

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

## ACCESS

### YEAR THREE ANNUAL REPORT

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## ABBREVIATIONS AND ACRONYMS

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<b>ACCESS</b>	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services
<b>ACNM</b>	American College of Nurse-Midwives
<b>ACT</b>	Artemisinin-based Combination Therapy
<b>AED</b>	Academy for Educational Development
<b>AMA</b>	Afghan Midwives Association
<b>AMTSL</b>	Active Management of the Third Stage of Labor
<b>ANC</b>	Antenatal Care
<b>ANE</b>	Asia and the Near East
<b>ANM</b>	Auxiliary Nurse Midwives
<b>ART</b>	Antiretroviral Therapy
<b>AWARE-RH</b>	Action for West Africa Region-Reproductive Health Project
<b>BASICS</b>	Basic Support for Institutionalizing Child Survival
<b>BCC</b>	Behavior Change Communication
<b>BEmONC</b>	Basic Emergency Obstetric and Newborn Care
<b>BPHS</b>	Basic Package of Health Services
<b>CAG</b>	Community Action Group
<b>CC</b>	Comprehensive Care
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHAK</b>	Christian Health Association of Kenya
<b>CHMT</b>	Council Health Management Teams
<b>CHW</b>	Community Health Worker
<b>CM</b>	Community Mobilization / Community Mobilizers
<b>CME</b>	Community Midwifery Education
<b>CMT</b>	Community Mobilization Team
<b>CORE</b>	The Child Survival Collaborations and Resources Group
<b>CORP</b>	Community-Owned Resource Person
<b>CSM</b>	Community Supervisor Mobilizer
<b>CT</b>	Counseling and Testing
<b>CTO</b>	Cognitive Technical Officer
<b>CTS</b>	Clinical Training Skills
<b>DOMC</b>	Division of Malaria Control
<b>DRH</b>	Division of Reproductive Health / Department of Reproductive Health
<b>EMNC</b>	Essential Maternal and Newborn Care
<b>EmOC</b>	Emergency Obstetric Care
<b>EmONC</b>	Emergency Obstetric and Newborn Care
<b>ENC</b>	Essential Newborn Care
<b>EOC</b>	Essential Obstetric Care

<b>EPI</b>	Expanded Program for Immunization
<b>EPT</b>	Expert Patient Trainer
<b>ESD</b>	Extending Service Delivery
<b>ESOG</b>	Ethiopian Society of Obstetricians and Gynecologists
<b>FANC</b>	Focused Antenatal Care
<b>FBO</b>	Faith-Based Organization
<b>FCHV</b>	Female Community Health Volunteer
<b>FP</b>	Family Planning
<b>GOJ</b>	Government of Jharkhand
<b>GON</b>	Government of Nepal
<b>HIDN</b>	Health, Infectious Diseases and Nutrition
<b>HSSP</b>	Health Service Support Project
<b>IEC</b>	Information, Education and Communication
<b>IMA-WH</b>	Interchurch Medical Assistance World Health
<b>IMAI</b>	Integrated Management of Adult Illnesses
<b>IMCI</b>	Integrated Management of Childhood Illnesses
<b>INHSAC</b>	Institute for Health and Community Action
<b>IHS</b>	Institute of Health Science
<b>IP</b>	Infection Prevention
<b>IPT/IPTp</b>	Intermittent Preventive Treatment / Intermittent Preventive Treatment in pregnancy
<b>IR</b>	Intermediate Result
<b>IRB</b>	Institutional Review Board
<b>ITN</b>	Insecticide-Treated (bed) Net
<b>IUD</b>	Intrauterine Device
<b>KMC</b>	Kangaroo Mother Care
<b>LAC</b>	Latin America and Caribbean
<b>LBW</b>	Low Birth Weight
<b>LGA</b>	Local Government Authority
<b>LRP</b>	Learning Resource Package
<b>LTTA</b>	Long-term Technical Advisor
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MAC</b>	Malaria Action Coalition
<b>MCH</b>	Maternal and Child Health
<b>MCP</b>	Mexico City Policy
<b>MIP</b>	Malaria in Pregnancy
<b>MNC</b>	Maternal and Newborn Care
<b>MNH</b>	Maternal and Newborn Health
<b>MOH</b>	Ministry of Health

<b>MOPH</b>	Ministry of Public Health
<b>MOU</b>	Memorandum of Understanding
<b>MIPWG</b>	Malaria in Pregnancy Working Group
<b>MVA</b>	Manual Vacuum Aspiration
<b>MWRA</b>	Married Women of Reproductive Age
<b>NASCOP</b>	National AIDS Control Program
<b>NESOG</b>	Nepal Society of Gynecology and Obstetrics
<b>NFHP</b>	Nepal Family Health Program
<b>NGO</b>	Nongovernmental Organization
<b>NHTC</b>	National Health Training Center
<b>NMEAB</b>	National Midwifery Education Accreditation Board
<b>NMCHC</b>	National Maternal and Child Health Center
<b>NMCP</b>	National Malaria Control Program
<b>PAC</b>	Postabortion Care
<b>PAHO</b>	Pan American Health Organization
<b>PHC</b>	Primary Health Center
<b>PHMT</b>	Provincial Health Management Team
<b>PITC</b>	Provider Initiated Testing and Counseling
<b>PLHA</b>	People Living with HIV/AIDS
<b>PMI</b>	President's Malaria Initiative
<b>PMNCH</b>	Partnership for Maternal, Newborn and Child Health
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>PNC</b>	Postnatal Care
<b>POPPHI</b>	Prevention of Postpartum Hemorrhage Initiative
<b>PPG</b>	Performance-based Partnership Grants
<b>PPH</b>	Postpartum Hemorrhage
<b>PY</b>	Program Year
<b>QA</b>	Quality Assurance
<b>RBM</b>	Roll Back Malaria
<b>RCLS</b>	Network of Religious Leaders to prevent HIV/AIDS
<b>RH</b>	Reproductive Health
<b>RHMT</b>	Regional Health Management Team
<b>SBA</b>	Skilled Birth Attendance/Attendant
<b>SBAI</b>	Safe Birth Africa initiative
<b>SBM-R</b>	Standards-Based Management and Recognition
<b>SIP</b>	Syphilis in Pregnancy
<b>SM</b>	Safe Motherhood

<b>SMA</b>	Safe Motherhood Advocate
<b>SMV</b>	Safe Motherhood Volunteer
<b>SNL</b>	Saving Newborn Lives
<b>SP</b>	Sulfadoxine-Pyrimethamine
<b>STI</b>	Sexually Transmitted Infection
<b>TA</b>	Technical Assistance
<b>TAG</b>	Technical Advisory Group
<b>TB</b>	Tuberculosis
<b>TBA</b>	Traditional Birth Attendant
<b>TERREWODE</b>	Re-orientation and Rehabilitation of Teso Women for Development
<b>TIMS</b>	Training Information Monitoring System
<b>TNMC</b>	Tanzania Nurses and Midwives Council
<b>TOT</b>	Training of Trainers
<b>TT</b>	Tetanus Toxoid
<b>UCMB</b>	Ugandan Catholic Medical Bureau
<b>UMMB</b>	Ugandan Muslim Medical Bureau
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UPMB</b>	Ugandan Protestant Medical Bureau
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counseling and Testing
<b>VLBW</b>	Very Low Birth Weight
<b>WARN</b>	West Africa Roll Back Malaria Network
<b>WHO</b>	World Health Organization
<b>WHO/AFRO</b>	WHO/Regional Office for Africa
<b>WIRB</b>	Western Institutional Review Board
<b>WRA</b>	White Ribbon Alliance
<b>WRATZ</b>	White Ribbon Alliance Tanzania

# PART 1

## I. PROGRAM HIGHLIGHTS

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### INTRODUCTION

ACCESS is a five-year, \$75 million, Leader with Associate award to JHPIEGO in collaboration with Save the Children, Constella Futures, Academy for Educational Development (AED), American College of Nurse-Midwives (ACNM), and IMA World Health (IMA-WH). Since its start date in July 2004, ACCESS has received \$62.2 million. With an additional figure of approximately \$4 million in anticipated funds, the total anticipated obligations as of September 2008 are \$66.1 million, leaving approximately \$9 million for FY08 obligations. ACCESS has received three Associate Awards: ACCESS-FP approved with a \$20 million ceiling; ACCESS/Afghanistan for \$20 million; and ACCESS/Cambodia for \$1.8 million. Large country programs under ACCESS are located in Bangladesh, Tanzania, Kenya and Nigeria (average annual budget of \$1-\$3 million). In Program Year 3 (PY3), ACCESS added large programs in Malawi, Ethiopia and Rwanda. Overall, the ACCESS Program has demonstrated growth—beginning with field support in three countries and expanding to include activities in 25 countries—while addressing the serious challenges required in meeting Millennium Development Goals 4 and 5 in regions that contribute the most to worldwide maternal and neonatal deaths.

Highlights from the past year include strategic core investments that generated critical interest in addressing Maternal and Newborn Health (MNH) in the field<sup>1</sup>. Technical strengths of the Program contributed to its lead role in the September 2008 Asia and Near East (ANE) Best Practices Meeting in Bangkok, which was attended by 450 participants from more than 18 countries. The ACCESS team also presented the Afghanistan and Nigeria programs to more than 25 U.S. congressional staffers this year. ACCESS Began implementation of the Safe Birth Africa Initiative (SBAI) will continue in the second phase and expand beyond the initial four districts in Rwanda in collaboration with the MOH and the Twubakane Project. Pilot programs initiated in PY2 and 3 for addressing postpartum hemorrhage (PPH) in community settings are being scaled up in Nepal and Afghanistan. Regional AFR/SD activities, supported by core funds, strengthened the planning/implementation of the Road Map for Safe Motherhood (SM) in several countries and upgraded preservice training in four countries—Ethiopia, Ghana, Malawi and Tanzania. Five country programs (Rwanda, Nigeria, Malawi, Nepal and Bangladesh) have moved forward to adopt or expand Kangaroo Mother Care (KMC).

ACCESS disseminates materials through its partners to their country programs and through international meetings. In an effort to make ACCESS materials available to a global audience, ACCESS has developed several e-learning courses now posted on the Global Health website. During this period, 1,068 people completed the ACCESS e-learning courses on Antenatal Care (ANC), Postpartum Care, Essential Newborn Care (ENC), and Preventing Postpartum Hemorrhage (PPH). Two additional e-learning courses—on Emergency Obstetrical and Newborn Care (EmONC) and Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT)—are in development.

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<sup>1</sup> Examples include Cambodia - PPH; ESOG – Ethiopia; and Kenya - PPH. For example, the Kenya Mission has mandated each of its regional bilateral programs to undertake PPH activities under their umbrella.

This report presents the key achievements of the ACCESS Program during the period from 1 October 2006 to 30 September 2007. Section I, or “Program Highlights,” which provides an overview of key program results during this reporting period, is organized by four of the result pathways of the United States Agency for International Development’s (USAID) Office of Health, Infectious Diseases and Nutrition (HIDN). These results pathways are: 1) Skilled Birth Attendance (SBA); 2) ANC; 3) PPH; and 4) Newborn Care. ACCESS results presented under the pathways are further divided into those achieved using core and regional funds and those achieved using field support funds. Some critical results that do not fit under any of these pathways are also presented under an “other results” category. Section I ends with a discussion of the challenges the Program has faced over this reporting period and emerging programmatic opportunities.

More detailed discussion of achievements and related activities can be found in the detailed core and field sections II and III/IV, respectively. Section II presents core-funded results (organized by intermediate result, or IR, and by activity) and Sections III and IV have field-support funded results (organized by regional initiative and country, respectively). Country and regional narratives are followed by their M&E frameworks.

Several annexes also accompany this report. Annex A presents a complete list of regularly disseminated materials. Annex B provides funding and key activities tables. In Annex C, program coverage achieved by ACCESS country interventions focusing on service delivery and demand generation for maternal and newborn services is presented by country and intervention. Annex D captures country “success stories” of particular interest. Annex E captures results achieved at the global level through a “progress update” for indicators included in the Program’s global monitoring and evaluation (M&E) framework. Annex F is an activity summary of the ACCESS small grants for prevention of obstetric fistula. Annex G is a portfolio review report submitted to the HIDN office with information on global OP indicators relevant to ACCESS.

## **MAJOR ACCESS ACHIEVEMENTS**

### **Skilled Birth Attendance**

#### **Core funds**

- Technical leadership for MNH at USAID’s regional meeting on Scaling Up Family Planning (FP)/MNCH Best Practices in Asia and Mideast. ACCESS and ACCESS-FP were responsible for arranging several sessions—1 on scaling-up, 5 on maternal health, 3 on neonatal health and 2 on FP—and supported 38 participants and panelists.
- Collaborated with global stakeholders to support the Women Deliver conference. Supported over 20 participants and panelists to the conference. Several panels submitted by ACCESS and ACCESS-FP on PPH, SBA, PPF, Faith-based Organizations (FBOs), and Malaria in Pregnancy (MIP) accepted for presentation. ACCESS continued support for the technical advisor to the Partnership for Maternal, Newborn, and Child Health (PMNCH) to assist with the implementation of their global activities, strategic planning and fundraising.
- In **Rwanda**, ACCESS is implementing SBAI, aimed at accelerating and increasing SBA and coverage. ACCESS and in-country partners developed a strategic approach, conducted a baseline facility assessment, and held several stakeholder meetings which strengthened partnerships and agreement on skill sets (such as Emergency Obstetric Care, or EmOC). ACCESS introduced performance quality improvement in the training of trainers (TOT) for EmOC conducted by the Twubakane program.



Newly-trained ANMs visit communities, promote birth preparedness, offer care and build partnerships with other local providers

training is in progress. ACCESS also initiated behavior change communication activities in 180 communities through Safe Motherhood Advocates (SMAs) and Safe Motherhood Volunteers (SMVs)—leaders in the community who mobilize women and families to access care provided by the trained ANMs.

- In Jharkhand, **India**, ACCESS is piloting an expanded training to improve the SBA skills of auxiliary nurse-midwives (ANMs)—growing from the current government approved 3-week training to a more expanded skills intensive training of 3 months. Although only midstream, the Government of Jharkhand (GOJ) has shown interest in scaling-up this approach. Additionally, ACCESS is working with the communities of Dumka District to increase utilization of these ANMs. Site assessment and strengthening were completed at two facilities. Additional resources were leveraged by the GOJ to train the ANMs and upgrade the training sites. The first group of ANMs has been trained and a second training is in progress. ACCESS also initiated behavior change communication activities in 180 communities through Safe Motherhood Advocates (SMAs) and Safe Motherhood Volunteers (SMVs)—leaders in the community who mobilize women and families to access care provided by the trained ANMs.
- In **India**, ACCESS conducted a baseline household survey in Jharkhand of pregnant women and women who delivered in the past year that revealed: more than 80% planned to give birth at their home; most were attended by a Traditional Birth Attendant (TBA) and less than 15% by a skilled provider; awareness of key steps to plan for childbirth and danger signs in mothers and newborns is very low; about 50% attended ANC at least once and over 90% received Tetanus Toxoid (TT) injections.
- In **Ethiopia**, the Ethiopian Society of Obstetricians and Gynecologists (ESOG) received support to build capacity of skilled providers in Emergency Obstetric and Neonatal Care (EmONC). One clinical site—involving 40 staff—strengthened at Ambo hospital to improve BEmONC services; additionally, 20 providers trained in BEmONC.
- An equity analysis of baseline household survey data from Zamfara state in northern **Nigeria** revealed both household location and poverty affect women’s use of antenatal services. The main barriers to ANC for rural women were distance to the nearest facility and out-of-pocket fees. Access to delivery services, particularly for the poorest rural women, were related to distance to the facility and their own belief that such delivery services were not necessary. Communities in Nigeria will be able to use this information to develop the most appropriate financing schemes.
- Members of country-level White Ribbon Alliances (WRAs) from **Tanzania, Zambia, Malawi and South Africa** developed a plan for a concerted regional effort on the human resources crisis and its effect on MNH at a WRA regional workshop for National Alliance members held in Malawi.

### Regional: AFR/SD and Core Funds

- During the Partnership Forum for operationalization and resource mobilization for the African Road Map organized by the World Health Organization (WHO), ACCESS increased its visibility as a key player in efforts to reduce maternal and newborn mortality in Africa and accepted requests for hands-on technical assistance (TA) in **Madagascar** and **Niger**. TA visits to each

country helped to transfer knowledge and skills on mapping MNCH interventions and creating links of how such information will feed back into the operationalization of the Road Map.

- A total of 70 midwifery tutors and clinical preceptors from **Ethiopia, Ghana, Malawi and Tanzania** have updated clinical skills in Basic Emergency Obstetric and Newborn Care (BEmONC). Of these, 14 received advanced training in clinical training skills (CTS) and curriculum design. In each country, one high-caseload health facility was strengthened to be a training site, and staff from these clinical sites were oriented to and coached in best practices in BEmONC.

### Regional: West Africa Funds

- During follow-up visits, observers reported that active management of third stage of labor (AMTSL) is being practiced consistently by providers trained by ACCESS in **Mauritania**.
- The Regional Hospital Center in the Sokode district, **Togo**, was strengthened to serve as an EmONC clinical training site, and the capacity of providers from nearby facilities was strengthened.
- Community action plans, which include social mobilization, were developed in 18 health zones in **Cameroon** during auto-diagnostic participatory sessions with community members to analyze problems related to MNH. A followup visit to 13 zones in August revealed the zones have either strengthened or revived their community health insurance schemes in order to address equity in access to health services. Furthermore, community health workers (CHWs) in these zones demonstrated improved organization, planning and implementation of health education sessions on the importance of ANC, vaccination and birth planning

### Field Funding

- In **Afghanistan**, the Health Service Support Project's (HSSP) Performance-based Partnership Grants (PPG) to Nongovernmental Organizations (NGOs) and other stakeholders is resulting in improved quality and integration of standards for the implementation of a quality Basic Package of Health Services (BPHS) delivery strategy. Evidence-based quality standards for use at the hospital level have been developed and applied at 31 health facilities across 4 provinces, with 225 people trained in the quality improvement process.
- In **Afghanistan** to date, through HSSP awards of midwifery and community midwifery grants, 159 midwives have graduated from Nangahar, Herat, Balkh and Kabul hospital midwifery training programs, and an additional 143 community midwifery students are expected to graduate soon. The skilled attendance at birth has increased from 4% to 43% in Herat province in the last few years.
- Capacity of the NGOs and health providers in **Afghanistan** to deliver the BPHS services has been improved through training of 885 people in the rational use of drugs; monitoring,



A student at Herat Institute of Health Science simulating a clinical procedure with a model

supervision and evaluation; basic EmOC; effective teaching skills; identification of gender indicators; and provincial capacity building.

- In **Nepal**, the Ministry of Health (MOH) disseminated the ACCESS-developed maternal and newborn care (MNC) learning resource package (LRP) for SBA for inservice and preservice training for ANMs, nurses and doctors.
- A study in rural **Nepal** on factors that contribute to the successful utilization of SBA services revealed that facility characteristics that may be associated with a high volume of delivery services include: “24/7” services/staffing; availability of basic EmOC; easy access; referral system and/or ambulance; dynamic facility leader; energetic community collaboration; and employment of local personnel. Study findings are being used to inform national planning for the SBA program.
- In **Nigeria**, in collaboration with the MOH, WHO, UNICEF and PATH, performance standards for EmONC—including PPH—in hospitals and primary health centers (PHC) were developed and roll out of the standards is planned for all tertiary health facilities in the country. To date, 13 facilities have conducted baseline assessments using the standards, with scores ranging from 0 to 25% of standards met.
- In **Tanzania**, more than 10,000 people marched to raise awareness about the need for home-based life-saving skills in the Morogoro district through the WRA, Tanzania.
- ACCESS expanded postabortion care (PAC) services to **Guinea’s** Forest Region, building the capacity of providers at six facilities and providing supportive supervision. An assessment of the availability and quality of PAC services revealed that all 9 facilities were providing all elements of PAC: from January to June 2007, a total of 618 women were treated for incomplete abortion; 67% of PAC clients left facilities with a FP method, including 75% of adolescents; at all facilities, bleeding after pregnancy loss was treated using manual vacuum aspiration.

## **Prevention of Postpartum Hemorrhage**

### **Core Funds**

- ACCESS staff participated in WHO’s Experts Panel on review of the evidence for prevention and treatment of PPH. WHO released a technical report based on the review that is being used globally to develop and strengthen programs for addressing PPH.
- In past years, ACCESS awarded small grants to seven local organizations in six African countries (**Madagascar, Kenya, Ethiopia, Burkina Faso, Mali and DR Congo**), who are continuing their country-level PPH activities to expand training for AMTSL.
- ACCESS **Kenya** supported implementation of the action plan that resulted from the regional conference held in Uganda. This included the establishment of a technical advisory group (TAG) to engage MOH officials, preservice and inservice education stakeholders, and professional associations to promote national policy and regulatory issues for PPH, as well as the development of clinical practice guidelines for AMTSL.
- ACCESS chaired the Prevention of Postpartum Hemorrhage Initiative (POPPHI) technical working groups on community-based PPH and training, and provided input into the statement on community-based PPH using misoprostol.

- In **Cambodia**, ACCESS supported a national-level technical meeting on PPH and oriented national stakeholders to the global data and research on AMTSL and evidence on use of misoprostol for PPH reduction. The meeting also resulted in the formation of a PPH TAG, and consensus for the development of a demonstration project on expanded use of AMTSL among skilled providers and community-based distribution of misoprostol to pregnant women in settings where there is no skilled attendant.

## Field Funds

- A midterm evaluation of the community-based Prevention of PPH pilot project in **Afghanistan** presented to the Afghanistan PPH TAG demonstrated that the use of misoprostol to prevent PPH during home births is safe, acceptable, feasible and programmatically effective. The Ministry of Public Health (MOPH) informed ACCESS that it will take the intervention to scale on a national level. Preliminary analyses show that, of the 570 postpartum women interviewed, 98% of women accepted misoprostol during the eighth month antenatal visit, 65% took the drug in accordance with their instructions, and 32% received an injectable uterotonic at a health facility. Therefore, only 3% of the women in the intervention areas did not receive an uterotonic drug to prevent PPH compared with 74% of women in the control areas.
- ACCESS worked with the **Nepal** Family Health Program (NFHP) to prepare for scale up of PPH prevention using misoprostol. ACCESS assisted with an external midterm evaluation of the community-based prevention of PPH program in Banke district and provided recommendations to help plan for a national roll out of use of misoprostol for prevention of PPH.

## Newborn Care

### Core Funds

- ACCESS staff co-authored chapters in “Opportunities for Newborns in Africa,” a regional review of newborn health in Africa and supported the publication and dissemination of the report. It was launched at the African Health Ministers Meeting and at several other events to garner support for addressing neonatal mortality in Africa.
- In **Nepal**, a national workshop was held to sensitize stakeholders from the MOH medical schools and nursing, ob-gyn and pediatric professions on KMC, resulting in the creation of a national KMC advisory group and the introduction of KMC at five health facilities—two zonal hospitals and three PHCs.
- In **Rwanda**, ACCESS collaborated with the MOH to introduce KMC, establishing a training center, developing a core group of national-level trainers, and equipping three district hospitals with related materials. Additional partners and donors, including UNICEF, are requesting expansion of the KMC sites to other districts in Rwanda.



Rwandan mother practicing KMC.

### Regional Latin America and Caribbean Funds

- ACCESS collaborated with PAHO, USAID, BASICS, the CORE Group and MOHs in Latin America and the Caribbean (LAC) to prepare the Regional Strategy and Action Plan on Neonatal Health within the Continuum of Maternal, Newborn and Child Care in LAC. ACCESS

coordinated with partners to finalize and translate the Strategy into English, Spanish, French and Portuguese and to launch the Strategy at a meeting at PAHO headquarters in June 2006. ACCESS is further assisting to disseminate the document to MOH and NGO partners in 11 focus countries in the region as well as US-based partner organizations.

## Field Funds

- ACCESS **Nigeria** strengthened providers' capacity in EmOC, KMC and postpartum FP, and the SBM/R approach to quality improvement. The first KMC center was featured in a documentary aired four times on local and national television stations.
- In **Nepal**, ACCESS collaborated with the NFHP and the MOH to introduce a project in one district to identify and manage low birth weight (LBW) infants at the community level. From January to September 2007, a total of 769 newborns were identified as LBW by female community health volunteers (FCHVs). This represents 19% of the over 4145 deliveries registered in the communities. Among the FCHVs whose performance was observed, 80% properly used KMC. At the national level, ACCESS also supported development of LBW management guidelines in collaboration with a national TAG.
- Former Senate majority leader Bill Frist visited the ACCESS/**Bangladesh** Safe Motherhood (SM) and Newborn Care project in Sylhet division, where he met with on-site service providers and was briefed about immunization and vaccine services provided in the community.
- In **Bangladesh**, ACCESS counselors (ACs) are identifying pregnant women and conducting planned home counseling visits to encourage healthy maternal and newborn outcomes, Community Mobilizers (CMs) are mobilizing community action, support and demand for the practice of healthy MNH behaviors. To date, a total of 4,584 women who delivered received postnatal visits during the reporting period. Among them: 31% had a birth plan; approximately 72% of newborns were attended by a newborn care person; 84% of mothers practiced clean cord care; nearly 75% of mothers initiated breastfeeding within one hour of birth; 72% of newborns were dried and wrapped immediately; and almost 52% of mothers delayed bathing their newborns by three days.



FCHVs, who identify LBW infants in the community, with traditionally-dressed local women in Nepal



AC conducting home visits in Bangladesh

## Antenatal Care Pathway

### Core Funds

- In **Rwanda**, ACCESS and the Rwanda Network of Religious Leaders to prevent HIV/AIDS mobilized religious leaders for advocacy on SM through a national-level workshop on SBA in Kigali attended by Islamic and Christian religious leaders. ACCESS also provided five Rwandan District Hospitals with equipment and supplies.

## Core Malaria Action Coalition (MAC)/Malaria Funds

- ACCESS technical support to FBOs in **Uganda** led to the development of nationally adopted MIP training materials, as well as improved knowledge, attitudes and practices among service providers at five health facilities. This resulted in an increase in intermittent preventive treatment (IPT) 1 from 43% to 94%, and an increase in IPT2 uptake from 63% to 76% of ANC clients.
- ACCESS provided technical guidance to countries in Africa as they worked toward scale up of prevention of MIP interventions. Since October 2006, ACCESS has provided support in **Kenya** and **Rwanda** through the development of workplans that will support national goals and the President's Malaria Initiative (PMI).

## Field Funds

- Since October 2006, ACCESS has expanded PMTCT counseling and testing (CT) to 23 facilities in **Haiti**, reaching more than 18,400 pregnant women. Of these women, 3.6% were HIV+ and 58% of those who tested positive were enrolled in the PMTCT program.
- In **Kenya**, ACCESS expanded FANC to include a Tuberculosis (TB)/ANC training package, which is now being implemented in one province. In addition, central and provincial supervisors from the Department of Reproductive Health (DRH) and National AIDS and Sexually Transmitted Infection (STI) Control Program (NASCOP) have improved supervision skills, having been trained to use an integrated PMTCT/Maternal and Child Health (MCH) supervision tool.
- In **Tanzania**, ACCESS continued to scale up clinical training, service delivery, and quality improvement capacity for FANC/MIP in government and FBO-affiliated health facilities and midwifery schools. During FY 07, about 4,031 health care providers, trainers and graduates were trained in FANC. As a result, the number of facilities implementing FANC services with providers trained by ACCESS increased to a total of 1,192 facilities, representing about 24% of the total facilities in the country.
- Among ACCESS-supported facilities reporting service statistics during this reporting period (n=102), over 23,000 ANC clients received IPT 1 (59%) and over 16,000 ANC clients received IPT 2 (41%). In addition, over 27,000 ANC clients received TT2 (69%) and over 36,000 received ITN vouchers (93%).



FANC in Tanzania

## Other Access Results (Women's health such as obstetric fistula and family planning)

### Core Funds

- In **Niger**, **Uganda**, and **Nigeria**, local NGOs received ACCESS small grants to prevent obstetric fistula. In Niger, ONG Dimol completed community sensitization work and used drama presentations to inform the population about the causes, consequences and potential prevention of fistula. The Ugandan Private Midwives Association (UPMA) improved communication techniques of midwives to engage with communities on discussions on fistula

prevention. In Nigeria, 60 facilitators in two communities in Ebonyi State were trained. Post intervention, 20% of pregnancies in the target communities were referred with danger signs; facility births rose from 16% to 23%; 40% of respondents knew the laws that protect girls and women from violence; attendance at antenatal clinics increased; women formed a thrift collection group to save money for obstetric emergencies; 20% of pregnant women had a birth plan in place; five women with repaired fistula received microcredit for small businesses; emergency transport plans increased and men were organized into groups to ensure availability of transport for emergencies.

- In **Kenya**, ACCESS and the Division of Malaria Control (DOMC) sensitized 928 service providers on the artemisinin-based combination therapy (ACT) regimen for case management of clinical malaria, use of quinine, sulfadoxine-pyrimethamine (SP) and prevention and control of MIP in line with the new MOH guidelines. (MAC field funds)
- Since May 2007, 161 clients at 16 health facilities in **Haiti** benefited from long-term methods of FP. Of these clients 73% opted for Norplant, 20% received tubal ligation, and 17% had IUDs inserted.

### **Core ACCESS-FP Funds**

- ACCESS-FP has supported **Kenya's** Division of Reproductive Health (DRH) to reinvigorate postpartum care services with an emphasis on FP. ACCESS-FP developed the first postpartum FP orientation package for Kenya, successfully used to train 98 providers.

### **Field Support Funds**

- As documented in an endline survey, contraceptive uptake increased an average of 15% in the three districts in **Kenya** where ACCESS provided technical support aimed at facilities based on survey findings. This was a remarkable increase; the target was set at 5% by the MoH and the Implementing Best Practices consortium in Kenya.
- Also in **Kenya**, ACCESS supported the rollout of integrated management of adult illnesses (IMAI) for HIV, including TOT and advocacy/planning meetings. As a result, the MOH/NASCOP was able to establish ART services according to the national standards at 71 new ART sites in four provinces. In addition, provider-initiated CT training materials developed by Kenya's NASCOP with ACCESS support have been adopted as part of the national HIV training materials.
- The first Antiretroviral (ART) Services Standard-Based Management and Recognition (SBM-R) tool has been finalized in **South Africa** and baseline assessments have been completed in five ART sites. These sites scored a mean of 34 % of the ART standards, with scores ranging from 26% to 43%. ACCESS is assisting them to improve their performance based on action plans. In addition, ACCESS increased knowledge of National HIV/AIDS clinical guidelines for ART for Adults and Children (two provinces) and Palliative Care (two provinces).
- Also in **South Africa**, Glaxo SmithKline and ACCESS funds have been used to scale up cervical cancer prevention services, supporting 3 providers trained in Thailand last year to train 11 nurses to implement visual inspection of the cervix with acetic acid and cryotherapy in 11 new facilities.
- In **Haiti**, ACCESS developed a core group of intrauterine device (IUD) and Norplant trainers who will be training providers at target sites in long-term FP methods to help revitalize use of

these methods. A total of 76 providers at 34 facilities have strengthened capacity to provide long-term FP services. Since May 2007, 115 clients at 16 ACCESS-supported health facilities benefited from long-term methods of FP. Of these clients, 62% opted for Norplant, 20% received tubal ligation, and 17% had IUDs inserted.

## **EXPANDED PROGRAM REACH FOR ACCESS**

- **Cambodia, Rwanda, Ghana, Malawi and Ethiopia** have been added to the ACCESS portfolio this year as countries to expand MNH activities. Work began this year in Cambodia, Rwanda and Ghana and will soon begin in Ethiopia and Malawi.
  - In **Cambodia**, ACCESS used core funds to begin implementing a program to strengthen PPH, and field funds for newborn health and SBA activities.
  - In **Rwanda**, ACCESS initiated SBAL.
  - In **Ghana**, ACCESS is collaborating with the MOH to improve SBA training and coverage in three select government facilities in Birem North District in Eastern Region. The sites have already seen changes in attitudes and behaviors, such as documenting service statistics, using partographs and protocols in the facilities.
  - In **Malawi**, a MNH program was developed to support the government of Malawi's Road Map for SM. Initial work using core funds has started to support the strengthening of pre-service and in-service curricula for BEmONC. ACCESS and USAID Malawi are working on a final proposal and work plan.
  - In USAID/**Bangladesh** has requested ACCESS to add complementary interventions to strengthen community-based services and to expand the program through 2011. ACCESS submitted the revised workplan to the Mission.
  - ACCESS also received funding from USAID/**Ethiopia** to build the capacity of key Ethiopian institutions charged with training health officers and health extension workers in essential MNH care. ACCESS received USAID Ethiopia approval in August 2007.

## **CHALLENGES**

### **Continued Interest from Missions to Address Maternal and Newborn Mortality with Limited Ceiling and End Date of the Program**

ACCESS has seen a remarkable growth in the last three years. The program has expanded from working in a few countries to current activities spanning over 25 countries. Some of the Missions are envisioning multi-year programs, but as mentioned earlier, ACCESS will have only \$9 million remaining toward the ceiling after FY 07 and early FY08 funding is complete. The ACCESS CTO and the ACCESS team are working with Missions to examine the possibility of developing Associate Awards to continue with their efforts to reduce maternal and newborn mortality in their countries. ACCESS team is also discussing possibility of a no-cost extension with the CTO to ensure that the field funded programs are able to deliver results with existing funds.

### **Field Programs Vulnerable in Politically Unstable Countries**

Some of the countries (Haiti, Nepal, Afghanistan and Nigeria) where ACCESS works are currently undergoing a period of political instability. This hampers ACCESS' ability to implement the full extent of the programs and often causes delays. However, the focus of ACCESS on building in-

country capacity to implement programs has allowed many program activities to continue even during the periods of political unrest and travel bans.

### **Reporting requirements and timelines**

ACCESS has had to address new expanded reporting requirements for all the different funding sources. In many instances, these reporting requirements come at different times as compared to the dates required by the Cooperative Agreement. For instance, the Annual Report due date is October 30, yet the results are needed for HIDN portfolio review by October 12. This creates a dual reporting requirement for ACCESS staff. USAID Missions also request separate reports, including pipeline information, at other points in the year. ACCESS will be discussing optimal options with USAID/Washington, and the ACCESS management team.

### **Adjusting to Hopkins One—An Enterprise Wide System Adopted by The Johns Hopkins University**

As of January 1, 2007, The Johns Hopkins University's Hopkins-One enterprise system (with purchasing, travel, human resources and financial components) went live. While in the long run this system should greatly improve program implementation and financial reporting, the initial start-up period has required a learning curve for all staff throughout the University. We firmly believe that this system will be efficient and responsive. ACCESS Program administrative and finance staff are working diligently with partners and USAID to continue to manage financial reporting and to assure the system responds to program needs.

## **OPPORTUNITIES**

### **Continuing Growth in Programs**

The increase in the number of ACCESS country programs is a clear demonstration of the need experienced by USAID Missions to focus on MNH care programs and a preference for buying in to Global Programs. With a responsive approach to Missions, an array of highly technical and experienced staff, and supportive guidance and direction from USAID/Global, ACCESS is working to address maternal and neonatal mortality in 25 countries. Some of these programs, such as Malawi, are just starting in PY 4.

### **Developing New Associate Awards**

ACCESS has three associate awards and may see some of the field funding directed into associate awards over the remaining years of the program. During this reporting period, ACCESS initiated the implementation of ACCESS-Cambodia. Associate awards require additional startup coordination and management efforts but are a great testament to the success of the ACCESS Program's mandate.

### **Utilizing ACCESS Partner Presence to Initiate Programs Rapidly**

ACCESS has partners that have a strong presence on the ground. The program has a flexible approach of ensuring administrative and financial support through an existing partner on the ground to decrease the startup costs and delays, thereby making the best use of USAID resources. For instance in Rwanda, all the administrative and logistical support will be provided by Constella Futures, which is already on the ground with an office and administrative staff. Similarly, under the ACCESS Associate Award for Cambodia, AED is providing comparable support and services for the long-term advisor. In Malawi, a very quick startup is anticipated, building on the solid presence and track record of JHPIEGO and Save the Children in that country.

## **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. ACCESS hopes that this information would be valuable to USAID and our field programs to demonstrate tangible results over the life of the program.

## **Key Strategic Activities for Program Year 4**

In the coming year, ACCESS will continue to provide global leadership in MNH with a focus on scaling up interventions to increase SBA and ANC, prevent PPH, and improve newborn health and survival. A few highlights include:

- Using results from core-funded interventions for safe motherhood in India to inform national policies and programs on skilled birth attendance.
- In Rwanda, continue collaboration with in-country partners and expand beyond the initial four districts in Rwanda, including expansion of KMC at the facility level.
- Collaborate with FBOs at the global and national levels, particularly in Africa, to advocate for and expand resources, capacities and services for MNH.
- Support dissemination of evidence-based practices for MNH in Asia, including technical leadership for the MotherNewBorNet newsletter issues on neonatal infection and KMC. .
- Continue expansion of KMC for improved management of LBW babies in Nepal and introduction of KMC in Ethiopia.
- Scale up PPH treatment and prevention interventions in Kenya, Rwanda and Malawi.
- Expand our scope of work in Tanzania through PEPFAR funding to integrate PMTCT into reproductive health, focused antenatal care and postpartum care in up to 4 districts.
- ACCESS will be implementing MIP programs at the national level with focused ANC in 6 PMI countries—Ghana, Kenya, Madagascar, Malawi, Tanzania and Rwanda.
- Implement a demonstration project on integrated treatment and prevention of PPH through use of AMTSL by midwives in facilities and community-based distribution of misoprostol in Cambodia.
- Work with MOH and UNICEF to implement integrated postnatal care package in Cambodia.
- Implementation of a maternal and newborn health program in Malawi to support the government's Road Map for Safe motherhood.
- In Ethiopia, ACCESS will begin implementation of a program to improve capacity of district health officers and health extension workers in MNH.
- Develop Associate Award proposals to support longer term ACCESS programs in Bangladesh, Nigeria, Kenya, and South Africa.
- Continued dissemination of results and evidence-based practices in maternal and newborn health.

## II. DETAILED PROGRAM ACHIEVEMENTS: CORE FUNDS

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ACCESS continues to use core funds to maintain its role as a global leader in MNH while investing in scaling up key evidence-based interventions in select countries to increase the quality and demand for MNH services at the country level. Below are descriptions of ACCESS work in India, Rwanda and Ghana. Two other countries, Cambodia and Nepal, have combined core and field funding and are discussed in the field section of this report. Details on two important regional initiatives with mixed core and AFR/SD funding—preservice midwifery education and the Africa Road Map for reducing maternal and neonatal mortality—are included in the section III on regional results.

### GLOBAL LEADERSHIP

ACCESS maintains its global leadership position through collaboration with WHO and support to the WRA and PMNCH, production and dissemination of MNH tools and resources, engagement of FBO health networks, and small grants awards for innovative work with potential for programmatic lessons learned and scale-up.

**Global Partnerships.** ACCESS collaborated with WHO to strengthen tools and materials used by providers worldwide, including an update to the IMPAC manual on complications in pregnancy and childbirth. ACCESS is also assisting WHO/MPS in formulating an implementation guide for use with the IMPAC manual on management of newborn problems, and in their collaboration with the WHO/HIV division to formulate a curriculum on PMTCT for primary care providers. In collaboration with USAID, ESD and other partners, ACCESS provided technical leadership for MNH at USAID's regional meeting on scaling up FP/MNCH best practices in Asia and Mideast. ACCESS and ACCESS-FP were responsible for arranging 11 of the maternal, neonatal and FP sessions, and supported 38 participants and panelists. Among the panels were the plenary panels on MNH, KMC, ENC, community-based management of neonatal infection, SBA, and community-based management of PPH.

**Partnership for Maternal, Newborn and Child Health.** Through ACCESS' support of a technical advisor to the PMNCH, the partnership raised funds to support implementation of their global activities, finalized a staffing plan, and assisted in organizing for the Partner's Forum in Tanzania in April 2007. ACCESS continues its work on POPPHI's Training Task Force, including a training package on AMTSL, remains involved in the PPH Working Group, and leads the community-based PPH task force.

**White Ribbon Alliance.** Through WRA, ACCESS held a regional workshop for National Alliance members from Tanzania, Zambia, Malawi and South Africa in Lilongwe in October 2006 and, as a result of the meeting, introduced the HBLSS manual to its membership. The manual has since been adopted by the MOH and other partners, translated into Kiswahili, and launched at White Ribbon Day in March 2007. WRATZ and the MOH are now seeking funding to pilot HBLSS in Babati District in Tanzania. Additionally, the national alliances developed specific action plans around one of four MNH key interventions and each received a small grant to facilitate a meeting with their broader membership to finalize the action plan and encourage broader buy-in from their membership.

**Dissemination.** As part of ACCESS' mandate to disseminate latest evidence, tools and resources in MNH globally, in October 2006, ACCESS assisted USAID with the U.S. launch of the Lancet Special Supplement on Maternal Survival in Washington, D.C. Over 200 stakeholders in maternal health—policy makers, implementers, advocates and clinicians—attended. The Woodrow Wilson Center webcast the event, live, to a global audience and is still available for viewing on their website.

**Faith-based Organizations.** ACCESS continues to expand its partnerships with FBOs to strengthen their capabilities for MNH care delivery, scale up, and advocacy. ACCESS established partnerships with WHO's Partnerships Office and the World Council of Churches to discuss the development of a joint call to action to mobilize FBOs for safe motherhood. Presentations on FBO models for improving maternal and newborn health were given to ACCESS partner staff and a panel abstract submitted to Global Health Council for 2008. In addition, a brief—"Faith-based models for Improving Maternal and Newborn Health"—was completed and is being disseminated widely. Highlighting the contributions of FBOs to the development of successful, replicable and sustainable models of comprehensive health care, the brief focuses on FBO health networks and facility-based services in Uganda and Tanzania.

ACCESS provided small grants to FBOs in Kenya, Tanzania and Uganda following the 2005 ACCESS regional FBO workshop. These grants have enabled FBO health networks in the three countries to build capacity in FANC/MIP. FBOs now have trainers and providers who are scaling up FANC/MIP throughout the networks, which provide 40-60% of healthcare in the three countries.

In each country, the grants have led to at least two trainers and 20-40 providers per network who are trained in FANC/MIP; provision of supportive supervision; improved coordination with district health offices on supplies and equipment; and increased advocacy at the national level. In Tanzania, as part of a larger effort to equip FBO frontline health service providers with updated knowledge and skills regarding FANC/MIP, 21 providers were trained from primary FBO health facilities. Similarly, in Uganda and Kenya, the grants have improved capacity among FBO providers to deliver high-quality FANC/MIP services and updated these providers on national guidelines and policies. Training in FANC/MIP has been completed for 16 ANC providers from five FBO facilities in Kampala, Uganda; these providers have shared their new knowledge with their colleagues, resulting in changes at their facilities (e.g., ANC staff dispensing SP using the DOT method; modified record keeping to track SP usage). Focus group discussions are also mobilizing religious leaders. In Kenya, 25 providers from 11 Christian and Islamic facilities have increased capacity in FANC/MIP and have been oriented to the national guidelines.

In Rwanda, in partnership with MoH and Twubakane, religious leaders have been mobilized to support the safe birth initiative. Efforts are underway to strengthen facilities through donated medical equipment and supplies with local FBOs. With ACCESS funding, several FBO leaders from **Uganda, the Democratic Republic of Congo and Tanzania** participated in the PMNCH forum in Tanzania and are actively pursuing implementation of best practices. In **Tanzania, Uganda, Kenya and Malawi**, the capacity of FBOs was strengthened in delivering evidence-based maternal and newborn care (FANC/MIP/PMTCT) services through training and implementation.

**Fistula and PPH Small Grants.** In addition to awarding small grants to FBOs addressing ANC/MIP (described above), ACCESS awarded grants to organizations to implement activities addressing obstetric fistula and prevention of PPH. The most mature grants were for obstetric

fistula, as demonstrated by end of project results in Uganda, Nigeria and Niger. In Uganda, under a project with UPMA, 30 UPMA midwives conducted a total of 274 outreach activities to communities and 301 outreach activities to schools, reaching a total of 2,895 people within the targeted districts. Also in Uganda, the Association for the Reorientation and Rehabilitation of Teso Women for Development (TERREWODE) carried out successful fistula repairs for 76 women, as well as sensitizing more than 2,000 community members, 20 district and health officials, and 30 members of NGOs and CSOs on the issue of fistula. Additionally, radio talk shows—with population coverage of one million—were aired to raise awareness. In Nigeria, fistula activities targeting two communities in Izzi, Ebonyi State, included a survey to gather data on maternal health status, as well as training 30 facilitators in each community. Following the intervention, 20% of all pregnancies in the target communities were identified as involving some complications or danger signs and were referred; institutional births rose from 16% to 23%; emergency transport plans increased to 35%; 40% of respondents knew the laws that protect girls and women from violence; increased attendance at antenatal clinics was recorded during the project period; women formed a thrift collection group to save money for obstetric emergencies; 20% of pregnant women had a BP/CR plan in place; five women with repaired fistula received microcredit for small scale businesses; and men were organized into groups to ensure availability of transport in cases of obstetric emergencies. Finally, in Niger, ONG Dimol conducted community sensitization and used drama presentations to sensitize the largely illiterate population to the causes, consequences and potential prevention of fistula.

In the area of PPH, ACCESS awarded small grants to seven local organizations in six African countries (Madagascar, Kenya, Ethiopia, Burkina Faso, Mali and DR Congo), who are continuing their country-level PPH activities. Although activities were delayed at one organization in Burkina Faso and another in Mali, the remaining five organizations reporting increasing capacity for PPH by training 130 community and facility health care providers and 47 community leaders. In addition to the training of health workers, numerous activities have been conducted by the grant receivers, including: work with communities to increase PPH awareness; birth preparedness and complication readiness; policy and managerial support for the prevention of PPH; promotion of networking among groups with programs in AMTSL; work with preservice programs to incorporate curricula on AMTSL into midwifery and nursing schools; ensuring targeted centers have the equipment and basic supplies for the prevention and management of PPH; and development of support and monitoring systems to track progress.

### **RWANDA (Program Years: October 2007-July 2009)**

In 2007, ACCESS initiated a 3-year SBAI in Rwanda, aimed at strengthening and expanding key maternal and newborn health interventions. With in-country partners, ACCESS developed a strategic approach, and conducted a baseline facility assessment of MNH services in four target districts. ACCESS also collaborated with the MOH to establish a KMC center at Muhima Hospital, conduct a KMC training for 12 pediatricians and nurses, and equip three district hospitals with related materials. Additional partners (and donors including UNICEF) are requesting expansion of the KMC sites to other districts in Rwanda. In addition, ACCESS in Rwanda is partnering with the Network of Religious Leaders to prevent HIV/AIDS (RCLS) to mobilize religious leaders for advocacy on SM through a national-level workshop on SBA in Kigali attended by Islamic and Christian religious leaders. During this workshop, the religious leaders issued a statement affirming their commitment to mobilize their constituencies for SM. Finally, ACCESS also leveraged support from IMA, who supplied facilities in the four districts where ACCESS is working with equipment

and supplies. A task force of representatives from Islamic and Christian Religious Leaders/providers, MOH, ACCESS and other stakeholders has been organized to develop a guide for Pastors and Imams to help them incorporate effectively SM messages in their sermons as well as other pastoral work.

### **GHANA (Program Years: October 2006-September 2008)**

In Ghana, ACCESS began work in 2007 to increase utilization of quality BEmONC services in three select government facilities in Birem North District in Eastern Region, where the number of births at facilities is low. Seven midwives from the health centers and the referral hospital received a skills update in BEmONC and are in the process of training others at their facilities. ACCESS also trained teams of clinicians, district officers, and administrative staff to use an SBM-R tool to measure quality of services and capture service statistics simultaneously. The tool has been a great motivator for each facility to reach a target score for quality, particularly since the SBM-R process includes all interested and accountable parties. In just a few months, sites have already seen changes in attitudes and behaviors, including documenting service statistics, using partographs and protocols in the facilities. Finally, to obtain information on barriers to accessing services, ACCESS also collected information from 12 community focus groups. Results from this activity are currently being documented and will be used to set the community performance standards and plan community activities to increase use of services.

#### **Applying BEmONC Skills in Ghana**

A midwife in Birem North District in Ghana trained in BEmONC skills encountered a situation where she had to put her newly acquired skills to use. She was required to manually remove a placenta and was able to remove the placenta on her own without referring the case to the tertiary hospital that is quite far. Now that she has found that she can perform the skill successfully, she has been performing manual removal of the placenta and no longer refers these cases. This success can be directly attributed to the training that she received through the project and is directly linked to expected outcomes for updating and training SBAs. Rather than risking the life of the mother by transferring her to the distant tertiary hospital, this midwife now has the skills to appropriately care for delivering mothers.

### **MALARIA ACTION COALITION (Program Years: October 2004-December 2008)**

From the beginning of the Program, ACCESS has played a technical advising role as well a secretariat support role for the Roll Back Malaria-MIP working group (RBM MIP WG). Support provided for the 7<sup>th</sup> MIP WG meeting held in Nigeria October 10-12, 2006, included: organization of the meeting; development of meeting agenda, invitations and coordination with all participants; writing and translating meeting minutes; and follow up with meeting representatives. ACCESS also participated in a MIP WG meeting on 19 and 20 March 2007 in Geneva to revise the MIP WG terms of reference and work plan for submission to the RBM Board. In addition, ACCESS participated in the coordination and follow-up meeting for national malaria control program (NMCP) implementation in West Africa, organized by the West African Health Organization (WAHO) and the West Africa Roll Back Malaria Network (WARN) from 31 July to 3 August 2007. At the country level, ACCESS is providing technical guidance to countries in Africa as they work towards scale up of MIP. In Uganda, ACCESS technical support led to the development of nationally adopted training materials, as well as improved knowledge, attitudes and practices in

prevention of MIP among service providers at five health facilities and clients in surrounding communities. The Ugandan Protestant Medical Bureau (UPMB), Ugandan Muslim Medical Bureau (UMMB), and Ugandan Catholic Medical Bureau (UCMB) are all supporting the prevention and treatment of MIP using the FANC platform. ACCESS conducted support supervision visits with trained service providers and conducted an endline survey to examine change in intermittent preventive treatment in pregnancy (IPTp) uptake and use of insecticide-treated bednets (ITNs). Both revealed a positive change in provider knowledge, attitudes and practices: IPTp1 increased from 43% to 94% and IPTp2 uptake increased from 63% to 76%; the percentage of women who received an ITN or purchased an ITN also increased from zero to 27%. Training of CORPs improved not only their knowledge of MIP prevention, but also of the necessity for enabling women to seek assistance in a timely manner. Community attitudes and preparedness were further strengthened by mobilizing religious leaders who are key to behavior change strategies.

In addition, ACCESS provided focused support in Kenya, Rwanda and Nigeria to develop workplans that will support national goals and the PMI.

### **INDIA (Program Years: June 2006-December 2008)**

In India, ACCESS aims to increase skilled care for pregnancy, childbirth and newborns in Dumka District in Jharkhand. Interventions to strengthen two schools and two clinical training sites in Dumka began in October 2006, and sites improved notably as measured by performance standards. In the first six months, one of the nursing schools improved to 59% (a 9% increase) and one of the clinical training sites doubled their score to 21%. The program will run two years.

Likewise, performance scores for management of pregnancy-related complications increased from 6 to 19%. The first batch of training at these sites produced 18 ANMs, who have been providing services since July/August 2007 and are supplied with equipment and medicines procured by CEDPA with GOJ funds. Training for the second batch of 22 ANMs is underway. Of these 18 trained ANMs, 9 of the 10 ANMs working at health subcenters reported delivering 50 women, all of whom received AMTSL and all newborns received ENC. Regular field supervision visits are being conducted to both support ANMs post-training and collect service statistics. Community-based ANMs are also expected to visit local subcenters monthly.

#### **Securing Government Commitment and Resources for Maternal and Newborn Care**

In India, the Government of Jharkhand (GOJ) and CEDPA, on behalf of the ACCESS Program, signed a memorandum of understanding (MOU) in January 2007 that formalizes a partnership to improve maternal and newborn care in Dumka. In this collaboration, GOJ contributed almost \$70,000 for clinical and training equipment, supplies and medicines; training-related costs for 40 ANMs; and support to 20 new contractually-hired community-based ANMs.

Throughout the year, GOJ and local Dumka officials continued their strong support and commitment to successful project implementation. CEDPA maintained close coordination and collaboration with both state and district officials to address and resolve issues that arose during implementation—such as the release of funds to support ANM training and most recently the hiring of newly-trained ANMs on a contractual basis in Dumka

A local Indian NGO, Chetna Vikas, and CEDPA developed a community mobilization (CM) strategy, mapped roles of various community level stakeholders and players, and reviewed and field tested existing SM materials for use in Dumka. CEDPA and Chetna Vikas also selected SMAs and

SMVs from the community who will be involved in CM on birth preparedness to reach mothers and families to help overcome local barriers to SM and help the community access care provided by the ANM trained under the project. The 40 community workers recruited for this project have all been trained in CM. Finally, to guide the program, ACCESS conducted a baseline household survey of pregnant women and women who delivered in the past year and is currently preparing the report. Preliminary results reveal that awareness of key steps to plan for childbirth and danger signs in mothers and newborns is very low. Moreover, more than 80% planned to give birth at their home, most were attended by a TBA and less than 15% by a skilled provider, about 50% attended ANC at least once, and over 90% received TT injection.

## ACCESS INDIA MONITORING AND EVALUATION FRAMEWORK

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>USAID/INDIA STRATEGIC OBJECTIVE 2:</b> Improved Health and Reduced Fertility in <i>Targeted</i> Areas of India, IR 2.1 Increased Use of Reproductive Health and Family Planning Services						
<b>ACCESS/INDIA PROGRAM RESULT:</b> Increased utilization of maternal and newborn health services and improved home-based maternal and neonatal care practices.						
A. Percent/number of women who gave birth in the past six months in ACCESS-Target areas who delivered with a skilled birth attendant (SBA) <sup>3</sup>	<ul style="list-style-type: none"> <li>Will be disaggregated by type of attendant, e.g., ACCESS-trained ANMs, other ANMs, doctors, etc.</li> <li>Facility service statistics will be collected in intervention and control areas</li> </ul>	<p>Population-based survey HMIS</p> <p>Community-based ANM records (Daily labor and delivery register)</p>	<p>Baseline and endline (% of women)</p> <p>Quarterly (# of women)</p>	<p>OR agency</p> <p>LHV supervisors (community-based ANM statistics), Princy (hospital statistics), Sanjay (PHC statistics)</p>	<p><i>Targets:</i> <i>PY3/FY07=0</i></p>	<p>Baseline survey=11% (private MBBS+ANM+district hosp dr)</p> <p>Excluded "others"= <i>villa geris doctor, PHC/CHC Doctor, Nurse</i></p>
B. Percent/number of women who gave birth in the past six months in ACCESS Target areas who received a postpartum visit within 3 days after childbirth* <sup>^</sup>	<ul style="list-style-type: none"> <li>Will be disaggregated by type of attendant, e.g., ACCESS-trained ANMs, other ANMs, doctors, etc. for population-based survey</li> <li>Service statistics will only be collected from trained ANMs- the Daily Labour and Delivery Register to capture "Number of postpartum/newborn visits by Trained Workers from USG-assisted Facilities and Communities within 3 days". "Trained workers" refers to the community-based ANMs trained with support from the ACCESS program</li> </ul>	<p>Population-based survey HMIS</p> <p>Community-based ANM records (Postpartum register)</p>	<p>Baseline and endline (% of women)</p> <p>Quarterly (# of women)</p>	<p>OR agency</p> <p>LHV supervisors (community-based ANM statistics), Princy (hospital statistics), Sanjay (PHC statistics)</p>	<p><i>Targets:</i> <i>PY3/FY07=0</i></p>	<p>Baseline survey =16.7% Only 22% received a PP visit; and 76% of these were within 3 days</p>

<sup>2</sup> \*=ACCESS global framework indicator; #=required for reporting to USAID/India mission, ^=listed as country operational plan indicator (not all 7 are in this plan)

<sup>3</sup> Definition of SBA in this M&E plan does not conform to WHO definition of SBA (<http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/>). For the purposes of this M&E plan, Auxiliary Nurse Midwives trained with ACCESS support are considered to be SBAs.

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>Result 1: Increased availability and quality of maternal and newborn health services through community-based ANMs.</b>						
1.1 Number of people trained in maternal and/or newborn health and nutrition care through USG-supported programs <sup>#^</sup>	<ul style="list-style-type: none"> <li>This indicator refers to ANMs and trainers trained through ACCESS-supported training events. The indicator will be disaggregated by type of person trained.</li> </ul>	Training participant tracking sheets and database	Quarterly	Princy	Baseline: 0 <i>Targets</i> PY3/FY07= 47 (7 trainers, up to 40 ANMs)	7 trainers 18 ANMs
1.2 Percent/number of ANMs who perform key maternal and newborn skills to standard	<ul style="list-style-type: none"> <li>ANMs trained by ACCESS will be assessed by LHV supervisors and/or ACCESS staff..</li> <li>Clinical skills to be assessed include 25 standards on prenatal counseling and services, labor and delivery, postpartum and newborn care.</li> <li>Performing to standard means a score of 80% and above</li> <li>% is calculated by dividing the total number of standards met (numerator) by the total number of standards observed (denominator)</li> </ul>	Observation checklist (part of ANM SBM/R standards tool)	Semi-annual for trained ANMs	LHV supervisors (community-based ANMs)  Princy (facility-based ANMs in intervention and control areas)	Baseline: 0 <i>Targets:</i> PY3/FY07: N/A(to be addressed in FY08)	Will report on this in FY08.

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
1.3 Percent/number of women who delivered in past 6 months in ACCESS-Targeted facilities/communities who received iron/folate supplementation*	<ul style="list-style-type: none"> <li>Number of women who delivered in past 6 months in ACCESS-Targeted facilities/communities who received iron/folate supplementation during pregnancy/Total number of women who delivered in past 6 months in ACCESS-Targeted facilities/communities interviewed</li> </ul>	<p>Population-based survey</p> <p>Community-based ANM records (ANC register)</p>	<p>Baseline and endline</p> <p>Quarterly</p>	OR agency	<p><i>Targets:</i> <i>PY3/FY07:</i> <i>Baseline measure only</i></p>	Baseline survey =66%
1.4 Number and Percentage of women giving birth in ACCESS Target areas where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) <sup>4</sup> in the past 6 months <sup>5</sup>	<ul style="list-style-type: none"> <li>AMTSL is defined as the following three elements: <ol style="list-style-type: none"> <li>Use of uterotonic drug within one minute of birth</li> <li>Performance of controlled cord traction.</li> <li>Performance of uterine massage after the delivery of the placenta.</li> </ol> </li> <li>The percentage is calculated by dividing the number of women who received AMTSL in the past 6 months where AMTSL is recorded (numerator) by the total number of women with vaginal deliveries recorded in the past 6 months (denominator)</li> <li>This indicator will only be collected for community-based ANMs, as this data is not available in facility-based HMIS.</li> </ul>	<p>Community-based ANM records (Daily Labour and Delivery Register)</p> <p>(Note: not available in facility-based HMIS)</p>	Quarterly	LHV supervisors, Princy	<p><i>Targets:</i> <i>PY3/FY07:</i> <i>N/A(to be addressed in FY08)</i></p>	100%, 50 women (8 trained facility-based ANMs reporting for July – August 2007)

<sup>4</sup> ANMs are considered SBAs for the purposes of this M&E plan

<sup>5</sup> This also covers the USAID operational plan indicator: “Number of women giving birth who received Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs.”

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
1.5 Percent/number of births in ACCESS-Targeted facilities/communities in the past 6 months that occurred with a skilled attendant using a partograph*	<ul style="list-style-type: none"> <li>• Women delivering in the past 6 months will be identified through community-based ANM records. The partograph is not used at facilities in the intervention or control areas.</li> <li>• Correct use of a partograph will be determined from review of the completed partographs by LHV supervisors or ACCESS staff.</li> <li>• 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).</li> </ul>	Community-based ANM records (Daily labour and delivery register), completed partographs	Quarterly	LHV supervisors (community-based ANM statistics)	<i>Targets: PY3/FY07: N/A(to be addressed in FY08)</i>	0 (Trained ANMs are not using the partograph. ACCESS is following up to learn why and to support them)
1.6 Percent/number of newborns in the past 6 months in ACCESS-Targeted facilities or communities dried and wrapped immediately after birth*^	<ul style="list-style-type: none"> <li>• Newborns in the past 6 months are those whose births are recorded in the 6 months prior to data collection.</li> <li>• This indicator will only be collected through service statistics for community-based ANMs, as this data is not available in facility-based HMIS.</li> <li>• The percentage will be calculated by dividing the number of newborns recorded in the past 6 months that were immediately dried and wrapped (numerator) by the number of births recorded in the past 6 months (denominator).</li> </ul>	Population-based survey  Community-based ANM records (Labour and Deliver register) (Note: Not available in facility-based HMIS)	Baseline and endline  Quarterly	OR agency  LHV supervisors, Princy	<i>Targets: PY3/FY07: Baseline measure only</i>	Baseline survey = about 10%(most mothers reported first bathing and then drying and wrapping)  HMIS=100%, 50 newborns (8 trained facility-based ANMs reporting for July – August 2007)

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
1.7 Percent/number of newborns in the past 6 months in ACCESS-Targeted facilities or communities with clean cord care*^	<ul style="list-style-type: none"> <li>Clean cord care means the cord was cut with a clean instrument and nothing was applied to the stump.</li> <li>This indicator will only be collected through service statistics for community-based ANMs, as this data is not available in facility-based HMIS.</li> <li>The percentage will be calculated by dividing the number of newborns recorded in the past 6 months that received clean cord care(numerator) by the number of births recorded in the past 6 months (denominator).</li> </ul>	<p>Population-based survey</p> <p>Community-based ANM records (Labour and Deliver register) (Note: not available in facility-based HMIS)</p>	<p>Baseline and endline</p> <p>Quarterly</p>	<p>OR agency</p> <p>LHV supervisors, Princy</p>	<p><i>Targets: PY3/FY07: Baseline measure only</i></p>	<p>Baseline survey=</p> <ul style="list-style-type: none"> <li>50% applied nothing to the cord stump</li> <li>95% used either a new razor (90%) or one from a delivery kit (5%)</li> </ul> <p>HMIS=100%, 50 newborns (8 trained facility-based ANMs reporting for July – August 2007)</p>
<b>Result 2: Increased knowledge and demand for evidence-based maternal and newborn health services/practices, including birth preparedness/complication readiness (BP/CR).</b>						
2.1 Percent/number of newborns in ACCESS-Targeted facilities or communities who are breastfed within one hour of birth*^	<ul style="list-style-type: none"> <li>Breastfeeding within 1 hour of birth is determined by information available in the records</li> <li>This indicator will only be collected through service statistics for community-based ANMs..</li> </ul>	<p>Population-based survey</p> <p>Labour and Delivery register (Note: HMIS delivery record records time of 1<sup>st</sup> feeding)</p>	<p>Baseline and endline</p> <p>Quarterly</p>	<p>OR agency</p> <p>LHV supervisors (community-based ANM statistics),</p>		<p>Baseline survey =48%(13% immed after birth + 35% within one hour)</p> <p>HMIS=100%, 50 newborns (8 trained facility-based ANMs reporting for July – August 2007)</p>
2.2 Percent/number of currently pregnant women who know key steps to plan for childbirth	<ul style="list-style-type: none"> <li>Key steps include: identify a skilled birth attendant, save money in case of emergency, identify emergency transport, identify a blood donor. The indicator will be disaggregated by step</li> <li>Number of currently pregnant women who know key steps to plan for childbirth /Total number of currently pregnant women interviewed</li> </ul>	<p>Population-based survey</p>	<p>Baseline and endline</p>	<p>OR agency</p>	<p><i>Targets: PY3/FY07: Baseline measure only</i></p>	<p>Baseline survey=</p> <p>33.8%= know all 4 key steps</p> <p>51.6%= know any 3 key steps</p> <p>68.1%= know any 2 key steps</p> <p>87.5%= know any key step</p>

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
2.3 Percent/number of women who gave birth in the past six months who can name three or more danger signs in the mother in pregnancy, labor and postpartum periods	<ul style="list-style-type: none"> <li>• Number of women who have recently given birth who can name three or more danger signs in Target [pregnancy, labor and postpartum] period/Total number of women who have recently given birth interviewed</li> <li>• Danger signs for the mother include: vaginal bleeding; severe headache; blurred vision; convulsions; swollen hands/face; high fever; loss of consciousness; difficulty breathing; severe weakness; severe abdominal pain; accelerated/reduced fetal movement; and water breaks without labor</li> </ul>	Population-based survey	Baseline and endline	OR agency	<i>Targets: PY3/FY07: Baseline measure only</i>	Baseline survey = 11.3%= can name 3 or more danger signs
2.4 Percent/number of women who gave birth in the past six months who can name three or more danger signs in the newborn	<ul style="list-style-type: none"> <li>• Number of women who have recently given birth who can name three or more danger signs in the newborn/ Total number of women who have recently given birth interviewed</li> <li>• Danger signs in the newborn include: difficult or fast breathing; yellow skin/eye color; poor sucking or feeding; pus, bleeding, or discharge from around the umbilical cord; very small baby; skin lesions or blisters; convulsions/spasms/rigidity; lethargy/unconsciousness; and red or swollen eyes with pus.</li> </ul>	Population-based survey	Baseline and endline	OR agency	<i>Targets: PY3/FY07: Baseline measure only</i>	Baseline survey = 5.9%= can name 3 or more danger signs

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
2.5 Percent/number of women who gave birth in the past six months who took key steps to plan for birth	<ul style="list-style-type: none"> <li>Key steps include: identified a skilled birth attendant, saved money in case of emergency, identified emergency transport. The indicator will be disaggregated by step.</li> <li>Number of women who have recently given birth who took key steps to plan for birth/ Total number of women who have recently given birth interviewed</li> </ul>	Population-based survey	Baseline and endline	OR agency	<i>Targets:</i> <i>PY3/FY07:</i> <i>Baseline measure only</i>	Baseline survey = 7.3%= took all 3 key steps 24.8%= took any 2 key steps 81.4%= took any key step
2.6 Number/% of ACCESS-Targeted communities with social mobilization approaches leading to achievement of improved birth planning and complication readiness*	<ul style="list-style-type: none"> <li>ACCESS-Targeted communities are those where program activities and alliances aim to enhance shared responsibility and collective action in birth preparedness/ complication readiness (BP/CR).</li> <li>Achievement of improved BP/CR is defined as having fulfilled one or more birth preparedness and complication readiness objectives of the community's self-developed action plan. Examples to be measured include: emergency financing system in place; plan for emergency transportation in the event of complications in place, or, blood donor plan in place.. Indicator will be disaggregated by type of system established.</li> <li>The number will be calculated as an annual count of Targeted communities meeting the definition criteria/Total number of Target communities..</li> </ul>	Program reports and activity tracking	Program and M&E review of program reports  Semi-annual	Chetna Vikas and CEDPA	<i>Targets:</i> <i>PY3/FY07:</i> <i>N/A (to be addressed in FY08)</i>	Will report on this in FY08

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
2.7 Number of community groups oriented / trained on birth preparedness/ complication readiness	<ul style="list-style-type: none"> <li>Community groups are organizations working with ACCESS,( e.g., CBOs, women's groups, NGOs) to increase women's knowledge of quality services and steps for preparing for birth through social mobilization and collective action strategies.</li> <li>Orientation is a shorter-term introduction; training is more in depth or ongoing.</li> </ul>	Program records Records review to document community group activities	Quarterly	Chetna Vikas and CEDPA	Baseline= 0  <i>Targets:</i> PY3/FY07: N/A	40 Community health workers trained by CEDPA. They will orient community groups in FY08.
2.8 Number of pregnant women reached by community health workers with information on birth preparedness/complication readiness	<ul style="list-style-type: none"> <li>This refers to community health workers supported by ACCESS. Birth preparedness and complication readiness information includes the need to: identify a skilled birth attendant, save money in case of emergency, identify emergency transport, and identify a blood donor.</li> </ul>	CHW register	Quarterly	Chetna Vikas and CEDPA	Baseline= 0  <i>Targets:</i> PY3/FY07: N/A	Will report on this in FY08
2.9 Number of pregnant women counseled about danger signs in pregnancy and childbirth by community health workers	<ul style="list-style-type: none"> <li>Danger signs for the mother include: vaginal bleeding; severe headache; blurred vision; convulsions; swollen hands/face; high fever; loss of consciousness; difficulty breathing; severe weakness; severe abdominal pain; accelerated/ reduced fetal movement; and water breaks without labor.</li> </ul>	CHW register	Quarterly	Chetna Vikas and CEDPA	Baseline= 0  <i>Targets:</i> PY3/FY07: N/A	Will report on this in FY08
<b>Result 3. Support systems for ANMs strengthened/developed through the government healthcare system and contributing to the performance of newly trained ANMs.</b>						
3.1 Number of people trained in maternal and/or newborn health and nutrition care through USG-supported programs <sup># ^</sup>	<ul style="list-style-type: none"> <li>This indicator refers to LHVs trained with ACCESS support.</li> </ul>	Training participant tracking sheets and database	Quarterly	Princy	Baseline: 0  <i>Targets</i> PY3/FY07= 50	6 LHVs, 3 medical officers

INDICATOR <sup>2</sup>	DEFINITIONS AND CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	BASELINE/TARGET	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
3.2 Percent/number of trained LHVs/supervisors conducting regular supervision visits	<ul style="list-style-type: none"> <li># of LHVs/supervisors conducting regular supervision visits/Total number of LHVs/supervisors trained</li> </ul>	Program records	Semi-annual	Princy	Baseline: 0  <i>Targets:</i> <i>PY3/FY07:</i> <i>N/A</i>	Will report on this in FY08
3.3 Percent/number of trained ANMs reporting they received a supervision visit in the previous quarter	<ul style="list-style-type: none"> <li># of trained ANMs reporting they received a supervision visit in the pervious quarter by an LHV/supervisor /Total number of trained ANMs interviewed</li> </ul>	ANM interview	Records and document review Semi-annual	OR agency	Baseline: 0  <i>Targets:</i> <i>PY3/FY07:</i> <i>N/A</i>	Will report on this in FY08

## CORE ACTIVITY MATRIX: OCTOBER 2007

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<b>IR 1: GLOBAL LEADERSHIP FOR MATERNAL, NEONATAL, AND WOMEN'S HEALTH AND NUTRITION PROGRAMS AND POLICIES STRENGTHENED</b>	
<p>1.1 Through global partnerships promote ways and means of overcoming policy and program barriers to ensure maternal, neonatal, and women's health goals and incorporation of evidence-based strategies in country programs</p>	<ul style="list-style-type: none"> <li>• Edited, critiqued, wrote numerous drafts of the Global Business Plan for MDGs 4 and 5 (now titled the Global Campaign for the Health MDGs, launched Sept 26 at the Global Clinton Initiative and the UN)</li> <li>• Organized a technical, expert review of 14 costing tools designed for health sector planning, Report due in December.</li> <li>• ACCESS supported a senior staff who was primarily tasked with the development of the strategic plan and business proposals that secured additional funding for PMNCH activities (core funds)</li> <li>• Coordinated with USAID the U.S. launch of Lancet Special Supplement on Maternal Survival, attended by over 180 maternal health stakeholders and webcast through the Woodrow Wilson Center website on October 5, 2007. The webcast was viewed live by 45 people and has had 89 visits since the event. Disseminated the Lancet series to attendees</li> <li>• Questionnaire on utilization/suggestions for revision of the IMPAC manual "Managing Complications in Pregnancy and Childbirth" disseminated worldwide in French and English; nearly fifty responses analyzed by ACCESS TA. In collaboration with Making Pregnancy Safer Department (MPS) at WHO/Geneva next steps identified to continue update and revision process for the MCPC.</li> <li>• Final draft of Implementation Guide for the IMPAC manual "Managing Newborn Problems" completed and sent to WHO/Geneva for review.</li> <li>• Action plans developed by 4 WRA National Alliances (Tanzania, Zambia, Malawi and South Africa) around a key intervention at regional workshop held in Malawi in October 2006.</li> <li>• Support leveraged by two Alliances (Tanzania and Zambia) for additional funding and MoH commitment.</li> <li>• Review completed and feedback sent to WHO on the IMAI/IMPAC Integrated PMTCT training course for nurses at first level health facility. (This course was formulated by WHO/Geneva in PY2/3 with ACCESS TA).</li> <li>• The MIP Implementation Guide has been reviewed by former MAC partners and is in the final formatting and editing process.</li> <li>• Existing LRP for Managing Newborn Problems reviewed by clinician; suggested improvements made to make it more relevant to implementers of the manual. In search of funding.</li> <li>• Continue to serve as key member of the MotherNewBorNet Secretariat.</li> <li>• Provided technical leadership on MNH for the USAID regional meeting on FP/MNCH held in Bangkok in September .</li> <li>• Provided technical review of proposals submitted by ANE countries for scale up of FP/MCH.</li> <li>• Provided TA for a joint statement on community-based newborn care and met with WHO, UNICEF, SC and BASICS.</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<p>1.2 Partner with faith-based health care networks to expand emergency MNC interventions</p>	<ul style="list-style-type: none"> <li>• MNC strengthened in FBO Health networks(Christian/Islamic) through training of FBO Providers in FANC/MIP in three countries in Africa (Tanzania, Kenya and Uganda)</li> <li>• Religious Leaders (more than 100) both Islamic and Christian mobilized for SM in Rwanda</li> <li>• Engaged with WHO to prepare a Joint statement on FBOs and EMNC.</li> <li>• Coordinated a presentation on Tanzania FBO Human Resources Information System/Geographic Information System (HRIS/GIS) mapping at Global Health Council meeting June 2007 and Christian Connections for International Health in May 2007 accepted.</li> <li>• ACCESS resources disseminated at the Religious Leaders and providers meeting in Rwanda, and also shared with Eglise du Christ au Congo (ECC-DRC).</li> <li>• In Tanzania, CSSC staff &amp; Zonal Coordinators, ACCESS staff, Tanzania Episcopal conference Health Coordinator and MEDA (ITN program) participated in training in HRIS/GIS Mapping data analysis and management.</li> <li>• Twenty-five health providers (22 Nurses, 2 Clinical Officers and one Medical Doctor) from the Nyanza and Southern Rift Region participated in a sensitization workshop on MIP and PMTCT.</li> <li>• In total, 60 providers have been trained through FANC small grants and an additional 50 through a special grant to CHAK.</li> <li>• ACCESS partnered with RCLS-Network of Religious Leaders to prevent HIV/AIDS to organize the workshop for 110 Religious Leaders. MoH, Twubakane, UNICEF, WHO, USAID representatives participated and presentations were made by MoH, Twubakane, ACCESS and UNICEF</li> </ul> <p><b>ACCESS Small Grants to FBOs</b></p> <p><b>Kenya – CHAK, Agha Khan &amp; MOH</b></p> <ul style="list-style-type: none"> <li>• Orientation workshop for 11 administrators/supervisors (CHAK &amp; Agha Khan) completed and training of 15 providers from 10 FBO facilities in focused ANC, MIP completed.</li> <li>• Training skills of country team trainers strengthened.</li> </ul> <p><b>Uganda – Uganda Protestant Medical Bureau, Uganda Methodist Medical Bureau &amp; MOH</b></p> <ul style="list-style-type: none"> <li>• Materials adapted and developed for the Uganda-MAC project will be used.</li> <li>• Baseline assessment underway at the selected facilities.</li> </ul> <p><b>Tanzania – CSSC and Agha Khan</b></p> <ul style="list-style-type: none"> <li>• Conducted orientation meeting with administrators/supervisors at the select facilities.</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<p>1.3 Disseminate ACCESS Program materials and resources to stakeholders worldwide to advance knowledge of and programming in MNH</p>	<ul style="list-style-type: none"> <li>• Printed and disseminated more than 10,500 copies of various Program materials. (See Annex A for complete list of regularly disseminated materials).</li> <li>• ACCESS dissemination of materials at conferences and workshops: Scaling-up High Impact FP and MNCH Best Practices conference in Thailand (Sept 2007); National Assembly of Religious Leaders in Rwanda (August 2007); Newborn Regional Meeting in Paraguay (August 2007); Ghana's teaching hospitals (June 2007); West Africa Health Organization meeting (June 2007); Global Health Council (May 2007); ACCESS congressional briefing for staffers (May 2007); ACNM annual meeting (Apr 2007); PMNCH launch in Tanzania (Apr 2007); CORE SM RH Spring Meeting (Apr 2007); Saving Newborn Lives (SNL) Program Managers meeting in South Africa (Feb 2007); SBA Stakeholders Meeting in Nepal (Nov 2006).</li> <li>• Materials completed: FBO/MIP technical brief; ACCESS pregnancy wheel tool for providers developed and translated into French and distributed to Bangladesh, Rwanda, Malawi and Ethiopia.</li> <li>• Training package and implementer's guide on community based use of misoprostol in the final stages of editing and production.</li> <li>• 1,068 people have completed the e-learning courses on ANC, Postpartum Care, ENC, and Preventing PPH developed by ACCESS. Two additional e-learning courses (on EmONC and PMTCT) are near publication; a third course (on Maternal Death and Disability) is near finalization.</li> <li>• ACCESS website: 9,423 visitors since last year, of which 6,460 have been unique visitors; downloads since October 2006 have increased monthly, including more than 2,500 downloads of various reports.</li> <li>• Translations: technical briefs translated into French (Providing Integrated Individualized Care during Pregnancy, Preventing PPH, Prevention and Treatment of MIP in Sub-Saharan Africa). Household-to-Hospital Continuum of Care manual translated into Spanish and Portuguese.</li> <li>• ACCESS is Chair on POPPHI Training and Community Task Force ACCESS also holds membership in POPPHI's PPH Working Group ACCESS has Co-authored POPPHI's AMTSL Reference Manual ACCESS assisted POPPHI to pretest AMTSL Reference Manual and skill checklist in Pakistan ACCESS assisted POPPHI with the process of development of the POPPHI PPH Toolkit (still in process) In December 2006, ACCESS attended POPPHI's Uterotonic Drugs and Devices Task Force.</li> <li>• Assisted POPPHI in the completion and subsequent dissemination of the French version of the AMTSL: A Demonstration CD-ROM.</li> </ul>
<p>1.4 Administer and manage small grants to expand and scale up EMNC, PPH, focused ANC (FBO), &amp; fistula interventions</p>	<ul style="list-style-type: none"> <li>• <b>PPH Grants:</b> Seven grants were awarded in November 2006 in the following countries: Burkina Faso, Mali, Ethiopia, Kenya, Madagascar, Democratic Republic of Congo. Five of the grantees submitted their first deliverable which includes training and publications for technical and branding review. These five organizations reported training a total of 112 facility-based providers, 17 community health workers and 47 community leaders in PPH. The grantee in Democratic Republic of Congo also held 6 advocacy meetings in two districts to discuss activities to reduce PPH.</li> <li>• <b>Obstetric Fistula Grants:</b> The grant cycle for the Obstetric Fistula grantees is nearing completion. Two grantees, one in Uganda and one in Niger, have completed their activities and have submitted their final reports. The other two grantees were granted no-cost extensions until 30 April 2007.</li> <li>• <b>FBO:</b> Two of the three grantees have completed their second deliverable. All three grantees—CHAK, CSSC and UPMB—have completed training and are in the supportive supervision phase, following up with trained providers as they implement FANC/MIP. (See Activity 1.2 for more details on FBO small grant accomplishments.)</li> </ul>
<p>1.5 TA—Strategic opportunities for TA to strengthen MNH programs</p>	<p>ACCESS provided hands-on technical assistance to selected countries to assist them in efforts to reduce maternal and newborn mortality.</p>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<b>IR 2: PREPARATION FOR CHILDBIRTH IMPROVED</b>	
<p>2.1 India: Field-test interventions to reduce maternal and neonatal mortality and morbidity based on guidelines for skilled attendance at birth developed for India's RCH II program Improve the quality of community and facility-based EMNC services(including integration of PMTCT services, prevention of PPH, newborn care, and postpartum care)</p>	<ul style="list-style-type: none"> <li>• Government of Jharkhand signed an MOU which will allow for the release of equipment, supplies and the ANMs in January 2007. Almost \$70,000 of funding committed by GOJ to CEDPA to support project implementation in Dumka.</li> <li>• OR design finalized, research agency contracted, tools developed and baseline conducted.</li> <li>• Site assessments completed at two sites in October 2006. Two clinical training sites strengthened in Dumka district (both clinical sites and training centers) complete with anatomic models, equipment, supplies, training materials in Hindi and teams of clinical trainers—10 % improvement seen after 6 months at both sites.</li> <li>• ANM standards finalized. ANM 3-month training curriculum and LRP developed, translated into Hindi and tested. A total of 7 clinical trainers prepared and conducting ANM training.</li> <li>• ANM 3-month MNC training conducted: first batch completed with 18 ANMs competent and second batch underway from October with 22 ANMs participating). A total of 10 newly-trained ANMs in government assigned to subcenter facilities providing services post-training since July; 8 new ANMs appointed and posted from September.</li> <li>• Visit to Masaliya Bloc PHC for assessment of the health facility and knowledge level of ANMs and their current practices with regards to maternal delivery care and sharing with district health department</li> <li>• Preparation of data bank for OR, including: Health Subcenter wise population; names of the ANMs; villages under each Health Sub Centre for PHCs; and the expected number of births in each Health Subcenter in a year.</li> <li>• Plotting of Health Sub Centre boundary and other resources in three block maps completed.</li> <li>• Chetna Vikas NGO selected, contracted and oriented/trained in Dumka. 40 community health workers trained by NGO on SM—and mobilized to train 900 community members from September.</li> <li>• BCC activities initiated in 180 locations of 3 blocks (Jarmundi, Shikaripara and Saraiyahat) by the local NGO, Chetna Vikas</li> </ul>
<p>2.2 Support MNH in Cambodia<sup>6</sup></p>	<ul style="list-style-type: none"> <li>• ACCESS proposal for an Associate Award for MNH in Cambodia approved by the USAID mission in December 2006. A long-term technical advisor (LTTA) was recruited and arrived in Cambodia in late February 2007 to work with the Cambodia MOH at the National Maternal and Child Health Center (NMCHC). Detailed Year 1 work plan submitted and approved by USAID/Cambodia.</li> <li>• ACCESS is a key member of a sub working group on strengthening newborn health in Cambodia and has assisted in developing the TOR's for the group, drafting the SOW for a situational analysis and drafting an integrated PNC package, designed to become the national standard of care</li> <li>• Following the work outlined above for the National Neonatal Advisory Group, ACCESS intends to field test the integrated PNC package with CARE Australia in their program province</li> <li>• Following a meeting of the High Level Midwifery Task Force, a secretariat under the NRHP has been set up to continue the work on major updating and revision of all aspects of midwifery in Cambodia. ACCESS, along with UNFPA, JICA and GTZ are members of that secretariat.</li> <li>• ACCESS supported a national-level technical meeting on PPH and oriented national stakeholders to the global data and research on AMTSL and evidence on use of misoprostol for PPH reduction. The meeting also resulted in the formation of a PPH TAG, and</li> </ul>

• 6 Cross-reference the field section of this report for more information on ACCESS work in Cambodia.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<p>consensus for the development of a demonstration project on expanded use of AMTSL among skilled providers and community-based distribution of misoprostol to pregnant women in settings where there is no skilled attendant.</p> <ul style="list-style-type: none"> <li>• The first two meetings of the PPH TAG have resulted in agreement on the terms of reference; selection of a demonstration site in Pursat Province; selection of RACHA as the local NGO to support the National RH Program with project implementation; and circulation of the draft project proposal for review and approval at the national level.</li> <li>• ACCESS contributed technical input toward development of a Newborn edition of the Health Messenger, which was printed and distributed to all health staff in Cambodia.</li> <li>• ACCESS completed renovation of the office in the NMCHC jointly with A2Z and the MOH.</li> <li>• Sponsored 10 panelists to attend the Scaling-up High Impact FP and Maternal, Newborn and Child Health Best Practices conference held in Bangkok in September 2007.</li> </ul>
2.3 Strengthen nutrition in the in-service and pre-service training of midwives in Tanzania	<ul style="list-style-type: none"> <li>• Responded to request for TA from the Tanzania Food and Nutrition Center (TFNC) to address gaps in nutrition, counseling and training in health facilities.</li> <li>• Carried out the literature review on nutrition during pregnancy in Tanzania in March 2007.</li> <li>• Designed and carried out with the TFNC, a training needs assessment on nutrition during pregnancy with midwives in selected health facilities. Presented the key findings of the assessment at a stakeholders' meeting in June 2007.</li> <li>• Finalized a training module on nutrition during pregnancy module to be used for in-service and pre-service training in Tanzania.</li> </ul>
2.4 Consolidate lessons learned through MAC in selected countries in Africa	<ul style="list-style-type: none"> <li>• In Burkina Faso, ACCESS continued to advocate for the expansion of training of providers in MIP. The MOH integrated a component on MIP into all provider training in 10 districts and trained 250 providers. ACCESS also supported the development of the MIP component of the Burkina Faso proposal for round seven of the GFATM grant process.</li> <li>• Provided technical support to Uganda to strengthen focused ANC services including MIP targeting three FBO organizations and the MOH. This support led to the development of nationally adopted training materials and improved knowledge, attitudes and practices among service providers at five health facilities and clients in the surrounding communities.</li> <li>• Provided Secretariat support for the RBM-MIPWG meeting held in Nigeria from October 10-12, 2006. Support included organization of the meeting, development of meeting agenda, invitation and coordination with all participants, writing and translating the meeting minutes and follow up with meeting representatives. In addition to the ACCESS Program's role of Secretariat, the ACCESS Program participates in the MIP WG meetings as a technical representative.</li> <li>• Providing technical guidance to countries in Africa as they work towards scale up of MIP. Since October 2006, ACCESS has provided focused support in Kenya and Rwanda through the development of workplans that will support national goals and the PMI.</li> </ul>
2.5 Mali ITN Advisor	<ul style="list-style-type: none"> <li>• Revised the country's behavior change communications plan and held stakeholder's meeting to disseminate the plan.</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<b>IR 3: SAFE DELIVERY, POSTPARTUM CARE, AND NEWBORN HEALTH</b>	
<p>3.1 Contribute to the knowledge and expansion of prevention of PPH in ACCESS countries</p>	<ul style="list-style-type: none"> <li>• As a follow up to the conference "Preventing Mortality from PPH in Africa: Moving from Research to Practice" held in Entebbe, Uganda from 4-7 April, 2006, a questionnaire was sent to all country teams who formulated action plans to promote evidence-based prevention and treatment of PPH. Responses from teams in Madagascar, Cameroon, Mali, Nigeria, and Democratic Republic of Congo indicated that they are all moving ahead to varying degrees at policy and implementation levels to promote use of oxytocin over ergometrine for AMTSL.</li> <li>• Collected updates from Nigeria, Malawi, Cameroon, Senegal, Ethiopia, Tanzania, and Zambia country teams indicating that participants are placing new emphasis on carrying out AMTSL using the correct components when they attend meetings, conferences, or while they are on the job. Highlights from selected countries: <ul style="list-style-type: none"> <li>➢ Ethiopia: the presidents of the Ethiopian Society of Obstetricians and Gynecologists and the Ethiopian Nurse-Midwives Association are actively promoting use of AMTSL to the members of their organizations as well as in their clinical work, and through activities funded by USAID and other donors are able to disseminate this knowledge in the country.</li> <li>➢ Nigeria: members of the ACCESS Nigeria team are collaborating with Venture Strategies (University of California, Berkeley) to hold several conferences on use of AMTSL throughout the country.</li> <li>➢ Malawi: Conference participants have ensured that AMTSL and other evidence-based interventions are included in revised national norms for use by nurse-midwife technicians, and that pre-service curricula are revised with updated information. This has led to great interest on the part of the MOH and other partners to rapidly update the skills of nurse-midwife technicians throughout the country.</li> </ul> </li> <li>• Kenya, Tanzania, Malawi, and Ethiopia: ACCESS core and field funding is being used in these countries for midwifery pre-service education activities which involve PPH conference participants. This has facilitated advocacy in the MOH and in pre-service programs in each country thus preparing the terrain for facilitating uptake of AMTSL and other interventions.</li> <li>• In Kenya, for the first time the MOH, with technical guidance from ACCESS, approved and disseminated a circular on the evidence-based use of oxytocin in the prevention of PPH to all provincial medical officers, district medical officers of health, and medical superintendents nationwide. Four staff from the two main GOK maternity centers in Nairobi, Kenyatta National Hospital and Pumwani Maternity Hospital, and two staff from the Provincial Hospitals in Central, Eastern, Nairobi, Nyanza, Rift Valley, and Western provinces were trained in AMTSL skills.</li> <li>• ACCESS TA led the development of the Prevention of PPH Guidelines for Health Care Providers with the Kenyan PPH TAG and National SM Stakeholders Forum. This draft document was used as the reference manual during the training on AMTSL for skilled providers and as such had an initial field-testing.</li> <li>• In Kenya, 14 providers (doctors and midwives) from four provinces were trained on use of AMTSL; 16 health care workers (two providers each from Central, Eastern, Nairobi, Nyanza, Rift Valley and Western provinces, and two providers each from Kenyatta National Hospital maternity and Pumwani Maternity Hospital) were trained in AMTSL; and two APHIA programs (Eastern and Western Provinces) built on the success of ACCESS's PPH/AMTSL activities in PY3 and have included the rollout of AMTSL in their annual work plans.</li> <li>• First field test of the draft curriculum on AMTSL developed by POPPHI in collaboration with ACCESS and other organizations.</li> <li>• Introduction of the SBAI/Rwanda program with USAID/Rwanda and major partners such as IntraHealth, MOH, UNICEF, etc. in October 2006. Assessment trip to formulate strategy for baseline assessments in ACCESS districts, and Joseph de Graft-Johnson to learn about community-based work being carried out by partners in which ACCESS can collaborate in November 2006.</li> <li>• Formulation of joint workplan for SBAI by Twubakane and ACCESS which has received approval from USAID/Washington and</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<p>Rwanda in March 2007. Waiting for approval from MOH.</p> <ul style="list-style-type: none"> <li>• Proposal for national-level meeting to launch SBAI and the Rwanda version of the Road Map sent to Twubakane who will provide feedback and present to MOH for their input and finalization.</li> <li>• Logistics related to office space and administrative support finalized. ACCESS will share an office and administrative staff with Constella Futures in Kigali. Long-term advisor arrived in Rwanda 14 April 2007.</li> <li>• Finalization of MOU with Rwanda School of Public Health who will carry out facility and community baseline assessments in ACCESS districts. Data collection tools have been finalized and translated. Training of data collectors and actual assessment to take place in April 2007.</li> <li>• Assessment visit to meet with USAID/Malawi and define use of core funds to facilitate rapid start-up of selected activities in February 2007. Core-fund work plan approved USAID/Washington and Malawi in March 2007; awaiting approval from MOH. Short-term advisor arrived in Malawi and began implementation of workplan. Planning for a national-level conference to define roll-out of training of nurse-midwife technicians in BEmONC, TOT from each region/district, follow-up and supervision, and clinical site strengthening; and national-level conference to bring pre-service tutors.</li> <li>• ACCESS awarded small grants to seven local organizations in six African countries in support of their expansion of country-level PPH activities (Madagascar, Kenya, Ethiopia, Burkina Faso, Mali and DR Congo) to expand training for AMTSL.</li> </ul>
<p>3.2 Build strategic opportunities to improve safe delivery in Africa</p>	<ul style="list-style-type: none"> <li>• In Rwanda, conducted initial assessment visits, including assessing FBO partnerships. Collaborated with ORC/Macro to conduct national-level Service Provision Assessment (SPA). Developed Joint Workplan with Intrahealth-led bilateral Twubakane. Designed baseline activities, protocols and tools. Conducted health facility assessment in 4 districts and community assessment in 2 districts for which data processing is underway. Workshop on how to use the SBM-R tool completed for 17 participants. Identified RCLS (Inter Religious Council) for community based interventions, BUFMAR (Bureau des Formations Médicales Agréées de Rwanda or the Office of Church-affiliated Health Facilities in Rwanda for coordinating facility level interventions such as refurbishing. Started the process for putting together a shipment of medical supplies to Rwanda.</li> <li>• In Malawi, created national implementation plan to strengthen provider knowledge and skills in BEmONC in preservice and inservice education. The plan describes roles and responsibilities for major stakeholders, including ACCESS, WHO, and UNICEF, in addressing gaps in provider knowledge and skills in BEmONC. Nurse-Midwife Technician curriculum addendum drafted and shared with RHU. Prepared proposal, work plan and budget for 2 year MNH program in Malawi; awaiting final approval from USAID Malawi.</li> <li>• In Ghana, completed two SBM-R workshops conducted and initial internal assessments. Three facilities in Birem North, Eastern Region utilizing SBM-R tool to improve services for community members accessing these facilities, seven Midwives in Birem North, Eastern Region facilities trained and standardized in BEmONC skills, 12 focus groups conducted in Birem North with community members from 4 catchment areas to obtain information on the barriers to accessing services at facilities.</li> <li>• Midwifery associations in Ethiopia, Kenya, and Malawi were provided assistance to complete the Midwifery Association Capacity Assessment Tool (MACAT) and the completed tool was submitted to ICM. ICM will use the completed MACATs to help develop appropriate interventions for its member associations in these countries.</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
3.3 Implement local financing mechanism to increase equity of health services to the most vulnerable in Nigeria	<ul style="list-style-type: none"> <li>The plan for studying financial barriers to EmONC was developed for focus Local Government Authorities (LGAs). Activities included working with CM groups and stakeholders to advocate for government support in addressing policy issues that will enable the poor to have greater access to EmONC.</li> <li>A literature review was written entitled "Framework to Address Financial and Economic Maternal and Neonatal Health Services Utilization Barriers" with a focus on Zamfara and Kano States.</li> <li>Data analysis was completed of the household baseline survey conducted in the four focus LGAs in Kano and Zamfara.</li> </ul>
3.4 Strengthen policies to improve retention and deployment of SBAs in Africa	<ul style="list-style-type: none"> <li>Through capacity-building of doctors, midwives and nurses, ACCESS is increasing the correct use of AMTSL for all women. As the demand for EMNC services increase, so will the demand and use of skilled birth attendants. Increased use of skilled birth attendants will have a secondary effect of better prevention and management of PPH.</li> <li>Activity not yet complete.</li> </ul>
<b>IR 4: MANAGEMENT OF OBSTETRIC COMPLICATIONS AND SICK NEWBORNS IMPROVED</b>	
4.1 Increase access to SBA through strengthening of pre-service midwifery education of frontline providers in four countries (Ethiopia, Ghana, Malawi, and Tanzania)	<p>Preservice education in four countries:</p> <ul style="list-style-type: none"> <li>A CTS/instructional design course was carried out in Addis Ababa in January 2007 for 14 midwife tutors from Ethiopia, Ghana, Malawi, and Tanzania. They are now preparing draft lesson plans to be utilized during country-level training activities.</li> <li>A field-test version of the generic curriculum in essential and BEmONC for midwives was developed and tested.</li> <li>ACCESS is working with WHO/Regional Office for Africa (WHO/AFRO) and the WHO country offices in each of the countries named above to select clinical sites that will be strengthened by the midwife tutors. A 1-week regional clinical training skills workshop has been done, as well as a 2-week clinical training in each country (taught by the midwives with support from ACCESS staff).</li> </ul> <p>Road Map:</p> <p>Meeting in Accra in June 2007 on the Road Map operationalization: more than a dozen African countries sensitized to the need to operationalize the Road Map for reducing maternal and neonatal mortality. 5 countries have already requested ACCESS support to operationalize their country road map (Benin, Burkina Faso, Madagascar, Niger, and Senegal)</p> <ul style="list-style-type: none"> <li>Road Map Forum on the Operationalization of the Road Map in Madagascar.</li> <li>Building the capacity of the national Road Map committee in Niger to analyze the MNH situation at the district level for the operationalization of the Road Map</li> <li>In Malawi, start-up has begun of an MNH program to support the government's Road Map for Safe Motherhood. Initial work using core funds has started to support the strengthening of preservice and in-service curricula for BEmONC.</li> </ul>
4.2 Assist ESOG to build capacity of skilled providers in EMNC	<ul style="list-style-type: none"> <li>1 clinical site strengthened at Ambo hospital in Ethiopia, which involved 40 hospital staff, to improve BEmONC services.</li> <li>Two three-week technical update and clinical skills standardization of providers at Ambo Hospital completed in May 2007; 20 providers trained in BEmONC to improve skilled attendance at birth.</li> </ul>
4.3 Expand KMC services for improved management of LBW babies (Nepal and	<p>In Nepal:</p> <ul style="list-style-type: none"> <li>Baseline survey on KMC for LBW conducted.</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
Rwanda (or one other African Country)	<ul style="list-style-type: none"> <li>• KMC sensitization workshop conducted for 53 managers and health workers.</li> <li>• TAG formed to initiate KMC at health facility.</li> <li>• KMC training manual for health workers developed.</li> <li>• “Maternal and Newborn Care Learning Resource Package for Skilled Birth Attendants” presented at the annual Nepal Society of Obstetrics and Gynecology conference.</li> <li>• KMC TOT conducted with 17 participants</li> <li>• KMC services established in two zonal hospitals and three primary health care centers in Nepal.</li> <li>• 18 doctors and nurses received the KMC training.</li> <li>• 144 doctors and nurses from six hospitals and 3 PHCs received training in KMC.</li> <li>• 412 managers and health workers received a one-day orientation on KMC.</li> <li>• Supported Nursing Association of Nepal to celebrate breastfeeding week, giving one day orientation to 56 nurses.</li> <li>• The KMC topics have been included in the MNC LRP for SBA and began teaching in three NHTC-recognized SBA training sites.</li> </ul> <p>Rwanda:</p> <ul style="list-style-type: none"> <li>• Household survey completed and community assessment initiated</li> <li>• Global KMC manual translated and adapted for use in Rwanda</li> <li>• KMC TOT conducted for 12 hospital staff including Pediatricians and Nurses</li> <li>• KMC center established at Muhima Hospital</li> </ul> <p>Nigeria:</p> <ul style="list-style-type: none"> <li>• Global manual adapted for use in Nigeria</li> <li>• TOT conducted for 15 participants including Pediatricians, Obstetricians and Nurses</li> <li>• KMC center established in two hospitals one each in Kano and Zamfara States</li> </ul>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<b>IR 5: PREVENTION AND TREATMENT OF PRIORITY HEALTH PROBLEMS OF NON-PREGNANT WOMEN OF REPRODUCTIVE HEALTH AGE (TARGETS OF OPPORTUNITY)</b>	
<ul style="list-style-type: none"> <li>• Technical oversight and documentation of current obstetric fistula small grants</li> </ul>	<p><b>Association for the Re-orientation and Rehabilitation of Teso Women for Development, Uganda.</b> Results include:</p> <ul style="list-style-type: none"> <li>• 79 women were identified and treated for repairs, 76 of which were successful.</li> <li>• More than 2000 community members sensitized (796 through community meetings, 20 district and health officials through advocacy meetings with district officials, 30 members of NGOs and CSOs during advocacy meeting)</li> <li>• 12 radio talk shows on the topic of fistula broadcast.</li> <li>• A five-member women's fistula drama group established. The group performed during 11 sensitization meetings, generating hot debate around human rights abuses and the low status of women in society, the failure of the government to improve RH facilities and services and the failure of the government to improve the justice system to address human rights abuses.</li> <li>• 2000 fistula sensitization posters translated into Ateso printed and disseminated, including at first-ever RH Empowerment Conference organized for Teso secondary school girls in December 2006. During the three-day conference, TERREWODE highlighted issues related to obstetric fistula to over 200 participants, including teachers and clan and cultural leaders from Teso region.</li> <li>• A delivery bed donated by Terrewode to maternity ward in Gweri in collaboration with the Women's Dignity Project.</li> <li>• In Soroti district, leadership seconded a midwife attached to the Obstetric Fistula Ward to work with Terrewode on a part-time basis for sensitization and mobilization of women with fistula, seconded a gynecologist during the advocacy workshop and paid for his services, and launched quarterly radio spot message about availability of treatment for women with fistula in the region</li> <li>• Three of six Teso districts drafted by-laws (ordinances) mainly to protect girls against child marriage and defilements with possible consequences such as obstetric fistula.</li> </ul> <p><b>Ugandan Private Midwives Association, Uganda. Results include:</b></p> <ul style="list-style-type: none"> <li>• Mapping done of the targeted districts; communities and midwives to be targeted identified; survey of 15 of the targeted midwives regarding knowledge of causes, consequences, and prevention of fistula and partograph completed</li> <li>• Cue cards to facilitate communication with communities and counseling during ANC developed</li> <li>• One day workshop conducted for 30 midwives to raise awareness of causes and prevention of obstetric fistula and update knowledge on the partograph. UPMA began supportive supervision of the 30 midwives in August 2007 that included interviews with the midwives, review of records, review of outreach activities, and partograph case studies developed by UPMA that were administered and then reviewed with midwife. Results were recorded on a supportive supervision tool also developed by UPMA. Increased use of partograph and counseling regarding causes, consequences and prevention of fistula during ANC were reported.</li> <li>• Outreach to 55 schools reaching a total of 2081 students completed. Outreach to 27 communities, a total of 814 people (605 women and 209 men) completed; a total of 274 outreach activities to the communities and 301 outreach activities to schools.</li> </ul> <p><b>Dimol, Niger. Results include:</b></p> <ul style="list-style-type: none"> <li>• Carried out sensitization caravan to 17 villages in Tera, the department with the highest rate of fistula in the country, from April 11-28, reaching more than 2,160 people.</li> <li>• Identified and referred additional women with fistula.</li> </ul> <p><b>ASMOP, Nigeria. Results include:</b></p>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<ul style="list-style-type: none"> <li>• Conducted survey to generate data on maternal mortality and morbidity ratios from Ndieze and Mbalaukwu (Ebonyi State) with particular emphasis on factors predisposing to obstetric fistula and prevalence of obstetric fistula.</li> <li>• Trained 30 facilitators in each of the two communities. Facilitators subsequently carried out six workshops, each for a total of 30 men, women and children.</li> <li>• Post-intervention data showed that 20% of all pregnancies in the project communities were identified as involving some complications or danger signs and were referred, institutional births rose from 16% to 23%, plans to have transport for an emergency rose to 35%, 40% of respondents knew the laws that protect the girl child and women from violence, and 20% of pregnant women had a birth preparedness and complication readiness plan in place.</li> <li>• In addition, women formed a thrift collection group to be used in cases of obstetric emergencies, women with repaired fistula received micro credit for small scale business, and men in the same neighborhood were organized into a club to ensure availability of transport in cases of obstetric emergencies.</li> </ul>

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

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

\*\*Cameroon's 58 departments are divided into 269 arrondissements and 53 districts. Data source: [www.reproductive-rights.org](http://www.reproductive-rights.org).

### III. DETAILED PROGRAM ACHIEVEMENTS: REGIONAL INITIATIVE FIELD FUNDS

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This section of the report provides detailed information on progress made during the reporting period for the following three major regional initiatives under ACCESS:

- AFR/SD
- USAID/West Africa
- MAC

#### **AFR/SD**

In 2003, the African Regional Reproductive health Task Force, spearheaded by WHO/AFRO, called upon countries and partners to develop and operationalize the Africa Road Map for Accelerating the Attainment of the Millennium Development Goals (MDGs) related to Maternal and Newborn Health. One of the major challenges identified to achieving the MDGs is the "weak national human resource development and management" found in many African countries. To this end, the ACCESS program, in collaboration with WHO/AFRO and under funding from both the AFR/SD Bureau of USAID and USAID GH-MCH core funds to ACCESS, decided to strengthen Pre-Service Midwifery Education in order to build a sustainable strategy for meeting the need for greater numbers of skilled birth attendants – especially those with competencies in Basic Emergency Obstetric and Newborn Care (BEmONC). In addition, ACCESS is providing technical assistance to selected countries in order to assist them in the realization of the Africa Road Map at the country level and working with international partners such as WHO/AFRO, UNFPA, and Africa 2010 to develop regional experts on the Road Map.

#### **1. Major Accomplishments**

- Sixteen midwifery educators from **Ethiopia, Ghana, Malawi and Tanzania** participated in a 6-day regional Clinical Training Skills (CTS)/Curriculum Design course in Ethiopia in January 2007. Building on lessons learned from a previous 2-day “ModCal (Modified Computer Assisted Learning) for Clinical Training Skills” course, participants honed their training skills and practiced curriculum design skills such as development of lesson plans. The participants from this workshop are now being referred to as tutor facilitators.
- A total of 70 midwifery tutors and clinical preceptors from **Ethiopia, Ghana, Malawi and Tanzania** have updated clinical skills in BEmONC, having been trained by the 16 clinical trainers developed earlier in the year. In each country, one high caseload health facility has been strengthened with training models, manuals and essential equipment to be a training site and 110 staff from these clinical sites were oriented to and coached in best practices in BEmONC.
- Staff from 4 clinical sites received technical updates in best practices in basic maternal and newborn care and was coached during practice by the tutor facilitators. This resulted in strengthened clinical services given to women and newborns in high-volume facilities in each country.

- At least 16 tutors and clinical preceptors from each of the 4 focus countries (total of 64) participated in a 2-week technical update and clinical skills standardization course co-facilitated by the tutor facilitators.
- Midwifery tutors in **Ghana** trained by ACCESS continue to demonstrate competence as verified through the follow-up visits with four Ghanaian nursing/midwifery tutors who participated in an ACCESS-supported clinical skills standardization and technical update course in May 2006. ACCESS assessed their MNH knowledge and skills through knowledge surveys and clinical observations using anatomic models. All four tutors performed the essential skills in MNC competently. The tutors are working to apply their training skills in the education of preservice midwifery students.
- Planned, in collaboration with WHO/AFRO, UNFPA and Africa 2010, a regional workshop on the operationalization of the Road Map for six countries (**Uganda, Kenya, Malawi, Zambia, Sierra Leone and Liberia**) to take place in Uganda with a tentative date of April 2008. Significant achievements were made in planning this workshop (i.e. drafting agendas, developing presentations, etc.), however, due to scheduling conflicts within WHO/AFRO the actual roll out has been postponed to a later date to be set by WHO/AFRO.
- Key ACCESS staff (Berengere de Negri) participated in the Road Map partnership forum held in Accra in June 2007, which contributed to increased USAID visibility as an active player in supporting country level Road Map initiatives in Africa through the ACCESS program. Furthermore, USAID/ACCESS participation informed the meeting on technical areas in which ACCESS and WHO/AFRO can support countries.
- During the partnership forum for operationalization and resource mobilization for the African Road Map organized by WHO, ACCESS increased its visibility as a key player in efforts to reduce maternal and newborn mortality in Africa. To date, 37 countries have developed their national Road Map documents and are working towards operationalizing them. Over the past year, ACCESS has assisted two of these countries, **Madagascar and Niger**. ACCESS's two-week technical assistance to both countries helped catalyze and maintain the momentum of the national Road Map committees. The national committees were able to select priority districts and priority interventions.

## 2. Progress Summary

### SBA and Newborn Results Pathway

Over the past year, ACCESS provided midwifery educators who received clinical training in PY 2 follow-up skills updates as well as a CTS and Curriculum Design course in January 2007. Prior to arrival at the regional workshop, the midwifery educators were introduced to CTS and competencies through interactive computer-based preparatory sessions. This allowed for more concentrated practice time and expansion into curriculum design skills during the week-long regional course held in Ethiopia.

Following this course, ACCESS and WHO/AFRO supported these new trainers to hone their skills in their home countries by supporting technical updates and clinical site strengthening for other midwifery/nursing educators at one model facility in each country. The candidate trainers trained a total of 70 midwifery tutors and clinical preceptors from the four focus countries during a two-week technical update and clinical skills standardization course on BEmONC. One clinical site in each country was strengthened to be a training site and 110 staff from these clinical sites were oriented to

and coached in best practices in BEmONC. The table below present's information about the numbers of people trained, trainers qualified, numbers of target preservice schools by country.

**Table 1: Preceptors, Providers and Trainers Trained in the Ethiopia, Ghana, Malawi and Tanzania**

Country	Number of Tutors and Clinical Preceptors Trained in BEmONC	Number of Staff at Clinical Sites Updated and Coached in BEmONC	Number of Candidate Trainers Qualified	Number of Clinical Sites Strengthened as Training Sites	Number/% of Pre-service Midwifery Schools with Updated Tutors
Ethiopia	17	20	4	1	6 out of 11 (55%)
Ghana	16	25	3	2*	8 out of 13 (62%)
Malawi	19	35	3	1	9 out of 18 (50%)
Tanzania	18	30	4	1	8 out of 25 (32%)
<b>TOTALS</b>	<b>70</b>	<b>110</b>	<b>16</b>	<b>4</b>	<b>31</b>

\*Tema Hospital in Accra was strengthened in 2006 in preparation for the first regional technical update and clinical skills standardization course.

Furthermore, ACCESS developed a generic pre-service nurse/midwifery curriculum that was pre-tested during the site strengthening updates. This will serve as the basis for curriculum revision and update initiatives that are taking place in each country.

At a June 2007 meeting in Accra organized by WHO/AFRO, more than a dozen African countries were sensitized to the need to operationalize the Road Map for reducing maternal and neonatal mortality. ACCESS was present at this meeting and worked with country teams to schedule individual planning sessions within their host countries. Five countries (Benin, Burkina Faso, Madagascar, Niger and Senegal) requested TA from ACCESS to support the operationalization of their country Road Maps.

In PY 3, ACCESS also worked closely with WHO/AFRO to advance efforts on the Road Map at country-level. ACCESS participated in the partnership forum on the operationalization and resource mobilization for the Africa Road Map in Accra in June 2007. During this forum, ACCESS



Aaron's mother feeding breast milk with syringe



The makeshift incubator

was approached by Madagascar and Niger as well as other countries for additional assistance. TA visits to each country were completed in September 2007. During both visits, ACCESS worked closely with the ministries of health to introduce and begin the process of mapping MNCH interventions in each of the countries. In Madagascar, this effort at data collection began with interviews of key players in MNCH, including representatives from the MOH, partners such as JICA and Marie Stopes Madagascar and international donors such as WHO and USAID. ACCESS also helped to organize a workshop for 30

participants to present the mapping process, select priority districts for conducting the mapping and create a plan and budget for completing the mapping. Similar assistance was provided to Niger during a workshop for 40 participants. The outcomes of both TA visits was to transfer the

knowledge and skills on mapping MNCH interventions and creating links of how such information will feed back into the operationalization on the Road Map.

ACCESS also planned a regional Road Map operationalization workshop in Uganda for selected countries (Uganda, Kenya, Malawi, Zambia, Sierra Leone and Liberia). Due to scheduling conflicts with WHO/AFRO, the meeting has been postponed until January 2008.

### **3. Challenges**

- In all four countries it was found that the current number of trainers is not sufficient. There have been numerous requests to increase the number of trainers from 3-4 per country to approximately 10 per country. To this end, ACCESS will work with WHO/AFRO, Africa 2010 and other partners to plan a second CTS course in Year 4. Potential strong trainers were already identified during recent in-country training courses.
- Funding limits restricted the length of time for the clinical update courses to two weeks in each country. This amount of time was found to be very tight to allow for sufficient clinical practice during the training. Trainers and participants alike were committed to working long hours as well as on weekends in order to maximize the amount of time allotted, however all evaluations called for at least one additional week of training.
- In each of the countries, gaps were found in the clinical knowledge and skills of the midwifery educators. For example, in Ghana, early pregnancy care is not currently included in midwifery training and therefore, the participants were weak in assessing early pregnancy. In Malawi, the majority of the participants lacked the skills of determining fetal descent and position which is critical in decision-making for vacuum extraction. As this is one of the core skills for midwives in Malawi, it needs to be strengthened.
- Systemic issues are a continuing challenge for clinical sites in all of the countries. In Tanzania, the irregular and unreliable supply of essential drugs and equipment to Morogoro Regional Hospital means that best practices are not always feasible. Bwaila Hospital in Malawi suffers from high staff burnout from too few staff with a very heavy caseload. These challenges pose considerable burden on the sustainability of the strengthening activities.
- Collaboration with WHO/AFRO can often be challenging due to their heavy workload as is exemplified in the postponement of the Uganda Road Map Operationalization workshop. ACCESS continues to be flexible and responsive to the needs expressed by WHO/AFRO.
- Funding limits have also restricted the number of countries in which ACCESS has been able to respond and provide TA on the operationalization of the Road Map. Additional countries to Madagascar and Niger have requested assistance, but it is unclear whether ACCESS will be able to respond directly. In each country, ACCESS works with local partners to cost-share activities. For example, the mapping workshops in both Madagascar and Niger were co-funded by the MOH. The planned Uganda workshop is also a cost-share between ACCESS, WHO, UNFPA and Africa 2010. Nevertheless, funding remains tight.

## AFR/SD MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>PRIORITY 1:</b> Support advocacy to mobilize resources and improve the policy environment for maternal and newborn care <b>AFR/SD Result:</b> <i>Increased resources for maternal and newborn health programs at the country level</i> <b>AFR/SD Result:</b> <i>Improved strategies and plans for maternal and newborn care at the country level</i>					
Number/% of Target countries with facilitators trained in how to implement the Africa Road Map	Trained facilitators are those who attended an ACCESS-supported training event.	Program records/reports	Semi-annual	Trainers, ACCESS Program staff	41 master trainers (8 Anglophone, 9 Francophone and 24 Lusophone) from 14 African countries have been trained to provide support and guidance for the implementation of the Road Map.
Number/% of Target countries receiving ACCESS support to implement the Road Map	Technical assistance will be provided using ACCESS funds.	Program records/reports	Semi-annual	ACCESS Program staff	2 countries: Madagascar and Niger
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	37 countries have developed Africa Road Map plans for MNH (not with direct ACCESS assistance)
<b>PRIORITY 2:</b> Disseminate effective approaches to improve the quality of integrated MNH care <b>AFR/SD Result:</b> <i>Improved quality of integrated essential maternal and newborn care</i>					
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.

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
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 total of 89 tutors and clinical instructors have been trained in integrated EMNC. An additional 110 service providers at selected clinical sites were trained on key elements of EMNC.
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	4 countries have a core group of at least 3 midwifery tutors able to train and develop midwifery curricula.
<p><b>PRIORITY 4:</b> African regional and national capacity to implement programs  <b>AFR/SD Result:</b> African institutions actively engaged in supporting the implementation of the WHO/AFRO Road Map  <b>AFR/SD Result:</b> Linkages strengthened among African Institutions and networks to coordinate with each other and strengthen their leadership in MNH  <b>AFR/SD Result:</b> National-level capacity to implement safe motherhood programs improved</p>					
Number of African facilitators trained in how to implement the Africa Road Map	Trained individuals are those who were trained in the Africa Road Map through ACCESS-supported training events or by ACCESS developed trainers.	Program records/reports	Semi-annual	Trainers, ACCESS Program staff	41
Number/percent of trained African facilitators in Target countries supporting country road map planning	Supporting the country road map may include holding stakeholder meetings, advocating for safe motherhood initiatives at the national level, etc. Facilitators in a subset of countries will receive technical assistance and follow-up.	Program records/reports	One time measure	ACCESS Program staff	Follow-up data not available
Number/% of Target countries with action plans for applying IMPAC guidelines in pre-service midwifery education and practice that have implemented at least one action item	Action plans will be created by EMNC training participants (midwifery tutors and clinical preceptors) at the end training.	Program records/reports	One time measure	ACCESS Program staff	Four countries: Ethiopia, Ghana, Tanzania and Malawi

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number of midwifery schools with trained tutors and clinical instructors for EMNC	Trained tutors and clinical instructors include those trained in EMNC through ACCESS-supported training events or by ACCESS-developed trainers.	TIMS	Semi-annual	Trainers, ACCESS Program staff	The 19 midwifery educators trained in May 2006 are from 12 midwifery schools, 5 teaching hospitals, and 2 MOH offices. (includes Nigeria which was not funded by AFR/SD)

\*This M&E framework was developed at a time when AFR/SD was following a strategic framework that is currently no longer in use due a significant change in priorities. As such, this framework will be revised in Year 4.

## **USAID/WEST AFRICA**

The main objective of the USAID/West Africa program has been to create the replication of best practices in MNC in non-USAID presence countries throughout the West Africa region. ACCESS has been working with the Action for West Africa Region-Reproductive Health (AWARE-RH), Mwangaza Action, UNICEF and partnering governments in building the knowledge and competences of doctors, nurses and midwives in evidence-based MNC, as well as building their training capacity. Along the HIDN results pathways, this program works to build the capacity of SBAs, and develops providers more equipped to address care of the newborn and practice AMTSL. This year, ACCESS added Togo to the other three West African countries—Cameroon, Mauritania and Niger. Interventions in all countries involve a combination of strengthening clinical services and mobilizing communities to seek such services. ACCESS is directly engaged in community mobilization work in Cameroon only, however.

### **1. Major Accomplishments**

- Active management of third stage of labor (AMTSL) reportedly being practiced consistently by providers trained by ACCESS in Mauritania. ACCESS conducted follow-up visits to seven of the 13 providers from the Kaedi district, Mauritania, who had been trained in EmONC in November 2006.
- The Regional Hospital Center in the Sokode district, Togo, was strengthened to serve as an EmONC clinical training site and the capacity of 23 providers from the district was strengthened during a training workshop in May. Two candidate trainers from Togo who had participated in the CTS course organized by ACCESS co-facilitated the course and became qualified as clinical trainers.
- Community action plans to address MNH concerns were developed by community members and community liaison teams in 18 health zones of Ngaoundere district in Cameroon. The community liaison teams conducted auto-diagnostic participatory sessions with community members where they were able to analyze their own problems related to MNH.
- Twenty service providers from the Tibati and Ngaoundere districts of Cameroon trained by ACCESS in EMNC demonstrated competency in key clinical skills during followup visits by ACCESS consultants and Cameroonian national trainers. The providers were given coaching and support during the visit. In addition, the four clinical sites where providers gathered for assessments all showed visible improvements in provision of EMNC.

### **2. Progress Summary**

At the end of last year, ACCESS in collaboration with AWARE-RH conducted a CTS course for candidate trainers from all four countries of intervention. During Year 3, ACCESS and AWARE-RH have focused on supporting the candidate trainers as they replicate Essential and Emergency Obstetric and Newborn Care training courses in their respective countries. The table below summarizes these efforts:

**Table 1: Trainers, Providers and Facilities Supported in the Four West African Countries**

Country	Number of Candidate Clinical Trainers supported	Number of Candidate Clinical Trainers Qualified	Number of service providers trained in EMNC/EmONC	Number of facilities with trained providers
Cameroon	5	5	20	19
Mauritania	3	0	17	n/a
Niger	5	5	20	11
Togo	2	2	23	13

### Cameroon

ACCESS has developed the Ngaoundere district hospital as a clinical training site and conducted three clinical courses at this site, training a total of 58 providers in Cameroon from three districts (Ngaoundere, Tibati and Tignere). Twenty of these service providers (those trained in August 2006) were followed up and assessed for retention and implementation of best practices in July 2007. ACCESS, along with Cameroonian counterparts, found that while there were improvements in practices, participants needed reinforcement of certain skills such as newborn and post-partum care. Furthermore, five strong providers from Cameroon were selected to participate in a Regional CTS course in Burkina Faso in September 2006. Having completed this course, these five providers were elevated to the level of “candidate clinical trainers.” As such, they organized another clinical training course at Ngaoundere district hospital for service providers including nurses, midwives and doctors from Ngaoundere, Tibati and Tignere districts—all in Adamaoua province. Under the tutelage of an ACCESS master trainer, they successfully completed the three week course for 20 of providers from 19 facilities. All of the candidate trainers are currently qualified clinical trainers and serve as a base for a national and sustainable team of trainers in EMNC.

#### **What Happens After a Regional Dissemination Conference? According to Cameroonian Participant: Plenty!**

As a follow up to the conference "Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice" held in Entebbe, Uganda in April 2006, a questionnaire collected information from country teams who had formulated action plans to promote evidence-based prevention and treatment of PPH. Justin Fombe of the Cameroon Baptist Convention Health Board (CBCHB) responded as follows:

*“In the 3 CBCHB hospitals and 25 health centres, we now systematically apply AMTSL in all vaginal deliveries. I first discussed AMTSL with our policy makers who then decided that it was the way for everyone to go. I held three seminars with medical and nursing supervisors in the three hospitals. Midwives followed and what we have now in place is as follows:*

- *Oral ergometrine is no longer in our formulary nor is it used any more.*
- *Oxytocin is the drug of choice.*
- *Misoprostol is used as the second line drug.*
- *Injectable Ergometrine is used only when there is PPH in the making and Oxytocin is not doing the job.”*

Social mobilization efforts are continuing in Ngaoundere district of Cameroon as well. Currently, 18 health zones are engaged in these efforts. In all 18 zones, the community liaison teams (two to three members per zone) conducted auto-diagnostic sessions in which community members were able to

analyze their specific problems related to MNH, formulate solutions and develop action plans. A return TA visit in July-August 2007 reviewed the action plans of 15 out of the 18 health zones and assisted in overcoming barriers. Some of the findings from the visit included noting that all the health zones have either strengthened or revived their community health insurance schemes in order to address equity in access to health services. Furthermore, follow up with community health workers found better organization, planning and implementation of health education sessions on topics such as the importance of ANC and vaccination and birth planning. Finally, a review at health facilities within the different health zones showed high rates of use of health services. For example, in Likok where approximately 300 births are expected for 2007, already 126 have been recorded at the health facility.

### **Mauritania**

In Mauritania, ACCESS continues to work to build the capacity of doctors, midwives and anesthetists in EmONC. In June 2007, the number of providers trained in EmONC increased from 20 to 37 with the training of an additional 17 providers from Brakna and Gorgol regions. The training in June was led by three candidate clinical trainers from Mauritania who had completed the CTS course in Burkina Faso in September 2006 along with one provider who had attended a clinical coaching session in Burkina Faso and the two ACCESS consultants. The site at Aleg was adequately equipped with training materials and essential equipment by ACCESS and UNICEF prior to the training. The clinical staff and other stakeholders at Aleg district hospital were well engaged in the training with the pediatrician joining in for selected sessions and assisting in the demonstrations on newborn care.

During an advocacy visit made to Mauritania by ACCESS and AWARE in January 2007, the MOH of Mauritania along with UNICEF acknowledged the difficulties of MNC in their country and agreed to support ACCESS master trainer, Dr. Ouedraogo Charlemagne to return to Mauritania and assist the national level to develop norms, policies, and training materials on EmONC. This visit was made in April 2007. During this visit, a draft training curriculum on EmONC adapted to the Mauritanian context was developed. The documents were pre-tested during the clinical training recently held in June 2007. ACCESS consultants offered feedback on the curriculum and urged the Ministry to finalize and disseminate throughout the country.

### **Niger**

Using the same training site (Zinder), which ACCESS had strengthened with materials in Year 2, a clinical skills standardization training in EmONC was completed in April 2007 for 20 providers from the Maradi district. The pool of providers included three doctors, one anesthetist aide, 13 midwives and three diploma nurses. The course was led by five candidate Nigerian trainers who participated in the Regional CTS course and under the supervision of an ACCESS clinical consultant and Dr. Lucien Djangnikpo, a previously trained JHPIEGO master trainer and doctor at Zinder hospital. Once again, Zinder proved to be an appropriate training site with adequate space for classroom teaching and a sufficient number of clinical cases for practicum sessions. The ACCESS consultant found that all of the Nigerian candidate trainers presented the material and topics with a strong mastery of the technical content and correctly demonstrated competencies on anatomical models. Hence, participants showed great improvements in their knowledge and skills over the timeframe of the course and all five were qualified as clinical trainers who can continue to replicate trainings on EmONC.

## **Togo**

In collaboration with AWARE-RH and Plan, ACCESS began clinical skills replication of best practices activities in Togo this year. A site assessment trip to an identified clinical training site in Sokode district was completed in October 2006. In addition, training materials and equipment including anatomical models have been purchased for the site and shipped in April 2007. The training for 23 providers was completed in May 2007 where two Togolese trainers were also qualified as clinical trainers.

### **3. Challenges/Opportunities**

In Cameroon, delays in implementation of activities due to the busy schedules of key in-country partners from the MOH and UNICEF delayed follow up visits to providers until one-year after the training course was completed. Ideally, these would have been conducted 3-4 months post-training. Recommendations following the visit included improving the regularity of external supervision and developing internal supervision systems for facilities as well. Although ACCESS and AWARE-RH had planned to introduce a supervision and quality improvement system based on performance standards, this series of activities was discontinued due to restricted funds and the pending completion of the AWARE-RH award.

In Mauritania, while moving the clinical training site to Aleg district hospital from Kaedi district hospital helped to improve the engagement of local staff and ensure the availability of certain essential materials, difficulties were found in the low number of clinical cases for practice. In addition, there were a number of IP practices that needed to be improved at the site and a list was provided to UNICEF of essential equipment necessary to improve the hospital. Another challenge in Mauritania lay with the strength of the trainers. Unfortunately, three of the candidate trainers were unable to join the training until three days following the start due to scheduling issues. Furthermore, it was clear that the trainers had not prepared prior to the training in terms of reviewing the material individually or working together to prepare the sessions. Therefore, it was necessary for the master trainers to frequently step in during presentations to clarify technical issues. The master trainers provided the candidate trainers daily feedback and worked with them to prepare the following day's lessons. At the end, the recommendation was that the training team undergoes another supervised training course before being qualified as trainers. In addition, it was recommended that the national training team in general be further built with additional trainers from different cadres including more doctors and nurses.

## USAID/WEST AFRICA MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>USAID/WEST AFRICA IR1:</b> Increased dissemination of best practices and use of cross border services region-wide <b>USAID/WEST AFRICA IR3:</b> Increased technical and management capacity of regional institutions and networks					
<b>ACCESS IR 3: Safe delivery, postpartum, and newborn care improved</b>					
Number of providers trained in EMNC or EmONC 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	80 providers were trained in EMNC and EmONC; 20 from Cameroon, 17 from Mauritania, 20 from Niger and 23 from Togo.
% of providers trained in ACCESS-supported clinical training courses competent in key EMNC/EmONC skills (AMSTL and at least one other skill) 2-3 months after training	<u>Numerator:</u> Number providers who completed an ACCESS-supported clinical training course who are competent in EMNC/EmONC clinical skills 2 months after EMNC/EmONC training  <u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC/EmONC course	Clinical observations during training follow up site visits	2-3 months after training	ACCESS consultant; ACCESS staff	29 out of 33 (88%); 20 out of 20 in Cameroon and 9 out of 13 in Mauritania where the remainder were not followed up for reasons of distance, time and movement to new areas of the country.
% of providers trained in ACCESS-supported EMNC training courses that have implemented at least 2 action items (including or in addition to AMSTL)	<u>Numerator:</u> Number of providers completed an ACCESS-supported EMNC course who have implemented at least 2 action items  <u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC course	Review of service statistics and actual partographs during training follow up site visits	2-3 months after training	ACCESS consultant  ACCESS staff	Providers at 6 out of 32 facilities: a) 4 sites out of 19 in Cameroon. Providers came to central sites for follow up. Trained providers at all 4 sites had implemented at least 2 best practices. b) 2 out of 13 sites in Mauritania. During follow up, 3 sites were visited.- providers at 2 had implemented best practices.
Number of trainers trained in clinical training skills for EMNC/EmONC 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	16 trainers were trained in PY2.

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number of candidate clinical trainers observed conducting a clinical skills course, demonstrating competency and qualified as clinical trainers	Qualified clinical trainers are persons trained in Clinical Training Skills who are observed and evaluated to continue independently by an experienced ACCESS master trainer.	Training participant tracking sheets and training database Training workshop summary reports	Annual	ACCESS consultant; ACCESS staff	12 out of 15 trainers were qualified to conduct clinical skills courses. 3 trainers from Mauritania were recommended to be observed for an additional training in order to strengthen their skills.
Number/% of Target facilities completing baseline assessments of maternal and newborn care using Standards Based Management and Recognition (SBM-R) tools developed with ACCESS support	SBM-R is a process for performance monitoring and quality improvement within clinical settings. Facilities use nationally set standards for practice to assess quality of care.	Program records/reports, completed baseline assessments	Annual	ACCESS consultant; ACCESS staff	0 – This activity was canceled due to funding and the pending completion of the AWARE-RH project.
Number of trained Social Mobilization trainers reporting having conducted advocacy activities using auto diagnostic tools in the last 3 months	Trained SMAs are ACCESS-trained advocates through the workshops in <i>Targeted</i> 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	27
Number of individuals trained through Social Mobilization Advocacy workshops in Target countries	<i>Targeted</i> individuals are members of communities identified through locally-coordinated efforts following the initiation of SMA efforts within the district  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	480

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number of communities completing action plans for social mobilization and implementing at least one action item	Action plans include steps for resolving issues agreed upon by the community as priority problems within the community. Action items may include issues such as devising savings schemes for emergency transport, etc.	Program records/reports , key informant interviews	Annual	Mwangaza Action ACCESS staff	18

## **MALARIA ACTION COALITION**

The ACCESS Program is a leader in the promotion, implementation and scale up of evidence-based interventions to prevent malaria in pregnancy. ACCESS has used both core and field Malaria Action Coalition (MAC) funding to carry out this work in the past. Currently, ACCESS work in this area is transitioning to Presidential Malaria Initiative Funding as MAC ends. The results below include only those achieved with at least some malaria field funding in the countries of Kenya, Rwanda and Madagascar.

### **1. Major Accomplishments (Mixed Core and Field Funds)**

- In **Kenya**, ACCESS and the DOMC sensitized 928 service providers on the artemisinin-based combination therapy (ACT) regimen for case management of clinical malaria, use of quinine, SP and prevention and control of MIP in line with the new MOH guidelines.
- In **Kenya**, 439 CORPs have strengthened RH outreach and counseling skills, including prevention of MIP. ACCESS supported the Kenya MOH in developing orientation materials for the CORPs training.
- In **Madagascar**, ACCESS and country stakeholders developed norms and protocols for malaria and MIP during a five-day workshop. This document provides clinicians at all levels of the health system with appropriately outlined tasks for the level of care they provide. Workshop participants also outlined a plan to validate and disseminate the document.

### **2. Progress Summary**

#### **Kenya**

ACCESS supported the MOH to develop orientation materials and training of CORPs on FANC and MIP. This training is in line with the new MOH strategy for delivering health services at level one (community level) and has been hailed as a forerunner in RH. The MOH has leveraged funding in reproducing the materials developed with the support of ACCESS.

The MOH/DOMC requested technical support from ACCESS to rollout the new malaria case management guidelines in seven districts in Coast province. In collaboration with DOMC, ACCESS developed an evidence-based orientation package—*Malaria Case Management Orientation Package for Service Providers*—that targets front-line providers with information from the malaria policy guidelines. Using the proven and successful cascade-echo approach, ACCESS and DOMC sensitized 928 service providers on the artemisinin-based combination therapy (ACT) regimen for case management of clinical malaria, use of quinine, SP and prevention and control of MIP in line with the new MOH guidelines. The objectives of the one day sensitization were to create/improve knowledge among service providers on the new treatment policy; discuss major aspects of malaria case management; and create a forum for service providers to discuss issues regarding implementation of the new policy.

#### **Rwanda (President’s Malaria Initiative Funds/Field Funds)**

The ACCESS program in Rwanda has supported the transition from MAC to PMI in the development of the ACCESS MIP- PMI workplan. This workplan outlines technical support to help Rwanda scale up focused ANC services including MIP. ACCESS is working closely with the NMCP and other PMI partners to build on the successful implementation of the MAC. ACCESS has worked closely with national partners including WHO and Twubakane (USAID bi-lateral) to identify priority sites for implementation and plans for coordination during programmatic rollout.

In collaboration with the Rwanda School of Public Health ACCESS conducted focus group discussions with pregnant women, women who delivered in the past year, and husbands of women who delivered in the past year in two target districts. The FGDs explored:

1. Perceived or real barriers to using ANC services and interventions for prevention of MIP;
2. Prevention of malaria in newborns, infants, and children;
3. Care of babies and children under five with fever/malaria.

The report is currently under preparation.

ACCESS also supported the Rwanda Service Provision Assessment, expanding the MIP-related information gathered. ACCESS contributed to the development of the Rwanda SPA questionnaires in collaboration with Macro International (implementor) to ensure MIP indicators are included. ACCESS also asked the survey team to conduct a maternity register and maternity patient chart review for documentation of delivery information and an ANC client register review to document information on uptake of IPT1 and IPT2. The information from these additional data sources will be entered into the Rwanda SPA data set and provided to ACCESS.

### ***Madagascar***

The Madagascar MOH/FP validated their national malaria policy in 2005 and identified a need to develop norms and protocols for its implementation and requested technical assistance from ACCESS. The norms and protocols provide health agents, midwives, nurses, and doctors at all levels of the health system with appropriately outlined tasks for the level of care they provide. During a five-day workshop in January 2007 with key stakeholders from the MOH/FP, ACCESS and stakeholders completed the document for malaria control in adults and children and MIP. After the workshop, the NMCP put in place a working group to coordinate review of the document by WHO, USAID, CDC, PSI, UNICEF. The final document was approved by the Minister of Health is now ready for printing and national dissemination.

In a second workshop in January, ACCESS worked with the NMCP to develop a job aid. It includes the following content areas:

- The importance of a confirmatory test before giving ACT treatment to children under age five
- Treatment of fever in children under the age of five in an endemic region
- Dosage of ACT by age and weight
- Importance of using ITNs

After a thorough review by multiple stakeholders, in September the job aid was approved by the Minister of Health and printed. It is now in the process of being disseminated to all health facilities.

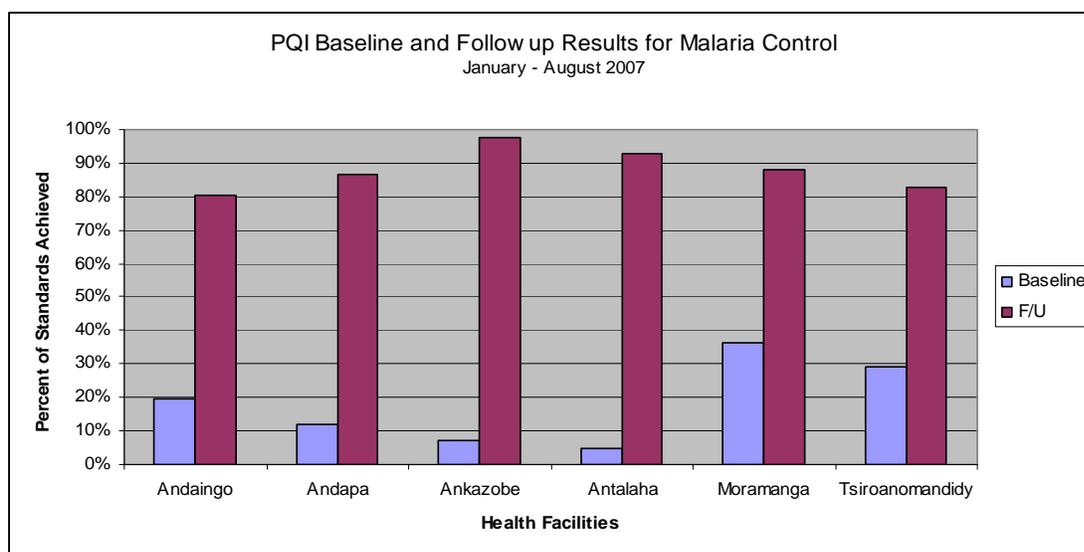
Finally, ACCESS worked with the NMCP and the DRH to strengthen the quality improvement process initiated over the last several years. JHPIEGO assisted the Ministry to expand the MIP clinical performance standards to include case management of adults and children. This includes:

- IEC between health providers and clients

- FANC
- Malaria case management
- Management systems
- Human and material resources
- IP practices

The tool was applied in six facilities in three regions. In January, the ACCESS team supported initiating the process and later the NMCP and service providers at the health facilities completed the baseline assessments and action planning at individual sites.

Between January and August, during routine supervisory visits, health providers were asked about progress on the action plans developed and encouraged to seek community involvement for resolving resource gaps. Community leaders who participated in the QA process met regularly with facility staff and encouraged pregnant women to come to the sites for ANC and MIP services. They provided sites with pots to boil water so that women could be directly observed by service providers taking SP using clean water at the health facilities. In August, the NMCP requested the regional supervisor and malaria representative for each of the six health facilities conduct a follow up assessment. Results are shown in the table below. Health facilities achieved an average of 16% of standards at the baseline and an average of 88% at the follow-up assessment. Significant improvements occurred in IEC (average 93% improvement) and in malaria case management (average 87% improvement). This vast improvement was due to a number of factors, including the high level engagement of community leaders and district health authorities and rigorous supervision of the sites throughout the year.



### 3. Challenges

- Kenya: Ensuring continued collaboration and active involvement of RH under the PMI initiative in order to address MIP.
- Rwanda: Funding has not yet arrived which has delayed implementation.

## **PART 2**

### **IV: DETAILED PROGRAM ACHIEVEMENTS: COUNTRY FIELD FUNDS**

This section of the report provides detailed information on progress made during the current reporting period for the following countries:

- Afghanistan
- Bangladesh
- Cambodia
- Guinea
- Haiti
- Kenya
- Nepal
- Nigeria
- South Africa
- Tanzania

## **AFGHANISTAN**

### **1. Major Accomplishments**

#### **Health Service Support Program (HSSP) Associate Award (Program Years: July 2006-September 2010)**

- The HSSP Performance-based Partnership Grants (PPG) to NGOs and other stakeholders is resulting in improved quality and integration of standards for implementation of a quality BPHS delivery strategy. To date, through HSSP, 159 midwives have graduated from Nangahar, Herat, Balkh and Kabul hospital midwifery training programs, and an additional 143 community midwifery students are expected to graduate soon. Skilled attendance at birth has increased from 4% to 43% in Herat province in the last few years.
- To enhance provision of quality services at the district hospital level, evidence-based Quality Assurance (QA) standards were developed, adapted and finalized in 13 areas for the Basic Package of Health Services (BPHS). To date, 31 health facilities across four provinces have completed assessments using the QA tool, and 225 people have been trained in the QA process.
- HSSP strengthened the capacity of NGOs and health providers delivering the BPHS. A total of 855 people were trained in a number of courses which included clinical competencies, M&E, USAID rules and regulations, gender, and human resource management. A total of 433 participants representing midwifery faculty and BPHS service providers received training in competency-based courses, such as Basic EOC, Advanced EmOC, Effective Teaching Skills, and Rational Drug Use
- ACCESS awarded 11 midwifery and community midwifery grants (including a new Community Midwifery Education, or CME, program in Ghor Province) to support the training of midwives and human resource needs in Afghanistan
- To promote an enabling environment of SBA, HSSP supported the celebration of the first National Safe Motherhood Day in Afghanistan on 8 October 2006, as well as International Day of the Midwife, celebrated on May 5, 2007, and the third annual Afghan Midwives Association (AMA) Congress in May 2007.
- All Information, Education and Communication (IEC) materials developed in Afghanistan collected, classified, indexed and shared with all PPG NGOs. 35 different IEC materials representing 12 technical areas were distributed to the grantees from the 13 PPG provinces

#### **ACCESS Afghanistan (Program Years: October 2005-December 2008)**

- A midterm evaluation of the community-based Prevention of PPH pilot project presented to the Afghanistan PPH TAG demonstrated the use of misoprostol to prevent PPH during home births is safe, acceptable, feasible and programmatically effective. The MOPH informed ACCESS that it will take the intervention to scale on a national level. Preliminary analyses show that, of 570 postpartum women interviewed, 98% accepted misoprostol during the eighth month antenatal visit, 65% took the drug in accordance with their instructions and 32% received an injectable uterotonic at a health facility. Therefore, only 3% of the women in the intervention areas did not receive an uterotonic drug to prevent PPH compared with 74% of women in the control areas.

- Results described above were disseminated at the Global Health Council and the ANE Scaling up of Best Practices in FP, MNCH meeting, Bangkok 2007.

## **2. Progress Summary**

### **PPH Results Pathway**

Midterm evaluation data from the PPH project in Kabul, Faryab and Jawzjan provinces was analyzed and preliminary results presented to the PPH TAG and key MOPH stakeholders in February and March 2006. Based on preliminary findings, the intervention was found to be safe; acceptable by pregnant women, their families and communities; feasible to provide counseling and distribute misoprostol to pregnant women in catchment areas through CHWs; and effective to provide misoprostol in settings where a large number of deliveries are carried out at home without a skilled provider. Following final data cleaning and analyses, these positive results will be used to inform the national roll out of the intervention through the MOPH with technical guidance provided by HSSP. The MOPH requested scaling-up the intervention to more provinces and identified next steps for this process, involving reviewing project results and planning for a stepwise expansion. Guidelines to incorporate misoprostol usage by CHWs in the BPHS will be developed as well as program implementation guidelines and monitoring tools. Efforts will also be made to pursue registration and importation of misoprostol.

### **SBA Results Pathway**

#### ***HSSP strengthened and integrated quality improvement tools to support quality of health service delivery.***

HSSP worked to develop, adapt, and strengthen a set of evidence-based QA standards for 13 areas of the BPHS to enhance the provision of quality services at the district hospital level. Between December 2006 and July 2007, HSSP conducted three workshops with key staff from MOPH, NGOs implementing the BPHS in Afghanistan through USAID-funded PPGs, and other stakeholders to orient them to the national QA process. A central QA Committee was established through the Afghan Public Health Institute to oversee the process, which involved adapting existing clinical and management standards developed under the USAID-funded REACH program<sup>7</sup>, identifying new clinical areas that required new standards for development, and integrating all standards into one QA tool. Standards targeted priority clinical areas and health facility management and included areas such as: ANC; normal labor, childbirth, and immediate newborn care; birth spacing/FP; Integrated Management of Childhood Illnesses (IMCI); EPI; infection prevention (IP); drug management; and facility management. The committee selected five provinces (Kabul, Paktiya, Bamyan, Tarkhar, and Herat) to implement Phase One of the QA process. To date, 31 health facilities in four of the provinces have completed baseline assessments using the QA tool (the unstable security situation in Paktiya prevented the baseline being conducted). Results from this baseline assessment showed an average score of 37% across all provinces and levels of health facilities. Higher scoring technical areas were facility management and immunization, with management of labor complications and care of the sick newborn scoring lower across all health facilities. Using results from these baseline assessments, health facilities have developed action plans to target their specific performance gaps. Implementation of actions plans by implementing NGOs and health center staff will continue in PY 2 to strengthen weak areas of performance. HSSP will continue working with NGOs to build their capacity to utilize the QA standards.

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<sup>7</sup> REACH was implemented from 2003 to 2005 by MSH and partnered by JHPIEGO.

### **Community Midwife in Afghanistan Saves Mother and Baby**

Mahsoma, a midwife working at a Basic Health Centre in the remote district of Jurm, Badakhshan province, graduated in 2006 from the HSSP-supported provincial Community Midwifery Education program. One day, a laboring woman arrived at the health center bleeding heavily and losing so much blood that she has gone into shock. Mahsoma assessed her situation and immediately started an intravenous fluid infusion. She then requested that the woman's relatives take her to the comprehensive EmOC facility in the provincial hospital in Fayzabad, since she did not have the facilities to manage her complications. Unfortunately, the woman's relatives did not have enough money to pay for the transport to take her the long distance to the hospital. Moreover, heavy rainfall had caused severe floods which resulted in the collapse of the bridge leading to the main road.

Mahsoma discussed the options with the woman's relatives. Together they decided that the woman and her baby's best chance of survival rested with Mahsoma trying to manage her critical condition and delivery in the health center. She was already in established labor and close to delivering, but there was an added complication—the baby was lying in the breech position, which if not delivered skillfully could cause brain damage and even death to the baby. Using the skills she gained in her midwifery training, Mahsoma, successfully delivered a healthy baby boy. She then managed the delivery of the woman's placenta by giving an injection of oxytocin and carrying out active management of the third stage. Mahsoma gave her more intravenous fluids, and slowly the woman regained consciousness.

As a result of Mahsoma's skills, competence and decision-making, she saved two lives in a province that has recorded the highest ever maternal mortality rate in the world.

### ***HSSP supported the training of community midwives.***

In PY 1, HSSP awarded four Institute of Health Science (IHS) midwifery and seven CME grants to NGOs for a total of \$3,325,115 for the training of midwives to support human resource needs in Afghanistan. HSSP supported the last year of two IHS midwifery programs in Balkh and Nangahar, which resulted in the graduation of 61 new midwives in May and August, with 38 and 23 students graduating respectively from the programs. Following a site assessment to identify a new CME program site in two provinces, Ghor Province was selected as the site for a new CME program. A competitive request for applications resulted in World Vision being awarded the CME grant for a period of 22 months. The new program began in September 2007 and is expected to enroll between 20 – 24 students in October 2007. To date, HSSP has supported a total of 338 enrolled students in 11 midwifery and community midwifery programs and anticipates 143 new midwives graduated and deployed in PY 2.

As part of HSSP's emphasis on health workforce planning, HSSP assisted NGO grantees to establish supportive supervision systems for follow up of graduates. A supervision checklist for new midwifery graduates was developed, an in-service training program was established and supervision visits for new graduates at their clinical sites were completed in six provinces.

The National Midwifery Education Accreditation Board (NMEAB), which receives secretarial and technical support from HSSP, conducted 10 board meetings. A total of 20 midwifery schools (out of 23) have now been accredited all over the country. All HSSP-supported schools are now accredited and 9 non-HSSP supported schools have also received accreditation support from the NMEAB and

HSSP. An accreditation workshop was conducted in September 2007 for midwifery education faculty from the 23 programs throughout the country. Two objectives of the workshop were to : 1) establish a mechanism through the board to provide ongoing support to the schools, and 2) address how to continue to maintain quality in the midwifery programs.

***Midwifery faculty and health service providers demonstrate improved capacity to implement the BPHS.***

HSSP facilitated eight Basic EOC training courses in five of the regional clinical training sites (Kabul, Balkh Nangahar, Kandahar and Herat), for midwifery faculty and BPHS providers, resulting in 138 participants being trained in its first year of implementation. This staff is now equipped with the skills to provide basic EOC services according to national EOC clinical standards. Additionally, Kandahar provincial hospital was re-established as a regional clinical training site for obstetric care. One Advanced EmOC course was conducted for 14 participants. In addition, five Effective Teaching Skills workshops were conducted for 84 midwifery faculty and BPHS providers— completion of this course is standard within the midwifery education standards for faculty staff. HSSP implemented a workshop for community members and health service providers to increase awareness about the link between gender and quality health service delivery and to identify health objectives and gender-related obstacles to achieving these objectives, as well as indicators to measure achievement of the objectives. HSSP also facilitated a rational use of drugs workshop for 91 BPHS health service providers; as well as a monitoring, supervision and evaluation workshop conducted for 30 NGO staff and BPHS health service providers to enhance monitoring and supervision of BPHS service delivery.

***Enabling environment for SBA continues to improve.***

On 8 October 2006, HSSP supported the first national Safe Motherhood Day of Afghanistan, with the slogan “Pregnancy and Childbirth is Special, Let’s Make it Safe”. Hosted by the MOPH and coordinated by the AMA, this event included themes on the importance of SBA and knowing the danger signs associated with pregnancy and childbirth. The celebration was launched nationally through a public forum in Kabul by MOPH departments and with HSSP technical support. Additional fora were held in eight provinces including Faryab, Takhar, Badakshan, Kandahar, Nangarhar, Bamyan, Herat, and Balkh. Moreover, the event served as a platform to launch a three-month communication campaign that involved printed materials, radio and TV spots.

With support from HSSP, the AMA continued to represent midwives at the national and provincial levels, advocate for the increased empowerment of the profession, and work with provincial health departments to lobby for a greater focus on maternal health issues. The AMA conducted the 3rd annual Congress on May 1-2, 2007 with 311 midwives in attendance from throughout the country and 24 AMA provincial branches represented. In addition, International Day of the Midwife was celebrated on May 5, 2007 and the Kabul ceremony was opened by the Minister of Public Health, Dr. Fatimie. AMA recognized 12 midwives from four maternity hospitals for their outstanding achievements and contributions in improving midwifery care in their hospitals. The day was also celebrated with activities in 10 provinces across Afghanistan. Three new AMA branches were established, resulting in a total of 18 provincial AMA branches.

***IEC department of MOPH receives greater donor funding and visibility due to HSSP TA.***

HSSP provided on-going TA to the IEC department, with key accomplishments including: raising their profile within the MOPH, increasing the level of donor funding to enable the department to

implement their own activity workplan, facilitating a technical roundtable to orientate key stakeholders to behavior change communication (BCC), IEC and CM theories, and revising the National IEC strategy.

***All IEC materials developed in Afghanistan collected, classified, indexed and analyzed.***

An inventory of all IEC materials developed under the REACH program was conducted and the information sent to PPG NGOs. Based on demand, 35 different IEC materials representing 12 technical areas were distributed to the grantees from the 13 PPG provinces. Monitoring of IEC material distribution and usage of materials was conducted through periodic follow-up joint visits with the MOPH IEC department and the NGOs.

***MOPH, NGOs and service providers trained in BCC and community mobilization.***

HSSP organized five BCC trainings for 119 NGO staff and provincial health directorate staff from nine PPG provinces. During the training, which covered situational analysis, strategic design, and, management and monitoring of BCC programs, participants developed action plans to generate demand for key health issues problematic in their catchment areas. As part of transfer of learning, many participants used the training to orient their colleagues and counterparts in BCC.

***HSSP contributed toward improving the enabling environment of SBA through support of gender awareness activities and gender sensitive service delivery practices.***

At the request of HSSP, PPG grantees continue to submit gender-related success stories for inclusion in the PPG Newsletter. In addition to conducting gender trainings for NGOs, HSSP shares its gender training materials and resources with NGOs to encourage and assist them in replicating gender trainings conducted by HSSP. HSSP continues to actively participate in the MOPH Gender and Reproductive Rights task force, which is adapting WHO gender guidelines for the Afghan context. HSSP awarded a subcontract to a local NGO to conduct a "Qualitative Study on Access, Quality of Care and Gender in Health Programs in Afghanistan". The purpose of the study was to provide information for a programmatic framework that identifies strategies and possible "best practices" for integrating gender perspectives into interventions for improving health quality and access. However, there were delays in obtaining MOPH ethical review board approval and as the finalization of the QA standards could not wait on the research results, a decision was made to cancel the research. In the next project year, HSSP will collaborate with WHO and UNFPA to subcontract gender research to assess the needs, level of knowledge, awareness and information on RH, reproductive rights, and gender issues.

While gender awareness was integrated into most HSSP trainings, HSSP also designed and conducted specific gender trainings on the following topics, among others: 1) Gender overview, 2) Why Gender is important in Afghanistan, 3) Gender and Islam/Islam and FP, and 4) Gender and Quality Health Services. 38 NGO participants and community shura members and mullahs attended a regional gender awareness training conducted in Paktiya Province in June 2007, and 32 NGO and health service providers attended a combined BCC and gender training in Badakshan in September. During all of these trainings, HSSP oriented participants to the importance of gender and the link between gender and quality health service delivery and improved health.

**Newborn Pathway**

HSSP hosted the national BCC/IEC strategy development workshop in May 2007 in coordination with the MOPH IEC department. The revised strategy focuses on ten health areas, including

maternal, newborn and child health. In addition, a newborn care LRP was developed based on national standards and reviewed by a group of in-country technical experts. Finally, QA standards for newborn care were developed and included in the national QA tool for improvement of service delivery in newborn and infant care.

### **3. Challenges**

- With the exception of CHW and CHS training, PPG NGOs do not have training funds. This presents both a challenge and an opportunity. The main challenge has been managing NGOs, MOPH, and donor expectations of HSSP. In response to this challenge, HSSP has used this as an opportunity to develop a targeted approach to NGO capacity building and has shared that approach on a number of occasions with the NGOs and MOPH. This approach includes ensuring that training is the most appropriate response to the gap identified, and if it is, then HSSP ensures that standards and a LRP are in place, thus ensuring standardization and quality of training. An opportunity exists to use un-spent PPG grantee funds to provide additional training to what HSSP is currently providing. HSSP is awaiting the response of the WHO, USAID and the GCMU as to the feasibility of this.
- A major challenge has been obtaining IRB approval for the gender qualitative research. The unexpected delay in obtaining approval delayed the entire research process, consequently rendering the research findings less useful, as they were to be used to inform the development of national QA standards that are gender sensitive. However, the standards have already been developed and finalized. Therefore, a decision was made to stop all research activities and re-evaluate the value of the research at this time.
- The three USAID-funded partner projects – HSSP, Tech-Serve and COMPRI-A have initiated monthly partners coordination meetings. The meetings are an opportunity to share workplan activities to ensure synergy between the projects and to prevent duplication.

## ACCESS/AFGHANISTAN MONITORING AND EVALUATION FRAMEWORK- SERVICE SUPPORT PROJECT (SSP) ASSOCIATE AWARD<sup>8</sup>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
<i>Intermediate Result 1: Strengthened and developed systems that support service delivery quality</i>								
1	No. of sites that have a functioning quality assurance system (cumulative life of project)	This refers to the number of PPG facilities that have applied the integrated quality assurance process to BPHS or EPHS as appropriate for the level of facility ( HFs that receive one External evaluation and 2 internal evaluations)	0	0	0 36 Health Facilities start the application of the integrated quality assurance process	Semi-annually	QA Database	<ul style="list-style-type: none"> <li>Information is collected semi-annually from HSSP Quality Assurance Database</li> <li>Year one was not enough time to recognize any sites that have a functioning quality assurance system and will be recognized in September 2008</li> </ul>
2	No. of service delivery sites recognized for quality assurance activities (cumulative life of project)	This refers to the number of PPG facilities that have applied the integrated quality process to BPHS and recognized for meeting defined levels of quality standards (80% of all standards met).	0	0	0 as above	Semi-annually	QA Database	<ul style="list-style-type: none"> <li>For year one it was not enough time to recognize any facility. The unified quality approach became ready between July to September 2007</li> </ul>
3	No. of referrals from basic centers served in secondary facilities	No. of OPD patients referred into PPG supported BHCs,	107,000	120,000	146,512 (122% of Target)	Quarterly	HMIS	<ul style="list-style-type: none"> <li>Referrals served in BHCs is also included</li> </ul>

<sup>8</sup> HSSP can only report on HMIS data through June 2007 as the HMIS (data entered quarterly) is not ready for the quarter ending in September 2007, and the reporting periods are slightly different as the MOPH HMIS uses the Afghan Shamsi (1<sup>st</sup> day of the month is the 21<sup>st</sup> of our month).

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
	(annual)	CHCs and District Hospitals (Section XX, HMIS MIAR)						<p>to include referrals from health posts.</p> <ul style="list-style-type: none"> <li>Data belongs to Period of July 2006 - June 2007.</li> </ul>
<b>Intermediate Result 2: Increased number and performance of BPHS and EPHS service providers, especially women in rural and underserved areas</b>								
4	PNC coverage within 6 weeks of birth	Proportion of mothers having a living child under 1 year old whose latest delivery was followed by a visit to a doctor, nurse or trained midwife to assess mother's health within 6 weeks or less	26% (Excludes Kabul City, only rural districts)	28%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is progress and the data will be ready in January 2008</li> <li>HSSP relies on MOPH/GCMU for conduction of this survey. Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
5	No. of community midwives enrolled in midwifery training programs (cumulative life of project)	Number of Community Midwifery Education students enrolled in SSP supported schools	0	330	143 (43% of Target)	Quarterly	Training Database	<ul style="list-style-type: none"> <li>Information is collected quarterly from HSSP supported community midwifery grants.</li> <li>No. enrolled will be slightly higher than the Target no. of graduates to make up for the dropouts and unsuccessful students.</li> <li>Data as of September 2007. Since individual student data is not yet available through the training database, this information was extracted from the Grants Database.</li> <li>The Target for the September 07 is actual Target for September 2010. Therefore it shows low percent of achievements and it will be revised in the next fiscal year.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
6	Number of community midwives successfully graduated through SSP-supported preservice education programs/schools (cumulative life of project)	Number of Community Midwifery Education students graduating from SSP supported schools	0	0	0	Quarterly	Training Database	<ul style="list-style-type: none"> <li>Information is collected quarterly from HSSP supported midwifery grants.</li> <li>The first round of graduations will not occur before September 2007.</li> </ul>
7	Number of ANC visits at PPG facilities (annual)	Number of pregnant women (0-9 mos) who have visited health facilities for receiving an ANC visit, break down by first and next visits	225,000	235,000	First visits 197,241 Other visits 123,719 (137% of Target)	Quarterly	HMIS	<ul style="list-style-type: none"> <li>Data belongs to Period of July 2006 - June 2007.</li> </ul>
8	Number of deliveries at PPG facilities by skilled birth personnel (annual)	The definition of skilled health personnel is that used by WHO: "An accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborns"	37,000	42,000	36,134 (86% of Target)	Quarterly	HMIS	<ul style="list-style-type: none"> <li>Data belongs to Period of July 2006 – June 2007.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
9	Number of postnatal visits at PPG facilities (annual)	Number of postpartum women who visited PPG health facilities for their health checkup within 6 weeks of delivery	90,000	94,000	92,222 (98% of Target)	Quarterly	HMIS	<ul style="list-style-type: none"> <li>Data belongs to Period of July 06 – June 07.</li> </ul>
10	Number of family planning visits at PPG facilities and health posts (annual)	Data will be disaggregated by 1st and returning visits, health post and health facility.	220,000 HF's 470,000 HP's	227,000 HF's 485,000 HP's	New clients in HF's 142,787 Repeat clients in HF's 105,547 (total 109% of the Target) 600,442 in HP's (124 % of the Target)	Quarterly	HMIS	<ul style="list-style-type: none"> <li>Data belongs to Period of July 2006 - June 2007.</li> </ul>
<b>Intermediate Result 3: Improved capacity and willingness of communities, families and individuals to make informed decisions about their health and support and sustained health-seeking behavior</b>								
11	Proportion of births attended by skilled attendants	Proportion of mothers having a living child under 1 year old in PPG intervention areas whose latest delivery was attended by a doctor or trained midwife	21% (excludes Kabul City, only rural districts)	23%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is ongoing and the data will be ready in January 2008.</li> <li>HSSP relies on MOPH/GCMU for conduction of this survey. Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
12	Appropriate care seeking behavior for diarrhea, fever and ARI	Proportion of children under 2 years old with an episode of either diarrhea, ARI or fever during the past two weeks in PPG intervention areas whose mothers reported appropriate care seeking practices	44% (excludes Kabul City, only rural districts)	47%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is ongoing and the data will be ready in January 2008.</li> <li>Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>
13	Knowledge of two modern family planning methods	Proportion of currently married, not pregnant women between 15-49 in PPG intervention areas who can name at least two modern contraceptive methods	54% (excludes Kabul City, only rural districts)	59%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is ongoing and the data will be ready in January 2008.</li> <li>Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
14	Knowledge about two danger signs of pregnancy	Proportion of mothers having a living child under 1 year old in PPG intervention areas who can name at least two danger signs of pregnancy	Not Available	Baseline	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>• New questions for measuring this indicator added to next round of PPG Household Survey in October 2007. That value will serve as a baseline for the following years.</li> <li>• HSSP relies on MOPH/GCMU for conduction of this survey. Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
15	% of children under 6 months exclusively breast fed	Proportion of children under 6 months old in PPG intervention areas who were fed exclusively with breast milk during the past 24 hours	44% (excludes Kabul City, only rural districts)	47%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is ongoing and the data will be ready in January 2008.</li> <li>Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> </ul>
16	% of children under 1 year who were immediately breast fed after delivery	Proportion of children under 1 year old in PPG intervention areas who were fed with breast milk within 1 of birth	50% (excludes Kabul City, only rural districts)	55%	N/A	End of 2007	PPG 2007 Household Survey	<ul style="list-style-type: none"> <li>Value provided from the REACH end-of-project household survey. Next measurement is ongoing and the data will be ready in January 2008.</li> <li>Annual measurements of this indicator may not be possible depending on the MOPH decision about how often PPG NGOs will be measuring the outcomes of their grants.</li> <li>HSSP asked MOPH</li> </ul>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
								for revising the definition of this indicator in the 2007 PPG household survey to "Proportion of children under 1 year old in PPG intervention areas who were put to the mother's breast within 1 hour of birth". In this case, a new baseline will be set as of October 2007 against which new sets of <i>Targets</i> will be defined and the progress will be measured accordingly.
<b>Intermediate Result 4: Integrated gender awareness and practice into BPHS and EPHS service delivery</b>								
17	No. of service delivery sites that have met the standards for gender sensitive delivery (cumulative life of project)	Number of service delivery sites that have met 80% of the gender standards	0	0	0 As for #1	Semi-annually	QA Database	<ul style="list-style-type: none"> <li>Information will be collected quarterly through HSSP QA database.</li> </ul>



## **BANGLADESH (Program years: October 2005-March 2009)**

### **1. Major Accomplishments**

- As a result of ACCESS recruitment, training and support during this year, 286 ACCESS counselors (ACs) are identifying pregnant women and conducting planned home counseling visits to encourage healthy maternal and newborn outcomes, 40 Community Supervisor Mobilizer (CSMs) are supervising the ACs at field level for household counseling, and 73 Community Mobilizers (CMs) are mobilizing community action, support and demand for the practice of healthy MNH behaviors.
- Using the ACCESS-established pregnancy surveillance system, as of August 2007, trained ACs registered 213,293 Married Women of Reproductive Age (MWRA) and identified 40,841 pregnant women during 15,658 block home visits. Once identified, pregnant women were scheduled for two antenatal/pregnancy preparedness visits and two postnatal/maternal & newborn care visit.
- To date, a total of 4,584 women who delivered received postnatal visits during the reporting period. Of these: 31% had a birth plan; approximately 72% of newborns were attended by a newborn care person; 84% of mothers practiced clean cord care; nearly 75% of mothers initiated breastfeeding within one hour of birth; 72% of newborns were dried and wrapped immediately; and almost 52% of mothers delayed bathing their newborns by 3 days.
- To develop a home visiting schedule for ACs and to guide community mobilization, 1,827 social/village maps were developed through participatory exercises with communities. CMs and CSMs led resource mapping at 222 villages, and facilitated 466 community-orientation meetings at which 44 core groups were formed, 50% of which are female. The CMs and CSMs are currently working with these core groups to identify problems and potential solutions to increase care-seeking behaviors.
- To increase appropriate, timely utilization of home and facility-based essential MNH services, mapping of service delivery points has been completed, as well as a TBA database for referrals. In addition, 1,444 TBAs attended 130 cluster meetings, and 3,030 TBAs and 4,687 NCPs were oriented to MNC during AC second pregnancy preparedness visits.
- Program activities are being monitored and evaluated through an MIS program that was developed, field tested and finalized with input from ACCESS and ICDRRB. A computer program for this system is currently being installed to ensure timely/efficient program reporting.
- ACCESS developed an ACCESS/Bangladesh proposal for complementary activities to the current program. This proposal was submitted to USAID and is currently being reviewed for approval.
- Western Institutional Review Board (WIRB) and local Institutional Review Board (IRB) approval has been obtained and baseline data collection is in-progress for a survey of 17,000 household to measure care seeking behaviors and home-based MNC practices at baseline.
- Former Senate majority leader Bill Frist visited Bangladesh as part of a USAID-supported campaign by Save the Children to reduce child mortality. Dr. Frist visited the ACCESS project in Sylhet division, where he met with on-site service providers.

## 2. Progress Summary

**Objective 1: to increase knowledge, skills and practice of healthy maternal and neonatal behaviors in the home.**

**Recruitment and Training:** ACCESS and its NGO partners recruited 286 ACs, 73 CSMs and 40 CMs. The ACs and CSMs were subsequently trained in counseling and facilitating negotiation sessions on proven healthy maternal and newborn household practices, as well as facilitating the Community Action Cycle. The ACs received basic training on counseling on MNH issues, the CSMs and CMs received basic training in community mobilization, and the CSMs received additional supervisory training on the MNH component. MNH sessions contained basic information on maternal /newborn health, pregnancy, childbirth, communication, counseling, negotiation and facilitation skills.

**Establishment of pregnancy surveillance system:** Currently each AC covers a population catchment area of 5,000, an average of 800 households in 6 villages. To prepare and execute the monthly work plan and ensure MWRA/Pregnancy registries are updated quarterly, ACs divided their individual cluster into 50 blocks. Based on national data, an estimated target of MWRA and pregnant women in the intervention area should be 287,324 and 43,315 respectively. As of August, 213,293 (74.2%) MWRA have been registered and a total of 40,841 (94%) pregnant women have been identified.

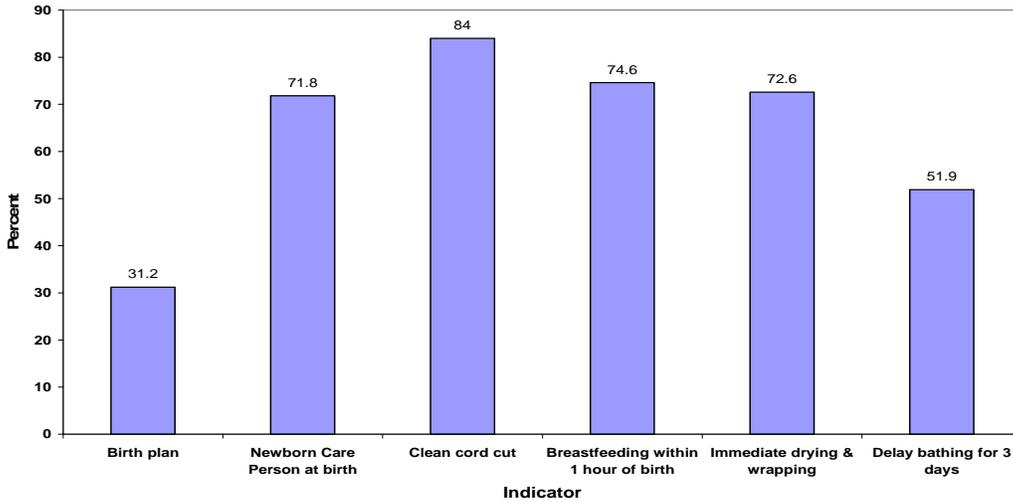
**Promotion of healthy maternal and neonatal behaviors in the home through AC home visits:** Home visits by ACs were initiated in mid-April. An initial 16,521 blocks were identified for visits by ACs, but due to heavy rains and flooding, ACs completed 15,658 block visits during the reporting period. After identifying pregnant women, ACs schedule four visits, comprised of: two antenatal/pregnancy preparedness visits (P1 and P2) and two postnatal/ maternal & newborn Care (MNC1 and MNC2) visits.<sup>9</sup>

During the reporting period, a total number of 14,151 (34.6%) pregnant women received P1 visits within 3-5 months of pregnancy and 11,996 (29.4%) pregnant women received P2 visits within 7-8 months of pregnancy. Of the 4,584 deliveries that were notified during the reporting period, ACs reached 1,879 (41%) recently delivered women within 24 hours and 2585 (56.4%) within 72 hours and conducted MNC1 visits.

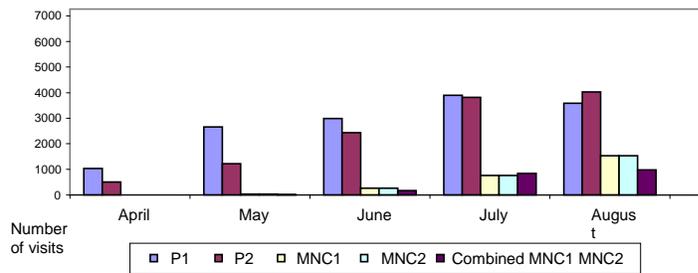
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<sup>9</sup> During P1 visits, women between 3-5 months of pregnancy receive counseling on TT immunization, routine ANC check up, prenatal nutrition, adequate rest, and recognition of danger signs for referral. During P2 visits (between 7-8 months of pregnancy), the AC counsels the mother, a TBA/FBA and a newborn care person on having a birth preparedness plan, use of CDK and clean delivery, ENC, and instructions on the referral system, transportation of mother and newborn, and delivery notification by the family. If an AC misses early pregnancy identification, a combined visit was designed to cover P1/P2 messages in a single visit. MNC1 depends on notification of delivery from each family. Within 24 hours after birth, ACs conduct MNC1 visits and schedule to check the newborn, observe for any danger signs in the newborn and mother, counsel the mother on exclusive breastfeeding, delayed bathing, cord care, recognition of maternal and newborn danger signs, and the appropriate referral system. The MNC2 counseling visit is conducted between 5-7 days after birth to follow up with any complications and provide messages on birth spacing and immunization. If the AC was not notified of the birth within 24 hours, they conduct a combined MNC visit.

**Figure 2. Progress update against some selected indicators**



**Figure 1. (Bangladesh) Counseling visits by ACCESS Counselors  
April 2007- August 2007**



In addition, the figure above shows the healthy maternal and neonatal behaviors adopted in the homes that were visited by the ACs, including: preparation of a birth plan prior to delivery, presence of NCPs at birth, clean cord care, breastfeeding within one hour of birth, immediate drying and wrapping of the newborn, and delayed bathing. Baseline data currently being collected and available in early 2008 will establish baseline measures for comparison purposes on this and other data.

**Objective 2: Increase appropriate, timely utilization of home and facility-based essential MNH services.**

**Promoting appropriate linkages and referrals:** ACCESS completed a mapping of service delivery points and outlets, as well as a list of health referral facilities and a plan to incorporate appropriate referral information into both the AC home visit and community mobilization. To promote appropriate linkages with TBAs, ACCESS completed a TBA listing and database. Subsequently, crucial links were established between ACs and 1,444 TBAs during 130 TBA cluster meetings, at which TBAs also received orientation on clean delivery practices and components of ENC. Finally, during the P2 counseling visits, ACs oriented 3,030 TBA/FBAs and 4,687 NCPs on having a birth

preparedness plan, use of CDK and clean delivery, ENC, and instructions on the referral system, transportation of mother and newborn, and delivery notification by the family.

### **Objective 3: Improve key systems for effective service delivery, CM and advocacy.**

**Creating systems for communication between all levels of partners:** Staff from partner NGOs and ACCESS/Bangladesh attended 11 monthly Program Management meetings, during which staff was updated on program progress, discussed challenges and lessons learned, and made decisions on technical and operational issues. In addition, Program Management Team Meetings were held to assist in program decision-making (e.g. implementation during the flooding, PNGO staff recruitment and relocation, administrative and financial issues, especially Mexico City Policy [MCP] management issues and USAID FP requirement compliance.) To complement these meetings, twice-a-month review meetings started in June for CSMs and ACs to report on field program activities (584 of these meetings have been held by 73 CSMs at the community level). Issues discussed during these meetings include: MWRA/pregnancy identification, target determination and number of visits conducted, quality of HH counseling, information collected through MIS forms, developing the monthly work plan of AC, and challenges faced by field staff. During each meeting a technical review was conducted on counseling, EDD calculation and/or any other issues as identified by ACs. Field Support Officers and ACCESS/Bangladesh staff attended these meetings to provide feedback and TA to ensure quality of the household counseling visits.

### **Objective 4: Mobilize community action, support and demand for the practice of healthy MNH behaviors**

**Resource Mapping:** For the first phase of community mobilization, i.e. resource mapping, villages and potential resources of each village were mapped to determine if community groups/clubs or NGO groups existed and were willing to work as Community Action Group (CAG) members within the ACCESS Program. In addition, resource mapping helped identify potential community resource persons and their present involvement within community organizations, including identification of a site for holding CAG group meetings, identification of community-based health service providers who may serve as a member of CAG and to identify village pharmacists. During this phase, 222 villages were selected for CAG activities.

**Core group formation:** As a first step of core group formation, ACCESS conducted 466 community orientation meetings, with a total attendance of 12,973 participants. After the community orientation, CMs/CSMs conducted meetings to form a core group consisting of participants from the most affected and vulnerable communities. Core groups play a key role in identifying and prioritizing local problems whereby action plans are subsequently developed. Core groups communicate with community resource persons to generate support for the larger community. Since May, 444 core groups have been formed in the 222 villages selected during Phase 1; of these core groups, 50% are female.

**Problem identification and priority setting:** Under the second phase of the Community Action Cycle, “Identifying the issues and set priorities,” CM/CSMs will work with each group to identify problems in different situations (pregnancy, delivery, and post delivery). Subsequently, mothers will assess



Problem identification, Bangladesh

the frequency and severity of identified problems and care seeking behaviors of the community will be identified related to these problems. To date, 465 problem identification meetings have been facilitated by CSMs and CMs with the participation of 6,520 group members. After identifying the problems, CMs and CSMs will facilitate priority-setting meetings to prioritize three problems in each group. The next meetings will be to generate Action Plans which will include health education sessions based on community needs.

**Objective 5: Increase key stakeholder leadership, commitment and action for MNH approaches**

**District coordination meeting with government officials:** On August 9, ACCESS held a district-level coordination meeting with government officials to enhance current collaboration and discuss how to improve referral linkages with Upazilla Health Complex & Family Welfare Center within target areas with minimum service availability. MOH officials from the central, district and Upazilla level of the government attended this meeting and expressed their willingness to increase cooperation to achieve the goals and objectives of ACCESS program. ACCESS staff at the Upazilla level were invited to the monthly meeting at Upazilla Health Complex, which includes staff from the MOH Health and FP Department to receive an update and improve collaboration. Additional advocacy meetings have also been conducted at the Upazilla level.

**National Safe Motherhood Day observation:** National Safe Motherhood day was observed on May 28<sup>th</sup> at Upazilla level. ACCESS level worked jointly with the local government administration and health authorities to mark the day by organizing rallies to generate awareness among people in the community. Seven rallies were organized in the ACCESS intervention area, with an average of 200 people participating in each rally, including TBAs/FBAs, pregnant mothers, government authorities, journalists from local media, and civil society members.



National Safe Motherhood Day Rally

**Development of MIS and M&E:** ACCESS developed a functioning MIS system to monitor and evaluate program activities. This system includes a supervisory checklist and guideline for AC field activities. Supervisory staff of PNGOs and ACCESS Bangladesh staff have been trained on use of the system and a computerized version is being installed.

**3. Challenges**

- This was further complicated because a control site was added to the baseline design, which warranted approval from local IRB and WIRB and led to a delay in conducting the baseline study.
- The ACCESS Program does not offer any services other than creating demand through counseling services. Moreover, it depends upon government and NGO health facilities for services, as ACs refer clients to the nearest appropriate facility for routine visits and danger signs. Existing service facilities are not sufficient for the projected population and are often not functioning well.

- Heavy rainfall and flash floods affected most Upazilas either partially or totally. ACs were prevented from meeting their daily targets since most areas affected by the flood are only accessible by boat.
- MWRA who are tea garden laborers, stone laborers and other daily laborers usually stay at their workplace during the day time. Thus they are not available to ACs during her planned visit at household level.
- Many CM group meetings are conducted at night, especially male groups, hence monitoring and supervision is difficult for ACCESS program staff.



Former Senator Bill Frist Visits ACCESS Safe Motherhood and Newborn Care Project in Bangladesh

### **Former Senator Bill Frist Visits ACCESS Safe Motherhood and Newborn Care Project in Bangladesh**

Former Senator William Harrison Frist from Nashville, Tennessee, former U.S. Senate majority leader and a pioneer in cardiothoracic transplant surgery, visited Bangladesh recently as part of a USAID-supported campaign by Save the Children to reduce child mortality. As part of the trip, Dr. Frist visited the USAID-supported ACCESS/Bangladesh Safe Motherhood and Newborn Care project in Sylhet division. He met with service providers on site and was briefed about immunization and vaccine services provided in the community. He also attended a counseling session for expectant mothers that provided information on birth preparedness, recognition of complications, antenatal care visits and maternal nutrition. He attended a post-natal maternal and newborn care visit to observe a project counselor examining a newborn and monitoring the newborn and mother for health complications.

"Bangladesh's advancements were also on display in Sylhet, a region in the country's far northeastern corner. I distributed vitamin A supplements and vaccinations to dozens of newborns, including the child of a young woman named Tahmina. Through the work of Save the Children and USAID, Tahmina received prenatal counseling and continued guidance regarding proper newborn care following her son's birth. As a result of this assistance, her child's chances of survival have increased dramatically," Dr. Frist said at the end of his visit.

*(From USAID Global Health News, October 2007)*

## ACCESS/BANGLADESH MONITORING AND EVALUATION FRAMEWORK

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>GOAL: To improve maternal and neonatal health outcomes</b>					
Neonatal mortality rate in ACCESS intervention area	Number of deaths of newborn 1-28 days in last year in ACCESS intervention area, by upazila x 1000 Total number live births in last year	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
<b>SO: To increase the practice of healthy maternal and neonatal behaviors in antenatal, childbirth, and postnatal periods in a sustainable and potentially scalable manner</b>					
*Percent of recent mothers <sup>10</sup> who had a birth plan during their last pregnancy	Number of recent mothers who reported having a birth plan during their last pregnancy x 100 Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	31.2%
*Percent of recent mothers whose birth was attended by a skilled <sup>11</sup> provider by type of provider, by place of delivery	Number of recent mothers attended at their last childbirth by a skilled provider by type of provider, by place of delivery x 100 Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	Home delivery: 89.4% Facility delivery: 10.6% Delivery by skilled provider: 14.9% Delivery by TBA: 72.1% Delivery relative: 13.0% Delivery by others: 0.1%
*Percent of recent mothers who gave birth at home whose newborns were attended by a Newborn Care Person at birth	Number of recent mothers who gave birth at home had a Newborn Care Person (counseled by ACCESS Counselor) at birth x 100 Total number of recent mothers who gave birth at home interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	71.8%
*Percent of recent mothers who gave birth at home whose newborns' cord were cut with clean/new instrument or that clean birth kit were used at their last childbirth	Number of recent mothers who gave birth at home whose newborns' cord were cut with clean/new instrument or that clean birth kit were used at their last childbirth x 100 Number of recent mothers who gave birth at home interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	84.0%

<sup>10</sup> "Recent mother" defined as having given birth within the last year (12 months)

<sup>11</sup> "Skilled provider" refers to doctor (specialist or non-specialist), nurse, midwife or their equivalent who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants are excluded.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
*Percent of newborns who were breastfed within the first hour after childbirth	Number of recent mothers who reported initiating breastfeeding within 1 hour of birth $\times 100$ Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	74.6%
*Percent of newborns who were exclusively breastfed in the last 24 hours	Number of recent mothers whose babies are less than 6 months old who reported exclusively breastfeeding their newborns in the last 24 hrs prior to the survey $\times 100$ Total number of recent mothers whose babies are less than 6 months old at time of interview (disaggregated by age/month of baby)	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	69.8%
*Percent of newborns whose first bath was delayed for 3 days	Number of recent mothers who reported delaying bathing their newborn for the first time until 3 day after birth $\times 100$ Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	51.9%
*Percent of newborns who were delivered at home who were dried and wrapped immediately after birth	Number of recent mothers who delivered at home who reported that their newborns were dried and wrapped before the delivery of the placenta $\times 100$ Total number of recent mothers who delivered at home interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	72.6%
*Percent of newborns who had nothing applied on to their umbilical stump after birth	Number of recent mothers who reported that their newborns had nothing applied to their umbilical cord after birth $\times 100$ Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	73.1%
Percent of recent mothers who reported receiving two TT immunizations during their last pregnancy	Number of recent mothers who reported receiving two TT immunizations during their last pregnancy $\times 100$ Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Percent of recent mothers who consumed iron/folate tablets during their last pregnancy	Number of recent mothers who reported consuming iron/folate tablet during their last pregnancy $\times 100$ Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who want to delay their next pregnancy for at least 2 years	Number of recent mothers who want to delay their next pregnancy for at least 2 years $\times 100$ Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers whose recent pregnancy were delayed for at least 2 years	Number of recent mothers whose recent pregnancy were delayed for at least 2 years $\times 100$ Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who accepted a modern contraceptive method by 6 week postpartum visit	Number of recent mothers who accepted a contraceptive method by 6 weeks postpartum $\times 100$ Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
<b>IR1: To increase knowledge, skills, and practices of healthy maternal and neonatal behaviors in the home</b>					
Percent of recent mothers who can cite the key components of birth plans	Number of recent mothers who listed preparation of birth materials and environment, maternal/newborn attendant arrangements, emergency transport plan, and arrangements for funds as part of a birth plan $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to seek at least 4 ANC from a skilled provider during pregnancy	Number of recent mothers who reported knowing to seek at least 4 ANC during pregnancy $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to consume iron/folate tablets during pregnancy	Number of recent mothers who reported knowing to consume iron/folate tablets during pregnancy $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Percent of recent mothers who know to use a skilled provider during childbirth	Number of recent mothers who reported knowing to use a skilled provider during childbirth $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who gave birth at home who know to use a Newborn Care Person at birth	Number of recent mothers who gave birth at home who reported knowing to use a Newborn Care Person at birth $\times 100$ Total number of recent mothers who gave birth at home interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who gave birth at home who know using clean/new instrument or clean birth kit to cut newborns' cord	Number of recent mothers who gave birth at home who reported knowing using clean/new instrument or clean birth kit to cut newborns' cord $\times 100$ Total number of recent mothers who gave birth at home interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to breastfeed their babies immediately after childbirth	Number of recent mothers who reported knowing to breastfeed their babies within 1 hour of birth $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to exclusively breastfeed their babies for the first 6 months	Number of recent mothers who reported knowing to exclusively breastfeed babies for the first six months of life $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to delay first bathing of their newborns for 3 days	Number of recent mothers who know to delay first bathing of their newborns for 3 days $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to dry newborns immediately after childbirth	Number of recent mothers who reported knowing drying newborns before the placenta is delivered $\times 100$ Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Percent of recent mothers who know to wrap newborns immediately after childbirth	Number of recent mothers who reported knowing wrapping newborns before the placenta is delivered x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know that nothing should be applied on to the umbilical stump of the newborn	Number of recent mothers who reported knowing that nothing should be applied on to the umbilical stump of the newborn x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who can cite at least three danger signs of pregnancy	Number of recent mothers who cited 3 danger signs of pregnancy x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who can cite at least three danger signs of childbirth	Number of recent mothers who cited 3 danger signs of childbirth x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who can cite at least three danger signs postpartum	Number of recent mothers who cited 3 danger signs postpartum x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who can cite at least three danger signs in newborn babies	Number of recent mothers who cited 3 danger signs in newborn babies x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who know to seek at least 2 PNC visits after delivery from a skilled provider	Number of recent mothers who reported knowing to seek PNC after delivery from a skilled provider x 100 Total number of recent mothers interviewed	PBS report	PBS Survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
<b>IR2: Increased appropriate and timely utilization of home and facility-based essential maternal and neonatal health services</b>					

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
*Percent of recent mothers who received at least four ANC visits from a skilled provider during their last pregnancy by type of provider	Number of recent mothers who received at least four ANC from a skilled provider during their last pregnancy by type of provider x 100 Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	2.9%
*Percent of recent mothers who reported having developed a danger sign during pregnancy and sought care from a skilled provider by type of provider	Number of recent mothers who reported developing a danger sign during pregnancy and sought care from a skilled provider by type of provider x 100 Total number of recent mothers who reported having developed a danger sign during their last pregnancy	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	47.6%
*Percent of recent mothers who reported having developed a danger sign during childbirth and sought care from a skilled provider by type of provider	Number of recent mothers who reported developing a danger sign during childbirth and sought care from a skilled provider by type of provider x 100 Total number of recent mothers who reported having developed a danger sign during their last childbirth	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	41.1%
*Percent of recent mothers who received a PNC visit within 3 days after childbirth	Number of recent mothers who received a PNC visit within 3 days after childbirth x 100 Total number of recent mothers interviewed	MIS Report; PBS report	AC visit record review; PBS survey	Quarterly; baseline and endline surveys	15.1%
Percent of recent mothers who received at least two PNC visits for themselves from a skilled provider after childbirth by type of provider	Number of recent mothers who received at least two PNC for themselves from a skilled provider after childbirth by type of provider x 100 Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who received at least two PNC visits for their newborns from a skilled provider after childbirth by type of provider	Number of recent mothers who received at least two PNC for their newborns from a skilled provider after childbirth by type of provider x 100 Total number of recent mothers interviewed	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who reported having developed a postpartum danger sign and sought care from a skilled provider by type of provider	Number of recent mothers who reported developing a postpartum danger sign and sought care from a skilled provider by type of provider x 100 Total number of recent mothers who reported having developed a danger sign after their last childbirth	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Percent of recent mothers who reported that their newborns developed a danger sign at birth or within 1 month after birth and sought care from a skilled provider by type of provider	Number of recent mothers who reported that their newborns developed a danger sign at birth or within 1 month after birth and sought care from a skilled provider by type of provider x 100 Total number of recent mothers who reported their newborns developed a danger sign at birth or within 1 month after birth	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
<b>IR3: Improved key NGO systems for effective intervention delivery</b>					
*Number of married women of reproductive age (MWRA) living in ACCESS intervention areas	The number of married women of reproductive age (MWRA) is the married female population between the ages of 15-49	MIS report	Census	Quarterly	213,293
*Number of pregnant women identified and registered in ACCESS intervention areas	The number of pregnant women identified from all sources and registered by ACCESS Counselor in ACCESS intervention areas	MIS report	Pregnancy Register Review	Quarterly	40,841
*Percent of recent mothers whose pregnancy was identified and registered at least 3 months before delivery	Number of recent mothers whose pregnancy was identified and registered at least 3 months before delivery x 100 Total number of recent mothers interviewed	MIS report	Pregnancy Register review	Quarterly	53.1%
*Percent of recent mothers who reported having received at least two home visits by an ACCESS Counselor during their last pregnancy	Number of recent mothers who reported receiving at least two home visits by an ACCESS Counselor during their last pregnancy x 100 Total number of recent mothers interviewed	MIS report; PBS report	Pregnancy Register review; PBS survey	Quarterly; endline survey	15.7%
Percent of recent mothers who reported receiving counseling from an ACCESS Counselor on the importance of 4 ANC visits	Number of recent mothers who reported receiving counseling from an ACCESS Counselor on the importance of 4 ANC visits by a skilled provider x 100 Total number of recent mothers interviewed	PBS report	PBS survey	Endline survey	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers with a danger sign during pregnancy who were referred by an ACCESS Counselor	Number of recent mothers with a danger sign during pregnancy who were referred by an ACCESS Counselor x 100 Total number of recent mothers with a danger sign during their last pregnancy	PBS report	PBS survey	Endline survey	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Percent of recent mothers who reported receiving counseling from an ACCESS Counselor on the importance of 2 PNC visits	Number of recent mothers who reported receiving counseling from an ACCESS Counselor on the importance of 2 PNC visits by a skilled provider x 100 Total number of recent mothers interviewed	PBS report	PBS survey	Endline survey	Information will be available after completion of baseline survey which is underway.
*Number of pregnant mothers who received birth kits from ACCESS Counselor	Birth kits consist of a square metre of plastic sheet, bar of soap, a razor blade, a length of string, and a pictorial instruction sheet.	MIS report	Pregnancy Register Review	Quarterly	2,784
*Percent of recent mothers who reported receiving home visit by an ACCESS Counselor within 24 hours after childbirth	Number of recent mothers who reported receiving home visits by an ACCESS Counselor within 24 hours after childbirth x 100 Total number of recent mothers interviewed	MIS report; PBS report	Pregnancy Register Review; PBS survey	Quarterly; endline survey	41.0%
*Percent of recent mothers who reported receiving home visit by an ACCESS Counselor within 5-7 days after childbirth	Number of recent mothers who reported receiving one home visit by an ACCESS counselor within 5-7 days after childbirth x 100 Total number of recent mothers interviewed	MIS report; PBS report	Pregnancy Register Review; PBS survey	Quarterly; endline survey	60.8%
Percent of recent mothers with a postpartum danger sign who were referred by an ACCESS Counselor	Number of recent mothers with a postpartum danger sign who were referred by an ACCESS Counselor x 100 Total number of recent mothers with a postpartum danger sign after their last childbirth	PBS report	PBS survey	Endline survey	Information will be available after completion of baseline survey which is underway.
Percent of newborns with a danger sign who were referred by an ACCESS Counselor	Number of newborns with a danger sign who were referred by an ACCESS Counselor x 100 Total number of newborns with a danger sign	PBS report	PBS survey	Baseline and endline surveys	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers satisfied with specified services by an ACCESS Counselor by type of service	Number of recent mothers satisfied with specified services (negotiation, counseling & referral) by an ACCESS Counselor by type of service x 100 Total number of recent mothers interviewed	PBS report	In-depth interview	Endline survey	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
*Percent of ACCESS Counselors who received two supervisory visits in the last month by Community Supervisor Mobilizer (CSM)	Number of ACCESS Counselors who received two supervisory visits in the last month by Community Supervisor Mobilizer x 100 Total number of ACCESS Counselors	MIS report	CSM visit record review	Quarterly	79.8%
<b>IR4:</b> To mobilize community action, support and demand for the practice of healthy maternal and neonatal behaviors					
*Percent of villages in ACCESS intervention areas that have a Community Action Group (CAG) <sup>12</sup>	Number of villages that have a CAG by intervention union x 100 Total number of villages in that union	MIS report	CM/CSM Register Review	Quarterly	12.3%
Percent of recent mothers who are aware of the existence of a Community Action Group (CAG) in their villages	Number of recent mothers who are aware of the existence of a Community Action Group (CAG) in their villages (if there are CAGs in the villages) x 100 Total number of recent mothers interviewed (in CAG villages)	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who are members of Community Action Group (CAG)	Number of recent mothers who are members of Community Action Group (CAG) (if there are CAGs in the villages) x 100 Total number of recent mothers interviewed in CAG village	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.
*Percent of Community Action Groups (CAG) that met at least once in the last 2 months	Number of CAG that met at least once in the last 2 months x 100 Total number of CAG	MIS report	CAG Register review	Quarterly	100%
*Percent of Community Action Groups (CAG) with action plans to advocate for improved EMNC services	Number of CAG with action plans x 100 Total number of CAG	MIS report	CAG Register review	Semi- annually	0%
*Percent of Community Action Groups (CAG) that implemented at least 70% of their action plans within six months following the development of action plans	Number of CAG that implemented at least 70% of their action plan within six months following the development of action plans x 100 Total number of CAG with action plans	MIS report	CAG Register review	Semi- annually	0%

<sup>12</sup> Community Action Group (CAG) has been renamed to Core Group (CG).

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
*Percent of Community Action Groups (CAG) with an emergency transport system	Number of CAG with an emergency transport system x 100 Total number of CAG	MIS report	CAG Register review	Semi- annually	0%
Percent of recent mothers who are aware of the existence of an emergency transport system	Number of recent mothers in CAG village with emergency transport system who are aware of the existence of an emergency transport system x 100 Total number of recent mothers interviewed in CAG village with emergency transport system	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who experienced a pregnancy-related complication, or whose newborns experienced a complication, who used the emergency transport	Number of recent mothers in CAG village with emergency transport system who experienced a pregnancy-related complication, or whose newborn experienced a complication, who used (during their last pregnancy/child birth/postpartum period) the emergency transport x 100 Total number of recent mothers who experienced a pregnancy-related complication, or whose newborns experienced a complication, in CAG village with emergency transport system interviewed	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.
*Percent of Community Action Groups (CAG) with an emergency financing system	Number of CAG with an emergency financing system x 100 Total number of CAG	MIS report	CAG Register review	Semi- annually	0%
Percent of recent mothers who are aware of the existence of an emergency financing system	Number of recent mothers in CAG village with emergency financing system who are aware of the existence of an emergency financing system x 100 Total number of recent mothers interviewed in CAG village with emergency financing system	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.
Percent of recent mothers who experienced a pregnancy-related complication, or whose newborns had a complication, who were benefited from the emergency financing system	Number of all recent mothers or those who experienced a pregnancy-related complication, or whose newborns had a complication, in CAG village with emergency financing system who were benefited (during their last pregnancy/child birth/postpartum period) from the emergency financing system x 100 Total number of all recent mothers or those who experienced a pregnancy-related complication, or whose newborns had a complication, interviewed in CAG village with emergency financing system	PBS report	PBS Survey	Endline survey	Information will be available after completion of baseline survey which is underway.

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
*Percent of Community Action Groups (CAG) that have representation from the nearest health facility	Number of CAG with at least one representative from the nearest health facility Total number of CAG x 100	MIS report	CAG Register review	Semi-annually	0%
<b>IR5:</b> To increase stakeholder leadership, commitment, and action for these maternal and neonatal health approaches					
An integrated advocacy strategy developed.	Yes/no measure. Activities will be identified and scoring will be done on the basis of the accomplishments.	Program report	Review of program report	Annually	Initiated the process with WRA.
Number of non-ACCESS supported organizations/programs that initiate or strengthen EMNC services in Program areas		District Health report	Review of district health report	Annually	Contingent on Integrated Advocacy Policy development which is in process.
Number of non-ACCESS supported organizations/programs that take action to expand home behavior messages or practices related to EMNC		Resource mapping report	Baseline/ End line mapping of activities	Baseline and endline	0

ILLUSTRATIVE INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Conferences, professional meetings, and formal presentations in which ACCESS Bangladesh staff contribute in Bangladesh		Program report (qualitative list)	Review of program report	Semi-annually	Contributed in the following: <ul style="list-style-type: none"> <li>• Corporate Working Group Meeting</li> <li>• Projahnmo Dissemination and Design Workshop</li> <li>• Meeting on Sepsis Management of Newborn at Community Level in Bangladesh</li> <li>• Consultative Meeting on Community based early postnatal care package</li> <li>• Consultation workshop on Community Based Postnatal Care (PNC) in Bangladesh</li> </ul>
Number of government and/or donor policies, strategies and/or programs modified to incorporate maternal and neonatal health approaches promoted by ACCESS		Program report (including qualitative list)	Review of program report	Annually	Contributing towards developing/modif-ying maternal and neonatal health strategy/policy with SNL.

Note: Source of data is the Routine MIS for the period from April 2007 to August 2007.

## **CAMBODIA (Program years: December 2006-December 2008)**

### **1. Major Accomplishments**

#### **Core Funds**

- ACCESS supported a national-level technical meeting on PPH and oriented national stakeholders to the global data and research on AMTSL and evidence on use of misoprostol for PPH reduction. The meeting also resulted in the formation of a PPH TAG, and consensus for the development of a demonstration project on expanded use of AMTSL among skilled providers, and community-based distribution of misoprostol to pregnant women in settings where there is no skilled attendant.
- The first two meetings of the PPH TAG have resulted in agreement on the terms of reference; selection of a demonstration site in Pursat Province; selection of RACHA as the local NGO to support the National RH Program with project implementation; and circulation of the draft project proposal for approval at the national level.

#### **Field Funds**

- ACCESS has been a key partner with UNICEF in developing the objectives of the National Neonatal Health Working Group, formed to examine newborn health needs and priorities in Cambodia. An integrated postnatal care package for Cambodia is currently being developed by the working group, and is intended to form the basis of the national NRHP standards of care. ACCESS will working in Koh Kong Province, with CARE Australia, to implement the package
- In order to build capacity of MOH counterparts, ACCESS jointly renovated with A2Z a space within the MOH to house the LTTA. ACCESS further sponsored participation of three key MOH staff from the Center to attend the Scaling-up High Impact FP and Maternal, Newborn and Child Health Best Practices conference held in Bangkok in September 2007.

### **2. Progress Summary**

#### **PPH Pathway**

ACCESS is assisting the MOH in addressing the problem of maternal mortality from PPH through a demonstration project to expand use of AMTSL among SBAs and implementation of a community-based scheme for birth preparedness with distribution of misoprostol in settings where there is no skilled attendant present at delivery.

ACCESS laid the foundation for this initiative through advocacy for the reduction of PPH, assisting the NRHP to conduct a national level technical and sensitization meeting on PPH reduction. In attendance were 65 participants, representing a wide range of national stakeholders such as the MOH, USAID/Cambodia, WHO, JICA, UNICEF, UNFPA, local NGOs, staff from major hospitals in Phnom Penh, and MNH care implementing partners. Participants were oriented to the global data and research on AMTSL and evidence on use of misoprostol for PPH reduction. The meeting resulted in identification of next steps for addressing the problem of PPH in Cambodia and recommendations for program implementation. In addition, this national technical meeting provided an opportunity for a wide range of national health staff to receive state-of-the-art information and data on global programs and evidence for PPH/maternal mortality reduction. The results were presented to the national MNCH sub committee and a demonstration program was sanctioned by the Director of the NRHP. A PPH TAG was formed consisting of key NRHP staff and

representatives of donor and technical partners agencies to steer the prevention of PPH demonstration project. The first two meetings of the PPH TAG have resulted in selection of a demonstration site in Sampov Meas Operational District in Pursat Province and selection of RACHA as the local NGO to support the NRHP for project implementation. A draft program proposal was circulated amongst the TAG members for feedback.

### **Newborn Pathway**

During the start-up period, ACCESS made notable contributions to the area of strengthening newborn health. ACCESS has been a key partner with UNICEF in developing the terms of reference and objectives of the National Neonatal Health Working Group, formed to examine newborn health needs and priorities in Cambodia. An integrated postnatal care package for Cambodia is currently being developed by the working group, using up-to-date global evidence and best practices. The aim is to develop this package as a national standard for use by the NRHP, and incorporate it into key SM training programs and protocols. Strong collaborative partnerships are the foundation of the ACCESS program to ensure sustainability of interventions. This package will be piloted by ACCESS in collaboration with CARE Australia in their field site and other agencies will also trial it in a similar way (e.g. UNICEF and others).

ACCESS was also asked to contribute technical and editorial input toward the development of a Newborn edition of the Health Messenger publication, which was printed and distributed to all Cambodian health staff in the country.

### **SBA Pathway**

ACCESS began work with the NMCHC to increase capacity for the provision of technical and management leadership for MNH. ACCESS recognizes that capacity building at the national level is the cornerstone to achieving the development of evidence-based and sustainable policies in maternal health and strengthening of an enabling environment for SBA's. To support this effort, ACCESS sponsored participation of 3 key MOH staff to attend the *Scaling-up High Impact FP and Maternal, Newborn and Child Health Best Practices* conference held in Bangkok in September 2007. This meeting provided a technical update in evidence-based MNH and encouraged priority-setting discourse among Cambodian participants to discuss next steps for scaling up evidence-based interventions.

## **3. Challenges**

- Human Resource Shortages: Staff shortages and the current hierarchy at the NRHP have made it challenging for the LTTA to have counterparts at the MOH on technical issues. ACCESS proposes that the USAID Health Officer continue to lobby with the MOH as appropriate to recruit the extra staff.
- There exists a lack of technical and operational collaboration between health technical sectors of the MOH which have overlapping responsibilities e.g. the National Nutrition Program and the NRHP. Unless these constraints are overcome, operationalization and achieving universal coverage of essential RH services will be extremely difficult.
- A conservative attitude regarding community health programs exists among the MOH and some key donors. There is a lack of development and utilization of community health volunteers and other community-based providers and reluctance from the MOH to increase their role in health services. The USAID health office and USAID-funded partners need to demonstrate the positive and vital role community-level providers can play if given sufficient training and support.

## **GUINEA (Program years: October 2006-September 2008)**

### **1. Major Accomplishments**

- ACCESS expanded PAC services to Guinea's Forest Region, building the capacity of providers at six facilities and providing supportive supervision. Followup visits found that four of the sites are now treating one to five PAC cases per month while two facilities need additional support from ACCESS next year to start service delivery.
- ACCESS conducted an assessment of PAC services in Upper and Forest Guinea, visiting nine facilities. The assessment examined the quality and availability of all aspects of PAC service delivery. Findings revealed that all nine facilities were still providing PAC services: from January to June 2007, a total of 618 women at the sites were treated with comprehensive PAC services; 67% of women receiving PAC services left the facility with a FP method, including 75% of adolescents; at all facilities, bleeding after pregnancy loss was treated using manual vacuum aspiration (MVA), not dilation and curettage.

### **2. Progress Summary**

ACCESS supported USAID/Guinea's Strategic Objective of "increased use of FP/MCH and STI/AIDS prevention services and practices" through expansion of PAC services to Guinea's Forest Region. Through this intervention, ACCESS increased access to and improved quality of FP/MCH and STI/AIDS prevention services and products. This effort built upon PAC programming initiated under JHPIEGO's former Training in Reproductive Health cooperative agreement in 1999. From the initial introduction of PAC to two teaching hospitals in Conakry in 1999, JHPIEGO, in collaboration with the USAID Guinea bilateral project, PRISM, expanded services to two regional hospitals, seven prefectural hospitals, and one district health center in Upper Guinea.

Over the past year, ACCESS expanded PAC services to an additional six health facilities in the refugee-affected area of Forest Guinea. ACCESS trained 16 health workers (four physicians, nine midwives, and three medical technicians) from the six facilities in provision of PAC services and conducted follow-up visits to these providers. The training covered the MVA procedure and FP. The health workers came from one regional hospital, four prefectural hospitals, and one health center. A follow-up visit to the facilities in March 2007 showed variability in the launch of PAC services in these sites. Four of the sites (N'zerekore Regional Hospital, Beyla and Macenta Prefectural Hospitals, and the Sinko Health Center) have successfully initiated PAC services and are treating one to five cases per month. In Yomou and Lola Prefectural Hospitals, PAC services have not yet been initiated and will need additional support in FY08. With the expansion of PAC services to these six new sites, the total number of sites with PAC services supported by USAID is now 17.

ACCESS conducted an assessment of PAC services in Upper and Forest Guinea, visiting nine facilities (eight hospitals and one health center). Sites were selected to include both facilities located in the capital and in the regions and préfectures. Given the rainy season, accessibility was also a selection criterion.<sup>13</sup> The purpose of the assessment was to examine the quality and availability of all aspects of PAC services including counseling, FP services, MVA, linkages to other essential RH services, and

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<sup>13</sup> The 9 PAC facilities are: Hôpital National Donka; Hôpital Régional (HR) Mamou; HR Kankan; HR de Kindia; CMC Minière, dans la ville de Conakry; Hôpital Préfectoral (HP) Dabola; HP Siguiri; HP Mandiana; HP Kouroussa

CM. Based on the findings, ACCESS made recommendations to PAC stakeholders in Guinea who will provide future support to PAC programming. Key highlights of this assessment include:

- PAC services are in place in all nine sites visited, including counseling, FP services, MVA, linkages to other essential RH services and community mobilization.
- From January to June 2007, a total of 618 cases of bleeding after pregnancy loss from the nine sites visited were treated with comprehensive PAC services
- A total of 67% of women receiving PAC services left the facility with a FP method. Adolescents had the highest acceptance rate at 75%.
- At all sites visited, bleeding after pregnancy loss was treated using MVA. No cases of dilation and curettage were noted.
- PAC services are supported by all hospital management. For instance, stakeholders cited anecdotal evidence that there was improved supply of materials and supplies, and in management arranged for rooms to be available for PAC services.
- Provider reported that PAC services have positively influenced other services and their quality, citing better IP practices, and the introduction of FP services
- PAC has been systematically transferred by trained providers to others on site to ensure continuity of PAC services
- PAC is included in the newest version of the Guinean FP Protocols, Norms and Procedures.

### **3. Challenges**

The main challenges were as follows:

- travel restrictions because of political instability
- scheduling activities given staff and consultant availability
- some project sites are difficult to reach in the rainy season as roads are closed

## HAITI (Program years: October 2004-December 2008)

### 1. Major Accomplishments

- Since October 2006, ACCESS has expanded CT for PMTCT to 23 facilities, reaching more than 18,400 pregnant women. Of these women, 3.6% were HIV+ and 58% of those who tested positive were enrolled in the PMTCT program.
- Since May 2007, 161 clients at 16 health facilities benefited from long-term methods of FP. Of these clients 73% opted for Norplant, 20% received tubal ligation, and 17% had IUDs inserted.
- Based on findings from a desk assessment of needs and constraints related to human resources and technical capacity for FP at 23 sites, ACCESS-FP drew up a plan, in concert with HS 2007, to reposition/reinvigorate FP. Actions from this plan implemented during this reporting period include: 20 providers trained in tubal ligation, 56 providers trained in IUD and Norplant insertion and removal, the establishment of a referral system between health facilities, and continuous liaison and advocacy with the national committee on FP.
- ACCESS, through IMA, donated approximately \$100,000 worth of equipment and supplies in October 2006 to support maternal and newborn services at 23 ACCESS-supported health facilities. In addition, ACCESS purchased items including delivery beds, C-section kits, aquachlore machines for water purification, and surge protectors. In addition, ACCESS provided another \$55,000 in equipment to support services for long-term FP.
- To continue building the capacity of the Institute for Health and Community Action (INHSAC), a Haitian training organization, ACCESS provided assistance to them to conduct PMTCT and VCT training for providers. As of August 2007, a total of 170 providers had been trained.
- ACCESS continued to advocate for the integration of PMTCT in the pre-service education curriculum of doctors and nurses, and has formally introduced the PMTCT modules into the curriculum of the national midwifery school.
- A proposal for the establishment of a PMTCT Task Force Committee was submitted to the Ministry of Health for approval/endorsement.



Haitian mother with two of her children.

### 2. Progress Summary<sup>14</sup>

#### Increasing Capacity to Provide Quality FP Services with a Focus on Long-term Methods

At the end of the 2006 calendar year, ACCESS conducted a desk assessment of needs and constraints related to human resources and technical capacity for FP at 23 sites. In addition to providing baseline information for M&E, this assessment served as the basis for the development, in concert with the local USAID project (HS2007), of a plan to reposition/reinvigorate FP. Actions from this plan implemented during this reporting period include:

<sup>14</sup> Progress made in Haiti under the ACCESS-FP Youth Initiative is described separately in the ACCESS-FP report.

- ACCESS conducted a TOT workshop for 14 trainers to train providers in long-term FP methods. With subsequent support from ACCESS, these trainers trained 20 providers in tubal ligation and 56 providers in IUD and Norplant insertion and removal.
- \$55,000 in equipment/instruments and expendable supplies was purchased and distributed by ACCESS to HS2007 service delivery sites to strengthen services for long-term methods of FP.

ACCESS collaborated in the design of a referral tool to link organizations that offer non reversible methods. The tool is currently been used by the HS 2007 network, and is under review for approval by the MOH. ACCESS staff in Haiti ensured continuous liaison and advocacy with the National FP Committee, including participating in planning activities and ensuring all activities were coordinated with the departmental committees that were formed to oversee and strategically plan the re-introduction of FP. JHPIEGO played an active role in the organization of meetings and departmental fora leading up to the National Conference on FP hosted by the Prime Minister and the U.S. Ambassador.

### **Expanding and Strengthening PMTCT sites**

During FY07, ACCESS continued to integrate and expand quality PMTCT services into a total of 23 sites (public and HS2007 sites), of which 18 are providing the full package of PMTCT services.

Efforts included:

- Sites already providing PMTCT service were strengthened through TA and monitoring activities in large part provided by five regional coordinators and the support of the country office in Haiti. In addition, PMTCT services were introduced to and are being established at “new” sites that did not previously offer the services.
- Continuing capacity-building efforts, ACCESS supported INHSAC to train 170 service providers in PMTCT and to follow-up at sites. Specifically, JHPIEGO provided them with all the training materials, participated in planning training activities; and co-facilitated training. A total of seven training activities were conducted between January and August 2007.
- ACCESS, through IMA, donated about \$100,000 worth of equipment, drugs and supplies in October 2006 to support maternal and newborn services at 20 ACCESS-supported health facilities.
- In view of reducing the need for inservice training of providers, ACCESS introduced the PMTCT training manual into the curriculum of the national school of midwifery. Moreover, OB/Gyn students are learning the PMTCT practices during their clinical training at the three hospitals that conduct practical training of medical students.

### **3. Challenges**

- The USAID Mission refocused its health strategy for Haiti on FP with the new initiative “*Repositionnement du Planning Familial en Haiti*” launched by the Government of Haiti at the end of 2006. As a result, ACCESS had to revise its original workplan, delaying the start of activities. ACCESS also did not receive FY07 field support funds for population to continue its activities, while at the same time the number of targeted sites supported by the ACCESS program increased from 12 to 23. In FY08, JHPIEGO will receive limited funding through MSH, the implementer of the follow-on to HS2007, necessitating a further reduction in scope and impact of activities in Haiti.

- At the facility level, other projects (e.g. supported by the U.S. Centers for Disease Control and Prevention, or CDC) pay providers extra fees for providing services they have been trained in. Thus, providers who were trained by ACCESS also expect some kind of remuneration or support to take on what is perceived as “new” or “extra” work. In addition, high staff turn-over at sites continues to be a challenge as many people trained by ACCESS have already moved to different sites.
- Logistical challenges are posed by (1) the difficulty of accessing sites for follow-up due to poor roads and infrastructure, and (2) difficulties in obtaining data, as the Ministry registers don’t include all the information that ACCESS needs to collect.
- Finally, ACCESS-trained trainers are in high demand and sought after for training in multiple areas (FP, IP, PMTCT, MNH, PAC) and for many different projects. At the same time, these individuals have demands on their time to provide services in their own institutions and are thus not always available when needed.

## ACCESS/HAITI MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>FAMILY PLANNING INDICATORS</b>				
Number of trainers trained in long term family planning methods		Training participant tracking sheets and training database	Quarterly	6 trainers trained in IUD insertion and removal (regional coordinators and key service providers)
Number of providers trained in FP by method		Training participant tracking sheets and training database	Quarterly	76 total 20 Tubal ligation and 56 IUD/ Norplant,
Number of sites strengthened and offering long term FP methods		Program records	Annual	21 from « zones cibles » and 8 department hospital
Number of clients referred for FP	Number of clients referred for FP  Service statistics at sites	FP registers - review of service statistics at sites  Referral tools, FP registers reviewed and analyzed	Quarterly	Not available
Number of women (maternity and/or FP) at Target facilities who received long term methods	<u>Numerator</u> : Number of women from maternity and/or FP at Target facilities who received long term method  <u>Denominator</u> : Total number of women visiting maternity ward and/or FP clinic at Target facilities	FP registers, Monthly FP monitoring form, FP database	Quarterly	115
<b>PMTCT INDICATORS<sup>15</sup></b>				

<sup>15</sup> Seven ACCESS-supported PMTCT facilities reported data for October 2006 –February 2007: Hôpital de l'Université d'Etat d'Haïti (Oct –Nov 2006), Hôpital Universitaire Justinien (Oct 06 –Fev 07), Hôpital Immaculée Conception de Port de Paix (Oct 06 –Fev 07), Hôpital La Providence des Gonaïves (Oct 06 –Fev 07), Hôpital Saint Michel de Jacmel (Oct 06 –Jan 07), Hôpital Immaculée Conception des Cayes (Oct 06 –Fev 07), Hôpital Sainte Thérèse de Miragoâne (Oct 06 –Fev 07)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number of qualified PMTCT/CT trainers developed	Qualified trainers include PMTCT /CT-trained providers who successfully completed an ACCESS-supported Clinical Training Skills (CTS) or Advanced Clinical Training Skills (ATS) course for PMTCT.	Training participant tracking sheets and training database	Annual	15
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. 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	170 providers
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 PEPFAR, the minimum package is defined as: <ul style="list-style-type: none"> <li>• Counseling and testing for pregnant women</li> <li>• ARV prophylaxis to prevent MTCT</li> <li>• Counseling and support for safe infant feeding practices</li> <li>• Family planning counseling or referral</li> </ul>	PMTCT follow-up assessment , ACCESS program records	6 months after baseline assessment	ACCESS has been supporting a total of 23 PMTCT sites.
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, , Maternity registers, CDC Global AIDS program database for Haiti	Quarterly	18,409 pregnant women were counseled and tested (12 facilities reporting)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number/% of pregnant women at Target facilities who have been tested for HIV	<p><u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT Target facilities who have been tested for HIV</p> <p><u>Denominator:</u> Total number of pregnant women (ANC and Maternity) at the PMTCT Target facilities (not available)</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	<p>18,409</p> <p><u>Note about denominator:</u> Total number of pregnant women (ANC and Maternity) counseled not available</p>
Number/% of pregnant women (ANC and Maternity) at Target facilities who received pre test counseling	<p><u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT Target facilities who received pre test counseling</p> <p><u>Denominator:</u> Total number of pregnant women (ANC and Maternity clients) tested for HIV at the PMTCT Target facilities</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	<p>18,409</p> <p>All pregnant accessing ANC services received pre-test counseling (this includes pregnant women who came for their first ANC visit and the ones who had not been test during their first visit.) Maternity clients who were counseled are also included in this number also.</p>
Number/% of pregnant women (ANC and Maternity) at Target facilities who received post test counseling	<p><u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT Target facilities who received post test counseling</p> <p><u>Denominator:</u> Total number of pregnant women (ANC and Maternity clients) tested for HIV at the PMTCT Target facilities</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	15,634 (85%)
Number of pregnant women (ANC and Maternity) who tested positive	<p><u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT Target facilities tested positive</p> <p><u>Denominator:</u> Total number of pregnant women (ANC and Maternity clients) tested for HIV at the PMTCT Target facilities</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	669 (3.6%)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number/% of pregnant women HIV (+) who are enrolled in the PMTCT program	<p><u>Numerator:</u> Number of pregnant women HIV (+) enrolled in the PMTCT program</p> <p><u>Denominator:</u> Total umber of pregnant women HIV (+) at Target facilities</p> <p>(Limited to ANC clients only)</p>	ANC PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	389 (58%)
Number/% of pregnant women (ANC and Maternity) HIV (+) who received ARV prophylaxis	<p><u>Numerator:</u> Number of ANC clients HIV (+) at Target facilities who received ARV prophylaxis</p> <p><u>Denominator:</u> Total number of ANC clients HIV (+) at the PMTCT Target facilities</p> <p style="text-align: center;">AND/OR</p> <p><u>Numerator:</u> Number of Maternity clients HIV (+) at Target facilities who received ARV prophylaxis</p> <p><u>Denominator:</u> Total number of Maternity clients HIV (+) at the PMTCT Target facilities</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	288 (43%) Number of pregnant women who receive ARV prophylaxis who were enrolled for PMTCT services.
Number /%of pregnant women who received single dose of Nevirapine at time of delivery	<p><u>Numerator:</u> Number of pregnant women HIV (+) who received single does of Nevirapine at time of delivery</p> <p><u>Denominator:</u> Number of pregnant women HIV (+) who delivered at Target facilities</p>	Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	101 (93.07%)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number /%of HIV (+) pregnant women who received HAART	<u>Numerator:</u> Number of pregnant women HIV (+) women who received HARRT  <u>Denominator:</u> Total number of HIV (+) pregnant women VIH (+) at Target facilities	PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	104 (44.64%)
Number/% of ANC clients HIV (+) who had a CD4 count test	<u>Numerator:</u> Number of ANC HIV (+) who had a CD4 count test  <u>Denominator:</u> Total number of ANC clients HIV (+) at Target facilities	PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	102 Data collected until June. Note that there is a stockout of reagents for CD4 count since last 3 months..
Number/% of ANC clients HIV (+) who referred their partners	<u>Numerator:</u> Number of ANC clients HIV (+) who referred their partners  <u>Denominator:</u> Total number of ANC clients HIV (+) at Target facilities	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	9 (4% )
Number/% of pregnant women who have been tested for syphilis	<u>Numerator:</u> Number of pregnant women who have been tested for syphilis  <u>Denominator:</u> Total number of ANC and maternity clients at Target facilities.	ANC PMTCT register, Monthly PMTCT monitoring form, PMTCT database	Quarterly	13,736
Number/% of pregnant women who have been diagnosed for syphilis	<u>Numerator:</u> Number of pregnant women with RPR (+) test  <u>Denominator:</u> Total number of pregnant women who have been tested for syphilis	ANC PMTCT register, Monthly PMTCT monitoring form, PMTCT database	Quarterly	660 (4.8%)
Number/% of pregnant women who have been treated for syphilis	<u>Numerator:</u> Number of pregnant women with RPR (+) test who have been treated for syphilis  <u>Denominator:</u> Total number of pregnant women diagnosed with RPR (+) test in Target facilities	ANC PMTCT register, Monthly PMTCT monitoring form, PMTCT database	Quarterly	342 (51%)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
Number/% of newborns with HIV (+) mothers who received ARV prophylaxis	<p><u>Numerator</u> : Number of newborns with HIV (+) mothers who received ARV prophylaxis</p> <p><u>Denominator</u> : Total number of newborns with HIV (+) mothers</p>	PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	249



## **KENYA (Program years: October 2006-September 2008)**

### **1. Major Accomplishments**

- ACCESS/Kenya supported implementation of the action plan that resulted from the regional PPH conference held in Uganda. This included the establishment of a TAG to engage MOH officials, preservice and inservice education stakeholders, and professional associations to promote national policy and regulatory issues for PPH, as well as the development of clinical practice guidelines for AMTSL.
- Contraceptive uptake increased on average 15% in three districts where ACCESS provided technical support aimed at facilities based on survey findings. This was a remarkable increase; the target was set at 5% by the MoH and the Implementing Best Practices consortium in Kenya.
- As the result of ART training in WHO's IMAI approach, the MOH/NASCOP was able to establish ART services according to the national standards at 71 new ART sites in four provinces (Central, Coast, Nairobi, and Eastern).
- A total of 928 service providers in seven malaria-endemic districts received sensitization of the new MOH treatment policy for malaria, providing them with the necessary knowledge to implement the new malaria case management policy.
- The capacity of 29 supervisors from the DRH and NASCOP (central-level and provincial-level) to use a supervision tool integrating PMTCT with all MCH service delivery was increased. These supervisors are currently using the tool (developed by ACCESS and adopted for use by the DRH and NASCOP) to evaluate performance in the provincial and district hospitals, and to develop action plans to address gaps in performance.
- ACCESS expanded FANC to include a TB/ANC training package in one province; supervisors from the DRH and NASCOP (central-level and provincial-level) were trained to use an integrated PMTCT/MCH supervision tool.
- Provider-Initiated Testing and Counseling (PITC) was launched in all nine Provincial-level General Hospitals and the two National Referral/Training hospitals following the training of 296 health workers in the new PITC methodology and approach.
- The DRH Reproductive Tract Cancer information pack, encompassing both breast and prostate cancer, was developed and disseminated.

### **2. Progress Summary**

#### **ANC Pathway**

**Malaria:** The MOH's Division of Malaria Control (DOMC) requested technical support from ACCESS to continue the rollout of the new Malaria Case Management Guidelines in Coast province. In order to reach more service providers with the funds available, ACCESS collaborated with the DOMC to develop an orientation package (the Malaria Case Management Orientation Package for Service Providers) designed for one-day sensitization workshops that target front-line providers with information from the national malaria policy guidelines, including the importance of SP for IPTp. This package was subsequently used by ACCESS and DOMC to sensitize 928 service providers in seven malaria-endemic districts of Coast Province. Outcomes include:

- Malaria Case Management Orientation Package for Service Providers developed.

- 928 service providers from 470 health facilities sensitized on artemisinin-based combination therapy (ACT) regimen for case management of clinical malaria, use of quinine, SP and prevention and control of MIP in line with new MOH guidelines

**TB/ANC:** ACCESS, in collaboration with the DRH and the USAID APHIA II Eastern Program, made great strides toward strengthening and integrating TB screening, referral, diagnosis and treatment for pregnant women into Focused Antenatal Care (FANC) services. This program builds on JHPIEGO’s successful efforts with DRH to scale up comprehensive FANC services in Kenya.

Key technical support from ACCESS included updating the existing FANC orientation package and training both trainers and service providers. Outcomes include:

- National *Focused ANC* materials have been updated and adopted to include integration of TB. Currently, WHO, APHIA II Eastern and APHIA II Coast are supporting the MOH to scale up the TB/ANC program.
- A core group of 30 ACCESS-developed TB/ANC trainers in Eastern province. APHIA II Eastern will build on these efforts to support and facilitate service provider orientations for TB/ANC in the coming years.

### Newborn Pathway

**PMTCT Support:** ACCESS provided technical support to both the DRH and NASCOP to strengthen supervision capacity among supervisors in PMTCT. To ensure success and longevity of this initiative, DRH and NASCOP worked together with ACCESS to improve supervision for PMTCT as an element of the MNH platform, rather than as an isolated service. In this effort, ACCESS

### Kenya: IMAI Training and PLHA Involvement

Expert patients (PLHAs) with health workers at the skills station during IMAI training

*“IMAI should have been introduced here a long time ago. It is the best ART training approach. The training involves the PLHAs who really know their condition and the clinicians who manage them -- what a combination!”* –Provincial AIDS and STI Coordinator (PASCO), Nairobi Province, during an IMAI planning and advocacy meeting in Nairobi

*“This is the best thing that JHPIEGO has done for my Province, many other partners should learn from JHPIEGO.”*—Provincial Medical Officer (PMO), Central Province, commending JHPIEGO for rolling out IMAI in Central Province for the first time. The PMO said that IMAI will bridge gaps inherent in traditional ART trainings.

*“This training has shown us that we can actually decentralize ART services to dispensaries and health centres so easily; something which NASCOP should scale up throughout the country if they want to put many patients on care and treatment”*—PASCO, Eastern Province, during opening ceremony of the first IMAI training in the Province



collaborated with the national PMTCT Technical Working Group to provide lead technical support to develop a comprehensive supervision tool integrating a performance improvement approach. Using the tool, supervisors can monitor quality against national standards in all RH service provision areas (FP, ANC, Maternity, Post-natal care, Child Welfare) and in HIV-specific service provision, including VCT and Comprehensive Care (CC). The tool also provides supervisors with a method to assess linkages between service provision and community support. Outcomes include:

- Development of the *Facilitative Supervision Tool for RH and HIV Services* for supervisors and service providers, adopted for use by the DRH and NASCOP.
- 29 supervisors from DRH and NASCOP (central-level and provincial-level) trained by ACCESS to use supervision tool. These supervisors are currently in the process of evaluating performance in provincial and district hospitals, and will develop action plans to address gaps in performance.

### **Crosscutting Support**

***Anti-retroviral Treatment:*** ACCESS provided lead technical support to NASCOP to shift the training methodology for ART to follow the WHO-endorsed IMAI approach, which integrates chronic HIV care, acute care, palliative care and general principles of good chronic care to provide a more comprehensive approach to the management of HIV/AIDS. The approach includes training people living with HIV/AIDS (PLHAs) to serve as “expert patient trainers” (EPTs). By participating in training courses, EPTs ensure service providers experience ‘real life’ situations in managing care for HIV-positive individuals. ACCESS supported the MOH to adapt the WHO IMAI approach and to roll out IMAI activities in four provinces. ACCESS technical support included adaptation of training materials, development of trainers, and training of service providers. ACCESS will continue to provide technical support to the MOH as NASCOP rolls out this innovative approach nationwide. Outcomes include:

- WHO IMAI training materials adapted for use in Kenya. Training materials include an orientation package for pediatric HIV care, which explains how to identify, follow up and refer HIV-exposed /infected children and adolescents. All of these materials have been endorsed by NASCOP, and are jointly used as a package.
- 58 clinical trainers from all eight provinces and the central level trained by ACCESS in ART, in the IMAI approach, and in pediatric orientation.
- 62 PLHAs (45% male, 55% female) from four provinces (Central, Coast, Eastern and Nairobi) trained as EPTs and subsequently used at skills stations during provider training.
- 256 service providers (41% male, 59% female) trained in ART using the IMAI approach.
- 71 new ART sites established in four provinces (17 in Central, 18 Coast, 18 Nairobi, and 18 in Eastern province).
- TA provided to trainers in Coast Province to facilitate training of 61 additional service providers and to establish 18 new ART sites in the province.

***Counseling and Testing:*** During the reporting period, ACCESS provided lead technical support to NASCOP at the central level and to the Provincial Health Management Teams (PHMTs) at the provincial level to launch PITC services in Kenya. ACCESS provided TA to NASCOP to develop and pretest the PITC LRP. With NASCOP-adoption of the LRP, the PHMTs have been sensitized to the program and are in place to support programmatic rollout. Outcomes include:

- NASCOP-adopted PITC LRP
- 296 health workers in the nine Provincial-level General Hospitals and the two National Referral/Training hospitals in Kenya trained in new PITC methodology and approach.
- 95 NASCOP and PHMT members trained in CTS to ensure quality in echo training.
- 75 PHMT members trained in supervision skills.
- With the introduction of PITC, CT services now available in all provincial hospitals throughout all clinical departments.

***DRH Central Support.*** ACCESS provided technical support to the DRH to address priority interventions as outlined in the DRH Annual Operating Plan for 2006/2007. Activities this year included: 1) addressing gaps in training materials for reproductive tract cancers, 2) incorporating breast and prostate cancers into existing cervical cancer information pack, 3) equipping DRH training sites with anatomic models to ensure effective teaching, and 4) strengthening skills of provincial level trainers in Post-Rape Trauma Counseling. Outcomes include:

- 25 anatomic model sets shipped and expected to arrive in Kenya in October 2007; ACCESS will orient trainers in care and use of the models once they arrive. DRH currently determining priority training sites for distribution.
- Support provided for development of a National Reproductive Tract Cancer information pack.
- 16 providers trained in Post Rape Trauma Counseling in Coast Province.

***Implementing Best Practices (IBP):*** Although support for IBP ended in project year two, an endline survey was completed during this reporting period in three of the four ACCESS-designated districts (Homa Bay, Nakuru and Nyeri). The survey showed an average increase for contraceptive uptake of 15%; this surpassed the MOH target of 5%. Targeted training and follow-up supervision among providers certainly contributed to this increase. During the endline survey, 95% of interviewed providers said that they are continuing to practice the skills they learned during the ACCESS training. It is expected that the USAID APHIA II partners throughout the country will continue to support the gains and draw on the lessons learned from this successful program.

### **3. Challenges**

- ACCESS funding for Kenya was not received until mid-January 2007 despite the beginning of the PY in October 2006; this resulted in a late start. However, program teams reacted quickly to implement activities to reach program goals and to satisfy national Kenyan targets. Although funding arrived late, the ACCESS Kenya team showed remarkable gains in a short amount of time.
- Both the DRH and NASCOP are losing staff more quickly than they are able to hire replacements. This high turnover results in understaffing in some key areas of ACCESS support, as well as the need for training new staff.
- IMAI is a new approach that requires commitment to the use of EPTs, which makes trainings more costly as these additional trainers are not typically included in training program budgets. In addition, EPTs, being HIV-positive, are more susceptible to illness during trainings and may

require medical attention. However, the benefit to their inclusion – both for the PLHAs to live positively with the disease and for the providers who gain experience working with ‘live’ patients – outweighs the cost and/or administrative implications.

- Linking DRH and NASCOP throughout the PMTCT program has been a challenge given their competing priorities.
- Demands on NASCOP in multiple technical areas have resulted in the inability to train all relevant staff in PITC at ACCESS trainings. However, it is expected that the ACCESS-trained managers will also orient their colleagues who are unable to attend trainings.
- In addition to high staff turnover, competing priorities within the DRH at the central level have made it challenging to implement activities on time.
- Although ACCESS had hoped to assist the MOH in scale-up of AMTSL, funding did not become available for this. Thus, ACCESS is working through the APHIA 2 East and West programs, on which JHPIEGO is a partner, to use its core funding to provide TA in their training of providers in AMTSL.

## ACCESS KENYA MONITORING AND EVALUATION FRAMEWORK

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
<b>USAID/KENYA I.R.3.2:</b> Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS					
<b>Support to Art Services</b>					
1. Total number of health workers trained to deliver ART according to national and international standards in the provision of ART treatment. *	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.  Data will be disaggregated by job function ( e.g trainer, supervisor and service provider)	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 200</i>  Result: 256 service providers
2. Number of trainers trained in clinical training skills	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 50</i>  Results: 58 clinical trainers; 62 Expert Patients Trainers
3. Number of supervisors of ART services trained in clinical mentorship skills	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 50</i>  Result: This was not done as the workplan focus changed to Integrated Management of Adult Illnesses (IMAI) at the request of the MOH (approved by the USAID Mission)

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
4. Number of service outlets providing ART *	As the result of the ART training, the MOH / NASCOP was able to establish ART according to the national NASCOP standards	Trainer reports	Trainer reports after training	Kenya Program staff, PASCOs and PARTOs	71( 17 Central, 18 Coast , 18 Nairobi ,18 Eastern )
5. Number of individuals newly initiating antiretroviral therapy during the reporting period	Data will be disaggregated by age, sex and type of SDP	Support Supervision report, MOH/NASCOP-726/727 forms	During support supervision	Support Supervision team, Kenya Program staff, MOH – DASCO,PASCO, PARTO	JHPIEGO Kenya is not currently monitoring ART at the health facility level. This is done either by the MOH or the USAID APHIA programs.
6. Number of individuals who ever received ART by the end of the reporting period	Data will be disaggregated by age, sex and type of SDP	Support Supervision report, MOH/NASCOP-726/727 forms	During monthly support supervision visit last 3 months End of project evaluation	Support Supervision team, Kenya Program staff MOH – DASCO,PASCO, PARTO	JHPIEGO Kenya is not currently monitoring ART at the health facility level. This is done either by the MOH or the USAID APHIA programs.
7. Number of facilities that receive at least one supervisory visit for ART	Supervisory visits are made to assess the quality of the ART sites and the training received	Support Supervision report	Once, when follow up visit conducted	Support Supervision team, Kenya Program staff; MOH – DASCO,PASCO, PARTO	<i>Target: 50</i>  Result: Focus was on training using IMAI approach. Supervision will be conducted in PY4
<b>Support to C&amp;T Services</b>					
1. Number of trainers trained in Clinical training skills	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 100</i>  Result: 95 NASCOP and PHMT members  All PHMT invited members were trained but five NASCOP members had last minute conflicts

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
2. Number of Supervisors trained in supervision skills	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 100</i>  Result: 75 PHMT members. Another session will be conducted in October 2007 during the no-cost extension period
3. Number of individuals trained in counseling and Testing according to national & International standards *	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted. Data will be disaggregated by job function ( e.g trainer, supervisor, provider)	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff	<i>Target: 270</i>  Result: 296 service providers
<b>USAID KENYA INTERMEDIATE RESULT: (3.1) Improved enabling environment for the provision of health services and (3.13) Quality of health services in health facilities improved</b>					
<b>Support to the Division of Reproductive Health (DRH)</b>					
1. Number of trainers and managers (central and provincial) whose knowledge has been updated in key RH technical areas.	Evidence-based RH knowledge will be informed by technical assistance from the ACCESS Program, international standards, and other stakeholders.	Technical Update Action Plans	Per Technical Update (twice/ year)	Kenya Program staff	<i>Target: not stated</i>  Result: None updated yet– difficulty has been arranging suitable time with. DRH staff Training in AMTSL is planned for October 2007
2. Number of equipment procured for DRH implementation support.	Equipment refers to: <ul style="list-style-type: none"> <li>• Madam Zoe (pelvic model)- 25</li> <li>• Arm model for implants- 25</li> <li>• IUCD handheld model- 25</li> <li>• Breast model- 25</li> <li>• Penile model- 25</li> <li>• African Baby Model- 25</li> </ul>	Procurement Statements	Annual	Kenya Program staff	<i>Target: not stated</i>  Result: All equipment ordered and shipped. Arrival expected end October 2007

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
3. Number of trainers, managers and tutors oriented to use of essential RH equipment.	Trainers, managers and tutors will be oriented to use of essential equipment (see above).	Orientation records	Annual	Kenya Program staff	<i>Target: DRH will determine</i> Result: Will be done after equipment arrives
4. Number of individuals trained in key technical RH areas	Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Kenya Program staff	<i>Target: no Targets as this is determined by DRH needs</i> Result: 16 – Post rape trauma
<b>Strengthening Malaria services</b>					
1. Number of service providers sensitized on ACTS	Sensitization course was one day. Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.	Self-administered Training Participant Registration forms as part of TIMS Training data base and other records	Immediately after training	Kenya program staff	<i>Target: not stated</i> Result: 928 service providers sensitized
<b>Enhancing and Integrating PMTCT with RH and HIV Services</b>					

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
1. Number of individuals who have been trained in PMTCT supervision according to national and international standards	<p>Trained individuals are those trained through ACCESS-supported training events or by ACCESS-developed trainers. Only those who complete a training event satisfactorily according to the criteria established for each course are counted.</p> <p>Data will be disaggregated by administrative level (e.g., DRH or NASCOP, and province)</p>	Self-administered Training Participant Registration forms as part of TIMS	Training records reviewed to compile relevant information annually ACCESS	Support Supervision team, Kenya Program staff; MOH – DRHT&S TEAMS	<p><i>Target: 20</i></p> <p>Result: 29 National and Provincial level trainers:</p> <ul style="list-style-type: none"> <li>• 1 DRH</li> <li>• 1 NASCOP</li> <li>• 2 Central</li> <li>• 2 Coast</li> <li>• 5 Eastern</li> <li>• 7 Nairobi</li> <li>• 3 North Eastern</li> <li>• 4 Nyanza</li> <li>• 2 Rift Valley</li> <li>• 2 Western</li> </ul>
2. Number of service delivery points (SDPs) providing the minimum package of PMTCT services according to national and international standards	<p>Service delivery points are medical facilities where clinical care is provided for clients. The PMTCT package of services aims to prevent HIV+ transmission through the provision of ANC including a number of HIV related interventions.</p> <p>The provision of integrated PMTCT, ANC and HIV services at ACCESS <i>Target</i> sites will be determined through follow-up and supportive supervisory review. Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private).</p>	Support Supervision reports Records review to compile <i>Targeted</i> SDPs that reach service provision goals	Annual	Support Supervision team, Kenya Program staff MOH – DRHT&S TEAMS,	<p><i>Target: not stated</i></p> <p>Result: JHPIEGO's role in PY3 was to train at the national and provincial levels. During PY4 the roll out will occur down to the service delivery level.</p>

INDICATOR *PEPFAR	DEFINITION / CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
3. Number of facilities that receive at least one supervisory visit for PMTCT, every 3 months	Supervisory visits are made to assess the quality of the ART sites and the training received	Support Supervision reports Records review to compile <i>Targeted</i> SDPs that reach service provision goals	Annual	Support Supervision team, Kenya Program staff; MOH – DRHT&S TEAMS,	<i>Target: not stated</i> Result: JHPIEGO support supervision planned for November; during no-cost extension approved by USAID
4. Number of facility, zonal and regional managers who have received the national PMTCT supervision guidelines / tool		Program activity records	Annual	Program technical staff with ACCESS M&E review	<i>Target: 16</i> Results: <ul style="list-style-type: none"> <li>• 80 attendees to the PMTCT Consultative Meeting in August.</li> <li>• 29 Provincial supervisors who are expected to share with colleagues</li> </ul>



## NEPAL (Program Years: March 2004-December 2007)

### 1. Major Accomplishments

#### Core Funds

- A national workshop was held to sensitize stakeholders from the MOH medical schools and nursing, ob-gyn and pediatric professions on KMC, resulting in the creation of a national KMC advisory group, a baseline facility survey, TOT and training of providers, and the introduction of KMC at five health facilities—two zonal hospitals and three PHCs.

#### Field Funds

- The MOH disseminated the MNC LRP for SBAs for inservice and preservice training for ANMs, nurses and doctors that was developed by ACCESS.
- ACCESS developed and applied resources to support use of the MNC LRP in national training systems, including three in-service training curricula, an SBA trainer orientation guide and SBA in-service training site quality improvement tools. Eight facilities used the tools to conduct self-guided baseline assessments and make improvements based upon assessment findings.
- ACCESS used field funds to complement core-funded KMC activities and introduce a project in one district to identify and manage LBW infants at the community level, in collaboration with the Nepal Family Health Program (NFHP) and the MOH. From January to September 2007, a total of 769 newborns were identified as LBW, by female community health volunteers (FCHVs). This represents 19% of the over 4,145 deliveries registered in the communities. Among the FCHVs whose performance was observed, 80% properly used KMC. At the national level, ACCESS also supported development of LBW management guidelines in collaboration with a national TAG.
- A study in rural Nepal on factors that contribute to the successful utilization of SBA services revealed that facility characteristics that may be associated with a high volume of delivery services include: “24/7” services/staffing; availability of BEmOC; easy access; referral system and/or ambulance; dynamic facility leader; energetic community collaboration; and employment of local personnel. ACCESS completed the study report, "Utilization of Rural Maternity Delivery Services in Six Districts of Nepal: A Qualitative Study," and disseminated the findings to stakeholders to inform national planning for the SBA program.
- ACCESS worked with the NFHP to prepare for scale up of PPH prevention using misoprostol. ACCESS assisted with an external midterm review of the community-based prevention of PPH program in Banke district and provided recommendations to help plan for a national roll out of use of misoprostol for prevention of PPH. ACCESS presented the study results at the USAID-sponsored meeting, *Scaling-up High Impact FP and Maternal, Newborn and Child Health Best Practices: Achieving the Millennium Development Goals in ANE*, held September 3-8, 2007 in Bangkok, Thailand.

### 3. Progress Summary

#### Skilled Birth Attendant Results Pathway

##### *Maternal and newborn care learning resource package for skilled birth attendants*

During this PY, ACCESS contributed the Maternal and Newborn Care Learning Resource Package for Skilled Birth Attendants to support the operationalization of the National Policy for Skilled Birth

Attendants (2006). In total, the LRP consists of a participant set (handbooks, reference materials and a clinical logbook in a green bag) and a trainer set (notebooks, reference materials and the User's Guide in a blue bag). A set of transparencies were also produced to deliver LRP content for each training site. The MNC LRP was finalized by the TAG in April 2007 following field testing and later sent to the Government of Nepal (GON), where it received its official endorsement.

ACCESS and the GON jointly launched and disseminated the LRP on June 21, 2007. ACCESS produced a total of 150 trainer sets, 250 participant's sets in English, and 300 participant's sets in Nepali for the National Health Training Center (NHTC). The LRP has been used in all SBA in-service trainings conducted to date—with a total of 87 nurses and doctors from 33 districts receiving training.

In addition, ACCESS developed a number of additional resources to aid NHTC trainers and other stakeholders to incorporate the MNC LRP into its trainings. For example, the User's Guide for both in-service and pre-service training programs was developed to aid trainers in becoming familiar with this new type of teaching materials.

To strengthen the training quality of the SBA training sites and ensure consistency with the MNC LRP, ACCESS Nepal supported the NHTC to develop SBA in-service training site Quality Improvement tools and introduced the SBM-R process. Based upon the MNC LRP and national SBA training documents, a total of 12 quality improvement tools were developed and finalized by stakeholders during a July workshop. Eight training sites (Bharatpur Hospital, Koshi Zonal Hospital, Maternity Hospital, AMDA Damak Hospital, Seti Zonal Hospital, Baglung Hospital, Dhulikhel Community Hospital and Lumbini Zonal Hospital) later used these tools to conduct a self-guided assessment. In August, ACCESS brought the sites together to share assessment findings, identify gaps and develop action plans for site strengthening. ACCESS also worked with the NHTC to share findings and identify common needs for support, resources and TA.

At the national level, ACCESS contributed to a number of key strategic discussions and meetings. For example, ACCESS staff have actively participated in national SBA strategic planning meetings



ACCESS and district health staff in Kanchanpur

and forum meetings, including work led by UNFPA; ACCESS has also assisted in the accreditation of SBA pre-service and in-service curricula. Notably, these discussions produced a consensus to use the SBA IST Quality Improvement tools as part of the formal accreditation process. ACCESS has also continued to meet with pre-service education stakeholders to ensure the MNC LRP will be incorporated into pre-service systems, curricula and schools. In September 2007, ACCESS supported the GON to develop a strategy for utilizing the MNC LRP in pre-service education. ACCESS presented the MNC LRP at the annual Nepal Society of Obstetric and Gynecology (NESOG) conference. Similarly, SBA working meetings organized by NHTC and with support from the SSMP were

attended by program staff members. The SBA working group mainly focused on the different roles of stakeholders and their role in supporting the SBA training.

### ***Study on the enabling environment to support skilled birth attendants in Nepal***

This study was conducted in six sites to identify the key factors that contribute to successful utilization of skilled birth attendants. In addition, the study looked at barriers and constraints to effective use of birth attendants, and potential models that might be recommended for use in rural Nepal.

Major findings of the study include that most women preferred and planned a home delivery and reserved attendance at a facility only as a back-up for complications. Cost was especially important to dalit women, as were concerns regarding possible discrimination due to caste. Facility factors which may be associated with a high volume of delivery services include "24/7" services and availability of BEOC; easy access; three or more trained staff available in PHCCs; a referral system and/or ambulance on site; dynamic leadership of the facility, energetic community collaboration; and employment of local personnel.

The study findings were shared with the GON and stakeholders in the national program review meeting of the FHD and NESOG. Nepal Country team identified "availability of maternal and neonatal "24/7" services" one key intervention and included in the plan of action developed in the Scaling-up FP/MNCH Best Practices in Asia and The Near East Technical Meeting.

### **PPH Results Pathway**

ACCESS continued its close collaboration on community-based MNC interventions with the NFHP, including prevention of PPH. Dr. Harshad Sanghvi, Medical Director at JHPIEGO, assisted with an external midterm review of the community-based PPH prevention program in Banke district. The evaluation provided recommendations on program activities and helped plan for a national roll out of use of misoprostol for prevention of PPH. Results from this collaboration were presented at the USAID-sponsored *Scaling-up High Impact FP and Maternal, Newborn and Child Health Best Practices: Achieving the Millennium Development Goals in ANE*, held September 3-8, 2007 in Bangkok, Thailand.

### **Newborn Results Pathway**

#### ***Community-based management of low birth weight infants in Kanchanpur district***

ACCESS also collaborated with NFHP on community-based programs for newborns. During the first six month period of the reporting period a series of trainings for health workers and FCHVs took place in Kanchanpur District. The LBW TOT was conducted for 20 government, NFHP and ACCESS staff members. All 771 FCHVs were trained on the Birth Preparedness Package (BPP). Among the 771 BPP trained FCHVs, a total of 220 FCHVs representing each ward were selected and trained in management of LBW babies. During the second six months of the reporting period, extensive data on the management and care of LBW newborns was collected through FCHVs trained in neonate management. Among the 4,145 total deliveries registered in the CB-MNC register, 19% (769/4,145) of neonates delivered during the 9 months period (October 2006 to June 2007) were found to be LBW or very low birth weight (VLBW) More than 60% (N=461) of mothers and families of LBW neonates practiced full or partial KMC. Practice of



Newly delivered mother and newborn

exclusive breast feeding in Kanchanpur is almost universal. About 95% of mothers exclusively breast fed their babies during the 28 day postpartum period. The proportion of mother and their neonates who received postnatal care (PNC) visits by FCHVs increased from 80% to 90% from the first quarter to third quarter.

To ensure proper management of newborns who are referred to health facilities, ACCESS Nepal developed a training package on ENC, aimed to strengthen knowledge, skills and attitudes of health assistants, staff nurses, community medical assistants and ANMs. The major components of the



FCHV examining newborn during home visit

package are immediate newborn care, newborn history with physical examination, breast feeding, identification of danger sign and referral, identification of LBW and its management, IP and neonatal resuscitation. A total of 42 doctors, nurses and health assistants from zonal hospitals, PHCs, and each Health Post received the ENC training. Twenty-six health workers were trained in how to mobilize communities for MNH in preparation for their role as trainers. These trainers conducted an orientation in CM for 261 community leaders and Health Management and Operation Committee members (33% were female) on MNH programs focusing on LBW care and management.

During this annual reporting period ACCESS Nepal has organized program learning visits for health workers, district program managers, FCHVs and members of the Health Management and Operation Committee. A total of 42 participants visited the Morang Innovative Neonatal Infection program in Morang district. This helped participants understand how neonatal infections are being managed at the community level, including how Cotrimaxozole tablets and Gentamicin injections are being administered by FCHVs and Village Health Workers. In 2007 the LBW program in Kanchanpur has been visited by government officials, UNICEF, SNL II and other, international experts in LBW neonates.

National guidelines for LBW infant management and KMC are in the process of being developed and will be sent to the GON for their endorsement in late December 2007.

### ***Kangaroo mother care at health facilities***

The KMC initiative at the health facility level is an ACCESS core-funded intervention, which was expanded in many hospitals this year. A facility survey was conducted during the first quarter at the Seti zonal hospital, Mahakali Hospital, and three primary PHCs (Beldandi, Dodhara and Shreepur) in the Kanchanpur district. The survey assessed the incidence of LBW babies, current care practices and survival status after discharge. Very little information on the LBW babies, including daily weight, was recorded in the available facility registers, making it difficult to properly assess the care given.

In the first quarter of this year, two ACCESS Nepal staff visited two active KMC centers at the All India Institute of Medical Sciences and King Edward Memorial Hospitals in Mumbai. With technical support of three consultants from India and a technical expert from ACCESS HQ, a KMC sensitization workshop for policy makers, decision makers and stakeholders was conducted on March 5-6 2007. A total of 53 participants participated in the workshop.

During the third and fourth quarters of 2007, a series of orientations and trainings for hospital managers and health workers were conducted to build capacity of local staff. A total of 18 doctors and nurses received the Clinical Training Skill (CTS) training. An additional 144 doctors and nurses from six hospitals and 3 PHCs received training in KMC. Similarly, 412 managers and health workers received a one-day orientation on KMC.

A Module on KMC has been included in the MNC LRP for SBAs and students have been trained in KMC in three NHTC-recognized SBA training sites.

### **3. Challenges**

- There is considerable urgency to begin the SBA in-service training quickly. This is due to several factors, including annual government workplans and budgets and approaching Millennium Development Goal commitments. As a result, it is challenging to ensure sufficient time, resources and technical support will result in quality in-service trainings, trainer preparation and site standardization.
- Although the GON supports SBA development, stakeholder coordination has waned during this period. This waning interest has contributed to delays in early 2007 in the initiation and timing of ACCESS activities.
- While there is a general agreement that pre-service education needs to be strengthened, limited efforts are underway to ensure all ANM and PCLN schools are producing SBAs. This is a huge and highly political challenge.
- The ACCESS Program in Nepal completed the ENC training in all health facilities in Kanchanpur. The LBW FCHVs are continually identifying problems and referring sick LBW newborns to the health facilities. The program area is still in need of quality services provided by trained health workers at these facilities, however.

## ACCESS NEPAL MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
<b>USAID/NEPAL INTERMEDIATE RESULT 2.2: Increased use of selected maternal and child health services.</b>							
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 in curricula of various SBA	This generic SBA Learning Resource Package will accommodate the competencies and skills of Skilled Birth Attendants as defined by SBA policy of Nepal.	Program records  SBA Learning Package	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0  Target: 1	<ul style="list-style-type: none"> <li>Standardize skills set and training package</li> <li>Provide a national standard to contribute to future activities</li> </ul>	Completed
Number of Community Strategies to identify and manage Low Birth Weight (LBW) infants developed, tested and provided to HMG and NNTAC for incorporation in national protocols	The community model will identify LBWs for <i>Targeted</i> home care by families and community workers and assist in referrals, if necessary.	LBW Community Strategy	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0  Target: 1	<ul style="list-style-type: none"> <li>Review approaches to identify strengths and weaknesses to improve successes</li> <li>Guide resource allocation and contribute to effective planning for future activities</li> </ul>	Ongoing

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
Number of LBW infants identified and managed per protocol	Newborn infants who are less than 2.5 kg will be identified in all Village Development Committees in Kanchanpur. LBW neonates cared for at home and at community health facilities, per protocol	Program records	Records review	ACCESS Program Manager and Program Officer (LBW)	Baseline: 0 Target: 1000 low birth weight neonates among total birth registered in the FCHV register	<ul style="list-style-type: none"> <li>Determine effectiveness of community based LBW intervention and protocol</li> </ul>	461
Number of guidelines developed for LBW infants to be included in the National Maternal and Neonatal standards and protocols	Based upon recommendations and information gained from relevant studies a National Guideline/ Protocol for LWB will be developed for use at all service delivery levels and these guidelines will be incorporated into national standards and protocols.	LBW Guidelines	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 Target: 1	<ul style="list-style-type: none"> <li>Contributes to National Standards and Protocols</li> </ul>	1

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	PROGRESS UPDATE FOR OCT 2006 – SEPT. 2007
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 explores public-private partnerships and other factors affecting skilled birth attendance.	Program records  Study report	Survey Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0  Target: 1	<ul style="list-style-type: none"> <li>• Review approaches to identify strengths and weaknesses toward improving successes</li> <li>• Guide resource allocation and contribute to effective planning for future activities</li> </ul>	Study completed. Report finalized and results disseminated.

## **NIGERIA (Program Years: October 2006-July 2009)**

### **1. Major Accomplishments**

#### **Core Funds**

- An equity analysis of baseline household survey data from Zamfara state in northern Nigeria revealed both household location and poverty affect women's use of antenatal services. The main barriers to ANC for rural women were distance to the nearest facility and out-of-pocket fees; access to delivery services, particularly for the poorest rural women, were related to distance to the facility and their own belief that such delivery services were not necessary. Communities in Nigeria will be able to use this information to develop the most appropriate financing schemes.

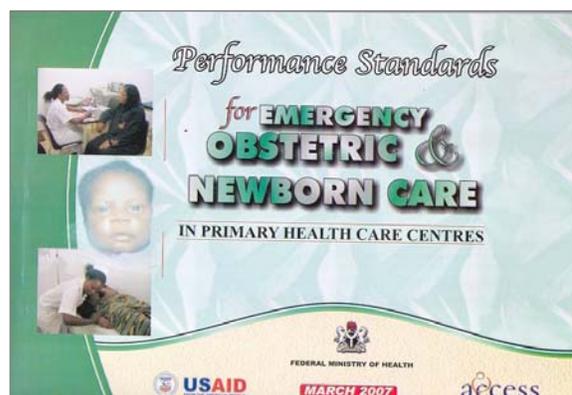
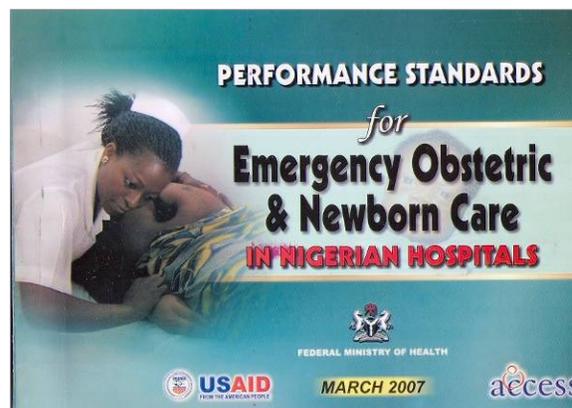
#### **Field Funds**

- In collaboration with the MOH, WHO, UNICEF and PATH performance standards for EmONC—including PPH—in hospitals and PHCs were developed and roll out of the standards is planned for all tertiary health facilities in the country. To date, 13 facilities have conducted baseline assessments using the standards, with scores ranging from 0 to 25% of standards met. Action plans are being developed to address the gaps in standards.
- Results of baseline facility and household surveys in Kano and Zamfara states confirmed that problems of access, quality of services, and socio-cultural factors hinder the utilization of MNH care services: less than 50% of women who delivered in the past year attended ANC services and only 20% delivered with a skilled attendant.
- Formative qualitative research conducted by ACCESS/Nigeria in the four program LGAs in Kano and Zamfara revealed that women and men save money in preparation for the birth of a baby and the baby's naming ceremony. However, they cannot or will not pay for delivery services at the hospital, nor do they feel the hospital environment accommodates religious practices. Female focus group participants mentioned untrained personnel, unhygienic conditions and insulting treatment by health care providers as reasons to avoid facility delivery. Poverty, distance to facilities and cultural/religious factors were also mentioned.
- ACCESS Nigeria strengthened providers' capacity in EmOC, KMC, postpartum FP, and the SBM/R approach to quality improvement. The KMC TOT and the first KMC center established in Nigeria were featured in a documentary aired four times on local and national television stations.

### **2. Progress Summary**

Results of a baseline household survey of 396 women who delivered in the past 12 months conducted in Kano and Zamfara states in November 2006 showed that:

- 48% of women in Kano and 36% of women in Zamfara had received ANC during their last pregnancies. The reason primarily given to explain not attending ANC services was distance to the facility. The second most common reason was cultural/religious factors.
- 80% of respondents delivered their last child at home, 19% delivered at a facility and 1% delivered elsewhere.
- About 18% of the women reported they received childbirth assistance from a nurse/midwife, 3% from a doctor, and 20% from a TBA. About 60% of respondents received assistance from family members, friends or other lay persons, which includes mother, mother-in-law, elderly family member and non-relatives (Note: multiple responses possible).
- Overall, 20% of women delivered with a skilled attendant (doctor or nurse/midwife) and 80% with other attendants.



EmONC Performance Standards

A baseline survey of 18 government health facilities in four local government areas (LGAs) of Kano and Zamfara (five hospitals and 13 PHCs/dispensaries) conducted by ACCESS/Nigeria confirmed widespread health systems weaknesses and low levels of maternity service provider competence in performing key maternal and newborn skills.

ACCESS developed performance standards for EmONC in hospitals and PHCs in collaboration with the Departments of Hospital Services and Community Development Activities of the FMOH, WHO, UNICEF and PATH. The FMOH intends to have the performance standards implemented in all tertiary health facilities in Nigeria. The Department of Community Development and Population Activities requested that the performance standards be field-tested in all six geopolitical zones of the country.

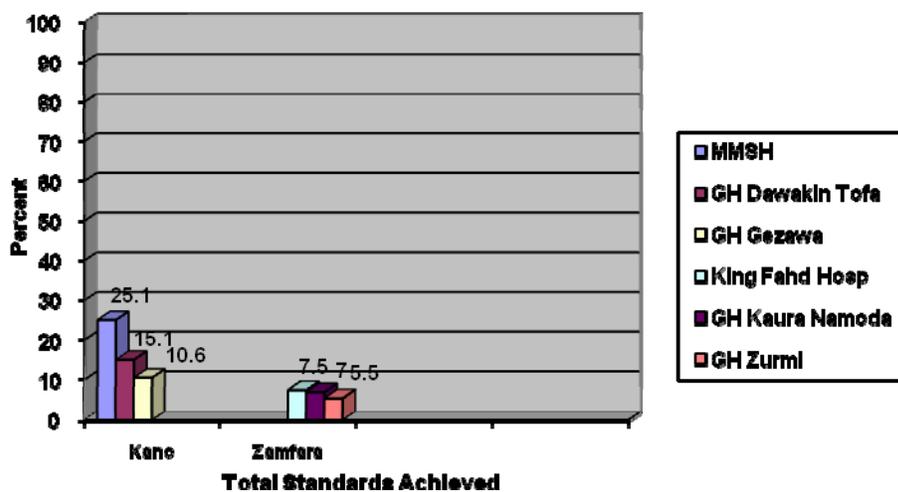
The ACCESS Nigeria program introduced the SBM-R approach for improving performance and quality at the hospitals and PHCs in the four target LGAs. The performance standards cover:

- Focused ANC
- Managing complications of pregnancy, labor, childbirth, immediate postpartum/newborn care
- Further postnatal care for the woman and newborn
- Support services, including blood banking, laboratory and pharmacy
- IEC services

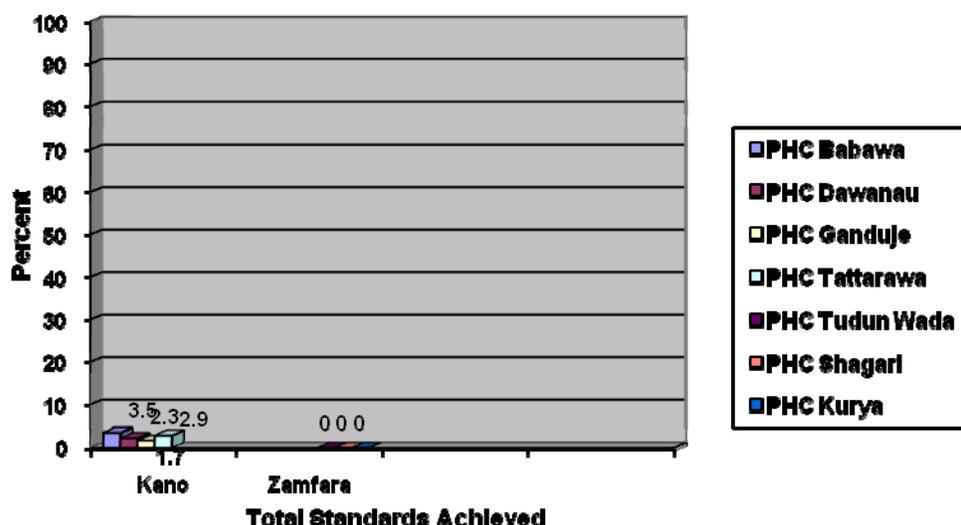
- Facility resources and management systems
- IP

A total of 24 health care providers from hospitals and PHCs in Kano and Zamfara now have the capacity to use the SBM-R quality improvement approach. Providers at 13 facilities conducted baseline assessments using the SBM-R assessment tool, with scores ranging from 0% in some PHCs to 25% in hospitals. ACCESS provided feedback to each facility, which subsequently developed action plans to address the identified performance gaps. Figure 1 below presents the results from hospitals in the two states, while Figure 2 present the results from PHCs. ACCESS is working with the facility quality improvement teams to find solutions to root causes of poor performance.

**Figure 1: Baseline compliance with EmONC Standards: Results from 5 Hospitals In Kano and Zamfara States**



**Figure 2: Baseline compliance with EmONC Standards - Results from 7 PHCs in Kano and Zamfara States**



ACCESS increased provider capacity to deliver MNH services through clinical training. ACCESS oriented 147 Nigeria Youth Service Corps medical and paramedical staff and sociology graduates in Kano and Zamfara to EmOND. A total of 24 Nigeria Youth Service Corps doctors, medical officers, nurse/midwives working in ACCESS-supported facilities were also trained in EmONC. Post-partum FP training was also conducted for a total of 33 health care providers comprising 18 nurse/midwives and 15 Community Health Extension Workers. ACCESS further improved health facility recordkeeping at health facilities in Kano and Zamfara. Maternity and newborn record forms and registers were revised and approved and 46 relevant health care providers were trained in their usage in Kano and Zamfara states.

To increase demand for improved MNH services, ACCESS initiated community counseling and CM activities. A total of 38 CMs in Kano and Zamfara states were trained as trainers in two workshops.



NYSC doctors and paramedical graduates oriented to EmONC in Zamfara State, Nigeria

Four subsequent trainings for CM Teams and Community Core Groups on how to mobilize communities for MNH were conducted in the four target LGAs in the two states. Several meetings of these CMT/CCG were held where the groups developed action plans that are currently being implemented.

Capacity of trainers of home counselors was also increased and materials for use in home-based counseling were developed and tested. A TOT workshop on MNH for home counselors was held. Twenty-two participants, comprising mainly Junior Community Health

Workers with one Senior Community Health Worker, attended the training. In addition, counseling flip charts containing twelve key messages agreed upon were developed and pre-tested during the period. A total of 16 focus group sessions were conducted with women of reproductive age, elderly

women, husbands of WRA and religious leaders to pretest the materials. The materials are being revised based on the feedback and training of volunteer home counselors is planned.

### ***Kangaroo Mother Care at Health Facilities***

ACCESS established KMC services in Zamfara and Kano. A KMC training manual was developed and a TOT on KMC was conducted for 15 providers, including obstetricians, pediatricians, nurse/midwives and RH coordinators from the Kano and Zamfara MOHs, who will soon be training providers.

Following the training, the first KMC centre in the country was built by the King Fahd Hospital in Zamfara and ACCESS Nigeria worked to strengthen the sites for delivery of KMC and provided necessary equipment and registers for effective running of the unit. Kano State converted a room in the Nursery Ward of the Pediatrics Department of the Murtala Mohammed Specialist Hospital for the KMC unit.

A documentary on the KMC TOT as well as the first KMC Centre was produced and aired four times on local and national television stations in the country.



First LBW baby admitted into centre, along with teenage mother

### **3. Challenges**

The baseline survey findings showed very weak record-keeping at most facilities, especially at the PHCs, indicating a need for major strengthening of the health management information system. In response to this, ACCESS in collaboration with the state MOHs revised the maternity and newborn care record forms, antenatal clinic register, delivery register and FP register. ACCESS also printed these forms and the registers and they are currently being used in the ACCESS-supported facilities.

Political activities during the year made interaction difficult with LGA chairmen and senior officials from state MOHs. Even after the change of Government, getting commitment from fresh appointees still posed challenges.

Signing of the tripartite MOU between the state government, local government authorities was put on hold as the USAID Mission in-country wanted to harmonize MOUs of all Implementing Partners working within the country. This has implications for commitment from the government parties.

## ACCESS NIGERIA MONITORING AND EVALUATION FRAMEWORK

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>USAID/NIGERIA SO 15:</b> Increased use of child survival and reproductive health services								
<b>ACCESS LOP Objective:</b> Increased utilization of quality EmONC services by pregnant women, mothers and newborns at selected LGAs in two Nigeria states, Kano and Zamfara								
1. Deliveries with a Skilled Birth Attendant [C 33.1]	<p><b>Definition 1:</b> Percent of births by skilled Birth Attendants in past 6 months / Total number of live births in past 6 months</p> <p>Definition 2: Number of births by skilled birth attendants in ACCESS-supported facilities in the past 6 month</p> <p><b>Unit of measurement:</b> Number &amp; Percent</p>	Baseline and endline survey reports, Program reports	Population-based survey Service statistics	Baseline, and End-of-Program (November 2006 and June 2009)  Quarterly	SO 13 Team	Baseline, and End-of-Program, Quarterly	SO 13 Team  ACCESS  State and LGA stakeholders	<b>7,685 births in 6 hospitals</b>
2. Caretakers of sick newborns who sought care from a skilled provider	<p><b>Definition:</b> Number of caretakers who sought care for a sick newborn aged 28 days or less/ total number of caretakers reporting sick newborns Skilled providers include nurses, midwives, doctors and ACCESS-trained CHEWS.</p> <p><b>Unit of measurement:</b> Percentage</p>	Baseline and endline survey reports	Population-based survey	Baseline and End-of-Program survey (September 2006 and June 2009)	SO13 Team	Baseline and End-of-Program survey	SO13 Team  ACCESS  State and LGA stakeholders	<b>163</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
3. Pregnant women who received at least 4 antenatal care visits [C 33.2]	<b>Definition:</b> Number of pregnant women who received at least 4 antenatal care visits during a specified period / Total number of live births in the same period  <b>Unit of measurement:</b> Percentage	Baseline and endline survey reports	Population-based survey	Baseline and End-of-Program (September 2006 and June 2009)	SO 13 Team	Baseline and End-of-Program  Annual	SO 13 Team  ACCESS  State and LGA stakeholders	<b>3,756</b>
4. Couple Years of Protection in USG-supported programs	<b>Definition:</b> The estimated protection against pregnancy provided by family planning services during one-year period based upon the volume of all contraceptives provided to clients during the length of reporting period  <b>Unit of measurement:</b> Number	ACCESS Program Annual Report	Service statistics/facility record review	Semi-annually, Annually	SO13 Team	Quarterly	SO13 Team  ACCESS  State and LGA stakeholders	<b>5,013</b>
5. Antenatal Care visits by skilled providers from USG-assisted facilities [C 33.2]	<b>Definition:</b> Number of pregnant women receiving antenatal care from skilled providers  <b>Unit of measurement:</b> Number	Baseline and endline survey reports, Program reports	Population-based survey Service statistics	Baseline and End-of-Program (November 2006 and June 2009)  Quarterly	SO 13 Team	Baseline and End-of-Program  Quarterly & Annually	SO 13 Team  ACCESS  State and LGA stakeholders	<b>28,446</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
6. Postpartum women using contraception (including LAM) 6 weeks postpartum	<p><b>Definition:</b> Number of women using a contraceptive method 6 weeks postpartum/ Total number of postpartum women with live births</p> <p>(If still breastfeeding appropriate methods include: LAM, IUCD or progestin-only method).</p> <p><b>Unit of measurement:</b> Percentage</p>	Baseline and endline survey reports	Population-based survey	Baseline and End-of-Program (September 2006 and June 2009)	SO13 Team	Baseline, and End-of-Program	SO13 Team ACCESS State and LGA stakeholders	<b>Training on PP FP just completed and facilities are yet to start reporting</b>
7. Number of counseling visits for FP/RH as a result of USG assistance	<p><b>Definition:</b> Number of people counseled on FP/RH disaggregated by gender</p> <p><b>Unit of measurement:</b> Number</p>	Baseline and endline survey reports, Program reports	Population-based survey Service statistics	Baseline and End-of-Program	SO 13 Team	Baseline and End-of-Program Quarterly & Annually	SO 13Team ACCESS State and LGA stakeholders	<b>11,924</b>
8. Postpartum/Newborn visits within 3 days of birth in USG-assited programs	<p><b>Definition:</b> Number of postpartum women/newborn in USG-assisted program who received postpartum care within 3 days of delivery</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS program reports	Service statistics/ facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	<b>7,534</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>USAID/NIGERIA IR 15.1:</b> Improved quality of child survival and reproductive health services								
<b>Sub-IR 1 (ACCESS Result 4):</b> Improved quality of family planning services in selected LGAs.								
1. Women receiving postpartum FP counseling at ACCESS-supported facilities	<p><b>Definition:</b> Number of postpartum women in ACCESS-supported facilities who received FP counseling/ Total number of postpartum women in ACCESS-supported facilities in specified time period</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS program reports	Service statistics/ facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	<b>This indicator is not previously tracked. ACCESS is putting and M&amp;E system in place to track this indicator.</b>
2. Trained providers performing FP services to standards	<p><b>Definition</b> Number of providers trained in FP observed to be performing to standard/ Total number of providers trained in FP observed</p> <p>Standard here refers to (National FP protocol , international FP standards (e.g., WHO) and SBM/R standards once developed)</p> <p><b>Unit of measurement:</b> Percent</p>	ACCESS program reports	Facility survey Supervisory/Observation checklist	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	<b>33</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
3. People Trained in FP/RH with USG-funds	<b>Definition</b> Number of providers trained in FP/RH  <b>Unit of measurement:</b> Number	ACCESS program reports	Facility survey Supervisory/Observation checklist	Quarterly	SO13 Team	Annual	SO13 Team  ACCESS  State and LGA stakeholders	<b>33</b>
<b>Sub-IR 2 (ACCESS Result 3): Improved quality of EmONC services in selected LGAs</b>								
1. Health facilities rehabilitated [C 20.9]	<b>Definition:</b> Number of health facilities rehabilitated  <b>Unit of measurement:</b> Number	ACCESS program reports	Review of program records Certification/ documentation issued for rehabilitated buildings	Quarterly	SO13 Team	Quarterly	SO13 Team  ACCESS  State and LGA stakeholders	<b>Awaiting approval for contract bids. Renovation will be done after approval by next quarter</b>
<b>2. Health facilities using SBM-R approach for performance improvement</b>	<b>Definition:</b> Number and Percent of health facilities using SBM-R approach  <b>Unit of measurement:</b> Number and Percent	ACCESS Program reports	SBM Observation checklist	Quarterly	SO13 Team	Quarterly	SO13 Team  ACCESS  State and LGA stakeholders	<b>18</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
3. Women receiving Active Management of the Third Stage of Labor (AMSTL)	<p><b>Definition:</b> Number and Percent of births in the past month at USG-supported facilities where active management of the third stage of labor (AMSTL) was applied in the past 6 months/Total number of vaginal births at ACCESS-supported facilities in the past quarter</p> <p><b>Unit of measurement:</b> Number &amp; Percent</p>	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team  ACCESS  State and LGA stakeholders	<b>6,835</b>
4. Management of women with eclampsia in USG-supported facilities	<p><b>Definition:</b> Number of eclamptic women seen in ACCESS facilities in the past quarter managed according to protocol/ Total number of eclamptic women seen in ACCESS facilities in the past quarter</p> <p><b>Unit of measurement:</b> Number &amp; Percent</p>	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Annual	SO13 Team  ACCESS  State and LGA stakeholders	<b>155</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
5. Births at USG-supported facilities where a partograph was used	<p><b>Definition:</b> Number of births with partograph in the past quarter / total number of births in the past quarter</p> <p><b>Unit of measurement:</b> Number &amp; Percent</p>	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	<b>4,409</b>
<p><b>USAID/Nigeria IR 15.2:</b> Strengthened enabling environment</p> <p><b>Sub-IR 3 (ACCESS Result 1):</b> Improved enabling environment for and scale-up of EmONC best practices at national and state levels.</p>								
1. Training curricula and strategy for preservice midwifery education revised and implemented in Kano and Zamfara states	<p>Number of schools in Kano and Zamfara states that have adopted and used the preservice education curricula revised with ACCESS support</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Review of training strategy document and program records	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	<b>Not yet done</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
2. Operational performance standards for EmONC developed and distributed	<p><b>Definition:</b> Number of Operational Performance Standards for EmONC distributed to ACCESS-supported facilities</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Operational performance standards document, Distribution list	Once	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	<p><b>Performance standard for EmONC developed and approved. Thirty five (35) copies distributed</b></p> <p>ATTN: Distributed to 5 ACCESS-supported hospitals and 4 PHCs, 1 other hospital Zumi in Zamfara where ACCESS will be working, Federal MOH and the two states MOHs</p>
3. National KMC policy and guidelines developed and distributed in ACCESS-supported facilities	<p><b>Definition:</b> Number of National KMC policy and guidelines developed and distributed to ACCESS-supported facilities</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	KMC policy and guidelines	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	<p><b>Draft guidelines distributed for review to FMOH and SMOHs</b></p>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<i>Sub-IR 4 (ACCESS Result 6). Improved management of maternal and newborn services in selected LGAs</i>								
1.USG-assisted Service Delivery Points experiencing Stockouts of specific tracer drugs	<p><b>Definition:</b> Number and Percent of BEmONC facilities that reported stock out of specific tracer drugs in the previous three months/Total number of BEmONC facilities</p> <p>Specific tracer drugs selected are: oxytocin, Hydrallazine, Diazepam, Ampiclox, Gentamicin, Metronidazole, Sulphadozine-pyrimethamine (SP), Iron/Folate tabs.</p> <p><b>Unit of measurement:</b> Number and Percent</p>	ACCESS Program reports	<p>Review of facility records, SBM-R/Supervision reports, service statistics</p> <p>Also Facility survey (baseline and endline)</p>	Quarterly Annual	SO13 Team	Quarterly Annual	SO13 Team  ACCESS  State and LGA stakeholders	<b>All 18 Facilities</b>

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<i>USAID/Nigeria IR 15.3: Expanded demand for improved child survival and reproductive health services</i>								
<i>Sub-IR 5 (ACCESS Result 5): Increased demand for maternal and newborn services in selected LGAs.</i>								
1. Beneficiaries of community Activities [C 20.10]	<p><b>Definition:</b> Number of beneficiaries of community activities: identified/ completed through community participation (e.g., rehabilitated clinics, participate in health outreach/education sessions sponsored by ACCESS, etc.)</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Review of program records, including community-based HMIS forms	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	1,842
2. Community committees' activities to reduce maternal and newborn deaths	<p><b>Definition:</b> Number of community committees that have work plans that include activities to reduce maternal and newborn deaths, including promoting birth spacing</p> <p>(Disaggregated by type activity and committee type (VDCs, WDCs and PHCDCs)</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Review of VDC, WDC and PHCDC work plans	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	6

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
**3 .Community with complication readiness plans	<b>Definition:</b> Number of communities with plans that include emergency funds and/or a transport system for maternal and newborn complications  <b>Unit of measurement:</b> Number	ACCESS Program reports	Key informant interviews with community leaders and/or community-based HMIS	Annual	SO13 Team	Annual	SO13 Team  ACCESS  State and LGA stakeholders	<b>6 (Represents number of community committees' with complication readiness plans in their workplans not individual community)</b>
4. People that have seen or heard a specific USG-supported FP/RH message	<b>Definition:</b> Number and Percent of people who heard or seen specific FP/RH message in past 12 months  <b>Unit of measurement:</b> Number and Percent	Baseline and endline survey reports, Program reports	Population-based survey Service statistics	Baseline, and End-of-Program Quarterly	SO 13 Team	Baseline, and End-of-Program, Quarterly	SO 13 Team  ACCESS  State and LGA stakeholders	<b>54,010</b>
<i>USAID/Nigeria IR 15.4: Increased access to child survival and reproductive health services</i>								
<i>Sub-IR 6 (ACCESS Result 2): Increased availability and distribution of EmONC trained health care workers in selected LGAs</i>								
1. Caesarean sections as a percentage of all births	<b>Definition:</b> Number of caesarean sections in LGA CEmONC facilities in Target LGA / Total number of all expected births in Target LGA (Recommended: between 5 % and 15% of all births)  <b>Unit of measurement:</b> Percentage	ACCESS Program reports	Review of facility records and estimated birth rates by LGA based on census data	Quarterly	SO13 Team	Quarterly	SO13 Team  ACCESS  State and LGA stakeholders	0.4% (439 CS)

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
2. Health facilities per 500,000 population providing essential obstetric and newborn care	<p><b>Definition:</b> Number of health facilities per 500,000 population in ACCESS-supported LGAs providing essential obstetric care (basic and comprehensive) <i>(Recommended 1 CEmONC and 4 BEmONC facilities per 500,000 population)</i></p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Health facility survey and estimates of LGA population	Quarterly	SO 13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	6 CEmONC 3 BEmONC
3. Births with complications treated at EmONC facilities	<p><b>Definition:</b> Number of births with complications treated at EmONC facilities/Total number of births expected to have complications (estimated at 15% of all expected births)</p> <p><b>Unit of measurement:</b> Percentage</p>	ACCESS Program reports	Review of facility records	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	576

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE AND REPORTING		
				SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	SCHEDULE/FREQUENCY	BY WHOM (PERSON/TEAM)	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
4. People trained in Maternal Health and/or newborn health [C 33.5]	<p><b>Definition:</b> Number of people trained on maternal (and newborn) disaggregated by Gender of people trained</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	Training information monitoring system (TIMS <sup>®</sup> )	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	<b>256 (F=148; F=108)</b>
<b>5.USG-assisted service delivery points providing FP counseling and/or services</b>	<p><b>Definition:</b> Number of USG-assisted service delivery points providing family planning counseling and services</p> <p><b>Unit of measurement:</b> Number</p>	ACCESS Program reports	ACCESS program record review Service statistics/Facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	<b>17</b>

\*\*Represents number of Community Committees and not number of Community. Community committees' activities cover defined catchment areas which are collection of communities.

## **SOUTH AFRICA (Program years: October 2006-September 2008)**

### **1. Major Accomplishments**

- The first Antiretroviral (ART) Services SBM-R tool has been finalized and baseline assessments have been completed in five ART sites. These sites scored a mean of 34 % of the ART standards, with scores ranging from 26% to 43%. ACCESS is assisting them to improve their performance based on action plans.
- Seven Department of Health sites in South Africa have improved capacity to track training through support from ACCESS for a Training Information Management Systems (TIMS), with five new sites initiating TIMS this year. The Eastern Cape Regional Training Centre has entered all training data into TIMS and runs reports for management, finance and training planning.
- ACCESS increased knowledge of National HIV/AIDS clinical guidelines for ART for Adults and Children (two provinces) and Palliative Care (two provinces) through trainings of 105 health workers. These workers included provincial program managers and district/subdistrict coordinators who were expected to “cascade” the training to all service providers in their province.
- GlaxoSmithKline and ACCESS funds have been used to scale up cervical cancer prevention services, supporting three providers trained in Thailand last year to train 11 more nurses to implement visual inspection with acetic acid and cryotherapy in 11 new facilities.

### **2. Progress Summary**

#### **Using Standards-based Management to improve the quality of ART services**

To address the quality of anti-retroviral therapy (ART), ACCESS and the Foundation of Professional Development (FPD) have been collaborating to implement the process of SBM-R in FPD-supported ART sites in South Africa's Gauteng & North West provinces. SBM-R uses detailed operational performance standards as the basis on which to measure the degree of quality at health facilities. JHIPIEGO developed these standards with ART stakeholders in South Africa and has recently pre-tested them.

A total of 23 service providers and managers of ART services were trained in the SBM-R approach. Trained health workers conducted baseline assessments in five ART facilities between January and May 2007. The ART SBM-R is a comprehensive tool with a total of 165 standards in the following areas: ART Treatment Readiness in Adults; ART Treatment Commencement in Adults; Follow-up and Management of ART Complications in Adults; ART Treatment Readiness in Children; ART Treatment Commencement in Children; Follow-up and Management of Complications in Children; Laboratory; Pharmacy; Marketing; IEC, and Community Participation; Medical Records and Information Systems; Human and Physical Resources; Management Systems.

On average, the five ART sites assessed scored 56 out of 165 (34%) on the ART SBM-R standards, with the lowest scoring facility getting 26% and the highest one getting 43%. The most interesting finding was that the facilities scored better on systems, i.e., pharmacy, general management, laboratory, compared to the clinical management of ART clients. These findings were also presented in the Third South African HIV & AIDS conference, held in Durban June 2007.

Feedback meetings with the five sites involved root-cause analysis and led to action plans developed by clinicians, counselors, dieticians, social workers, pharmacists and ART managers at each site with assistance from FPD and ACCESS. FPD staff is currently using the ART SBM-R tool to set up and develop new ART sites.

### **Tracking Training with the a Training Information Monitoring System (TIMS)**

ACCESS continued to provide TA to the National Department of Health's TB Unit, as well as the Regional Training Center in the Eastern Cape, with TIMS, a system developed by JHPIEGO. ACCESS customized and installed TIMS in four sites in Mpumalanga, and in the Western Cape Networking AIDS Community of South Africa, which is a non-governmental organization contracted by Western Cape Department of Health to provide training on HIV/AIDS.

In each province an orientation meeting was held prior to the installation of TIMS, during which the provincial teams reached consensus on data flow, identified TIMS site(s) and the computer and human resources for data management. JHPIEGO provide initial workshops and on-the job training on data entry, data cleaning and generating reports. Thereafter the sites are supported based on their request, with trouble-shooting sessions held by phone or during site visits. A total of 18 individuals have been trained on TIMS data entry, data cleaning and generation of reports.

The Eastern Cape Regional Training Centre is functioning best, since it has been in operation for more than two years. The ECRTC can enter training data into the TIMS, trouble-shoot and run necessary reports for management review, financial accounting and inform annual training plans. The rest of the sites have dedicated resources for TIMS, such as computers and data capturers, and are able to run their own reports for program management. All sites (except ETCR) are still experiencing some user challenges for which ACCESS is providing support. Examples include incomplete participant data, which results in TIMS software failing to retrieve such participants.

### **Disseminating National HIV/AIDS Guidelines for Palliative Care and ART**

A total of 52 health workers have been trained on National Palliative Care Guidelines, and 53 trained on National ART Guidelines. ACCESS disseminated Palliative Care Guidelines during two workshops in North West (18 participants) and Mpumalanga (34 participants) provinces. Participants included nurses, dieticians, nutritionists, and HIV/AIDS Program Coordinators. Provincial, district and subdistrict program managers are expected to cascade the training to all service providers in their province.

ACCESS oriented 28 workshop participants in KwaZulu Natal and 25 workshop participants in the North West to the National ART Guidelines for Adults and Children. The KwaZulu Natal workshop was attended by HIV/AIDS program managers from the provincial office and program coordinators from all 10 districts who are expected to cascade the training to all service providers in their province. The North West training was aimed at supporting the cascading of training by the provincial Programme Coordinator, and therefore the attendance was mainly by facility nurses. The training included a combination of group based orientation to national guidelines/in-service training and application of SBM-R. Orientation packages use a combination of group exercises, illustrated lectures with the goal of covering knowledge, skills, and attitudes of providers during provision of care. Co-facilitators from the national and provincial departments of health assisted with the workshops.

## Supporting the South African National Department of Health

ACCESS supports two senior technical advisors at the NDOH/TCS unit: a service delivery/accreditation expert, and a PLWHA coordinator. The PLWHA coordinator finalized stigma mitigation indicators for inclusion into the National HIV & AIDS Strategic Plan, national database for paralegals which is currently being printed by NDOH; the Workbook on HIV and AIDS human rights which is currently awaiting approval; and currently working on Advocacy toolkit for and by people living with HIV. The technical advisor for service delivery and accreditation has been working on policy development for nurse-initiated ART, supporting the accreditation processes, supporting the implementation of the Comprehensive, Care, Management and Treatment at national, provincial, selected district and facilities. He is also part of the team reviewing the existing pediatric and adult ART clinical guidelines.

## Preventing Cervical Cancer

Last year, in collaboration with NWP–DOH, JHPIEGO introduced the cervical cancer prevention and treatment program in North West Province with funding from Glaxo SmithKline. This year, Glaxo SmithKline funds and ACCESS funds have been used to scale up this initiative. Three providers trained in Thailand last year as a resource trained 11 more nurses to implement VIA cryotherapy in 11 facilities. ACCESS brought Malawi Cervical Cancer Specialists to provide mentoring and coaching to the Thailand-trained clinicians and to support them in training the new service providers. Training participants were nurses from three of the four districts in the North West Province. Ten were from PHC facilities and one from a hospital. Each participant is expected to start providing VIA services at their sites. This training also increased the Thailand trained service providers' skills in VIA cryotherapy and abilities to mentor other providers. This initiative is a great achievement for South Africa, where only pap smears have been used for cervical screening.



Skills training during cervical cancer prevention workshop

## 3. Challenges

- Incomplete data on the TIMS data collection tools, which causes inaccurate TIMS software report generation. This has remained a challenge that needs to be consistently addressed, particularly for the new sites.
- Delay in competing orientation packages for National Health Care Worker Guidelines and Continuum of Care Guidelines. The national guidelines have not been finalized by the NDOH.
- For the palliative care guidelines trainings, often trainings were attended by nurse and fewer multidisciplinary team members inclusive of doctors, pharmacist and others. The provinces have promised to address this gap in their future trainings.
- Unavailability of staff to work with ACCESS staff delayed pre-testing the SBM-R for ART tool. At times, it was difficult to observe the specific service at the targeted site on the day of the team's visit. As a result, the ART followup assessments using the SBM-R tool, which would have measured performance in comparison to be baseline assessments, were not completed.

## ACCESS SOUTH AFRICA MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006-SEPT. 2007
<b>USAID/South Africa (PEPFAR):</b> Support anti-retroviral therapy for 2 million HIV-infected individuals					
<b>USAID/South Africa (PEPFAR):</b> Support care for 10 million individuals infected and affected by HIV/AIDS, including orphans and vulnerable children					
<b>ACCESS Program Result:</b> <i>Prevention and treatment of priority health problems of non-pregnant women of reproductive age</i>					
Total number of health workers trained to deliver ART services, according to national and/or international standards (PEPFAR)	Health Care workers are those individuals involved in management or delivery of HIV/AIDS services at the provincial, district, or service delivery level (nurses, doctors, HIV/AIDS managers, etc). These services will include any aspect of HIV/AIDS care and continuum of care. Standards are set by the South Africa NDOH	Participant registration forms	Semi-annual	Lunah Ncube - ACCESS	A total of 105 health care workers trained; 53 trained on ART guidelines & 52 trained on palliative care guidelines
Number of local organizations provided with technical assistance for strategic information activities (PEPFAR)	Local organizations include regional training centers operating in any one of four <i>Targeted</i> provinces in South Africa (Eastern Cape, Mpumalanga, Northern Cape, and Limpopo) and National TB and PMTCT units. In this instance, strategic information refers to the capture of training data.	Activity reports/ Consultant reports	Semi-annual	Lunah Ncube – ACCESS	A total of 7 sites are supported; viz. 4 sites in Mpumalanga province; NACOSA; NDoH TB Unit & EC RTC.
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS) (PEPFAR)	Individuals refer to those individuals involved in the management and use of TIMS at Regional Training Centers and the National PMTCT and TB units at the NDOH. Training involves data entry, cleaning, running reports, trouble shooting, and analyzing training data.	Activity reports/ Consultant reports	Semi-annual	Lunah Ncube - ACCESS	Total of 18 individuals
Proportion of ART facilities <i>Targeted</i> for SBM-R achieving 85% of performance standards	This is the number of ART facilities <i>Targeted</i> for SBM-R achieving 85% of performance standards divided by the total number of ART facilities using the SBM-R approach	Performance standards	Semi-annual or annual	Lunah Ncube - ACCESS	None of the five facilities supported have reached 85% since they have not been evaluated for the 2 <sup>nd</sup> time using ART SBM-R tool

## **TANZANIA (Program years: October 2004-July 2009)**

### **1. Major Accomplishments**

- In collaboration with the MoHSW, ACCESS continued to scale up clinical training capacity and quality service delivery for FANC/MIP/SIP in government and faith based organization (FBO)-affiliated health facilities and pre-service education schools:
  - A total of 441 inservice clinical trainers have been trained since the start of the ACCESS Program in 2004: 415 of the trainers are providers from health facilities in 21 regions (mostly from 12 regions) and 26 of the trainers are Zonal and Regional RCH Coordinators from all eight zones.
  - To date, ACCESS has trained tutors and preceptors in FANC/MIP/SIP from all 51 preservice nursing and midwifery schools (28 diploma/higher level, 23 certificate level), representing 100% coverage. This year, over 1600 students will graduate from these pre-service programs where FANC/MIP/SIP was integrated into their curricula.
  - This year, ACCESS supported the training of 1,990 additional providers in FANC/MIP/SIP clinical skills—for a cumulative total of 2,431 (41%) of providers trained out of an estimated 6,000 in the country which offer antenatal care. To date, an estimated 24% of all ANC facilities (1,192) have been covered under the training program.
- Among ACCESS-supported facilities reporting service statistics during this reporting period (n=102), over 23,000 ANC clients received IPT 1 (59%) and over 16,000 ANC clients received IPT 2 (41%). In addition, over 27,000 ANC clients received TT2 (69%) and over 36,000 received ITN vouchers (93%).
- ACCESS played a key role in organizing the National White Ribbon Day, which had the theme “advocating for home-based lifesaving skills.” More than 25,000 people marched in Morogoro, where the event was held, and a number of influential people attended and addressed the gathering. The guest of honor, the Vice President of the United Republic of Tanzania, Dr. Ali Mohamed Shein pointed out the urgent need of his government to employ adequate qualified health staff to reduce maternal and newborn deaths. Six regions commemorated White Ribbon Day with other various activities and the events were covered by all national media houses.
- ACCESS worked closely with JSI-DELIVER to help minimize sulfadoxine pyrimethamine (SP) stockouts in ANC clinics by reporting SP stockouts to NMCP and USAID and following up with the Medical Stores Department (MSD) to address availability of SP. ACCESS advocacy from the national level to the district level focused on timely ordering of SP as well as the continuing need for SP for IPT in light of the switch to ACTs for treatment.
- ACCESS developed and updated several training materials with participation from various regional and national stakeholders. These activities included the following:
  - Updated and pre-tested focused ANC “Learners Guide for Service Providers and Supervisors”
  - Developed the “Facilitators Guide for Focused ANC Trainers” which standardizes training methodology
  - Developed a tool for assessing performance at health facilities providing ANC services;
  - Adapted/developed a pre-service education quality improvement tool for nursing and midwifery training institutions

- Developed a focused ANC/MIP/Syphilis in Pregnancy (SIP) advocacy guide targeting decision makers and MCH stakeholders at national, regional, district and health facility levels
- Finalized the “Infection Prevention and Control” English and Kiswahili pocket guides
- Finalized the pre-service LRP, which will help to ensure that nursing and midwifery students in different classes and schools will share a common curriculum around focused ANC/MIP.

## 2. Progress Summary

### Training and Capacity Building for Scaling up Quality FANC/MIP Services

During the past year, ACCESS-Tanzania continued to support the MoHSW to comprehensively scale up interventions to improve the quality of FANC services, including prevention and control of MIP using SP for intermittent

preventive treatment (IPT), counseling for use of insecticide treated nets (ITNs), prevention and treatment of syphilis during pregnancy, and infection prevention and control. ACCESS scaled up FANC through in- and pre-service training and quality improvement interventions using the ANC quality improvement approach, detailed below. To date 1192 health facilities have at least one health provider trained in FANC. (24% coverage)

#### *In-Service Training and Capacity Building:*

ACCESS-Tanzania and the MoHSW continued to use the cascade strategy for in-service training in FANC/MIP. A total of 2,431 health workers were trained in clinical skills on FANC in both the in-service and preservice setting (this figure includes 441 trainers who were trained in FANC training skills). Trainers trained by the MoHSW/ACCESS trained providers based at their own facilities as well as those from other hospitals, health centers and dispensaries in their districts. To help these trainers provide a standardized training in improved FANC services throughout the country, a Facilitator’s Guide was developed and experienced national trainers supported the training.

*Pre-Service Education:* ACCESS supported the MOHSW - Human Resource Development Department (HRDD) to improve the quality of preservice education (PSE QI initiative) at 40 schools (24 diploma, 16 certificate), by training 81 Midwifery Tutors and 80 preceptors responsible for FANC/MIP/SIP training of nursing and midwifery students in quality improvement for preservice education. This represents 78% of all preservice nursing and midwifery schools.

#### **Tanzania: Planting of a Memorial “FANC Tree”**

In January/February 2007, ACCESS/Tanzania supported the MoHSW to organize a FANC/MIP training of service providers in Njombe District. The training was opened by the District Commissioner Dali Ibrahim Rwegasira, who planted a memorial “FANC Tree” at Njombe School of Nursing and Midwifery, the site of the FANC training, to remind school faculty, preceptors and students about the importance of FANC and ensuring that pregnant women receive quality FANC services. The District Commissioner exhorted participants to work closely with policy makers to discuss and plan health programs in a timely manner so as to eventually reduce maternal deaths, and called upon all technical health personnel to join the village assemblies to address matters including use of ITNs and increasing male involvement in safe pregnancy.



Planting the FANC tree at Njombe.

**Table 1: Preservice Educators Trained in 2006-2007**

Training Intervention	# and % of Schools that Received Training (Coverage)	# of Tutors Trained	# of Preceptors Trained
FANC/MIP/SIP Clinical Skills	28 Diploma and Higher (100%)	30	49
FANC/MIP/SIP CTS	28 Diploma Schools and Higher (100%)	30	49
PSE QI	24 Diploma and Higher schools (86%) 16 certificate (70%)	81	80
ANC QI	13 Diploma and Higher schools (46%) and 1 Zanzibar (100%)	26	18

As shown in Table 2 below, ACCESS supported facilities have achieved an average of 59% of ANC clients receiving IPT 1 which is higher compared to the national average of 52% while IPT2 uptake nearly doubled that of the national average.

**Table 2: FANC/MIP Service Statistics for 102 ACCESS-supported facilities compared to national average (October 2006-June 2007)**

Service	Number of ANC Clients Receiving Service	Percent of ANC Clients Receiving Service	National Average (DHS 2004/05)
IPT 1	23,105	59%	52%
IPT 2	16,023	41%	22%
ITN Vouchers	36,502	93%	75% <sup>16</sup>
TT2+	27,892	69%	56%
Iron	75,233	60%*	N/A

\*The denominator here is all ANC visits. The denominator for other indicators is first ANC visits.

Increases in IPTp uptake have been achieved despite the fact that 25% of the 102 facilities reporting data had experience a stockout of SP at least once during the reporting period. Among facilities with no reported stock-outs (n=76), IPTp1 and IPTp2 coverage was much higher: 78% and 57%, respectively. ACCESS is working with other stakeholders to improve the availability of SP.

ACCESS is also in the process of collecting baseline and followup FANC service statistic data from 30 “sentinel sites”, 20 randomly selected facilities with providers trained in FANC through inservice training and 10 randomly selected preservice clinical practice sites with clinical preceptors trained in FANC. This data will be available for the next semi annual report.

In addition, at 102 ACCESS-supported facilities that reported on syphilis screening, 79% of ANC clients were screened for syphilis, with 3% of those tested having a positive test. All those who tested positive were treated.

<sup>16</sup> Reported in Hanson et al, IHRDC and LSHTM, 2007

## Performance and Quality Improvement

As part of the program's quality assurance work, ACCESS facilitated assessments at facilities with trained FANC/MIP/SIP providers through application of a standards-based quality assurance approach. To date, 81 health facilities (49 hospitals, 17 health centers and 15 dispensaries) conducted and reported ANC quality assessments at their facilities on FANC/MIP using the ANC quality improvement tool. Subsequent sharing meetings were held for 33 facilities. An overall trend of improvement was seen from baseline to subsequent assessments. Of the 81 facilities to which the facility-based ANC QI initiative was introduced, 59 (73%) showed improvements in meeting the standards for ANC quality service delivery, per the self-reported results of their follow-up assessments.

**Table 3: Tanzania Focused ANC/MIP Baseline and Follow-up QI Assessment Scores (Percentage)**

Visit	Mean	Median
Baseline (n=81)	42	40
1st Follow-up (n=74)	56	57
2nd Follow-up (n=40)	59	61
3rd Follow-up (n=29)	62	58

Based on the same performance improvement approach that was used to develop FANC quality standards, ACCESS developed a quality improvement tool for pre-service education in consultation with the MOH/HRDD, Muhimbili University College of Health Sciences and the other Diploma Nursing Midwifery schools to be used for assessing the quality of teaching in nursing and midwifery schools. The tool was pre-tested in various schools in the country before it was used to train the tutors. ACCESS introduced the process of ANC-QI approach in Nursing Midwifery schools:

- ANC- QI in 45 schools (28 Diploma, 16 Certificate and 1 Diploma in Zanzibar) and 46 health facilities affiliated to pre-service schools), representing 88% of all preservice nursing midwifery schools.
- PSE QI in 40 schools (24 diploma, 16 certificate), representing 78% of all preservice nursing midwifery schools.

## Advocacy for Improved Enabling Environment for FANC/MIP

*White Ribbon Alliance:* WRATZ launched a campaign to advocate for increasing qualified health workers as a strategy to reduce maternal deaths, focusing on the districts of Sumbawanga, Geita and Monduli, where a baseline assessment was conducted and an advocacy campaign was implemented. During a one-day meeting, the WRATZ advocacy package was disseminated to the Regional Commissioner, District Commissioners, District Executive Directors, District Councilors, Regional Health Management Team (RHMT) and Council Health Management Teams (CHMTs). Twenty-four dispensaries that had only one medical attendant were visited. Dialogue with medical attendants and the community around the dispensaries regarding the benefits of women giving birth at the health facilities was also conducted. Feedback with Regional and District leaders was given in another one-day meeting. A subsequent follow-up assessment was conducted in the districts of Sumbawanga and Monduli. The most striking findings were in Sumbawanga district, where some of the key results included:

- Increased deployment of medical staff in eight of the total 24 dispensaries (33%) of all dispensaries with increased staffing for labor and delivery
- The Sumbawanga district council started a nursing/midwifery school, with its intake coming from Sumbawanga secondary school, with the aim of local employment/deployment of graduates
- Sumbawanga has planned and budgeted to upgrade some staff to have the skills and qualification to conduct caesarean sections at the two health centers in the district.
- Most of the dispensaries had more than doubled the number of women delivering at the facilities as shown in the table below. As for the one dispensary that does not conduct deliveries, the medical attendant mobilized the community, motivating women to deliver at a nearby dispensary.

**Table 4: Changes before and after advocacy and mobilization at Sumbawanga Rural District (17 dispensaries)**

Period	# of Skilled Attendants (c/o, nurse/ midwives )	# of MCHA	# of Medical Attendants	# of Women Giving Birth at Dispensary	# of referrals to higher Facility level	# of BP Machines	# of Delivery Beds
Before Advocacy & Mobilization (Feb –July 2006)	8	5	9	227	3	13	3
After Advocacy and Mobilization (Feb – July 2007)	10	6	10	497	11	14	6

Similarly in Monduli district, there was an increase of skilled workers and deliveries at the facility six months following advocacy and mobilization. Two dispensaries in Monduli which had been closed were opened when health workers were posted there. The two facilities that remained closed belong to the Lutheran Church which charges a fee for MCH services. Clients preferred to seek services in government facilities to avoid the charges at the mission facility and therefore the district did not post staff at those two mission facilities.

**Table 5: Changes before and after advocacy and mobilization at Monduli District (7 facilities)**

Period	# of Skilled Attendants (c/o, nurse/ midwives)	# of MCHA	# of Medical Attendants	# of Women Giving Birth at Dispensary	# of closed facilities due to lack of workers
Before Advocacy & Mobilization (Feb –July, 2006)	2	1	4	0	4
After Advocacy and Mobilization (Feb – July 2007)	7	1	4	18	2

ACCESS is very proud to have been part of White Ribbon Day on March 25, when more than 25,000 people marched in Morogoro Region. The Rally was led by Hon Anna Mkapa, wife of the Third Term President of Tanzania, accompanied by The USAID Mission Director Pamela White, various Ministers, MPs and other UN representatives such as UNICEF, WHO, etc. The guest of honor was Hon. Dr. Ali Mohamed Shein, the Vice President of the United Republic of Tanzania, who launched a Home Based Life-Saving Skills Program in Tanzania that will inform pregnant women and their families of the need to demand life-saving services.

*Raising Awareness of Local Health Officials about Importance of FANC:* During this reporting period, leaders and policy makers in Mwanza, Ruvuma, Tanga, Shinyanga, Kigoma and Kilimanjaro regions participated in advocacy meetings to support FANC interventions and to ensure that funds for ANC interventions are allocated in the District Comprehensive Council Health Plans (CCHPs). Participants included Regional and District Medical Officers, District Commissioners, District Executive Directors, District Planning and Nursing Officers, Regional and District Pharmacists, and health management representatives from both FBO and government hospitals. To standardize the structure and content of the advocacy meeting, ACCESS developed the “FANC/MIP/SIP Advocacy Guide” which outlines the topics to be addressed during these meetings with target leaders and policy makers at national, regional, district and health facility levels.

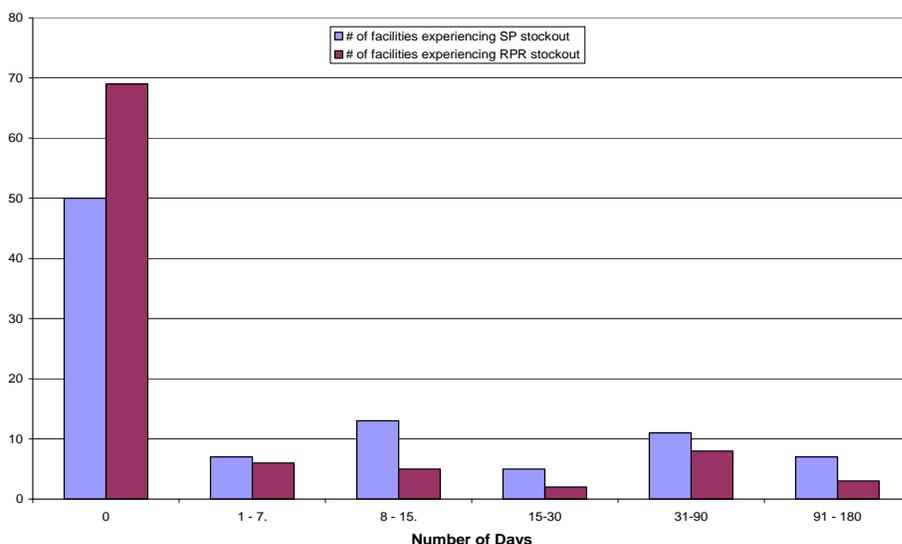
Advocacy meetings were held with preservice education stakeholders , including Principals of the Diploma and Higher Nursing Midwifery Schools, Tutors, Medical Officers from affiliated hospitals and District Medical Officers. Key accomplishments included a commitment to improve linkages between the schools and the clinical practical sites as well as with the CHMTs.

*Advocacy for Improved Logistics Management:* The ACCESS program was able to bring the problem of stockouts of SP to the attention of NMCP by increasing documentation and presenting evidence of stockouts through an improved reporting system. ACCESS worked with RCHS/MoHSW and NMCP to develop a reporting system for SP and other key ANC supplies and drugs (such as RPR kits for syphilis testing) that links in with the monthly EPI reporting system, in order to help facilities get a quicker response to the problem of SP stockouts. The graph and table below show the status of stockouts at reporting facilities for the past year – this information is regularly shared with NMCP and other agencies involved in supply of SP to facilities.

**Table 6: Facilities experiencing SP drugs and RPR kits Stockouts in the last 6 months (Jan – Jun 2007) (n=91)**

Facility Type	SP Drugs		RPR Kits	
	N	%	n	%
Hospitals	21	49	7	29
Health Centers	7	16	7	29
Dispensaries	15	35	10	42
Total	43		24	

**Figure 1: Number of Days Select ACCESS Facilities Experienced SP and RPR Kit Stockouts (n=91)**



### **Strengthening provision of sustainable quality FANC/MIP Services through FBO Networks**

ACCESS (IMA World Health in collaboration with JHPIEGO) and Christian Social Service Commission organized coordination workshops in 19 districts with a total of 163 participants comprising District Health Management Team, as well as FBO health facility management, to discuss strengthening provision of sustainable quality FANC/MIP services. Meeting participants identified many barriers which affect the provision of quality FANC, including: stockouts of SP, fees for RCH services in FBO facilities, traditional beliefs, customs and taboos (particularly with regard to SP and ITNs), referral for laboratory tests to non-FBO health facilities, late booking for ANC, poor recording of FANC services, lack of provider knowledge on FANC and lack of clear communication between DMO's office and the FBO facilities particularly on stockouts of medical supplies and laboratory kits. Participants agreed that the FBOs would improve reporting of FANC services, improve the quality of FANC services, improve communication with the DMO's office particularly on SP stockouts, re-think the fees charged for RCH services and intensify out-reach/mobile services to the community. The DMO agreed that his office would assist the FBO facilities to order ANC supplies (SP, RPR kits, Benzathine penicillin, etc. ), train health providers on FANC, and coach health providers in quantifying SP requirements and completing the quarterly facility statistics form.

ACCESS also organized a series of advocacy meetings that sensitized a total of 93 religious leaders from 4 districts on the control of MIP and other safe motherhood practices, so that they could subsequently disseminate the information to their congregations in an effort to lower maternal and infant mortality rates. Representatives included leaders from Roman Catholic, Lutheran, Anglican, Muslim, Moravian, and Pentecostal Churches. After identifying the challenges facing communities to access FANC services, it was decided that messages on FANC, use of ITNs, IPT, encouraging deliveries with skilled providers at health facilities, good nutrition and other safe motherhood practices would be given to the congregations during church gatherings. The leaders also requested the CHMT's support through the DMO to ensure that ANC supplies and drugs are made available at health facilities and to improve the negative attitude of health providers towards pregnant women.

ACCESS in collaboration with CSSC conducted FANC/MIP/SIP training for **21** front line health care providers from 15 FBO facilities in Mwanza region. The participants identified challenges in implementing FANC and resolved that: Regional RCH Coordinator should facilitate availability of SP from MSD through district RCH coordinators, each facility offering ANC service to order SP from MSD through the DMO's office, start giving SP as DOT, facilities to be encouraged to make their annual projections for FANC equipment & supplies and *timely* ordering through the DMO and District RCH coordinator.

### **Infection Prevention and Control**

The Infection Prevention and Control (IPC) English and Kiswahili Pocket Guides were finalized and 2000 copies of the Swahili version and 500 copies of the English version were printed for dissemination. These guides are intended to provide front line health providers at the peripheral health centers and dispensaries with a quick reference to the essentials of IPC practices in a simple, readable and easily understandable format. The guide will be disseminated to service providers and policy makers during FANC trainings as well as other relevant fora including meeting and trainings by the Health Services Inspectorate Unit of the MOHSW and other organizations working in IPC.

### **3. Challenges**

- The shortage of skilled health providers and lack of adequate equipment and supplies at health facilities continued to be a big barrier to the implementation of quality ANC services.
- Recruitment and training of new ACCESS program staff to implement and manage the program's portfolio was a time consuming process.
- Moving the office from Mgombani Street Regent Estate to Ring Street in Mikocheni caused interruptions of work schedules and there were disturbances associated with renovations/partitioning of the new offices and installation of Internet facilities.
- Insufficient coordination/collaboration with the MOHSW Reproductive and Child Health Section and NMCP delayed the finalization of the 2006/07 workplan and the focused ANC training materials.
- Stockouts of SP, ferrous sulphate 200mg tablets, folic acid 5mg tablets and RPR kits were experienced in a relatively large proportion of facilities, and in some cases in entire regions (e.g., Mwanza). ACCESS continues to work with partners and counterparts to rectify this supply chain problem.
- Obtaining information on facility performance improvement data on stockouts of ANC supplies and on performance improvement from facilities continued to be a problem. The facilities complained of lack of stationery for both the facility service statistics and the ANC quality improvement tool. ACCESS will reconsider strategies for ensuring optimal data collection for program reporting purpose.
- Inconsistent/incorrect reporting of SP provision by service providers on recording forms

## ACCESS TANZANIA MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006- SEPT. 2007
<b>ACCESS Program Objective:</b> Increased utilization of focused ANC services nationally, to meet the PMI and the MOHSW/MTSP Goals of 85% uptake of IPT by 2009.					
Percent/number of pregnant women who attended antenatal care services at ACCESS-Targeted facilities who received 1 <sup>st</sup> dose of intermittent preventative treatment (IPT1) under direct observation	<ul style="list-style-type: none"> <li>Calculation: Number of pregnant women who receive IPT1 under observation/Number of 1<sup>st</sup> ANC visits</li> <li>Receipt of IPT with SP will be determined from facility records.</li> </ul>	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	59% (102 facilities)
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"> <li>Calculation: Number of pregnant women who receive IPT2 under direct observation/Number of 1<sup>st</sup> ANC visits</li> <li>Receipt of IPT with SP will be determined from facility records.</li> </ul>	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	41% (102 facilities)
Percent/number of pregnant women who attended antenatal care services at ACCESS-Targeted facilities who received two tetanus toxoid injections during their current/most recent pregnancy	<ul style="list-style-type: none"> <li>Calculation using HMIS data: Number of ANC clients that received 2 TT shots / number of 1<sup>st</sup> ANC clients</li> </ul>	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	69% (102 facilities)
Percent/number of pregnant women who attended antenatal care services at ACCESS-Targeted facilities who received iron/folate supplementation during their current/most recent pregnancy	<ul style="list-style-type: none"> <li>Calculation using HMIS data: Number of ANC clients that received iron/folate supplementation / number of all ANC clients</li> </ul>	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	60% (102 facilities)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006- SEPT. 2007
Percent of 1 <sup>st</sup> visit ANC clients who received an ITN voucher	<ul style="list-style-type: none"> <li>Number of 1<sup>st</sup> visit ANC clients given voucher / Total number of 1<sup>st</sup> visit ANC clients</li> </ul>	HMIS; tally sheet Records kept by Tanzania National Voucher Scheme	Quarterly	Program country staff with ACCESS M&E review	93% (102 facilities)
<b>ACCESS Program Result:</b> <i>Nationally, the majority of in-service providers offering maternal and child health services have the capacity to provide prevention and referral for care of malaria during pregnancy using the platform of FANC.</i>					
Number of ANC providers who have been trained in the past year in focused ANC through ACCESS-supported in-service training events	<ul style="list-style-type: none"> <li>Providers may include midwives, nurses and are defined according to Tanzanian categories of instructors and care providers.</li> <li>ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff.</li> <li>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.</li> <li>Data will be disaggregated by affiliation of trainees (e.g., public, FBO, private).</li> </ul>	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	1,826 providers
Percent/number of districts with at least 4 qualified FANC trainers	<ul style="list-style-type: none"> <li>Number of districts with at least 4 qualified FANC trainers / Total number of districts</li> <li>Qualified FANC trainers are those who complete the FANC training event satisfactorily according to the criteria established for the course.</li> <li>There are currently 128 districts in Tanzania mainland, plus 10 districts in Zanzibar</li> </ul>	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	63 districts (cumulative)  46% of all districts

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS UPDATE FOR OCT. 2006- SEPT. 2007
Number of hospitals with at least 2 providers trained in focused ANC through ACCESS-supported training events;	<ul style="list-style-type: none"> <li>• The number will be calculated as a semi-annual count of SDPs that have sent at least two people to an ACCESS-supported FANC course and who satisfactorily completed that training as recorded in program records.</li> <li>• Providers, such as nurse-midwives, are defined according to local (Tanzania) categories of care providers.</li> <li>• Trained providers are those who complete a focused ANC training event satisfactorily according to the criteria established for the course.</li> <li>• Data will be disaggregated by affiliation of service delivery points (SDPs) (e.g., public, FBO, private).</li> </ul>	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	142 (cumulative)
Number of health centers and dispensaries offering maternal and child health services with at least 1 provider trained in focused ANC through ACCESS-supported training events;	<ul style="list-style-type: none"> <li>• The number will be calculated as a semi-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.</li> <li>• Providers, such as nurse-midwives, are defined according to local (Tanzania) categories of care providers.</li> <li>• Trained providers are those who complete a focused ANC training event satisfactorily according to the criteria established for the course.</li> <li>• Data will be disaggregated by affiliation of service delivery points (SDPs) (e.g., public, FBO, private).</li> </ul>	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	1,058 (cumulative)

<b>ACCESS Program Result: A continuous quality improvement process for ANC is implemented in all regional and district hospitals offering FANC</b>					
Percent/number of ACCESS-Targeted facilities implementing ANC Quality Improvement initiatives which have achieved at least 80% of standards in ANC care.	<ul style="list-style-type: none"> <li>ACCESS-Targeted facilities are those identified service delivery points (such as regional and district hospitals) where program activities and alliances aim to enhance quality of care through ANC quality improvement approaches.</li> <li>Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private).</li> </ul>	Program ANC Quality Improvement assessment tools; Records review	Annual	Program country staff with ACCESS M&E review	2 (2%) Both government
<b>ACCESS Program Result: All graduates of pre-service midwifery education programs from 2007 onwards are ready to practice FANC according to national standards</b>					
Number of tutors and clinical preceptors who have been trained in the past year in focused ANC through ACCESS-supported training events	<ul style="list-style-type: none"> <li>Tutors and practicum site preceptors are defined according to local (Tanzania) categories of instructors and care providers.</li> <li>ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff.</li> <li>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.</li> </ul>	Training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	79
Number of tutors and clinical preceptors who have been trained in the past year in clinical training and coaching skills through ACCESS-supported training events	<ul style="list-style-type: none"> <li>Tutors and practicum site preceptors are defined according to local (Tanzania) categories of instructors and care providers.</li> <li>ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff.</li> <li>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.</li> </ul>	Training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	79

<b>ACCESS Program Result: Improved enabling environment to address Safe Motherhood issues.</b>					
Percent/number of selected ACCESS supported regional and district hospitals reporting a stock out of SP in the ANC clinic in the last 6 months	<ul style="list-style-type: none"> <li>Number of regional/district hospitals reporting a stock out of SP in the last 6 months/ Total number of regional/district hospitals supported by ACCESS training events.</li> <li>ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff.</li> </ul>	Program ANC quality improvement assessments; tally sheets	Quarterly	Program country staff with ACCESS M&E review	47%
Percent of selected dispensaries in Sumbawanga, Monduli, and Geita districts which have increased the number skilled providers for maternal health in the last 1 year period	<ul style="list-style-type: none"> <li>Skilled providers include all cadres with a basic level of formalized health education, including doctors, nurse-midwives, nurses, midwives, clinical officers, matrons, MCHAs, etc.</li> </ul>	District Health Plans	Annual	Program country staff (WRATZ) with ACCESS M&E review	33 % (Sumbawanga and Monduli)

## ANNEX A: LIST OF ACCESS MATERIALS AND PRODUCTS REGULARLY DISSEMINATED

TITLE	TYPE	LANGUAGE
<b>ACCESS FINAL PRODUCTS</b>		
A List of Resources for Maternal and Newborn Care Programming	List	English
ACCESS Documents	CD	English
ACCESS Flyer	Flyer	English
ACCESS Flyer	Flyer	French
ACCESS Pregnancy Calculator	Calculator	English
ACCESS Pregnancy Calculator	Calculator	French
Focused Antenatal Care: Providing integrated, individualized care during pregnancy	Technical Brief	English
Focused Antenatal Care: Providing integrated, individualized care during pregnancy	Technical Brief	French
Building, Maintaining and Sustaining National White Ribbon Alliances: A Field Guide	Manual	English
Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health	Report	English
HHCC of Maternal and Newborn Care	Technical Brief	English
HHCC of Maternal and Newborn Care	Technical Brief	French
HHCC of Maternal and Newborn Care	Technical Brief	Spanish
HHCC of Maternal and Newborn Care	Technical Brief	Portuguese
Home and Community-Based Health Care for Mothers and Newborns	Report	English
Opportunities for Africa's Newborns	Report	English
Opportunities for Africa's Newborns - Executive Summary	Report	English
PPH Conference Presentations	CD	English
Preventing Mortality from Postpartum Hemorrhage in Africa Conference Report	Report	English
Preventing Mortality from Postpartum Hemorrhage in Africa Conference Report	CD	English
Preventing Postpartum Hemorrhage	Technical Brief	English
Preventing Postpartum Hemorrhage	Technical Brief	French
Prevention and Treatment of Malaria in Pregnancy in Sub-Saharan Africa	Technical Brief	English
Preventing Malaria in Pregnancy Through Focused Antenatal Care:	Technical Brief	English

TITLE	TYPE	LANGUAGE
Working with Faith-Based Organizations in Uganda		
Preventing Malaria in Pregnancy Through Focused Antenatal Care: Working with Faith-Based Organizations in Uganda	Technical Brief	French
State of the Art Seminar on Maternal and Neonatal Nutrition—ACCESS Program	CD	English
<b>POPPHI PRODUCTS DISSEMINATED BY ACCESS</b>		
Active Management of the Third Stage of Labor: Fact Sheet	Flyer	English
Active Management of the Third Stage of Labor: Fact Sheet	Flyer	French
Active Management of the Third Stage of Labor: Poster	Poster	English
Active Management of the Third Stage of Labor: Poster	Poster	French
Preventing Postpartum Hemorrhage: Active Management of the Third Stage of Labor	Binder	English
Preventing Postpartum Hemorrhage: Active Management of the Third Stage of Labor	CD	English
Preventing Postpartum Hemorrhage: Active Management of the Third Stage of Labor	CD	French
Preventing Postpartum Hemorrhage: Active Management of the Third Stage of Labor Toolkit	Toolkit	English
<b>ACCESS PRODUCTS - DRAFTS</b>		
Community Mobilization for Maternal and Newborn Health (Draft)	Manual	English
Tools for Community Mobilization for Maternal and Newborn Health (Draft) (Linked with Community Mob. For MNH)	Toolkit	English
Kangaroo Mother Care Training Manual (Draft)	Manual	English
<b>OTHER PRODUCTS ACCESS HAS DISSEMINATED</b>		
How To Mobilize Communities for Health and Social Change (Health Communication Partnership)	Manual	English
Lancet Maternal Survival Series	Technical Brief	English

## ANNEX B: ACCESS FUNDING AND KEY ACTIVITIES TABLES

ACCESS COUNTRIES: AFRICA.....	87
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ACCESS COUNTRIES: USAID REGIONAL BUREAU ACTIVITIES .....	93

### ACCESS Countries: Africa

ACCESS Country	Program Year	Key Activities
Ethiopia	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>• Build capacity of skilled providers in EMNC through Ethiopian Society of Obstetricians and Gynecologists</li> <li>• Training Health officers</li> <li>• Training Community Health Extension Workers</li> <li>• Collaboration with AFR/SD preservice initiative</li> </ul>
	4 (new)	<ul style="list-style-type: none"> <li>• Training Health officers in BEmONC</li> <li>• Training Community Health Extension Workers</li> <li>• Build capacity of skilled providers in EMNC through Ethiopian Society of Obstetricians and Gynecologists</li> <li>• Collaboration with AFR/SD preservice initiative</li> </ul>
Ghana	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>• Expand EmONC Training</li> <li>• Collaboration with AFR/SD preservice initiative</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Expand EmONC Training</li> <li>• Collaboration with AFR/SD preservice initiative</li> </ul>
Guinea	1	
	2 (new)	<ul style="list-style-type: none"> <li>• Expansion of PAC</li> </ul>

ACCESS Country	Program Year	Key Activities
	3	<ul style="list-style-type: none"> <li>Expansion of PAC and FP</li> </ul>
	4	<ul style="list-style-type: none"> <li>Revise preservice module for school of medicine</li> <li>Train medical faculty and update in clinical skills and instructional design</li> </ul>
Kenya	1	<ul style="list-style-type: none"> <li>Institutionalizing best practices for FP [activities began in PY 1 and will be reported in 1st annual report even though we never got an approved workplan]</li> </ul>
	2 (new)	<ul style="list-style-type: none"> <li>Institutionalizing best practices for FP</li> <li>Training for voluntary counseling and testing (VCT) counselors and Anti retroviral therapy (ART) within PMTCT programs</li> </ul>
	3	<ul style="list-style-type: none"> <li>Strengthen counseling and testing services for HIV in clinical setting</li> </ul>
	4	<ul style="list-style-type: none"> <li>Strengthen counseling and testing services for HIV in clinical setting</li> <li>Scaling up ART services</li> <li>Expanding AMTSL service delivery</li> </ul>
Madagascar	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>Quality and sustainability of focused antenatal care (FANC), intermittent preventive therapy (IPT) services</li> </ul>
	4	<ul style="list-style-type: none"> <li>Scale up FANC and quality improvements</li> </ul>
Malawi	1	
	2	
	3	<ul style="list-style-type: none"> <li>Expand EmONC Training</li> <li>Collaboration with AFR/SD preservice initiative</li> </ul>
	4 (new)	<ul style="list-style-type: none"> <li>Expansion of PAC, FP and Emergency Obstetric and Newborn Care (EmONC) in eight districts</li> <li>FANC/IPT</li> <li>Community-based maternal and newborn care</li> <li>Kangaroo Mother Care (KMC)</li> </ul>
Nigeria	1	

ACCESS Country	Program Year	Key Activities
	2 (new)	<ul style="list-style-type: none"> <li>Emergency obstetric care and obstetric fistula</li> </ul>
	3	<ul style="list-style-type: none"> <li>Improvement of EmONC services</li> <li>Community mobilization regarding access to skilled providers</li> <li>Policy work on deployment of skilled providers</li> <li>Conduct study on local financing mechanisms to increase equity of health services in Nigeria</li> </ul>
	4	<ul style="list-style-type: none"> <li>Improvement of EmONC services</li> <li>Community mobilization regarding access to skilled providers</li> <li>Policy work on deployment of skilled providers</li> <li>Apply lessons learned on local financing mechanisms to increase equity of health services in Nigeria</li> </ul>
Rwanda	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>Implementation of Safe Birth Africa Initiative</li> </ul>
	4	<ul style="list-style-type: none"> <li>Implementation of Safe Birth Africa Initiative</li> </ul>
	new	<ul style="list-style-type: none"> <li>Expand FANC/MIP</li> </ul>
South Africa	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>Dissemination of clinical guidelines around HIV/AIDS prevention and treatment</li> </ul>
	4	<ul style="list-style-type: none"> <li>Dissemination of clinical guidelines around HIV/AIDS prevention and treatment</li> </ul>
Tanzania	1 (new)	<ul style="list-style-type: none"> <li>Integrated ANC and PMTCT</li> <li>Preservice training in focused ANC</li> <li>Dissemination of IP guidelines</li> <li>Support to WRA</li> </ul>
	2	<ul style="list-style-type: none"> <li>Integrated ANC and PMTCT</li> <li>Preservice training in focused ANC</li> <li>Dissemination of IP guidelines</li> <li>Support to WRA</li> <li>Support to CEEMI (Malaria Center)</li> </ul>

ACCESS Country	Program Year	Key Activities
	3	<ul style="list-style-type: none"> <li>Scale up FANC and MIP</li> <li>Strengthen nutrition in in-service and pre-service training</li> </ul>
		<ul style="list-style-type: none"> <li>Collaboration with AFR/SD preservice initiative</li> </ul>
	4	<ul style="list-style-type: none"> <li>Scale up FANC and MIP</li> </ul>
		<ul style="list-style-type: none"> <li>Collaboration with AFR/SD preservice initiative</li> </ul>
Zambia	1	
	2	
	3 (new)	<ul style="list-style-type: none"> <li>Enhance the Social Mobilization effort to fight HIV/AIDS</li> </ul>
	4	
Malaria Action Coalition	1	<ul style="list-style-type: none"> <li>Field support from Kenya, Madagascar, REDSO ESA, Rwanda and WARP</li> <li>Coordination with MAC core funding</li> </ul>
	2	<ul style="list-style-type: none"> <li>Field support from Kenya, Madagascar, REDSO and Mali</li> </ul>
	3	<ul style="list-style-type: none"> <li>Personnel support in field and HQ to consolidate lessons learned</li> </ul>
	4	<ul style="list-style-type: none"> <li>Personnel support in field and HQ to consolidate lessons learned</li> </ul>

### ACCESS Countries: Asia

ACCESS Country	Program Year	Key Activities
Afghanistan	1	
	2 (new)	<ul style="list-style-type: none"> <li>Support to the Afghan Midwives Association (AMA)</li> <li>Assist in the development of a new maternal and newborn health strategy</li> <li>Establish demonstration project for the prevention of postpartum hemorrhage (PPH) for home births</li> <li>Feasibility study for a maternity waiting home in Badakhshan Province</li> </ul>

ACCESS Country	Program Year	Key Activities
	3 (new)	<ul style="list-style-type: none"> <li>• Support to AMA</li> <li>• Continuation of PPH study</li> <li>• Activities to support new program on improving quality of care in 13 provinces and training community midwives</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Support to AMA</li> <li>• Expansion and scale up of PPH prevention</li> <li>• Activities to support new program on improving quality of care in 13 provinces and training community midwives</li> </ul>
Bangladesh	1	
	2 (new)	<ul style="list-style-type: none"> <li>• Support a community based initiative in Sylhet to improve access to evidence-based maternal and newborn health interventions</li> </ul>
	3	<ul style="list-style-type: none"> <li>• Community mobilization and behavior change for maternal and newborn health</li> <li>• Policy work and advocacy for strengthening services</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Community mobilization and behavior change for maternal and newborn health</li> <li>• Policy work and advocacy for strengthening services</li> <li>• TBA training</li> </ul>
Cambodia	1	
	2	<ul style="list-style-type: none"> <li>• Policy support for maternal and newborn health</li> <li>• Strengthen midwifery skills and increasing access to skilled providers</li> </ul>

	3 (new)	<ul style="list-style-type: none"> <li>• Policy support for maternal and newborn health</li> <li>• Strengthen midwifery skills and increasing access to skilled providers</li> <li>• Expansion of evidence-based maternal and newborn interventions</li> </ul>
		<ul style="list-style-type: none"> <li>• PPH prevention</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Policy support for maternal and newborn health</li> <li>• Strengthen midwifery skills and increasing access to skilled providers</li> <li>• Expansion of evidence-based maternal and newborn interventions</li> </ul>
		<ul style="list-style-type: none"> <li>• PPH prevention</li> </ul>
India	1	<ul style="list-style-type: none"> <li>•</li> </ul>
	2 (new)	<ul style="list-style-type: none"> <li>• Improving Auxiliary Nurse midwives (ANMs) skills to provide services and increasing demand in the community</li> </ul>
	3	<ul style="list-style-type: none"> <li>• Improving ANM skills to provide services and increasing demand in the community</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Improving ANM skills to provide services and increasing demand in the community</li> </ul>
Nepal	1 (new)	<ul style="list-style-type: none"> <li>• Development of human resource strategy for skilled birth attendants (SBA) and community-based maternal and newborn care</li> </ul>
	2	<ul style="list-style-type: none"> <li>• Develop SBA learning resource package</li> <li>• Develop and test a community strategy for the identification and management of low birth weight (LBW) infants</li> <li>• Assist with national guidelines for LBW in the National Neonatal Health strategy</li> <li>• Policy work on the enabling environment of SBAs in rural communities.</li> <li>• CEDPA (Adolescent health)</li> </ul>
	3	<ul style="list-style-type: none"> <li>• Curriculum development and training for skilled providers</li> <li>• Guidelines development for LBW infants</li> <li>• Community management of LBW infants</li> </ul>
		<ul style="list-style-type: none"> <li>• KMC</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Continue expansion of KMC</li> </ul>

## ACCESS Countries: Latin America and Caribbean

ACCESS Country	Program Year	Key Activities
Haiti	1 (new)	<ul style="list-style-type: none"> <li>• Increased accessibility and use of PMTCT</li> <li>• Strengthened reproductive health – postabortion care (PAC), infection prevention and family planning (FP)</li> <li>• Assess Cervical Cancer Prevention</li> </ul>
	2	<ul style="list-style-type: none"> <li>• Increase accessibility and use of PMTCT services</li> <li>• Strengthen RH – PAC, FP, IP</li> <li>• Assess Cervical Cancer Prevention activities</li> </ul>
	3	<ul style="list-style-type: none"> <li>• Strengthen PMTCT training and services</li> <li>• Strengthen RH – PAC, FP, IP</li> </ul>
	4	<ul style="list-style-type: none"> <li>• Field test PAC module</li> <li>• Revise curriculum</li> </ul>

## ACCESS Countries: USAID Regional Bureau Activities

ACCESS Bureau	Program Year	Countries	Key Activities
USAID/ East Africa	1		
	2		
	3	Kenya	<ul style="list-style-type: none"> <li>• Strengthen and integrate TB screening and referral, diagnosis for pregnant women into FANC services</li> </ul>
	4		<ul style="list-style-type: none"> <li>• Wrap up activities</li> </ul>
AFR/SD Bureau	1 (new)	Angola, Ethiopia, Ghana, Mozambique, Nigeria, Mali, Senegal, Tanzania	<ul style="list-style-type: none"> <li>• Training of technical experts/facilitators for the implementation of the Africa Road Map</li> <li>• Preservice midwifery education</li> </ul>
	2	Zambia, Niger, Senegal, Burkina Faso, Mauritania, Ghana*, Ethiopia*, Malawi*, Tanzania*	<ul style="list-style-type: none"> <li>• Implementation of Africa Road Map in 5 countries</li> <li>• Preservice midwifery education in 4 countries*</li> <li>• Lusophone conference</li> </ul>

ACCESS Bureau	Program Year	Countries	Key Activities
	3	Ghana, Tanzania, Ethiopia, Malawi	<ul style="list-style-type: none"> <li>• Improve pre-service midwifery education</li> <li>• Support WHO's Road Map for Safe Motherhood in Africa</li> </ul>
	4	Ghana, Tanzania, Ethiopia	<ul style="list-style-type: none"> <li>• Improve pre-service midwifery education</li> <li>• Support WHO's Road Map for Safe Motherhood in Africa</li> </ul>
ANE Bureau	1	Nepal, Bangladesh, Cambodia, Afghanistan, India, Indonesia, Philippines, Pakistan, West Timor	<ul style="list-style-type: none"> <li>• Support to WHO/SEARO</li> <li>• Country level advocacy for Lancet series on neonatal health</li> <li>• Technical support to scaling up prevention of PPH</li> <li>• Development and integration of community-based postpartum care MotherNewBorNet in Asia</li> </ul>
	2	Nepal, Bangladesh, Cambodia, Afghanistan, India, Indonesia, Philippines, Pakistan, West Timor	<ul style="list-style-type: none"> <li>• Support MotherNewBorNet</li> <li>• Support to WHO/SEARO for a regional meeting</li> <li>• Support to USAID and MOH/Cambodia</li> </ul>
	3		<ul style="list-style-type: none"> <li>• Support panelists and participants to ANE Best Practices meeting</li> </ul>
	4		
LAC Bureau	1 (new)	Guatemala, Peru, , Bolivia, DR, Paraguay	<ul style="list-style-type: none"> <li>• Research and preparation of strategic document for newborn health with multiple stakeholders</li> </ul>
	2	Bolivia, DR, Guatemala, Peru	<ul style="list-style-type: none"> <li>• Completion of regional newborn strategy on EMNC</li> </ul>
	3		<ul style="list-style-type: none"> <li>• Printing and dissemination of Newborn Policy</li> </ul>
USAID/ West Africa	1 (new)	Mauritania, Cameroon	<ul style="list-style-type: none"> <li>• Development of EMNC providers in Cameroon</li> <li>• Training of community social mobilizers</li> </ul>

ACCESS Bureau	Program Year	Countries	Key Activities
	2	Cameroon, one new country TBD	<ul style="list-style-type: none"> <li>• Development of EMNC providers in Cameroon and Mauritania</li> <li>• Training for social mobilization trainers</li> </ul>
	3	Cameroon, Mauritania, Togo, Niger	<ul style="list-style-type: none"> <li>• Development of EMNC providers</li> <li>• Training for social mobilization</li> </ul>
	4	Cameroon, Mauritania, Togo, Niger	<ul style="list-style-type: none"> <li>• Wrap up activities</li> </ul>

## ANNEX C: ACCESS PROGRAM COVERAGE MATRIX

ACCESS clinical (e.g., capacity building and service delivery) and community-based (e.g., demand generation) interventions have reached women and families in Afghanistan, Bangladesh, Burkina Faso, Cameroon, Ethiopia, Ghana, Haiti, India, Kenya, Nigeria, Madagascar, Malawi, Mauritania, Nepal, Niger, Nigeria, South Africa, Tanzania and Togo. **Table 1** below presents information on the types of interventions being implemented in each country and the associated potential population coverage (those living in the intervention target communities and/or facility catchment areas).

It is important to note that this matrix does not always capture national-level policy work. In addition, ACCESS country programs are at different stages of implementation – some began in 2004 while others began in 2007 – thus, coverage may be vastly different. Finally, ACCESS is a global, core-funded program that uses its core funds primarily for technical leadership and global learning. Core-funded country-level interventions tend to be relatively small in geographic scope and serve to demonstrate transfer of research to practice of evidence-based approaches in MNH. These results are then used to inform national and global policy and programming. Field support funded programs, on the other hand, tend to have larger geographic scope and funding for scale up.

**Table 1: 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)
<b>AFGHANISTAN</b>							
Community-based PPH study: Counseling + misoprostol	N/A	6	3 out of 329	1%	2 out of 34	79,500	18,285
Community-based PPH study: Counseling alone	N/A	3	3	1%	2 out of 34	35,840	8244
PPG Skilled Birth Attendant Intervention	N/A	36,088	118 out of 329	36%	13 out of 34	9,513,316	1,902,663
<b>BANGLADESH</b>							
Prenatal/postnatal Community Outreach visits and referral	7 sub-districts (upazillas)	N/A	1 out of 64	1.6%	N/A	1,443,841	287,324
<b>BURKINA FASO</b>							
FANC/MIP service		49	5 out of 53	9%	1 out of 11	3,849,335	798,737

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)
delivery scale-up							(estimate)
<b>CAMEROON</b>							
EMNC (SBA) training and service delivery		26	3 (Ngaoundere, Tignere and Tibati) out of 58 departments*	5%	1 out of 10	285,667	68,274 (estimate)
Social mobilization for quality maternal and newborn care	Communities in 18 facility catchment areas/health zones	N/A	1 (Ngaoundere) out of 58 departments	2%	1 out of 10	244,009	58,318 (estimate)
<b>ETHIOPIA</b>							
Technical Updates and Clinical Skills Standardization for Midwifery Educators		1	1 (Addis Ababa) out of 80 zones	1%	1 out of 10 divisions	N/A	N/A
<b>GHANA</b>							
Technical Updates and Clinical Skills Standardization for Midwifery Educators		2	1 (Accra City) out of 138 districts	1%	1 out of 10 regions	2,029,143	515,402 (estimate)
SBM-R Process and MNH Technical Updates and Clinical Skills Standardization for maternity providers		3	1 (Birem North) out of 138 districts	1%	1 out of 10 regions	151,401	73,884
<b>HAITI</b>							
PMTCT service delivery (ANC clinic and maternity)	N/A	23	7 out of 10	70%	N/A	2,797,200	668,531
Long-term family planning service delivery	N/A	21	8 out of 10	80%	N/A	N/A	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)
<b>INDIA</b>							
Skilled birth attendance (community-based and facility-based midwives plus community mobilization)	213 villages	3	1 district	4.1 % (1 district out of 24 districts in the state of Jarkhand)	N/A	118,878	20,208
<b>KENYA</b>							
Postpartum Family Planning (ACCESS-FP)	N/A	4 facilities	1 district- Embu	1.3%	1 out of 7	318,724	78,087
Orientation to malaria case management guidelines	N/A	470	7 / 76 Kilifi, Kwale, Malindi, Mombasa, Lamu, Tana River, Taita Taveta	9.2%	1 out of 8 Coast	3,031,878	774,067
TB / ANC Training Package Pilot and Provincial and District training	N/A	3 Pilot in one district Mbeere	9 / 76 Embu, Kitui, Machokas, Mbeere, Meru Central, Meru North, Meru South, Tharaka	11.8%	1 out of 8 Eastern	4,709,58	1,201,609
ART <sup>1</sup>	N/A	71	28 / 76 All seven districts in Central Province, all 13 districts in Eastern Province and all 8 districts in Nairobi Province	36.8%	3 / 8 Central, Eastern, Nairobi	12,224,133 GOK Province projections 2007: Central 4,076,631 Eastern 5,206,592 Nairobi 2,940,910	3,358,814 GOK Province projections 2007: Central 1,176,872 Eastern 1,286,460 Nairobi 895,482

<sup>1</sup> The focus of the ART and CT projects in Kenya are on training of national and provincial trainers. However, through support supervision or through echo training, trainings are rolled down to reach the health facility level.

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)
HIV/AIDS Counseling and Testing	N/A	11 9 Provincial level Hospitals and 2 National Referral/ Teaching Hospitals	10 / 76 Districts where the provincial and national hospitals are located: Embu, Garissa, Kakamega, Kiambu, Kisumu, Machakos, Mombasa, Nairobi, Nakuru, Uasin Gishu	11.8%	8 out of 8	10,110,947	2,683,670
<b>MADAGASCAR</b>							
FANC/MIP service delivery scale-up		76	4 out of 22	18%	2 out of 6	710,808	164,197 (estimate)
<b>MALAWI</b>							
Technical Updates and Clinical Skills Standardization for Midwifery Educators		1	1 out of 27 (Kasungu)	0.4%	3	480,659	106,706 (estimate)
<b>MAURITANIA</b>							
EmONC (SBA) service delivery		13	7 out of 44*	16%	6 out of 13	1,063,755	245,727 (estimate)
<b>NEPAL</b>							
SBA LRP pretest		3: 2 hospital s and 1 nursing campus	Pretesting: 2 out of 75 districts (Chitwam, Morang)	2.6% of districts	2 region out of 5	1,143,316	270,034
SBA training site upgrade		8 facilities	8 out of 75 districts	11%	4 regions out of 5	5,304,408	969,442
Mgmt. of LBW infants at community level	19 Village Development committees (60,158 households)	22: 10 SHP, 8 HP, 3 PHCC, 1 zonal hospital	1 out of 75	2%	1 region out of 5	380,461	74,518

COUNTRY INTERVENTION	# OF COMMUNITIES	# OF FACILITIES	# OF DISTRICTS/ DEPARTMENTS	% OF DISTRICTS/ DEPARTMENTS	# OF REGIONS/ PROVINCES	TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS)	# OF WOMEN OF RE-PRODUCTIVE AGE (15–49)
SBA Study	90 groups	1 HP, 1 clinic, 4 PHCC	6 out of 75 districts (Morang, Panchthar, Kavre, Nawalparasi, Kapilvastu, Baitadi)	8%	4 regions out of 5	2,952,618	893,182
Facility Based KMC	61 Village Development Committees, 3 municipalities	5: 2 zonal hospitals and 3 primary healthcare centers	2 districts out of 75	3%	1 out of 5	1,016,204	197,103
<b>NIGER</b>							
EmONC (SBA) service delivery		11	2 (Maradi and Zinder) out of 7 departments	29%	2 out of 7	617,046*	141,921
<b>NIGERIA</b>							
Emergency obstetric and newborn care as an entry point to postpartum family planning and community mobilization	144	18: 6 General Hospitals and 12 primary healthcare centers	5 LGAs (districts) out of 774 (Gusau, Kaura Namoda and Zurmi in Zamfara state and Gezawa and Dawakin Tofa in Kano state)	3%	1 out of 6	4,354,551	1,010,256 (estimate)
<b>SOUTH AFRICA</b>							
Implementation of Antiretroviral Service Standard-based Management	N/A	5	2	4%	2 out of 9	1,068,771	287,878

\* Population data for Niger from [www.world-gazetteer.com](http://www.world-gazetteer.com).

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)
<b>TANZANIA</b>							
FANC/MIP service delivery scale-up		1,192	90 out of 133 (mainland)	68%	19 out of 21	31,481,125	7,494,579
Technical Updates and Clinical Skills Standardization for Midwifery Educators		1	1 (Morogoro) out of 130	1%	1 out of 21	1,753,362	3,507,462
<b>TOGO</b>							
EmONC (SBA) service delivery		13	6 out of 31 prefectures (Sotouba, Tchaoudjo, Blitta, Tchamba, Est-Mono, Lomé)	19%	3 out of 5 divisions	1,189,000	273,470

Note: Data sources for population figures include national census data; US Census Bureau, International Database, <http://www.census.gov/ipc/www/idbpyr.html>; World Gazetteer at [www.world-gazetteer.com](http://www.world-gazetteer.com) (Cameroon); <http://population.wn.com> (Nepal, Mauritania, Burkina,);; <http://www.odci.gov/cia/publications/factbook/index.html> (Mauritania, Madagascar); <http://en.wikipedia.org/wiki/Region> (Burkina); *Kenya 1999 Population and Housing Census Volume VII: Analytical Report on Population Projections, 2002* (Kenya)

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

\*\*Cameroon's 58 departments are divided into 269 arrondissements and 53 districts. Data source: [www.reproductive-rights.org](http://www.reproductive-rights.org).

## ANNEX D: SUCCESS STORIES

### India: Strengthening Auxiliary Nurse Midwives Clinical Training in Dumka

In June 2006, when ACCESS first visited Dumka, many opportunities were identified to strengthen the quality of clinical training for ANMs at the government-run ANM Training Center (ANMTC) and the mission-run Mohulpahari Christian Hospital (MCH) Nursing School. These sites would need to be strengthened to deliver quality, competency-based training for ANMs in the expanded skills set required in the new national guidelines. It was also recognized that ANMs might need refresher training on basic childbirth and newborn care skills. Additionally, the assessment found the MNC training offered at the government Sadar District Hospital (SDH) and mission-run Mohulpahari Christian Hospital (MCH) needed strengthening to create a positive and standardized learning environment for ANMs during their clinical practice. For example, SDH was under-equipped and poorly organized to provide quality MNC services. Despite 50-70 births a month, the labor ward was not fully functional, even lacking sheets and mattresses on beds.



Newly-trained ANMs visit communities, promote BP/CR, offer Care and build partnerships with other local providers

Over the past year, ACCESS, with CEDPA and the Government of Jharkhand (GOJ), worked to strengthen these ANM training centers and the clinical training sites. ACCESS provided on-site TA to prepare them to conduct clinical skills training for 40 ANMs in 2007, conducting baseline assessments and developing action plans to improve the quality of clinical training and care. Since the October baseline assessments, much improvement has been made at SDH and MCH. GOJ funded about \$3,500 of equipment and supplies for SDH—including an autoclave, delivery beds, delivery kits and basic supplies, such as gloves and drapes. ACCESS provided clinical skills standardization for staff at both hospitals and on-site support to adopt best practices. Within six months, notable improvements in reaching quality standards were seen from baseline: MCH improved to 59% (9% increase) and SDH doubled their score to 21%. For example, management of pregnancy-related complications increased from 6 to 19%.

The clinical training sites have also improved with the influx of resources, on-site support and renovations. GOJ provided more than \$10,000 of supplies and equipment, and ACCESS donated a full set of training materials, including anatomic models, training supplies and reference materials. These sites now have eight trainers developed by ACCESS who apply a 3-month ANM refresher training course supported by a LRP in Hindi. This combination of efforts led to the first three-month ANM refresher training course beginning in April 2007, which resulted in 18 ANMs with appropriate skills (10 practicing ANMs from current government posts, 8 new ANMs to be posted). The second batch of ANMs are currently being trained. Finally, with a view towards scaling up, ACCESS continues to



Anms Learn Basic Childbirth Skills in the newly-equipped Skills Lab, supported by GOJ, ACCESS and CEDPA

provide ongoing support to ANM training sites in Dumka, and is creating a set of resources (training materials, assessment tools, minimum equipment/supplies checklist, clinical trainers) that the district and state can use to replicate and expand this skills-based ANM training.

### **India: Introducing ANMs as Skilled Birth Attendants and Mobilizing Communities for Birth Preparedness and Complication Readiness in Dumka**

Findings from an initial assessment visit to Dumka in June 2006 included the following information regarding knowledge and practices among women and their communities:

- Communities have many barriers to accessing skilled care.
- Health-seeking behaviors for pregnant women are low, and no birth preparedness is done.
- Without plans to handle an emergency, communities were not prepared to respond to complications.
- Communities currently have some mechanisms to support improved access to skilled care.
- Communities are interested in having MNC services available from an ANM close by.



An ANM helps map communities near her post

With this basic understanding of the challenges and opportunities for increased knowledge and involvement in seeking and accessing care, CEDPA partnered with a local NGO in Dumka, *Chetna Vikas*, to achieve four objectives in project communities:

- Enhance community awareness of MNH needs;
- Influence MNCH health-seeking behavior of individuals and families, and help families/communities prepare for birth and emergencies;
- Increase the demand for skilled care (ANMs); and
- Facilitate the practice of the ANMs by creating demand for their services at the community level.

CEDPA worked with Dumka officials to select and assess three intervention blocks where the ANMs would be selected from or placed in communities for the operations research. For example, the Jarmundi PHC area contains 32 subcenters, 481 villages, 47 ANMs and over 150,000 people. The expected number of births per year was also estimated for each subcenter. Mapping with subcenter staff helped visually depict boundaries and resources. With this information, ACCESS then developed CM activities, adapted existing materials, oriented NGO staff and introduced the NGO to the selected communities. From July 2007 when the first batch of ANMs completed the refresher training, ACCESS supported a series of activities to introduce ANMs to communities in their area and promote their services. Further, beginning in September, CEDPA and the local NGO are training a total of 40 Community Workers (CWs), 180 Advocates (SMAs), 360 Safe Motherhood Volunteers (SMVs) and 360 mahila mandal members.

## Kenya: Integrated Approach to PMTCT Performance Improvement

Finalizing the national supervision tool was a great success for the DRH, NASCOP and ACCESS. During the national stakeholder’s meeting, the Provincial AIDS/STI Coordinating Officers said: “At last—there is an integrated tool [*Facilitative Supervision Tool for Reproductive Health and HIV Services*].” During the supervision training, participants said it was an eye-opener for them, especially the performance improvement approach and use of standards to monitor quality. They realized they needed these skills to effectively supervise service providers. Some said they had previously gone through the training with other organizations but remarked that this time it was clear how to implement the approach because group work was used to put the knowledge into practice.

## Nigeria: Initiatives in Support of Kangaroo Mother Care

During the past year, ACCESS introduced KMC (“Goyon Dangata”) in Nigeria, and encouraged the King Fahd Women and Children Hospital to establish a separate facility for the method. The facility management decided to build a new KMC center, which is now complete (see photos). To reward this initiative, ACCESS donated essential equipment and furniture for the center, as well as registers to record services provided. Additionally, a TOT on KMC was conducted for 15 providers, including obstetricians, pediatricians, nurse/midwives and RH coordinators from the Kano and Zamfara MOHs. Kano State converted a room in the pediatrics department of the Murtala Mohammed Specialist Hospital for the KMC unit. A documentary on the KMC TOT and the first KMC center was produced and aired four times on local and national television.



Newly-constructed KMC Facility

## Nigeria: Community Mobilization Transforms a Community

Tudun Wada CCG exemplifies how CM can transform a community. The core group has been meeting weekly and has detailed plans to ensure that the health of women and children greatly improve. In one meeting, a woman thanked ACCESS for its work in her community and called on the women to patronize the ACCESS-supported health facility. Five of her 11 children were born in the hospital and she said she now clearly understands the difference between a hospital and home birth. “*What impressed me in delivering in the hospital is the neatness and even the way they handle the baby’s cord. You just go home, enter your room with your baby without concerning yourself with the cleaning of all the mess that comes with delivery,*” she said. Another woman said that maternal mortality is a problem that needs urgent attention in her community. She asked women to take decisions in their hands and give birth in a hospital. “*After all, if we die the men will say it is the will of God and marry a brand new wife to replace us,*” she said, adding, “*If worse comes to the worse, sell your things and seek medical attention.*” ACCESS staff informed the group that, come September, the School of Nursing and Midwifery would open in the State. One of the male members who had planned to marry off his teenage daughter said, “*I will do anything possible to make sure that she goes to that school and become a nurse to save lives courtesy of ACCESS.*”



A female participant making a point

## White Ribbon Alliance in Tanzania: Advocacy and Mobilization Promotes Change at Policy and Community Levels

Under the White Ribbon Alliance Tanzania (WRATZ), ACCESS disseminated an advocacy package to regional district and village leaders in February 2007, incorporating feedback based on WRATZ assessment visits to villages and dispensaries in Sumbawanga and Monduli districts. (A planned visit to Geita District could not take place because of bad roads and weather.) Based on assessment information, district health management teams (DHMTs) developed action plans to address maternal, newborn and child health and, simultaneously, to achieve MDGs 4 and 5. Six months later, WRATZ followed-up in Sumbawanga and Monduli regarding changes resulting from the advocacy meetings. A questionnaire based on the indicators from the February 2007 district action plan and the situation at the dispensaries and community around these dispensaries guided the data collection. Visits with the Regional and District Medical Officers revealed that districts had already implemented several activities based on their action plans, such as deploying skilled workers and equipping some dispensaries with delivery beds, sphygmomanometers, stethoscope/fetal scope and writing letters to the villages encouraging facility deliveries.

The team found several other encouraging changes, including an impressive 70% increase of skilled workers in the 24 dispensaries (see Table 1). In the Sumbawanga district, the number of women delivering at dispensaries more than doubled. Even at the dispensaries that could not conduct deliveries, the medical attendant mobilized his community so the women gave birth at a nearby dispensary. In Monduli, there was an increase of five skilled workers, facility deliveries increased from 0 to 18, and two facilities have been re-opened. Moreover, the district authorities are currently changing two dispensaries into health centers so they can handle BEmOC. The district medical officer reported a discussion on training clinical officers to become assistant medical officers so they can conduct C-sections, as well as building maternity waiting homes.

**Table: Changes Before and Six Months After Advocacy and Mobilization at Sumbawanga and Monduli Districts**

INDICATOR	SUMBAWANGA DISTRICT (17 DISPENSARIES)		MONDULI DISTRICT (7 DISPENSARIES)	
	Before	After	Before	After
Number of skilled attendants (clinical officers, nurse/midwives)	8	10	2	7
Number of MCA	5	6	1	1
Number of Medical Attendants	9	10	4	4
Number of recorded women giving birth at dispensary	227	497	0	18
Number of referrals to higher facility level	3	11	Not avail.	Not avail.
Number of BP machines	13	14	Not avail.	Not avail.
Number of delivery beds	3	6	Not avail.	Not avail.
Closed due to lack of workers	Not avail.	Not avail.	4	2

Ntuntumbe Dispensary in Sumbawanga district was one of the dispensaries that assisted many deliveries. However, the team visited a TBA who painfully told her story in the local language. The translators said the TBA was recalling a young woman she assisted to deliver at home. The 18-year

old woman delivered a dead fetus. What followed was a prolapsed uterus that did not return after several days. *“The thing protruding through her was smelling terribly,”* said the TBA. The young woman was traced and told the following story:

*“My name is Mariam. I am 18 years old. My mum and daddy died when I was 5 years old. I lived with my aunt who was a teacher. Last year I completed standard seven and passed my exam to continue with secondary education at a government school. As a requirement to be admitted into the school I was examined. I was found to be pregnant. My aunt and I reported to the village authority who advised us to report to the police. We went to the police. They wrote down the entire story how I got pregnant. They told us to go home. I just waited at home until one day I experienced severe pain. My aunt and other relatives took me to our dispensary. The nurse examined me and said I have to go to Sumbawanga Regional Hospital because she could not help me. The nurse called for transport. She and I jumped in the car ready to go. My aunt came quickly and took me off the car. We went home. The pain was very severe. The following day my mother came with an old lady who assisted me. I delivered a dead baby. I bled profusely. I fainted. The old woman poured cold water on me and I came to my senses again. I was bleeding and bleeding. There was something like a piece of meat between my legs. It started to smell and something watery was flowing. My aunt died. My cousin and other relatives took me to the dispensary. The nurse said I should go to Sumbawanga Hospital. My cousin took me to Sumbawanga, but they told us to go back home and wait for experts in November. So my cousin brought me here to leave with my other aunt”.*

Subsequently, the young woman was successfully repaired and now she is ready to go to school. The team promised to help with her studies since she is a complete orphan.

### **Tanzania: Effecting Sustainable Change for Infection Prevention and Control**

In collaboration with ACCESS, the Tanzanian Ministry of Health & Social Welfare (through the Health Services Inspectorate Unit [MOHSW/HSIU]), is scaling up a whole-site IP and quality improvement initiative country-wide. Following training of health center staff, health care workers, housekeeping and waste disposal staff raised concerns to management about the risks they faced on the job without appropriate or adequate IP equipment and supplies. A group of waste handlers at Mbeya Regional Hospital went to the administration block and told management, “We are not going to do the job today.” When they were asked why, they replied, “We need personal protective equipment for our safety.” This same situation was repeated at Morogoro Regional Hospital, where staff took their concerns about running water, availability of gloves and antiseptics and other IP issues to management. The management teams at these hospitals subsequently took action to provide staff with some limited supplies, while incorporating a line item in their annual budget for continued provision of sufficient quantities of IP equipment and supplies for their health facilities.

### **Tanzania: Improving Midwifery Preservice Education**

In the past year, the ACCESS/Tanzania program continued to make a significant impact on the preservice midwifery education system. After involvement in ACCESS activities and discussion with ACCESS staff, the Tanzania Nurses and Midwives Council (TNMC) adopted FANC/MIP/SIP as a critical component of midwifery education and mandated that all preservice midwifery curricula include FANC/MIP/SIP-related topics and clinical skills. In addition, TNMC developed Standards of Proficiency for midwifery education and practice in Tanzania, emphasizing a competency-based approach. TNMC also developed standards to support learning and practice assessments in order to give additional guidance and support to standardization of training efforts by clinical instructors and preceptors. Mr. Gustav Moyo, TNMC Registrar, has noted that all of these achievements were due

to exposure to the ACCESS/Tanzania program—“*training has been very useful,*” he said, and he hopes that the strong collaboration will be maintained.

### **Tanzania: ANC QI**

Ms. Agness Haule is a service provider at Ngerengere Health Centre RCH clinic who participated in a MoHSW/ACCESS FANC/MIP/SIP service provider training this past year and who is working with colleagues at her facility to implement a quality improvement approach for improving ANC service delivery. Following the training, Ms. Haule thought it important to establish a system at her health center whereby pregnant women were sure to have access to clean and safe water for taking their SP under DOT. The first few days she boiled the water but found that purchasing kerosene to do so was very expensive, and she was not able to prepare enough boiled water for all of the women coming to the health center. Feeling empowered by the ANC quality improvement approach, which taught her to develop sustainable solutions, she advocated with facility management to purchase tablets of Water Guard, a water disinfectant product distributed locally by PSI. Each tablet costs only 10 Tanzanian shillings and makes 20 liters of clean and safe drinking water—a much less costly and time-consuming approach than using kerosene to boil water. Says Ms. Haule: “*I urge all service providers to replicate this in their health facilities, and the challenge of safe drinking water for DOT will be a thing of the past.*”

## ANNEX E: ACCESS GLOBAL M&E FRAMEWORK WITH RESULTS<sup>2</sup>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<b>ACCESS Program Result:</b> <i>Increased use and coverage of maternal/neonatal and women's health and nutrition interventions</i>						
<p><b>A.</b> 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&amp;E plan and budget agreed by USAID Mission</p> <p>(collection is field-dependent)</p>	<ul style="list-style-type: none"> <li>Indicators to track, appropriate to areas of program activity, will be determined from the final country M&amp;E plans and budget agreed by USAID Mission, but potentially include: %/# of births attended by skilled attendants; %/# of mothers who report immediate and exclusive breastfeeding for last live birth; %/# of mothers who receive antenatal iron folate, IPT, ITN use rates, etc.</li> </ul>	Program records and country reports, population-based surveys by ACCESS, HMIS	M&E review of country-level M&E indicators  Annual	Baseline: 0  <i>Target: selected ACCESS countries, including: Tanzania, Haiti, Nigeria, Bangladesh, Nepal, India, Cambodia, Rwanda</i>	2: Tanzania and Haiti  Tanzania ANC clients with: -IPT1=65% -IPT2=44% -iron=100% -TT2=70%  Haiti: -83% of ANC clients counseled about PMTCT	7: Tanzania, Haiti, Nigeria, Bangladesh, Nepal, India, Afghanistan
<p><b>B.</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"> <li>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: :%/# of births attended by skilled attendants; %/# of mothers who report immediate and exclusive breastfeeding for last live birth; %/# of mothers who receive antenatal iron folate, IPT, ITN use rates, etc.</li> </ul>	National or other project data (e.g., DHS, MICS, etc.)	M&E collaboration with other organizations and USAID  Annual	Baseline: 0  <i>Target: selected ACCESS countries with relevant data</i>	1: Tanzania  Tanzania DHS 2004/2005 showed: -52.1% of ANC clients received IPT1 -21.7% of ANC clients received IPT2 -32% of pregnant women slept under any mosquito net the previous night -15.6% of pregnant women slept under an ITN the previous night	N/A

<sup>2</sup> Baseline surveys conducted—Nigeria: fall 2006; Bangladesh: winter 2008; Rwanda: fall 2007; India: fall 2007.

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<b>C.</b> (Country-level) Estimated population of women of reproductive age living in communities or catchment areas of facilities <i>Targeted</i> by ACCESS interventions	<ul style="list-style-type: none"> <li>The number of reproductive age women is the female population estimated to be between the ages of 15–49.</li> <li>Communities or catchment areas <i>Targeted</i> by ACCESS will be determined at the country level.</li> <li>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.</li> </ul>	National census data, DHS data or other national sources as available	Program and M&E analysis and review of available national data per <i>Targeted</i> areas  Semi-annual	Baseline: 0  <i>Target: all ACCESS countries with relevant data</i>	11,244.811	28,190,208
<b>ACCESS Program Intermediate Result 1: Global leadership for maternal, neonatal, and women's health and nutrition program and policies strengthened</b>						
<b>1a.</b> Number of technical approaches and/or products being promoted for international use through ACCESS leadership roles	<ul style="list-style-type: none"> <li>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.</li> <li>Promotion for use occurs through many venues: meetings, collaboration, alliances and partnership implementation.</li> </ul>	Program reports and activity tracking	Program and M&E review of activity results per indicator criteria  Semi-annual	Baseline: 0  <i>Targets: Year 3: 28</i>	25+	26

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>1b.</b> 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"> <li>• Policies, including clinical care and service delivery guidelines, are national instructions meeting international evidence-based quality criteria related to ACCESS goals.</li> <li>• 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.</li> </ul>	<p>Program reports and activity tracking</p>	<p>Program and M&amp;E review of activity results per indicator criteria</p> <p>Annual</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 3: 4 <i>Tanzania, Haiti, Nepal, India</i></p>	<p>2 countries:</p> <p>Tanzania – National Infection Prevention Guidelines</p> <p>Haiti – National PMTCT guidelines</p>	<p>4 countries:</p> <p>Tanzania – National Infection Prevention Guidelines</p> <p>Haiti – National PMTCT guidelines</p> <p>Nepal-Skilled Birth Attendance Policy</p> <p>India-Skilled Birth Attendance guidelines</p>
<p><b>1c.</b> 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"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<p>Program reports and activity tracking</p>	<p>Program and M&amp;E review of activity results per indicator criteria</p> <p>Annual</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 3: <i>Afghanistan, Nigeria, Malawi</i></p>	<p>2 national policies in 2 countries:</p> <p>Nepal – National Skilled Birth Attendant policy</p> <p>Afghanistan – National 5-year MNH Health Strategy</p>	<p>4 policies:</p> <p>Nigeria: National performance standards for maternal and newborn health developed</p> <p>Kenya: <i>Prevention of Postpartum Hemorrhage Guidelines for Health Care Providers</i></p> <p>Madagascar: Norms and Protocols for malaria control in adults and children and malaria in pregnancy</p> <p>Nepal: KMC guidelines</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<b>ACCESS Program Intermediate Result 2: Preparation for childbirth improved</b>						
<p><b>2a.</b> 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"> <li>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.</li> <li>Achievement of improved birth planning is defined as having fulfilled birth preparedness goals of the community's self-developed action plan.</li> </ul>	Program reports and activity tracking	<p>Program and M&amp;E review of program reports</p> <p>Annual</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 3: 4 countries, Cameroon, Nigeria, Bangladesh Rwanda</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>Nigeria- communities in 5 districts</p> <p>Bangladesh-1716 (villages where ACs and CMs are working) in 7 upazilas/1 district</p> <p>Cameroon – 1 department</p> <p>Burkina Faso – 1 district</p> <p>India- 40 communities in 3 blocks of one district in Jarkhand state</p> <p>Rwanda-community work will begin in FY08</p>
<p><b>2b.</b> 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 1<sup>st</sup> visit ANC clients]</p>	<ul style="list-style-type: none"> <li>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).</li> <li>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.</li> </ul>	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&amp;E plan.</p> <p>Annual</p>	<p>Baseline: not known at country levels</p> <p><i>Targets:</i> <i>Year 3:3 countries, Tanzania, Nigeria, Bangladesh</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Tanzania – 70% (56 facilities)</p>	<p>Tanzania – 69% (134 facilities)</p> <p>Nigeria baseline: 74% (TT1 or TT2)</p> <p>Bangladesh: data will be available in FY08</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>2c.</b> Percent/number of women who delivered in past 6 months in ACCESS- <i>Targeted</i> 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)/Total number ANC visits]</p>	<ul style="list-style-type: none"> <li>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).</li> <li>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.</li> </ul>	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&amp;E plan.</p> <p>Annual</p>	<p>Baseline: not known at country levels</p> <p><i>Target: Year 3: 2 countries, Tanzania, Bangladesh</i></p> <p><i>% TBD per final country workplans</i></p>	Tanzania – 167% (56 facilities. Figure exceeds 100% since iron is given to ANC revisit clients in addition to first visit clients)	<p>Tanzania – 60%% (134 facilities)</p> <p>Nigeria baseline- 94%</p> <p>India-66% at baseline</p> <p>Bangladesh-data will be available in FY08</p>
<p><b>2d.</b> 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"> <li>Women delivering in communities in the past 6 months will be identified through program records or if appropriate facility-based records.</li> <li>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.</li> </ul>	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&amp;E plan.</p> <p>Semi-annual</p>	<p>Baseline: not known at country levels</p> <p><i>Target: Year3: 1 country, Tanzania</i></p> <p><i>% TBD per final country workplans</i></p>	Tanzania proxy indicator: 93% of ANC clients received ITN voucher (56 facilities)	<p>Tanzania proxy indicator: 93% of ANC clients received ITN voucher (134 facilities)</p> <p>Uganda- women who received an ITN or purchased an ITN increased from 0% at baseline to 27% (5 facilities)</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>2e.</b> Percent/number of pregnant women who attended antenatal care services at ACCESS-Targeted facilities who received 1<sup>st</sup> dose 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"> <li>Calculation: Number of pregnant women who receive IPT1 under observation/ Number of 1<sup>st</sup> ANC visits</li> <li>This indicator will be reported by country only where ACCESS activities Target IPT with sulfadoxine-pyrimethamine (SP) as an area for improvement.</li> <li>Receipt of IPT with SP will be determined from facility records.</li> <li>These indicators will be measured in malaria- endemic countries only.</li> </ul>	HMIS	<p>Availability records TBD in context of developing the country-level M&amp;E plan.</p> <p>Semi-annual</p>	<p>Baseline: TBD country level</p> <p>Target: Year 3: 2 countries, Tanzania, Uganda</p> <p>%TBD per final country workplans</p>	<p>Tanzania – 65% (56 facilities)</p> <p>Madagascar – 48% (5 facilities)</p>	<p>Tanzania – 59% (134 facilities)</p> <p>Uganda – 94% (5 facilities)</p>
<p><b>2f.</b> Percent/number of pregnant women who attended antenatal care services at ACCESS-Targeted facilities who received 2<sup>nd</sup> 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"> <li>Calculation: Number of pregnant women who receive IPT2 under observation/ Number of 1<sup>st</sup> ANC visits</li> <li>This indicator will be reported by country only where ACCESS activities target IPT with SP as an area for improvement.</li> <li>Receipt of IPT with SP will be determined from facility records.</li> <li>This indicator will be measured in malaria-endemic countries only.</li> </ul>	HMIS	<p>Availability records TBD in context of developing the country-level M&amp;E plan.</p> <p>Semi-annual</p>	<p>Baseline: TBD country level</p> <p>Target: Year 3: 2 countries, Tanzania, Uganda</p> <p>%TBD per final country workplans</p>	<p>Tanzania – 44% (56 facilities)</p> <p>Madagascar – 40% (5 facilities)</p>	<p>Tanzania – 41% (134 facilities)</p> <p>Uganda – 76% (5 facilities)</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>2g.</b> 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"> <li>ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.</li> <li>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).</li> </ul>	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>Baseline: 0</p> <p><i>Target:</i> Year 3: 2 countries, Tanzania, Haiti</p>	<p>Haiti – 312 providers from 40 facilities trained in PMTCT:</p> <ul style="list-style-type: none"> <li>90 physicians</li> <li>218 nurses</li> <li>2 auxiliary nurse-midwives</li> <li>1 epidemiologist</li> <li>1 social worker</li> </ul> <p>Burkina – 114 providers in FANC/MIP</p> <p>Madagascar – 14 trainers and 96 providers in FANC/MIP</p> <p>Tanzania- 366 service providers, 90 trainers, 25 tutors and 33 preceptors. for a total of 514 health workers FANC/MIP.</p> <p>Nigeria –28 RBM and RH coordinators in FANC and PQI</p>	<p>Haiti – 170 service providers trained in PMTCT</p> <p>Tanzania: 1,990 providers trained in FANC/MIP/SIP and 1600 midwifery preservice graduates</p> <p>Bangladesh-399 lay counselors, community supervisor mobilizers and community mobilizers</p> <p>India-18 ANMs</p> <p>Nepal: 87 nurses and doctors trained in MNH skills</p> <p>Global e-learning Antenatal Care course – 388</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>2h.</b> Total number of pregnant women provided with PMTCT services at <i>Target</i> facilities, including counseling and testing<sup>3</sup></p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	HMIS, Centers for Disease Control and Prevention (CDC) Global AIDS program database	Availability records TBD in context of developing the country-level M&E plan.  Semi-annual	Baseline: 0  <i>Target:</i> <i>Year 3: 1 country, Haiti</i>  <i>Number/% TBD per final country workplans</i>	Haiti – 10410 pregnant women were counseled and tested (12 facilities)	Haiti – 18,409 pregnant women were counseled and tested (12 facilities)
<b>ACCESS Program Intermediate Result 3: Safe delivery, postpartum care, and newborn health improved</b>						
<p><b>3a.</b> Number of ACCESS-Targeted facilities with PQI initiatives contributing to compliance with international standards</p>	<ul style="list-style-type: none"> <li>ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches.</li> </ul>	Program PQI records PQI database	Records and document review  Semi-annual	Baseline: 0  <i>Target:</i> <i>Year 3: 3 countries, Tanzania (FANC), Nigeria (EMONC), Rwanda (EMONC)</i>  <i>Number of facilities TBD per final country workplans</i>	Haiti : 6 facilities have teams trained in PQI for PAC  Madagascar: 5 facilities conducted follow-up assessments in FANC/MIP this year. Baseline assessments were done in Year 1.  Tanzania: 64 facilities have conducted baseline assessments -- 59 during this reporting period. First followup assessments were completed by 15 facilities this year; second followup assessments were completed by four facilities; and a third followup assessment by one facility.	Tanzania: Of 81 facilities implementing ANC QI initiative, 59 (73%) showed improvements in meeting the ANC standards  Nigeria: 24 providers were trained in SBM/R for EMONC and 13 facilities conducted baseline assessments  Ghana- 3 facilities applying PQI for BEmONC  Rwanda: TOT conducted for providers at 7 district hospital on EmONC/PQI  Madagascar: 6 facilities applying PQI for MIP/malaria control in adults and children.

<sup>3</sup> PEPFAR indicator

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>3b.</b> 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"> <li>Women delivering in the past 6 months will be identified through facility records.</li> <li>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.</li> <li>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).</li> </ul>	Facility records, completed partographs	Records review  Annual	<p>Baseline: TBD country level</p> <p><i>Target: Year 3 :1 country, Nigeria</i></p> <p><i>% TBD per final country workplans</i></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>Nigeria:</p> <ul style="list-style-type: none"> <li>Baseline facility survey data in Nigeria showed that the partograph is currently not used.</li> <li>HMIS data post intervention: 4409</li> </ul> <p>India HMIS: 0% (trained ANMs not using it yet)</p>
<p><b>3c.</b> 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"> <li>Births in the 6 months prior to data collection will be identified through facility records and/or program records at the community level.</li> <li>AMTSL is determined by information available in the records.</li> <li>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.</li> </ul>	HMIS and/or program records where data are available	Records review, where data are available  Annual	<p>Baseline: TBD country level</p> <p><i>Target: Year 3: 4 countries, Nigeria, India, Rwanda, Cambodia</i></p> <p><i>%TBD per final country workplans</i></p>	Not available. Nigeria-baseline study will be conducted by November 2006 and HMIS data will be collected.	<p>Nigeria: 6,835</p> <p>India: 50 (100%) of births attended by 8 trained ANMs reporting for June-July 2007</p> <p>Ghana-94.6% (from Jan – June 2007)</p> <p>Data for Rwanda and Cambodia will be available in FY08</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>3d.</b> Percent/number of newborns in the past 6 months in ACCESS-<i>Targeted</i> facilities or communities dried and warmed immediately after birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Facility and/or program records if data are available</p>	<p>Records review, if data are available</p> <p>Annual</p>	<p>Baseline: country level TBD</p> <p><i>Target: Year 3: 2 countries, Bangladesh and Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007.</p>	<p>Bangladesh MIS data: 72.6%</p> <p>Nigeria: HMIS data will be available in FY08</p> <p>India baseline: 10%</p>
<p><b>3e.</b> Percent/number of newborns in ACCESS-<i>Targeted</i> facilities or communities that are breastfed within one hour of birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<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>Baseline: country level TBD</p> <p><i>Target: Year 3: 2 countries, Bangladesh and Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007.</p>	<p>Bangladesh MIS data: 74.6%.</p> <p>Nigeria baseline data: 34%</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>3f.</b> Percent/number of providers with adequate knowledge of essential newborn care</p>	<ul style="list-style-type: none"> <li>Adequate knowledge will be determined based on country's definition.</li> </ul>	<p>Provider knowledge survey</p>	<p>Survey  Annual</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3: 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>The Nigeria and India programs have not started yet.</p>	<p>Results for Nigeria baseline knowledge survey (18 facilities, 45 providers):</p> <ul style="list-style-type: none"> <li>First step in thermal care: 18% correct</li> <li>Maintaining babies temp.: 47%</li> <li>Immediate newborn care:36%</li> <li>Cord care: 9%</li> <li>Newborn resuscitation: 47%</li> <li>Breastfeeding: 47%</li> </ul> <p>Nepal-80% of KMC community health workers demonstrated KMC to standard</p> <p>India: 18 (100%) of trained ANMs had adequate knowledge of newborn care at graduation</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>3g.</b> Percent/number of women in ACCESS-<i>Targeted</i> facilities or communities who accept a contraceptive method by 6 weeks postpartum<sup>4</sup></p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> <li>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).</li> </ul>	Facility and/or program records	Records review  Semi-annual	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3:</i> <i>2 countries,</i> <i>Nigeria and</i> <i>Kenya</i></p> <p><i>% TBD per final country workplans</i></p>	Not Available. Depends on when/where ACCESS-FP can obtain buy in from USAID Missions.	<p>Kenya/ACCESS-FP by PP visit:</p> <ul style="list-style-type: none"> <li>1st (within 48 hours) - 3,613 out of 3,701</li> <li>2nd (2 weeks) 827 out of 1,007</li> <li>3rd (6 weeks) 688 out of 781</li> </ul> <p>Nigeria - Training on PP FP just completed. Will begin reporting on this in FY08.</p>
<p><b>3h.</b> Percent/number of women who delivered in past 6 months in ACCESS-<i>Targeted</i> facilities/communities who received a postpartum visit within 3 days after childbirth</p>	<ul style="list-style-type: none"> <li>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).</li> <li>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.</li> </ul>	HMIS and/or home records or community survey	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&amp;E plan</p> <p>Annual</p>	<p>Baseline: not known at country levels</p> <p><i>Target:</i> <i>Year 3: 2 countries,</i> <i>Bangladesh,</i> <i>Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	Bangladesh and Nigeria programs have just started. Nigeria baseline study will be conducted by November 2006. Availability of Bangladesh baseline data will be available in January 2007.	<p>Nigeria HMIS data: 7,534</p> <p>Ghana: 875 (all deliveries at 3 target facilities)</p> <p>Nepal: 90% of mothers in KMC target communities</p> <p>Bangladesh baseline data will be available in July 2007.</p>

<sup>4</sup> This indicator will be collected through ACCESS-FP.

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<b>ACCESS Program Intermediate Result 4: Management of obstetric complications and sick newborns improved</b>						
<p><b>4a.</b> Percent/number of women attending ACCESS-<i>Targeted</i> facilities with eclampsia who appropriately receive magnesium sulfate</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> <li>Women with eclampsia attending <i>Targeted</i> 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.</li> <li>The percentage is calculated by dividing the numerator (women recorded at ACCESS-<i>Targeted</i> facilities with eclampsia and receiving magnesium sulfate) by the denominator (all women recorded at ACCESS-<i>Targeted</i> facilities with eclampsia).</li> </ul>	Facility records	Records review	<p>Baseline: TBD country level</p> <p><i>Target:</i> Year 3: 1 country, Nigeria</p> <p>% TBD per final country workplans</p>	Nigeria program has just started. Nigeria baseline study will be conducted by November 2006.	Nigeria HMIS data-155
<p><b>4b.</b> 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"> <li>ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.</li> <li>Training that <i>Targets</i> 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.</li> <li>Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues.</li> <li>Trained providers are those who complete a training course satisfactorily according to the course criteria.</li> </ul>	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>Baseline: 0</p> <p><i>Target:</i> Year 3: Providers in 4 countries, Cameroon, Mauritania, Nigeria, Nepal</p>	<p>Mauritania: 13 providers, 4 trainers Niger: 4 trainers Togo: 4 trainers Cameroon: 20 providers, 4 trainers</p> <p>Ghana: 4 Ethiopia: 4 Tanzania: 4 Malawi: 4 Nigeria: 4</p> <p>Total: 69</p>	<p>Nigeria: 24 providers trained in EMONC,</p> <p>Ghana/ Ethiopia/ Tanzania/</p> <p>Malawi: 84 midwifery educators</p> <p>Global e-learning course on Essential Newborn Care – 315</p> <p>Rwanda: 20 providers/trainers trained in EMONC</p> <p>Ethiopia/ESOG: 20 providers trained in EmONC</p> <p>Ghana: 7 midwives trained in BeMONC</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTIO N METHOD/ FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<p><b>4c.</b> 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"> <li>ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff.</li> <li>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.</li> <li>Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues.</li> <li>Trained providers are those who complete a training course satisfactorily according to the course criteria.</li> </ul>	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 3: Providers in 2 countries, Nigeria and Nepal</i></p>	<p>Nigeria program has just started. Nigeria baseline study will be conducted by November 2006.</p>	<p>Nigeria- 15 providers trained as KMC trainers</p> <p>Rwanda-12 national-level trainers</p> <p>Nepal-18 doctors and nurses received the Clinical Training Skill training in KMC. An additional 144 doctors and nurses from six hospitals and 3 PHCs trained in KMC. 412 managers and health workers received a one-day orientation on KMC</p>
<p><b>4d.</b> 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"> <li>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.</li> <li>Achievement of improved complication readiness is defined as having fulfilled complication readiness goals of the community's self-developed action plan.</li> </ul>	Program reports and activity tracking	<p>Program and M&amp;E review of program reports</p> <p>Annual</p>	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 3: Communities in 4 countries: Cameroon, Nigeria, Bangladesh, India</i></p>	<p>Kenya – 3 districts and 6 divisions</p> <p>Cameroon – one department</p>	<p>Nigeria- communities in 5 districts</p> <p>Bangladesh-1716 (villages where ACs and CMs are working) in 7 upazilas/1 district</p> <p>Cameroon – 1 department</p> <p>Burkina Faso – 1 district</p> <p>India- 40 communities in 3 blocks of one district in Jarkhand state</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	BASELINE (AND ANNUAL TARGET)	PROGRESS FOR PY2 (OCT. 2005- SEPT. 2006)	PROGRESS FOR PY3 (OCT. 2006- SEPT. 2007)
<b>ACCESS Program Intermediate Result 5: Prevention and treatment of priority health problems of non-pregnant women of reproductive age improved (Targets of Opportunity)</b>						
5a. Number of linkages with international obstetric fistula networks initiated and technical assistance provided	<ul style="list-style-type: none"> <li>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.</li> <li>Linkages are working relationships on identified tasks toward specified goals agreed between a network and ACCESS.</li> </ul>	Program records	Records review	Baseline: 0  <i>Targets:</i> <i>Year 3: 1</i>	ACCESS is an active member of one international obstetric fistula network	ACCESS is an active member of one international obstetric fistula network

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

## **ANNEX F: SUMMARY REPORT OF ACCESS SMALL GRANT RECIPIENTS FOR PREVENTION OF OBSTETRIC FISTULA**

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### **Ong Dimol, Niger**

To prevent obstetric fistula, Dimol proposed to bring a sensitization caravan to 17 villages in Tera, the department with the highest rate of fistula in the country. Activities were as follows:

- Meetings with the administrative authorities
- Meetings with the village chiefs
- Identification of target groups
- Radio announcement prior to arrival of the caravan in each village
- Discussions on the causes and consequences of obstetric fistula
- Presentation by woman afflicted with fistula
- Dramatic presentations by the youth group Ado-Dimol
- Discussion of contraceptive methods available at the health centers at minimal cost

### **Results**

- The sensitization caravan took place from April 11-28 with the planned activities taking place in 17 villages reaching a total of more than 2,169 people.
- Additional women with fistula were identified and referred for treatment.
- Dramatic presentation was an effective way to sensitize the largely illiterate population to the causes, consequences and potential prevention of fistula.

### **Challenges**

- The preparatory mission coincided with the opening of the traditional fight at Diffa and certain authorities were absent
- Access to certain villages was difficult
- Sabara Gueriel and Sedey were visited in lieu of other hamlets due to access problems
- There is a shortage of contraceptives in some health centers

### **UPMA (Uganda Private Midwives Association, Uganda)**

Uganda Private Midwives Association (UPMA), with support from ACCESS /Constella Futures project, initiated a project with a goal of reducing the incidence of obstetric fistula in 3 Districts (Masaka ,Kayunga and Mukono) where some of the private midwives practice.

#### **Results:**

On 19 January 2006, UPMA organized a one-day workshop on Obstetric Fistula to raise awareness and update 30 UPMA members on causes and prevention of obstetric fistula. The workshop included an update on the partograph, a tool that can be used both to document labor progress and identify prolonged/obstructed labor.

Beginning in February 2006, 30 midwives who had participated in the Obstetric Fistula workshop began to implement outreach activities to raise awareness in their respective communities to prevent fistula, identify women suffering with fistula and refer them for treatment, and conduct deliveries using the partograph..

UPMA began a supportive supervision activity of the 30 midwives in August 2007 that included interviews with the midwives, review of records, review of outreach activities, and partograph case studies developed by UPMA that were administered and then reviewed with midwife. Results were recorded on a supportive supervision tool also developed by UPMA.

The 30 UPMA midwives conducted a total of 274 outreach activities to the communities and 301 outreach activities to schools.

### **Challenges**

- Outreach to the community is more difficult to conduct than outreach to schools because, in some instances, community leaders expect to be remunerated to be involved in community mobilization.
- In some instances, members of the community are at work or busy with different activities, especially the men.
- Some youths view sex in adolescence as a ‘rite of passage’ and are less inclined to abstain from the practice despite counseling regarding possible consequences.
- In some communities it is perceived that fistula is caused by the midwife ‘pinching’ the bladder during the course of helping the delivery of a baby.

**TERREWODE Uganda** applied to ACCESS for a small grant to prevent fistula with the overall goal of raising awareness in the community of Gweri sub-county, Soroti district, Teso region, about the causes and consequences of fistula and providing support to women who have been treated for fistula.

### **Results:**

- Fifty-four (54) women with fistula from Soroti district were identified and supported for repairs during the project period. Seventeen (17) more women with fistula from Gweri-Soroti and eight (8) women from Kaberamaido district were identified with repairs pending. The MOH is collaborating with TERREWODE to provide support for these repairs.
- More than 2000 community members were sensitized
  - 796 through community meetings
  - 20 district and health officials through advocacy meetings with district officials
  - 30 members of NGOs and CSOs during advocacy meeting
  - radio talk shows including FM stations Veritas and Voice of Teso with population coverage of one million
- 250 targeted community leaders were sensitized. In six out of nine parishes sensitized, community members resolved to start a reproductive/maternal health savings scheme to handle obstetric emergency care services among the members. In all nine parishes, reproductive health sub-community groups were established, some of which have already approached TERREWODE with plans for health activities they would like to initiate.
- 12 radio talk shows on the topic of fistula were broadcast. During the last eight talk shows, many listeners phoned in, some of them district leaders and health professionals, and thanked TERREWODE for initiating such “an important development concern”. They made recommendations to improve the program and expressed the possibility of partnership in the future.
- A five (5) member women’s fistula drama group was established. The group performed during eleven (11) sensitization meetings. Their drama generated hot debate around human rights abuses and the low status of women in society, the failure of the government to

improve reproductive health facilities and services and the failure of the government to improve the justice system to address human rights abuses.

- 2000 fistula sensitization posters were translated into Ateso printed and disseminated
  - Some of these posters were displayed at the first ever Reproductive Health Empowerment Conference organized for Teso secondary school girls in December 2006. During the three day residential conference, TERREWODE highlighted issues related to obstetric fistula to the over 200 participants that included senior women teachers and clan and cultural leaders from the entire Teso region.
- A delivery bed was donated by TERREWODE to maternity ward in Gweri in collaboration with the Women's Dignity Project.
- In Kaberamaido district, the head of Health Centre III was cautioned after Terrewode reported neglect of duty.
  - Soroti district leadership
    - Seconded a midwife attached to the Obstetric Fistula Ward to work with Terrewode on a part-time basis during sensitization and mobilization of women with fistula.
    - seconded a gynecologist during the advocacy workshop and paid for his services
    - launched a quarterly radio spot message about availability of treatment for women with fistula in the region
- A good working relationship established between Terrewode and the hospital staff in terms of timely screening of women with fistula referred for treatment.
- Three of six Teso districts drafted by-laws (ordinances) mainly to protect girls against child marriage and defilements with possible consequences such as obstetric fistula.
- An external project final evaluation was completed by Ms.Grace Lwanga, consultant from Tororo-Uganda with positive results.

### **Challenges**

- The number of women with fistula who can be identified in Teso region is limited by availability of resources to conduct mobilization and provide counseling.
- Improving the quality of rural health services will take a longer time mainly because of resource constraints facing the districts.
- Supervision by district health officials of RH facilities is still not the best despite awareness.
- Poverty poses an ongoing challenge as husbands want to help their wives but are afraid of the costs.
- People fear going to theatre for operation because of some community myths that operations create some other sicknesses.
- Continued efforts are needed to address community attitude; victims are still being stigmatized and discriminated against.

### **ASMOP Nigeria**

The Access program in support of activities to prevent obstetric fistulas was implemented in two Communities (Ndieze and Mbalaukwu) in 1zzi Local government area of Ebonyi State Nigeria. The project lasted for 12 months, from March 15<sup>th</sup> 2006 to April 30<sup>th</sup> 2007.

- The first activity was to conduct a survey to generate data on maternal mortality and morbidity ratios from Ndieze and Mbalaukwu with particular emphasis on factors predisposing to

obstetric fistula, prevalence of obstetric fistula, availability of health institutions to provide emergency obstetric care, and the degree of involvement of the community in preventing

discrimination and stigmatization of persons disabled by obstetric fistula.

- The data generated was used to design & implement an intervention.
- 30 facilitators were trained in each of the two communities over a period of two days. Topics included introduction to obstetric fistula, danger signs, Rights Based Approach, facilitation skills, story telling (a particular story had been developed) and discussion skills.
- Six workshops were held, each for a total of 30 men, women and children.

### **Results**

1. 20% of all pregnancies in the project communities were identified as involving some complications or danger signs and were referred.
2. Institutional births rose from 16% to 23%
3. Plans to have transport for an emergency rose to 35%
4. 40% of respondents knew the laws that protect the girl child and women from violence.
5. Increased attendance at antenatal clinic was recorded during the project period.
6. Women formed a thrift collection group. The aim was to assist women make compulsory savings to be used in cases of obstetric emergencies.
7. 20% of pregnant women had a birth preparedness and complication readiness plan in place
8. 5 women with repaired fistula received micro credit for small scale business.
9. Men in the same neighborhood were organized into a club to ensure availability of transport in cases of obstetric emergencies.

### **Challenges**

- ◆ Poor topography that made project implementation almost impossible especially during the rainy season.
- ◆ Poor record keeping in health facilities makes it difficult to collect data.
- ◆ High inflation prevalent in the country caught up with the project. The inflation affected mostly cost of fuel and maintenance of project vehicle which was always breaking down due to very bad roads.
- ◆ High rate of illiteracy in the communities
- ◆ Political instability from constant changing of the local government chairmen in Ebonyi State affected project implementation.

## ANNEX G: HIDN RESULTS PATHWAYS REPORT AND OP INDICATORS

### Skilled Care at Delivery

Maternal mortality ratios reflect the widest disparity in human development indicators between developed and developing countries and between the rich and the poor within countries. Each year more than 500,000 women die due to complications of pregnancy and childbirth. Another 15 to 20 million women suffer direct and long-term disabilities that are easily prevented if safe delivery care is provided to the majority of childbearing and referral to specialized level of care to a small percentage who develop complications. The major direct causes of maternal mortality are: hemorrhage, hypertensive disorders, infection, abortion, obstructed labor and anemia. Many of these complications can be prevented or appropriately managed if a skilled birth attendant (SBA) is conducting the delivery at a facility or at home. Skilled birth attendant (SBA) is defined as a health provider with medical training such as a doctor, midwife, or nurse. These skilled individuals require the mandate, commodities, drugs and equipment to provide skilled care. USAID is supporting policies, strategies and programs that promote safe delivery by skilled birth attendants, as well as immediate postpartum care. Because of the stagnant or increasing maternal mortality ratios in Africa, USAID will focus its activities to address this problem particularly in African countries.

**1.1 Research** to analyze global data to guide programming; to assess new interventions and document effectiveness and cost effectiveness of selected strategies; to address remaining challenges, including human resources constraints, financial barriers and equity gaps to service utilization and in particular SBA use by the marginalized and underserved women.

Activity Title	Expected result	End Date	Status	Implementing mechanism	FY06 Budget (\$ 000)	Total Budget (\$ 000)
Assessment of maternity care and birth outcomes.	<ul style="list-style-type: none"> <li>- Direct causes of maternal mortality (MM)</li> <li>- Perinatal and neonatal mortality</li> <li>- MM global estimates</li> <li>- Impact of cesarean section</li> <li>- Physical, psychological and economic consequence of mortality and morbidity</li> <li>- Impact of FP on MM</li> </ul>	FY06 FY06 FY07 FY 07 FY08 FY 07	Completed Completed Ongoing Ongoing New New	WHO WHO WHO WHO JHU/ICDDR Futures/PDI		
Maternal mortality measurement tools	<ul style="list-style-type: none"> <li>- Sampling at service site (SSS) to measure MM</li> <li>- RAPID to measure MM in facilities</li> <li>- Verbal autopsy</li> </ul>	FY08 FY 08 FY08	Ongoing Ongoing Ongoing	University of Aberdeen/IMMPACT		
Implementation approaches	<ul style="list-style-type: none"> <li>- Quality improvement collaboratives</li> <li>- Continuity and quality of care</li> <li>- Financing</li> </ul>	FY08 FY 09 FY 09	Ongoing Ongoing Ongoing	URC/QAWD URC/QAWD TBD/HS 20/20		

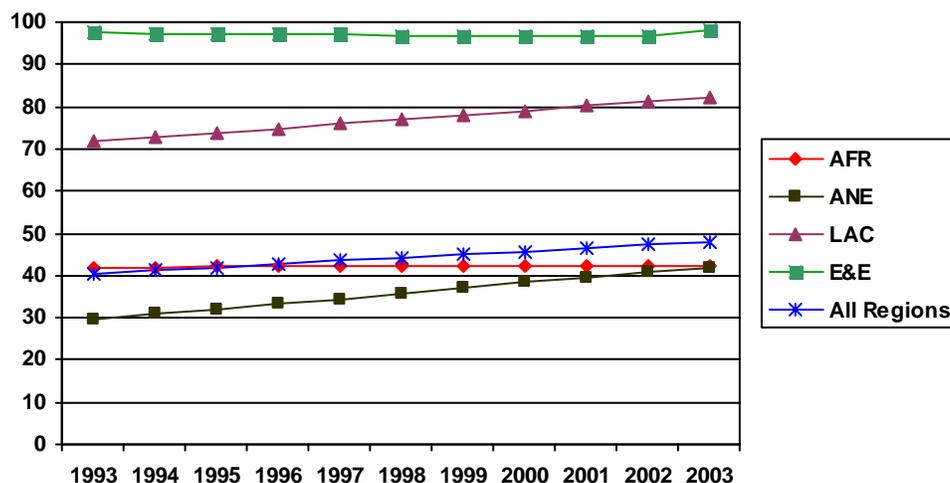
**1.2 Introduction and expansion of proven interventions** includes technical leadership, advocacy and policy dialogue with MOH and Missions to ensure safe birth promoting use of proven interventions, such as clean delivery, use of the partograph, etc., by SBAs to address the major direct causes of maternal death. Introduction in countries which have weak maternal health services will focus on one district (at least 20% of population or facilities). Expansion is defined as moving beyond one district and covering 20% of the population in a district/state/country. SBA is an indicator captured by DHS. Attempt will also be made to capture data at

distinct/provisional level where USAID partners are active. *Also see the pathway on prevention of postpartum hemorrhage.*

Activity Title	Expected result	End Date	Target				Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
			FY05	FY06 (Actual)	FY07	FY08			
Technical leadership and partnership to advance SBA activities at a country level	Tools disseminated & partnership with FBOs, PMNCH & WRA to initiate country level SBA activities	FY08	New	Ongoing (Includes preservice work in 4 countries- Ghana, Malawi, Tanzania and Ethiopia- as well as leadership in all countries with ACCESS field support)	Ongoing	Complete	ACCESS		
Introduction of interventions for skilled birth attendance through Essential Maternal and Newborn Health (EMNH)	SBA introduced in 7 countries (at least 20% in one district)	FY09	-	7 (Malawi, Ghana, Cameroon, Mauritania, Niger, Togo, India)	3 additional countries (Ethiopia, Cambodia, and Haiti* )	TBD	ACCESS		
Expansion of skilled birth attendance in countries	SBA expanded in 3 countries through pre-service training	FY09	-	3 ( Nepal, Nigeria, Afghanistan )	4 additional countries (Malawi, Bangladesh , Ethiopia, Tanzania)	TBD	Mission funded		
Safe Birth Africa Initiative	Focus in 1 African countries to increase SBA and coverage with proven interventions	FY2011		New (Rwanda)	Continued in 1 country (Rwanda)	Continued in 1 country (Rwanda)	ACCESS		

\*This refers to testing of the Postabortion Care Package.

**PERCENTAGE OF DELIVERIES ASSISTED BY SKILLED BIRTH ATTENDANT**  
**GLOBAL AND REGIONAL TREND**  
*1993 – 2003*



**Antenatal Care Pathway**

While antenatal care attendance has been rising slowly throughout the world, it remains quite low in Asia. Most pregnant women in Asia and Africa do not make the recommended minimal number of antenatal visits (4 visits). Quality antenatal care improves maternal health and helps to promote healthy outcomes for women and newborns. Antenatal care can assist in early detection of obstetric complications and medical problems exacerbated by pregnancy. It is a key entry point for pregnant women to receive a broad range of preventive health services including nutrition supplementation; prevention and treatment of malaria, HIV/AIDS, syphilis; and tetanus toxoid immunization; and counseling about use of a skilled birth attendant. GH will expand programs to strengthen focused antenatal care which provides assessment and action to provide care for each woman’s individual situation --taking into consideration the existing country specific prevalence of infections, such as malaria and HIV/AIDS for malaria in pregnancy (MIP) and prevention of maternal-to-child-transmission (PMTCT) programs.

**2.1 Research** to assess the effectiveness of micronutrients supplementation and nutritional approaches on neonatal and maternal survival.

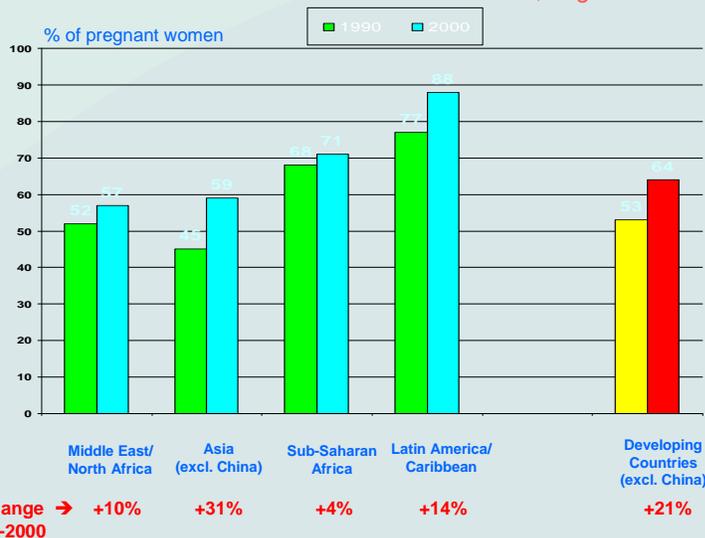
Activity Title	Expected result	End Date	Status	Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
Nutritional approaches for neonatal/ maternal health	Effects of low dose Vit A on birth outcomes	FY08	Ongoing	JHU/GRA		

**2.2 Introduction and expansion** will include activities to increase focused antenatal care in African countries with high malaria and HIV/AIDS prevalence to prevent HIV transmission from mothers to child. Strengthening ANC will be part of Essential Maternal and Newborn Health (EMNC) activities in most targeted countries.

Activity Title	Expected result	End Date	Target				Implementing Mechanism	FY06 Budget (1000)	Total Budget (1000)
			FY05	FY06 (Actual)	FY07	FY08			
Promotion of focused ANC with WHO, ICM, WRA and FBOs	Development and dissemination of technical materials and promotion of focused ANC at country level	FY07	-	-	Revision of the Managing complications of Pregnancy book	Ongoing	ACCESS	\$160	\$ 350
Introduction of focused ANC within EMNC	Focused ANC implemented in 3 countries	FY08	-	4 countries (Zambia, Uganda, India, Kenya)	2 additional countries (Malawi, Rwanda)	TBD	ACCESS	\$170	\$500
Expansion of Anemia prevention activities <i>See also the nutrition pathways</i>	Scale up anemia prevention activities in one country	FY08	-	In Tanzania will monitor distribution of iron during ANC visits in multiple areas (completed)	2 countries (Tanzania, Afghanistan)	TBD	ACCESS	\$100 and Mission funded	\$300
Expansion of focused ANC in Tanzania	All ANC services upgraded with MIP and PMTCT nation wide	FY09	4 regions (all districts in the regions)	6 regions (all districts in the region)	11 regions (select districts)	Remaining districts across 11 regions for a total of 128 districts	ACCESS	\$800 \$2,000 ? Mission funded	\$4,600

## Trends in antenatal care, 1990-2000

*Use of antenatal care in developing countries rose by a fifth; smallest increase in sub-Saharan Africa, largest in Asia*



Source: AbouZahr and Wardlaw, 2002

## Prevention of Postpartum Hemorrhage Pathway

Severe bleeding is the single most important cause of maternal death worldwide. Over 30% of all maternal deaths are due to hemorrhage in Asia and Africa. About 14 million cases of severe PPH occur every year with a case fatality rate of about 1 percent (140,000 deaths). Uterine atony accounts for 70-90% of all PPH cases; AMTSL is an evidence-based, feasible, low-cost intervention that can prevent 60% of uterine atony that leads to hemorrhage and death.

1. **Research** to develop a simple syringe mechanism to deliver a uterotonic drug (oxytocin) in a pre-filled device (Uniject) which could be easily transported and administered in the facility and home by trained skilled birth attendants or community health workers). Research will also compare the relative impact of oxytocin versus controlled cord traction.

Activity Title	Expected result	End Date	Status	Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
Oxytocin in Uniject development	Oxytocin in Uniject available for field trial and commercialization	FY08	Ongoing	HealthTech		
Comparison of relative effectiveness of three AMTSL components	Relative effectiveness of oxytocin vs. controlled cord traction clarified for future program emphasis	FY 08	Planning	POPPHI		

2. **Introduction and expansion** will include technical leadership in mobilizing Mission support for prevention of PPH programs; assisting Missions with the introduction of PPH interventions in a total of 9 countries by 2008; and expanding to a total of 8 countries with Mission support.

Activity Title	Expected result	End Date	Target				Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
			FY05	FY06 (Actual)	FY07	FY08			
Technical leadership	Increased awareness of AMTSL standards in 25 countries	FY07	20	28 <sup>5</sup>	16	0	ACCESS		
Introduction of PPH prevention programs into countries	PPH programs introduced in at least 12 focus countries (at least 25% of facilities in one district)	FY08	12 countries	8 (Cameroon, Mauritania, Niger, Togo, Democratic Republic of the Congo, Nepal, Nigeria, India)	Continued 5 new (Cambodia, Rwanda, Ethiopia, Kenya, Ghana)	Continued	ACCESS		
Expansion of PPH prevention programs in countries	PPH prevention programs expanded in 6 countries (20% of facilities in country)	FY08	1 country	1 (Afghanistan)	Continued 2 new (Rwanda, Malawi)	Continued	ACCESS		

<sup>5</sup> This includes 11 African countries plus the 17 Asian countries that attended the ANE meeting in Bangkok.

## Newborn Health Pathway

Each year, approximately 4 million newborns die within the first month of life accounting for over 60% of infant mortality and almost 40% of deaths among children under five years of age. Most neonatal deaths are caused directly by infections (36%) and low birth weight is the most important indirect cause of death with 60 to 80% of neonatal deaths occurring among newborns that are born too small. Priority must be placed on home- and community-based approaches because a large majority of births occur at home and can be prevented and managed at home. An additional consideration in the African context is that over half a million newborns are infected by the HIV virus annually through mother-to-child- transmission (MTCT). The uptake of Prevention of MTCT (PMTCT) continues to be limited, ranging from 1% to 10% in sub-Saharan Africa. The relatively high antenatal care coverage in Africa (over 75% for one visit) and skilled birth attendance (45%), provide an excellent platform for scaling up PMTCT if the two programs are better linked. **Total FY 06 Budget: \$3.768 million**

1. **Research** to assess program feasibility and effectiveness of community based *Essential Newborn Care* (clean delivery and cord care, warmth, early and exclusive breastfeeding, and early recognition and referral for complications); community based *infection management* (home-based postnatal care, Chlorhexidine for cord care, simplified antibiotic regimen); *newborn care and PMTCT integration; and newborn technology development* (Gentamicin in Uniject, Chlorhexidine, Resuscitation device). **Sub-Total FY 06 Budget for Research: \$1.753 million**

Activity Title	Expected result	End Date	Status	Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
Community based ENC in Bangladesh	Program feasibility of community based ENC demonstrated	FY06	Ongoing study to be completed in 2006	GRA/JHU		
Community based infection prevention and management: 1. Chlorhexidine (JHU, B'desh) 2. Multi-center sepsis (WHO & BU) 3. Standby-by antibiotic & resuscitation (BU, Zambia)	Effectiveness & program feasibility demonstrated	FY08	CHX: started Sepsis trial: planning Zambia: started	WHO (CAHD), GRA/JHU CRA/BU		
Newborn technology	1. Gentamicin in Uniject available for field trial 2. Delivery mechanism for CHX developed 3. Use of resuscitation devices evaluated in India and more widely available in Africa	FY 06 FY 08	Genta available in Jan '07 for field trial in '07 CHX: planning Resus: Ongoing	HealthTech		
Meta-analysis of global newborn data (30 countries)	Global status of newborn care assessed	FY 06	Started	MACRO		

2. **Introduction and expansion** will include technical leadership in mobilizing Mission support for newborn health programs; assisting Missions with the introduction of newborn interventions in a total at least 6 *new countries* by 2008; and *expanding* to a total of 18 *countries* with Mission support. **Sub-Total FY 06 Budget for Implementation: \$2.015 million.**

Activity Title	Expected result	End Date	Targets				Implementing mechanism	FY06 Budget (1000)	Total Budget (1000)
			FY05	FY06 (Actual)	FY07 targets	FY08 targets			
Technical leadership	Technical guidelines & materials developed	FY08	-	Started in 8 countries (Rwanda, Nigeria, Malawi, Cambodia, India, Afghanistan, Nepal, Bangladesh)*	Midterm (8 continuing and 1 new - Ethiopia)	Completed	ACCESS		
Introduction of newborn care into countries	ENC introduced in at least 12 new countries (at least 20% of one district)	FY08	3 new countries with FY 05 core funds and Mission funds	8 new countries with FY 06 core funds & Mission funds (Nepal, India, Kenya <sup>6</sup> , Mauritania, Togo, Cameroon, Niger, Rwanda/KMC)	7 cont'd with FY 07 core funds and Mission funds plus Cambodia	Continued	BASICS, ACCESS, QAP and mission co-funding		
Expansion of newborn care in countries	ENC expanded in 7 new countries (>1 district)	FY08	0	3 new countries with FY 06 core funds and Mission funds (Nigeria, Bangladesh, Afghanistan)	3 new & 3 continuing countries with FY 07 core funds and Mission funds (Nigeria, Bangladesh, Afghanistan, Cambodia, Malawi, Rwanda)	TBD	ACCESS, & co-funded by Missions		

\* Examples include: “Opportunities for Africa’s Newborns,” the KMC training manual, “Demystifying Community Mobilization for EMNC”, etc.

<sup>6</sup> Kenya was covered through work under the ACCESS-FP associate award.

**PROGRESS FOR ACCESSS OPERATIONAL PLAN INDICATORS**

Operational Plan Indicator	FY 06 Funding (October 2006 to September 2007)	
	Target	Actual
1. Number of people trained in research with USG assistance	0	0
2. Number of people trained in maternal and/or newborn health and nutrition care through USG-supported programs	3360	4499
3. Number of baselines studies or feasibility studies prepared by USG	0	5 Rwanda Baseline Facility Survey on Maternal and Newborn Care; Nigeria Baseline Household and Facility Surveys on Maternal and Newborn Care; Nepal Kangaroo Mother Care Baseline Study, India Baseline Household Survey on Maternal and Newborn Care; Uganda FANC/MIP Baseline Facility Survey
4. Number of special studies	0	3 Nepal SBA Policy study, Nigeria Qualitative Equity Study, Afghanistan Community-based Prevention of PPH study
5. No. of countries with introduction of PPH prevention	6	8 Countries: Cameroon Mauritania, Niger, Togo, Democratic Republic of the Congo, Nepal, Nigeria, India
6. No. of countries with expansion of PPH prevention	6	1 Countries: Afghanistan <sup>7</sup>
7. No. of countries with introduction of NB care	5	8 Countries: Nepal, India, Cameroon, Mauritania, Togo, Niger, Rwanda
8. No. of countries with expansion of newborn care	0	3 Countries: Nigeria, Afghanistan, Bangladesh <sup>8</sup>
9. Number of countries with Introduction of other HIDN pathway interventions: Focused antenatal care and prevention of malaria in pregnancy	0	4 Uganda, India, Kenya, Zambia
10. Number of countries with expansion of other HIDN pathway interventions: Focused antenatal care and prevention of malaria in pregnancy	0	4 Tanzania, Madagascar, Burkina Faso, Nigeria
11. Total amount of core funding \$3,847,350		MCH \$3.617,350 ( Rwanda, Tanzania, Ghana, Ethiopia, India and Nepal) Malaria \$100,000 (reginal) FP/RH \$130,00 (Haiti)
12. Total amount of Mission funding \$19, 63, 158		MCH \$ ? Malaria ? HIV/AIDS ?

<sup>7</sup> Associate Award,.

<sup>8</sup> Field Support