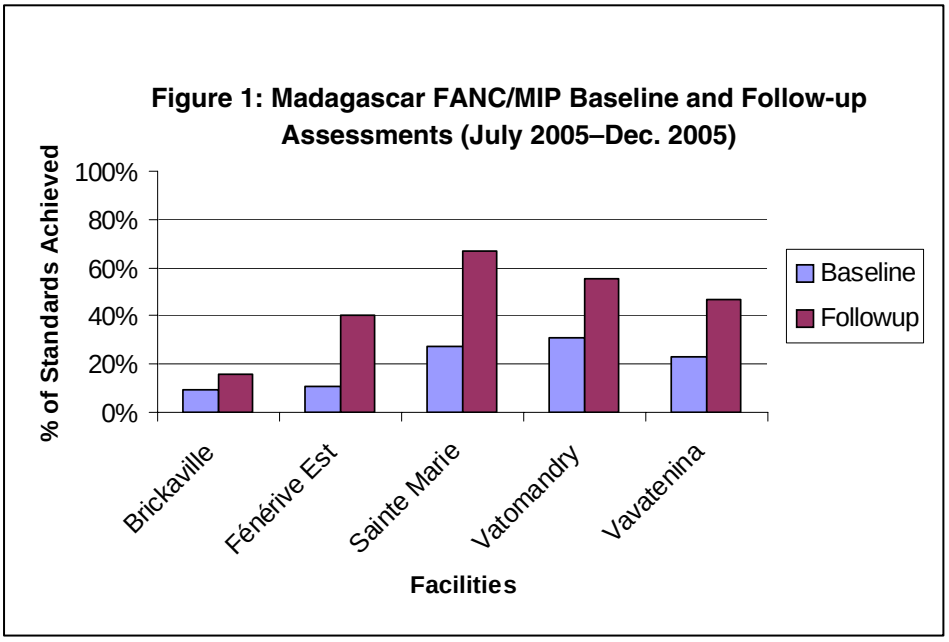
ACCESS worked with the National Malaria Control Program (NMCP) and National Safe Motherhood Program (NSMP) in Madagascar to revise training materials, job aids and service delivery standards developed in previous years. ACCESS and partners developed two job aids that describe the IPT protocol for health care service providers. The program supported printing and dissemination of French and Malagasy posters and handouts. A total of 2,728 health centers now have job aids available in the ANC service provision area. Also, MAC partners held a workshop to revise the MIP training materials to include Madagascar's policy for case management of malaria using artemisinin-based combination therapies. ACCESS/MAC printed and disseminated 280 reference manuals and participant guides and 70 facilitator guides once they were finalized. Finally,

ACCESS/MAC supported the NMCP in the revision of the desired MIP performance standards tool for use by external supervisors of MIP services.

ACCESS worked to improve the quality of services in health sites with providers trained FANC/MIP. ACCESS supported the NMCP's core group of trainers to conduct three IP trainings for 78 providers from 68 facilities in four districts in Antananarivo province. The NSMP and the District Health Medical Teams then joined the NMCP to conduct follow-up visits to assess the progress made in FANC/MIP service delivery, as well to coach providers.

In March 2006, ACCESS conducted a clinical training skills course for 14 participants and qualified three advanced trainers. Seven of these participants conducted MIP training and were qualified as clinical trainers. A total of 96 providers were trained in MIP as a result of these training-of-trainer activities.

To foster sustainability of the MIP programming interventions, ACCESS conducted a facilitative supervision course for 21 supervisors of health providers who have been trained in FANC/MIP. These supervisors used their new skills to monitor MIP service provision from 115 health facilities located in Toamasina, Toliary, Fianarantsoa and Antananarivo provinces. During the site visits, the supervisors discovered a need for additional SP at the health facilities. The Malaria Control Program used this information to advocate with United Nations Children's Fund (UNICEF) for improved procurement and distribution of SP and UNICEF subsequently worked to address these concerns.




In FY05, MAC demonstrated how to implement a PQI process at five model FANC/MIP sites in the Toamasina province. This process allowed the NMCP and NSMP to identify key weaknesses in overall FANC/MIP implementation, using a set of clinical performance standards. Lessons learned from the PQI analysis helped redirect supplies of SP and ITNs, and helped underscore the need for proper follow up of new services at health centers. Results from the follow-up assessments revealed that the quality of FANC/MIP services at the five model facilities improved substantially during this reporting period. Follow-up PQI assessments, conducted at each of the sites by MOH/FP staff six months after the baseline assessments, revealed that the facilities improved their average overall performance score from 20% to 45% of standards

achieved (**Figure 1**). In 2005, these five facilities averaged approximately 48% coverage for ITP1 and 40% coverage for IPT2 using the denominator of total number of pregnancies in the year.[7]

## Kenya

In Kenya, ACCESS supported the MOH to scale up the implementation of the community RH/MIP orientation package; develop capacity in reproductive health/malaria in pregnancy; strengthen MIP interventions in urban areas and conduct re-invigoration of MIP activities primarily using field support funds plus $50,000 in unloaded MAC core funds. A clinical training skills course (CTS) for the MOH staff was carried out in Nairobi and included 26 participants from the Division of Reproductive Health and the Division of Malaria Control. A core team of trainers is now available to facilitate nation-wide scale up of FANC/MIP using the various pots of funding available both to JHPIEGO and the MOH. A total of 94 service providers and 171 community-owned resource persons (CORPs) in three districts (Makueni, Kwale and Bondo) were orientated to all aspects of community reproductive health with a special emphasis on MIP. Participants were also taken through the PQI process in anticipation of a "harmonization meeting" to take place between the trained service providers and CORPs. The aim of the orientation was to strengthen the health facility–community linkages, which had been identified as weak the previous year. A total of 116 CORPs were updated in three malaria-endemic districts: Makueni, Kwale and Bondo. The CORPs discussed the challenges faced in terms of motivation and deeply entrenched community values. The feedback given has guided further scale-up of the community reproductive health program. In addition, a total of 22 service providers from several health facilities, whose catchment area is within the Mombasa slums, were trained in FANC/MIP; 29 CORPs affiliated with them were trained in community reproductive health and MIP. This is part of a continuous effort to support safe motherhood interventions in urban slums affected by malaria.

ACCESS, in collaboration with the MOH, also oriented 33 provincial health team members and district health personnel around emerging issues in malaria in pregnancy and concerns in reproductive health at a "re-invigoration" meeting. In attendance were eight provincial RH teams and personnel from Makueni, Kwale and Bondo, three districts that have implemented the ACCESS community RH/MIP orientation package.

## Mali

In November 2005, ACCESS collaborated with USAID/Mali, Assistance Technique Nationale (the bilateral program), the NMCP, the Division of Reproductive Health (DRH) and national-level partners to provide technical assistance to complement ongoing activities in the Mali MIP program. In June 2006, ACCESS facilitated a workshop to develop performance standards and tools to assess the performance of Mali's MIP program. The bilateral, NMCP and DRH conducted assessment visits in eight regions to gather performance data, using the tools developed in June. ACCESS also facilitated two workshops. During the first workshop, the performance data gathered by the national partners was analyzed, gaps were revealed and action plans were developed to address them. Information from this workshop was used during the second workshop to revise Mali's MIP training materials. ACCESS provided suggestions to partners and the USAID Mission for next steps to scale up MIP training and the performance improvement process in Mali.

[7] ACCESS is working with the MOH/FP to use the WHO-recommended MIP indicators (using the denominator of first ANC visits) to calculate and report future data on IPT coverage.

**Rwanda**
ACCESS participated with other MAC partners in supervision visits for FANC and MIP at six health facilities in Rwanda in February 2006. The purpose of the visits was to assess the delivery of FANC including MIP. On the whole, providers were knowledgeable about the effects of malaria on the mother and fetus, and about the delivery of SP and advantages of ITNs during pregnancy. Providers were less knowledgeable about danger signs in pregnancy and the importance of birth preparedness and complication readiness. Clients' general knowledge of malaria, including use of ITNs, was good, but their knowledge of IPT, danger signs in pregnancy, birth preparedness and complication readiness needs improvement. The supportive supervision visits provide good insight into providers' capacity, although they are not representative of the national population.

## USAID East Africa

With support from USAID East Africa, a document summarizing MIPESA network country best practices and experience implementing MIP interventions has been finalized and disseminated widely to policymakers, program planners, donors and implementing partners in the sub-region through the MIPESA focal persons. WHO also disseminated the publication through its country and headquarters offices.

**USAID West Africa**
Under USAID West Africa, ACCESS, in collaboration with MAC partners, provided support to the second annual meeting of RAOPAG and a workshop on MIP tools and resources held in October 2005. During the workshop, the *Malaria during Pregnancy Resource Package: Tools to Facilitate Policy Change and Implementation* was disseminated and participants from member countries were given the opportunity to review and adapt the materials. Participants included the nine RAOPAG member countries, RAOPAG Secretariat, West Africa Health Organization, WHO/Geneva, WHO/Regional Office for Africa (AFRO), WHO/International Comparison Program, USAID West Africa and Action for West Africa Region-Reproductive Health (AWARE-RH). Member countries presented their country reports and action plans for implementation of national MIP programs.
ACCESS also supported participation of RAOPAG Secretariat members in key partner meetings including: the West African Ministers of Health meeting, the RBM Forum V and Multi-lateral Initiative on Malaria conference in November 2005 and the West African RBM meeting in February 2006. Participation in the meetings has contributed to shaping RAOPAG's 2006 action plan and four-year strategic plan.

ACCESS assisted RAOPAG in developing draft legal texts to establish RAOPAG as an independent entity that can engage in contractual and financial relationships directly with partners. ACCESS is also supporting the network to develop a database of MIP information that will be made available on the RAOPAG website to facilitate sharing experiences among member countries to further encourage scale-up of MIP at the national level (co-funded with core funds).

## Haiti

The ACCESS Program in Haiti is building the capacity of ANC clinic and maternity ward service providers to integrate PMTCT services through training and establishing systems to support improved services at 18 facilities. Since October 2005, ACCESS trained 312 providers at 40 sites in PMTCT, VCT, rapid testing and infant feeding. The program conducted baseline assessments at each site prior to inviting providers for training. ACCESS also conducted a technical update to raise awareness of nutritional counseling in PMTCT programming for participants. Training covered

basic nutrition concepts plus concrete recommendations for how to counsel HIV-positive pregnant women and breastfeeding women.

ACCESS is collaborating with other organizations to provide ongoing support for implementation of PMTCT at 18 sites. To prepare sites for PMTCT services, ACCESS has donated material and equipment to maternity wards, depending on need, such as delivery kits and inverters. ACCESS is working with partners, particularly the Centers for Disease Control and Prevention (CDC) and Management Sciences for Health (MSH), to ensure provision of HIV rapid test kits, antiretrovirals (ARVs) and other resources, and complete small renovations.

PMTCT services within antenatal clinics were launched at the National University Hospital of Haiti (HUEH) in Port-au-Prince in December 2005, at Justinien Hospital in November 2005, at Fort Liberte Hospital in October 2005, at St. Michel de Jacmel Hospital in February 2006, at Cayes Hospital in March 2006 and at others in the last six months. **Table 3** provides information about PMTCT clients served at 12 facilities between December 2005 and September 2006.

**Table 3: PMTCT Service Delivery Statistics for ACCESS Haiti (October 2005–September 2006)***

| FACILITY (N = 12)** | NUMBER | PERCENT | CALCULATION |
|---|---|---|---|
| 1st ANC visits | 13,644 | | |
| ANC clients who received PMTCT pretest counseling | 11,271 | 83% | Denominator is 1st visit ANC clients |
| All pregnant women who received PMTCT pretest counseling*** | 11,883 | 87% | Denominator is 1st visit ANC clients |
| All pregnant women tested for HIV | 10,410 | 87.6% | Denominator is all pregnant women counseled |
| HIV+ pregnant women | 445 | 4.3% | Denominator is all pregnant women tested for HIV |
| All pregnant women tested for HIV who were HIV+ and received post-test counseling | 398 | 89.4% | Denominator is all pregnant women tested for HIV |
| All pregnant women tested for HIV who were HIV- and received post-test counseling | 8,147 | 78.3% | Denominator is all pregnant women tested for HIV |
| HIV+ pregnant women enrolled in the PMTCT program | 333 | 83.7% | Denominator is HIV+ pregnant women who received post-test counseling |
| HIV+ pregnant women enrolled in the PMTCT program who were given ARVs | 210 | 63% | Denominator is HIV+ pregnant women enrolled in the PMTCT program |
| Newborns with HIV+ mothers who received ARVs | 85 | 97% | Denominator is number of HIV+ mothers who delivered at the facilities |

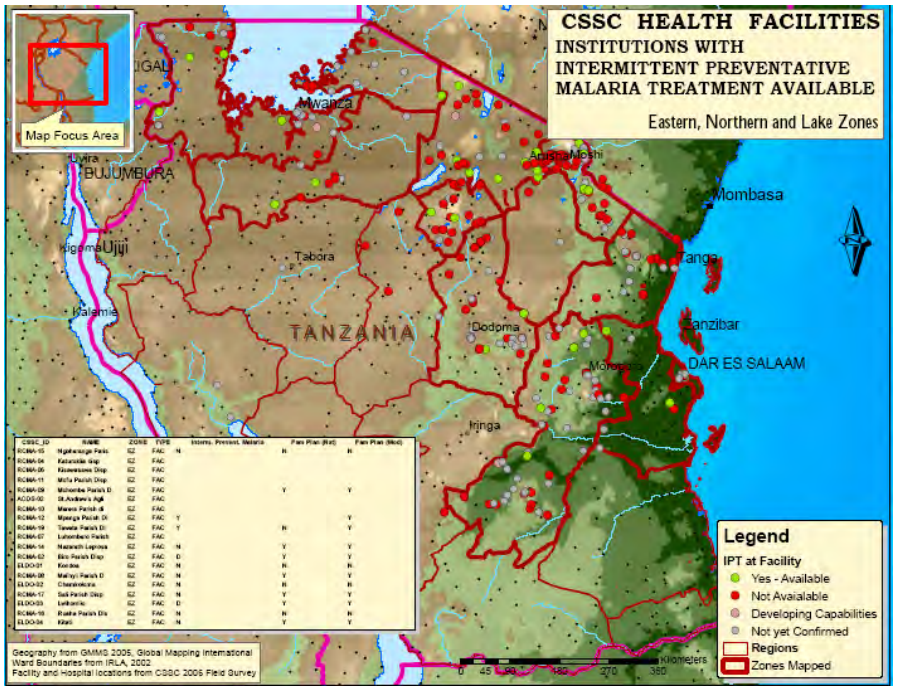
*Facilities reported data for different numbers of months during this timeframe (as their services started up).
**Facilities reporting data include: Hôpital de l'Université d'Etat d'Haïti, Hôpital Food For the Poor, Hôpital Universitaire Justinien, Hôpital de Fort-Liberté, Hôpital La Providence des Gonaives, Hôpital Saint Michel de Jacmel, Hôpital Immaculée Conception des Cayes, Maison de Naissance à Torbeck, Hôpital Saint Antoine de Jérémie, Hôpital Sainte Thérèse de Miragoâne, Hôpital de Port Salut, Hôpital de Ouanaminthe
***All pregnant women include PMTCT clients from the antenatal clinic and the maternity/labor and delivery ward.

## B. Skilled Birth Attendant Results Pathway

### CORE-FUNDED RESULTS

#### FBO Mapping in Tanzania

**Figure 2: Mapping of FBOs in Tanzania: CSSC Facilities that Offer IPT**




Above: Example map that IMA is developing with CSSC based on mapping data.

ACCESS is working with FBOs at both the global and country levels to strengthen EMNC work. ACCESS sponsored a seminar in November 2005 at USAID on the role of FBOs in maternal and neonatal health. In Tanzania, ACCESS is working with the Christian Social Service Commission to identify areas in need of improvement in maternal and newborn health care. This work includes the mapping of existing EMNC services of FBOs in Tanzania to support the national health assets planning and policy development process in Tanzania (**Figure 2**). FBOs in Tanzania manage 40% of health facilities and, in rural areas, provide more than 50% of all health services. However, these resources have not yet been effectively integrated with the national health information systems. According to WHO, the current Service Availability Mapping (SAM) conducted in many PEPFAR countries has not included FBO facilities. FBOs need to be on the map in order to improve their internal functioning as well as their collaboration with MOHs, donors, medical missions and individual churches.

For instance, in responding to the HIV/AIDS crisis, a number of PEPFAR countries are ramping up the workforce to accommodate the additional burden—a process that often means simply moving personnel from the FBO to MOH facilities. Collecting personnel information as part of a mapping process will help resolve this problem by creating compatible human resource information systems. This effort will also assist in national health assets planning and policy development, which can help improve health care services and reduce disparities in service delivery within the country. A working database is nearly complete and will enable ACCESS to scale up FANC (as requested by the Tanzania Mission) through the FBO network.[8]

[8] Currently, 90% of the database is in place: data collection in all five zones is complete; data cleaning is in process; and the database is complete for the zones funded by ACCESS (eastern and northern).

**Safe Motherhood Model**
ACCESS and its partners have developed a policy instrument to assist in decision-making on EMNC issues using a priority-setting process facilitated by the application of the upgraded Safe Motherhood Model (SMM). The success of this implementation will contribute to USAID's HIDN results pathway of improving the quality of antenatal care, newborn care and skilled birth attendance. ACCESS has implemented an application of the SMM in Ghana, a priority country for USAID, to support the country's strategic planning process while it is undergoing a revision of its National Reproductive Health Strategy.

At the invitation of the Reproductive and Child Health (RCH) unit and the Ghana Health Service (GHS), ACCESS gathered information on the cost of various maternal and neonatal health interventions to assist in identifying priority interventions for the next five-year Program of Work. This activity used the SMM to examine national information to inform reasonable estimates of the cost of implementing an improved reproductive health care program, and to identify potential gaps in coverage. Identifying the lack of care provided at the Community-Based Health Planning and Services (CHPS) and health Center levels, as well as the lack of care for neonatal complications, provided the GHS and RCH unit with information to better plan the Program of Work and National Reproductive Health Strategy. Using the results of the SMM application, district-level meetings will be held to formulate advocacy plans for local governments to strategically seek funding for maternal and child health programs.

**Midwifery Association Capacity Assessment**
The International Confederation of Midwives (ICM) developed a Midwifery Association Capacity Assessment Tool (MACAT)[9] to assess the capacity of local midwifery associations and identify ways to strengthen their capacity to improve skilled birth attendance in multiple countries. Stronger midwifery associations can be expected to result in an increased ability of midwives worldwide to improve the health of newborns and pregnant and non-pregnant women. In July 2006, ACCESS assisted the Midwifery and Nursing Association of Liberia (MNAL) in conducting a pilot assessment using the MACAT in that country. Results were analyzed collaboratively between ACNM, ICM and MNAL to identify areas needing strengthening. ICM will follow up with MNAL to identify gaps in capacity and develop recommendations for strengthening the MNAL to enable them to improve the capacity of skilled providers in the country. ACNM collaborated with ICM to identify lessons learned from the experience of applying the MACAT in Liberia. The tool will test in other countries in Africa, and this input will be used to inform ICM's revision of the tool.

**Obstetric Fistula Small Grants**
ACCESS supported the USAID goal of preventing obstetric fistula through awarding small grants to four local organizations from Uganda, Nigeria and Niger in September 2005. Since that time, ACCESS has provided technical assistance to support the integration of fistula prevention with the EMNC activities of these organizations. This assistance includes reviewing curricula, contributing to the development of partograph training for midwives, monitoring the achievement of milestones and providing feedback to grantees. Activities have focused on educating community leaders, women and families about the complications of obstructed labor, the importance of avoiding delay in seeking and obtaining care from a skilled attendant, and the advantages of delivering with a skilled attendant. The expected result is an increase in the number of women receiving care from a skilled

[9] Adapted from the UNAIDS OCAT 1997 and PACT Zimbabwe 2000

attendant in a health facility.

**Sharing Evidence-Based MNH Knowledge to Improve Services**
The technical paper *Saving the Lives of Women and Newborns: Effective Home and Community Interventions* is complete and being printed. The paper, which will be ready for dissemination in PY3, provides guidance on evidence-based and best practice interventions at the home and community level that will decrease maternal and neonatal morbidity and mortality. A training package and implementer's guide on community-based use of misoprostol is also in the final stages of development before dissemination. The Maternal and Neonatal Health Program manual *Guidelines for Assessment of Skilled Providers after Training in Maternal and Newborn Healthcare* was translated into French for global use by the ACCESS Program.

The ACCESS Program is reviewing approaches from JHPIEGO, Save the Children and the Quality Assurance Project to develop *Performance and Quality Improvement Approaches for Use in Maternal and Newborn Health*, a guide that describes the PQI process and its use for maternal and newborn health. The guide, now under review, will describe current knowledge and application of approaches by international programs, and aims to increase use of quality improvement methods to enhance health service delivery, supervision of services and capacity building of providers.

**Advocating for Safe Motherhood through Strengthened National Alliances of the White Ribbon Alliance (WRA)**
In December 2005, a WRA capacity-building workshop for national secretariat coordinators and key core committee members was held in Agra, India. National Alliance representatives from 14 countries attended the workshop. The workshop provided participants a platform for sharing and learning from each other's experiences of running WRAs in various regions. Establishing a WRA not only raises awareness on the issues of maternal and newborn mortality and advocates for a better enabling environment, but also creates a network for SBAs and advocates to improve their knowledge through learning of intra- and inter-country experiences. WRA has developed a "how to" guide—entitled *Building, Maintaining and Sustaining WRA National Alliances: A Field Guide*—that presents the experiences of local alliances and defines the process for sustainability. The Guide aims to disseminate information on effective WRAs and provide critical input as to how to prepare guidance on starting and maintaining a national secretariat. These WRAs have a national reach and the information they provide to country networks reaches an average of 230 members (organizational and individual) per country in almost all districts and provinces. This guide will assist local WRAs in building capacity to sustain advocacy work for maternal and newborn health.

## WHO/AFRO

To support implementation of the Africa Road Map for Safe Motherhood to enhance reduction of maternal mortality by developing skilled attendants, the ACCESS Program continues to collaborate with WHO/AFRO on two key Africa regional initiatives: strengthening preservice midwifery education in Anglophone Africa, and training of facilitators for the implementation of the Africa Road Map. Both of these regional initiatives support the four priority areas outlined in USAID/Africa Bureau's Maternal and Newborn Health Framework for Action 2004–2006. They also contribute to HIDN's ANC, PPH, and Newborn results pathways in addition to SBA.

The goal of the Preservice Midwifery initiative is to assess the current status of the midwifery curriculum and training in four Anglophone African countries—Ghana, Ethiopia, Tanzania and

Malawi—and work with appropriate stakeholders to strengthen these services. In August 2005, teams from all four countries were introduced to the initiative and given a WHO-adapted tool for conducting in-country assessments of midwifery education. All four countries completed these assessments this year and shared results with ACCESS and at national level stakeholders meetings that were supported by ACCESS.[10] The stakeholders meetings also served as a forum for discussing strategies for strengthening preservice midwifery education, and participants—including ACCESS, WHO/AFRO, UNICEF, United Nations Population Fund (UNFPA), various MOH representatives and other affiliated organizations—were called upon to make commitments to putting such strategies into place.

Also in PY2, ACCESS and WHO/AFRO conducted a three-week technical update and clinical skills standardization course in Accra, Ghana from 15 May to 2 June 2006. Prior to the course, Tema Hospital underwent an intensive, two-week site-strengthening activity to enable it to serve as an appropriate clinical training facility. This strengthening included providing materials and equipment as well as personal coaching and technical assistance to staff on maternal and newborn care. Four midwifery educators (tutors, clinical preceptors or representatives from MOH or midwifery councils) from each country were selected and brought to Ghana to participate in the course. In addition, four participants from Nigeria joined the training, supported by ACCESS/Nigeria funds. During the course, participants had technical updates on MNH care components such as AMSTL and use of the partograph. They were also given the opportunity to put learning into practice through clinical practicums. At the end of the training, each country team developed an action plan to implement upon return to their countries.

Next, three of the four country teams were followed-up by ACCESS midwifery staff to assess their retention of knowledge and skills. In Tanzania, three of the four participants were assessed and showed high retention: all received a passing score (80% or above) on knowledge tests, and were competent in skills, either on the first round or after reviewing the skill together.[11] In Malawi, all three participants were followed-up and proved to be competent. ACCESS is still awaiting results from the assessments of the Ethiopian providers. These midwifery educators will later be developed as advanced trainers and supported as they begin to update their in-country colleagues.

In order to move forward the agenda of the Africa Road Map for Safe Motherhood and to influence maternal and newborn health care in key countries, ACCESS—in coordination with WHO/AFRO and Africa 2010—is preparing and training a core group of Road Map technical experts/facilitators in select countries. The group is being trained not only to work in their own countries, but also to provide technical assistance to other countries if needed. The facilitators provide support with the step-by-step development and implementation of the Road Map, in promoting partnerships and in setting up mechanisms for monitoring the level of progress. In PY1, a successful workshop was held for facilitators from both Francophone and Anglophone countries: Senegal, Burkina Faso, Mauritania, Niger, Guinea, Ghana, Ethiopia, Tanzania and Zambia. A third workshop was held in July 2006 in Mozambique for 24 participants from Lusophone countries: Mozambique, Angola, Guinea Bissau, Cape Verde and Sao Tome. Twenty-four facilitators were trained at the workshop,

[10] The Ethiopia meeting is set for 24 October 2006.
[11] The fourth participant was not followed up due to the distance of her site from Dar es Salaam.

and participants agreed that each country represented at the workshop would aim to finish the final draft of the Road Map by the end of 2006.

## FIELD SUPPORT-FUNDED RESULTS

### Afghanistan

In Afghanistan, ACCESS contributed to an improving the enabling environment for skilled attendance at birth by building the capacity of the Afghan Midwives Association (AMA). In November 2005, the AMA was admitted to the ICM. In February of this year, the AMA established an office provided by the Ministry of Public Health (MOPH). ACCESS assisted the AMA to develop a public relations plan and a business development plan. The Second Annual Congress was held in May 2006 and was followed by events to celebrate International Day of the Midwife. The organization's admission to the ICM is an important step for the AMA in linking the association and Afghan midwives with colleagues globally. Membership is up from 210 to 750. There are not accurate numbers of the total number of midwives in the country so it is not possible to say what percentage of midwives are members of the AMA. At the start of May 2005, the AMA was limited to Kabul and three or four other provinces. Since then, this figure has increased to 18 out of a total 34 provinces that have a functioning provincial chapter. In addition, in July of this year, ACCESS initiated the formation of a National Safe Motherhood Advocacy group led by the AMA with involvement from key stakeholders, including the MOPH. The group already successfully advocated for a national Safe Motherhood Day, which will be celebrated annually on 8 October. The message of the first Safe Motherhood Day is "*pregnancy is special, let's make it safer*."

ACCESS also conducted a comprehensive review of the maternal and newborn health situation in Afghanistan, resulting in the development of a new five-year national MNH strategy. The strategy has been placed within the National Reproductive Health (RH) strategy, also developed with support from ACCESS. Both the RH and MNH strategies have been endorsed by the MOPH. This activity is close to completion, with the final stages being translation into the two national languages, development of a five-year work plan for the RH department of the MOPH and dissemination to the provincial MOPH offices. As part of this process, ACCESS established a working group to develop a list of key MNH indicators that would allow the reproductive health department to measure the impact of maternal and newborn health program interventions.

The review of the MNH situation in Afghanistan, conducted at the request of the MOPH, entailed conducting a costing and budgeting analysis with locally hired consultants who collected data in six provinces on 12 standard MNH interventions. As part of this process, ACCESS trained key reproductive health department MOPH and ACCESS staff in Afghanistan in the application and use of the Safe Motherhood Model and Mother-Baby Model. This training was used to apply the model to the development of the reproductive health department action plan, and to enable the reproductive health department within the MOPH to allocate funding for maternal and newborn health—specifically those interventions that will have an impact on reducing maternal and newborn mortality.

Application of the SMM encourages priority-setting dialogue by supporting improved strategic plans, focusing on increased efficiency in the use of funding resources. One important finding from the review using the SMM was the lack of ability for most facilities to provide treatment of neonatal complications. Of the three levels of health care, only the tertiary level facilities surveyed were found to have treated newborn complications. Another finding was that very few women are being treated

for pregnancy-related complications in health facilities (see **Table 4**). There were two main reasons for this. The first is that there is limited access to emergency services. Because many of the lower level health facilities do not have the equipment needed to treat obstetric complications, a woman's only alternative—aside from not going to a facility at all—is to travel to a hospital. And in Afghanistan this means hours, if not days, of traveling over poor roads. The second reason is that there are cultural barriers to providing care. Many health care facilities do not to have female health care providers, and male providers do not treat obstetric patients in this country.

**Table 4: Patient Utilization of MNH Services for Pregnancy and Newborn-Related Complications**

| TYPE OF COMPLICATION | BASIC HEALTH CENTER | COMPREHENSIVE HEALTH CENTER | HOSPITAL | TOTAL |
|---|---|---|---|---|
| Eclampsia | 0 | 0 | 308 | 308 |
| Neonatal Complications | 0 | 0 | 5,778 | 5,778 |
| Obstructed Labor | 0 | 0 | 2,716 | 2,716 |
| Sepsis | 0 | 14 | 371 | 385 |
| **Total for all Interventions** | 508,482 | 549,935 | 166,355 | 1,224,772 |
| **Per Facility** | 746 | 1,345 | 1,680 | 1,029 |

As a result of the review, the MOPH was better informed to make planning and budget decisions. A costing/budgeting framework to be included in the updated national Safe Motherhood strategy was developed. The estimation of a realistic budget that has been mapped to maternal health outcomes allows the MOPH to better advocate for resources from external donors. In addition, support for FP services was included in the MOH MNH strategic plan and budget. During the modeling process, discussions on which interventions to include, the MOH planned to include MNH antenatal services, SBAs and expansion of emergency services. Through the demonstration of the impact of FP services on maternal health in the Safe Motherhood Model, the MOPH determined that including FP services in the MNH strategy would be cost-effective.

Also in Afghanistan, ACCESS conducted a feasibility study of maternity waiting homes between November 2005 and January 2006 in three provinces—Bamyan, Badakshan and Jawzjan. The report (co-funded by UNICEF) shows that maternity waiting homes could potentially have an impact on maternal health indicators; however, the design needs to be tailored to fit the provincial cultural context. Interest in piloting this initiative has been considerable, and ACCESS has developed a set of guidelines for establishing maternity waiting homes. UNICEF and some NGOs are seeking funding for a pilot project; the province of Badakshan, which has the highest recorded maternal mortality rate in the world, is expected be one of the first pilot sites.

**Afghanistan Service Support Project (SSP)**

In the start-up phase of SSP, 25 new staff members have been hired for all partners, all key positions have been filled, nine midwifery education grant agreements have been issued, the Year One workplan has been developed and submitted to the USAID/Kabul Mission, and presentations with partners, key stakeholders and the MoPH have been made to introduce the project. In September 2006, an NGO capacity-building planning workshop, attended by 60 participants, was held to orientate NGO grantees to the SSP technical approach, and to involve them in the planning of SSP capacity-building initiatives. Additionally, two workshops were held for midwifery grantees (both SSP and non-SSP), one on effective student selection and recruitment and deployment, and another on the midwifery accreditation process. The latter aimed to review the educational standards for

midwifery programs. Additional activities were establishing the project monitoring and evaluation systems, finalizing and translating learning resource materials and initiating the process of reviewing the national information, education and communication strategy of the MOPH.

## Haiti

ACCESS continued to support postabortion care (PAC) services in Haiti this year. In the period from October 2005 to September 2006, eight facilities reported PAC service delivery data, as shown in **Table 5** below.

**Table 5: PAC Service Delivery Data from Eight Facilities in Haiti (October 2005–September 2006)**

| SITE | CASELOAD | | | RECEIVED FP COUNSELING | | RECEIVED FP METHOD | |
|---|---|---|---|---|---|---|---|
| | MVA | D&C | TOTAL | # | % | # | % |
| Cap Haitien (Oct. '05 – July '06) | 0 | 396 | 396 | 359 | 90.7% | 125 | 31.6% |
| Cayes (Oct. '05 – June '06) | 4 | 56 | 60 | 27 | 45% | 5 | 8.3% |
| Fort Liberte (Oct. '05 – May '06) | 10 | 23 | 33 | 33 | 100% | 9 | 27.3% |
| HUEH (Dec. '05 – Aug. '06) | 114 | 17 | 131 | 136 | 96.3% | 36 | 27.5% |
| Isaie Jeanty* (Jan. '06 – June '06) | 195 | 6 | 201 | 55 | 27.4% | 0 | 0% |
| Jérémie (May '06 – July '06) | 2 | 13 | 15 | 15 | 100% | 8 | 53.3% |
| Ouanaminthe (Feb. '06 – July '06) | 5 | 30 | 35 | 35 | 100% | 3 | 8.6% |
| Port de Paix (Oct. '05 – March '06 | 9 | 8 | 17 | 17 | 100% | 9 | 52.9% |
| **TOTAL** | 339 | 549 | 888 | 677 | 76.2% | 195 | 21.9% |

*FP methods are not available in the PAC service delivery area at Isaie Jeanty. PAC providers say they are too busy to offer them.

A total of 888 women received PAC services at ACCESS-supported facilities: 76% of PAC clients were counseled about family planning and 22% received a family planning method. Two facilities (HUEH and Cap Haitien) reported that family planning methods were not available in the PAC Unit in the Maternity from October 2005 to March 2006. In these cases, PAC clients were referred to the outpatient family planning clinics at their facilities, which reportedly did have family planning methods in stock. Furthermore, FP methods were not available in the PAC area at Isaie Jeanty the entire period. The large PAC caseloads at these three facilities depressed the overall percentage of PAC clients who received a family planning method.

Also in Haiti, ACCESS conducted an evaluation of the Agent/Matrone Program at Hopital Bienfaisance de Pignon, a USAID-funded pilot project aimed at training a new cadre of community health workers focused on maternal health in August 2005. To follow up on this evaluation,

ACCESS conducted a three-day workshop with 23 agent/matrones and five supervisors to reinforce their knowledge about caring for women during the antenatal, labor and birth, and postpartum phases. The workshop provided an orientation to the PMTCT program since many of them also serve as *accompagnateurs* to community members who take antiretroviral medication.

## Nepal

ACCESS contributed to major policy changes in Nepal. The National Skilled Birth Attendance (SBA) Policy for Nepal, to which ACCESS contributed, has recently been endorsed by the Nepal Government. This policy defines a set of competencies an SBA must have. These competencies are consistent with the definition of SBA provided by WHO, ICM and the International Federation of Gynecology and Obstetrics. ACCESS also provided input into the MOH's Safe Motherhood long-term plan, particularly in the SBA and Human Resource Development planning and service delivery sections.

**Women' s Festival and Birth Preparedness Messages in Kanchanpur, Nepal**

Teej is one of the holy national festivals celebrated by Hindu women. The purpose of the festival is to pray for their husbands to have long lives. Women typically celebrate Teej by fasting, worshiping gods, and singing and dancing in large public gatherings. ACCESS/Nepal and the Nepal Family Health Program jointly organized a folk song competition—*"Dhohori Song"*—among FCHVs and their six mothers groups within the Suda village development committee in Kanchanpur. The competition aimed to raise awareness of birth preparedness messages within the community. Each group composed songs using messages found in the Birth Preparedness Package (BPP) or *Jeevan Suraksha Flip Charts.* The songs were mainly focused on BPP messages (e.g., danger signs of the antenatal, natal, postnatal and neonatal periods).

ACCESS/Nepal developed a generic SBA Learning Resources Package (LRP) for SBAs based upon competencies defined in the new national SBA policy. The SBA LRP is modeled after the Afghanistan Community Midwifery model. ACCESS/Nepal—in conjunction with the Family Health Division, MOHP and other key stakeholders including professional bodies—participated in a workshop in May and developed the draft package. Participants identified barriers to the advancement of the SBA, such as: what cadre could be included under the definition of a SBA, challenges associated with training of SBAs, retaining SBAs and the number of SBAs needed in country to provide adequate services. Following the workshop, an action plan, including field-testing of the package, was developed by ACCESS/Nepal and its program partners. Site visit and field-testing plans were finalized with input from the Nepal Family Health Program (NFHP) and Family Health Division (FHD). The draft SBA LRP package was field-tested in three training sites of the NFHP, and that included Koshi Zonal Hospital in Morang, BalKumari Campus and Bharatpur Hospital in Chitwan. The revised SBA LRP will be presented and finalized during a workshop to be held in November 2006.

ACCESS/Nepal has been coordinating with related stakeholders for adaptation of a comprehensive SBA package, which would standardize SBA curricula and services. In 2006, a series of meetings were held to coordinate the adaptation of the SBA LRP package along with WHO, Support for Safe Motherhood Program (SSMP), Nick Simon Institute (NSI), UNFPA, UNICEF and Institute of Medicines (IOM) program staff. In May 2006, a technical update on the SBA LRP was given by an international expert to 30 members of the Safe Motherhood and Neonatal Subcommittee.

The WHO is conducting a pilot test to upgrade inservice auxiliary nurse midwives to the level of SBAs at Bisheswor Prasad Koirala Institute of Health and Science (BPKIHS) in Dharan. The draft SBA LRP package was provided to WHO to ensure that competencies were consistent and standardized. The package also provided orientation to lead trainers in their use of the SBA Learning Resource Package.

To guide development of SBA/LRP, a SBA LRP Technical Advisory Group was formed in March 2006 under the Family Health Division, with membership of 15 technical experts from Government of Nepal, international NGOs, and educational and professional organizations including: National Health Training Center, Council for Technical Education and Vocational Training, Institute of Medicine, Nursing Campus, Sustainable Soil Management Programme, Save the Children, UNICEF, Nursing Council, Maternity Hospital, Nepal Society of Obstetricians and Gynaecologists, and Nepal Family Health Program.

ACCESS/Nepal is also supporting policy work through a study entitled *Factors Affecting the Enabling Environment for Skilled Birth Attendants in Nepal.* Key stakeholders of Safe Motherhood activities in Nepal were involved in developing the objectives, processes and sites for the study, and the study was approved by the Safe Motherhood and Neonatal Health Subcommittee, which is chaired by the FHD in the MOHP. The study will identify the key factors that contribute to successful utilization of SBA services, barriers and constraints to effective use, and the models that might be recommended for rural Nepal. More specifically, the study is examining: the range or types of approaches to implementing SBA services; in what contexts they are being implemented; community, family, and recently-delivered women's perceptions of the need for SBA services, their experiences with these services, and the underlying motivating factors and barriers for use and non-use of them; SBAs' attitudes and perceptions of services as well as their working environment, roles and expectations for professional growth.

Data were collected from six sites in varying geographical locations: four sites were functioning well and two were not. Standardized measurement instruments and in-depth interviews and focus group discussions were used. Community members interviewed included women who had used and not used the services, and key family members. Female community health volunteers (FCHVs) and traditional birth attendants were also interviewed. Staff at all of the sites, policy makers and managers were also interviewed. In November 2006, the study team will share findings with stakeholders and the group will then make a series of recommendations for functioning SBA model(s), which will incorporate the best lessons learned from currently successful service delivery sites.

**Nigeria**

ACCESS received funding from USAID/Nigeria this year to design and implement a program focused on using the HHCC approach to increase uptake of high-quality EmONC and postpartum FP services for healthy timing and spacing of pregnancies. The program is being implemented in two northern states: Zamfara and Kano. Final versions of the program's proposal, results framework, workplan, budget and

performance monitoring plan were submitted to USAID in July 2006 and approved in October 2006.

During this start-up phase, ACCESS also completed several program activities. The program facilitated a two-day national stakeholders meeting on EmONC in Abuja in January 2006, which resulted in the identification of a list of potential start-up states for the ACCESS EmONC program in Nigeria (Zamfara, Kwara, Kogi, Kebbi, Tabara and Yobe). Zamfara and Kano States were finally selected as start-up states.


ACCESS Team with Emir of Kaura Namoda, Zamfara State

During two advocacy visits to Kano and Zamfara states in (April and June/July 2006, ACCESS and USAID/Nigeria staff oriented stakeholders to the new ACCESS program to gain their support and collaboration. The first team met with political and traditional leaders as well as senior MOH officials and other stakeholders in the two states. The team worked with Safe Motherhood Committee members in each state to select four LGAs for program implementation (two in each state). The team also oriented health officials in the two selected LGAs in Zamfara to the ACCESS program, obtaining their collaboration and commitment, as well as selecting health facilities for inclusion in the program. A second team followed the same process in Kano State. ACCESS supported four midwives (two per state) to participate in a Regional Emergency Obstetric and Newborn Care Workshop in Tema, Ghana.

ACCESS also initiated its baseline survey, developing the study protocol and data collection instruments, obtaining approval from JHPIEGO's designated institutional review board (WIRB) and the Federal MOH, and training the data collectors for the planned household and facility surveys. Data collection will commence at the end of October 2006.

**Tanzania**

ACCESS continued to work through USAID field support to the White Ribbon Alliance of Tanzania (WRATZ), to support WRATZ's ability to become a leading voice in the much neglected area of human resource shortages in maternal health service delivery. On 25 March 2006, the WRATZ held a successful and well-attended rally on Safe Motherhood. Commitments were made by the MOHSW as well as other organizations to address issues surrounding safe motherhood and human resources for health. For example, the MOHSW committed to looking into acquiring new staff and Aga Khan University School of Nursing pledged to revise its curriculum to include life-saving skills.

Through support from UNICEF and the MOHSW, WRATZ also sponsored a debate forum entitled "Should Tanzania Invest in Community Midwives?" on 23 August 2006. Large numbers of qualified, capable health workers are either unemployed or employed yet overburdened, and they lack the incentives and/or motivation to work efficiently and effectively in Tanzania.[12] WRATZ is

[12] A case in point: The minimum threshold of skilled workers worldwide is 2.5 for every 1,000 people. Tanzania faces a shortfall of 35,000 workers to reach the minimum threshold.

advocating for adequate, qualified staff to be employed to provide skilled attendance at birth. Part of this advocacy effort involves the dissemination of information and a call for action to WRATZ coalition members, non-government and government actors, and donors to take steps to improve the situation.

The Tanzania MOHSW is making efforts to improve the quality of EMOC services and aims eventually to increase the number of health facilities available to women. The use of community midwives has generated much interest as a means of alleviating the situation in the short term, as these midwives have the required competencies and are typically based within the community. When the Minister for Health and Social Welfare opened the WRATZ Action Plan and Annual General Meeting on 29 September 2006, he advocated for the use of community midwives. More than 300 members were there, representing 17 regions, to develop action plans at the district level to support the advocacy and community mobilization work around increased use of skilled attendants. In addition, the ministry organized a large meeting of its leaders (500 ministerial policymakers), where the President of Tanzania spoke on maternal and newborn deaths and the shortage of human resources. The outcome was that the President stated that all unemployed skilled workers be recruited and employed, and that maternal and newborn deaths are not acceptable.

**USAID West Africa**

ACCESS has been working in West Africa with AWARE-RH, Mwangaza Action, UNICEF and partner governments to build the capacity of SBAs (including active management of the third stage of labor, use of the partograph and care of the newborn) and develop regional and national training capacity in MNH. This year, ACCESS continued to work in Cameroon and Mauritania, and expanded to a third country, Niger. The ACCESS program in Cameroon has also worked to mobilize communities to seek strengthened services offered by SBAs. This program also contributes to USAID's Newborn Results Pathway.

In Cameroon this year, ACCESS trained a second cohort of 20 providers from a second district, Tibati, using the training site developed in Ngaoundere district last year. Selected providers showing strong technical and leadership skills from these two districts, combined with those from other countries, participated in a regional clinical training skills workshop, which is described below. ACCESS, in partnership with Mwangaza Action, also conducted social mobilization activities in Ngaoundere district. ACCESS and Mwangaza assisted community leaders in selecting 22 members of a provincial-level pool of representatives to serve as social mobilization trainers. This pool participated in a training-of-trainers workshop to understand and use the community auto-diagnostic (ADC) tools for social mobilization, which were developed by ACCESS. Trainees worked with the ACCESS facilitators to conduct community auto-diagnostic sessions in two sample villages and then conducted independent ADC workshops in 16 other villages. In September 2006, the training participants gathered to compare data collected, discuss lessons

learned and review action plans developed by the communities. In addition, capacity-building strategies were defined in order to assist communities in carrying out their action plans. All community work is linked to the health facility that serves that community.

In Mauritania, ACCESS strengthened MNH clinical skills and training capacity. ACCESS conducted a clinical training in EmONC for 13 providers in Kaedi district in November 2005 and later followed them up to assess their performance (see **Box** below).

**Providers Trained in EMNC in Mauritania Apply New Skills on the Job**

Follow-up visits to trained providers conducted in January and March 2006 revealed:

- All 13 trained providers completed a partograph case study with an average score of 63% (range: 38%–81%).
- One facility out of 10 with trained providers reported regular use of the partograph. The other facilities did not have copies of the partograph, mainly because doctors or others in the facility did not feel it was important.
- Four of 13 trained providers were observed performing normal labor and delivery using a clinical observation checklist (two on clients and two on the anatomic model). All four scored "competent" in this skill set.
- Four of 13 trained providers were observed performing newborn resuscitation using a clinical observation checklist (all four on the anatomic model). All four scored "competent" in this skill set.
- All 13 trained providers completed a PPH case study with an average score of 86% (range: 50%–100%).
- Twelve of 13 providers who completed an EMNC knowledge survey scored 70% or above; the thirteenth provider scored 50%.

During both the initial training and follow-up visits, the lack of buy-in of the program by supervising doctors was clear. Most of the doctors participating in the November training left the training after three days and did not complete the course. In addition, during follow-up visits, nurses and midwives who did complete the training noted disapproval by supervising doctors as a barrier to implementation of new practices. In order to address these difficulties, six physicians and two national-level midwives were selected to travel to Burkina Faso for an intense training and coaching session that was led by ACCESS master trainers based in Burkina Faso and held at the providers' sites. Follow-up visits to these Mauritanian providers at their sites are planned for the first quarter of PY3 activities, along with continued advocacy discussions with decision-makers at both national and district levels.

In Niger, ACCESS conducted an initial needs assessment visit in mid-March of this year. ACCESS staff and consultants, accompanied by AWARE, Mwangaza Action and UNICEF staff, visited the program target region of Maradi and developed a plan of action. Shortly after this trip, ACCESS learned that UNICEF was currently using a clinical training site in the Zinder region of Niger to train providers from Maradi. ACCESS staff visited Niger in May 2005 to visit the Zinder training site and found that it was functioning well and that best practices were being taught under the leadership of Dr. Lucien Djangnikpo, a JHPIEGO-trained master trainer. However, there was little emphasis on follow-up visits post-training.

Two regional activities were completed. In early September 2006, a three-day capacity-building workshop was held for current ACCESS trainers. The purpose of the workshop was to increase their capacity to conduct quality follow-up visits with trained providers using the *Guidelines for Assessments of Skilled Providers* manual. The second regional activity was a Clinical Training Skills course held in Burkina Faso in September 2006 for 16 participants from four countries—Cameroon, Mauritania, Niger and Togo. This course was designed to build the training capacity of each country in order to scale up the use of evidence-based practices.

## C. Postpartum Hemorrhage Results Pathway

### CORE-FUNDED RESULTS

**PanAfrican Prevention of PPH Conference**

A highlight of ACCESS' work in the area of PPH was the "Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice" conference—held in collaboration with POPPHI, RCQHC, and East, Central and Southern Africa Health Secretariat—in April 2006. About 200 participants from 22 African countries and Canada, Denmark, Haiti, India and the United States came to the Entebbe, Uganda conference to examine best practices and discuss strategies. Country teams developed action plans to guide them in their efforts to address the challenge of decreasing maternal mortality from PPH in their settings. Proceedings from the conference are now complete and being disseminated. ACCESS supported participation of a five-person Nigeria team at the conference. The Nigeria team included a physician and midwife from Zamfara state, one Lagos-based obstetrician and gynecologists from the private sector, Deputy Director of the Reproductive Health Unit and the Principal of Gwagwalada School of Midwifery.

Updates on post-conference activities were provided by participants from Angola, Burkina Faso, Cameroon, the Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Nigeria, Senegal, Tanzania and Uganda. All provided a briefing of the conference material to appropriate MOH officials, relevant professional associations, and appropriate reproductive health conferences in their countries. In Nigeria, one participant lectured 135 medical professionals on AMTSL. In Malawi and Tanzania, participants made progress incorporating AMTSL in the preservice midwifery curriculum, with a draft version of the midwifery curricula currently under review by the Malawian MOH. A participant from the Cameroon Baptist Convention Health Board persuaded his organization to commit to increasing the distribution of misoprostol and organizing inservice trainings on AMTSL for 40 midwives, 20 doctors and 40 nurses, from both faith-based health networks and government health facilities, in four districts. A participant from the delegation from Kenya presented a session on PPH for post-graduate students in the Department of Obstetrics/Gynecology at the University of Nairobi. Another participant from Kenya employed by the Christian Health Association of Kenya (CHAK) debriefed with CHAK Secretariat staff; placed the PPH conference presentations and training materials in the CHAK resource center; and wrote a proposal for a training of trainers in AMTSL for skilled health providers in CHAK health units.

**PPH Small Grants Program**

ACCESS expanded the small grants program in PY2 to include supporting organizations to strengthen and expand key PPH services and interventions in maternal and newborn health at the household and community levels. The request for proposal was sent out to 23 countries (22 in Africa and India). Multisectoral teams were encouraged to apply for grant funding in order to integrate and strengthen the coordination of the delivery of services. Seven small grants aimed at the prevention and treatment of PPH were awarded in six countries. The grantees' activities will encourage the use of measures at the clinical and community level that are appropriate for low-resource settings, and they will be implemented through December 2007. The anticipated results from the small grants programs primarily support SBA and PPH results pathways. **Table 6** below presents an overview of the sub-grantees and their major planned activities.

**Table 6: Overview of ACCESS PPH Grantees**

| NAME OF ORGANIZATION | COUNTRY | MAJOR ACTIVITIES |
|---|---|---|
| Staff association of the Ob/Gyn department in Befelatanana (ASGOB) | Madagascar | Community education and communication about PPH; advocacy with national and regional policy makers about PPH; training of health care providers in PPH |
| Association des sage – femmes du Mali (ASFM) | Mali | Train health care workers in AMTSL; supervise trained health care workers; work with private pharmacists and others to ensure appropriate supply and storage of oxytocin; disseminate information about the project to stakeholders, policymakers, others |
| Society of Ob/Gyn, Ethiopia | Ethiopia | Print AMTSL service guidelines, job aids and training manuals and literature on AMTSL; hold advocacy workshops to ensure support for PPH in three regions; incorporate AMTSL in to the preservice curricula of 50% of the midwifery and nursing schools; train tutors and service providers in PPH |
| Organization for Health, Education and Research Services (OHERS) & Community Capacity Building Initiative (CCBI) | Kenya | Educate and advocate with providers about AMSTL; advocate for inclusion of AMSTL in preservice education curriculum; train providers in PPH and AMSTL at target health facilities and in communities (retired midwives); educate community about the value of skilled attendance at birth; disseminate project information |
| Baptist Community of Western Congo (CBCO) | Democratic Republic of the Congo | Community education and communication about PPH;T rain opinion leaders in target communities on PPH; adapt training manuals for providers and train providers in AMSTL; ensure supplies for AMSTL are in place; provide support supervision |
| Réseau de prévention de la mortalité maternelle du Burkina Faso (RPMM/B) | Burkina Faso | Determine the the maternal case fatality rate by cause at the CHU-YO maternity ward in Ouagadougou; train 86 health care providers in prevention and treatment of PPH at this facility; followup and evaluate trained providers |
| Family Care International (FCI) | Burkina Faso | Provide theoretical training for 22 maternity providers working in Ouargaye district and their supervisors in life saving techniques, notably the prevention and management of PPH; Provide clinical skills training for 15 providers; ensure regular supervision; provide tools, resources and protocols for providers |

### Sharing Evidence-Based Knowledge on PPH

ACCESS supported the work of POPPHI, a USAID-funded project, by helping to distribute worldwide a *Prevention of PPH Toolkit,* which includes a CD-ROM demonstrating AMTSL. In April 2006, the CD-ROM was converted to the web to provide better global access through the ACCESS Program's website.

ACCESS has assisted WHO in preparing the final draft of the curriculum for the PMTCT training and the training package in antenatal, intrapartum, postpartum and newborn care. Reviewers' comments are being incorporated and a final review will be conducted by December 2006. ACCESS technical assistance will be utilized to carry out a field test of the package, and WHO/Geneva will publish the final document. In addition, a technical brief on the prevention of PPH is now complete and available for dissemination.

### Asia and Near East (ANE): Cambodia

In October 2005, ACCESS and BASICS collaborated with Cambodia's MOH and other partners[13] on a national maternal and neonatal health workshop. In addition to sharing evidence-based interventions and increasing partner commitments to improving maternal and newborn health in Cambodia, ACCESS, BASICS and USAID prepared MNH-related recommendations for long- and short-term opportunities for the MOH and USAID. These recommendations were for long- and short-term opportunities that the MOH and USAID could support to accelerate the reduction in maternal and newborn mortality.

ACCESS then worked with USAID/Cambodia in March 2005 to identify strategic support for maternal and newborn health that would be carried out in collaboration with the appropriate USAID/Cambodia local partners. The proposed program aims to increase the numbers and building the capabilities of SBAs at the facility and community levels, as well as introduce and scale up community-based interventions for maternal and newborn health. Program activities will include policy development, system strengthening and program implementation. The overall objective is to assist the MOH, USAID and its local partners, and key stakeholders in improving the availability of and access to high-quality, sustainable maternal and newborn health services. Response to the proposal was received from the Mission in July 2006 and a revised proposal, incorporating the Mission's comments, was resubmitted in September 2006 and recently approved by the USAID Mission. ACCESS is awaiting final approval from the Mission to initiate program implementation.

## FIELD SUPPORT-FUNDED RESULTS

### Afghanistan

The Afghan MOPH's Ethical Review Board approved the PPH study protocol submitted by ACCESS, and a PPH Technical Advisory Group was appointed to approve field implementation guidelines. The study is currently underway in selected districts of Faryab, Jawzjan and Kabul provinces. A formative research study in selected districts (Qaramqul, Qurghan, Khamab, Qarqin, Guldara and Qarabagh) was completed in December 2005. Based on the findings of the formative study, educational materials and data collection tools were developed and then field-tested in April 2006. ACCESS completed community-sensitization activities as well as training of existing community health supervisors and community health workers (trained by the supervisors) who are participating in the study intervention and data collection activities.

### Nepal

In Nepal, the USAID-funded bilateral NFHP continued implementation of a pilot project to test the prevention of PPH at homebirth using misoprostol in Banke district. From November to December 2005, 488 pregnant women received Matri Suraksha Chhakki (misoprostol). This number represents 88% of women who were registered by FCHVs in the community-based maternal and neonatal care register. Among the women who received misoprostol, 84% took the full dose, while 16% of the women returned the medicine.

[13] USAID, WHO, UNFPA, UNICEF, PATH, Reproductive and Child Health Alliance, Partners for Development, University Research Corporation, Reproductive Health Association of Cambodia, CARE, MEDiCAM

## D. Newborn Results Pathway

### CORE-FUNDED RESULTS

**ANE: WHO/SEARO, MotherNewBorNet and Cambodia**

In PY1, ACCESS laid the groundwork for strengthening partnerships and future relations through its involvement with MotherNewBorNet and collaboration with WHO/SEARO. In October 2005, ACCESS collaborated with WHO/SEARO to conduct a Continuum of Care for Maternal and Newborn Health workshop in Bangkok, Thailand, which contributed to both Newborn and SBA Results Pathways. The workshop focused on country- and regional-level interventions for maternal and newborn health, with particular attention given to newborn health, skilled birth attendance, and the human resource issues and other constraints affecting maternal and newborn health programming. In attendance were 50 participants from 11 countries, including Cambodia, from the Regional Office for the Western Pacific region, and Afghanistan, from the Regional Office for the Eastern Mediterranean region. Most of the meeting participants were key MOH country staff working in safe motherhood and/or child health; a few were WHO country and regional representatives. In addition, there were representatives from UNICEF, USAID and a few other agencies.

A September 2006 training course was held in Dhaka, Bangladesh for 17 health care professionals working in newborn health from Bangladesh, Nepal and India. Hosted by WHO/SEARO and the WHO Regional Office in Bangladesh, the five-day training course developed and strengthened the capacities of trainers, through lectures and hands-on practice, in the essential newborn care course developed by WHO. Attendees developed follow-up action plans, including national-level trainings in Bangladesh and Nepal.

In July 2006, ACCESS participated in the Asia Region USAID MotherNewBorNet meeting in New Delhi, India, including supporting the participation of two MOH staff from Cambodia. The annual MotherNewBorNet meeting provided participants with opportunities to learn about state-of-the-art interventions and research, and explore and share innovative approaches to maternal and newborn health. Participants also discussed challenges for scaling up evidence-based interventions to address maternal and newborn deaths in the community, and identified gaps in program work and ways to overcome them. ACCESS brought together technical experts to address the issue of prevention and management of LBW babies in the community, including overviews on global and regional LBW issues, the role of KMC and findings from a community-based research program in Bangladesh. ACCESS also supported the session on maternal infections. As a follow on to the meeting, ACCESS will work with USAID programs in Asia to accelerate uptake and scale up of programs for PPH and community-based maternal and newborn care, particularly to address infections.

In October 2005 in Phnom Penh, the Cambodia MOH joined ACCESS and other partners (USAID, WHO, UNFPA, UNICEF, PATH, Reproductive and Child Health Alliance, Partners for Development, University Research Corporation, Reproductive Health Association of Cambodia, CARE, MEDiCAM, and BASICS) to hold a National Workshop on Maternal and Neonatal Health for approximately 150 participants. Contributing to the SBA Results Pathway, the workshop served as a technical update in evidence-based maternal and newborn health; relevant experiences and programs from Cambodia, as well as other countries in the region, were also highlighted. Participants included policymakers, clinicians and administrators from throughout Cambodia, as well as representatives from the partners cited above. Following the workshop, ACCESS prepared a

proposal in response to USAID's Cambodia request for ACCESS support to strengthen maternal and newborn health.

**Latin America and the Caribbean**

During PY2, ACCESS continued to collaborate with partner organizations (PAHO, BASICS, CORE Group and others) in the development of a regional strategy for newborn care for Latin America and the Caribbean (LAC). The development of the Neonatal Regional Strategy is the culmination of a collaborative process that began in April 2005, during a meeting to commemorate World Health Day in Washington, D.C. ACCESS assisted in drafting the LAC Neonatal Regional Strategy document, which was submitted for review to PAHO and the partner organizations. A Regional Workshop in Guatemala brought participants from the region together to review and discuss the draft Neonatal Regional Strategy. The draft of the regional strategy was then revised and shared with the PAHO Executive Committee in June 2006, and was presented to PAHO governing bodies in September.

In June 2006, ACCESS technical assistance was asked to participate as an observer in the executive committee meeting of PAHO, where a resolution to accept the Neonatal Regional Strategy was approved. During this same week, ACCESS organized a brown bag presentation at Save the Children headquarters. Key staff from ACCESS, PAHO and USAID gave a presentation to over 30 participants from 13 different private voluntary organizations. Presenters discussed both the process used in the development of the strategy and lessons learned.

During the last week of September, the PAHO Council of Directors, which includes every MOH in the region, met to endorse the final resolution of the Neonatal Regional Strategy. In PY3, ACCESS will assist in editing, translating and printing the final document. The strategy will be translated into four languages—English, Spanish, French and Portuguese—and will be disseminated to important stakeholders in every country of the region.

**Sharing Evidence-Based Knowledge on Newborn Health**

In conjunction with the INFO Project of the Health Communication Partnership, ACCESS has supported the completion of two new USAID-sponsored e-learning mini-courses in global health fundamentals for technical officers and program managers. The courses, on essential newborn care and prevention of PPH, are now available online. In addition, a third course, entitled "Program Issues in Reducing Maternal Death and Disability," will be available in November 2006. The e-learning courses aim to increase the knowledge among USAID staff of new approaches, techniques and evidence-based safe motherhood programming information. ACCESS also assisted USAID with the US launch of the special supplement of *The Lancet* on maternal survival.

Working with a network of partners, ACCESS helped to develop *Opportunities for Africa's Newborns*, a publication aimed at advancing the integration and scale-up of interventions to reduce newborn deaths in Africa. This report includes situation analyses for 46 countries and a review of relevant policies and programmatic tools led by those implementing the programs. The target audience is policymakers and program implementers in Africa, as well as donors and policymakers supporting programs in Africa. ACCESS staff have co-authored or reviewed sections on ANC, postpartum care, and the maternal, neonatal and child health continuum of care. The final document will be available in November 2006.

ACCESS has also completed a draft of a global training resource, the competency-based *Kangaroo Mother Care (KMC) Training Manual*, to teach health care workers at all levels how to care for low birth weight babies. The document is currently being adapted for use in Nigeria and Nepal. Feedback on its use will be collated in the next program year, and the manual will be finalized in PY4.

**Nepal**

ACCESS Nepal has recently added a new component to the program focusing on establishing a facility-based KMC services using core funds. ACCESS/Nepal will initiate a KMC care and management program at the Seti Zonal Hospital in Kailali, in Mahakali Zonal Hospital in Kanchanpur and in three primary health care centers (PHCs) in the Kanchanpur district. The Seti Zonal Hospital in Kailali is a NFHP training site for basic emergency obstetric care and PAC services. This component will complement the community-based maternal and newborn care program for LBW babies in Kanchanpur by linking community and household activities with facility-based KMC. The PHCs and zonal hospitals would receive cases referred from FCHVs in the communities. A National Technical Advisory Group (NTAG) is being formed and plans are in process for site assessments and baseline data collection.

ACCESS is committed to taking the learning from Kanchanpur district and work done at the national level to develop national guidelines for care of LBW newborns. This activity, which was earlier planned to take place in Year 1 of the project, will be conducted in Year 2. This change in timing was made to take into account the ongoing efforts of other partners in the area of standards and protocols. Furthermore, results from Kanchanpur will take at least a year to process before they can be shared at the national level.

## FIELD SUPPORT-FUNDED RESULTS

### Nepal

Using USAID Nepal Mission funds, ACCESS has been working closely with the NFHP to implement a comprehensive community-based maternal and newborn care (CBMNC) program in the Kanchanpur district of Nepal. The data collection for the baseline survey was completed jointly with NFHP and a final report will be available in late October 2006. The CBMNC package consists of the Birth Preparedness Package (BPP) and Home-Based Postnatal Care (HB-PNC) package, and also includes a component on strengthening health facilities for mothers and newborns who have been referred for care. The ACCESS LBW program builds on the HB-PNC, which offers routine PNC care. At the initial visit, LBW infants are identified and a more intensive schedule of visits and care is given to those babies, including the use of home-based KMC. All of the 580 FCHVs, 18 village health workers (VHWs) and 10 maternal and child health workers (MCHWs) have received the BPP/PNC training at the community level, which included identification of LBW. Of those who were trained, 200 FCHVs have been selected to be the LBW neonate care providers who will carry out the more intensive schedule of visits and care.

ACCESS/Nepal, along with the Family Health Division and National Health Training Center, has developed a draft LBW neonate care and management training manual in Nepali. A LBW neonate care and management module has also been included in the SBA LRP. Different skill observation learning guides and checklists for weighing babies, taking temperatures and LBW neonate register guidelines have recently been developed.

Program indicators and data collection tools have also been developed to monitor and evaluate the LBW program in Kanchanpur. This includes a simple pictorial register for FCHVs to collect data on LBW neonates and mothers. This register, along with training materials, is currently being field-tested.

A District Technical Advisory group was formed including eight technical experts from Kanchanpur, who will provide technical assistance to the ACCESS program, as needed. The group has met twice to discuss formative research of LBW neonates in Kanchanpur. The formative study on LBW care and management is complete and a draft report will be ready in October 2006.

## Bangladesh

The ACCESS/Bangladesh program launched the program in both Dhaka and Sylhet with participation from the Ministry of Health and Family Welfare (MOHFW), Senior Officials, ACCESS headquarters, USAID Washington, USAID/Bangladesh Mission, in-country key stakeholders on maternal and newborn health, UN agencies and NGOs. Those who spoke during the launch emphasized the importance of timely intervention for maternal and neonatal health behaviors for reduction of high maternal and neonatal mortality rates in Sylhet.


A series of workshops were conducted (technical maternal and neonatal health, community mobilization, and monitoring and evaluation) to refine and finalize the proposed intervention designs. These "intervention design" workshops included participants from a cross-section of experts from the government, UN agencies, NGOs, and implementing partners. One major component of the ACCESS/Bangladesh project is to improve healthy maternal and neonatal behavior and practices at the household level. This includes development of appropriate messages and strategies for counseling and negotiation by the ACCESS Counselors at the household level. The number and content of household visits, including targeted behaviors, counseling messages for pregnant women and an approach to identify pregnant women, were identified during the workshops.

Community mobilization (CM) is another major component of the ACCESS/Bangladesh project. Through CM-related efforts, the project focuses on implementation of the community action cycle at the community level, and seeks to identify sustainable, appropriate and effective actions to achieve healthy maternal and neonatal outcomes. A CM plan and specific strategies were outcomes of this workshop. The community mobilization workshop conducted in Sylhet included participation from local NGOs, government stakeholders and NGO partners. During the M&E workshop, the proposed indicators were revisited and finalized for development of an M&E plan.

A ceremony to launch the ACCESS/Bangladesh program at the district level was organized in Sylhet in August 2006. The purpose of the launch, attended by 300 participants, was to orient the GOB, NGO, local government and local decision-makers to the ACCESS/Bangladesh program. Likewise, upazila-level orientations have also taken place in the seven upazilas where ACCESS will be conducting interventions. In attendance at the upazila orientations were community and religious leaders, members of women's groups and local level government officials who play a critical role in involving community members and implementing the program at the local level. The orientation helped create greater awareness among community members. One participant from a women's group stated, "We are mothers in Sylhet, we know the pains of becoming a mother here, and we want to become involved with a project which works for better outcomes for mothers and their newborns."

In addition, the program developed a plan to strengthen the capacity of the two local partner organizations to address project needs, and developed a manual and curriculum for community mobilization trainings for MNH.

### Haiti

In Haiti, ACCESS, through its partner AED, has continued to provide technical assistance in the area of HIV and infant feeding, primarily through the presentation of a three-hour module included in the ACCESS/PMTCT trainings. During this reporting period, 64 health care providers were trained in the module, which covers the risk of mother-to-child transmission of HIV through breastfeeding, advantages and disadvantages of various feeding methods, and criteria to consider when helping a mother choose a method of feeding. The trainings included:

- A module on HIV and infant feeding for three PMTCT trainings organized by ACCESS:
- HUEH personnel (41 participants)
- MIJ personnel—first training (42 participants)
- Cayes personnel (23 participants)
- A technical update on HIV and infant feeding for HUEH pediatric residents, interns and nurses (25 participants)
- Training on HIV and infant feeding, which was co-funded by LINKAGES (Eight of the participants came from HUEH, which is one of the ACCESS intervention sites, and two teachers came from the Ecole des Sages Femmes.)

Behavior change communication materials on HIV and infant feeding were prepared and shipped to Haiti (co-funded with LINKAGES). These consist of a Question/Answer guide for health providers and three brochures for mothers on different feeding methods (breastfeeding, formula feeding and expression/heating of breast milk).

## III. Program Coverage

ACCESS clinical (e.g., capacity building and service delivery) and community-based (e.g., demand generation) interventions reached women and families in Nepal, Afghanistan, Haiti, Kenya, Mauritania, Cameroon, Burkina Faso, Tanzania and Madagascar. **Table 7** below presents detailed information on the types of interventions being implemented in each country and the associated population coverage.

**Table 7: ACCESS Program Coverage**

| COUNTRY INTERVENTION | # OF COMMUNITIES | # OF FACILITIES | # OF DISTRICTS/ DEPARTMENTS | % OF DISTRICTS/ DEPARTMENTS | # OF REGIONS/ PROVINCES | TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS) | # OF WOMEN OF RE-PRODUCTIVE AGE (15–49) |
|---|---|---|---|---|---|---|---|
| **AFGHANISTAN** | | | | | | | |
| Community-based PPH study: Counseling + misoprostol | N/A | 5 | 3 out of 279 | 1% | 2 out of 6 | 117,059 | 23,411 |
| Community-based PPH study: Counseling alone | N/A | 3 | 3 | 1% | 2 out of 6 | 49,465 | 9,892 |
| **BURKINA FASO** | | | | | | | |
| FANC/MIP service delivery scale-up | | 49 | 5 out of 53 | 9% | 1 out of 11 | 3,849,335 | 798,737 (estimate) |
| **CAMEROON** | | | | | | | |
| EMNC (SBA) training and service delivery | | 26 | 2 (Ngaoundere and Tibati) out of 58 departments* | 3% | 1 out of 10 | 281,111 | 67,186 (estimate) |
| Social mobilization for quality maternal and newborn care | 18 catchments areas | N/A | 1 (Ngaoundere) out of 58 departments | 2% | 1 out of 10 | 244,009 | 58,318 (estimate) |

| COUNTRY INTERVENTION | # OF COMMUNITIES | # OF FACILITIES | # OF DISTRICTS/ DEPARTMENTS | % OF DISTRICTS/ DEPARTMENTS | # OF REGIONS/ PROVINCES | TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS) | # OF WOMEN OF RE-PRODUCTIVE AGE (15–49) |
|---|---|---|---|---|---|---|---|
| **GHANA** | | | | | | | |
| Technical Updates and Clinical Skills Standardization for Midwifery Educators | | 1 | 1 (Accra City) out of 138 districts | 1% | 1 out of 10 regions | 2,029,143 | 515,402 (estimate) |
| **HAITI** | | | | | | | |
| PMTCT service delivery (ANC clinic and maternity) | N/A | 28 | 7 out of 10 | 70% | N/A | 2,797,200 | 668,531 |
| PAC service delivery | N/A | 11 | 8 out of 10 | 80% | N/A | 1,978,800 | 472,933 |
| **KENYA** | | | | | | | |
| Implementing Best Practices: Service delivery in FP, Contraceptive Tech. Update and IP, including facilitative supervision | N/A | Nakuru district-164<br>Nyeri district-100<br>Homabay district-35<br>Migori district-60 | 4 out of 76 | 6% | 3 out of 7 | Nakuru district 1.5 million<br>Nyeri district-799,697<br>Homabay district-320,000<br>Migori district-35,818 | Nakuru district-367,500 (estimate)<br>Nyeri district 676,053<br>Homabay district – 78,400 (estimate)<br>Migori district-8,775 (estimate) |
| CT for HIV/AIDS service delivery | N/A | Central province 7<br>Eastern 13<br>Nairobi 8 | 28 out of 76 | 37% | 3 out of 7 | 3,714,382 | 910,024 (estimate) |
| ART service delivery | | Eastern 13<br>Nairobi 8 | 21 out of 76 | 28% | 2 out of 7 | 2,582,200 | 632,639 (estimate) |

| COUNTRY INTERVENTION | # OF COMMUNITIES | # OF FACILITIES | # OF DISTRICTS/ DEPARTMENTS | % OF DISTRICTS/ DEPARTMENTS | # OF REGIONS/ PROVINCES | TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS) | # OF WOMEN OF RE-PRODUCTIVE AGE (15–49) |
|---|---|---|---|---|---|---|---|
| Demand generation for RH/MIP services- scale-up of community RH/MIP package | 2 divisions (Usigu & Madiany) in Bondo district<br><br>2 divisions (Wote & Kaiti) in Makueni district<br><br>2 divisions (Lunga Lunga, Msabweni & Kinango) in Kwale district | | 3 malaria-endemic districts out of a total of 45 malaria-endemic districts | 7% | 3 out of 7 | -Bondo district-287,014<br><br>-Makueni district-887,266<br><br>-Kwale district-600,000 | -Bondo district-70,318 (estimate)<br><br>-Makueni district- 217,380 (estimate)<br><br>-Kwale district-13,679 |
| **MADAGASCAR** | | | | | | | |
| FANC/MIP service delivery scale-up | | 76 | 4 out of 22 | 18% | 2 out of 6 | 710,808 | 164,197 (estimate) |
| **MALAWI** | | | | | | | |
| Technical Updates and Clinical Skills Standardization for Midwifery Educators | | 1 | 1 out of 27 (Kasungu) | 0.4% | 3 | 480,659 | 106,706 (estimate) |
| **MAURITANIA** | | | | | | | |
| EmONC (SBA) service delivery | | 13 | 7 out of 44* | 16% | 6 out of 13 | 1,063,755 | 245,727 (estimate) |
| **NEPAL** | | | | | | | |
| SBA LRP pretest | | Pretesting: 2 hospital and 1 campus | Pretesting: 2 out of 75 districts | 2.6% | 2 region out of 5 | Not available | Not available |

| COUNTRY INTERVENTION | # OF COMMUNITIES | # OF FACILITIES | # OF DISTRICTS/ DEPARTMENTS | % OF DISTRICTS/ DEPARTMENTS | # OF REGIONS/ PROVINCES | TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS) | # OF WOMEN OF RE-PRODUCTIVE AGE (15–49) |
|---|---|---|---|---|---|---|---|
| SBA training site upgrade | | 6 IST sites | 6 out of 75 districts | 8% | 4 regions out of 5 | Not available | Not available |
| SBA study | 6 | 1 HP, 1 clinic, 4 PHCC | 6 out of 75 districts | 8% | 4 regions out of 5 | Not available | Not available |
| Mgmt. of LBW infants at community level | 60,158 households | 10 SHP, 8 HP, 3 PHCC, 1 zonal hospital | 1 out of 75 | 2% | 5 | 377,899 | 185,989 |
| Facility Based KMC | 65 Village Development Committees | 2 zonal hospitals and 3 PHCC | 2 districts out of 75 | 3% | 1 out of 5 | 1,101,857 | 258,944 |
| **NIGERIA** | | | | | | | |
| Technical Updates and Clinical Skills Standardization for Midwifery Educators | | 2 | 2 LGAs (districts) out of 774 (Gusau in Zamfara state and Kano Municipal in Kano state) | .3% | 1 out of 6 | 4,060,714 | 942,086 (estimate) |
| **TANZANIA** | | | | | | | |
| FANC/MIP service delivery scale-up | | 356 | 62 out of 128 | 48.4% | 18 out of 21 | 18,542,012 | 3,703,002 |
| Technical Updates and Clinical Skills Standardization for Midwifery Educators | | 1 | 1 out of 128 (Newala) | 1% | 1 out of 21 | 183,930 | 48,982 |

Note: Data sources for population figures include national census data; US Census Bureau, International Database, http://www.census.gov/ipc/www/idbpyr.html; World Gazetteer at www.world-gazetteer.com (Cameroon); http://population.wn.com (Nepal, Mauritania, Burkina, Kenya); http://www.geohive.com (Kenya); http://www.odci.gov/cia/publications/factbook/index.html (Kenya, Mauritania, Madagascar); http://en.wikipedia.org/wiki/Region (Burkina).

*Districts in Mauritania include: Nouakchott, Kaedi, Bababe, Aleg, Aioun, Kiffa and Neima; Regions: Nouakchott, Gorgol, Brakna, Hodh El Gharbi, Assaba and Hodh Ech Chargui

**Cameroon's 58 departments are divided into 269 arrondissements and 53 districts. Data source: www.reproductive rights.org.

# IV. Challenges and Opportunities

## Challenges

### Matching Human Resources to Meet Growing Project Needs

Several country programs have either started or expanded in size in the last two years. It has been a challenge to meet the human resource needs to rapidly expand programs in countries like Tanzania, Bangladesh and Nigeria. ACCESS is currently implementing programs in over 15 countries. This growth in the number of country programs is accompanied by the need to provide technical and management input from ACCESS headquarters staff for the planning and start-up of these programs. ACCESS works to utilize existing partner staff in country for these programs; however, because ACCESS is a global cooperative agreement, there is also a need to train local partners to handle ACCESS management, including financial and reporting systems.

While we have experienced program growth, we have also experienced staff transitions. During this past year, ACCESS addressed the retention of the Deputy Director position. ACCESS also successfully transitioned the Deputy Director position to operate from Washington, D.C. In addition, ACCESS filled two major positions on the project, Senior Program Manager and Associate Director, Field Programs.

**Supporting Associate Awards**:
ACCESS views associate awards as both an opportunity and a challenge. ACCESS has two associate awards in place (ACCESS-FP and Afghanistan-SSP) and anticipates hearing about a third award. While ACCESS staff are in the best position to write the proposals for these awards, it may take a substantial commitment of time to develop these proposals as well as the detailed work plans. ACCESS believes that associate awards need to be closely affiliated with the ACCESS Lead, which may require that ACCESS Lead award staff be involved in the supervision and management of some of these awards.

ACCESS-FP is a global award. While ACCESS Lead and ACCESS-FP coordinate efforts well together and have established an effective management system, the field missions do not always see the value in inviting both programs to work in the same country. Missions prefer to deal with fewer management units.

**Adjusting to a Changing Environment at USAID**
USAID introduced the HIDN pathways and requested that programs develop activities and report along these Result Pathways. This has created an additional burden for ACCESS to map its IR activities to HIDN pathways. However, the ACCESS team has adjusted to this request and has also takes these results pathways into account in work plan development. USAID also introduced the Safe Birth Africa Initiative that mandated that ACCESS allocate approximately $1 million to two countries targeted by the Initiative . This required a major adjustment of activities under ACCESS, which may have implications for the ACCESS partnership in the future. The new focus on service delivery does not allow for all program partners to participate in obtaining program results.

**Potential Decrease in Core Funding**
USAID has advised ACCESS that there may be substantial cuts in core funding in the next few years. ACCESS was built on an anticipated core funding of $5 million per year, but that level of funding has not materialized. While ACCESS firmly believes in implementing country programs on

the basis of building in-country program staff, supporting these country programs under a global program requires human resources at the headquarters level. However, several field missions are reluctant to have Baltimore-based staff charge their time to country programs. Declining core funding and growing field programs will put ACCESS in a very difficult situation in the future. This will certainly have an impact on ACCESS' ability to fully draw on the strengths of the ACCESS partnership, as presented to USAID in the ACCESS proposal.

**Delays in Publishing Technical Documents**
ACCESS adopted an approach to seek wide participation of external reviewers in the production of technical documents. The program has experienced some delays in publication because we have not always received timely feedback from external reviewers. For example, for the document "Saving lives of women and newborns: Effective home and community interventions," the key challenge has been to ensure a thorough review by experts in the field and to focus the document on feasible and doable ways to implement these approaches. For the *EMNC Community Mobilization Facilitators' Guide*, the main challenge was timely submission of comments by internal and external reviewers. ACCESS has found that with many documents, both internal and external reviewers are very busy and have limited time to review documents outside of their own work. We strive to overcome this challenge by implementing a firm deadline for receipt of comments.

**Vulnerability of Field Programs in Politically Unstable Countries**
Some of the countries (Haiti, Nepal and Afghanistan) that ACCESS works in are currently undergoing a period of political instability. This hampers our ability to implement the full extent of the programs. However, our focus on using local ACCESS partner organizations and building in-country capacity to implement programs has allowed ACCESS to continue activities, even during the periods of political unrest and travel bans.

## Opportunities

### Continuing Growth in Programs
The increase in number of ACCESS country programs is a clear demonstration of the need experienced by USAID Missions to focus on maternal and newborn health care programs. With a responsive approach to Missions, an array of highly technical and experienced staff, and supportive guidance and direction form USAID/Global, ACCESS hopes to escalate this growth still further in the coming years. ACCESS envisions implementation of country-level activities by working through bilateral programs, partners such as professional associations, and FBOs and other NGOs on the ground.

**Developing New Associate Awards**
During this reporting period, ACCESS initiated the implementation of ACCESS-FP and was awarded a $19 million, four-year Service Support Project for Afghanistan. ACCESS anticipates hearing about a third associate award from Cambodia. The associate awards count toward the success of the program and demonstrate a growing interest among Missions in addressing maternal and newborn health.

### Ability to Contribute to USAID Safe Birth Africa
Safe Birth Africa is a highly visible program initiated by USAID/Washington. ACCESS is delighted that it can contribute to this program in Rwanda, and has reserved $650,000 dollars from core funds

to do so. In addition, ACCESS will leverage additional funds by directing other core-funded activities into Rwanda.

**Moving Core-Funded Activities into Country Programs**

In response to the message from USAID at the last management review, ACCESS has made a significant effort to move away from global activities and toward more country-level activities. This year, ACCESS initiated a core-funded program in India and will add new country-level activities in Kenya, Ghana and Malawi through core funds.

# ANNEX A: ACCESS CORE ACTIVITY MATRIX (1 October, 2005–30 September, 2006)

| 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 to ensure maternal and newborn health goals and evidence-based strategies are incorporated into health policies** | |
| 1.1.a. | Coordinate and support the Partnership for Maternal, Newborn and Child Health (PMNCH) to promote advocacy and action at the country level for maternal, neonatal and child health | • ACCESS support consultant to PMNCH to prepare funding proposal<br>• Authored and reviewed the report, "Opportunities for Africa's Newborns"; support printing and dissemination of report.<br>• Assist with U.S. launch of the Lancet series on maternal survival. |
| 1.1.b. | Collaborate with WHO/Geneva to strengthen PMTCT, pre-service education and MIP programs and services | • A final draft of the training package was developed including PMTCT in antenatal, intrapartum, postpartum and newborn care. Reviewers' comments will be taken into account and final review conducted by December 2006. WHO/Geneva will then edit and format the document. ACCESS technical assistance will be utilized to carry out a field test of the package after which publication of the final document will occur through WHO/Geneva<br>• Collaborating with WHO to develop an implementation guide for MIP that will be included in the toolkit for global fund applicants. |
| 1.1.c. | Support professional alliances such as ICM to contribute to improved quality of care for mothers and newborns | • ICM Midwifery Association Capacity Assessment Tool (MACAT) piloted in Liberia<br>• Liberian Midwives Association needs for strengthening identified and reported to ICM<br>• Lessons learned for application of MACAT in other developing countries<br>• Young Leaders workshop in Malawi postponed from June to October 2006. |
| 1.1.d. | Advance social mobilization through the WRA to help individuals, communities and organizations move from awareness to action for improved newborn and maternal health | • Prepared WRA guide entitled "Building, Maintaining and Sustaining WRA National Alliances: A Field Guide".<br>• Provided support to 14 WRA Alliances to build capacity and sustainability approaches at the National Secretariat Workshop, 5-9 December 2005. |

| CORE ACTIVITY | | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|---|
| **1.2** | **Collaborate with Faith Based Organizations (FBOs) to strengthen maternal and newborn services provided by FBO affiliated networks** | |
| 1.2.a. | Support FBOs to build and strengthen linkages with FBOs, USAID missions, government agencies and other maternal and newborn health stakeholders to improve and scale up EMNC services provided by FBOs | • Organized November 2005 interfaith FBO Seminar in Washington DC on opportunities and challenges for providing MNC services through FBO networks<br>• FBO Strategy paper, FBO Advocacy Brochure and Technical Brief at review and editing stage.<br>• Established good contacts with mission in Tanzania and working on proposal to scale up FANC through the Christian Social Service Commission (CSSC) network.<br>• FANC Job Aid produced and distributed to all of the 256 health units affiliated with Uganda Protestant Medical Bureau (an outcome of FBO Workshop on strengthening FANC) to update facility –based providers in FANC.<br>• Conducted workshops on FANC, MIP and PMTCT, updating knowledge of 25 facility –based providers, 25 CORPS and held a mobilization meeting with 10 Religious Leaders in Kasese District of Uganda. Facility and Community Orientation Packages for FANC, MIP, PMTCT adapted, tested and are currently being reviewed and edited.<br>• Tanzania, Kenya and Uganda country teams (made up of FBO, MOH representatives) are implementing first quarter activities for FANC small grants they received. Three small grants—awarded to the Christian Health Association of Kenya (CHAK), Christian Social Services Commission (CSSC) of Tanzania, and Uganda Protestant Medical Bureau—of $14,000 each will enable 120 providers in these countries to provide more effective FANC and MIP services.<br>• ACCESS resources shared with approximately 50 FBO providers of maternal and newborn services.<br>• Completed FBO health assets assessment in India with the Christian Medical Association of India, Interchurch Medical Assistance's partner. IMA technical experts reviewing data before issuing report. |
| 1.2.b. | Support FBO action plans to provide quality maternal and newborn healthcare services in select countries | • FBO Health Assets Mapping in Tanzania will enable strengthening and expansion of maternal & newborn services by revealing gaps and strengths in the network of facilities and community programs<br>• Completed instruments and implementation process for mapping of FBO health assets in Tanzania. ACCESS-funded portion of data collection complete; additional data cleaning on-going. |
| **1.3** | **Improve health care financing schemes and policies to address economic barriers to utilization of maternal and newborn care services and better allocate resources** | • Draft literature review and framework to address financial and economic barriers and improve access and utilization of maternal health services for the poor completed.<br>• Implemented SMM in Ghana to support the country's strategic planning process while it is undergoing a |

| CORE ACTIVITY | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|
| | revision of its National Reproductive Health Strategy. Using the results of the SMM application, district-level meetings will be held to formulate advocacy plans for local governments to strategically seek funding for maternal and child health programs. |
| **1.4 Disseminate ACCESS Program materials and resources worldwide to advance knowledge of and programming in maternal and newborn health** | |
| 1.4.a. Develop outreach strategy for ACCESS materials to ensure they reach key stakeholders | • New materials during this period:<br>• Technical report “Home and Community-Based Health Care for Mothers and Newborns” complete<br>• KMC training manual completed; field testing begun.<br>• Community Mobilization for Maternal and Newborn Health facilitator’s guide completed; being adapted for field-testing in Nigeria and Bangladesh.<br>• Community Mobilization technical brief completed; being printed.<br>• Household-to-Hospital Continuum of Maternal and Newborn Care report translated into Spanish, French and Portuguese; dissemination in process.<br>• Guidelines for Assessment of Skilled Providers after Training in Maternal and Newborn Healthcare translated to French for global use;<br>• AMTSL web demonstration launched March 2006.<br>• “Preventing Mortality from PPH in Africa: Moving from Research to Practice” conference proceedings completed; being printed.<br>• Technical briefs on FANC, MIP, prevention of PPH, and essential newborn care completed; being designed and printed.<br>• Materials in process:<br>• FBO technical brief in development.<br>• WRA guide entitled "Building, Maintaining and Sustaining WRA National Alliances: A Field Guide” nearing completion.<br>• Training package and implementer’s guide on community-based use of misoprostol in the final stages of editing before dissemination.<br>• Article on community-based use of misoprostol in Indonesia submitted to the International Journal of |

| CORE ACTIVITY | | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|---|
| | | Gynecology and Obstetrics in January 2006; .<br>• Dissemination list developed and used for the release of all new ACCESS documents.<br>• ACCESS website downloads since its launch in October 2005 have increased monthly, including more than 3,000 downloads of the HHCC report. To date, the site has seen 6,727 unique visitors.<br>• ACCESS dissemination of materials at conferences and workshops: FBO workshop (8/05, Tanzania); WRA national secretariat workshop (12/05, India); Preventing Cervical Cancer in Low-Resource Settings: From Research to Practice (12/05, Bangkok); LAC Workshop on the Regional Strategy for Reduction of Neonatal Mortality and Morbidity (12/05, Guatemala); Preventing PPH conference (4/06, Uganda); African Union Ministers of Health Conference (9/06, Mozambique); WHO PPH meeting(10/06, Geneva); MotherNewBorNet (7/06, India); Goa PPH Conference (7/06, Goa); WHO Reproductive Health Task Force Meeting (10/06, Brazzaville); MotherNewBorNet market stall at Global Health Forum (10/06, Cairo); CORE meeting (10/06, DC); FBO Conference (10/06, India). |
| 1.4.b. | Develop e-learning courses to increase knowledge of new approaches, techniques and evidence-based safe motherhood programming information among USAID staff | • Completed two new USAID e-learning courses on Postpartum Care and Essential Newborn Care; both available online.<br>• A third course, entitled “Program Issues in Reducing Maternal Death and Disability” nearing completion; should be available November 2006. |
| **1.5** | **Award, administer and manage small grants to expand and scale up EMNC interventions** | • Obstetric fistula: see IR 5 (Four small grants awarded for obstetric fistula work).<br>• FBOs working on EMNC: Small grants mechanism process to support EMNC activities of several FBOs in Africa is under way: Country Teams from Tanzania, Malawi, Kenya and Uganda submitted their Small Grant proposals and based on initial feed back from technical team members are continuing to revise them. SEE LIST UNDER IR 1.<br>• PPH Grant RFA distributed at PPH Conference in April; ACCESS has proceeded to fund 7 of the PPH proposals received, representing 6 countries. SEE LIST UNDER IR 3.1. |
| **1.6** | **Provide technical assistance to strengthen maternal, newborn and women’s health services** | • No activity to report during this period. |
| **IR 2:** | **Preparation for childbirth improved** | |
| **2.1** | **Implement either a comprehensive approach or strategic elements of the Household-to-Hospital Continuum of Care in several ACCESS countries to increase utilization of quality EMNC services and improved EMNC practices within the household and community** | |

| CORE ACTIVITY | | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|---|
| 2.1.a. | Improve the quality of maternal and newborn health services (including EmOC, prevention of PPH, newborn care and postpartum care) in Cambodia | • Collaborated with USAID, MOH, and other local partners to conduct a technical workshop on maternal and newborn health in Cambodia.<br>• Collaborated with USAID and BASICS to prepare a report on accelerating the reduction of maternal and neonatal mortality in Cambodia.<br>• Participated in Cambodia Joint Annual Health Sector Review in March 2006 and prepared a draft proposal for ACCESS support to Cambodia for the period of April 2006–September 2008.<br>• ACCESS supported two Cambodian MOH staff to attend the second annual MotherNewBorNet meeting and the PPH conference held in India in July. |
| 2.1.b. | Field-test a state level intervention to reduce maternal and neonatal mortality and morbidity, based on guidelines for skilled birth attendance, in India | • Program design team traveled to India in July to work with CEDPA and the India MOH to plan for a program to field-test guidelines for skilled birth attendance.<br>• Team designed an operations research protocol including the key interventions to be implemented and how their impact will be assessed.<br>• Submitted protocol to USAID/Washington and USAID/India Proposal approved in September 2006. |
| **2.2** | **Contribute to global, regional and national knowledge of the Household-to-Hospital continuum of care to promote comprehensive programming for EMNC** | • HHCC report, Home and Community-Based Health Care for Mothers and Newborns paper, and Community Mobilization facilitator's guide and related technical brief: see IR 1.4 for dissemination. |
| 2.2.d | Improve technical leadership on maternal and infant nutrition in ACCESS programming | • Nutrition module for use in pre-service and in-service education developed.<br>• ACCESS held a state of the art seminar on maternal and neonatal nutrition in September 2006 for 50 US-based policy makers and program planners. |
| 2.2.e | Continue to enhance quality EMNC services by applying PQI and other QA work in EMNC | • Adapted approaches from JHPIEGO, Save the Children, and the Quality Assurance Project (QAP) to develop Performance and Quality Improvement Approaches for Use in Maternal and Newborn Health, a guide that describes current knowledge and application of approaches by international programs and aims to increase use of quality improvement to enhance health service delivery, supervision of services and capacity building of providers. Guide is in final review; ready for external review in October.<br>• Qualitative information is being gathered from relevant ACCESS programs to assess the effect of performance and quality improvement on maternal and newborn health care delivery in these programs. By December this information will be collated into a report with the goal of sharing common experiences, challenges, and lessons learned across ACCESS countries. It is hoped that this effort will establish an on-going dialogue among programs and underline the contribution of performance and quality improvement in |

| CORE ACTIVITY | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|
| | all aspects of programs.<br>• Existing training materials in process of being assessed, draft module on use of a PQI process to be completed for pre-test in regional pre-service training in Ghana. |
| **2.3 Provide technical assistance to one country in Africa to integrate PMTCT with EMNC and to strengthen newborn health strategy to enhance the opportunities to provide care to mothers and their newborns** | • This is yet to be planned. |
| **2.4 Provide leadership to the Malaria Action Coalition (MAC) to improve access to prevention of malaria in pregnancy services** | • 28 Nigerian RBM and RH program managers updated in PQI for FANC/MIP/PMTCT.<br>• FANC/MIP/PMTCT action plans developed for 15 Nigerian states.<br>• 114 Burkinabè service providers from 5 districts trained in FANC and MIP.<br>• 57 Burkinabè service providers evaluated in their clinical sites.<br>• Supervision visits conducted for providers at six health facilities in Rwanda.<br>• MIPESA best practices document developed and disseminated for policymakers, program planners and others.<br>• RAOPAG strategic plan for 2006-2010 developed.<br>• RAOPAG legal documents developed to enable the network to function as an independent entity.<br>• 27 participants from six African countries developed action plans to overcome barriers to collaboration among NMCP and national reproductive health divisions. |
| **2.5 Support an Insecticide Treated Nets Advisor in Mali to strengthen the National Malaria Network and Partnership for Prevention of Malaria in Pregnancy** | • Mali ITN distribution plan harmonized: free distribution of ITN to all children under 5 and pregnant women for 5 years (2006 to 2010).<br>• ITN and net re-impregnation data report form drafted and validated during the ITN distribution plan meeting.<br>• Created ITN and net re-impregnation distribution database.<br>• Drafted malaria control activities monitoring tool.<br>• Organized National Malaria Control Program partners' bimonthly meetings to exchange experiences, discuss progress of activities and obstacles in the ITN distribution. |

| CORE ACTIVITY | | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|---|
| **IR 3:** | **Safe delivery, postpartum care, and newborn health** | |
| **3.1** | **Contribute to the knowledge and expansion of prevention of postpartum hemorrhage in ACCESS countries** | • Planned and conducted "Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice" regional conference (4–7 April) in Entebbe, Uganda; more than 200 participants from over 20 African countries attended.<br>• Nineteen country teams from the PPH conference formulated action plans, which are being followed up. Eleven teams provided a briefing of the conference material to appropriate MOH officials, relevant professional associations, and appropriate reproductive health conferences in their countries. In Nigeria, one participant lectured 135 medical professionals on AMTSL. In Malawi and Tanzania, participants made progress incorporating AMTSL into the preservice midwifery curriculum, with a draft version of the midwifery curricula currently under review by the Malawian MOH. One participant from the Cameroon Baptist Convention Health Board persuaded his organization to commit to increase distribution of misoprostol and organize inservice trainings on AMTSL to 40 midwives, 20 doctors and 40 nurses from both faith-based health networks and government health facilities in four districts of Cameroon.<br>• Seven small grants aimed at prevention and treatment of PPH awarded in six countries: ASGOB, Madagascar; ASFM, Mali; OB/Gyn Society, Ethiopia; CBCO, Congo; RPMM/B, Burkina Faso; OHERS and CCBI, Kenya; FCI, Burkina Faso. Grants will be implemented through December 2007. |
| **IR 4:** | **Management of obstetric complications and sick newborns improved** | |
| **4.1** | **Building regional capacity in Africa in managing maternal and newborn complications to improve health outcomes of mothers and newborns** | • Assessments of midwifery pre-service education programs carried out in Ghana, Malawi, and Tanzania. The Ethiopia pre-service assessment will be completed by October 2006.<br>• Results of assessments presented in stakeholders meetings in Ghana, Malawi, and Tanzania. The Ethiopia stakeholders meeting will be carried out on 24 October 2006.<br>• EMNC Technical Update and Clinical Skills Standardization courses held in Accra, Ghana, May/June 2006 for 20 tutors from the 4 aforementioned countries and Nigeria.<br>• Follow-up of participants from the Ghana Technical Update and Clinical Skills Standardization Course carried out in Malawi and Tanzania. Ethiopia's follow-up will be completed by 15 October and Ghana's by the end of November 2006. |
| **4.2** | **Promote Kangaroo Mother Care for improved management of low birth weight babies** | • Final draft of the KMC training manual completed; being adapted for use in Nigeria and Nepal. |
| **4.3** | **Transfer lessons learned from research and program work on sick newborns and use this information to inform program work** | • Collaborating with Saving Newborn Lives to create a matrix of ongoing research for tracking global newborn research. |

| CORE ACTIVITY | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|
| | • Collaborate with SNL on sharing program learning on neonatal health. |
| **IR 5: Prevention and treatment of priority health problems of non-pregnant women of reproductive health age (Targets of Opportunity)** | |
| **5.1 Provide technical oversight and review of small grants for the prevention of obstetric fistula** | Activities conducted to support the four organizations that received fistula small grants:<br>**Uganda Private Midwives Association (UPMA Uganda)**<br>• Reviewed plans for training midwives in partograph for UPMA, Uganda; tools and recommendations provided for evaluation<br>• Identified 30 midwives from three districts for participation in one-day fistula workshop (included refresher on partograph and AMTSL) and to conduct subsequent community outreach<br>• Completed community mapping of 10 targeted communities<br>• Developed three cue cards for use during community outreach<br>• Completed 55 school outreaches by midwives, reaching 2,081 pupils<br>• Completed 27 community outreaches by midwives, reaching 605 women and 209 men<br>**Association of Safe Motherhood Promoters Nigeria (ASMOP)**<br>• Developed survey instrument<br>• Completed survey report to generate data on maternal morbidity and mortality in Ndieze and Mbalaukwu in Ebonyi State of Nigeria<br>• Trained 80 community members<br>• Distributed 1000 copies of IEC/BCC materials on prevention of obstetric fistulas<br>• Distributed 1000 copies of IEC/BCC materials on stigma and discrimination reduction<br>• Distributed 1000 copies of IEC/BCC materials on community involvement in safe motherhood<br>• Published three newspaper articles on fistula in Ebonyi State newspaper<br>• Broadcast to millions of people via cable television Abakaliki and Ebonyi State Broadcasting Station TV information on existing legislations, sections of the constitution of the federal republic of Nigeria and the child rights law that prohibit practices that infringe on the rights of women and girl child<br>• Broadcast to millions in Ebonyi State via cable television Abakaliki and Ebonyi State Broadcasting Station the findings of the panel discussion in two communities |

| CORE ACTIVITY | MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED |
|---|---|
| | • Conducted advocacy visits to selected religious leaders in Mbalaukwu and Ndieze communities<br>• Conducted advocacy visit to the traditional ruler of Ndieze community; His Royal Highness (HRH) Eze Thomas Elo<br>• Conducted advocacy visit to chairman Izzi local government area comrade Joseph Nwonumorah with 20 persons contacted including chairman, councilors, heads of department and social mobilization officer<br><br>**Teso Women for Development (TERREWODE Uganda)**<br>• Reviewed TBA training curriculum for The Association for Re-orientation and Rehabilitation of Teso Women for Development (TERREWODE, Uganda). Technical assistance provided in country by American College of Nurse-Midwives (ACNM) prior to the April PPH conference in Uganda.<br>• Broadcast two radio talk shows on fistula<br>• Identified and supported for repairs 12 women with fistula from Soroti district<br>• Developed and translated in Atesto 1,000 fistula sensitization posters<br>• Held two community meetings Dokolo and Amusia for 106 participants, including community leaders<br>• Mobilized five women with fistula to form a drama group in Gweri<br><br>**Ong Dimol (Niger)**<br>• Held March 2006 planning meeting with administrative authorities from Dept. of Tera<br>• Met in March 2006 with village chiefs and identified target groups within 17 villages; discussed project objectives, project duration, partners and expected results; agreed on letter of information and radio spot to be aired prior to caravan<br>• Conducted April 2006 caravan to 17 villages |

# ANNEX B: TANZANIA FANC/MIP STANDARDS-BASED QUALITY ASSURANCE ASSESSMENT RESULTS

## Tanzania Standards-Based Quality Assurance Assessment Scores for All 64 Facilities (Program Years 1 and 2)

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **1. KAGERA REG Hosp (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 6 | 2 | 4 | 2 | 4 | 18 |
| % Achieved | 32% | 50% | 80% | 23% | 45% | 39.1% |
| **KAGERA REG Hosp (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 4 | 5 | 4 | 5 | 29 |
| % Achieved | 58% | 100% | 100% | 45% | 56% | 63% |
| **KAGERA REG Hosp (2nd assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 2 | 4 | 3 | 5 | 21 |
| % Achieved | 37% | 50% | 80% | 33.3% | 56% | 46% |
| **2. MONDULI Hosp (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 2 | 0 | 3 | 0 | 6 | 11 |
| % Achieved | 11% | 0% | 60% | 0% | 67% | 23.9% |
| **MONDULI DH (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 2 | 4 | 5 | 6 | 28 |
| % Achieved | 58% | 50% | 80% | 56% | 67% | 60.9% |
| **3. ARUMERU HOSPITAL (Baseline)** | | | | | | |
| Observed Standards | 19 | 3 | 4 | 8 | 9 | 43 |
| Achieved Standards | 9 | 1 | 3 | 3 | 3 | 19 |
| % Achieved | 48% | 34% | 75% | 38% | 34% | 44.2% |
| **ARUMERU HOSPITAL (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| Achieved Standards | 7 | 3 | 4 | 4 | 8 | 26 |
| % Achieved | 37% | 75% | 75% | 45% | 89% | 56.5% |
| **ARUMERU HOSPITAL (2nd assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 6 | 3 | 4 | 4 | 6 | 23 |
| % Achieved | 67% | 75% | 75% | 45% | 67% | 50% |
| **ARUMERU HOSPITAL (3rd assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 2 | 4 | 6 | 6 | 25 |
| % Achieved | 37% | 50% | 75% | 67% | 67% | 54.3% |
| **4. MUHEZA DDH (Baseline)** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 5 | 2 | 3 | 5 | 7 | 22 |
| % Achieved | 28% | 50% | 60% | 56% | 78% | 49% |
| **MUHEZA DDH (1st Assessment)** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 11 | 3 | 3 | 6 | 8 | 31 |
| % Achieved | 61% | 75% | 60% | 67% | 89% | 69% |
| **MUHEZA DDH (2nd Assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 18 | 4 | 5 | 6 | 9 | 42 |
| % Achieved | 95% | 100% | 100% | 67% | 100% | 91.3 |
| **5. SAME DDH (Baseline)** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 8 | 1 | 3 | 4 | 5 | 21 |
| % Achieved | 47% | 25% | 60% | 45% | 56% | 47.7% |
| **SAME DDH (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 2 | 3 | 3 | 6 | 23 |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| % Achieved | 47% | 50% | 60% | 33.3% | 67% | 50% |
| **SAME DDH (2nd Assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 4 | 3 | 4 | 7 | 29 |
| % Achieved | 58% | 100% | 60% | 44% | 77% | 63% |
| **6. NEWALA DH (Baseline )** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 9 | 2 | 3 | 4 | 4 | 22 |
| % Achieved | 50% | 50% | 60% | 45% | 45% | 48.9% |
| **NEWALA DH (1st Assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 15 | 3 | 4 | 3 | 5 | 30 |
| % Achieved | 79% | 75% | 80% | 34% | 56% | 65% |
| **7. ST. CAMILLIUS DISP (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 0 | 2 | 3 | 3 | 15 |
| % Achieved | 37% | 0% | 40% | 33. 3% | 33.3% | 33.3% |
| **ST. CAMILLIUS DISP (1st Assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 12 | 1 | 4 | 4 | 5 | 26 |
| % Achieved | 63% | 25% | 80% | 44% | 56% | 57% |
| **8. ST. FRANCIS HOSP (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 1 | 2 | 1 | 5 | 16 |
| % Achieved | 37% | 25% | 40% | 12% | 56% | 35% |
| **ST. FRANCIS HOSP (2nd assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 10 | 3 | 3 | 4 | 6 | 26 |
| % Achieved | 53% | 75% | 60% | 44% | 67% | 56% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **9. MNAZI MMOJA HC (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 6 | 1 | 2 | 3 | 4 | 16 |
| % Achieved | 32% | 25% | 42% | 33.3% | 44.4% | 35% |
| **MNAZI MMOJA HC (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 3 | 3 | 3 | 5 | 27 |
| % Achieved | 68% | 75% | 60% | 33% | 56% | 63% |
| **10. ILEMBULA Hosp (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 2 | 0 | 3 | 0 | 7 | 12 |
| % Achieved | 11% | 0% | 60% | 0% | 78% | 26% |
| **ILEMBULA Hosp (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 10 | 0 | 4 | 2 | 7 | 23 |
| % Achieved | 53% | 0% | 80% | 22.2% | 78% | 50% |
| **11. KOROGWE DH (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 2 | 3 | 3 | 5 | 22 |
| % Achieved | 48% | 50% | 60% | 34% | 56% | 48% |
| **KOROGWE DH (1st Assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 4 | 5 | 6 | 7 | 35 |
| % Achieved | 68.4% | 100% | 100% | 67% | 78% | 76% |
| **12. BUGURUNI HC (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 1 | 2 | 5 | 6 | 23 |
| % Achieved | 48% | 75% | 42% | 56% | 67% | 50 |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **BUGURUNI HC (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 3 | 2 | 5 | 3 | 5 | 18 |
| % Achieved | 15% | 50% | 100% | 33% | 55% | 39% |
| **13. SELIAN ELTC HOSP (Baseline)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 1 | 3 | 3 | 8 | 26 |
| % Achieved | 58% | 25% | 60% | 34% | 89% | 57% |
| **SELIAN ELTC HOSP (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 16 | 3 | 4 | 7 | 8 | 38 |
| % Achieved | 84% | 75% | 80% | 78% | 89% | 83% |
| **14. PERAMIHO HOSP (Baseline)** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 7 | 1 | 2 | 4 | 4 | 18 |
| % Achieved | 39% | 25% | 40% | 45% | 45% | 40% |
| **PERAMIHO HOSP (1st assessment)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 17 | 3 | 4 | 8 | 7 | 39 |
| % Achieved | 90% | 75% | 75% | 75% | 78% | 85% |
| **15. NZEGA D HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 0 | 3 | 3 | 6 | 21 |
| % Achieved | 48% | 0% | 60% | 34% | 67% | 45.7 |
| **16. ILLOVO D HOSPITAL** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 10 | 1 | 4 | 3 | 8 | 26 |
| % Achieved | 59% | 25% | 80% | 34% | 89% | 59.1% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **17. CARD RUGAMBWA HOSP (UKONGA)** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 6 | 0 | 3 | 2 | 4 | 15 |
| % Achieved | 32% | 0% | 60% | 23% | 45% | 32.6% |
| **18. KILIMATINDE D HOSPITAL** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 2 | 3 | 2 | 6 | 22 |
| % Achieved | 50% | 50% | 60% | 23% | 67% | 48.9% |
| **19. BUNDA D HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 4 | 1 | 2 | 0 | 2 | 9 |
| % Achieved | 21% | 25% | 40% | 0% | 23% | 19.6% |
| **20. MVUMI HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 8 | 0 | 2 | 1 | 1 | 12 |
| % Achieved | 43% | 0% | 40% | 12% | 12% | 26% |
| **21. KILOSA HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 10 | 1 | 2 | 2 | 6 | 21 |
| % Achieved | 53% | 25% | 40% | 23% | 67% | 45.7% |
| **22. MAHENGE+ HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 2 | 5 | 7 | 7 | 32 |
| % Achieved | 58% | 50% | 100% | 78% | 78% | 69.6% |
| **23. NYAKAHANGA HOSPITAL** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 4 | 0 | 4 | 1 | 4 | 13 |
| % Achieved | 24% | 0% | 80% | 11% | 44% | 30% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **24. ISINGIRO HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 3 | 1 | 2 | 0 | 1 | 7 |
| % Achieved | 16% | 25% | 40% | 0% | 5% | 15% |
| **25. BUYEKERA DISPENSARY** | | | | | | |
| Observed Standards | 12 | 4 | 5 | 5 | 9 | 35 |
| Achieved Standards | 2 | 0 | 3 | 3 | 5 | 13 |
| % Achieved | 16.6% | 0% | 60% | 60% | 55.5% | 37.1% |
| **26. ZAMZAM DISPENSARY** | | | | | | |
| Observed Standards | 12 | 4 | 5 | 7 | 6 | 34 |
| Achieved Standards | 2 | 1 | 2 | 3 | 1 | 9 |
| % Achieved | 16.7% | 25% | 40% | 43% | 16.7% | 26.5% |
| **27. KASHAI RCH CLINIC** | | | | | | |
| Observed Standards | 13 | 4 | 5 | 7 | 5 | 34 |
| Achieved Standards | 3 | 2 | 4 | 3 | 1 | 13 |
| % Achieved | 23.0% | 50% | 80% | 42.8% | 20% | 38.2% |
| **28. BIHARAMULO DISTRICT HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 10 | 3 | 4 | 4 | 6 | 27 |
| % Achieved | 53% | 75% | 80% | 44.4% | 67% | 59% |
| **29. CHATO HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 2 | 2 | 4 | 3 | 24 |
| % Achieved | 58% | 50% | 40% | 44% | 33% | 52% |
| **30. NDOLAGE HOSPITAL** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 10 | 2 | 4 | 4 | 7 | 27 |
| % Achieved | 59% | 50% | 80% | 44.4% | 78% | 61.4% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **31. MURGWANZA HOSPITAL** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 12 | 2 | 5 | 4 | 6 | 29 |
| % Achieved | 67% | 50% | 100% | 44% | 67% | 64% |
| **32. KAGERA SUGAR HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 0 | 3 | 1 | 5 | 22 |
| % Achieved | 68% | 0% | 60% | 11% | 56% | 48% |
| **33. NGETA DISPENSARY** | | | | | | |
| Observed Standards | 17 | 4 | 4 | 8 | 5 | 38 |
| Achieved Standards | 7 | 2 | 2 | 2 | 4 | 17 |
| % Achieved | 41% | 50% | 50% | 25% | 80% | 45% |
| **34. TUMBI SPECIAL HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 12 | 2 | 3 | 2 | 8 | 27 |
| % Achieved | 6% | 5% | 6% | 22% | 89% | 58% |
| **35. BAGAMOYO DISTRICT HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 3 | 1 | 4 | 0 | 2 | 10 |
| % Achieved | 16% | 25% | 80% | 0% | 22% | 22% |
| **36. KILINDONI DISTRICT HOSPITAL** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 9 | 1 | 3 | 3 | 5 | 21 |
| % Achieved | 53% | 25% | 60% | 33% | 56% | 48% |
| **37. KIRONGWE DISPENSARY** | | | | | | |
| Observed Standards | 15 | 3 | 5 | 9 | 5 | 37 |
| Achieved Standards | 11 | 1 | 3 | 2 | 3 | 20 |
| % Achieved | 73% | 33% | 60% | 22% | 60% | 54% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **38. UTETE HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 5 | 0 | 4 | 3 | 5 | 17 |
| % Achieved | 26% | 0% | 80% | 33% | 55% | 36% |
| **39. KIBITI HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 8 | 1 | 2 | 2 | 1 | 14 |
| % Achieved | 42% | 25% | 40% | 22% | 11% | 30% |
| **40. MZENGA HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 1 | 1 | 1 | 3 | 2 | 8 |
| % Achieved | 5% | 25% | 20% | 33% | 22% | 17.3% |
| **41. BUNGU DISPENSARY** | | | | | | |
| Observed Standards | 15 | 4 | 5 | 8 | 9 | 41 |
| Achieved Standards | 5 | 2 | 3 | 3 | 5 | 18 |
| % Achieved | 33% | 50% | 60% | 38% | 56% | 44% |
| **42. MKOANI URBAN HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 2 | 2 | 2 | 4 | 19 |
| % Achieved | 47% | 50% | 40% | 22% | 44% | 41% |
| **43. KONGOWE DISPENSARY** | | | | | | |
| Observed Standards | 17 | 3 | 5 | 9 | 8 | 42 |
| Achieved Standards | 4 | 2 | 2 | 2 | 4 | 14 |
| % Achieved | 23.5% | 66% | 40% | 22.2% | 50% | 33.3% |
| **44. HOMBOZA DISPENSARY** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 8 | 1 | 4 | 0 | 2 | 15 |
| % Achieved | 42% | 25% | 80% | 0% | 22% | 32.6% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **45. MKAMBA HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 2 | 4 | 6 | 7 | 32 |
| % Achieved | 68.4% | 50% | 80% | 66.6% | 77% | 69.5% |
| **46. BALENI DISPENSARY** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 5 | 42 |
| Achieved Standards | 4 | 0 | 3 | 1 | 2 | 10 |
| % Achieved | 21% | 0% | 60% | 11% | 40% | 24% |
| **47. LUGOBA HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 13 | 1 | 1 | 0 | 2 | 17 |
| % Achieved | 68% | 25% | 20% | 0% | 22% | 37% |
| **48. MLANDIZI HC** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 4 | 1 | 3 | 0 | 5 | 13 |
| % Achieved | 21% | 25% | 60% | 0% | 56% | 28% |
| **49. MWENDAPOLE DISP** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 6 | 43 |
| Achieved Standards | 10 | 3 | 1 | 2 | 1 | 17 |
| % Achieved | 53% | 75% | 20% | 22% | 17% | 40% |
| **50. MANEROMANGO HC** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 3 | 3 | 1 | 4 | 18 |
| % Achieved | 37% | 75% | 60% | 11% | 44% | 39% |
| **51. IKWIRIRI HEALTH CENTRE** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 3 | 3 | 2 | 5 | 24 |
| % Achieved | 58% | 75% | 60% | 22% | 56% | 52% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **52. MCHUKWI MISSION HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 8 | 2 | 2 | 4 | 3 | 19 |
| % Achieved | 42% | 50% | 40% | 44% | 33% | 41% |
| **53. MOROGORO REG HOSP** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 11 | 0 | 3 | 3 | 5 | 22 |
| % Achieved | 58% | 0% | 60% | 33% | 56% | 48% |
| **54. BEREGE HOSP** | | | | | | |
| Observed Standards | 16 | 4 | 5 | 9 | 9 | 43 |
| Achieved Standards | 7 | 1 | 2 | 2 | 3 | 15 |
| % Achieved | 44% | 25% | 40% | 22.2% | 33.2% | 35% |
| **55. MCHUKWI MISSION HOSPITAL** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 9 | 1 | 2 | 2 | 6 | 20 |
| % Achieved | 47% | 25% | 40% | 22% | 67% | 44% |
| **56. TURIANI HOSP** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 16 | 4 | 5 | 3 | 9 | 37 |
| % Achieved | 84% | 100% | 100% | 34% | 100% | 80.4% |
| **57. MTIBWA HOSP** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 17 | 4 | 3 | 5 | 6 | 35 |
| % Achieved | 89% | 100% | 60% | 55% | 66% | 76% |
| **58. MAHENDE DH** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 10 | 2 | 5 | 6 | 6 | 29 |
| % Achieved | 53% | 50% | 100% | 67% | 67% | 63% |

| NAME OF FACILITY | FOCUSED ANTENATAL CARE | INFORMATION, EDUCATION AND COMMUNICATION | INFECTION PREVENTION | MANAGEMENT SYSTEMS | HUMAN, PHARMACY AND LABORATORY RESOURCES | TOTAL |
|---|---|---|---|---|---|---|
| **59. MAZIMBU HOSP (Baselie)** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 2 | 3 | 4 | 1 | 6 | 17 |
| % Achieved | 17% | 75% | 80% | 11% | 67% | 38% |
| **MAZIMBU HOSP (1st assessment)** | | | | | | |
| Observed Standards | 18 | 4 | 5 | 9 | 9 | 45 |
| Achieved Standards | 3 | 1 | 3 | 4 | 6 | 17 |
| % Achieved | 17% | 25% | 60% | 11% | 67% | 38% |
| **60. NGERENGERE HC** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 4 | 0 | 4 | 2 | 6 | 16 |
| % Achieved | 21% | 0% | 80% | 22% | 67% | 35% |
| **61. TAWA HC** | | | | | | |
| Observed Standards | 17 | 4 | 5 | 9 | 9 | 44 |
| Achieved Standards | 8 | 0 | 2 | 0 | 4 | 14 |
| % Achieved | 47% | 0% | 40% | 0% | 44% | 32% |
| **62. MAGOMENI H/C** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 8 | 1 | 2 | 4 | 4 | 19 |
| % Achieved | 42% | 25% | 40% | 44% | 44% | 41.3% |
| **63. MKURANGA DHOSP** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 6 | 0 | 2 | 1 | 3 | 12 |
| % Achieved | 32% | 0% | 40% | 11% | 33% | 26% |
| **64. MIONO HC** | | | | | | |
| Observed Standards | 19 | 4 | 5 | 9 | 9 | 46 |
| Achieved Standards | 7 | 1 | 3 | 0 | 4 | 15 |
| % Achieved | 37% | 75% | 60% | 0 | 45% | 33% |

# ANNEX C: ACCESS GLOBAL M&E FRAMEWORK WITH RESULTS

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **ACCESS Program Result**: Increased use and coverage of maternal/neonatal and women's health and nutrition interventions | | | | | | |
| **A.** Number of ACCESS countries demonstrating improvement in ACCESS target areas in the past year in indicators appropriate to areas of program activity as determined by country-specific M&E plan and budget agreed by USAID Mission<br><br>(collection is field-dependent) | • ACCESS countries will be identified on an annual basis according to funding levels and scopes of work. Countries with funding under $300K per year may be considered ACCESS countries if the SOWs are extensive enough, e.g., include activities under at least 4 ACCESS IRs.<br>• Indicators to track, appropriate to areas of program activity, will be determined from the final country M&E plans and budget agreed by USAID Mission, but potentially include:<br>• i. %/# of births attended by skilled attendants<br>• ii. %/# of mothers who report immediate and exclusive breastfeeding for last live birth<br>• iii.. %/# of ANC clients in malaria-endemic areas who receive IPT and appropriate counseling on ITN use during pregnancy and for newborns<br>• iv. %/# of ANC clients who receive appropriate HIV/AIDS counseling for PMTCT<br>• vi. %/# of mothers who receive antenatal iron folate<br>• The number will be calculated as an annual count of countries meeting the definition criteria. | Program records and country reports, population-based surveys by ACCESS, HMIS | M&E review of country-level M&E indicators<br><br>Annual | Program lead staff and M&E staff of ACCESS | Baseline: 0<br><br>*Target: selected ACCESS countries, including: Tanzania, Haiti, Nigeria, Bangladesh, Nepal* | 2: Tanzania and Haiti<br><br>Tanzania ANC clients with:<br>-IPT1=65%<br>-IPT2=44%<br>-iron=100%<br>-TT2=70%<br><br>Haiti:<br>-83% of ANC clients counseled about PMTCT<br><br>Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007. Nepal LBW intervention will begin in 2007. |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **B.** Number of ACCESS countries demonstrating improvement since the last survey in appropriate impact/outcome indicators collected by other mechanisms (e.g., DHS, MICS, RAMOS, SPA, and others)<br><br>(collection is field-dependent) | • ACCESS countries: see above.<br>• Indicators to track will be determined in conjunction with the country's USAID Mission considering planned data collection activities relevant to maternal, neonatal, and women's health and nutrition status and potentially include:<br>• i. % of births attended by skilled attendants (national)<br>• ii. % of mothers reporting breastfeeding within the first hour of birth for last child (national)<br>• iii. immunization coverage rates<br>• iv. ITN use rates for (a) population; (b) mothers/newborns<br>• v. % of facilities offering maternal/neonatal services that provide integrated PMTCT services<br>• The number will be calculated as an annual cumulative count of countries meeting the definition criteria. | National or other project data (e.g., DHS, MICS, etc.) | M&E collaboration with other organizations and USAID<br><br>Annual | M&E in collaboration with country USAID and other MNH stakeholders | Baseline: 0<br><br>*Target: selected ACCESS countries with relevant data that correspond with ACCESS intervention areas, incl.: Tanzania, Haiti, Nigeria and Bangladesh* | 1: Tanzania<br><br>Tanzania DHS 2004/2005 showed:<br>-52.1% of ANC clients received IPT1<br>-21.7% of ANC clients received IPT2<br>-32% of pregnant women slept under any mosquito net the previous night<br>-15.6% of pregnant women slept under an ITN the previous night |
| **C.** (Country-level) Estimated population of women of reproductive age living in communities or catchment areas of facilities targeted by ACCESS interventions | • The number of reproductive age women is the female population estimated to be between the ages of 15–49.<br>• Communities or catchment areas targeted by ACCESS will be determined at the country level.<br>• The number will be calculated as country totals *where appropriate and available* and a global total for all of the countries meeting the definition. | National census data, DHS data or other national sources as available | Program and M&E analysis and review of available national data per targeted areas<br><br>Semi-annual | Program lead staff and M&E staff of ACCESS | Baseline: 0<br><br>*Target: all ACCESS countries with relevant data* | 11,244.811 |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| • **ACCESS Program Intermediate Result 1**: Global leadership for maternal, neonatal, and women's health and nutrition program and policies strengthened | | | | | | |
| **1a.** Number of technical approaches and/or products being promoted for international use through ACCESS leadership roles | • Technical approaches and products include those advocated by USAID. Some may be strengthened by ACCESS prior to promotion while other approaches that are already proven will simply be promoted by ACCESS.<br>• Technical approaches and/or products strengthened by ACCESS are those where ACCESS review and improvement activities are reported to have been successfully completed.<br>• Promotion for use occurs through many venues: meetings, collaboration, alliances and partnership implementation. | Program reports and activity tracking | Program and M&E review of activity results per indicator criteria<br><br>Semi-annual | ACCESS technical staff and M&E | Baseline: 0<br><br>*Targets:*<br>*Year 1: 10*<br>*Year 2: 25* | 25+ |
| **1b**. Number of countries that implement and promote national policies, including service delivery guidelines, to increase access to high-quality maternal and neonatal health services | • Policies, including clinical care and service delivery guidelines, are national instructions meeting international evidence-based quality criteria related to ACCESS goals.<br>• Countries increasing access to high-quality EMNC services are those whose national leadership, MOH and/or others ensure dissemination of such standards in strategies that reach the point of service delivery and service providers. | Program reports and activity tracking | Program and M&E review of activity results per indicator criteria<br><br>Annual | ACCESS technical staff and M&E | Baseline: 0<br><br>*Targets:*<br>*Year 1: 4*<br>*Year 2: 4, Tanzania, Haiti, Nepal, Afghanistan* | 2 countries:<br><br>Tanzania – National Infection Prevention Guidelines<br><br>Haiti – National PMTCT guidelines |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **1c**. Number of international and/or national policies, including service delivery guidelines, revised and/or strengthened to promote access to and coverage of integrated EMNC services | • Policies and guidelines are international or national instructions to health system decision-makers (e.g., clinical service delivery points, managers, and service providers) meeting international evidence-based quality criteria related to ACCESS goals.<br>• Policies and guidelines promoting access to integrated EMNC services are those whose focus includes expanding availability or coverage of service delivery covering the ACCESS-recommended package of EMNC and other services.<br>• Revised or strengthened policies and guidelines are those where ACCESS review and improvement activities targeting EMNC service integration are reported to have been successfully completed. | Program reports and activity tracking | Program and M&E review of activity results per indicator criteria<br><br>Annual | ACCESS technical staff and M&E | Baseline: 0<br><br>*Targets:*<br>*Year1: 3*<br>*Year 2: 2*<br>*Afghanistan*<br>*Nigeria* | 2 national policies in 2 countries:<br><br>Nepal – National Skilled Birth Attendant policy<br><br>Afghanistan – National 5-year MNH Health Strategy |
| • **ACCESS Program Intermediate Result 2**: Preparation for childbirth improved | | | | | | |
| **2a.** Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved birth planning<br><br>(applicability is field-dependent) | • ACCESS-targeted communities are those identified social and geographic areas where program activities and alliances aim to enhance shared responsibility and collective action in birth preparedness/ complication readiness.<br>• Achievement of improved birth planning is defined as having fulfilled birth preparedness goals of the community's self-developed action plan.<br>• The number will be calculated as an annual count of targeted communities meeting the definition criteria. | Program reports and activity tracking | Program and M&E review of program reports<br><br>Annual | Program staff in-country with ACCESS M&E review | Baseline: 0<br><br>*Targets:*<br>*Year 1: 0*<br>*Year 2: 4 countries, Cameroon, Mauritania, Nigeria, Bangladesh*<br><br>*Number of communities TBD per final country workplans* | Kenya – 3 districts and 6 divisions<br><br>Cameroon – 1 department<br><br>Burkina – 1 district |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **2b.** Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received 2 tetanus toxoid (TT) injections<br><br>(applicability is field-dependent)<br><br>[Note: Tanzania definition:<br>Number of ANC clients with 2 doses of TT/Number of 1st visit ANC clients] | • This indicator will be reported by country only where ACCESS activities target TT as an area for improvement. Activities may target facilities, or home-based care.<br>• Percent of women delivering in facilities is according to facility records showing 2 TT injections having been given to the mother: Number of women's records that show a delivery in the past 6 months and 2 TT injections prior to that delivery (numerator)/ number of women's records that show a delivery in the past 6 months (denominator).<br>• Number delivering in communities will be calculated from home records if available (e.g., if the country uses cards the client keeps) or program records. | HMIS and/or home records | Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.<br><br>Annual | Program country staff with ACCESS M&E review | Baseline:<br>not known at country levels<br><br>*Targets:*<br>*Year 2:4 countries, Tanzania, Nigeria, Bangladesh, Cambodia*<br><br>*% TBD per final country workplans* | Tanzania – 70% (56 facilities) |
| **2c.** Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received iron/folate supplementation<br><br>(applicability is field-dependent)<br><br>[Note: Tanzania definition:<br>Number of ANC clients who received iron (alone)/Number of 1st visit ANC clients] | • This indicator will be reported by country only where ACCESS activities target iron/folate supplementation as an area for improvement. Activities may target facilities, or home-based care.<br>• Percent of women delivering in facilities will be calculated from facility records that show iron/folate supplementation having been given to the mother: Number of women's records that show a delivery in the past 6 months and iron/folate supplementation prior to that delivery / number of women's records that show a delivery in the past 6 months (numerator/denominator).<br>• Number of women delivering in communities will be calculated from home records if available (e.g., if the health system uses cards that the client keeps) or program records. | HMIS and/or home records | Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.<br><br>Annual | Program country staff with ACCESS M&E review | Baseline:<br>not known at country levels<br><br>*Target:*<br>*Year 2: 2 countries, Tanzania, Bangladesh*<br><br>*% TBD per final country workplans* | Tanzania – 167% (56 facilities. Figure exceeds 100% since iron is given to ANC revisit clients in addition to first visit clients) |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **2d.** Percent/number of women who gave birth in the past 6 months who received counseling/information/ materials for ITN use during pregnancy and with newborn<br><br>(applicability is field-dependent) | • This indicator will be reported by country only where ACCESS activities target ITN use for improvement.<br>• Women delivering in communities in the past 6 months will be identified through program records or if appropriate facility-based records.<br>• Delivery/receipt of counseling, information and/or materials (including vouchers) for ITN use will be determined from program records or if appropriate facility-based records.<br>• The number will be calculated as a semi-annual count of women meeting the definition criteria. | HMIS and/or home records | Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline: not known at country levels<br><br>*Target: Year 2: 1 country, Tanzania*<br><br>*% TBD per final country workplans* | Tanzania proxy indicator: 93% of ANC clients received ITN voucher (56 facilities) |
| 2e. Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 1st does of intermittent preventive treatment (IPT1) under direct observation<br><br>[Note: Madagascar used "all pregnancies" as the denominator for this indicator.] | • Calculation: Number of pregnant women who receive IPT1 under observation/ Number of 1st ANC visits<br>• This indicator will be reported by country only where ACCESS activities target IPT with sulfadoxine-pyrimethamine (SP) as an area for improvement.<br>• Receipt of IPT with SP will be determined from facility records.<br>• These indicators will be measured in malaria- endemic countries only. | HMIS | Availability records TBD in context of developing the country-level M&E plan.<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline: TBD country level<br><br>*Target: Year 2: 2 countries, Tanzania, Madagascar*<br><br>*%TBD per final country workplans* | Tanzania – 65% (56 facilities)<br><br>Madagascar – 48% (5 facilities) |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **2f.** Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 2nd dose of intermittent preventive treatment (IPT2) under direct observation<br><br>(applicability is field-dependent)<br><br>[Note: Madagascar used "all pregnancies" as the denominator for this indicator] | • Calculation: Number of pregnant women who receive IPT2 under observation/ Number of 1st ANC visits<br>• This indicator will be reported by country only where ACCESS activities target IPT with SP as an area for improvement.<br>• Receipt of IPT with SP will be determined from facility records.<br>• This indicator will be measured in malaria-endemic countries only. | HMIS | Availability records TBD in context of developing the country-level M&E plan.<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline:<br>TBD country level<br><br>*Target:*<br>*Year 2: 2 countries, Tanzania, Madagascar*<br><br>*%TBD per final country workplans* | Tanzania – 44% (56 facilities)<br><br>Madagascar – 40%<br>(5 facilities) |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **2g.** Number of antenatal care providers trained through ACCESS-supported curricula or events in focused antenatal care and/or prevention of maternal to child transmission<br><br>(applicability is field-dependent) | • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.<br>• Training that targets focused ANC and/or PMTCT is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills to provide evidence-based ANC and PMTCT (CT for HIV).<br>• Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues.<br>• Trained providers are those who complete a training course satisfactorily according to the course criteria.<br>• The number is a semi-annual count of providers meeting the definition criteria. | Training records | Compilation of totals from training records.<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline: 0<br><br>*Target:*<br>*Target:*<br>*Year 2: 4 countries, Tanzania, Haiti, Burkina Faso, Madagascar* | Haiti – 312 providers from 40 facilities trained in PMTCT:<br>• 90 physicians<br>• 218 nurses<br>• 2 auxiliary nurse-midwives<br>• 1 epidemiologist<br>• 1 social worker<br><br>Burkina – 114 providers in FANC/MIP<br><br>Madagascar – 14 trainers and 96 providers in FANC/MIP<br><br>Tanzania- 366 service providers,<br>90 trainers,<br>25 tutors and<br>33 preceptors.<br>for a total of 514 health workers FANC/MIP.<br><br>Nigeria –28 RBM and RH coordinators in FANC and PQI |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| 2h. Total number of pregnant women provided with PMTCT services at target facilities, including counseling and testing[14]<br><br>(applicability is field-dependent) | • Pregnant women include those attending ANC services and/or those delivering in the maternity at the PMTCT target facilities, as applicable to the country program.<br>• This indicator will be reported by country only where ACCESS activities target PMTCT as an area for improvement. | HMIS, Centers for Disease Control and Prevention (CDC) Global AIDS program database | Availability records TBD in context of developing the country-level M&E plan.<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline: 0<br><br>*Target:*<br>*Year 2: 1 country, Haiti*<br><br>*Number/% TBD per final country workplans* | Haiti – 10410 pregnant women were counseled and tested (12 facilities) |
| • **ACCESS Program Intermediate Result 3**: Safe delivery, postpartum care, and newborn health improved | | | | | | |

[14] PEPFAR indicator

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **3a**. Number of ACCESS-targeted facilities with PQI initiatives contributing to compliance with international standards | • ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches. | Program PQI records<br>PQI database | Records and document review<br><br>Semi-annual | Program technical staff with ACCESS M&E review | Baseline: 0<br><br>*Target:*<br>*Year 2: 3 countries, Haiti (PAC and PMTCT), Tanzania (FANC) Nigeria (EMONC)*<br><br>*Number of facilities TBD per final country workplans* | Haiti : 6 facilities have teams trained in PQI for PAC<br><br>Madagascar: 5 facilities conducted follow-up assessments in FANC/MIP this year. Baseline assessments were done in Year 1.<br><br>Tanzania: ANC staff at 64 facilities have been trained in PQI for FANC/MIP- 59 during this reporting period. All 64 facilities have conducted baseline assessments -- 59 during this reporting period. First followup assessments were completed by 15 facilities this year; second followup assessments were completed by four facilities; and a third followup assessment by one facility. |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **3b.** Percent/number of births in ACCESS-targeted facilities in the past 6 months that occurred with a skilled attendant using a partograph<br><br>(applicability is field-dependent) | • This indicator is reported by country only where ACCESS activities target correct use of a partograph as an area for MNH improvement.<br>• Women delivering in the past 6 months will be identified through facility records.<br>• Correct use of a partograph will be determined from facility records. Skilled attendants are those employed in skilled service provider categories according to the standards of the country.<br>• The percentage will be calculated by dividing the number of births recorded in the past 6 months that occur with a skilled attendant using a partograph (numerator) by the number of births recorded in the past 6 months (denominator). | Facility records, completed partographs | Records review<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: TBD country level<br><br>*Target: Year 2:3 countries, Cameroon, Mauritania, Nigeria*<br><br>*% TBD per final country workplans* | Not available Mauritania: Only 1 out of 10 facilities with providers trained in EmOC reported using the partograph regularly (documentation of its use was not available). The other 9 facilities reported a lack of copies of the partograph, largely due to lack of support from colleagues not trained in its use.<br><br>Nigeria- baseline study will be conducted by November 2006. |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **3d.** Percent/number of births in the past 6 months in ACCESS-targeted facilities/communities with active management of third stage of labor<br><br>(applicability is field-dependent) | • This indicator is reported by country only where ACCESS activities target AMTSL as an area for improvement, either in facilities, communities, or both.<br>• Births in the 6 months prior to data collection will be identified through facility records and/or program records at the community level.<br>• AMTSL is determined by information available in the records.<br>• For facility births, the percentage is calculated by dividing the number of births recorded in the past 6 months where AMTSL is recorded (numerator) by the number of births recorded in the past 6 months (denominator). For community or home births, the number is an annual count of the births in the 6 months prior to data collection meeting the definition criteria. | HMIS and/or program records where data are available | Records review, where data are available<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: TBD country level<br><br>*Target: Year 2: 1 country, Nigeria*<br><br>*%TBD per final country workplans* | Not available. Nigeria- baseline study will be conducted by November 2006. |
| **3e.** Percent/number of newborns in the past 6 months in ACCESS-targeted facilities or communities dried and warmed immediately after birth<br><br>(applicability is field-dependent) | • This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement.<br>• Newborns in the past 6 months are those whose births are recorded in the 6 months prior to data collection. Being dried and warmed immediately after birth is determined by information available in the records.<br>• This indicator is an annual count of newborns meeting the definition criteria. | Facility and/or program records if data are available | Records review, if data are available<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: country level TBD<br><br>*Target: Year 2: 2 countries, Bangladesh and Nigeria*<br><br>*% TBD per final country workplans* | Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007. |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **3f.** Percent/number of newborns in ACCESS-targeted facilities or communities that are breastfed within one hour of birth<br><br>(applicability is field-dependent) | • This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement.<br>• Breastfeeding within 1 hour of birth is determined by information available in the records or through exit interviews with new mothers at facilities or interviews with recent mothers in the community.<br>• This indicator is an annual count of newborns meeting the definition criteria. | Facility and/or program records if data are available<br><br>Client exit interviews<br><br>Community survey | Records review, if data are available<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: country level TBD<br><br>*Target: Year 2: 2 countries, Bangladesh and Nigeria*<br><br>*% TBD per final country workplans* | Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007. |
| **3g.** Percent/number of providers with adequate knowledge of essential newborn care | • This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement.<br>• Adequate knowledge will be determined. | Provider knowledge survey | Survey<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: country level TBD<br><br>*Target: Year 2: 5 countries, Nigeria, India, Cameroon, Mauritania, Nepal*<br><br>*Target=100% of trained providers* | Mauritania – 12 of 13 providers trained in EmOC surveyed scored 70% or higher. One scored 50%.<br><br>The Nigeria and India programs have not started yet. |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **3g.** Percent/number of women in ACCESS-targeted facilities or communities who accept a contraceptive method by 6 weeks postpartum[15]<br><br>(applicability is field-dependent) | • This indicator will be reported by country only where ACCESS activities target integrated family planning as an area for improvement.<br>• Women who accept a contraceptive method are those recorded in facility or community outreach records as receiving the contraceptives or a prescription for a method (if appropriate in context).<br>• The number is a semi-annual count of women recorded at ACCESS-targeted facilities or through community outreach as meeting the definition criteria. | Facility and/or program records | Records review<br><br>Semi-annual | Program country staff with ACCESS M&E review | Baseline: country level TBD<br><br>*Target: Year 2: TBD, depends on ACCESS-FP*<br><br>*% TBD per final country workplans* | Not Available. Depends on when/where ACCESS-FP can obtain buy in from USAID Missions. |
| 3h. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received a postpartum visit within 3 days after childbirth | • This indicator will be reported by country only where ACCESS activities target postpartum care as an area for improvement. Activities may target facilities, or home-based care.<br>• Percent of women delivering in facilities will be calculated from facility records that show the mother receiving postpartum care. Number of women's records that show a delivery in the past 6 months and postpartum care within 3 days/number of women's records that show a delivery in the past 6 months (numerator/denominator).<br>• Number of women delivering in communities will be calculated from home records if available (e.g., if the health system uses cards that the client keeps) or program records. | HMIS and/or home records or community survey | Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: not known at country levels<br><br>*Target: Year 2: 2 countries, Bangladesh, Nigeria*<br><br>*% TBD per final country workplans* | Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007. |

[15] This indicator will be collected through ACCESS-FP.

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| • **ACCESS Program Intermediate Result 4:** Management of obstetric complications and sick newborns improved | | | | | | |
| **4a.** Percent/number of women attending ACCESS-targeted facilities with eclampsia who appropriately receive magnesium sulfate<br><br>(applicability is field-dependent) | • This indicator will be reported by country only where ACCESS activities target facility-based eclampsia treatment as an area for improvement.<br>• Women with eclampsia attending targeted facilities are those recorded as presenting at the facility with clinical symptoms. Appropriate treatment with magnesium sulfate is determined according to the clinical record or aggregated records.<br>• The percentage is calculated by dividing the numerator (women recorded at ACCESS-targeted facilities with eclampsia and receiving magnesium sulfate) by the denominator (all women recorded at ACCESS-targeted facilities with eclampsia). | Facility records | Records review | Program technical staff with ACCESS M&E review | Baseline: TBD country level<br><br>*Target: Year 2: 1 country, Nigeria*<br><br>*% TBD per final country workplans* | Nigeria program has just started. Nigeria baseline study will be conducted by November 2006. |
| **4b.** Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in infant resuscitation<br><br>(applicability is field-dependent) | • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.<br>• Training that targets infant resuscitation is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills to treat infant asphyxia.<br>• Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues.<br>• Trained providers are those who complete a training course satisfactorily according to the course criteria.<br>• The number is a semi-annual count of providers meeting the definition criteria. | Training records | Compilation of totals from training records.<br><br>Semi-annual | ACCESS M&E | Baseline: 0<br><br>*Target: Year 2: Providers in 4 countries, Cameroon, Mauritania, Nigeria, Nepal* | Mauritania: 13 providers, 4 trainers<br>Niger: 4 trainers<br>Togo: 4 trainers<br>Cameroon: 20 providers, 4 trainers<br><br>Ghana: 4<br>Ethiopia: 4<br>Tanzania: 4<br>Malawi: 4<br>Nigeria: 4<br><br>Total: 69 |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| **4c.** Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in management of LBW newborns/KMC<br><br>(applicability is field-dependent) | • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.<br>• Training that targets KMC is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills related to management of LBW babies.<br>• Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues.<br>• Trained providers are those who complete a training course satisfactorily according to the course criteria.<br>• The number is a semi-annual count of providers meeting the definition criteria. | Training records | Compilation of totals from training records.<br><br>Semi-annual | ACCESS M&E | Baseline: 0<br><br>*Target: Year 2: Providers in 1 country, Nigeria* | Nigeria program has just started. Nigeria baseline study will be conducted by November2006. |
| **4d.** Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved complication readiness<br><br>(applicability is field-dependent) | • ACCESS-targeted communities are those identified social and geographic areas where program activities and alliances aim to enhance shared responsibility and collective action in birth preparedness/ complication readiness.<br>• Achievement of improved complication readiness is defined as having fulfilled complication readiness goals of the community's self-developed action plan.<br>• The number will be calculated as an annual count of targeted communities meeting the definition criteria. | Program reports and activity tracking | Program and M&E review of program reports<br><br>Annual | Program country staff with ACCESS M&E review | Baseline: 0<br><br>*Target: Year 2:Communities in 5 countries: Cameroon, Mauritania, Nigeria, Bangladesh, India* | Kenya – 3 districts and 6 divisions<br><br>Cameroon – one department |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|
| • **ACCESS Program Intermediate Result 5**: Prevention and treatment of priority health problems of non-pregnant women of reproductive age improved (Targets of Opportunity) | | | | | | |
| **5a.** Number of linkages with international obstetric fistula networks initiated and technical assistance provided | • International obstetric fistula networks are those organizations or groups of organizations who identify obstetric fistula as a key area of international concern and needed activism.<br>• Linkages are working relationships on identified tasks toward specified goals agreed between a network and ACCESS.<br>• Initiation of linkages is the agreement to develop such a working relationship, and the provision of technical assistance is the role ACCESS plays in the tasks to be pursued.<br>• The number will be an annual count of networks linking with ACCESS tasks, and a qualitative report of technical assistance may also be provided. | Program records | Records review | ACCESS M&E | Baseline: 0<br><br>*Targets:*<br>*Year 1: 4*<br>*Year 2: 1* | ACCESS is an active member of one international obstetric fistula network |

Note: This version of the ACCESS Global M&E framework reflects the modifications mutually agreed upon by ACCESS and USAID in January 2006.

# ANNEX D: COUNTRY AND REGIONAL INITIATIVE M&E FRAMEWORKS WITH RESULTS

## ACCESS/AFGHANISTAN MONITORING AND EVALUATION FRAMEWORK

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| **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 | Completed |
| AMA conducting productive Executive Board meetings | A productive meeting is one with a clear agenda and where business decisions are made. | AMA meeting minutes, program records | Annual | AMA staff | 3 annual meetings held; meeting procedures followed, minutes recorded |
| AMA continuing education guidelines developed | Yes/no measure | Continuing Education Guidelines, AMA records | One-time occurrence | AMA staff, ACNM | Not complete; integrated into SSP workplan |
| 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 | Complete; Action plan & BD implemented |
| Feasibility assessment of the Maternity Waiting Home in Badakhshan, Bamyan and Jawzjan completed and findings shared with stakeholders | Yes/no measure. The assessment will examine cultural appropriateness, funding, community contribution, relationship to the community midwife programs in the 3 provinces, etc. | Maternity Waiting Home Feasibility assessment report, program records | Semi-annual | JHPIEGO | Complete. Report complete; Guidelines in establishing MWH complete (English). |
| **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 | Completed |
| PPH reduction Ministerial Advisory Group established | Yes/no measure | ACCESS Program records | Annual | MOPH, JHPIEGO | Completed |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| 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) | Monthly | Local NGOs, JHPIEGO | 113 |
| Number of health care workers trained to supervise the provision of misoprostol by community-based workers | | Training Information Monitoring System (TIMS) | Monthly | Local NGOs, JHPIEGO | 9 |
| Number of pregnant women counseled on birth planning and provided with misoprostol through approved distribution channels | | Community health Worker logbook | Monthly | Community health worker<br>CHW Supervisor<br>Local NGOs | 515 |
| 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 health Worker logbook | Monthly | Community health worker<br>CHW Supervisor<br>Local NGOs | 115 |
| 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 health Worker logbook | Monthly | Community health worker<br>CHW Supervisor<br>Local NGOs | None |
| **USAID/Afghanistan/REACH I.R. 3.1.3: Strengthen government health systems** | | | | | |
| National Maternal and Newborn Health Strategy developed | Yes/no measure.<br>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<br>Futures Group | Achieved; strategy developed & endorsed by MOPH |
| Safe motherhood indicators defined and tracked quarterly | Part of the process to revise the national strategy is to define how progress will be measured and then track it. These indicators should be defined on/about December 2005. | MOPH records and data sources depending on how the indicators are defined | Quarterly in 2006 and beyond | MOPH, ACCESS field staff | Indictors selected by RH task force |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Maternal and Neonatal Program Index (MNPI) 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 follow-up | Futures Group | Report developed & disseminated |

## AFR/SD MONITORING AND EVALUATION FRAMEWORK

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| **PRIORITY 1: Support advocacy to mobilize resources and improve the policy environment for maternal and newborn care**<br>***AFR/SD Result: Increased resources for maternal and newborn health programs at the country level***<br>***AFR/SD Result: Improved strategies and plans for maternal and newborn care at the country level*** | | | | | |
| Number/% of target countries with facilitators trained in how to implement the Africa Road Map | Trained facilitators are those who attended an ACCESS-supported training event. | Program records/reports | Semi-annual | Trainers, ACCESS Program staff | 41 master trainers (8 Anglophone, 9 Francophone and 24 Lusophone) from 14 African countries have been trained to provide support and guidance for the implementation of the Road Map. |
| Number/% of target countries receiving ACCESS support to implement the Road Map | Technical assistance will be provided using ACCESS funds. | Program records/reports | Semi-annual | ACCESS Program staff | No countries are currently receiving ACCESS support to implement the Road Map. |
| Number of (target) countries with Africa Road Map plans for maternal and newborn health | A plan, or implementation guidelines, for the Africa Road Map has been developed and is in place in target countries. | Actual plan<br>Communication with trained facilitators | Semi-annual | AED/Berengere de Negri | 21 countries have developed Africa Road Map plans for MNH (not with direct ACCESS assistance) |
| **PRIORITY 2: Disseminate effective approaches to improve the quality of integrated MNH care**<br>***AFR/SD***<br>***Result: Improved quality of integrated essential maternal and newborn care*** | | | | | |
| Number/% of target countries integrating WHO IMPAC standards and guidelines into pre-service training curricula for nursing or midwifery schools | | Program records/reports<br>Update curricula | Semi-annual | ACCESS staff | ACCESS is promoting the integration of WHO IMPAC standards into pre-service training and curricula in 4 countries: Ghana, Malawi, Tanzania, and Ethiopia. |
| Number of tutors and clinical instructors trained in integrated EMNC | Trained individuals are those who were trained in EMNC through ACCESS-supported training events or by ACCESS-developed trainers. | TIMS | Semi-annual | Trainers, ACCESS Program staff | A training for a total of 19 tutors and clinical instructors was conducted in May 2006. Four of the participants were from Nigeria and supported by ACCESS/Nigeria funds |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number of target countries with core group of midwifery tutors able to train and develop midwifery curricula | These tutors and clinical instructors at pre-service midwifery education institutions are trained in integrated EMNC at ACCESS-supported training events. This will be addressed in Year 3. | TIMS | Semi-annual | Trainers, ACCESS Program staff | Tutors and clinical preceptors from 4 countries will be given skills to train and develop midwifery curricula in Year 3. |
| **PRIORITY 4: African regional and national capacity to implement programs**<br>***AFR/SD Result: African institutions actively engaged in supporting the implementation of the WHO/AFRO Road Map***<br>***AFR/SD Result: Linkages strengthened among African Institutions and networks to coordinate with each other and strengthen their leadership in MNH***<br>***AFR/SD Result: National-level capacity to implement safe motherhood programs improved*** | | | | | |
| Number of African facilitators trained in how to implement the Africa Road Map | Trained individuals are those who were trained in the Africa Road Map through ACCESS-supported training events or by ACCESS developed trainers. | Program records/reports | Semi-annual | Trainers, ACCESS Program staff | 41 |
| Number/percent of trained African facilitators in target countries supporting country road map planning | Supporting the country road map may include holding stakeholder meetings, advocating for safe motherhood initiatives at the national level, etc. Facilitators in a subset of countries will receive technical assistance and follow-up. | Program records/reports | One time measure | ACCESS Program staff | Followup data not available |
| Number/% of target countries with action plans for applying IMPAC guidelines in pre-service midwifery education and practice that have implemented at least one action item | Action plans will be created by EMNC training participants (midwifery tutors and clinical preceptors) at the end training. | Program records/reports | One time measure | ACCESS Program staff | Four countries: Ethiopia, Ghana, Tanzania and Malawi |
| Number of midwifery schools with trained tutors and clinical instructors for EMNC | Trained tutors and clinical instructors include those trained in EMNC through ACCESS-supported training events or by ACCESS-developed trainers. | TIMS | Semi-annual | Trainers, ACCESS Program staff | The 19 midwifery educators trained in May 2006 are from 12 midwifery schools, 5 teaching hospitals, and 2 MOH offices. (includes Nigeria which was not funded by AFR/SD) |

## ACCESS/HAITI MONITORING AND EVALUATION FRAMEWORK

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| **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 and Recognition (SBM-R) is a process for improving performance of health facilities promoted by JHPIEGO. It can be applied to multiple health areas. | Program records/reports | Annual | Program staff | 6<br>Completed in Y1 |
| 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.<br>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.<br>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 | Annual | Program staff | None – not part of Year 2 workplan. |
| 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 or Advanced Training Skills course for PAC OJT. | Training participant tracking sheets and training database | Annual | Program staff | 10<br>Completed in Y1 |
| Number /%of PAC target facilities that achieved at least 40% of PAC SBM-R standards at follow-up assessment | Numerator: Number of PAC target facilities trained in SBM-R for PAC that achieved at least 40% of the standards<br><br>Denominator: Total number of PAC target facilities trained in SBM-R for PAC | PAC SBM follow-up assessment | 6 months after training | PAC facility staff, Program staff | 0<br>(4 are completing SBM-R action plans. Follow up assessments will be completed at a later date.) |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| 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 | Annual | Program staff | 2 |
| Number/% of PAC clients at target facilities who received family planning counseling | Numerator: Number of PAC clients at PAC target facilities who received family planning counseling<br><br>Denominator: Total number of PAC clients at PAC target facilities | PAC registers, Monthly PAC monitoring form, PAC database | Quarterly | PAC facility staff, Program staff | 677/888=76.2% (8 facilities) |
| Number/% of PAC clients at target facilities who received a family planning method | Numerator: Number of PAC clients at PAC target facilities who received a family planning method<br><br>Denominator: Total number of PAC clients at the PAC target facilities | PAC registers, Monthly PAC monitoring form, PAC database | Quarterly | PAC facility staff, Program staff | 195/888=21.7% |
| Number/% of PAC clients at target facilities who were referred for a family method outside of the PAC service delivery area | Numerator: Number of PAC clients at PAC target facilities who were referred for a family planning method outside of the PAC service delivery area<br><br>Denominator: Total number of PAC clients at the PAC target facilities | PAC registers, Monthly PAC monitoring form, PAC database | Quarterly | PAC facility staff, Program staff | Only 2 of 8 PAC facilities reporting data this period reported on this indicator:<br>-67%<br>-3% |
| Number/% of PAC clients at target facilities who were referred for other reproductive health services | Numerator: Number of PAC clients at PAC target facilities who were referred for other reproductive health services<br><br>Denominator: Total number of PAC clients at the PAC target facilities | PAC registers, Monthly PAC monitoring form, PAC database | Quarterly | PAC facility staff, Program staff | Only 3 of 8 PAC facilities reporting data this period reported on this indicator:<br>-25%<br>-1%<br>-33% |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| **USAID/Haiti IR3: Reduced transmission of selected infectious diseases** | | | | | |
| ***Haiti ACCESS Program Result: Increased accessibility and use of PMTCT services.*** | | | | | |
| Total number of health workers newly trained or retrained in the provision of PMTCT services according to national or international standards | 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.<br>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.<br>The number will be calculated as an annual count of persons satisfactorily completing ACCESS PMTCT courses as recorded in program records. | Training participant tracking sheets and training database | Annual | Program staff | 312 providers from 40 facilities:<br>• 90 physicians<br>• 218 nurses<br>• 2 auxiliary nurse-midwives<br>• 1 epidemiologist<br>• 1 social worker |
| Total number of target service outlets providing the minimum package of PMTCT services according to national or international standards. | Number of target facilities providing the minimum package of PMTCT services according to national or international standards. Under the President's Emergency Plan for AIDS Relief (PEPFAR), the minimum package is defined as:<br>• counseling and testing for pregnant women<br>• ARV prophylaxis to prevent MTCT<br>• Counseling and support for safe infant feeding practices<br>• family planning counseling or referral | Program records/reports | Annual | Program staff | 12 |
| 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 | Quarterly | PMTCT facility staff, Program staff | 10410 pregnant women were counseled and tested (12 facilities) |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| % of antenatal care clients at target facilities tested for HIV/AIDS | Numerator: Number of ANC clients at the target facilities tested for HIV/AIDS<br><br>Denominator: Total number of ANC clients at the target facilities | ANC registers, VCT registers | Quarterly | PMTCT facility staff, Program staff | 72.7% of first visit ANC clients |
| 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 | Quarterly | PMTCT facility staff, Program staff | 445 (12 facilities) |
| Prevalence of HIV among PMTCT clients tested at target facilities | Numerator: Number of PMTCT clients at the target facilities tested for HIV/AIDS who tested positive<br><br>Denominator: Total number of PMTCT clients at the target facilities who were tested for HIV/AIDS | ANC registers, Maternity registers, CDC Global AIDS program database for Haiti | Quarterly | PMTCT facility staff, Program staff | 4.3% (12 facilities) |
| Number/% of antenatal clients at target facilities counseled about infant feeding options | Numerator: Number of antenatal clients at target facilities counseled about infant feeding options<br><br>Denominator: Number of all antenatal clients at target facilities | ANC register, ANC client record review | Quarterly | PMTCT facility staff, Program staff | NA – not collected. Not part of PMTCT register so indicator will be removed next year. |
| 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 | Quarterly | PMTCT facility staff, Program staff | 210 -- 63% of those enrolled in the PMTCT program (type of ARV not available) |
| 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 | Quarterly | PMTCT facility staff, Program staff | 85 (97%) |

| INDICATOR | DEFINITION/CALCULATION | DATA SOURCE/COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number/% of maternity clients at target facilities who accepted a family planning method postpartum | Numerator: Number of maternity clients at target facilities who accepted a family planning method postpartum<br><br>Denominator: Number of all maternity clients at target facilities | Maternity register, maternity client record review | Quarterly | PMTCT facility staff, Program staff | NA – not collected this period. Not part of PMTCT register so indicator will be removed next year. |

## ACCESS/KENYA MONITORING AND EVALUATION FRAMEWORK (* indicates a required PEPFAR indicator)

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| **USAID/ Kenya S.O. 3: Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning health services** | | | | | |
| **USAID/Kenya I.R.3.2: Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS** | | | | | |
| Total number of individuals who received a CT consultation at target facilities disaggregated by sex | CT consultations are those where clients received counseling about HIV and voluntary testing services | RHIS<br>Record review during support supervision visits | Semi-annual | CT Service providers, Kenya Program staff | N/A: USAID/Kenya did not ask ACCESS to report on this indicator and this indicator will be eliminated from the framework for next year. |
| Total number of individuals who received counseling and testing (at target facilities), disaggregated by sex* | | RHIS<br>Record review during support supervision visits | Semi-annual | CT service providers, Kenya Program staff | N/A: USAID/Kenya did not ask ACCESS to report on this indicator and this indicator will be eliminated from the framework for next year. |
| Total number of CT clients referred for ART | | RHIS<br>Record review during support supervision visits | Semi-annual | CT service providers, Kenya Program staff | Nairobi - 1575 clients ( 496 before training)<br>Eastern – 3285 clients ( 3284 before training) |
| Total number of individuals receiving ART treatment (at target facilities), disaggregated by sex, age and pregnancy status* | Ages are divided into 2 groups: 0–14 and 15 and older. | RHIS<br>Record review during support supervision visits | Semi-annual | ART service providers, Kenya Program staff | N/A: USAID/Kenya did not ask ACCESS to report on this indicator and this indicator will be eliminated from the framework for next year. |
| Number of **new** individuals with advanced HIV infection receiving ART* | This is a subset of the number of individuals with advanced HIV infection | RHIS<br>Record review during support | Semi-annual | ART service providers, Kenya Program staff | N/A: USAID/Kenya did not ask ACCESS to report on this indicator and this indicator will be eliminated from the framework for next year. |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| | receiving ART. Advanced HIV infection is defined as those HIV-infected persons with HIV-related conditions that most likely will result in death within 2 years if untreated (estimated at 15% of those currently infected). Ages are divided into 2 groups: 0–14 and 15 and older). | supervision visits | | | |
| Number of current clients receiving **continuous** ART for more than 12 months, disaggregated by sex, age and pregnancy status* | This is a subset of the number of individuals with advanced HIV infection receiving ART. Ages are divided into 2 groups: 0–14 and 15 and older. | RHIS<br>Record review during support supervision visits | Semi-annual | ART service providers, Kenya Program staff | N/A: USAID/Kenya did not ask ACCESS to report on this indicator and this indicator will be eliminated from the framework for next year. |
| **ACCESS Program Result: Strengthened provider and health system capacity to deliver quality CT services.** | | | | | |
| Total number of (target) service outlets providing counseling and testing according to national or international standards* | | Program records/reports | Semi-annual | Kenya Program staff | 63 sites established after CT orientation |
| Total number of individuals trained in counseling and testing according to national or international standards* | Trained individuals are those who were trained through ACCESS-supported training events or by ACCESS-developed trainers. Data will be disaggregated by job function (e.g., trainer, supervisor and provider). | Self-administered Training Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | 455 (including 41 trainers) |
| Number of trained service providers providing CT services at target sites | Trained service providers are those who were trained in CT through ACCESS-supported training events or by ACCESS-developed trainers. | Support Supervision Report,<br>TIMS | • During support supervision visit (once)<br>• End of project evaluation | Support Supervision Team, Kenya Program staff | It was difficult to collect this information as most sites lacked the HIV test kits to start the service but referred clients to TB and other centres offering testing. |
| **ACCESS Program Result: Strengthened provider and health system capacity to deliver quality ART services.** | | | | | |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number of trainers trained in clinical training skills | Trained trainers are those who were trained in clinical training skills through ACCESS-supported training events or by ACCESS-developed trainers. | Self-administered Training Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | 24 |
| Number of supervisors of ART services trained in supervision skills | Trained supervisors are those who were trained in supervision skills through ACCESS-supported training events or by ACCESS-developed trainers. | Self-administered Training Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | Not done due to funding constraints |
| Total number of health workers trained, according to national or international standards, in the provision of (ART) treatment* | Trained health workers are those who were trained in ART through ACCESS-supported training events or by ACCESS-developed trainers. Data will be disaggregated by job function (e.g., trainer, supervisor and provider). | Self-administered Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | 284 doctors, nurses, clinical officers, nutritionists<br>7 pharmacists |
| **USAID/Kenya I.R.3.3: Increased customer use of FP/RH/CS services** | | | | | |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number of family planning clients at target facilities | FP clients will be disaggregated by type of visit: new or returning. | RHIS | Semi-annual | FP service providers, Kenya Program staff | **DISTRICT**<br>**NEW 05 NEW 06 % change**<br>Homabay 1045 1129 8<br>Nakuru 1291 1959 51.7<br>Nyeri 1352 1525 12.8<br>Total 3688 4613 25.1<br><br>**REV05 REV06 %change**<br>Homabay 4433 5459 23.1<br>Nakuru 6504 6684 2.8<br>Nyeri 6891 7603 10.3<br>Total 17828 19746 10.8<br><br>**MIGORI**<br>**NEW REVISITS TOTAL**<br>May 133 521 654<br>June 152 423 575<br>July 101 398 499<br>386 1342 **1728**<br><br>Total number of family planning clients (new and revisits) in FY06: 4613+19746+1728=26,087 |
| **ACCESS Result: Strengthened provider and health system capacity to deliver quality FP services.** | | | | | |
| Total number of service providers trained in contraceptive technology and family planning counseling | Trained service providers are those who were trained in contraceptive technology and family planning counseling through ACCESS-supported training events or by ACCESS-developed trainers. Data will be disaggregated by cadre. | Self-administered Training Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | NAKURU: **50**<br>NYERI:**52**<br>HOMABAY: **51**<br>MIGORI**:26**<br>CLINICAL OFFICERS**:24**<br><br>Total of **203** service providers |
| Number of service providers trained in IP practices | Trained service providers are those who were trained in IP through ACCESS-supported training events or by ACCESS-developed trainers. Data will be disaggregated by cadre. | Self-administered Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | NAKURU: **50**<br>NYERI:**52**<br>HOMABAY: **51**<br>MIGORI**: 26**<br>CLINICAL OFFICERS**: 24**<br><br>Total of **203** service providers |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| % of trained service providers providing FP services according to standards | FP services include counseling and method provision. | Clinical observation checklist | During Support Supervision visits (once) | Support Supervision Team | **Over 70%** |
| % of trained service providers performing IP practices according to standards | | Clinical observation checklist | During Support Supervision visits (once) | Support Supervision Team | **Over 70%** |
| % of FP clients satisfied with FP services received | Compared with baseline | FP client exit interview | During Support Supervision visits (once) | Support Supervision Team | Baseline:**73**%<br>Endline:**76%** |
| % of trained service providers with adequate FP knowledge for counseling | Adequate knowledge to be determined | - FP knowledge survey | During Support Supervision visits (once) | Support Supervision Team | **Over 70%** |
| Number/% of target health facilities with functional IP committees | Committees meet on a regular basis and take action in the facility. | Interviews/ discussions with service providers<br>Support Supervision Report | During Support Supervision visits (once) | Support Supervision Team | **58** out of 77 facilities<br>25% |
| Number/% of service providers trained on the job by IP core training team | All service providers at the target facility | Interviews and discussions with service providers<br>Support Supervision Report<br>IP Core training team records<br>TIMS | During Support Supervision visits (once) | IP Core training team, Support Supervision Team | NAKURU: **500**<br>NYERI:**520**<br>HOMABAY: **560**<br>MIGORI**: 270** |
| Number of supervisors and administrators trained on supervision of health services | | Self-administered Participant Registration forms as part of TIMS | Immediately after training | Trainers, Kenya Program staff | **41** supervisors from Nakuru, Nyeri Homabay and Migori. |
| % of trained supervisors applying skills on the job | | Interviews and discussions with service providers<br>Supervisor skills assessment forms by colleagues<br>Support supervision | During Support Supervision visits (once) | Support Supervision Team | **10** out of 41 supervisors were followed and observed to be applying skills on the job |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| | | report | | | |
| **ACCESS Result: Increased informed demand and collective action for quality essential maternal and newborn care and family planning.** | | | | | |
| Communication strategy for Safe Motherhood and Malaria in Pregnancy developed | Yes/no measure | Review of communication strategy | Once time measure | Kenya program staff | N/A: Not included in final workplan for this year. |
| Materials to implement communication strategy developed and approved by MOH | Yes/no measure. Materials include: orientation packages, community leaflets and radio spots. | Materials inventory<br>Training/ orientation reports | After materials production | Kenya program staff | Community RH/MIP package developed in Year 1 for education and communication of community members.<br>[Note: ACCESS did not develop a communication strategy document.] |
| Number of advocacy meetings for Safe Motherhood and Malaria in Pregnancy held in target districts for key stakeholders | Advocacy meetings consist of gatherings of key stakeholders to discuss program, materials, methods, MOH priorities, etc. | Meeting reports | One time measure 3 months after program start up | Kenya Program staff | One meeting with 33 participants (representatives from the eight provincial reproductive health teams and district health management team members from the programme three districts -Makueni, Kwale and Bondo). |
| Number of key stakeholders at the district level who participated in advocacy meetings for Safe Motherhood and Malaria in Pregnancy | Key stakeholders include District Health Management Teams, Medical Officers of Health, District Public Health Nurses, etc. | Advocacy meeting reports | One time measure 3 months after program start up | Meeting Facilitators, Kenya Program staff | One meeting with 33 participants (representatives from the eight provincial reproductive health teams and district health management team members from the programme three districts -Makueni, Kwale and Bondo) |
| Number of community coordinators trained to mobilize communities in 3 districts. | Trained community coordinators are community leaders/leader-appointed, who participated in ACCESS-supported training events. | Self-administered Participant Registration forms as part of TIMS | Immediately after trainings | Trainers, Kenya Program staff | 171 CORPs were orientated to all aspects of community reproductive health with a special emphasis on malaria in pregnancy. |
| Number of community coordinators given additional technical assistance, materials, and support, in 3 districts | | Supportive supervision reports | During Support Supervision visits (once) | Support Supervision team | 171 CORPs were orientated to all aspects of community reproductive health with a special emphasis on malaria in pregnancy. |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLECTION METHOD | FREQUENCY OF DATA COLLECTION | RESPONS-IBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number of community members reached with messages about SMI and MIP, through community meetings, using orientation package | | Community meeting reports<br>Supportive supervision reports | Every 3-4 months | Support Supervision team | 900 expected--the assumption is that each of the trained COPRS on average reached five community members |
| Number/% of target communities that have developed action plans to improve SMI and MIP | | Supportive supervision reports | During Support Supervision visits (once) | Support Supervision team | 4 divisions (Usigu, Madiany, Rarieda, Nyagoma) in Bondo district<br>3 divisions (Wote & Kaiti, Mbooni) in Makueni district<br>4 divisions (Lunga Lunga, Msabweni & Kinango, Samburu) in Kwale district |
| Number/% of target communities with an action plan to improve SMI and MIP that have implemented at least one item on their plan | | Supportive supervision reports | During Support Supervision visits (once) | Support Supervision team | Data were not collected for this indicator. |
| Family planning community orientation package developed | Yes/No Measure | Review of orientation package materials | One time measure | Kenya Program staff | The Community RH/MIP package was developed by ACCESS with MAC funds in Year 1.The family planning component was developed by ACCESS using IBP funds. |
| Total number of community-owned resource persons (CORPs) trained | Trained CORPs are those who were trained in community mobilization through ACCESS-supported training events or by ACCESS-developed trainers. | Self-administered Participant Registration forms as part of TIMS | Immediately after training | | 171 CORPs were orientated to all aspects of community reproductive health with a special emphasis on malaria in pregnancy |

## ACCESS/NEPAL MONITORING AND EVALUATION FRAMEWORK

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | USE OF DATA | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|---|
| ***USAID/Nepal* Intermediate Result 2.2: Increased use of selected maternal and child health services.** | | | | | | | |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | USE OF DATA | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|---|
| Generic Skilled Birth Attendant (SBA) Learning Resource Package developed and tested and provided to HMG and key partners to be adapted and incorporated in curricula of various SBA | This generic SBA Learning Resource Package will accommodate the competencies and skills of Skilled Birth Attendants as defined by SBA policy of Nepal. | Program records<br><br>SBA Learning Package | Records review | ACCESS Nepal Program Manager and Program Officer (HR) | Baseline:<br>0<br><br>*Target:*<br>*1* | • Standardize skills set and training package<br>• -Provide a national standard to contribute to future activities | In process of development |
| Community Strategy to identify and manage Low Birth Weight (LBW) infants developed, tested and provided to HMG and NNTAC for incorporation in national protocols | The community model will identify LBWs for targeted home care by families and community workers and assist in referrals, if necessary. | LBW Community Strategy | Records review | ACCESS Nepal Program Manager and Program Officer (LBW) | Baseline:<br>0<br><br>*Target:*<br>*1* | • Review approaches to identify strengths and weaknesses to improve successes<br>• Guide resource allocation and contribute to effective planning for future activities | In process of development |
| Number of LBW infants identified and managed ,per protocol | Newborn infants who are less than 2.5 Kg will be identified in all Village Develop-ment Committees in Kanchanpur. Cared for LBW neonates at home and at community health facilities per protocol | Program records | Record review | ACCESS Program Manager and Program Officer (LBW) | Baseline: 0<br><br>*Target: TBD based on expected pregnancy and percentage of LBW* | • Determine effectiveness of community based LBW intervention and protocol | Implementation in Year 2 |

| INDICATOR | DEFINITIONS AND CALCULATION | DATA SOURCE | COLLECTION METHOD/ FREQUENCY | RESPONSIBLE PARTY | BASELINE (AND TARGET) | USE OF DATA | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|---|---|
| Guidelines developed for LBW infants to be included in the National Maternal and Neonatal standards and protocols | Based upon recommendations and information gained from relevant studies a National Guideline/ Protocol for LWB will be developed for use at all service delivery levels and these guidelines will be incorporated into national standards and protocols. | LBW Guidelines | Records review | ACCESS Nepal Program Manager and Program Officer (LBW) | Baseline:<br>0<br><br>*Target:*<br>*1* | • Contributes to National Standards and Protocols | Implementation in Year 2 |
| Study conducted to assess factors affecting skilled birth attendance and provide recommendations to HMG and other key stakeholders | Study will be conducted thorough review of successes and failures of projects and investigate the perceptions and needs of community and the service provides, and explore public-private partnerships and other factors affecting skilled birth attendance. | Program records<br><br>Study report | Records review | ACCESS Nepal Program Manager and Program Officer (LBW) | Baseline:<br>0<br><br>*Target:*<br>*1* | • Review approaches to identify strengths and weaknesses toward improving successes<br>• Guide resource allocation and contribute to effective planning for future activities | TOR in process of development |

## ACCESS/Tanzania Monitoring and Evaluation Framework

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| ***ACCESS Program Result: Partnerships initiated towards increasing community support for birth planning*** | | | | | |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Number of community groups that are aware of new evidence-based skills and practices for maternal and child health | • Community groups are organizations working to improve local conditions, e.g., the White Ribbon Alliance, FBOs, etc.<br>• Groups that agree to work with ACCESS will pursue increased knowledge of quality services through social mobilization, empowerment and collective action strategies.<br>• Evidence-based MCH skills and practices will be informed by technical assistance from the ACCESS Program, international standards and other stakeholders. | Program records<br>Records review to document community group activities | Annual | ACCESS, Muthoni Magu-Kariuki | • The White Ribbon Alliance-Tanzania (WRATZ) held a rally in Dar-es-Salaam to advocate for an increase of skilled attendance at birth to reduce the high maternal mortality rate in Tanzania. A total of 13 organizations attended the rally and are working with communities and include: JHPIEGO; CARE; Women Dignity; Policy project; Medical Women Association of Tanzania; Association of Gynecologists and Obstetricians of Tanzania; and Tanzania Midwives Association; Plan-Tanzania; Elizabeth Glaser Pediatric AIDS Foundation; UNICEF; WHO; BOT and IMA<br>• After the WRATZ Rally:<br>• CARE has been working with community groups in Mwanza and Manyara regions to educate communities on Safe Motherhood.<br>• WRATZ developed an Advocacy Package that appeals to the following bodies to act on the shortage of skilled staff in facilities: Members of Parliament, Civil Society/Private, Civil Servant Department (CSD), President's Office, Regional and Local Authority Government (PORAG), Ministry of Health, Development Partners, the President, Ministry of Finance, Ministry of Community Development Gender, and Children's Affairs, Family/Community and Individuals. The Advocacy Package was used in the October 06 meeting at Arusha by district, regional, zonal and national MOH&SW Policy Makers for group work in discussions on employing more skilled attendants.<br>• WRATZ held the Annual General Meeting for members on Sept 29, 2006. About 300 members from 17 regions attended.<br>• TV and radio have been broadcasting Safe Motherhood messages to the community. |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| ***USAID/Tanzania Result (Health IR2): Family level access to target services increased*** | | | | | |
| ***ACCESS Program Result: National pre-service/in-service curricula and actual practice (core competencies) reviewed/assessed*** | | | | | |
| Number of tutors, clinical preceptors, nurse-midwives who have been trained in the past year in focused ANC through ACCESS-supported training events | • Tutors, site preceptors, and nurse-midwives are defined according to local (Tanzania) categories of instructors and care providers.<br>• ACCESS-supported training events include ACCESS technical assistance, training materials and approved staff.<br>• Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.<br>• Data will be disaggregated by affiliation of trainees (e.g., public, FBO, private). | Training database and/or other training records | Compiled from training database raw data semi-annually | ACCESS, Muthoni Magu-Kariuki | In 2005/06 ACCESS trained:<br>201 service providers,<br>90 trainers<br>17 CEEMI trainers<br>25 tutors and<br>33 preceptors.<br>Thus a total of 363 health workers were trained in focused ANC. |
| Number of individuals trained in injection safety (PEPFAR) | ACCESS-supported training events include ACCESS technical assistance, training materials and approved staff.<br>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. | Training database and/or other training records | Compiled from training database raw data semi-annually | ACCESS, Muthoni Magu-Kariuki | 363 health workers were trained on 2005/06 on injection safety as part of the FANC and Infection Prevention and Control training |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/ communities who received 2 tetanus toxoid injections<br><br>**[Note updated indicator/definition** : # of ANC clients that received 2 TT injections/# of 1st visit ANC clients] | • This indicator will be reported for districts only where ACCESS activities target TT as an area for improvement. Activities may target facilities, or home-based care.<br>• Percent of women delivering in facilities is according to facility records showing 2 TT injections having been given to the mother: Number of women's records that show a delivery in the past 6 months and 2 TT injections prior to that delivery (numerator)/number of women's records that show a delivery in the past 6 months (denominator).<br>• Number delivering in communities will be calculated from home records if available (e.g., if the country uses cards the client keeps) or program records. | HMIS and/or SBM tools | Annual | ACCESS, Muthoni Magu-Kariuki | 70% (56 facilities reporting data) |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
|---|---|---|---|---|---|
| Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received iron/folate supplementation<br><br>**[Note updated indicator/definition**: # of ANC clients that received iron/# of 1st visit ANC clients] | 1. This indicator will be reported for districts only where ACCESS activities target iron/folate supplementation as an area for improvement. Activities may target facilities or home-based care.<br>2. Percent of women delivering in facilities will be calculated from facility records that show iron/folate supplementation having been given to the mother: Number of women's records that show a delivery in the past 6 months and iron/folate supplementation prior to that delivery/ number of women's records that show a delivery in the past 6 months (numerator/denominator).<br>3. Number of women delivering in communities will be calculated from home records if available (e.g., if the health system uses cards that the client keeps) or program records. | HMIS and/or SBM tools | Annual | ACCESS, Muthoni Magu-Kariuki | 58% of all ANC clients (56 facilities reporting data) |

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| Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 1st dose of intermittent preventative treatment (IPT1) under direct observation | • Calculation: Number of pregnant women who receive IPT1 under observation/Number of 1st ANC visits<br>• Receipt of IPT with SP will be determined from facility records. | HMIS | Semi-annual | Program country staff with ACCESS M&E review | 65% (56 facilities reporting data) |
| Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 2nd dose of intermittent preventative treatment (IPT2) under direct observation | • Calculation: Number of pregnant women who receive IPT2 under observation/Number of 1st ANC visits<br>• Receipt of IPT with SP will be determined from facility records. | HMIS | Semi-annual | Program country staff with ACCESS M&E review | 44% (56 facilities reporting) |

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
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| ***USAID/Tanzania Result (Health IR3): Sustainability reinforced for target health program*** | | | | | |
| ***ACCESS Program Result: National pre-service/in-service curricula and actual practice (core competencies) reviewed/assessed (improved)*** | | | | | |
| 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.<br>• Nurse-midwives are defined according to local (Tanzania) categories of care providers.<br>• Trained nurse-midwives are those who complete a focused ANC training event satisfactorily according to the criteria established for the course.<br>• 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.<br>• Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). | Program records including training database and/or other training records | Training records reviewed to compile relevant information annually<br>ACCESS | Muthoni Magu-Kariuki | • 356 facilities have at least one nurse midwife trained in 2005/06. (52 hospitals, 78 health centers, 226 dispensaries)<br><br>From Oct 2004 to Sept 2006 ACCESS trained service providers and trainers from 449 service delivery points:<br>• 378 government<br>• 71 FBOs (46 Hospitals, 14 health centers, and 11 dispensaries) |

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| Number of service delivery points providing integrated FANC and PMTCT services | • Service delivery points are medical facilities where clinical care is provided for clients.<br>• 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.<br>• The provision of integrated ANC and PMTCT services at ACCESS target sites will be determined through follow-up and supportive supervisory review.<br>• Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). | Program records<br>Records review to compile targeted SDPs that reach service provision goals | Annual | Muthoni Magu-Kariuki | 24 facilities with providers trained in Year 1 are still providing integrated services in Year 2. |
| Number of ACCESS-targeted facilities with PQI initiatives contributing to compliance with international standards | • ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches.<br>• Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). | Program PQI records review | Annual | Program technical staff with ACCESS M&E review | 64 facilities, including 39 hospitals, 14 health facilities, and 11 dispensaries, conducted baseline FANC/MIP PQI assessments. Fifteen facilities did a 1st follow-up assessment after the baseline, 4 did a 2nd assessment and 1 did a 3rd assessment. |

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| 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.<br>• Receiving national infection-prevention guidelines will be accomplished through advocacy meetings.<br>• The number of managers receiving the guidelines will be calculated from the program records concerning attendance at these meetings.<br>• Data will be disaggregated by affiliation of managers (e.g., public, FBO, private). | Program records | Summary information will be compiled at the end of the reporting year. | Muthoni Magu-Kariuki | The printing process for the simplified IP guidelines has started and they should be printed by December 06. Dissemination will be done soon after that. |

## ACCESS/USAID/WEST AFRICA MONITORING AND EVALUATION FRAMEWORK

| INDICATOR | DEFINITION/ CALCULATION | DATA SOURCE/ COLLEC-TION METHOD | FREQUENCY OF DATA COLLECTION | RESPONSIBLE PARTY | PROGRESS FOR OCT. 2005-SEPT. 2006 |
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| ***WARP IR 5.1 Improved approaches to FP/RH, STI/HIV/AIDS and child survival services disseminated region wide***<br>R 5.1.B Number of AWARE-supported applications of promising and best practices in FP/RH, STI/HIV/AIDS, CS & ID<br>***WARP IR 5.3 Increased capacity of regional institutions and networks***<br>***IR 5.3.A Number of AWARE-supported technical leadership institutions showing an improvement in institutional capacity*** | | | | | |
| ***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. | Training participant tracking sheets and training database<br>Training workshop summary reports | Annual | ACCESS consultant<br>ACCESS staff | 40 providers were trained in EMNC knowledge and skills: 20 in Mauritania and 20 in Cameroon |
| % of providers trained in ACCESS-supported EMNC training courses competent in key EMNC skills (AMSTL and at least one other skill) 23 months after EMNC training | Numerator: Number providers who completed an ACCESS-supported EMNC course who are competent in EMNC clinical skills 2 months after EMNC training<br><br>Denominator: Total number of providers who completed an ACCESS-supported EMNC course | Clinical observations during training follow-up site visits | 2-3 months after training | ACCESS consultant<br>ACCESS staff | • 13 providers trained in EMOC in Mauritania were followed up:<br>• 13 providers completed a partograph case study with an average score of 63% Note: Only 1 out of 10 sites with trained providers reported actually using the partograph.)<br>• 13 providers complete a postpartum hemorrhage case study with an average score of 86%<br>• 4 providers were observed performing normal labor and delivery (2 on patients, 2 on models) and all 4 were competent [Note: Several sites reported barriers to doing AMTSL, e.g., lack of support from untrained doctors. Oxytocin out of stock at one site]<br>• 4 providers were observed performing resuscitation of the newborn on an anatomic model. All 4 were competent.<br>• The remaining 27 providers have yet to be followed up. |

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| % of providers trained in ACCESS-supported EMNC training courses that have implemented at least 2 action items (including or in addition to AMSTL) | Numerator: Number of providers completed an ACCESS-supported EMNC course who have implemented at least 2 action items<br><br>Denominator: Total number of providers who completed an ACCESS-supported EMNC course | Review of service statistics and actual partographs during training follow-up site visits | 2–3 months after training | ACCESS consultant<br>ACCESS staff | Trainees at the EmONC training in Mauritania did not prepare action plans. |
| Number of trainers trained in clinical training skills for 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. | Training participant tracking sheets and training database<br>Training workshop summary reports | Annual | ACCESS consultant<br>ACCESS staff | • 16 providers were trained in clinical training skills and are currently candidate clinical trainers.<br>• 15 trainers were updated on conducting follow-up visits to trained providers. |

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| 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.<br>• Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.<br>• 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 Training workshop summary reports | Annual | Mwangaza Action ACCESS staff | 22 members of the Provincial Pool in Ngaoundere, Cameroon, were trained as social mobilization trainers |
| Number of trained Social Mobilization trainers reporting having conducted advocacy activities using auto diagnostic tools in the last 2-3 months | • Trained SMAs are ACCESS-trained advocates through the workshops in targeted countries.<br>• Auto-diagnostic tools are a key focus of the training. | Program records/ reports, completed auto-diagnostic tools | 2–3 months after training | Mwangaza Action ACCESS staff | All 22 social mobilization trainers from Ngaoundere reported conducting advocacy activities in a total of 18 villages. |