

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

ACCESS

YEAR TWO SEMI-ANNUAL REPORT

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TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS.....	III
I. INTRODUCTION.....	1
Spotlight on Major Results and Activities.....	1
New Horizons for ACCESS.....	3
II. PROGRAM RESULTS BY HIDN RESULTS PATHWAYS.....	6
A. Antenatal Care Results Pathway.....	6
B. Skilled Birth Attendant Results Pathway.....	11
C. Postpartum Hemorrhage Results Pathway.....	16
D. Newborn Results Pathway.....	17
III. PROGRAM COVERAGE.....	21
IV. CHALLENGES AND OPPORTUNITIES.....	24
Challenges.....	24
Opportunities.....	25
ANNEX A: ACCESS RESULTS FRAMEWORK LINKAGES WITH HIDN RESULTS PATHWAYS.....	26
ANNEX B: ACCESS CORE ACTIVITY MATRIX.....	27
ANNEX C: ACCESS GLOBAL M&E FRAMEWORK WITH RESULTS.....	32
ANNEX D: COUNTRY AND REGIONAL INITIATIVE M & E FRAMEWORKS WITH RESULTS.....	46
ACCESS/Afghanistan Monitoring and Evaluation Framework.....	46
AFR/SD Monitoring and Evaluation Framework.....	48
ACCESS Haiti Monitoring and Evaluation Framework.....	50
ACCESS Kenya Monitoring and Evaluation Framework.....	54
ACCESS Nepal Monitoring and Evaluation Framework.....	60
ACCESS Tanzania Monitoring and Evaluation Framework.....	62
ACCESS WARP Monitoring and Evaluation Framework.....	69

ABBREVIATIONS AND ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services
ACNM	American College of Nurse-Midwives
AED	Academy for Educational Development
AFRO	Regional Office for Africa
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
HB-PNC	Home Based Post Natal Care
HHCC	Household-to-Hospital Continuum of Care
HIDN	Health, Infectious Disease 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
LRP	Learning Resource Package
M&E	Monitoring and Evaluation
MAC	Malaria Action Coalition
MCH	Maternal and Child Health
MIJ	Maternity Isaie 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
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
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
SEARO	Regional Office for South-East Asia
SMA	Social Mobilization Advocacy
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
WARP	West Africa Regional Program
WHO	World Health Organization
WRA	White Ribbon Alliance

I. Introduction

This document presents an overview of key achievements of the Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS) Program over the period 1 October 2005–31 March 2006. Now in its second year of operation, ACCESS has evolved into a mature program and is proud to present global results in international leadership, capacity building, demand generation and service delivery in maternal and newborn health. This report identifies the challenges of the Program, the approaches and solutions for overcoming them, and the critical activities planned for the next period.

The narrative section of this document, entitled “Program Results by HIDN Results Pathways,” is structured around the four results pathways developed by the United States Agency for International Development’s (USAID’s) Office of Health, Infectious Disease and Nutrition (HIDN) that pertain to the ACCESS Program: 1) Antenatal Care; 2) Skilled Birth Attendance; 3) Postpartum Hemorrhage; 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, and complementary to, the ACCESS Program’s five intermediate results (IRs). (See Annex A for a graphic depiction of the linkages.)

In addition to the narrative presentation of results, this document also 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 B.

Spotlight on Major Results and Activities

ACCESS supports a groundbreaking PanAfrican conference to address maternal mortality

In April, ACCESS carried out the “Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice” conference in collaboration with the Prevention of Postpartum Hemorrhage Initiative (POPPHI), Regional Centre for the Quality of Health Care, and East, Central and Southern Africa Health Secretariat. Nearly 200 participants from 22 African countries and Canada, Denmark, Haiti, India and the US came to the 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 postpartum hemorrhage (PPH) in their settings. Proceedings from the conference will be documented and disseminated.

ACCESS champions national mobilization event to save women’s lives

On 25 March, ACCESS joined government officials, nongovernmental organization (NGO) workers, health care providers, families and individuals in Tanzania to show concern over the needless deaths of women and children in the country. The event, hosted by the White Ribbon Alliance (WRA)/Tanzania and supported by ACCESS, provided a platform for the Tanzanian Ministry of Health and Social Welfare to confirm its commitment to reducing maternal and neonatal morbidity and mortality. In attendance were retired Tanzanian President Ali Hassan Mwinyi, former First Lady Mama Mkapa, the Minister of Education, senior ministry of health and other government officials, USAID and other Safe Motherhood Cooperating Agencies. The challenge for the ACCESS

Program and the WRA is to maintain the level of excitement generated by the event among stakeholders to move these crucial issues from discussion into action.

ACCESS continues to increase access to quality maternal and newborn care services

ACCESS achieved other important results in the areas of global leadership, performance and quality improvement, capacity building and service delivery. In collaboration with the World Health Organization (WHO)/Geneva, ACCESS is developing a curriculum for front-line health providers on the prevention of mother-to-child transmission of HIV (PMTCT), and a guide for malaria in pregnancy. ACCESS has worked with WHO/Regional Office for South East-Asia (SEARO) on a regional workshop on maternal and newborn health, and with the Pan American Health Organization (PAHO) and USAID in Latin America to develop a regional neonatal health strategy. ACCESS staff have also collaborated with global and African technical leaders on the preparation of the Report on Opportunities for African Newborns.

In addition, ACCESS developed key global resources, including a companion facilitator's guide to the Johns Hopkins University Center for Communication Programs community mobilization training manual *How to mobilize communities for health and social change*. The guide aims to generate public and private sector dialogue to fuel effective, community-driven solutions to use for essential maternal and newborn care (EMNC) services. ACCESS developed a guide that describes the performance and quality improvement (PQI) process and its use for maternal and newborn health, and assisted in developing two new USAID-sponsored e-learning mini-courses in global health fundamentals for technical officers and program managers: Essential Newborn Care and Prevention of PPH. To teach health care workers at all levels how to care for low birth weight (LBW) babies, ACCESS completed a draft of a global training resource, a competency-based Kangaroo Mother Care (KMC) Training manual.

As a follow-on to the successful faith-based organization (FBO) workshop in Tanzania in August 2005, ACCESS and its FBO partners initiated a program to scale-up EMNC in Africa, enabling FBOs from Kenya, Malawi, Tanzania, Uganda and Zambia to strengthen and/or scale-up specific interventions in maternal and newborn health.

ACCESS support to Nepal and Afghanistan resulted in national policy initiatives in skilled birth attendance and maternal and newborn health, respectively. In Madagascar and Haiti, ACCESS-supported facilities demonstrated improved performance in focused antenatal care/malaria in pregnancy (FANC/MIP) during follow-up assessments as part of a quality improvement process. Haiti documented PMTCT services received at three facilities that recently established services with ACCESS support. Tanzania and Madagascar provided service delivery data on the provision of FANC/MIP services at six and five facilities, respectively, and Nepal recorded provision of misoprostol as part of a community-based PPH prevention program. In Mauritania, ACCESS built the capacity of clinicians to provide skilled attendance at birth. And in Haiti, ACCESS continued to build the capacity of clinicians to provide PMTCT services, while the Kenya program strengthened capacity of providers in counseling and testing (CT) and antiretroviral therapy (ART).

ACCESS improves capacity for implementing country programs

From 6–10 March, field staff from Burkina Faso/West Africa Regional Program (WARP), Kenya, Tanzania, Afghanistan and Indonesia joined US-based staff for an ACCESS staff retreat. The retreat provided the opportunity to share programmatic approaches in the field, discuss technical

innovations in maternal and newborn health, and introduce field staff to USAID as well as ACCESS partners in Baltimore and Washington, D.C. Evaluations showed that participants valued the program and technical updates, but many would have appreciated time to discuss strategic visioning or the next year's workplanning. In the end, the retreat generated positive energy through the mixing of field staff, US staff and ACCESS partners, which strengthened relationships and allowed for valuable knowledge sharing.

New Horizons for ACCESS

ACCESS launched new programmatic initiatives in Cambodia, India, Nigeria and Bangladesh over the past six months. A new Associate Award under the ACCESS Program, ACCESS-FP, also commenced activities during this time, and a draft proposal for a second associate award for Afghanistan was prepared. A brief description of each is provided below.

Cambodia

In October 2005, ACCESS and Basic Support for Institutionalizing Child Survival (BASICS) collaborated with the Ministry of Health (MOH) and other partners (USAID, WHO, United Nations Population Fund [UNFPA], United Nations Children's Fund [UNICEF], PATH, Reproductive and Child Health Alliance, Partners for Development, University Research Corporation, Reproductive Health Association of Cambodia, CARE, MEDiCAM) 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 recommendations 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 a program that would be carried out in collaboration with the appropriate USAID/Cambodia local partners. The ACCESS Program will include activities to support policy and program work aimed at increasing the number and skills of skilled birth attendants at the facility and community levels, as well as the introduction and scale-up of community-based interventions for maternal and newborn health.

The next step is for USAID/Cambodia to approve the basic elements of the program. ACCESS will then develop a preliminary work plan and budget, including a long-term technical advisor for maternal and newborn health, technical assistance to strengthen the prevention of PPH, and initial planning to improve midwifery skills in the country.

India

ACCESS received a proposal from CEDPA/WRA in January 2006 to work in a state of India to field-test interventions to reduce maternal and neonatal mortality and morbidity based on the guidelines for skilled attendance at birth developed in 2005 as part of India's Reproductive and Child Health II Program. ACCESS worked with CEDPA in February 2006 to further refine the proposal, and obtain USAID approval and approval from officials in Jharkhand, India. Currently, ACCESS and CEDPA are planning a team visit to the selected district State of Dumka in Jharkhand to field-test the revised Reproductive and Child Health II guidelines.

This program entails a focus on skilled birth attendant training, especially for the new elements included in the guidelines, mobilization for behavior change at the community level, and an

enhanced focus on newborn care. The program will be implemented as an operations research project and results from a control district will be compared against those achieved in the interventions area, Dumka.

Nigeria

During this reporting period, ACCESS also received confirmation that USAID/Nigeria has provided funding for a program to improve emergency obstetric and newborn care (EmONC). To date, \$1 million have been received, though the Mission has reportedly obligated \$2 million. In January 2006, an ACCESS team participated in a federal MOH-led stakeholders meeting to clarify efforts to date and define the needs in EmONC. As a result of this visit and briefings regarding the household-to-hospital continuum of care (HHCC) for maternal and newborn health, a concept paper was drafted and is currently under review by the Mission for a three-year, roughly \$6 million program in two northern states in Nigeria. ACCESS will apply the HHCC model in this program. In mid-April, a second team visited with state-level stakeholders to further clarify the scope and sites for ACCESS interventions.

Bangladesh

USAID/Bangladesh is supporting the establishment of a Safe Motherhood and Newborn Care Program in the Sylhet Division of Bangladesh under the Mission's Strategic Objective (SO) for its Population, Health and Nutrition Program. The long-term goal of this activity is to improve maternal and neonatal outcomes. Achievement of this goal will contribute to the SO for USAID's population and health program, which is to reduce fertility and improve family health. Therefore, the overall objective of this activity is to increase the practice of healthy maternal and neonatal behaviors in a sustainable and potentially scalable manner. The ACCESS/Bangladesh program, approved by USAID in February, is a three-year program with the potential for two additional years, and is aimed at increasing the practice of healthy maternal and neonatal behaviors at scale and in a sustainable manner in Sylhet District. The initial program planning would cover four upazillas covering a total population of ~987,000 to ~1,084,000. Discussion is under way with the Mission to cover an additional three upazillas.

Save the Children/Bangladesh will be responsible for implementation of the program and will work with local partners—Shimantik, International Centre for Diarrhoeal Disease Research, Bangladesh, and perhaps one other NGO—to implement the program. The ACCESS Program Manager has been hired, other key staff are currently being recruited, and a project office in Sylhet District has been established. The initial planning workshops for the program will take place in July 2006.

ACCESS-FP

Focusing primarily on meeting the family planning/reproductive health needs of women in the postpartum period, the ACCESS-FP program seeks to reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. ACCESS-FP was designed by the Population and Reproductive Health Office as a centrally-funded associate award into the ACCESS-LEAD program, and its interventions are designed to complement those of the ACCESS-LEAD Program. This includes the promotion and scale-up of postpartum family planning through community and clinical approaches suitable for low-resource settings. Currently, ACCESS-FP is exploring opportunities in Haiti, Kenya, Bangladesh and Nigeria.

Afghanistan-SSP

ACCESS prepared a first draft of a proposal, submitted to USAID/Afghanistan, for an Associate Cooperative Agreement to support Service Delivery and Quality of basic Services in Afghanistan. The proposed program - the Service Support Project (SSP) - will last for a period of five years. The proposal outlined a strategy for the provision of technical assistance and implementation support to nongovernmental organizations (NGOs) to improve the planning, management, implementation and monitoring of the delivery of quality Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) in 13 provinces in Afghanistan. The Project should begin in July 2006.

II. Program Results by HIDN Results Pathways

A. Antenatal Care Results Pathway

CORE-FUNDED RESULTS

During this period, ACCESS worked with FBO partners to scale up EMNC through local FBOs in Africa. 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 three countries have already submitted EMNC proposals. Another outcome of this workshop was the production and distribution of a FANC job aid to all 256 health units affiliated with the Uganda Protestant Medical Bureau.

ACCESS has prepared technical briefs on focused *antenatal care*, malaria in pregnancy and essential newborn care, which present evidence-based approaches for strengthening antenatal care (ANC) programs. To complement the community mobilization training manual *How to mobilize communities for health and social change* developed by The Johns Hopkins University Center for Communication Programs, ACCESS developed a companion facilitator's guide. The two documents will assist country programs to improve 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*, 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.

In malaria work, ACCESS collaborated with Malaria Action Coalition (MAC) partners to develop the Malaria in Pregnancy Implementation Guide, which will serve as a tool for countries to initiate the implementation process or to strengthen the existing implementation process for MIP prevention and control. ACCESS also worked with WHO to finalize the Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition documentation of best practices and lessons learned, which will be printed and disseminated throughout the MIPESA region and to other countries in an effort to share these experiences broadly and influence country scale-up. In addition, ACCESS 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 continues to support regional networks like the East and Southern Africa Roll Back Malaria Network and the West Africa Regional Network. ACCESS/JHPIEGO continues to participate in the Roll Back Malaria (RBM) Malaria in Pregnancy Working Group and serves as the Secretariat for this working group. ACCESS also helped develop and provided input to the final RBM MIP monitoring and evaluation (M&E) framework and report, which will be disseminated by WHO and RBM partners in the near future.

ACCESS is conducting a policy study on the economic barriers to utilization of maternal and newborn health services. The first step is to develop an economic framework to identify effective interventions to address economic barriers. Review of the published and unpublished literature is currently being conducted. The framework will also list the conditions under which successful interventions are most appropriate in maternal and newborn health care settings. The results of this

project will improve utilization of *antenatal care, delivery and newborn care* by decreasing the barriers to access to care. This in turn will increase the number of women who deliver with a skilled birth attendant present. Planning of the project has resulted in a potential leveraging of ACCESS's profile in this arena of work. Discussions with researchers from MEASURE and the follow on to the Policy II Project, who are also examining the issue of equity in family planning and reproductive health, have created an opportunity for cross-project learning and coordination of research so that results from each of the projects can be somewhat comparable.

In Burkina Faso, ACCESS, in collaboration with the National Malaria Control Program and Division of Reproductive Health, adapted MIP training materials for service providers in Burkina Faso. Twenty-seven service providers from 21 facilities have been trained in FANC and MIP.

FIELD SUPPORT-FUNDED RESULTS

Tanzania

In Tanzania, ACCESS is establishing FANC as part of routine MCH services through in-service and pre-service training and quality improvement interventions. With respect to capacity-building interventions, during the past six months ACCESS trained 10 trainers from the Center for the Enhancement of Effective Malaria Interventions to update their training skills. These trainers are engaged in the process of training a cadre of District Malaria/Integrated Management of Childhood Illness Focal Persons who will work to help implement malaria interventions at the community level.

ACCESS facilitated site assessments using the Standards-Based Management and Recognition (SBM-R) quality improvement approach using an assessment tool with 46 operational performance standards for quality FANC/MIP services, including such areas as FANC, information, education and communication, infection prevention (IP), management systems, and human, pharmacy and laboratory resources. To date, ACCESS has facilitated baseline SBM-R assessments in 13 facilities (six during this reporting period), and supported the completion of second assessments in two facilities: Arumeru Hospital and Peramiho Hospital (both in the last six months). Performance scores are presented in Table 1 below.

Table 1: Tanzania FANC/MIP Baseline and Follow-up Assessment Scores

FACILITY	BASELINE RESULTS	SECOND ASSESSMENT RESULTS
Arumeru District Hospital	44%	91%
Peramiho Hospital (FBO)	40%	84.7%
Muheza Designated Dist. Hospital (FBO)	55%	
Kagera Regional Hospital	47%	
St. Francis – Ifakara Dist. Hospital (FBO)	24%	
Sikonge Designated Dist. Hospital (FBO)	24%	
Ikonda Hospital (FBO)	51%	
Huruma Hospital	63%	
Ilembula Lutheran Hospital (FBO)	26%	
Hai District Hospital	15%	
Monduli Hospital	24%	
Selian Hospital	59%	

Bulogwa Hospital	22%	
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Tremendous improvements were found in both Arumeru Hospital and Peramiho Hospital during the second assessment, with both facilities achieving over 80% of the total standards, the target percentage for quality services. Through the process of identifying the gaps in the quality of their performance, each facility was able to make small changes that vastly improved the FANC/MIP services they offered. For example, in Arumeru, a few IP techniques were improved such as the use of paper towels, the appropriate storage of cleaning materials, and the 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. However, in both facilities, more difficult gaps remain that are a challenge to continued success, such as the inability to conduct laboratory work at the ANC clinic—all samples need to be sent to the main hospital. This can hinder the routine use of lab tests for every woman coming for ANC. Each facility has the SBM-R tool and can follow their action plans for continued success with other issues.

Six facilities in Tanzania reported FANC/MIP services statistics, including intermittent preventive treatment (IPT) uptake, for this reporting period. See Table 2 below:

Table 2: FANC/MIP Service Statistics for ACCESS Tanzania (October 2005–March 2006)

INDICATOR	NUMBER OF ANC CLIENTS	PERCENT OF 1ST VISIT ANC CLIENTS
IPT 1	1252	67%*
IPT 2	1043	56%
Tetanus Toxoid (2 doses)	859	46%**
Iron	1753	94%

* One facility had a stockout of sulfadoxine-pyrimethamine (SP) for the entire period.

**Two facilities did not record iron distribution in their logbooks and are therefore averaged in as 0. The percentage is still very high since some facilities give iron to both 1st ANC visit clients and return clients.

ACCESS worked with key MOH 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 FY05, into an “Infection Prevention pocket guide” during a four-day workshop held in March. The document has been reviewed and will be printed in English and translated into Swahili.

Finally, the WRA held a successful and well-attended rally on Safe Motherhood. Commitments were made by the MOH as well as other organizations to address issues surrounding safe motherhood. For example, the MOH committed to looking into acquiring new staff and Aga Khan University School of Nursing pledged to revise their curriculum to include Life Saving Skills.

Madagascar

The quality of FANC/MIP services at the five model MIP facilities supported by the ACCESS Program in the Tamatave Province 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. Scores for each facility’s baseline (July 2005) and follow-up (December 2005) assessments are provided in Figure 1 below.

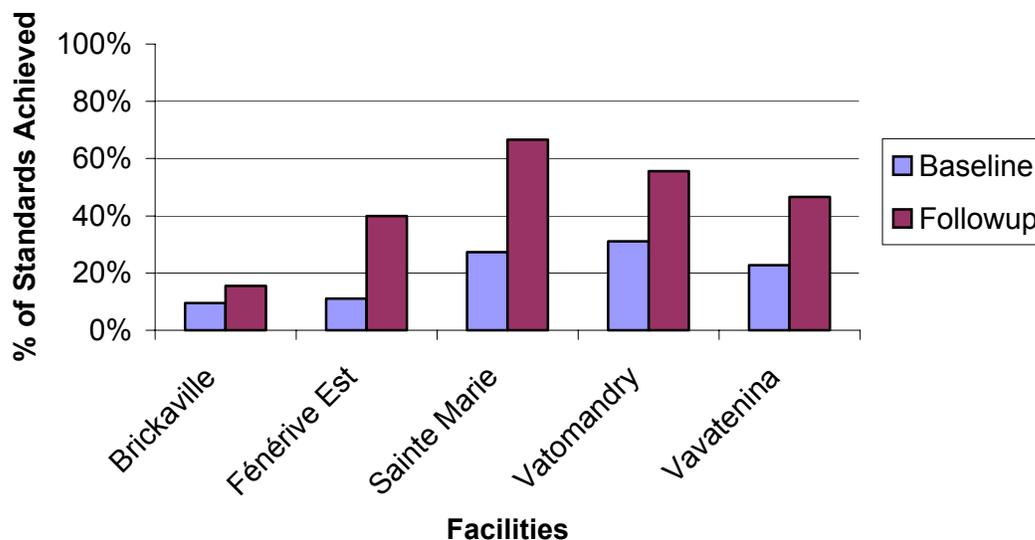


Figure 1: Madagascar FANC/MIP Baseline and Follow-up Assessments (July '05–Dec. '05)

In 2005, these five facilities averaged approximately 48% coverage for IPT1 and 40% coverage for IPT2 using the denominator of total number of pregnancies in the year. 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.

In January, ACCESS assisted the MOH/FP and WHO to develop a MIP implementation guide and to revise the MIP training materials to take into account Madagascar’s new malaria case management policy for pregnant women. The MIP learning resource package is now in the final review stage with ACCESS and will be ready for utilization in May.

Kenya

ACCESS, in collaboration with the MOH, sensitized 33 provincial health team members and district health personnel around emerging issues in malaria in pregnancy and concerns in reproductive health at a “reinvigoration” meeting. Eight provincial reproductive health teams and personnel from three districts that have implemented the ACCESS community reproductive health/MIP orientation package (Makueni, Kwale and Bondo) attended. In addition, the meeting served as a springboard to planning scale-up activities in the three districts.

Mali

In November 2005, ACCESS assisted in the development—with USAID/Mali, Assistance Technique Nationale (the bilateral program), National Malaria Control Program, Division of Reproductive Health and national-level partners—a scope of work for ACCESS technical assistance to complement ongoing activities in the Mali MIP program. The scope of work includes training providers in FANC and MIP, developing evaluation tools and providing follow-up to trained providers. Assistance Technique Nationale and the Division of Reproductive Health have since

suggested shifting ACCESS's technical assistance to follow-up of providers already trained. A revised scope of work is being negotiated.

Nigeria

ACCESS conducted an integrated workshop for FANC/MIP, including supervision and sensitization to the link between HIV and malaria in Abuja in February 2006. 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 PQI process for FANC as a platform for MIP and PMTCT. Participants developed action plans targeting FANC, MIP and PMTCT activities for 15 states they represented at the workshop.

Regional Economic Services Development Office and WARP

With support from the Regional Economic Services Development Office, a document summarizing MIPESA network country best practices and experience with implementing MIP interventions has been finalized and will be disseminated in the near future to policymakers, program planners, donors and others.

Under WARP, 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/WARP 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 Secretariat members in key partner meetings including: the West African Ministers of Health meeting and 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.

Haiti

ACCESS continued to build the capacity of ANC clinic and maternity ward service providers to integrate PMTCT services into their existing services and will support the provision of these services at 18 facilities. Since October 2005, 173 providers at 25 sites were trained in PMTCT, VCT, rapid testing, and infant feeding. In order to determine the specific needs of the program in each site, baseline assessments were conducted prior to inviting providers for training. ACCESS also conducted a technical update to raise awareness of nutritional counseling in PMTCT programming for 18 participants, followed by four 3-day trainings. Each training covered basic nutrition concepts plus concrete recommendations for how to counsel HIV-positive pregnant women and breastfeeding women. A total of 62 health providers were trained.

ACCESS is collaborating with other organizations to provide ongoing support for implementation of PMTCT at 18 sites, and is therefore dependent on others' interventions in order to organize services. 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 Management Sciences for Health (MSH), to ensure provision of HIV rapid test kits, antiretrovirals (ARVs), small renovations and other resources.

PMTCT services within prenatal 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, and at Cayes Hospital in March 2006. The table provides information about PMTCT clients served at these facilities.

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

FACILITY	# OF CLIENTS COUNSELED	# OF CLIENTS TESTED	% OF ALL CLIENTS TESTED	# OF HIV+ CLIENTS	HIV PREVALENCE RATE
HUEH (Dec. '05 –March '06)	288	222	77%	5	2.3%
Justinien (Nov. and Dec. '05)	96	96	26.8%	13*	13.5%
Fort Liberte (Oct. '05-March '06)	328	328	100%	9**	2.7%
St Michel de Jacmel (Feb – Mar '06)	19	19	100%	0	0%
Cayes (Mar '06)	13	13	100%	1	7.7%

*All 13 enrolled in PMTCT program

**4 placed on AZT

B. Skilled Birth Attendant Results Pathway

CORE-FUNDED RESULTS

ACCESS and its partners have developed a policy instrument to assist with decision-making on EMNC issues using a priority-setting process facilitated by the application of the upgraded Safe Motherhood Model. 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*. Ghana, a priority country for USAID, is a potential site for implementation of this model. The country is currently undergoing a revision of its maternal and newborn health strategy and this application would be timely to support the strategic planning process.

ACCESS is working with FBOs at both the global level and country level to strengthen EMNC work. ACCESS sponsored a seminar 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 to improve maternal and newborn health care. This work includes a mapping of existing EMNC services of FBOs in Tanzania. This will support the national health assets planning and policy development process in Tanzania.

ACCESS supported the USAID goal of preventing obstetric fistula through awarding small grants to four local organizations from Uganda, Nigeria and Niger in September. Since that time, ACCESS has provided technical assistance to support the integration of fistula prevention into the EMNC activities of these organizations. This assistance includes reviewing curricula, monitoring the

achievement of milestones and planning a training of midwives in use of the partograph.

A training package and implementer's guide on community-based use of misoprostol is also in the final stages of editing before dissemination. ACCESS is still awaiting word on the acceptance of an article on community-based use of misoprostol in Indonesia, which was submitted to the *International Journal of Gynecology and Obstetrics* in January 2006. The Maternal and Neonatal Health (MNH) 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 technical paper *Saving the Lives of Women and Newborns: Effective Home and Community Interventions* will soon be completed. The paper provides guidance on evidence-based and best practice interventions at the home and community level that will decrease maternal and neonatal morbidity and mortality.

The ACCESS Program has adapted 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, which is in final review, will assist countries by sharing approaches aimed to define, develop and maintain the improvement and quality of antenatal, delivery, and postnatal maternal and newborn care.

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 countries and regions. Input from the workshop is informing a practical guide for emerging national secretariats, which is in progress. Establishing a WRA not only raises awareness on the issues of maternal and newborn mortality and advocates for a better enabling environment, the organizations also create a network for skilled birth attendants and advocates to improve their knowledge through learning of intra- and inter-country experiences. These WRAs are a national representation and the information provided to the country networks reaches an average of 230 members (organizational and individual) per country, in almost all districts and provinces.

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 to improve pre-service midwifery curricula and training in four countries: Ethiopia, Ghana, Malawi and Tanzania. Teams from each country have carried out assessments of midwifery education and are planning stakeholders' meetings to present the results of the assessments and engage high-level decision-makers to support activities that increase the quality of EMNC in their countries. At this time, intense planning is occurring to:

- Complete stakeholders' meetings in three countries (Ghana 18 April).
- Revise the EMNC curriculum and add components on postpartum family planning, nutrition and PQI.
- Carry out Technical Update and Clinical Skills Standardization Courses in Accra, Ghana, for four-person teams from each country from 15 May–2 June 2006.
- Site strengthening has already occurred at Tema Hospital so that it is ready for this activity.

FIELD SUPPORT-FUNDED RESULTS

Afghanistan

ACCESS/Afghanistan achieved results that contribute to the Skilled Birth Attendance (SBA) Results Pathway, especially with respect to improving the enabling environment for SBA. The three major activities were:

- Support to the Afghan Midwives Association (AMA),
- Conducting a Comprehensive Review of Maternal and Newborn Health Strategy in Afghanistan, and
- Conducting a Feasibility Study on the acceptability of Maternity Waiting Homes in Afghanistan.

ACCESS continued to provide support to the establishment, organization and strengthening of the AMA. In February 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 AMA increased its membership: within four months, membership figures have increased by 42% and another three provincial offices have been established. In November 2005, the AMA was admitted to the International Confederation of Midwives (ICM).

ACCESS conducted a comprehensive review in Afghanistan in order to develop a new MNH strategy. This 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 and Mother-Baby Model. This training will be used to apply the model to the development of the reproductive health department action plan and 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. ACCESS also worked with the MOPH to develop a new five-year national MNH strategy. The strategy was developed using a consultative processes that included the provincial reproductive health officers. The draft has been presented to the deputy minister, planning and policy, and reproductive health departments and is now awaiting finalization of the reproductive health strategy and policy. In addition, ACCESS established a working group to develop a list of key MNH indicators to allow the reproductive health department to measure the impact of maternal and newborn health program interventions.

ACCESS conducted a Feasibility Study of Maternity Waiting Homes between November and January in three provinces—Bamyan, Badakshan and Jawzjan. Initial findings from the report show that Maternity Waiting Homes in Afghanistan will have to be adapted to fit the specific provincial cultural context.

AFR/SD

ACCESS has been engaged in a close collaboration with WHO/AFRO in the start-up of two key Africa regional initiatives: (1) Training of facilitators for the implementation of the Africa Road Map and, (2) Strengthening pre-service midwifery education in Anglophone Africa. 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. Furthermore, they specifically address HIDN’s Skilled Birth Attendance results pathway, but also contribute to the ANC, PPH and newborn care results pathways as well.

In order to successfully move the Africa Road Map for Safe Motherhood forward and 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 selected countries. In Year 1, a successful workshop was held for facilitators from both Francophone and Anglophone countries. Countries participating in this exercise included Senegal, Burkina Faso, Mauritania, Niger, Guinea, Ghana, Ethiopia, Tanzania and Zambia. During this reporting period, as a follow-up to the workshop, ACCESS assisted Tanzania in the completion of their country Road Map document—incorporating the Mission’s feedback—and discussions are ongoing with Ethiopia, Senegal and Burkina Faso.

The goal of the pre-service midwifery initiative is to improve the policy and practice environments for midwives as well as to increase the knowledge and skills on the part of midwifery tutors and clinical preceptors in key African countries. Details on achievements are provided under the “core-funded” section of this results pathway as activities are co-funded with core and field funds.

Haiti

In August 2005, ACCESS conducted an evaluation of the Agent/Matrone Program at Hopital Bienfaisance de Pignon, a USAID-funded pilot project to train a new cadre of community health workers focused on maternal health. 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 prenatal, 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.

ACCESS also continued to support postabortion care (PAC) services in Haiti. In the period from October 2005–March 2006, five facilities reported PAC service delivery data, as shown in the table below. All sites except HUEH have reported data from October–December 2005. HUEH reported data from October 2005–February 2006.

Table 4: PAC Service Delivery Data from Five Facilities in Haiti

SITE	CASELOAD		RECEIVED FP COUNSELING		RECEIVED FP METHOD	
	MVA	D&C	#	%	#	%
Cap Haitien	0	57	57	100%	0	0%
Cayes	7	8	8	53%	5	33%
Fort Liberte	0	6	6	100%	3	50%
HUEH	38	17	38	69%	0	0%
Port de Paix	9	8	17	100%	9	53%
TOTAL	54	96	126	84%	17	11.3%

Two facilities (HUEH and Cap Haitien) reported that family planning methods were not available in the Maternity, where PAC services are provided, and therefore they referred PAC clients to the outpatient family planning clinics at their facilities, which reportedly did have family planning methods in stock. ACCESS is investigating this problem further.

Nepal

The national SBA Policy for Nepal, which ACCESS helped develop, is in the process of being endorsed. 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. Nepal has a range of cadres of service providers providing essential obstetric and neonatal care. There is variation in the content of several in-service and pre-service curricula, resulting in wide variation in their competencies, and several of these cadres do not have all the skills defined by the SBA policy. 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.

ACCESS is supporting the development of a generic Skilled Birth Attendants Learning Resource Package (LRP), which will have all the competencies of SBA. This Learning Resource Package could later easily be adapted for training of various cadres (e.g., auxiliary nurse-midwives, nurses, physicians or even midwives) of service providers whether it is in-service training or pre-service education. A SBA LRP Technical Advisory Group was formed under the Family Health Division with membership of national experts from key stakeholders (National Health Training Center, Council for Technical Education and Vocational Training, Institute of Medicine, Nursing Campus, Sustainable Soil Management Programme, SAVE, UNICEF, Nursing Council, Maternity Hospital, Nepal Society of Obstetricians and Gynaecologists, and Nepal Family Health Program {NFHP}) to guide development of SBA/LRP. The first Technical Advisory Group meeting was held and the roles and responsibility of the SBA the SBA-LRP development process were agreed upon.

Planning for a study of the enabling environment for SBAs was initiated. ACCESS worked with several selected partners to identify the components of the SBA study. These will be shared with the Safe Motherhood Neonatal Sub-committee for input and endorsement by all stakeholders. Smaller working groups too will be formed to work on the various components of the study. The Team Leader of this study has been identified and tentative commitments received. Recent political unrest has adversely affected the program and will be monitored closely.

WARP

The ACCESS/WARP program is working to build the capacity of skilled birth attendants and develop providers more equipped to address care of the newborn in Cameroon, Mauritania and Niger, as well as increase demand for services in Cameroon. ACCESS is working with AWARE-RH, Mwangaza Action, UNICEF and partnering governments. ACCESS conducted a needs assessment visit and follow-up visit to Mauritania. A clinical training in Emergency Obstetric and Newborn Care was subsequently held in the Kaedi district in November 2005 for 13 providers. Follow-up visits 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 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 out of 13 providers who completed an EMNC knowledge survey scored 70% or above; the thirteenth provider scored 50%.

ACCESS conducted a needs assessment visit to Niger in mid-March. ACCESS staff and consultants, accompanied by AWARE, Mwangaza Action and UNICEF staff, visited the program target site and developed a plan of action. Activities will target the region of Maradi and will begin with a site strengthening visit in May followed by two training courses for teams of providers from facilities in the region.

C. Postpartum Hemorrhage Results Pathway

CORE-FUNDED RESULTS

A highlight of ACCESS work in PPH was the “Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice” conference in collaboration with POPPHI, Regional Centre for the Quality of Health Care (RCQHC), and East, Central and Southern Africa Health Secretariat in April. Nearly 200 participants from 22 African countries and Canada, Denmark, Haiti, India and the US came to the 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 currently in development.

ACCESS supports the work of POPPHI, a USAID-funded project, by helping to distribute worldwide a Prevention of PPH Toolkit, which includes a CD-ROM demonstrating active management of the third stage of labor (AMTSL). In April 2006, the CD-ROM was converted to the web to provide better global access through the ACCESS Program’s website.

The third small grants program, also started in PY2, aimed at 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). In both cases, multi-sectoral teams are encouraged to apply for grant funding in order to integrate and strengthen the coordination of the delivery of services. The anticipated results from the small grants programs primarily support *SBA and PPH* results pathways.

ACCESS has developing a Memorandum of Understanding with WHO Geneva and supports the work of a consultant and WHO to write the curriculum for the PMTCT orientation for BASIC ART course.

FIELD SUPPORT-FUNDED RESULTS

Afghanistan

The Afghan Ministry of Public Health's (MOPH) 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 will be conducted in selected districts of Faryab, Jawzjan and Kabul Provinces.

A formative study in selected districts (Qaramqul, Qurghan, Khamab, Qarqin, Gul dara and Qarabagh) was completed in December 2005. The analysis process is completed. Based on the findings of the formative study, educational materials and data collection tools were developed and then field-tested in April 2006, and the analysis of the result is in process.

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 percent of women who were registered by Female Community Health Volunteers in the Community-Based Maternal and Neonatal Care register. Among the women who received misoprostol, 84 percent took the full dose, while 16 percent of the women returned the medicine.

D. Newborn Results Pathway

CORE-FUNDED RESULTS

ACCESS has supported the development of two new USAID-sponsored e-learning mini-courses in global health fundamentals for technical officers and program managers: Essential Newborn Care and prevention of PPH. In conjunction with the INFO Project of the Health Communication Partnership, learning objectives, key concepts, detailed outlines and content have been developed for both courses. Discussions are under way with USAID HIDN on the development of a third course (an overview of global maternal health issues). Further discussion will happen when the findings from the *Lancet* series on Safe Motherhood are released.

In collaboration with a network of partners, ACCESS is developing a publication to advance the integration and scaling-up of interventions to reduce *newborn* deaths in Africa through a collaborative situation analysis for 46 countries and a review of relevant policies and programmatic tools led by those implementing the programs. The target audience will be policymakers and program implementers in Africa and donors and policymakers supporting program in Africa. ACCESS staff have co-authored or reviewed sections on ANC, postnatal care and the maternal, neonatal and child health continuum of care. A final draft will be ready in May and the launch in October.

ACCESS has completed a draft of a global training resource, a competency-based KMC training manual, to teach health care workers at all levels how to care for LBW babies. Field-testing will begin in Nigeria in the coming months.

FIELD SUPPORT-FUNDED RESULTS

Asia-Near East (ANE)

The Cambodia Ministry of Health joined with 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 from 24–26 October 2005 in Phnom Penh for approximately 150 participants. The workshop served as a technical update in evidence-based maternal and newborn health and relevant experiences and programs from Cambodia as well as other countries in the region were highlighted. Participants included policymakers, clinicians and administrators from throughout Cambodia as well as representatives from the partners cited above. This workshop also contributes to the **SBA** results pathway.

Following the workshop, a team composed of representatives from ACCESS, BASICS and USAID performed an assessment of the current maternal and newborn health situation in Cambodia by meeting with MOH policymakers and key stakeholders to review current policies and programs. The findings from this assessment were summarized, gaps in action and knowledge identified and key recommendations presented for accelerating maternal and newborn health in the country. The resulting document, titled “Recommendations to Accelerate Maternal and Newborn Health Care in Cambodia,” was submitted to USAID and the MOH.

ACCESS next developed a concept paper outlining specific activities that ACCESS could implement using core funds. ACCESS staff also attended the Joint Annual Health Sector Review from 13–17 March at the invitation of USAID Cambodia.

ACCESS collaborated with WHO/SEARO to conduct a Continuum of Care workshop in Bangkok, Thailand, in October 2005, which contributed not only to the Newborn Results Pathway but also to the SBA Results Pathway. Fifty 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, attended. Most of the participants at the meeting were key MOH country staff working in safe motherhood and/or child health and a few WHO country and regional representatives. In addition, there were representatives from UNICEF, USAID and a few other agencies. The workshop focused on country and regional level interventions for maternal and newborn health, with particular attention on newborn health, skilled birth attendance, and the human resource issues and constraints for maternal and newborn health programming. ACCESS will provide additional support to selected countries that participated in the meeting; WHO/SEARO has been working to identify one or two key countries that require additional technical assistance to implement their workplans, based on brief proposals that were submitted to request seed funding. Once the countries are selected, funds will be transferred to WHO/SEARO. It is expected that this will occur prior to the end of the program year.

Haiti

The Academy for Educational Development (AED) has continued to provide technical assistance in the area of HIV and infant feeding, primarily through the presentation of a three-hour module during the ACCESS/PMTCT trainings. During this reporting period, 64 health care providers were trained in the module, which covers the risk of MTCT through breastfeeding, advantages and disadvantages of various feeding methods, and criteria to consider when helping a mother to choose a method:

- AED presented a three-hour 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)
- At the request of the HUEH training coordinator, AED conducted a four-hour Technical Update on HIV and infant feeding for HUEH pediatric residents, interns and nurses (25 participants).
- AED conducted a five-day 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.

AED also printed copies of behavior change communication materials on HIV and infant feeding and shipped them 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). ACCESS will receive 800 copies of each brochure and 250 copies of the Q&A guide.

Latin America and the Caribbean (LAC)

In Program Year 1, ACCESS collaborated with partner organizations (PAHO, BASICS and CORE Group) to define guidelines to develop a regional strategy for newborn care, based on a situation analysis in the region. Since then, ACCESS continues to collaborate with these partners to develop the draft of the regional strategy on newborn care. The first draft of the strategy document was submitted for review to the partner organizations, and all comments were integrated to produce the official draft for distribution to countries. PAHO distributed the document to MOHs, by means of a regional workshop. Each country's participants had the opportunity to review the document before attending the regional strategy workshop, according to a set of established guidelines.

The regional neonatal strategy workshop was conducted in Antigua, Guatemala, the week of 21–24 February, 2006, with ACCESS support to present and discuss the draft LAC regional strategy for newborn care. A total of 95 participants from 15 different countries attended. Participants reviewed the draft of the strategy and contributed to discussions on its revision. ACCESS together with PAHO and BASICS coordinated the document review process. ACCESS also contributed with the organization, logistics, and facilitation of the meeting. The draft of the regional strategy will be revised and shared with the PAHO Executive Committee in June and presented to the PAHO governing bodies in September.

Nepal

ACCESS has been working in close coordination with the NFHP to implement a comprehensive Community-Based Maternal and Newborn Care program for LBW newborns in Kanchanpur district of Nepal. The Community-Based Maternal and Newborn Care package consists of the Birth Preparedness Package, Home Based Post Natal Care (HB-PNC) visits for mothers and newborns, special care at home for LBW infants and strengthening of health facilities for the care of referred mothers and newborns. ACCESS is supporting the HB-PNC and LBW components of the community program and also selected components of facility strengthening.

ACCESS partners have organized several rounds of planning meetings with NFHP partners, and workplans, roles, responsibilities and budget divisions for all components of work have been thoroughly discussed and finalized. JHPIEGO and Save the Children US have also been involved in the finalization of the innovative Birth Preparedness Package training methodology, which is being revised to make it more interactive, problem-solving and participatory. Work on this package is under way and is expected to be complete by May 2006. ACCESS has outlined the design for the HB-PNC, LBW package and identified questions for evaluation, and indicators to measure and track progress of the project. ACCESS is also working closely with NFHP to finalize the baseline tools to conduct the baseline survey in mid May 2006. A trip to Shivgarh, India, where a community-based newborn program, which includes care of LBW infants, by MOH, NFHP and ACCESS staff was planned for April but has been postponed due to political unrest in the country.

Monitoring and evaluation activities related to the HB-PNC and LBW work in Kanchanpur that has taken place during the reporting period have been focused on three areas: 1) the development of both an approach to monitoring progress of the HB-PNC and LBW as well as tools to collect monitoring data; 2) the identification of questions to be included on the baseline household survey instrument to measure change in key HB-PNC and LBW indicators; and 3) the identification of questions of interest to explore through a formative study of local knowledge and practices related to LBW neonates in Kanchanpur district. LBW monitoring and evaluation approaches and tools build on the existing tools and approaches that have been developed for the Community-Based Maternal and Newborn Care Program in Kanchanpur within which the LBW is integrated.

ACCESS is committed to take the learning from Kanchanpur district and work 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 now be conducted in Year 2. This change in timing has been made to take into account various ongoing work on standards and protocols that may be done by other partners. Furthermore, results from Kanchanpur will take at least a year to be ready to share at national level.

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. Please see the table below for detailed information on the types of interventions being implemented in each country and the associated population coverage.

Table 3: 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)
NEPAL							
Mgmt. of LBW infants at community level	60,158 households	10 SHP, 8 HP, 3 PHCC, 1 regional hospital	1 out of 75	2%	5	377,899	185,989
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
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	N/A	Nakuru district-164 Nyeri district-100 Homabay district-35	4 out of 76	6%	3 out of 7	Nakuru district 1.5 million Nyeri district-799,697 Homabay district-320,000	Nakuru district-N/A Nyeri district 676,053 Homabay district – N/A

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)
supervision		Migori district-60					Migori district-N/A
CT for HIV/AIDS service delivery	N/A	Central province 7 Eastern 13 Nairobi 8	28 out of 76	37%	3 out of 7	Not available-ACCESS working only in district hospitals	Not available-ACCESS working only in district hospitals
ART service delivery		Eastern 13 Nairobi 8	21 out of 76	28%	2 out of 7	Not available-ACCESS working only in district hospitals	Not available-ACCESS working only in district hospitals
Demand generation for RH/MIP services-scale up of community RH/MIP package	2 divisions (Usigu & Madiany) in Bondo district 2 divisions (Wote & Kaiti) in Makueni district 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 -Makueni district-887,266 -Kwale district-600,000	-Bondo district-Not available -Makueni district-Not available -Kwale district-13,679
MAURITANIA							
EmONC (SBA) service delivery		10	4 out of 44	9%	3 out of 13	273,306	Not available
CAMEROON							
EMNC (SBA) training and service delivery		15	1 (Ngaoundere) out of 58 departments*	2%	1 out of 10	244,009	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)
BURKINA FASO							
FANC/MIP service delivery scale-up		21	5 out of 53	9%	1 out of 11	1,654,443	343,304
MADAGASCAR							
FANC/MIP service delivery scale-up		76	4 out of 22	18%	2 out of 6	710,808	Not available
TANZANIA							
FANC/MIP service delivery scale-up		109	42 out of 127	33%	18 out of 26	13,033,777	3,086,929

Note: Data sources for population figures include national census data; 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).

*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

Implementing a global program that is evolving and growing brings certain challenges. These include matching human resource capacity within the program to growing demands from program expansion. From a three-country program in Year 1, ACCESS has matured into an effective global program that is responsive to Mission needs in over 12 countries currently. This growth in new countries is also accompanied by increased field support funding in existing countries. While we have experienced program growth, we have also experienced staff transitions. This can be expected within any large program. During this period, ACCESS has been actively recruiting to replace the senior Program manager position.

Implementing the Household to Hospital Continuum of Care (HHCC)

The ACCESS document describing the HHCC approach was disseminated at various conferences and workshops, through the ACCESS website and presentations made at various meetings. ACCESS had planned to implement the HHCC approach in a least one country. However, a major challenge has been the difficulty in getting USAID Missions to support the implementation of the full approach. Missions choose to support selected components of the concept. For example, in Tanzania the mission elected to support only the expansion of facility-based FANC, and in Bangladesh the program focus is on the community component of maternal and newborn health. In Nigeria, the mission agreed to support the full continuum but with a focus on EmONC.

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 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 hope to overcome this challenge by implementing a firm deadline for receipt of comments.

Field programs vulnerable in politically unstable countries

Some of the countries (Haiti, Nepal, 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 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 from USAID/Global, ACCESS hopes to escalate this growth still further in the coming years. ACCESS envisions implementation in country level activities by working through bilateral programs; partners like professional associations; and FBOs and other NGOs on the ground.

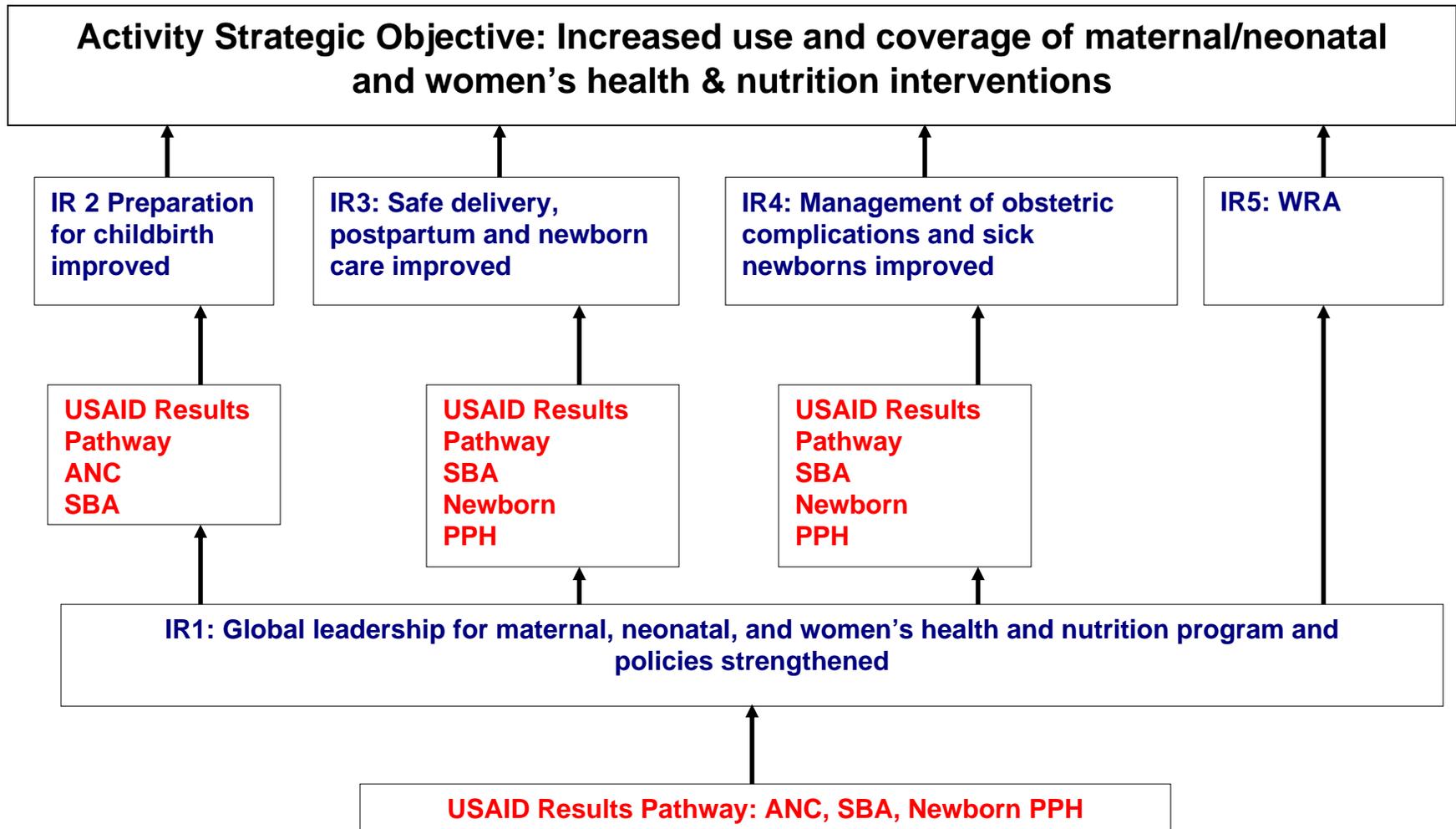
Developing new Associate awards

During this reporting period, ACCESS initiated the implementation of ACCESS-FP and worked on the proposal for the Service Support Project for Afghanistan. The Associate awards require additional coordination and management efforts but are a great testament to the success of the ACCESS Program's mandate.

Ability to contribute to USAID Results Framework

ACCESS places strong emphasis on providing M&E skills to country programs to enable them to provide results, not just in numbers trained but also in terms of population coverage. We hope that this information would be valuable to USAID and our field programs to demonstrate tangible results over the life of the program.

ANNEX A: ACCESS Results Framework Linkages with HIDN Results Pathways



ANNEX B: ACCESS CORE ACTIVITY MATRIX (October 1, 2005-March 31, 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	<ul style="list-style-type: none"> • USAID HIDN asked that ACCESS delay initiating communication with PMNCH until USAID has discussions on key activities that ACCESS can support. • Written and reviewed sections of the Africa Newborn Health report. A draft will be circulated by the organizers of the report in April, and the report launched in October 2006.
1.1.b. Collaborate with WHO/Geneva to strengthen PMTCT, pre-service education and MIP programs and services	<ul style="list-style-type: none"> • Developing a Memorandum of Understanding with WHO Geneva. • Supported a consultant to work with WHO to write the curriculum for the PMTCT orientation for BASIC ART course. • 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	<ul style="list-style-type: none"> • Continued networking with ICM to promote maternal and newborn health in their global agenda. • 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	<ul style="list-style-type: none"> • Provided support to 14 WRA Alliances to build capacity and sustainability approaches at the National Secretariat Workshop, 5-9 December 2005. • Draft of a "how to" guide for new, emerging and existing Alliances, including case studies, is in process and expected to be ready in July 2006.
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	<ul style="list-style-type: none"> • Organized November 2005 FBO Seminar in Washington, D.C. on opportunities and challenges for providing MNC services through FBO networks. • Established contacts with USAID mission in Tanzania on FBO work and supported development of a proposal to scale up FANC through the Christian Social Service Commission network. • FANC job aid produced and distributed to all 256 health units affiliated with the Uganda Protestant Medical Bureau (an outcome of the FBO Workshop on strengthening FANC). • Started FBO health assets assessment in India with the Christian Medical Association of India, Interchurch Medical Assistance's partner. Report with data expected August 2006.
1.2.b. Support FBO action plans to provide quality maternal and newborn healthcare services in select countries	<ul style="list-style-type: none"> • Completed instruments and implementation process for mapping of FBO health assets in Tanzania. Implementation to begin by 20 April and results expected by July 2006.
1.3 Improve health care financing schemes and policies to address economic barriers to utilization of maternal and newborn care services and better	
	<ul style="list-style-type: none"> • Discussions held with USAID and partners to define the objectives and scope of equity work. Project work started in April 2006. • Information sharing meeting held with other projects working on equity in family planning and reproductive

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
allocate resources	<p>health.</p> <ul style="list-style-type: none"> Application of the Safe Motherhood Model proposed for Ghana. Discussions currently under way with USAID mission and key stakeholders.
1.4 Disseminate ACCESS Program materials and resources worldwide to advance knowledge of and programming in maternal and newborn health	<ul style="list-style-type: none">
1.4.a. Develop outreach strategy for ACCESS materials to ensure they reach key stakeholders	<ul style="list-style-type: none"> New materials during this period: KMC training manual completed; field testing to begin in Year 2. Community Mobilization for Maternal and Newborn Health facilitator's guide completed; field-testing to begin in May 2006. Technical paper Saving Lives of Women and Newborns: Effective Home and Community Interventions in final review; printed in May 2006. Household-to-Hospital Continuum of Maternal and Newborn Care report translated into Spanish, French and Portuguese; dissemination in process. Guidelines for Assessment of Skilled Providers after Training in Maternal and Newborn Healthcare translated to French for global use; AMTSL web demonstration launched March 2006. Materials in process: Technical briefs on FANC, MIP, prevention of PPH, and emergency newborn care in final review; "Preventing Mortality from PPH in Africa: Moving from Research to Practice" conference proceedings in process; Performance and Quality Improvement Approaches for Use in Maternal and Newborn Health guide in final review; Four country profiles (Afghanistan, Haiti, Nepal, Tanzania) in process; Training package and implementer's guide on community-based use of misoprostol in the final stages of editing before dissemination; Article on community-based use of misoprostol in Indonesia submitted to the International Journal of Gynecology and Obstetrics in January 2006; awaiting word on its acceptance. Dissemination list developed for the release of all new ACCESS documents; HHCC report, annual report, AMSTL web demonstration disseminated/announced globally via this mechanism. ACCESS website downloads since its launch in October 2005 have increased monthly, including more than 500 downloads of the HHCC report. 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).
1.4.b. Develop e-learning courses to increase knowledge of new approaches, techniques and evidence-based safe motherhood programming information among USAID staff	<ul style="list-style-type: none"> Learning objectives, key concepts, and detailed outlines developed for the Essential Newborn Care and Postpartum Care e-learning courses in conjunction with the INFO Project of the Health Communication Partnership. Internal review of above carried out by key USAID/W and Cooperating Agency colleagues (BASICS and ESD), suggestions incorporated, content created, and sent to INFO Project for formulation of a draft course. Discussions under way with USAID HIDN on development of a third course (an overview of global maternal health issues). Further discussion will happen when the findings from the <i>Lancet</i> series on Safe Motherhood are released.
1.5 Award, administer and manage small grants to expand and scale up EMNC interventions	<ul style="list-style-type: none"> Obstetric fistula: see IR 5 (Four small grants awarded for obstetric fistula work). FBOs working on EMNC: Small grants mechanism process to support EMNC activities of several FBOs in Africa is under way: Proposals from Kenya, Malawi, Tanzania and Uganda are under review by grant committee. PPH Grant RFA distributed at PPH Conference in April.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
1.6 Provide technical assistance to strengthen maternal, newborn and women's health services	<ul style="list-style-type: none"> 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	
2.1.a. Improve the quality of maternal and newborn health services (including EmOC, prevention of PPH, newborn care and postpartum care) in Cambodia	<ul style="list-style-type: none"> Collaborated with USAID, MOH, and other local partners to conduct a technical workshop on maternal and newborn health in Cambodia. Collaborated with USAID and BASICS to prepare a report on accelerating the reduction of maternal and neonatal mortality in Cambodia. 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.
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	<ul style="list-style-type: none"> Collaborated with CEDPA and the India MOH to plan for a program to field-test guidelines for skilled birth attendance. A development plan was prepared and a team will go to India in May to design the intervention.
2.2 Contribute to global, regional and national knowledge of the Household-to-Hospital continuum of care to promote comprehensive programming for EMNC	<ul style="list-style-type: none"> HHCC report, Effective Home and Community Interventions paper, and Community Mobilization facilitator's guide: see IR 1.4 for dissemination. Consultant hired to collaborate with ACCESS-led interagency working group to develop a technical brief on the community mobilization contribution to the reduction of maternal and newborn mortality.
2.2.d Improve technical leadership on maternal and infant nutrition in ACCESS programming	<ul style="list-style-type: none"> AED nutrition specialist and ACCESS technical team met to discuss collaboration. Formulation of a nutrition module begun by AED nutrition specialist for use in pre-service and in-service education; first draft to be presented by mid-April. AED, ACCESS technical team and A2Z team met to determine possible areas of collaboration in country programs; discussions ongoing regarding work in Cambodia. AED nutrition specialist provided with ACCESS PQI approach and assessment tools to determine how to integrate appropriate nutrition content into ANC and PMTCT activities.
2.2.e Continue to enhance quality EMNC services by applying PQI and other QA work in EMNC	<ul style="list-style-type: none"> ACCESS countries using SBM-R or other PQI approaches identified (e.g., Haiti, Madagascar, Nigeria) and general information about activities solicited. Formulation of specific data-gathering tool to be completed by mid-April to obtain precise information on the use of SBM-R, challenges, lessons learned, and next steps in ACCESS countries.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<ul style="list-style-type: none"> Existing training materials in process of being assessed, draft module on use of a PQI process to be completed by end of April for pre-test in regional pre-service training in Ghana. Adapted approaches from JHPIEGO, Save the Children, and the Quality Assurance Project (QAP) to develop <i>Performance and Quality Improvement Approaches for Use in Maternal and Newborn Health</i>, a guide that describes the PQI process and its use for maternal and newborn health. Guide is in final review; to be printed in May/June 2006.
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 28 Nigerian RBM and RH program managers updated in PQI for FANC/MIP/PMTCT. FANC/MIP/PMTCT action plans developed for 15 Nigerian states. 27 Burkinabè service providers from 5 districts trained in FANC and MIP. Draft strategic plan for RAOPAG developed. RH/MIP community orientation package for Kenya finalized. 33 MOH staff sensitized on community RH/MIP in Kenya to promote community RH/MIP package to increase demand for services. MIPESA best practices document developed for policymakers, program planners and others.
2.5 Support an Insecticide Treated Nets Advisor in Mali to strengthen the National Malaria Network and Partnership for Prevention of Malaria in Pregnancy	<ul style="list-style-type: none"> Mali ITN distribution plan harmonized: free distribution of ITN to all children under 5 and pregnant women for 5 years (2006 to 2010). ITN and net re-impregnation data report form drafted and validated during the ITN distribution plan meeting. Conceived ITN and net re-impregnation distribution database. Drafted malaria control activities monitoring tool. Organized National Malaria Control Program partners' bimonthly meetings to exchange experiences, discuss progress of activities and obstacles in the ITN distribution.
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	<ul style="list-style-type: none"> Planned and conducted "Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice" regional conference (4–7 April) in Entebbe, Uganda; approximately 180 participants from 22 African countries attended. Mechanism for soliciting proposals for small grants relating to prevention and treatment of PPH developed; to be presented to conference participants with instructions for formulating proposals.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
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	<ul style="list-style-type: none"> • Communication with participants from 4 African countries involved in PY1 activity (consensus on assessment of pre-service midwifery programs) to carry out curriculum reviews and stakeholders meetings; reviews done in Malawi, Tanzania and Ghana, with Ethiopia in process. Stakeholders meetings planned for April in all countries. • EMNC Technical Update and Clinical Skills Standardization courses planned for Accra, Ghana, 15 May–2 June for 20 tutors from the 4 countries mentioned above, plus Nigeria. • Review and revision of materials for above course in process. • Site strengthening visit to Accra scheduled for 11 April to prepare for courses.
4.2 Promote Kangaroo Mother Care for improved management of low birth weight babies	<ul style="list-style-type: none"> • Final draft of the KMC training manual completed; field-testing in Nigeria in the coming months. Copies of the completed draft have been shared with various NGOs and partners.
4.3 Transfer lessons learned from research and program work on sick newborns and use this information to inform program work	<ul style="list-style-type: none"> • Held meeting with Saving Newborn Lives, Associate Director for Research, and an initial matrix of ongoing global newborn research drafted. More information is being gathered from other organizations (e.g., BASICS and Johns Hopkins University Global Research Activity) to update the draft matrix.
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	<ul style="list-style-type: none"> • Activities conducted to support the four organizations that received fistula small grants. <ul style="list-style-type: none"> ➤ Traditional Birth Attendant training curriculum reviewed 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. ➤ “Rights Based Approach Document and Advocacy and Media Reports” survey report reviewed for the Association of Safe Motherhood Promoters (ASMOP, Nigeria); recommendations made to achieve milestone. ➤ Plans for training midwives in partograph reviewed for UPMA, Uganda; tools and recommendations provided for evaluation.

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-MARCH 2006
ACCESS Program Result: Increased use and coverage of maternal/neonatal and women's health and nutrition interventions						
<p>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</p> <p>(collection is field-dependent)</p>	<ul style="list-style-type: none"> • 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. • 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: <ul style="list-style-type: none"> • i. %/# of births attended by skilled attendants • ii. %/# of mothers who report immediate and exclusive breastfeeding for last live birth • iii.. %/# of ANC clients in malaria-endemic areas who receive IPT and appropriate counseling on ITN use during pregnancy and for newborns • iv. %/# of ANC clients who receive appropriate HIV/AIDS counseling for PMTCT • vi. %/# of mothers who receive antenatal iron folate • The number will be calculated as an annual count of countries meeting the definition criteria. 	<p>Program records and country reports, population-based surveys by ACCESS, HMIS</p>	<p>M&E review of country-level M&E indicators</p> <p>Annual</p>	<p>Program lead staff and M&E staff of ACCESS</p>	<p>Baseline: 0</p> <p><i>Target: selected ACCESS countries, including: Tanzania, Haiti, Nigeria, Bangladesh, Nepal</i></p>	<p>Not applicable-update in Annual Report only</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2005-MARCH 2006
<p>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)</p> <p>(collection is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS countries: see above. • 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: <ul style="list-style-type: none"> • i. % of births attended by skilled attendants (national) • ii. % of mothers reporting breastfeeding within the first hour of birth for last child (national) • iii. immunization coverage rates • iv. ITN use rates for (a) population; (b) mothers/newborns • v. % of facilities offering maternal/neonatal services that provide integrated PMTCT services • 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 Annual	M&E in collaboration with country USAID and other MNH stakeholders	Baseline: 0 <i>Target: selected ACCESS countries with relevant data that correspond with ACCESS intervention areas, incl.: Tanzania, Haiti, Nigeria and Bangladesh</i>	Not applicable – update in Annual Report only
<p>C. (Country-level) Estimated population of women of reproductive age living in communities or catchment areas of facilities targeted by ACCESS interventions</p>	<ul style="list-style-type: none"> • The number of reproductive age women is the female population estimated to be between the ages of 15–49. • Communities or catchment areas targeted by ACCESS will be determined at the country level. • The number will be calculated as country totals <i>where appropriate and available</i> 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 Semi-annual	Program lead staff and M&E staff of ACCESS	Baseline: 0 <i>Target: all ACCESS countries with relevant data</i>	5,480,721*

*Several districts covered by ACCESS interventions did not have data available for women of reproductive age, just total population for all ages.

ACCESS Program Intermediate Result 1: Global leadership for maternal, neonatal, and women's health and nutrition program and policies strengthened

<p>1a. Number of technical approaches and/or products being promoted for international use through ACCESS leadership roles</p>	<ul style="list-style-type: none"> • 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. • Technical approaches and/or products strengthened by ACCESS are those where ACCESS review and improvement activities are reported to have been successfully completed. • Promotion for use occurs through many venues: meetings, collaboration, alliances and partnership implementation. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Semi-annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 1: 10 Year 2: 25</p>	<p>11</p>
<p>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</p>	<ul style="list-style-type: none"> • Policies, including clinical care and service delivery guidelines, are national instructions meeting international evidence-based quality criteria related to ACCESS goals. • 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. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 1: 4 Year 2: 4, <i>Tanzania, Haiti, Nepal, Afghanistan</i></p>	<p>2 countries:</p> <p>Tanzania – National Infection Prevention Guidelines</p> <p>Haiti – National PMTCT guidelines</p>

<p>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</p>	<ul style="list-style-type: none"> • 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. • 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. • 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. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 1: 3</i> <i>Year 2: 2</i> <i>Afghanistan</i> <i>Nigeria</i></p>	<p>2 countries:</p> <p>Nepal – National Skilled Birth Attendant policy</p> <p>Afghanistan – National 5-year MNH Health Strategy</p>
<p>ACCESS Program Intermediate Result 2: Preparation for childbirth improved</p>						
<p>2a. Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved birth planning</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • 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. • Achievement of improved birth planning is defined as having fulfilled birth preparedness goals of the community's self-developed action plan. • The number will be calculated as an annual count of targeted communities meeting the definition criteria. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of program reports</p> <p>Annual</p>	<p>Program staff in-country with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 1: 0</i> <i>Year 2: 4 countries, Cameroon, Mauritania, Nigeria, Bangladesh</i></p> <p><i>Number of communities TBD per final country workplans</i></p>	<p>Kenya – 3 districts and 6 divisions</p> <p>Cameroon – 1 department</p> <p>Burkina – 1 district</p>

<p>2b. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received 2 tetanus toxoid (TT) injections</p> <p>(applicability is field-dependent)</p> <p>[Note: Tanzania definition: Number of ANC clients with 2 doses of TT/Number of 1st visit ANC clients]</p>	<ul style="list-style-type: none"> 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. 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). 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. 	<p>HMIS and/or home records</p>	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: not known at country levels</p> <p><i>Targets:</i> Year 2: 4 countries, Tanzania, Nigeria, Bangladesh, Cambodia</p> <p><i>% TBD per final country workplans</i></p>	<p>Tanzania – 46% (6 facilities)</p>
<p>2c. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received iron/folate supplementation</p> <p>(applicability is field-dependent)</p> <p>[Note: Tanzania definition: Number of ANC clients who received iron (alone)/Number of 1st visit ANC clients]</p>	<ul style="list-style-type: none"> 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. 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). 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. 	<p>HMIS and/or home records</p>	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: not known at country levels</p> <p><i>Target:</i> Year 2: 2 countries, Tanzania, Bangladesh</p> <p><i>% TBD per final country workplans</i></p>	<p>Tanzania – 94% (6 facilities)</p>

<p>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</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target ITN use for improvement. Women delivering in communities in the past 6 months will be identified through program records or if appropriate facility-based records. 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. The number will be calculated as a semi-annual count of women meeting the definition criteria. 	<p>HMIS and/or home records</p>	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: not known at country levels</p> <p><i>Target:</i> Year 2: 1 country, Tanzania</p> <p>% TBD per final country workplans</p>	<p>Tanzania – Not available. ITN voucher program for pregnant women is still being rolled out. Data should be available in October 2006.</p>
<p>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</p> <p>[Note: Madagascar used “all pregnancies” as the denominator for this indicator.]</p>	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT1 under observation/ Number of 1st ANC visits This indicator will be reported by country only where ACCESS activities target IPT with sulfadoxine-pyrimethamine (SP) as an area for improvement. Receipt of IPT with SP will be determined from facility records. This indicators will be measured in malaria-endemic countries only. 	<p>HMIS</p>	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> Year 2: 2 countries, Tanzania, Madagascar</p> <p>%TBD per final country workplans</p>	<p>Tanzania – 67% (6 facilities)</p> <p>Madagascar – 48% (5 facilities)</p>
<p>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</p> <p>(applicability is field-dependent)</p> <p>[Note: Madagascar used “all pregnancies” as the denominator for this indicator]</p>	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT2 under observation/ Number of 1st ANC visits This indicator will be reported by country only where ACCESS activities target IPT with SP as an area for improvement. Receipt of IPT with SP will be determined from facility records. This indicator will be measured in malaria-endemic countries only. 	<p>HMIS</p>	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> Year 2: 2 countries, Tanzania, Madagascar</p> <p>%TBD per final country workplans</p>	<p>Tanzania – 56% (6 facilities)</p> <p>Madagascar – 40% (5 facilities)</p>

<p>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</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. • 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). • Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. • Trained providers are those who complete a training course satisfactorily according to the course criteria. • The number is a semi-annual count of providers meeting the definition criteria. 	<p>Training records</p>	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Target:</i> <i>Year 2: 4 countries, Tanzania, Haiti, Burkina Faso, Madagascar</i></p>	<p>Haiti – 173 providers in PMTCT</p> <p>Burkina – 27 providers in FANC/MIP</p> <p>Madagascar – 3 trainers and 86 providers in FANC/MIP</p> <p>Tanzania – Data will be available in Oct. 2006</p> <p>Nigeria – trained 28 RBM and RH coordinators in FANC and PQI</p>
<p>2h. Total number of pregnant women provided with PMTCT services at target facilities, including counseling and testing¹</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • 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. • This indicator will be reported by country only where ACCESS activities target PMTCT as an area for improvement. 	<p>HMIS, Centers for Disease Control and Prevention (CDC) Global AIDS program database</p>	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 2: 1 country, Haiti</i></p> <p><i>Number/% TBD per final country workplans</i></p>	<p>Haiti – 712 (3 facilities)</p>
<p>• ACCESS Program Intermediate Result 3: Safe delivery, postpartum care, and newborn health improved</p>						

¹ PEPFAR indicator

<p>3a. Number of ACCESS-targeted facilities with PQI initiatives contributing to compliance with international standards</p>	<ul style="list-style-type: none"> ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches. 	<p>Program PQI records PQI database</p>	<p>Records and document review</p> <p>Semi-annual</p>	<p>Program technical staff with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Target:</i> Year 2: 3 countries, Haiti (PAC and PMTCT), Tanzania (FANC) Nigeria (EMONC)</p> <p><i>Number of facilities TBD per final country workplans</i></p>	<p>Haiti : 6 facilities have teams trained in PQI for PAC</p> <p>Madagascar: 5 facilities have conducted baseline and follow-up assessments in FANC/MIP</p> <p>Tanzania: ANC staff at 24 facilities have been trained in PQI for FANC/MIP. 13 baseline and 2 follow-up assessments completed</p>
<p>3b. Percent/number of births in ACCESS-targeted facilities in the past 6 months that occurred with a skilled attendant using a partograph</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator is reported by country only where ACCESS activities target correct use of a partograph as an area for MNH improvement. Women delivering in the past 6 months will be identified through facility records. 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. 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). 	<p>Facility records, completed partographs</p>	<p>Records review</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> Year 2:3 countries, Cameroon, Mauritania, Nigeria</p> <p><i>% TBD per final country workplans</i></p>	<p>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.</p>

<p>3d. Percent/number of births in the past 6 months in ACCESS-targeted facilities/communities with active management of third stage of labor</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • This indicator is reported by country only where ACCESS activities target AMTSL as an area for improvement, either in facilities, communities, or both. • Births in the 6 months prior to data collection will be identified through facility records and/or program records at the community level. • AMTSL is determined by information available in the records. • 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. 	<p>HMIS and/or program records where data are available</p>	<p>Records review, where data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> <i>Year 2: 1 country, Nigeria</i></p> <p><i>%TBD per final country workplans</i></p>	<p>Not available. Nigeria baseline study will be conducted by September 2006.</p>
<p>3e. Percent/number of newborns in the past 6 months in ACCESS-targeted facilities or communities dried and warmed immediately after birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. • 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. • This indicator is an annual count of newborns meeting the definition criteria. 	<p>Facility and/or program records if data are available</p>	<p>Records review, if data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 2: 2 countries, Bangladesh and Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh and Nigeria programs have not started yet. Nigeria baseline study will be conducted by September 2006. Availability of Bangladesh data TBD.</p>

<p>3f. Percent/number of newborns in ACCESS-targeted facilities or communities that are breastfed within one hour of birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. • 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. • This indicator is an annual count of newborns meeting the definition criteria. 	<p>Facility and/or program records if data are available</p> <p>Client exit interviews</p> <p>Community survey</p>	<p>Records review, if data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> Year 2: 2 countries, Bangladesh and Nigeria</p> <p>% TBD per final country workplans</p>	<p>Bangladesh and Nigeria programs have not started yet. Nigeria baseline study will be conducted by September 2006. Availability of Bangladesh data TBD.</p>
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<p>3g. Percent/number of providers with adequate knowledge of essential newborn care</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. Adequate knowledge will be determined. 	<p>Provider knowledge survey</p>	<p>Survey Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 2: 5 countries, Nigeria, India, Cameroon, Mauritania, Nepal</i></p> <p><i>Target=100 % of trained providers</i></p>	<p>Mauritania – 12 of 13 providers trained in EmOC surveyed scored 70% or higher. One scored 50%.</p> <p>Follow-up visits to Cameroon will take place later this fiscal year.</p> <p>The Nigeria and India programs have not started yet.</p>
<p>3g. Percent/number of women in ACCESS-targeted facilities or communities who accept a contraceptive method by 6 weeks postpartum²</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target integrated family planning as an area for improvement. 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). The number is a semi-annual count of women recorded at ACCESS-targeted facilities or through community outreach as meeting the definition criteria. 	<p>Facility and/or program records</p>	<p>Records review Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 2: TBD, depends on ACCESS-FP</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Not Available. Depends on when/where ACCESS-FP can obtain buy in from country USAID Missions.</p>

² This indicator will be collected through ACCESS-FP.

<p>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</p>	<ul style="list-style-type: none"> 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. 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). 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. 	<p>HMIS and/or home records or community survey</p>	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: not known at country levels</p> <p><i>Target:</i> Year 2: 2 countries, Bangladesh, Nigeria</p> <p>% TBD per final country workplans</p>	<p>Bangladesh and Nigeria programs have not started yet. Nigeria baseline study will be conducted by September 2006. Availability of Bangladesh data TBD.</p>
<p>ACCESS Program Intermediate Result 4: Management of obstetric complications and sick newborns improved</p>						
<p>4a. Percent/number of women attending ACCESS-targeted facilities with eclampsia who appropriately receive magnesium sulfate</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target facility-based eclampsia treatment as an area for improvement. 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. 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). 	<p>Facility records</p>	<p>Records review</p>	<p>Program technical staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> Year 2: 1 country, Nigeria</p> <p>% TBD per final country workplans</p>	<p>Nigeria program has not started yet. Nigeria baseline study will be conducted by September 2006.</p>

<p>4b. Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in infant resuscitation</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. • 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. • Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. • Trained providers are those who complete a training course satisfactorily according to the course criteria. • The number is a semi-annual count of providers meeting the definition criteria. 	<p>Training records</p>	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>ACCESS M&E</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 2:</i> <i>Providers in 4 countries, Cameroon, Mauritania, Nigeria, Nepal</i></p>	<p>Mauritania – 13</p>
<p>4c. Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in management of LBW newborns/KMC</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. • 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. • Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. • Trained providers are those who complete a training course satisfactorily according to the course criteria. • The number is a semi-annual count of providers meeting the definition criteria. 	<p>Training records</p>	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>ACCESS M&E</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 2:</i> <i>Providers in 1 country, Nigeria</i></p>	<p>Nigeria program has not started yet. Nigeria baseline study will be conducted by September 2006.</p>

<p>4d. Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved complication readiness</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • 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. • Achievement of improved complication readiness is defined as having fulfilled complication readiness goals of the community's self-developed action plan. • The number will be calculated as an annual count of targeted communities meeting the definition criteria. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of program reports</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 2:Communities in 5 countries: Cameroon, Mauritania, Nigeria, Bangladesh, India</i></p>	<p>Kenya – 3 districts and 6 divisions</p> <p>Cameroon – one department</p>
<p>ACCESS Program Intermediate Result 5: Prevention and treatment of priority health problems of non-pregnant women of reproductive age improved (Targets of Opportunity)</p>						
<p>5a. Number of linkages with international obstetric fistula networks initiated and technical assistance provided</p>	<ul style="list-style-type: none"> • 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. • Linkages are working relationships on identified tasks toward specified goals agreed between a network and ACCESS. • 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. • The number will be an annual count of networks linking with ACCESS tasks, and a qualitative report of technical assistance may also be provided. 	<p>Program records</p>	<p>Records review</p>	<p>ACCESS M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 1: 4</i> <i>Year 2: 1</i></p>	<p>ACCESS is an active member of one international obstetric fistula network</p>

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	STATUS
USAID/Afghanistan I.R. 3.1: Increase access of women and children under the age of five to quality basic health services, especially in the rural and underserved areas					
USAID/Afghanistan I.R. 3.1.1: Expand the access to quality Basic Package of Health Services (BPHS)					
Afghan Midwives Association (AMA) established with approved "Rules of the Association"	Yes/no measure	AMA meeting minutes, program records	Annual	AMA staff, ACNM and ICM representatives, JHPIEGO	Yes, 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	Partially achieved
AMA continuing education guidelines developed	Yes/no measure	Continuing Education Guidelines, AMA records	One-time occurrence	AMA staff, ACNM	In progress
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	In progress Plans completed Implementation starting
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	Study Completed; report draft being edited. Guidelines for implementation being drafted.
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	Yes completed
PPH reduction Ministerial Advisory Group established	Yes/no measure	ACCESS Program records	Annual	MOPH, JHPIEGO	Yes
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	No, to be completed by May

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	STATUS
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	No, to be completed by Apr
Number of pregnant women counseled on birth planning and provided with misoprostol through approved distribution channels		Community health Worker logbook	Monthly	Community health worker CHW Supervisor Local NGOs	No
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 CHW Supervisor Local NGOs	No
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 CHW Supervisor Local NGOs	No
USAID/Afghanistan/REACH I.R. 3.1.3: Strengthen government health systems					
National Maternal and Newborn Health Strategy developed	Yes/no measure. The strategy will include costing information and be operationalized by supporting a core safe motherhood committee.	Program records, Implementation plans	One time occurrence	ACCESS field staff Futures Group	Draft complete
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	Draft complete
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	Completed

AFR/SD Monitoring and Evaluation Framework

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
PRIORITY 1: Support advocacy to mobilize resources and improve the policy environment for maternal and newborn care AFR/SD Result: Increased resources for maternal and newborn health programs at the country level 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	Seventeen (17) master trainers (8 Anglophone and 9 Francophone) coming from 9 African countries have been trained to provide support and guidance to 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	Four (4) countries are receiving on-going support in the Road Map implementation intervention (Ethiopia, Tanzania, Senegal and Burkina Faso)
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 Communication with trained facilitators	Semi-annual	AED/Berengere de Negri	Same as above
PRIORITY 2: Disseminate effective approaches to improve the quality of integrated MNH care AFR/SD 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 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 16 tutors and clinical instructors is planned for May 2006.

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
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 <i>AFR/SD Result: African institutions actively engaged in supporting the implementation of the WHO/AFRO Road Map</i> <i>AFR/SD Result: Linkages strengthened among African Institutions and networks to coordinate with each other and strengthen their leadership in MNH</i> <i>AFR/SD Result: National-level capacity to implement safe motherhood programs improved</i>					
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	17
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	A stakeholders meeting will be held in 1 country, Ghana, on pre-service midwifery education by the end of April. –Each of the 4 countries supported by ACCESS to receive technical assistance and support from the RM Master African trainers
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	Training and development of action plans will take place in May 2006.
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	Depends on outcome of May 2006 training.

ACCESS Haiti Monitoring and Evaluation Framework

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FROM 10/1/05 - 3/31/06
USAID/Haiti IR2: Increased use of quality reproductive health services					
<i>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.</i>					
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 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. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS PAC courses as recorded in program records.	Training participant tracking sheets and training database	Annual	Program staff	0
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 Completed in Y1
Number /%of PAC target facilities that achieved at least 40% of PAC SBM-R standards at follow-up assessment	<u>Numerator</u> : Number of PAC target facilities trained in SBM-R for PAC that achieved at least 40% of the standards <u>Denominator</u> : 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	NA – Assessment not conducted. 4/6 are completing action plans

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FROM 10/1/05 - 3/31/06
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	<u>Numerator:</u> Number of PAC clients at PAC target facilities who received family planning counseling <u>Denominator:</u> Total number of PAC clients at PAC target facilities	PAC registers, Monthly PAC monitoring form, PAC database	Quarterly	PAC facility staff, Program staff	84/93 = 90%
Number/% of PAC clients at target facilities who received a family planning method	<u>Numerator:</u> Number of PAC clients at PAC target facilities who received a family planning method <u>Denominator:</u> Total number of PAC clients at the PAC target facilities	PAC registers, Monthly PAC monitoring form, PAC database	Quarterly	PAC facility staff, Program staff	17/93 = 18%
Number/% of PAC clients at target facilities who were referred for a family method outside of the PAC service delivery area	<u>Numerator:</u> Number of PAC clients at PAC target facilities who were referred for a family planning method outside of the PAC service delivery area <u>Denominator:</u> Total number of PAC clients at the PAC target facilities	PAC registers, Monthly PAC monitoring form, PAC database	Quarterly	PAC facility staff, Program staff	0
Number/% of PAC clients at target facilities who were referred for other reproductive health services	<u>Numerator:</u> Number of PAC clients at PAC target facilities who were referred for other reproductive health services <u>Denominator:</u> Total number of PAC clients at the PAC target facilities	PAC registers, Monthly PAC monitoring form, PAC database	Quarterly	PAC facility staff, Program staff	N/A Data not collected for this indicator

USAID/Haiti IR3: Reduced transmission of selected infectious diseases

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FROM 10/1/05 - 3/31/06
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. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS PMTCT courses as recorded in program records.	Training participant tracking sheets and training database	Annual	Program staff	173 25 residents 30 physicians 90 nurses 28 nurse-midwives
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: -counseling and testing for pregnant women -ARV prophylaxis to prevent MTCT -Counseling and support for safe infant feeding practices -family planning counseling or referral	Program records/reports	Annual	Program staff	6 Currently in implementation phase, so not offering the full package of services yet
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	712 (3 facilities)
% of antenatal care clients at target facilities tested for HIV/AIDS	<u>Numerator:</u> Number of ANC clients at the target facilities tested for HIV/AIDS <u>Denominator:</u> Total number of ANC clients at the target facilities	ANC registers, VCT registers	Quarterly	PMTCT facility staff, Program staff	2 facilities: HUEH: 77% Justinien: 27%

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FROM 10/1/05 - 3/31/06
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	27 (3 facilities)
Prevalence of HIV among PMTCT clients tested at target facilities	<u>Numerator:</u> Number of PMTCT clients at the target facilities tested for HIV/AIDS who tested positive <u>Denominator:</u> 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	4.2% (3 facilities)
Number/% of antenatal clients at target facilities counseled about infant feeding options	<u>Numerator:</u> Number of antenatal clients at target facilities counseled about infant feeding options <u>Denominator:</u> 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.
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	NA – not collected this period. Will be available in October 2006.
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	NA – not collected this period. Will be available in October 2006.
Number/% of maternity clients at target facilities who accepted a family planning method postpartum	<u>Numerator:</u> Number of maternity clients at target facilities who accepted a family planning method postpartum <u>Denominator:</u> 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. Will be available in October 2006.

ACCESS Kenya Monitoring and Evaluation Framework (* indicates a required PEPFAR indicator)

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 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 Record review during support supervision visits	Semi-annual	CT Service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
Total number of individuals who received counseling and testing (at target facilities), disaggregated by sex*		RHIS Record review during support supervision visits	Semi-annual	CT service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
Total number of CT clients referred for ART		RHIS Record review during support supervision visits	Semi-annual	CT service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
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 Record review during support supervision visits	Semi-annual	ART service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
Number of new individuals with advanced HIV infection receiving ART*	This is a subset of the number of individuals with advanced HIV infection 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).	RHIS Record review during support supervision visits	Semi-annual	ART service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support 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 Record review during support supervision visits	Semi-annual	ART service providers, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 2006)
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	Data will be available by May 31, 2006 after completion of support supervision visits.
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, TIMS	<ul style="list-style-type: none"> • During support supervision visit (once) • End of project evaluation 	Support Supervision Team, Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
ACCESS Program Result: Strengthened provider and health system capacity to deliver quality ART services.					
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 7 pharmacists

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 2006)			
USAID/Kenya I.R.3.3: Increased customer use of FP/RH/CS services								
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	HOMABHOMA AY			
					NEW	REVISITS	TOT	
					October	262	1057	1319
					November	272	839	1111
					December	248	1012	1260
					Jan-15	148	622	880
						930	3530	4570
					NAKURU	NEW	REVISITS	
					October	407	1440	1847
					November	814	3476	4290
					December	870	3108	3978
					Jan-15	530	1543	2073
						2621	9567	12188
NYERI	NEW	REVISITS						
October	972	8892	9864					
November	1135	6017	7152					
December	1330	6457	7787					
Jan-15	278	1871	2149					
	3715	23237	26952					
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 NYERI: 52 HOMABAY: 51 Total of 153 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 NYERI: 52 HOMABAY: 51 Total of 153 service providers			
% of trained service providers providing FP services according to	FP services include counseling and method	Clinical observation checklist	During Support Supervision visits	Support Supervision	Data will be available by May 31, 2006 after completion of support supervision visits.			

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 2006)
standards	provision.		(once)	Team	
% of trained service providers performing IP practices according to standards		Clinical observation checklist	During Support Supervision visits (once)	Support Supervision Team	Data will be available by May 31, 2006 after completion of support supervision visits.
% of FP clients satisfied with FP services received	Compared with baseline	FP client exit interview	During Support Supervision visits (once)	Support Supervision Team	Data will be available by May 31, 2006 after completion of support supervision visits.
% 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	Data will be available by May 31, 2006 after completion of support supervision visits.
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 Support Supervision Report	During Support Supervision visits (once)	Support Supervision Team	Data will be available by May 31, 2006 after completion of support supervision visits.
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 Support Supervision Report IP Core training team records TIMS	During Support Supervision visits (once)	IP Core training team, Support Supervision Team	Data will be available by May 31, 2006 after completion of support supervision visits.
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	19 supervisors from Nakuru, Nyeri and Homabay.
% of trained supervisors applying skills on the job		Interviews and discussions with service providers Supervisor skills assessment forms by colleagues Support supervision report	During Support Supervision visits (once)	Support Supervision Team	Follow-up on supervisors set to be done in May 2006
ACCESS Result: Increased informed demand and collective action for quality essential maternal and newborn care					

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 2006)
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	Data will be available by May 31, 2006 after completion of support supervision visits.
Materials to implement communication strategy developed and approved by MOH	Yes/no measure. Materials include: orientation packages, community leaflets and radio spots.	Materials inventory Training/ orientation reports	After materials production	Kenya program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
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	Data will be available by May 31, 2006 after completion of support supervision visits.
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	Data will be available by May 31, 2006 after completion of support supervision visits.
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	Data will be available by May 31, 2006 after completion of support supervision visits.
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	Data will be available by May 31, 2006 after completion of support supervision visits.
Number of community members reached with messages about SMI and MIP, through community meetings, using orientation package		Community meeting reports Supportive supervision reports	Every 3-4 months	Support Supervision team	Data will be available by May 31, 2006 after completion of support supervision visits.

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS DURING THIS REPORTING PERIOD (1 OCTOBER 2005 – 31 MARCH 2006)
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	Data will be available by May 31, 2006 after completion of support supervision visits.
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 will be available by May 31, 2006 after completion of support supervision visits.
Family planning community orientation package developed	Yes/No Measure	Review of orientation package materials	One time measure	Kenya Program staff	Data will be available by May 31, 2006 after completion of support supervision visits.
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		Data will be available by May 31, 2006 after completion of support supervision visits.

ACCESS Nepal Monitoring and Evaluation Framework

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPON-SIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	STATUS
USAID/Nepal Intermediate Result 2.2: Increased use of selected maternal and child health services.							
Number of Generic Skilled Birth Attendant (SBA) Learning Resource Package developed and tested and provided to HMG and key partners to be adapted and incorporated curricula of various cadre of 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 SBA Learning Package	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0 <i>Target: 1</i>	-Standardize skills set and training package - Provide a national standard to contribute to future activities	In process of development
Number of Community Strategies to identify and manage Low Birth Weight (LBW) Infants developed, tested and provided to HMG and NNTAC for incorporation into the national protocols	The community model will identify LBWs for targeted care at the home level by families and community workers and assist in referral if necessary.	LBW Community Strategy	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 <i>Target: 1</i>	-Review approaches to identify strengths and weaknesses toward improving successes -Guide resource allocation and contribute to effective planning for future activities	In process of development
Number of LBW infants identified and managed as per protocol	Newborn infants who are less than 2.5 Kg will be identified in all Village Development Committees in Kanchanpur. Cared for at home and community health facilities as per the protocol developed.	Program records	Record review	ACCESS Program Manager and Program Officer (LBW)	Baseline: 0 <i>Target: TBD based on expected pregnancy and percentage of LBW</i>	- Determining effectiveness of community based LBW intervention and protocol	Implementation in Year 2

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPON-SIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	STATUS
Number of guidelines developed for LBW infants to be included in the National Maternal and Neonatal standards and protocols	Based on 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: 0 Target: 1	-Contributes to National Standards and Protocols	To be done in Year 2
Number of studies 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 partnership and other factors affecting skilled birth attendance.	Program records Study report	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 Target: 1	- Review approaches to identify strengths and weaknesses toward improving successes -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	SEMI-ANNUAL STATUS
ACCESS Program Result: Partnerships initiated towards increasing community support for birth planning					
Number of community groups that are aware of new evidence-based skills and practices for maternal and child health	<ul style="list-style-type: none"> Community groups are organizations working to improve local conditions, e.g., the White Ribbon Alliance, FBOs, etc. Groups that agree to work with ACCESS will pursue increased knowledge of quality services through social mobilization, empowerment and collective action strategies. Evidence-based MCH skills and practices will be informed by technical assistance from the ACCESS Program, international standards and other stakeholders. 	Program records Records review to document community group activities	Annual	ACCESS, Muthoni Magu-Kariuki	<p>Organizations that attended the White Ribbon Alliance/Tanzania (WRATZ) rally and are working with communities include:</p> <ul style="list-style-type: none"> CARE Women Dignity Policy project <p>After the WRATZ Rally:</p> <ul style="list-style-type: none"> MOH said they will look into employing new staff Agha Khan University school of Nursing said they will revise curriculum to include Life Saving Skills. CARE has been working with community groups in Mwanza and Manyara regions to educate communities on Safe Motherhood. CARE had an exhibition with Members of Parliament in Dodoma. As a result: One Minister in the President's office promised to look into the issue of shortage of staff WRATZ has developed a brochure 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.

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
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	<ul style="list-style-type: none"> Tutors, site preceptors, and nurse-midwives are defined according to local (Tanzania) categories of instructors and care providers. ACCESS-supported training events include ACCESS technical assistance, training materials and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. 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	Training will start in April 06. Due to the delay in approval of workplan by USAID, training has been delayed and is starting in April 06.
Number of individuals trained in injection safety (PEPFAR)	ACCESS-supported training events include ACCESS technical assistance, training materials and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.	Training database and/or other training records	Compiled from training database raw data semi-annually	ACCESS, Muthoni Magu-Kariuki	Training will start in April 06. Due to the delay in approval of workplan by USAID, training has been delayed and will start in May 06.

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
<p>Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/ communities who received 2 tetanus toxoid injections</p> <p>[Note updated indicator/definition : # of ANC clients that received 2 TT injections/# of 1st visit ANC clients]</p>	<ul style="list-style-type: none"> • 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. • 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). • 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	46% (6 facilities)

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
<p>Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received iron/folate supplementation</p> <p>[Note updated indicator/definition : # of ANC clients that received iron/# of 1st visit ANC clients]</p>	<ul style="list-style-type: none"> • 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. • 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). • 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	94% (6 facilities)
<p>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</p>	<ul style="list-style-type: none"> • Calculation: Number of pregnant women who receive IPT1 under observation/Number of 1st ANC visits • Receipt of IPT with SP will be determined from facility records. 	HMIS	Semi-annual	Program country staff with ACCESS M&E review	67% (6 facilities, one had stockout of SP)

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
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	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT2 under observation/Number of 1st ANC visits Receipt of IPT with SP will be determined from facility records. 	HMIS	Semi-annual	Program country staff with ACCESS M&E review	56% (6 facilities, one had stockout of SP)
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	<ul style="list-style-type: none"> Service delivery points are medical facilities where clinical care is provided for clients. Nurse-midwives are defined according to local (Tanzania) categories of care providers. Trained nurse-midwives are those who complete a focused ANC training event satisfactorily according to the criteria established for the course. The number will be calculated as an annual count of SDPs that have sent at least one person to an ACCESS-supported FANC course and who satisfactorily completed that training as recorded in program records. 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 ACCESS	Muthoni Magu-Kariuki	Training of service providers has not started for FY2.

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
Number of service delivery points providing integrated FANC and PMTCT services	<ul style="list-style-type: none"> • Service delivery points are medical facilities where clinical care is provided for clients. • The Prevention of Mother to Child Transmission package of services aims to prevent HIV+ transmission through the provision of ANC including a number of interventions. • The provision of integrated ANC and PMTCT services at ACCESS target sites will be determined through follow-up and supportive supervisory review. • Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). 	Program records Records review to compile targeted SDPs that reach service provision goals	Annual	Muthoni Magu-Kariuki	Training of service providers has not started for FY2
Number of ACCESS-targeted facilities with PQI initiatives contributing to compliance with international standards	<ul style="list-style-type: none"> • ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches. • Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). 	Program PQI records Records review	Annual	Program technical staff with ACCESS M&E review	Six hospitals conducted baseline FANC/MIP PQI (SBM) assessments this period. Three of these hospitals are FBOs while 3 are local government facilities. Two additional facilities completed follow-up FANC/MIP PQI assessments (among the 7 facilities that did baseline assessments during the previous fiscal year).

INDICATOR	DEFINITION/ CALCULATION	DATA SOURCE/ COLLEC- TION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
Number of zonal and regional managers who have received the national IP guidelines through ACCESS-led dissemination	<ul style="list-style-type: none"> • Zonal and regional managers are GOT employees responsible for health standards leadership for SDPs in their geographic areas. • Receiving national infection-prevention guidelines will be accomplished through advocacy meetings. • The number of managers receiving the guidelines will be calculated from the program records concerning attendance at these meetings. • 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 simplified IP guidelines are now being reviewed by the MOH staff. We have not done FANC advocacy meeting yet.

ACCESS WARP Monitoring and Evaluation Framework

WARP IR 5.1 Improved approaches to FP/RH, STI/HIV/AIDS and child survival services disseminated region wide R 5.1.B Number of AWARE-supported applications of promising and best practices in FP/RH, STI/HIV/AIDS, CS & ID WARP IR 5.3 Increased capacity of regional institutions and networks 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 Training workshop summary reports	Annual	ACCESS consultant ACCESS staff	13 providers were trained in Mauritania in EmONC knowledge and skills.
% 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	<p><u>Numerator</u>: Number providers who completed an ACCESS-supported EMNC course who are competent in EMNC clinical skills 2 months after EMNC training</p> <p><u>Denominator</u>: Total number of providers who completed an ACCESS-supported EMNC course</p>	Clinical observations during training follow-up site visits	2-3 months after training	ACCESS consultant ACCESS staff	All 13 providers trained in EMOC in Mauritania were followed up: -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. 13 providers complete a postpartum hemorrhage case study with an average score of 86% -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] -4 providers were observed performing resuscitation of the newborn on an anatomic model. All 4 were competent.
% of providers trained in ACCESS-supported EMNC training courses that have implemented at least 2 action items (including or in addition to AMSTL)	<p><u>Numerator</u>: Number of providers completed an ACCESS-supported EMNC course who have implemented at least 2 action items</p> <p><u>Denominator</u>: Total number of providers who completed an ACCESS-supported EMNC course</p>	Review of service statistics and actual partographs during training follow-up site visits	2–3 months after training	ACCESS consultant 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 Training workshop summary reports	Annual	ACCESS consultant ACCESS staff	To date, no trainers have been trained in clinical training skills. The Clinical Training Skills course is planned for July/August 2006.
Number of targeted participants trained through Social Mobilization Advocacy (SMA) workshops in target countries	Targeted participants will be defined in the WARP implementation and management plan and identified through agreed processes through locally-coordinated efforts following the initial assessment. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. The number will be calculated as an annual count of persons satisfactorily completing ACCESS SMA courses as recorded in program records.	Training participant tracking sheets and training database Training workshop summary reports	Annual	Mwangaza Action ACCESS staff	25 participants from Ngaoundere district in Cameroon
Number of trained Social Mobilization trainers reporting having conducted advocacy activities using auto diagnostic tools in the last 2-3 months	Trained SMAs are ACCESS-trained advocates through the workshops in targeted countries. Auto-diagnostic tools are a key focus of the training.	Program records/ reports, completed auto-diagnostic tools	2-3 months after training	Mwangaza Action ACCESS staff	No data available