

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

ACCESS

YEAR THREE SEMI-ANNUAL REPORT

1 October 2006–31 March 2007

Submitted to:
United States Agency for International Development
Under Cooperative Agreement #GHS-A-00-04-00002-00

Submitted by:
JHPIEGO in collaboration with
Save the Children
Constella Futures
Academy for Educational Development
American College of Nurse-Midwives
Interchurch Medical Assistance

Submitted: April 2007
Revised: June 2007



TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS	III
I. PROGRAM HIGHLIGHTS	1
Introduction	1
Major ACCESS Achievements.....	2
Challenges	8
Opportunities.....	9
II. DETAILED PROGRAM ACHIEVEMENTS: CORE FUNDS	12
Global Partnerships	12
Country-level Activities.....	15
ACCESS Small Grants	19
Malaria Action Coalition	20
III: DETAILED PROGRAM ACHIEVEMENTS: COUNTRY FIELD FUNDS.....	33
Afghanistan	33
Bangladesh.....	36
Cambodia.....	41
Haiti.....	42
Kenya.....	45
Nepal.....	48
Nigeria.....	53
Tanzania	55
IV. DETAILED PROGRAM ACHIEVEMENTS: REGIONAL INITIATIVE FIELD FUNDS	61
AFR/SD	61
Malaria Action Coaliton	62
West Africa.....	64
ANNEX A: ACCESS PROGRAM COVERAGE MATRIX	1
ANNEX B: ACCESS GLOBAL M&E FRAMEWORK WITH RESULTS	5
ANNEX C: COUNTRY AND REGIONAL INITIATIVE M&E FRAMEWORKS WITH RESULTS	23
ACCESS/Afghanistan Monitoring and Evaluation Framework- Service Support Project (SSP) Associate Award	23
AFR/SD Monitoring and Evaluation Framework	31
ACCESS/Bangladesh Monitoring and Evaluation Framework.....	33
ACCESS/Haiti Monitoring and Evaluation Framework	48
ACCESS Nepal Monitoring and Evaluation Framework	53
ACCESS Nigeria Monitoring and Evaluation Framework	55
ACCESS TANZANIA Monitoring and Evaluation Framework.....	67
ACCESS WARP Monitoring and Evaluation Framework.....	71

ABBREVIATIONS AND ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
ACNM	American College of Nurse-Midwives
AED	Academy for Educational Development
AMA	Afghan Midwives Association
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ANE	Asia and the Near East
ANM	Auxiliary Nurse Midwives
ART	Antiretroviral Therapy
ARV	Antiretroviral
AWARE-RH	Action for West Africa Region-Reproductive Health
BASICS	Basic Support for Institutionalizing Child Survival
BEmONC	Basic Emergency Obstetric and Newborn Care
BPHS	Basic Package of Health Services
CAG	Community Action Group
CDC	Centers for Disease Control and Prevention
CHAK	Christian Health Association of Kenya
CM	Community Mobilization
CMT	Core Management Team
CORE	The Child Survival Collaborations and Resources Group
CORP	Community-Owned Resource Person
CSM	Community Supervisor Mobilizer
CT	Counseling and Testing
CTO	Cognitive Technical Officer
DRH	Division of Reproductive Health
EMNC	Essential Maternal and Newborn Care
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
EOC	Essential Obstetric Care
EPI	Expanded Program for Immunization
ESD	Extending Service Delivery
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FBO	Faith-Based Organization
FCHV	Female Community Health Volunteer
FHD	Family Health Division

FMOH	Federal Ministry of Health
FP	Family Planning
HIDN	Health, Infectious Diseases and Nutrition
IEC	Information, Education and Communication
IMA	Interchurch Medical Assistance
IMAI	Integrated Management of Adult Illnesses
INHSAC	Institute for Health and Community Action
IP	Infection Prevention
IPT	Intermittent Preventive Treatment
IR	Intermediate Result
ITN	Insecticide-Treated (bed) Net
IUD	Intrauterine Device
KMC	Kangaroo Mother Care
LAC	Latin America and Caribbean
LBW	Low Birth Weight
LGA	Local Government Areas
LRP	Learning Resource Package
LTTA	Long-term Technical Advisor
M&E	Monitoring and Evaluation
MAC	Malaria Action Coalition
MCH	Maternal and Child Health
MIP	Malaria in Pregnancy
MIS	Management Information System
MNC	Maternal and Newborn Care
MNH	Maternal and Newborn Health
MNPI	Maternal and Neonatal Program Index
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MPWG	Malaria in Pregnancy Working Group
MSPP	Ministère de la Santé Publique (Haitian MOPH)
MWRA	Married Women of Reproductive Age
NASCOP	National AIDS and STI Control Program
NFHP	Nepal Family Health Program
NGO	Nongovernmental Organization
NMCHC	National Maternal and Child Health Center
NMCP	National Malaria Control Program
OP	Operational Plans

PAC	Postabortion Care
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Center/Primary Healthcare
PHMT	Provincial Health Management Team
PITC	Provider Initiated Counseling and Testing
PMI	President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
POPHI	Prevention of Postpartum Hemorrhage Initiative
PPG	Performance-based Partnership Grants
PPH	Postpartum Hemorrhage
PQI	Performance and Quality Improvement
PY	Program Year
RAOPAG	West Africa Network against Malaria during Pregnancy
RBM	Roll Back Malaria
RCLS	Network of Religious Leaders to prevent HIV/AIDS
RFA	Request for Application
RH	Reproductive Health
RPR	Rapid Plasma Reagin (a rapid test for syphilis)
SBA	Skilled Birth Attendance/Attendant
SBAI	Safe Birth Africa initiative
SBM-R	Standards-Based Management and Recognition
SIP	Syphilis in Pregnancy
SM	Safe Motherhood
SMA	Social Mobilization Advocacy
SMM	Safe Motherhood Model
SMOH	State Ministry of Health
SNL	Saving Newborn Lives
SP	Sulfadoxine-Pyrimethamine
SSP	Service Support Project
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TBA	Trained Birth Attendant
TERREWOD	Re-orientation and Rehabilitation of Teso Women for Development
TIMS	Training Information Monitoring System

TOT	Training of Trainers
TT	Tetanus Toxoid
UMMB	Ugandan Muslim Medical Bureau
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPMB	Ugandan Protestant Medical Bureau
URC	University Research Corporation
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
WHO	World Health Organization
WHO/AFRO	WHO/Regional Office for Africa
WHO/SEARO	WHO/Regional Office for South-East Asia
WIRB	Western Institutional Review Board
WRA	White Ribbon Alliance

I. PROGRAM HIGHLIGHTS

INTRODUCTION

The Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS) Program is now in its third year of implementation and is making significant progress in advancing policies and implementing programs at scale in maternal and newborn health (MNH). ACCESS is a five-year, \$75 million Leader with Associate award to JHPIEGO and partners Save the Children, Academy for Educational Development (AED), American College of Nurse Midwives, Constella Futures, and Inter Church Medical Assistance. ACCESS began in July 2004 and is currently active in 25 countries. Bangladesh, Afghanistan, Nepal, Cambodia, Tanzania, Rwanda, Kenya and Nigeria have large, multi-year programs funded either with field funding or through associate awards. To date, the ACCESS Leader Program has received three associate awards. The ACCESS-Family Planning (FP) and ACCESS/Afghanistan associate awards both have ceilings of \$20 million. During this reporting period, the associate award in Cambodia was negotiated. Three other important ACCESS programs were initiated—the Safe Birth Africa Initiative in Rwanda and program development started for MNH activities in Malawi and Ethiopia.

The report presents the key achievements of the ACCESS Program during the period from 1 October 2006 to 31 March 2006. This “Program Highlights” section of the report provides an overview of some of the key program results during the reporting period and is organized by four results 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) Antenatal Care (ANC); 3) Postpartum Hemorrhage (PPH); and 4) Newborn Care. These four pathways are linked with, and complementary to, the ACCESS Program’s five intermediate results (IRs). The results 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. At the end of this section, there is a discussion of the challenges the Program has faced over this reporting period, the strategies pursued to overcome them, and emerging programmatic opportunities.

More detailed discussion of the achievements and the 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 IR and activity) and Sections III and IV have field-support funded results (organized by country and regional initiative, respectively).

Several annexes also accompany this report. In Annex A, 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. Annexes B and C capture results achieved at the global and country/regional levels through a “status update” for indicators included in the Program’s global and country/regional monitoring and evaluation frameworks.

MAJOR ACCESS ACHIEVEMENTS

Skilled Birth Attendance

Core funds

- ACCESS contributed to the World Health Organization's (WHO) technical meeting on post partum hemorrhage.
- Disseminated the message of the Lancet Special Supplement on Maternal Survival globally through webcast and for over 180 participants in Washington DC by supporting USAID for the U.S. launch of Lancet Series on October 5, 2007.
- ACCESS continued support for the technical advisor to the Partnership for Maternal, Newborn, and Child Health (PMNCH) who is assisting with the implementation of their global activities.
- In **Rwanda**, ACCESS and in-country partners developed a strategic approach for the Safe Birth Africa initiative (SBAI) and initiated start up of the baseline assessment and planning for the national-level meeting to launch SBAI and the Rwanda version of the Road Map.
- Mobilized additional resources for skilled attendance at birth (SBA) from the Ministry of Jharkhand in **India**. ACCESS partner in India, CEDPA, received a check from the Ministry of Health (MOH) of Jharkhand to procure equipment and supplies for the core-funded operations research study in Jharkhand.
- In Jharkhand, **India**, pilot testing of MOH plan to improve SBA skills and increase their utilization is under way in Dumka District. Site assessment and strengthening completed at two Dumka facilities and training of auxiliary nurse-midwives (ANMs) begun.
- Global Health's Postpartum Care e-learning course was completed by an estimated 96 users.
- 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 maternal newborn health at a WRA regional workshop for National Alliance members held in Malawi in October 2006.

Regional: AFR/SD

- Fourteen midwives trained to serve as pre-service midwifery educators in **Ethiopia, Ghana, Malawi and Tanzania**. A Clinical Training Skills/Instructional Design course was carried out in Addis Ababa in January 2007. This training included a two-day computer-based course entitled "ModCal (Modified Computer Assisted Learning) for Clinical Training Skills."
- 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. Their MNH knowledge and skills were assessed through knowledge surveys and clinical observations using anatomic models. All four tutors performed the essential skills in maternal and newborn care competently. The tutors are working to apply their training skills in the education of preservice students.

Regional: West Africa Funds

- 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 emergency obstetric and newborn care (EmONC) in November 2006.
- The Regional Hospital Center in the Sokode district, **Togo**, was strengthened to serve as an EmONC clinical training site.
- Community action plans, which include social mobilization, were developed in 18 health zones in **Cameroon**. These community liaison teams conducted auto-diagnostic participatory sessions with community members.

Field Funding

- In **Nigeria**, the ACCESS program is in full implementation and the baseline household survey and the health facility survey were completed. These surveys confirmed that problems of access, quality of services, and socio-cultural factors hinder the utilization of MNH care services. Preliminary analysis of the baseline household survey of 414 women who delivered in the past 12 months conducted in Kano and Zamfara states found that:
 - 48% of women in Kano and 35.3% 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 19% of the women received childbirth assistance from a nurse/midwife and 20% from a traditional birth attendant. 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. Less than 1% received assistance from a medical doctor.
- Performance standards for EmONC, including PPH, in hospitals and primary health centers were developed in collaboration with the Departments of Hospital Services and Community Development Activities of the Federal Ministry of Health (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.
- ACCESS **Nigeria** conducted workshops in EmOC, Kangaroo Mother Care (KMC) and Standards-Based Management and Recognition (SBM-R) quality improvement. ACCESS also strengthened the existing facility-based maternal and newborn recordkeeping system in the two program states.
- USAID/**Cambodia** granted ACCESS an associate award for maternal and newborn health on 15 December 2006. The Long-Term Technical Advisor has had strategic planning meetings with USAID Cambodia, the MOH and other local partners and has prepared a detailed workplan.

- In **Nepal**, a maternal and newborn care learning resource package (LRP) for SBA for in-service and pre-service training for auxiliary nurse midwives, nurses and doctors was finalized.
- ACCESS completed a study in rural **Nepal** on factors that contribute to the successful utilization of SBA services last year. Analysis of the data this year revealed:
 - Most women preferred a home delivery and reserved attendance at a facility only for complications. This was due to the high costs of transportation to the facility, facility fees and negative perceptions of facility staff.
 - Facility staff said the lack of providers inhibited the availability of services and that they lacked training, equipment, drugs, decent housing, professional advancement opportunities and education for their children.
 - Facility factors that may be associated with high volume of delivery services include “24/7” services/staffing, availability of basic emergency obstetric care; easy access; a referral system and/or ambulance; dynamic facility leader, energetic community collaboration; and employment of local personnel.
- At a national workshop and at the national annual program review meeting of the Family Health Division, stakeholders identified potential applications of study findings that would be used to inform 1) behavior change communication programs and approaches; 2) management of ANC & delivery services; and 3) for further research and other implications for health policies.
- In **Afghanistan**, the Service Support Project’s (SSP) 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.
- Capacity of NGOs is being improved to deliver the BPHS services in **Afghanistan** through training and workshops in the rational use of drugs; monitoring, supervision and evaluation; basic EmOC; effective teaching skills; identification of gender indicators; and provincial capacity building.
- On 8 October 2006, SSP collaborated with the Ministry of Public Health (MOPH) and the Afghan Midwives Association (AMA) on the first national Safe Motherhood Day of **Afghanistan**, with the slogan “Pregnancy and Childbirth is Special, Let’s Make it Safe.”
- 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. The theme was “Advocating for Home-based Lifesaving Skills.”

Prevention of Postpartum Hemorrhage

Core Funds

- 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**). Six of the grantees submitted their first deliverable, which included training and publications for technical and branding review.
- In **Kenya**, an assessment of the national policies, service delivery guidelines, and pre-service and in-service education curricula for gaps relating to prevention and treatment of PPH is under way

and will inform advocacy and policies based on internationally accepted evidence-based information. With ACCESS support, a technical advisory group (TAG) has also been set up that engages MOH officials, pre-service and in-service education stakeholders, medical and nursing/midwifery council and association representatives around national policy and regulatory issues for PPH.

- Provided technical guidance on WHO's statement on addressing PPH at the facility and community levels. Harshad Sanghvi, JHPIEGO Medical Director, participated in the technical expert panel held in Geneva in October 2006 to review the key research findings and develop recommendations for WHO.
- Global Health's Preventing PPH e-learning course was completed by an estimated 67 users.
- ACCESS members chair the Prevention of Postpartum Hemorrhage Initiative (POPHI) technical working groups on community-based PPH and training. In March 2007, Harshad Sanghvi served as a technical expert at a WHO-sponsored technical meeting that led to a statement on community-based PPH using misoprostol.
- In **Cambodia**, ACCESS began planning with the MOH for demonstration activities related to AMTSL and community-based distribution of misoprostol that would inform approaches of possible scale-up of the intervention. A follow-up technical update on PPH in Cambodia is scheduled for May.

Field Funds

- Midterm evaluation data from the community-based Prevention of PPH pilot project in **Afghanistan** presented to the Afghanistan PPH Technical Advisory Group demonstrated the use of misoprostol to prevent PPH during home births is safe, acceptable, feasible and programmatically effective. The MoPH informed ACCESS that it wants to take the intervention to scale on a national level. The midterm evaluation will be finalized soon, but preliminary data show that ACCESS of the 570 postpartum interviews conducted, 556 (98%) of women accepted misoprostol during the eighth month antenatal visit, 372 (65%) took the drug in accordance with their instructions and 180 (32%) received an injectable uterotonic at a health facility, which equal 97% of the 570 women received a uterotonic drug to prevent PPH. Only 3% of women did not receive an uterotonic as compared to 74% of women in the control site.

Newborn Care

Core Funds

- Global Health's Essential Newborn Care (ENC) e-learning course was completed by an estimated 122 users.
- ACCESS began work with the MOH to introduce and expand KMC for low birth weight infants in **Nepal**. In March, a Training of Trainers (TOT) took place for trainers from the MOH, private hospitals and training institutions, including service providers from health facilities in Kanchanpur and Kailali. KMC services were initiated in two facilities— Kailali District Hospital and Kathmandu Medical College. This activity complements the field-funded community-based KMC activities.

- 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 this report.
- ACCESS joined a working group to develop the WHO/UNICEF Joint Statement on community-based postnatal newborn care.
- In **Rwanda**, ACCESS is developing ENC and KMC activities as part of the SBAI.

Regional: ANE Funds

- ACCESS is collaborating with USAID, Extending Service Delivery, WRA, and other partners in developing technical sessions on MNH for the Asia regional technical meeting planned to take place in Bangkok in September. ACCESS is participating in planning the Regional ANE meeting as is coordinating most of the maternal and newborn health sessions.

Regional LAC Funds

- ACCESS, in collaboration with PAHO, USAID, BASICS, the CORE group and ministries of health in Latin America, disseminated the Regional Strategy and Plan of Action on Neonatal Health within the Continuum of Maternal, Newborn and Child Care in preparation to share at the upcoming Latin America regional meeting on newborn health.

Field Funds

- In **Nepal**, ACCESS used field funds to complement Core-funded KMC activities:
 - In one district in Nepal, a program to identify and manage low birth weight (LBW) infants at the community level is being implemented with the Nepal Family Health Program (NFHP) and the MOH. From January to February this year, a total of 176 newborns were identified as LBW (150) or very LBW (26) by female community health volunteers (FCHVS). Of the FCHVs observed, 80% properly used KMC.
 - National LBW management guidelines were developed in collaboration with a national technical advisory group in Nepal
- In **Bangladesh**, a program to scale up community MNH interventions is being implemented in the Sylhet district. It covers seven sub-districts with a population of 1,443,841. Community mobilization training of ACCESS counselors and resource mapping of health services in the district were completed.

Antenatal Care Pathway

Core Funds

- Global Health’s Antenatal e-learning course was completed by an estimated 137 users.

Core MAC Funds

- ACCESS provided technical support to **Uganda** to strengthen focused ANC services including malaria in pregnancy (MIP) targeting three faith-based organizations (FBOs) and the MOH. ACCESS technical 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. Intermittent preventive treatment (IPT) 1 increased from 43% to 94% and IPT2 uptake increased from 63% to 76%. Pregnant women who received/purchased an insecticide-treated bednet (ITN) increased from none to 27%.

- ACCESS supported the Secretariat for the Roll Back Malaria—Malaria in Pregnancy working group meeting held in Nigeria from October 10–12, 2006.
- ACCESS is 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 President’s Malaria Initiative (PMI).

Field Funds

- In **Tanzania**, ACCESS continued to scale up clinical training, service delivery and quality improvement capacity for focused ANC/MIP in government- and FBO-affiliated health facilities and midwifery schools. Availability of focused ANC was expanded through newly trained health facility providers from six regions and 26 Zonal and Regional Reproductive and Child Health Coordinators from all zones.
- At 54 ACCESS-supported facilities in **Tanzania** during this reporting period, over 10,000 ANC clients accessed IPT 1 (58%) and over 8,500 ANC clients received IPT 2 (50%). Close to 11,000 ANC clients received tetanus toxoid (TT) 2 (63%) and about 15,000 received ITN vouchers (86%).
- ACCESS finalized the Pre-Service Learning Resources Package in **Tanzania**, which will, for the first time, help ensure that nursing and midwifery students in different classes and schools will share a common curriculum around focused ANC/MIP.
- In **Kenya**, ACCESS developed Tuberculosis (TB)/ANC training materials, building on the existing JHPIEGO focused ANC training package. This package is being implemented at key clinical training sites.
- Since October 2006 at seven ACCESS-supported facilities in **Haiti**, Prevention of Mother-to-Child Transmission of HIV (PMTCT) providers counseled and tested 6,072 pregnant women. Of these women, 3.8% were HIV+ and 63% of those who tested positive were enrolled in the PMTCT program. Of those newborns with HIV+ mothers who were delivered at the facilities, 93% received antiretroviral (ARV) prophylaxis at birth.
- ACCESS donated, through its partner Interchurch Medical Assistance (IMA), about \$100,000 worth of equipment and supplies to 20 health facilities in **Haiti**. Another \$60,000 in equipment, drugs and supplies was donated by IMA and shipped to Haiti in March 2007.
- In **Haiti**, ACCESS continued to build the capacity of the Institute for Health and Community Action (INHSAC), a local training organization, by providing assistance to them to conduct a PMTCT training for service providers.

Other Access Results (Women’s health such as fistula and family planning)

Core Funds

- Two obstetric fistula grantees, one in Uganda and one in Niger, raised awareness of fistula in their target communities. In Niger, Ong Dimol completed community sensitization work and used drama presentations to inform the largely illiterate population about the causes, consequences and potential prevention of fistula. The small grant the Ugandan Private Midwives Association received for fistula prevention resulted in 30 midwives with improved communication techniques for engaging in discussions with communities regarding fistula prevention. In addition, 2,895 people in communities and schools in Uganda were reached with outreach activities in the targeted districts.

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**, which has been successfully used to train 98 providers.

Field Support Funds

- In Kenya, an endline survey conducted by ACCESS revealed that contraceptive uptake increased an average of 15% in the three districts where ACCESS provided technical support for FP aimed at facilities. This is a remarkable increase—the target was set at only 5% by the MOH and the Implementing Best Practices consortium in Kenya.
- The ACCESS Kenya program supported the National AIDS and Sexually Transmitted Infection (STI) Control Program in the development of provider-initiated counseling and testing (CT) training materials, which have now been adopted as part of the national HIV training materials in Kenya.
- In Kenya, ACCESS supported the rollout of integrated management of adult illnesses for HIV, including: a training of trainers to develop competency, and advocacy and planning meetings with all target provinces (Easter, Central and Nairobi). This effort supported the National AIDS, STI Control Program’s strategy to address care and support with antiretroviral therapies (ARTs).
- ACCESS/Kenya worked closely with the DRH and the National AIS and STI Control Program (NASCOP) to strengthen supervision for PMTCT services, producing a supervision manual for PMTCT services.
- In Haiti, ACCESS developed a core group of intrauterine device (IUD) trainers who will be training providers at target sites in long-term family planning methods to help revitalize use of these methods.

EXPANDED PROGRAM REACH FOR ACCESS

Cambodia, Malawi, Ghana and Ethiopia have been added to the ACCESS portfolio this year as countries to expand MNH activities.

- In Cambodia, ACCESS began implementing a program to strengthen PPH, newborn health and SBA activities

- In Ghana, a program to improve SBA training and coverage that is being implemented in collaboration with the MOH is now under way
- In Malawi, a MNH program is being developed to support the government of Malawi's Road Map for Safe Motherhood. Initial work using core funds has started to support the strengthening of pre-service and in-service curricula for basic emergency obstetric and newborn care (BEmOC).
- In Bangladesh, the USAID Mission has requested ACCESS to add some complementary interventions to strengthen community-based services and to expand the program through 2011. ACCESS is working with the Mission on this revised workplan.
- ACCESS also submitted a concept paper to USAID Ethiopia with proposed activities to build the capacity of key Ethiopian institutions charged with training health officers and health extension workers in essential MNH care.

CHALLENGES

Continuing growth while Program Prepares for Year Four

ACCESS has seen a remarkable growth in the last two years. The program has expanded from working in a few countries to current activities spanning over 25 countries. This expansion reflects a tremendous growth in field support from USAID Missions and a redirection of core funds into country specific activities such as SBAI. Concomitantly, it has demanded an increase in hiring staff overseas for the field programs with a limited growth in Baltimore. Moreover, as some of the Missions are envisioning multi-year programs, ACCESS has to evaluate the implications of new resources given the end date of the program and the program ceiling. ACCESS is already discussing these details with the CTO to develop the best response for the Missions in their efforts to impact maternal and neonatal mortality in their country.

Staffing

With the growth of the program, there is continuous need to match human resource capacity within the program to growing demands from program expansion. ACCESS successfully recruited for the director of field programs and the senior program officer positions based in Washington. However, as with any large program, there are continuous staff transitions and changes. ACCESS is currently preparing for a transition of a key staff to the field, and will be discussing optimal options with USAID 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 financial system went live. While in the long run, this system should have great benefits in improving generation of reports and improving efficiencies within the system, the initial period has required a learning curve. The ACCESS administrative and finance staff are working diligently with partners and USAID to continue to manage financial reporting and to assure the financial systems respond to program needs. We firmly believe that this system will be efficient and responsive within the six-month period.

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 our ability to implement the full extent of the programs and often causes delays. However, our focus on building in-country capacity to implement programs has allowed ACCESS to continue activities even during the periods of political unrest and travel bans.

USAID Operational Plans

During the past year, USAID has instituted the operational plans (OP), which is a new tool to assist in planning and tracking, in a unified manner, all US Foreign Assistance funds to all US operating units. ACCESS has worked closely with our USAID CTO and the USAID Missions to assure that the ACCESS activities are linked to appropriate OP indicators. ACCESS, with our USAID and other cooperating agency colleagues, has provided input to this process so that these indicators can monitor concrete achievements in MNH. ACCESS continues to use the Performance Monitoring Plan to document information on program capacity building, service delivery and quality improvement.

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 in Malawi and Ethiopia, are just starting in year three.

Developing New Associate Awards

ACCESS currently 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. The BASICS program in Cambodia has said they would like to work with AED to develop a similar mechanism for their long-term advisor. In Malawi, we anticipate a very quick startup, 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 monitoring and evaluation (M&E) skills to country programs to enable them to provide results, not just in numbers trained but also in terms of population coverage. We hope that this information would be valuable to USAID and our field programs to demonstrate tangible results over the life of the program.

II. DETAILED PROGRAM ACHIEVEMENTS: CORE FUNDS

ACCESS continues to use core funds to maintain its role as a global leader in MNH. In addition, ACCESS invests core funds in activities implemented in specific countries in order to create impact on MNH at the country level. A summary of core-funded activities is below.

GLOBAL PARTNERSHIPS

ACCESS maintains its global leadership position through activities that include collaboration with WHO, support to the WRA and MotherNewBorNet, engagement of FBO health networks, and production and dissemination of MNH tools and resources.

ACCESS completed the first steps in revising the WHO IMPAC series manual “Managing Complications in Pregnancy and Childbirth.” In collaboration with WHO’s Making Pregnancy Safer Unit, ACCESS developed and distributed a user’s survey to gather feedback from the global community of providers that will inform the revision of the manual. ACCESS also joined with partners including WHO, UNICEF, Save the Children/SNL, and BASICS to collaborate on a joint statement on community-based newborn health that will be used to advance commitment to scaling up community-based newborn health interventions. UNICEF and Save the Children are leading this effort, with ACCESS available to provide technical input as required.

ACCESS assisted USAID with the U.S. launch of the Lancet Special Supplement on Maternal Survival in Washington, D.C. on October 5, 2006. Over 200 participants, comprised of a variety of stakeholders in maternal health, including policy makers, implementers, advocates and clinicians, attended the launch. In presenting the series, two of the authors, Marge Koblinsky, of ICDDR, and Carine Ronsmans, of the London School of Health and Tropical Medicine, stated the immediate priority for governments and donors should include investment in the training, deployment and retention of skilled attendants, especially midwives. Koki Agarwal, of ACCESS, Lynn Freedman of Columbia University, Ann Starrs of Family Care International and Anne Tinker of Save the Children comprised the panel of speakers. The Woodrow Wilson Center webcast the event, live, to a global audience and is still available for viewing on their website. Since the event, 45 people have accessed the webcast.

Through ACCESS’ support of a technical advisor to the Partnership for Maternal, Newborn and Child Health (PMNCH), the PMNCH successfully raised funding to support implementation of their global activities. The technical advisor was instrumental in the PMNCH receiving funding from GTZ, MacArthur Foundation, Gates Foundation, the Government of Norway and the World Bank. The technical advisor assisted the PMNCH to finalize a staffing plan and assist in organizing for the Partner’s Forum in Tanzania in April 2007.

ACCESS continued its work on POPPHI’s Training Task Force and together is working to formulate a training package on AMTSL. The Training Task Force is preparing a draft for external review. ACCESS continues to be involved in the PPH Working Group and leads the community-based PPH task force.

White Ribbon Alliance

Through ACCESS' support, the WRA held a regional workshop for National Alliance members from Tanzania, Zambia, Malawi and South Africa in Lilongwe, Malawi in October 2006. The workshop intended to aid National Alliances in prioritizing issues, identify new evidence and best practices related to key MNH interventions, and provide technical assistance for action plans for the dissemination of evidence, promotion of best practices and advocacy in their countries.

Technical updates were led by members of the National Alliances, drawing on the expertise within the membership, such as ACCESS work on focused ANC in Tanzania and saving newborn lives (SNL) approaches to newborn care in Malawi. The workshop included a special emphasis on the human resources crisis and its effect on MNH. Key strategies, including new strategies by the MOH in Malawi, were presented and debated.

The four national alliances developed specific action plans around one of the following key interventions: focused ANC, prevention of PPH, newborn care, skilled attendance at birth and fistula. With added support from the Health Policy Initiative-Task Order 1, each national alliance received a small grant to facilitate a meeting with their broader in-country membership to finalize the action plan and encourage broader buy-in from their membership. The focus areas are:

Zambia—fistula and SBA

South Africa – PPH

Tanzania – SBA and newborn care (through home-based life saving skills)

Malawi – focused ANC

WRA/Tanzania has continued building on their advocacy efforts around increasing the number of qualified health personnel as a strategy to increase deliveries with a SBA and reduce maternal and newborn mortality and morbidity. WRA/Tanzania introduced home-based life saving skills to their membership and the MOH and other partners have adopted and translated the manual. It was launched at White Ribbon Day in March 2007.

MotherNewBorNet /Asia Regional Technical Work on MNH

The MotherNewBorNet collaborates with bilateral projects in the Asia region to strengthen community-based postpartum maternal and newborn programs to improve maternal and neonatal health outcomes. The ACCESS deputy director met with the MotherNewBorNet Secretariat in Bangladesh in November to plan for the annual MotherNewBorNet meeting, with inquiries made to USAID Nepal and USAID Indonesia to host this meeting. In January, however, the USAID ANE Bureau decided to support a regional ANE meeting on best practices in Asia in place of the MotherNewBorNet meeting. ACCESS is collaborating with the Extending Service Delivery (ESD) Project, the University Research Corporation (URC) and USAID to plan the meeting. ACCESS is leading the development of the technical agenda for maternal and newborn health for the meeting.

Faith-Based Organization Work in Maternal and Newborn Health

ACCESS continues to expand its partnerships with FBOs to strengthen their MNH care delivery capabilities, advocacy for safe motherhood, while advocating scale up of MNH services through FBOs. The ACCESS FBO coordinator met with representatives from the World Council of Churches and WHO to discuss a joint statement for furthering Millennium Development goals 4–6

through intentional engagement with FBOs, especially in Africa. The joint statement between WHO and several Christian Health Associations, e.g. Ugandan Protestant Medical Bureau (UPMB), Ugandan Muslim Medical Bureau (UMMB), Christian Health Association of Kenya (CHAK), and Eglise du Christ au Congo in Africa will provide a unified voice for FBOs in their advocacy efforts to improve MNH services.

ACCESS is working with the CHAK to roll out MIP and PMTCT interventions in selected region(s) using the platform of focused ANC in both facility and community programs. This project will do the following: 1) increase uptake of IPT; 2) increase use of ITNs among pregnant women; 3) improve capacity among providers to deliver comprehensive ANC services; and 4) increase number of pregnant women receiving ANC in the first trimester. Twenty-five health providers from 22 facilities from the Nyanza and South Rift Regions participated in a sensitization workshop on MIP and PMTCT.

Dissemination of Tools and Resources

ACCESS has continued disseminating evidence-based maternal and newborn materials, tools and approaches at the global and country levels. ACCESS staff co-authored chapters in the “Opportunities for Newborns in Africa,” a regional review of newborn health in Africa and supported the publication and dissemination of this report. ACCESS has finalized, printed and disseminated several publications and tools, including, “Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health,” and the Pregnancy Wheel, a tool to assist focused ANC providers. With ACCESS support, the WRA has printed and disseminated 50 copies of their guide “Building, Maintaining and Sustaining WRA National Alliances: A Field Guide.” ACCESS continues disseminating materials through its partner to their field officers and through international meetings.

ACCESS collaborated with partner organizations—the Pan American Health Organization (PAHO), BASICS and CORE—to finalize the Regional Newborn Strategy, according to PAHO parameters, and aid in dissemination of the document. The executive committee of PAHO approved a resolution, permitting submission of the strategy to the directors’ council, during their meeting in late 2006, where it was approved. It will be shared at the new proposed dates for the consultation on newborn health regional plan of action in August. The Regional Newborn Strategy in each of the four PAHO languages (English, Spanish, French and Portuguese) will be disseminated within countries where input has been provided. ACCESS has leveraged additional funds from Save the Children/SNL to complete this activity.

In an effort to make ACCESS materials available to a global audience, ACCESS continues to use technologies to include more MNH stakeholders in its dissemination activities through developing e-learning courses on the Global Health website and producing CD-ROMs to support existing training materials. With the support of ACCESS, POPPHI has translated the AMTSL CD-ROM into French and Spanish. The ACCESS website continues to act as a source of information sharing and through the dissemination of tools and materials. Since October 1, 2006, the ACCESS website has hosted 2,502 unique visitors and 3,562 visits to the ACCESS website.

ACCESS involvement in the Global Health e-learning courses has led to trained MNH stakeholders from many countries. ACCESS designed four online courses specifically for USAID Health,

Population and Nutrition Officers and their colleagues. From October 1, 2006 – March 31, 2007, an estimated 422 people completed and received certificates for the four ACCESS-developed courses:

- ANC – 137
- Essential Newborn Care – 122
- Postpartum Care – 96
- Preventing PPH – 67

Many others took the courses but did not complete the final evaluation to receive their certificates and so are not included in the numbers above.

Those taking the e-learning courses come from a diverse set of countries: Afghanistan, Azerbaijan, Australia, Bangladesh, Cambodia, Cameroon, Canada, Chad, Dominican Republic, Egypt, Fiji, Ghana, Guinea-Bissau, India, Iran, Iraq, Malawi, Nigeria, Pakistan, Republic of Moldova, Saudi Arabia, Somalia, South Africa, Tanzania, Turkmenistan, Uganda, Vietnam, Zambia and Zimbabwe.

ACCESS plans to introduce three additional e-learning courses to the Global Health website. The PMTCT course has been externally reviewed and the INFO Project is conducting a final review before opening the course to the general public. The Reducing Maternal Death and Disability course is nearly final and should go out for external review in April. The EmONC course is drafted and should go out for external review by June.

COUNTRY-LEVEL ACTIVITIES

In addition to maintaining its global leadership position, ACCESS has invested core funds in country-level community and clinically focused activities of varying size. In Rwanda, ACCESS is advancing the implementation of a USAID SBAI to bring measurable improvement at scale in SBA and postpartum/newborn care and coverage with selected proven life-saving interventions, such as AMTSL and essential newborn care, within three to five years. In India, core funds are supporting a program to support SBA at homebirth through training ANMs. Core funds in Cambodia will complement the ACCESS-Cambodia Associate Award and support a pilot project of community-based distribution of misoprostol. Other countries, such as Ethiopia, Malawi, Ghana and Tanzania, have core funds supporting smaller scale projects and the ACCESS small grant mechanism is supporting local organizations in focused ANC, fistula and prevention of PPH. Finally, ACCESS is providing leadership to the Malaria Action Coalition (MAC) and supporting MIP activities at the country-level

India

In India, the ACCESS program “Increasing Skilled Care for Pregnancy, Childbirth and Newborns in Dumka District, Jharkhand, India” project completed startup activities. These activities included: amending the CEDPA sub-contract; signing a memorandum of understanding (MOU) with the Government of Jharkhand; signing a sub-contract with Mohalpari Christian Hospital; competitively bidding and selecting a research agency; and signing a sub-contract with the research agency. The program successfully hired Dumka-based staff, completed district-level orientations and finalized the M&E plan.

From October 2006, technical assistance in Dumka strengthened the project's two clinical training sites. Initial assessments showed both sites had adequate caseload to support training, but clinical services required standardization according to evidence-based medicine and practices. Site strengthening was initiated and improvements were made. Draft training materials were adapted and translated into Hindi. At the national level, a TAG meeting was conducted to introduce the training materials and approaches. For community mobilization, an assessment of community needs and perceptions, as well as community interventions was conducted. An assessment of the local NGOs was conducted and the local NGO, Chetna Vikas, was selected as a partner in the ACCESS work.

Cambodia

USAID Cambodia provided ACCESS with a three-year associate award to improve availability and access to quality sustainable MNH services, leading to increased utilization of services and practice of healthy maternal and neonatal behaviors at scale. USAID granted the award in December 2006 and project startup in-country has commenced with the hiring and placement of the long-term technical advisor (LTTA) at the Cambodia MOH in February 2007. In this startup phase, the detailed workplan for program year one was developed and will be submitted to USAID/Cambodia in April 2007. ACCESS began discussions with the MOH to outline collaboration for an activity in the Year One workplan, which would provide office renovation to the National Maternal and Child Health Center at the MOH. An MOU was drafted and is currently being reviewed by the MOH and USAID/Cambodia. ACCESS utilized contractual mechanisms available under the Leader award to coordinate administrative support to the LTTA in-country through AED's A2Z project, which has an established presence in Cambodia and facilitated the rapid project startup from an administrative perspective.

The LTTA has conducted meetings with various stakeholders and partners in-country, including the MOH, USAID/Cambodia, and other key stakeholders, including UNICEF, UNFPA, DFID, CARE, RHAC, GTZ, World Relief, ADRA, JICA and RACHA, thereby positioning the project at an early stage to identify areas of collaboration and creating essential country-level partnerships. ACCESS was invited to join an informal working group to discuss the strengthening of neonatal health interventions. ACCESS had input into a presentation given to the Maternal and Child Health (MCH) sub working group by Dr. Tung Rathavy, Deputy Director of the National Maternal and Child Health Center (NMCHC) and Program Manager for Reproductive Health Services, on the need for more focus on neonatal health and, as a result of this presentation, the NMCHC Director agreed to form a specific neonatal technical working group. ACCESS intends to continue its role in the MOH technical working group, and to strengthen newborn health through existing strategies and services.

To complement the ACCESS-Cambodia Associate Award, ACCESS will use core funding to initiate AMTSL and community-based distribution of misoprostol through demonstration sites to show these interventions to be safe, feasible and acceptable in rural Cambodia and inform methods of possible scale up of the intervention. Short-term technical assistance was provided by ACCESS to assist with the startup of planning for this work and included setting dates and working on the objectives for a national level technical meeting, which will be the first essential step to gaining consensus and agreement from the MOH and other key partners.

Tanzania

In Tanzania, with technical assistance from headquarters, ACCESS worked together to design the technical update in nutrition for tutors in midwifery schools and a training of trainers module to be pre-tested with midwifery tutors. ACCESS is currently reviewing the literature on women's nutrition during pregnancy in Tanzania in order to address the informational gaps.

Kenya

In Kenya, an assessment of the national policies, service delivery guidelines, and pre-service and in-service education curricula for gaps relating to prevention and treatment of PPH is under way. The results of this assessment will inform advocacy with groups mentioned below to update policies based on internationally accepted evidence-based information. As this review moves forward, ACCESS/Kenya will identify one or more facility(ies) to strengthen in the area of PPH prevention and treatment and will carry out a technical update and clinical skills standardization for up to 20 providers who will go on to become trainers.

To engage pertinent stakeholders, ACCESS/Kenya has formed a TAG to include MOH officials, pre-service and in-service education stakeholders, medical and nursing/midwifery council and association representatives. Moving forward, the TAG will hold regular meetings to effect necessary policy and regulatory change, and to update all on progress of activities and steps to take at national level.

Rwanda

ACCESS and in-country partners finalized a joint workplan and the parameters of the baseline assessment. A MOU with the Rwanda School of Public Health was signed for them to conduct facility and community baseline assessments in ACCESS districts. Data collection tools have been finalized and translated. Training of data collectors and implementation of the assessment will take place in April 2007.

Administrative details and logistics have been finalized. ACCESS will share an office and administrative staff with Constella Futures. A long-term technical advisor was hired and relocated to Rwanda. Her first task will be finalizing a national-level meeting to launch SBAI and the Rwanda version of the Road Map. The ACCESS SBAI program will include a KMC component and ACCESS has discussed selection of sites and logistics for KMC activities with the chair of the Safe Motherhood Task Force. In addition, ACCESS is translating the draft KMC manual into French for use in Rwanda.

To support the FBO component of the SBAI, ACCESS' FBO Coordinator discussed with local FBOs opportunities to collaborate on a plan of action for mobilizing FBOs for advocacy and action. FBOs expressed interest in advocacy for safe motherhood as well as equipping both their facilities and the communities. ACCESS chose the Network of Religious Leaders to prevent HIV/AIDS (RCLS) as its point of entry within the FBO community because of their connection with religious leaders in Rwanda on HIV/AIDS prevention. With RCLS, ACCESS is exploring means of integrating SBAI messages in addition to FP to RCLS' existing interventions.

Ghana

ACCESS completed a few startup activities to assist the interventions to take place in April 2007. A tool was adapted to assist in monitoring, coaching and ensuring higher quality standard of care in the

select facilities of Birim North District in Eastern Region. The tool contains a component on the continuum of care between the community and the local health facility, either health center or the hospital. In February 2007, ACCESS tested the validity of the tool through a pilot test at a health center outside of the Eastern Region. A workshop was held for the staff and facilitators of this pilot project in Birim North from March 27 to March 29, 2007. The workshop trained the participants to use the tool and capture service statistics simultaneously. Participants developed an action plan for the targeted facilities and communities that the District Health Management Team will target with community outreach activities.

Malawi

At the end of 2006, ACCESS offered some limited core funds to USAID Malawi to support priority maternal and newborn health work. USAID Malawi then expressed an interest in using ACCESS to implement a larger maternal and newborn intervention with field funding. The initial core funds are being used to support the strengthening of pre-service and in-service curricula for BEmOC and to develop the long-term country program on MNH. ACCESS has placed a short-term midwifery advisor in Malawi to work with the in-country organizations already implementing programs and services that target MNH. The short-term midwifery advisor will work with the MOH and WHO to carry out national stakeholders meeting to develop joint implementation plan for in-service training of nurse midwife technicians in basic emergency obstetric and newborn care (BEmONC) and conduct a national forum of pre-service educators to discuss integration of new midwifery practices. She is also working with existing Performance and Quality Improvement (PQI) staff to review data from eight districts where Quality Assurance activities have occurred previously to determine strengths and weaknesses and lessons learned in process to date; and draft recommendations in expansion of SBM-R process to include BEmONC skills.

Africa Regional Pre-service Education in Ethiopia, Ghana, Malawi and Tanzania

ACCESS continued strengthening teams of midwifery tutors and clinical preceptors in Ethiopia, Ghana, Malawi and Tanzania. In January 2007, 14 midwife tutors from the four countries participated in a clinical training skills/instructional design course. After returning to their countries, each team is preparing draft lesson plans to use for the planned country-level training activities. The generic curriculum in essential and basic emergency obstetric and newborn care for midwives has been drafted and will be field tested during country-level activities. In the next phase of the project, ACCESS, in close collaboration with WHO/AFRO and the WHO country offices in each of the four countries, is selecting clinical sites that will be strengthened by the midwife tutors. Following the site strengthening, the four trained midwifery tutors, with support from ACCESS staff, will lead a two-week technical update and clinical skills standardization course for providers and other midwifery tutors.

Ethiopia

In addition to the pre-service education activity in Ethiopia, ACCESS is collaborating with the Ethiopian Society of Obstetricians and Gynecologists (ESOG) to update doctors, midwives and nurses skills in three facilities. In January 2007, Ambo Hospital was assessed and an action plan agreed upon by ESOG and Ambo Hospital staff. ESOG and Ambo hospital staff concluded the site strengthening process in March, prior to the start of two three-week technical update and clinical skills standardization courses for providers scheduled to complete by the end of May 2007.

Nepal

ACCESS is using core funds in collaboration with the MOH to introduce and expand KMC for LBW infants. The National KMC advisory group was formed and a two-day KMC sensitization workshop was conducted, which was attended by over 40 participants from MOH, NGOs, donors (UNICEF and USAID), and medical and nursing pre-service training institutions. A baseline needs assessment on KMC was conducted in two zonal hospitals and three primary health care facilities in two districts: Kanchanpur and Kailali. In March, a TOT took place for trainers from the MOH, private hospitals and training institutions, including service providers from health facilities in Kanchanpur and Kailali. KMC services were initiated in Kailali District Hospital and Kathmandu Medical College.

ACCESS SMALL GRANTS

ACCESS has awarded grants to in-country organizations to implement activities in obstetric fistula, focused ANC/MIP through FBO health networks, and prevention of PPH. Each set of grants is in a different stage of completion, with the obstetric fistula grants being the first to conclude.

Obstetric Fistula Grants: 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. In Niger, Dimol completed its community sensitization work in April and used drama presentations to sensitize the largely illiterate population to the causes, consequences and potential prevention of fistula. In Uganda, the Ugandan Private Midwives Association completed the milestones for their fistula prevention small grant. The results included a survey of 15 midwives regarding knowledge of causes, consequences and prevention of fistula, one sensitization workshop for 30 midwives on communication techniques with communities regarding fistula prevention, and outreach activities reached 2,895 people in communities and schools within the targeted districts.

The Association for the Re-orientation and Rehabilitation of Teso Women for Development (TERREWOD) in Uganda, was granted a no-cost extension through April 30, 2007 to finish activities. Accomplishments to date include: the selection of 54 women with fistula to be supported for repairs. An additional 25 women were selected and their repairs are pending. The MOH is collaborating with TERREWODE to provide support for these repairs. Through ACCESS support, more than 2000 community members were sensitized through community meetings and 20 district and health officials through advocacy meetings with district officials. Additionally, radio talk shows were aired to raise awareness about fistula.

FBO/Focused ANC-MIP: In Kenya, 15 providers from 10 FBO facilities were trained in focused ANC and prevention of MIP. In Uganda, a baseline assessment is under way and materials from the MAC-funded grants will be used during project implementation. Finally, in Tanzania the orientation of administrators and supervisors at the selected facilities is complete.

PPH Grants: Seven small grants were awarded in November 2006 in the following countries: Burkina Faso, Mali, Ethiopia, Kenya, Madagascar and the Democratic Republic of Congo. Six of the grantees submitted their first deliverable, which includes training and publications for technical and branding review.

MALARIA ACTION COALITION

RBM Malaria in Pregnancy Working Group

Since 2003, ACCESS provided Secretariat Support to the Roll Back Malaria (RBM) MIP working group (WG), made up of global and regional partners that advise the RBM Secretariat on the pertinent issues affecting the implementation of prevention and control of MIP. Partners include WHO, Centers for Disease Control and Prevention (CDC), USAID, DFID, World Bank, Malaria Consortium, Africa 2010, JHPIEGO/ACCESS, and regional networks and coalitions. ACCESS participated in the seventh MIP WG meeting in Abuja, Nigeria from 10–12 October 2006, which focused on issues relevant to the effective prevention and management of MIP in Africa. Partners concluded that a need exists to adopt a more comprehensive approach to MIP that is not limited to IPT, more guidance is needed from WHO on the use of ACTs and other anti-malarial medication for case management and to strengthen collaboration between regional African MIP networks and RBM regional networks to improve south-to-south exchange of experiences. ACCESS also participated in a MIP WG meeting from 19–20 March 2007 in Geneva to revise the MIP WG terms of reference and workplan for submission to the RBM Board.

Malaria Resource Package

ACCESS collaborated with MAC partners to develop the MIP Implementation Guide, which will serve as a tool for countries to initiate the implementation process or to strengthen the existing implementation process for MIP prevention and control. ACCESS is revising the Malaria Resource Package developed in 2003 to add updated information on MIP and to include the implementation guide.

Kenya

The ACCESS program in Kenya continues to support the scale-up of MIP services through focused ANC building on lessons learned and results. As Kenya transitions from MAC-funded support to PMI support, the ACCESS training approaches are an important piece not only in the continued scale-up of MIP service delivery but also in support of rolling out ACT treatment support. ACCESS continues to work closely with Division of Malaria Control and the DRH to support plans for malaria control.

Nigeria

ACCESS collaborated with MAC partners to provide short-term technical assistance to overcome bottlenecks to implementation of the Nigeria Global Fund grants for malaria. The technical assistance was provided in two phases. In Phase I, ACCESS and MAC partners formed work teams with the principal recipient (Yakubu Gowon Center) and the sub-recipient (National Malaria Control Program (NMCP)) of Nigeria's Global Fund grants, as well as the RH Department of the MOH and RBM partners working in Nigeria. They reviewed the nature of the bottlenecks related to management and coordination, monitoring and evaluation and procurement and supply management for malaria in general. This resulted in the development of action plans to improve program management and coordination, address bottlenecks to procurement and supply management systems, and to develop a national malaria M&E strategy to enhance reporting to the Global Fund. The action plans were designed, including next steps, responsible parties and dates. In Phase II, ACCESS hosted a one-week meeting with the CDC, the Principal Recipient (Yakubu Gowon Center) and the Sub-Recipient (NMCP) of Nigeria's Global Fund grants, the RH Department of the MOH, and RBM partners to address bottlenecks that influence IPTp coverage,

M&E for MIP and ITN access for pregnant women. A series of recommendations were formulated into action plans targeting improved MIP program visibility and management, ITN distribution through ANC, IPT approaches and procurement, case management, training for service provision and advocacy, and monitoring and evaluation. The key recommendation was the need to hold a workshop to develop a national strategy to scale-up MIP interventions. ACCESS hosted a two-day workshop, which involved federal and state-level stakeholders from RH and malaria control departments, the primary and sub-recipients to the Global Fund grants and RBM partners. The key accomplishment of the workshop was the collaboration between malaria control and RH departments to develop joint action plans for MIP activities at national and state levels.

Rwanda

The ACCESS program in Rwanda 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 worked closely with the NMCP and other PMI partners to build on the successful implementation of the MAC.

Uganda

(Co-funded by MAC/Core, AFR-SD and MAC/REDSO field support)

In Uganda, 50% of MCH services are provided through FBOs. The ACCESS program through IMA and JHPIEGO, collaborated with three FBOs—the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Catholic Medical Bureau— to address the prevention and treatment of MIP using the focused ANC platform.

Since October 2006, ACCESS conducted support supervision visits with service providers trained earlier and conducted an endline survey to examine change in IPT uptake and ITN use. They revealed a positive change in provider knowledge, attitudes and practices. IPT 1 increased from 43% to 94% and IPT 2 uptake increased from 63% to 76%. Also, the percentage of women who received an ITN or purchased an ITN increased from none to 27%.

Training of Community-Owned Resource Persons (CORPs) improved not only their knowledge of MIP prevention, but also of the necessity for enabling women to seek assistance in a timely manner. The community attitudes and preparedness were further strengthened by mobilizing religious leaders who are key to behavior change strategies. As a result of this program:

The MOH will use this project as a model to scale up in both the private and public sector.

In scale-up, pilot facilities can be used as mentors to other facilities adapting this approach.

The training approaches used with the training materials were essential to ensuring a change in knowledge and attitudes among providers and clients.

Core Activity Matrix: 1 April 2007

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
IR 1: GLOBAL LEADERSHIP FOR MATERNAL, NEONATAL, AND WOMEN'S HEALTH AND NUTRITION PROGRAMS AND POLICIES STRENGTHENED	
<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"> • 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 • Technical advisor to PMNCH supported through January 31, 2008. • In collaboration with WHO's Making Pregnancy Safer Unit, begun revision of IMPAC series manual "Managing Complications in Pregnancy and Childbirth." A Users Survey has been drafted and will be disseminated to Users of the manual in April 2007. Feedback will inform the revisions of the manual. • 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. • Support leveraged by two Alliances (Tanzania and Zambia) for additional funding and MoH commitment. • ACCESS continues to be a key member of the MotherNewBorNet Secretariat. • At the request of USAID, the annual MotherNewBorNet Meeting will now happen as part of the upcoming ANE Region Best Practice Meeting on Maternal, Newborn, and Infant Health and Family Planning planned for September 2007. • ACCESS is collaborating with USAID, ESD, URC, WHO and other partners on the planning for the ANE regional meeting and the follow on work to provide TA to countries to roll out EMNC. • ACCESS reviewed an initial plan for a joint statement on community-based newborn care and met with WHO, UNICEF, SC and BASICS.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<p>1.2 Partner with faith-based health care networks to expand emergency maternal and newborn care interventions</p>	<ul style="list-style-type: none"> • Engaged with WHO to prepare a Joint statement on FBOs and EMNC. • 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. • ACCESS resources disseminated at the Religious Leaders and providers meeting in Rwanda, and also shared with Eglise du Christ au Congo (ECC-DRC). • In Tanzania, CSSC staff & Zonal Coordinators, ACCESS staff, Tanzania Episcopal conference Health Coordinator and MEDA (ITN program) participated in a training in HRIS/GIS Mapping data analysis and management. • 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. <p>ACCESS Small Grants</p> <p>Kenya – CHAK, Agha Khan & MOH</p> <ul style="list-style-type: none"> • Orientation workshop for 11 administrators/supervisors (CHAK & Agha Khan) completed and training of 15 providers from 10 FBO facilities in focused ANC, MIP completed. • Training skills of country team trainers strengthened. <p>Uganda – Uganda Protestant Medical Bureau, Uganda Methodist Medical Bureau & MOH</p> <ul style="list-style-type: none"> • Materials adapted and developed for the Uganda-MAC project will be used. • Baseline assessment underway at the selected facilities. <p>Tanzania – CSSC and Agha Khan</p> <ul style="list-style-type: none"> • Conducted orientation meeting with administrators/supervisors at the select facilities.

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 maternal and newborn health</p>	<ul style="list-style-type: none"> • During this period, 422 people from 29 countries took the e-learning courses on Antenatal Care, Postpartum Care, Essential Newborn Care, and Preventing Postpartum Hemorrhage developed by ACCESS. • ACCESS website has 1333 first-time visitors since October 1, 2006. • Between 31 October 2006 and 31 March 2007, there have been 2,502 unique visitors and 3,562 visits to the ACCESS Website • ACCESS website downloads since October 2006 have increased monthly, including more than 2500 downloads of the various reports. • Printed and disseminated "Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health." • ACCESS pregnancy wheel tool for providers developed and translated into French and distributed to Bangladesh, Rwanda, Malawi and Ethiopia. • ACCESS dissemination of materials at conferences and workshops: at the Saving Newborn Lives Program Managers meeting in Johannesburg, South Africa in February 2007 and the SBA Stakeholders Meeting in November 2006 held in Nepal. • ACCESS dissemination of materials to stakeholders during assessment visits to: Rwanda (1/07), Malawi (2/07), Bangladesh (3/07). • Completed preparation of one e-learning course on Essential Newborn Care; available on line. • Two additional e-learning courses on Emergency Obstetrical and Newborn Care and PMTCT are under development. The PMTCT is undergoing a quality check prior to going live on the site and the Emergency Obstetrical and Newborn Care course is at the external review phase. • Household-to-Hospital Continuum of Care manual translated into Spanish and Portuguese. • ACCESS informational flyer updated. • Training package and implementer's guide on community based use of misoprostol in the final stages of editing. • 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. • Assisted POPPHI in the completion and subsequent dissemination of the French version of the Active Management of the Third Stage of Labor: A Demonstration CD-ROM.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
<p>1.4 Administer and manage small grants to expand and scale up EMNC, postpartum hemorrhage, focused ANC (FBO), & fistula interventions</p>	<ul style="list-style-type: none"> • PPH Grants: Seven grants were awarded in November 2006 in the following countries: Burkina Faso, Mali, Ethiopia, Kenya, Madagascar, Democratic Republic of Congo. Six of the grantees submitted their first deliverable which includes training and publications for technical and branding review. The grantee in Democratic Republic of Congo One grantee has held 6 advocacy meetings in two districts to discuss activities to reduce postpartum hemorrhage. • Obstetric Fistula Grants: 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. • FBO: Two of the three grantees have completed their second deliverable. Please see activity 1.2 for details on FBO small grant accomplishments
<p>1.5 Technical Assistance—Strategic opportunities for TA to strengthen maternal and newborn health programs</p>	
<p>IR 2: PREPARATION FOR CHILDBIRTH IMPROVED</p>	
<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"> • Site assessment completed in October 2006. • Government of Jharkhand signed the MOU which will allow for the release of equipment, supplies and the ANMs in January 2007. • 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 dept. • ANMs standards finalized. • Review of one Health Sub Centre as per IPHS format completed – (to assess the gaps which will be helpful for advocacy at the district level and sharing with district health dept). • Preparation of data bank – Health Sub Centre wise population and names of the ANMs and also villages under each Health Sub Centre for two PHCs. It also includes the expected number of births in each Health Sub Centre in a year. • Plotting of Health Sub Centre boundary and other resources in three block maps completed.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
2.2 Support maternal and newborn health in Cambodia	<ul style="list-style-type: none"> • ACCESS developed a proposal for Associate Award for Maternal and Newborn Health in Cambodia that was approved by USAID mission on 15 December 2006. • Long Term Technical Advisor recruited and arrived in Cambodia in February 2007 to work with the Cambodia Ministry of Health at the National Maternal and Child Health Center (NMCHC). • Detailed Year 1 work plan submitted to USAID/Cambodia in April 2007. • Discussions with partners, key stakeholders and the MOH conducted by the Long Term Technical Advisor, on the potential components of the workplan. • Administrative support in-country arranged with AED/A2Z via contractual mechanism under Lead award • MOU drafted between ACCESS and MOH to outline roles and responsibilities for office renovation of the NMCHC. • Agreement from the MOH to hold a national technical meeting on the use of misoprostol at community level to reduce post partum hemorrhage.
2.3 Strengthen nutrition in the in-service and pre-service training of midwives in Tanzania	<ul style="list-style-type: none"> • Collaborated with ACCESS Tanzania staff to design the nutrition activity to be carried out in Tanzania. The outputs include a technical update in nutrition for tutors in midwifery schools and a training of trainers module to be pre-tested with midwifery tutors. • Initiated the literature review on women nutrition during pregnancy in Tanzania to be completed in April 2007.
2.4 Consolidate lessons learned through MAC in selected countries in Africa	<ul style="list-style-type: none"> • ACCESS provided technical support to Uganda to strengthen focused ANC services including MIP targeting three FBO organizations and the MOH. ACCESS technical 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. • ACCESS through JHPIEGO provided Secretariat support for the Roll Back Malaria- Malaria in Pregnancy working group meeting held in Nigeria from October 10-12, 2006. This support included organization of the meeting, development of the 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. • ACCESS is 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 President's Malaria Initiative.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
2.5 Mali ITN Advisor	<ul style="list-style-type: none"> The USAID Mission in Mali had developed a scope of work for two additional activities: 1- Strengthen the managerial capacity of the PNL, and 2- Revise the country's behavior change communications plan. ACCESS has identified potential consultants for this work and shared these CVs with USAID Mali. We are currently waiting for the Mission's decision.
IR 3: SAFE DELIVERY, POSTPARTUM CARE, AND NEWBORN HEALTH	
3.1 Contribute to the knowledge and expansion of prevention of PPH in ACCESS countries	<ul style="list-style-type: none"> 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: 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. From the technical advisor for the AWARE Program in West Africa: AMTSL is becoming more systematically used in Mauritania and Cameroon. Additional details have been requested – i.e. if it means policy changes, pre-service curricula revisions, etc. and will get the information to you once I get it from Fanta in Accra. Mali: a sub-regional conference on AMTSL is being organized and they will inform us of the outcome Nigeria: members of the Nigeria team are collaborating with Venture Strategies (University of California, Berkeley) to hold several conferences on use of AMTSL throughout the country. 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. 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 active management of third stage of labor and other interventions.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<ul style="list-style-type: none"> • Introduction of the SBAI/Rwanda program by Nahed Matta, Koki Agarwal and Patricia Gomez in discussions with USAID/Rwanda and major partners such as IntraHealth, MOH, UNICEF, etc. in October 2006. • Assessment trip carried out by Barbara Rawlins 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. • Logistics related to office space and administrative support finalized. ACCESS will share an office and administrative staff with Constella Futures in Kigali. • Formulation of joint workplan for SBAI by Twubakane and ACCESS which has received approval from USAID/Washington and Rwanda in March 2007. Waiting for approval from MOH. • 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. • Long-term advisor arrived in Rwanda 14 April 2007. • 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. • Formulation of draft PMI workplan based on conversation with USAID PMI advisor; final approval pending. • Consultant engaged by SC to translate the draft KMC manual into French for use in Rwanda. Conversations ongoing with the Safe Motherhood Task Force chair to discuss selection of sites and logistics for KMC program. • Completion of the adapted focus group discussion guides for conducting the community needs assessment (From Joseph) • Assessment visit made to Malawi by Patricia Gomez 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. Waiting for approval from MOH. • Short-term advisor arrived in Malawi in March 2007 to begin implementation of workplan.

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<ul style="list-style-type: none"> • Planning for first major core-funded activities under way: national-level conference to define roll-out of training of nurse-midwife technicians in BEmONC in relation to formulation of learning materials, training of trainers from each region/district, follow-up and supervision, and clinical site strengthening; and national-level conference to bring pre-service tutors from all programs together to plan revision of curricula to include basic EmONC.
3.2 Build strategic opportunities to improve safe delivery in Africa	<ul style="list-style-type: none"> • SBM-R for assess staff performance in providing selected EMNC services has been adapted and piloted. • Workshop on how to use the SBM-R tool has completed for 17 participants (This will be done from March 27-29, 2007) • Contacts made with several FBOs in Rwanda during assessment visits in February 2007. • 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.
3.3 Implement local financing mechanism to increase equity of health services to the most vulnerable in Nigeria	<ul style="list-style-type: none"> • The plan for studying financial barriers to EmONC was developed for focus Local Government Authorities (LGA). Activities will concentrate on working with community mobilization groups and stakeholders to advocate for government support in addressing policy issues that will enable the poor to have greater access to EmONC. • 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. • A data analysis was initiated using the household baseline survey conducted in the four focus LGAs in Kano and Zamfara. The analysis includes a further refinement of the financial data beyond what is presented in the Baseline Report (ACCESS/Nigeria Safe Motherhood Project: Emergency Obstetric and Newborn Care Services in Kano and Zamfara States) written by a local consultant.
3.4 Strengthen policies to improve retention and deployment of skilled birth attendants in Africa	

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
IR 4: MANAGEMENT OF OBSTETRIC COMPLICATIONS AND SICK NEWBORNS IMPROVED	
<p>4.1 Increase access to skilled attendance at birth through strengthening of pre-service midwifery education of frontline providers in four countries (Ethiopia, Ghana, Malawi, and Tanzania)</p>	<ul style="list-style-type: none"> • A clinical training skills/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. • A field-test version of the generic curriculum in essential and basic emergency obstetric and newborn care for midwives has been formulated and will be tested in country-level activities beginning June 2007. • ACCESS is working with 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, after which a two-week technical update and clinical skills standardization course will be taught by them with support from ACCESS staff.
<p>4.2 Assist the Ethiopian Society of Obstetricians and Gynecologists (ESOG) to build capacity of skilled providers in EMNC</p>	<ul style="list-style-type: none"> • Site assessment of Ambo Hospital completed in February 2007. Action plan for site strengthening based on site assessment created in conjunction with ESOG. Site strengthening completed in March 2007. • MOU developed with ESOG delineating the activities they will carry out to strengthen a clinical site and train providers in basic emergency obstetric care using Ambo Hospital. • Two three-week technical update and clinical skills standardization of providers at Ambo Hospital scheduled to begin in April 2007 and will be completed in May 2007.
<p>4.3 Expand Kangaroo Mother Care services for improved management of low birth weight babies (Nepal and Rwanda (or one other African Country))</p>	<p>In Nepal, ACCESS has:</p> <ul style="list-style-type: none"> • Baseline needs assessment on KMC conducted in two zonal hospitals and three primary health care facilities in two districts, Kanchanpur and Kailali • National KMC advisory group formed. • Conducted a two-day KMC sensitization workshop which was attended by over 40 participants from MOH, NGOs, donors (UNICEF and USAID), and medical and nursing pre-service training institutions. • Conducted TOT in March 2007 in Kathmandu for 17 trainers from MOH, private hospitals and training institutions, including service providers from health facilities in Kanchanpur and Kailali. • KMC services has been initiated in two facilities: Kailali district hospital, and Kathmandu medical college. <p>In Rwanda ACCESS is translating the KMC manual into French.</p>

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
IR 5: PREVENTION AND TREATMENT OF PRIORITY HEALTH PROBLEMS OF NON-PREGNANT WOMEN OF REPRODUCTIVE HEALTH AGE (TARGETS OF OPPORTUNITY)	
5.1 Technical oversight and documentation of current obstetric fistula small grant	<ul style="list-style-type: none"> • Association for the Re-orientation and Rehabilitation of Teso Women for Development, Uganda small grant for prevention of fistula no cost extension until April 30, 2007 granted. Results to date include: • 250 targeted community leaders 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. • 12 radio talk shows on the topic of fistula 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”. • A five (5) member women’s fistula drama group established. The group performed during eleven (11) sensitization meetings. • 2000 fistula sensitization posters translated into Ateso printed and disseminated • Three of six Teso districts have drafted by-laws (ordinances) mainly to protect girls against child marriage and defilements with possible consequences such as obstetric fistula. • Uganda Private Midwives Association small grant for fistula prevention milestones completed and final report submitted. Results include: • 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 • Cue cards to facilitate communication with communities and counseling during ANC developed • One day workshop conducted for 30 midwives on principles of communication, communicating with communities (use of cue cards developed for this purpose), causes, consequences, and ways to prevent fistula, and partograph update • Outreach to 55 schools reaching a total of 2081 students completed • Outreach to 27 communities reaching a total of 814 people (605 women and 209 men) completed • Targeted midwives report increased use of partograph and counseling regarding causes, consequences and prevention of fistula during ANC

CORE ACTIVITY	MAJOR PROGRAMMATIC OUTPUTS/DELIVERABLES PRODUCED
	<ul style="list-style-type: none"> • Ong Dimol, Niger's small grant recipient for prevention of fistula submitted final report. Results include: <ul style="list-style-type: none"> • 17 villages of covering more than 2,169 people sensitized to causes, consequences, and prevention of fistula • Women with fistula identified and transferred for treatment. • Association of Safe Motherhood Promoters, Nigeria, small grant for prevention of fistula no cost extension until April 30, 2007 granted.

III: 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
- Haiti
- Kenya
- Nepal
- Nigeria
- Tanzania

AFGHANISTAN

1. Major Accomplishments

Service Support Program Associate Award

- Workshop conducted with key staff from the Afghanistan MoPH, NGOs receiving PPGs and other stakeholders to initiate quality improvement and integration of standards for the implementation of a quality BPHS delivery strategy. A Central Quality Assurance Committee established within the MoPH. Standards in essential obstetric care, FP and infection prevention (IP) developed, adapted and integrated into one quality assurance tool.
- SSP strengthened capacity of NGOs that deliver BPHS services through various trainings and workshops in the rational use of drugs; monitoring, supervision and evaluation; basic emergency obstetric care; effective teaching skills; USAID rules and regulations; identification of gender indicators; and provincial capacity building. A total of 302 people participated in these various workshops and trainings, which included NGO staff, midwifery faculty, BPHS providers, community elders and provincial MoPH staff.
- All IEC materials developed in Afghanistan collected, classified, indexed and analyzed. A total of 35 different information, education and communication (IEC) materials representing 12 technical areas were distributed to the grantees from the 13 PPG provinces.
- On 8 October 2006, SSP supported the first national Safe Motherhood Day of Afghanistan, with the slogan “Pregnancy and Childbirth is Special, Let’s Make it Safe.” The event was hosted by the MoPH and coordinated by the AMA.

ACCESS Afghanistan

Midterm evaluation data from the PPH project analyzed preliminary results presented to the PPH Technical Advisory Group and key stakeholders from the MoPH. Analyses found the intervention to be safe, acceptable, feasible and programmatically effective. The MoPH informed ACCESS that it wants to take the intervention to scale on a national level.

2. Progress Summary

PPH Results Pathway: ACCESS Afghanistan

Midterm evaluation data from the PPH project in Kabul, Faryab and Jawzjan provinces was analyzed and preliminary results were presented to the PPH Technical Advisory Group and key MoPH stakeholders in February and March 2006. Based on preliminary findings of the midterm analyses, 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 community health volunteers; 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 SSP.

Advocacy efforts at the national, provincial, district and community levels have continued, with meetings conducted at provincial health hospitals, district health hospitals, with supporting NGOs, community health worker groups, village leaders and shuras.

SBA Results Pathway: Service Support Project

SSP made strides toward strengthening and integrating quality improvement tools to support quality of health service delivery, including standards in antenatal, delivery and postnatal care. In December 2006, SSP conducted a two-day workshop on quality assurance with key staff from the Afghanistan MoPH, NGOs implementing the BPHS in the country through USAID-funded PPGs and other stakeholders. A central Quality Assurance Committee was established through the Afghan Public Health Institute to oversee and guide the adaptation, development and integration of all standards and quality improvement tools for the country. The committee's inception in January 2007 has enabled the MoPH, to identify priority clinical areas in the BPHS to develop an integrated standards and quality assurance approach, under the technical guidance of SSP. The quality assurance process involves adapting existing clinical and management standards that were developed under the USAID-funded REACH program¹ ensuring they are gender sensitive, identifying clinical areas that require new standards to be developed, integrating all standards into one quality assurance tool and piloting the tool in 36 health facilities in five PPG provinces. To date, standards have been developed in essential obstetric care, FP and IP.

SSP improves the enabling environment of SBA through support to midwifery and community midwifery education programs. Through a competitive request for application (RFA) in December 2006, SSP awarded IbnSina the community midwifery education program grant for Paktya province. Additionally, SSP extended the funding of the IMC midwifery education program in Nangarhar for six months from January to June 2007 through a contractual modification to ensure completion of the curriculum, and graduation of the currently enrolled class. To date, SSP has awarded 10 midwifery and community midwifery grants, with a total of 338 currently enrolled students. A site assessment to identify a new community midwifery education program site was carried out in the Ghazni and Ghor provinces.

SSP conducted a workshop on USAID rules and regulations for 25 participants of implementing NGOs to increase capacity of financial managers and ensure financial compliance in grants.

¹ REACH was implemented from 2003 to 2005 by MSH and partnered by JHPIEGO.

SSP builds capacity of NGOs that implement BPHS to improve quality of services. SSP facilitated five basic essential obstetric care (EOC) training courses in Kabul for midwifery faculty and BPHS providers from six provinces. A total of 87 staff have received this training under SSP to date and are now equipped with the skills required to provide basic EOC services according to national EOC clinical standards. Participants have included clinical preceptors, faculty members and health service providers. Additionally, one refresher training for 18 national EOC trainers was conducted in November 2006. These trainers will be responsible for conducting basic and advanced EOC courses in five regional EOC training sites throughout SSP. Two effective teaching skills workshops for 52 midwifery faculty and BPHS providers were conducted. Completion of effective teaching skills course is standard within the midwifery education for faculty. A workshop to increase awareness about the link between gender and quality health service delivery and identify health objectives and gender-related obstacles to achieving these objectives, and indicators to measure achievement of the objectives was carried out for community members and health service providers.

SSP also facilitated a rational use of drugs workshop for 31 BPHS health service providers and a monitoring, supervision and evaluation workshop was conducted for 29 NGO staff and BPHS health service providers to enhance monitoring and supervision of BPHS service delivery.

As one of its capacity-building approaches for NGOs and strengthening linkages between provincial MoPH officers and NGO staff, SSP technical staff carried out a technical assistance visit to Herat province. The visit provided an opportunity for SSP to introduce its capacity-building approach, update MoPH officers and NGOs on the quality assurance process and identify different methodologies to reduce the PHO and NGO gaps in improving quality of care.

SSP improves the enabling environment of SBA through support to the first national Safe Motherhood Day in Afghanistan and a national communication campaign. On 8 October 2006, SSP supported the first national Safe Motherhood Day of Afghanistan, with the slogan “Pregnancy and Childbirth is Special, Let’s Make it Safe.” The event was hosted by the MoPH and coordinated by the AMA. The day’s themes included the importance of having a skilled attendant at birth and knowing the danger signs associated with pregnancy and childbirth. The celebration was launched nationally through a public forum organized in Kabul by the Reproductive Health and IEC departments of the MoPH and with the technical support of SSP. Additional forums were held in four districts of Kabul and eight other provinces had advocacy campaigns, including Faryab, Takhar, Badakshan, Kandahar, Nangarhar, Bamyan, Herat and Balkh. The event was used as a platform to launch a three-month communication campaign, which involved printed materials, radio and TV spots.

SSP supports distribution of IEC materials to NGOs by collecting, classifying, indexing and analyzing all IEC materials developed in Afghanistan.

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.

SSP contributes toward improving the enabling environment of SBA through support of gender awareness activities and gender sensitive service delivery practices.

At the request of SSP, PPG grantees continue to submit gender-related success stories for inclusion in the PPG newsletter. In addition to conducting gender trainings for NGOs, SSP shares its gender training materials and resources with NGOs to encourage and assist them in replicating gender trainings that are conducted by SSP. SSP continues to actively participate in the MoPH Gender and Reproductive Rights task force, which is adapting WHO gender guidelines for an Afghan context. SSP has awarded a subcontract to a local NGO, Bakhtar Development Network, to conduct a “Qualitative Study on Access, Quality of Care and Gender in Health Programs in Afghanistan.” The purpose of the study is 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.

3. Challenges

SSP had received criticism from PPG grantees for the perceived low number of training activities planned in year one. In response, SSP has developed a capacity building paper outlining a number of technical approaches that build capacity, which do not always require training, such as job aids, standards and establishing learning centers where health workers can learn from each other.

BANGLADESH

1. Major Accomplishments

- Recruitment of ACCESS counselors and community mobilizers is complete (396 staff). Each ACCESS counselor is assigned to work in a catchment area of 5,000 people, referred to as a cluster.
- The MNH and community mobilization (CM) training manual was developed and two TOT workshops in MNH and CM were held: 28 field staff participated in the TOT for MNH and 16 field officers participated in the TOT for CM. A total of 70 ACCESS counselors were in turn trained in how to promote proven healthy maternal and newborn household practices, including appropriate care-seeking behaviors.
- A total of 1,827 social/village maps were developed with communities through use of participatory exercises in order to develop a home visiting schedule plan and system for each ACCESS counselor.
- Resource mapping is an initial CM activity within the ACCESS Project. All CM and community supervisor mobilizers (CSMs) conducted resource mapping to select the villages for first-phase community action groups, whereby 222 villages were initially selected

2. Progress Summary

USAID/Bangladesh is supporting the establishment of a Safe Motherhood and Newborn Care Program in the Sylhet Division of Bangladesh under the Mission’s Strategic Objective for its Population, Health and Nutrition Program. The ACCESS/Bangladesh program is aimed at increasing the practice of healthy maternal and neonatal behaviors at scale and in a sustainable manner in the Sylhet district. The program is covering seven Upazilla serving a total population of 1.5 million. ACCESS is working with several local partners—Shimantik, FIVDB and ICDDR, B.

To build awareness of the Program, seven Upazilla orientation sessions were conducted with participation from the MOH and FP, the Upazilla Chairman, religious leaders and community leaders. The objective was to sensitize religious leaders, the Upazilla Chairman and community leaders on MNH issues and generate support for program interventions within the targeted communities.

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

Staff Recruitment:

A total of 286 ACCESS counselors were recruited by the partner NGOs as of March 2007. Sixty-three additional counselors were recruited as a result of re-clustering of the projected catchment population for each counselor. FIVDB recruited 96 counselors in three Upazillas; and SHIMANTIK recruited 190 in an additional four Upazillas.

A total of 73 CSMs are recruited; among these, 25 CSMs were recruited by FIVDB and 48 CSMs by SHIMANTIK.

A total of 37 CMs are now working in the ACCESS Project. Of these, 13 CMs were recruited by FIVDB and 24 by SHIMANTIK.

Working demography/Population counting: The major objectives in determining the population of the project target area includes:

- Determining the actual number of persons living in ACCESS target Upazillas
- Designating ACCESS counselors, CSMs and CMs throughout the project area
- Readjusting a cluster for counselors depending upon their communication network, geographical situation and/or other challenges

The population was found to be 1,500,592 in the ACCESS target area. Both partner NGO core staff and ACCESS technical staff were oriented to guidelines and formats specific to population counting; after orientation, field staff visited all households within the project implementation area.

Social/Village Mapping: A total of 1,827 social/village maps were developed during participatory exercises conducted in each community to develop a home visiting schedule plan and system for ACCESS counselors. Field staff conducted the mapping through the participatory rapid appraisal process. First, staff visited targeted villages, conducting a transect walk within the village, communicating with villagers; next, they expressed the purpose of the mapping activity and invited them to participate in the mapping process. With the help of the community, field staff prepared a draft map; 1,827 village maps were completed and then used to help identify each household within the village.

Cluster Separation: Each ACCESS counselor will be assigned to work within a previously identified cluster. The major objectives of cluster separation in the catchment areas are to recruit counselors from their areas of work (same cluster) and to finalize the CSM and CMs working sites. Partner NGO core and field staff (counselor, CSM, CM and field support officer) worked jointly in the development of clusters for the population area, as follows:

- Total number of clusters: 286
- Average population per cluster: 5,000
- Average number of households per cluster: 800

Married Women of Reproductive Age (MWRA) Registration: One of the most important objectives of the ACCESS project is to reduce maternal and neonatal death. To achieve this objective, a system for identifying MWRA (15–49) and pregnant women among the MWRA was established. After initial registration with eligible participants, ACCESS counselors will begin household counseling of pregnant women and their families in an effort to promote healthy MNH practices. Counselors will visit every household and update MWRA registration during each quarter.

After cluster separation it was determined that each counselor will be assigned to a population area of 5,000 (each cluster has an average of 800 households and 6.29 villages). Counselors will divide their cluster according to monthly working days—it is estimated that each AC will work approximately 50 days every quarter. For this reason, each cluster was separated into 50 blocks; counselors should complete one block per each day's work.

Capacity Building: The MNH and CM manual was developed, reviewed by external and internal staff and consultants, and translated into Bengali.

A TOT was held to prepare the trainers to train the ACCESS counselors with the necessary knowledge and skills to promote healthy maternal and newborn household practices, including appropriate care-seeking behavior. During the TOT, trainers were presented with basic information on MNH; communication, counseling and negotiation skills; and demonstrations and role plays on drying, wrapping, cord cutting, use of clean delivery kits and breast feeding.

Objective 2: To increase appropriate, timely utilization of home and facility-based essential MNH services

Identification and assessment of modern health service resources: Mapping of service delivery points and outlets, including location of nearby service providers, is complete. A health facility assessment tool was developed and field tested; and the assessment is now complete. The ACCESS team in Sylhet and partner NGOs were oriented on how to use the tool. A tool for referring women to health facilities based on their location is in the process of being finalized.

Objective 3: To improve key systems for effective service delivery, community mobilization and advocacy

Monthly meetings were conducted with Dhaka and Sylhet-based ACCESS staff, as well as technical staff, Upazilla team leaders and field support officers from partner NGOs. Objectives of these meetings were to share progress at the field level; discuss work plans and new activities; and identify and incorporate technical input from ACCESS staff, which helps build upon partner NGO field staff skills.

A total of 84 Upazilla-based staff meetings were conducted during the reporting period; and two review meetings were conducted in each Upazilla per month. All Upazilla-based staff members and

TFPs, including ACCESS staff members were present at the meetings. During each meeting, work schedules were reviewed and adapted and field staff shared their experiences with supervisors and others present.

Financial and administrative management:

The deputy manager for finance and administration visited seven Upazilla offices to monitor their financial systems.

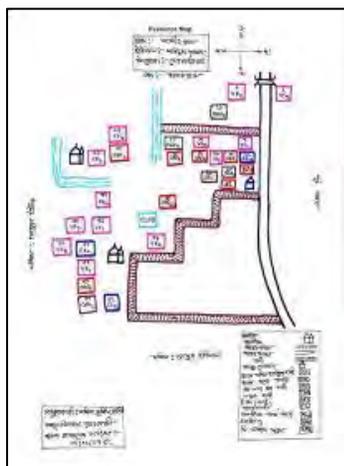
An internal audit team visited each partner NGO twice during the reporting period to monitor their financial and administrative systems and to verify quarterly expenses.

An international level audit was conducted by Save the Children headquarters in February 2007 to monitor each partner's financial and administrative systems.

These monitoring and audit activities helped strengthen partner NGO capacity for systematic procurement, financial reporting, proper budgeting and documentation.

Objective 4: To mobilize community action, support and demand for the practice of healthy MNH behaviors

TOT on CM: The TOT to train master trainers on how to conduct basic trainings on CM took place on March 19, 2007; and 110 CSM and CMs were trained on CM by these master trainers.



Resource Mapping: Resource mapping is one of the initial tasks of CM activities of the ACCESS project. All CMs and CSMs conducted resource mapping of his/her working areas to identify the potential resources in each village, which could be useful for conducting CM activities. This activity included mapping existing community groups/clubs, NGO groups, CORPs, CMs also identified/selected potential places for community action group (CAG) group meetings, as well as community-based health service providers who could serve as member of CAG during the first phase, CAG 222 villages were initially selected.

Community entry and initial inventory of resources is being conducting by the CSM and CM. There were 222 villages selected for the first phase; and field staff conducted initial meetings with Upazillas, existing groups, and village leaders, and are in the process of mapping resources at the village level. The assessment of community resources will be completed by April 2007 and will include a list of potential CORPs who have been selected by field staff.

Objective 5: To increase key stakeholder leadership, commitment and action for these MNH approaches

ACCESS/Bangladesh supported the Government of Bangladesh National Immunization Day by participating in a campaign in areas where ACCESS works. Save the Children's global activity "Caps to the Capital-Uniting for Newborns" took place in Sylhet; and a press briefing, highlighting the ACCESS project, also occurred.

MONITORING AND EVALUATION

The following activities were accomplished during the reporting period, to develop functioning Management Information System (MIS) and M&E systems:

Establishment of supervisory/support system for ACCESS counselors: A supervisory checklist and guidelines were developed to support ACCESS counselor field activities; and supervisors of counselors were oriented on the checklists and guidelines.

Establishment of a pregnancy identification system: MWRA and pregnancy registers were developed and field tested. Partner NGOs have been oriented on MWRA and pregnancy registration. Initial MWRA and pregnancy registration is ongoing.

Development MIS program: The forms and formats necessary for creation of the MIS program have been drafted and shared with partner NGOs.

Ethical review of evaluation protocol: Program evaluation protocol, survey instrument and other supporting documents submitted to institutional review boards in the United States (Western Institutional Review Board (WIRB)) and Bangladesh WIRB and review is in progress. The mapping and listing of households for the survey sample is currently under way in the field.

Planning for the Future: Extension of the ACCESS/Bangladesh Program

USAID Bangladesh requested ACCESS to plan for additional activities, which would complement and enhance the current program design. A preliminary concept note was prepared and submitted to USAID Bangladesh in December 2006. In March 2007, ACCESS sent an assessment team to prioritize the proposed activities and identify which were most feasible and could result in the greatest impact. These include:

- Enhance the ACCESS counselors home-based preventive package by introducing community based KMC and community distribution of misoprostol.
- Initiate focused training of trained birth attendants (TBAs) in the ACCESS program area to reduce harmful practices, ensure clean delivery, increase timely and appropriate referral, and increase knowledge and practice of emergency first aid.
- Provide technical updates to the sub-assistant community medical officers and family welfare visitors at the family welfare centers as the first referral point for the ACCESS Program.
- Accelerate the training of SBAs in the ACCESS program area.

3. Challenges

- Delay in baseline implementation has affected the timely implementation of all planned activities; the training plan and the roll out of household counseling has been revised several times due to delays in startup.
- Political instability in Bangladesh has disrupted the implementation of activities at the field level.
- Most women are not aware of their regular menstrual cycle, thus are confused and unaware of how to interpret a missed period. Post partum amenorrhea often extends beyond six months, which can lead to missed identification of a suspected pregnancy.

CAMBODIA

1. Major Accomplishments

- ACCESS developed a proposal for Associate Award for Maternal and Newborn Health in Cambodia that was approved by the USAID Mission on 15 December 2006.
- Long-term technical advisor recruited and arrived in-country to work with the Cambodia MOH at the national MNH Center.
- Detailed Year 1 workplan initiated with plans to submit final version to USAID/Cambodia in April 2007.
- Presentations with partners, key stakeholders and the MOH conducted by the long-term technical advisor, including discussions on drafting a plan for the community-based distribution of misoprostol.
- Administrative support in-country arranged with AED/A2Z via contractual mechanism under Lead award.
- MOU drafted between ACCESS and MOH to outline roles and responsibilities for office renovation of the national MNH Center.

2. Progress Summary

SBA and Newborn Pathway

The ACCESS advisor had initial meetings with USAID, MOH and key stakeholders to identify priority in MNH and further define ACCESS work in these areas. Meetings have been conducted with the MOH and initial plans have been formed to create a technical working group on neonatal health. ACCESS intends to collaborate with this MOH technical working group, and others, to ensure that skilled midwifery training to promote improved MNH survival.

PPH Pathway

As part of the program's effort to assist local partners to implement evidence-based MNH interventions, ACCESS-Cambodia will use core funding to demonstrate that community-based distribution of misoprostol, is safe, feasible and acceptable in rural Cambodia.

Targeted short-term technical assistance expertise was provided by ACCESS to assist with startup of planning for implementing community-based distribution of misoprostol, including approaches for advocacy, technical, communication and monitoring. This draft implementation plan has drawn on

expertise, materials, protocols and lessons learned from misoprostol demonstration projects in Indonesia, Afghanistan and Nepal. The draft design was built upon previous discussions with the MOH by ACCESS staff in 2006.

In addition to the aforementioned community intervention for PPH prevention at homebirth, ACCESS-Cambodia will promote use of AMSTL where there are skilled providers and EmOC to reduce PPH.

Project Startup and Management

USAID Cambodia provided ACCESS with an associate award for three years to improve availability and access to quality sustainable MNH services, leading to the increased utilization of services and practice of healthy maternal and neonatal behaviors at scale. The award was granted in December 2006 and project startup in-country has commenced with the hiring and placement of the LTTA at the Cambodia MOH in February 2007. In this startup phase, the detailed workplan for program Year One has been developed and will be submitted to USAID/Cambodia in April 2007. ACCESS has begun discussions with the MOH to outline collaboration for an activity in the Year One workplan which would provide office renovation to the national MNH Center at the MOH. An MOU has been drafted and is currently being reviewed by the MOH and USAID/Cambodia to clarify roles and responsibilities. The LTTA has conducted meetings with various stakeholders and partners in-country, including the MOH, USAID/Cambodia, and other key stakeholders, including UNICEF, UNFPA, DFID, CARE, RHAC and RACHA, thereby positioning the project at an early stage to identify areas of collaboration and creating essential country-level partnerships.

Lastly, ACCESS has utilized contractual mechanisms available under the Lead award to coordinate administrative support to the LTTA in-country. This support will be provided via AED's A2Z project, which has an established presence in Cambodia, and will facilitate rapid project startup from an administrative perspective.

3. Challenges and Opportunities

Uniqueness of ACCESS-Cambodia staffing paradigm: This project is ACCESS' first experience employing a staffing structure whereby the key staff member is the sole ACCESS employee based in-country. The model was designed to leverage local partner resources and provide technical assistance, primarily through the LTTA. To provide the necessary administrative support required for activities in-country, ACCESS employed a contractual mechanism with AED/A2Z under the Lead award.

HAITI

1. Major Accomplishments

- Since October 2006 at seven ACCESS-supported facilities, PMTCT providers counseled and tested 6,072 pregnant women. Of these women, 3.8% were HIV+ and 63% of those who tested positive were enrolled in the PMTCT program. Of those newborns with HIV-positive mothers, 93% (n=104) received ARV prophylaxis at birth.
- 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. Items included delivery beds, C-section kits, aquachlore machines (for water

purification) and surge protectors. Another \$60,000 in equipment, drugs and supplies was purchased and shipped to Haiti in March 2007 as part of IMA's cost share.

- A desk assessment to determine the needs and the constraints related to human resources and technical capacity for family planning at all target sites is currently underway with MSH.
- Five regional coordinators have been recruited to carry out ACCESS program activities.
- A proposal for the establishment of a PMTCT Task Force Committee was submitted to the appropriate ministries for approval/endorsement.
- ACCESS conducted a TOT for 14 participants—regional coordinators and key service providers—in IUD insertion and removal.
- A total of 129 service providers received training in PMTCT from INHSAC with technical assistance and coaching from ACCESS.

2. Progress Summary

In FY07, ACCESS is developing institutional capacity and increasing human capacity in health facilities to provide FP services (with emphasis on reversible and non-reversible long-term methods) and PMTCT services to vulnerable populations in Haiti. Assistance is targeted to seven departments through 23 service delivery sites managed either by NGOs or by the Government of Haiti (i.e., zones Ciblées).

In addition, ACCESS-FP, through support from USAID's Office of Population and Reproductive Health, is implementing a new youth initiative in Haiti. JHPIEGO will replicate a successful youth reproductive health model from Nepal that focuses on increasing young women's (<20) use of FP, maternal, and neonatal services, through community-based initiatives that are closely linked with available health services. The service delivery site for this initiative is currently being negotiated with USAID/Haiti and will be selected shortly.

Increasing Capacity to Provide Quality Family Planning Services with a Focus on Long-term Methods

Using existing data collected by HS2007 and the results of the MOH and USAID-led assessments conducted in late 2006 for the Repositionnement du Planning Familial en Haiti initiative, ACCESS is currently conducting a desk assessment to determine the needs and the constraints related to human resources and technical capacity for all sites. This will serve as the basis for the development of action plans for each health facility as well as a baseline for monitoring and evaluation. The desk assessment is being carried out jointly with HS2007/MSH.

ACTIVITY 2: Strengthen family planning services at 11 HS2007 sites and 12 public sites (zones ciblées)

ACCESS continues its efforts to build the capacity of INHSAC and its staff. ACCESS conducted a TOT workshop to reintroduce IUDs into the method mix in Haiti. Designed to upgrade the training skills of the regional coordinators and key service providers who will be trainers at the targeted sites, the training was conducted using recently updated JHPIEGO training packages and materials that include the latest WHO standards and guidelines on FP. ACCESS also provided some equipment

(mostly instruments) and expendable supplies to HS2007 service delivery sites to help strengthen long-term and permanent contraceptive services.

ACTIVITY 3: Establish referral system linking FP clients requesting non-reversible FP methods to sites that provide permanent contraception services

ACCESS is working closely with MSH to adapt existing referral tools/cards for use at the service delivery sites. Staff at the sites will be oriented and/or trained on use of referral tools/cards and on the system of referral for the program once the forms have been finalized.

ACTIVITY 4: Facilitate regular contacts among the stakeholders of the National Family Planning Committee to ensure that family planning issues are addressed at all departmental levels

Following a year of policy and advocacy by USAID, a national committee was established at the Haitian MOPH (MSPP) to outline the essential requirements to reposition family planning as a primary component of reducing maternal mortality and improving child survival.

The MSPP determined it would engage community decision makers and partners that deliver services to work together to re-launch FP in their programs. Departmental committees have been formed to oversee and plan strategically for the re-introduction of family planning as a necessary component of maternal health. Demonstrating the importance of the FP program to the government, in late 2006, the Prime Minister and U.S. Ambassador hosted the national conference, *Repositionnement du Planning Familial en Haiti*.

In December 2007, ACCESS/Haiti staff worked with stakeholders and counterparts at targeted departments to review, elaborate and finalize the departmental plans within the context of repositioning FP. The elaboration of these national plans is currently under way and ACCESS/Haiti staff will continue to provide technical assistance to the MSSP on this activity, particularly for the seven departments that include ACCESS-supported sites.

Expanding and Strengthening PMTCT Services

During FY07, ACCESS will continue to integrate and expand quality PMTCT services into a total of 23 sites (public and HS2007 sites). Efforts are currently under way to continue strengthening those sites that are already providing PMTCT services through technical assistance and monitoring activities. PMTCT services will be introduced and established at the “new” sites that do not offer such services through supporting INHSAC in the training of service providers and site-strengthening. Communication activities to increase demand for PMTCT services and to promote the new sites will also be implemented. In addition to the above, INHSAC has trained a total of 129 services providers in PMTCT through six training workshops.

3. Challenges

As a result of a new initiative “*Repositionnement du Planning Familial en Haiti*” launched by the Government of Haiti at the end of 2006, the USAID Mission refocused its health strategy for Haiti on FP services. This had major implications on the work of all partners in-country: workplans submitted in September 2006 were not approved and resulted in major delays in the startup of

activities for FY07. ACCESS submitted a revised workplan focusing on long-term and permanent contraception and PMTCT in early January 2007.

In addition to a change in focus of activities, the number of targeted sites supported by the ACCESS program has increased from 12 to 23 sites.

ACCESS has been advised that there will be no field support funds for population in FY07. If the funding levels at the USAID/Haiti Mission are reinstated to the previous levels received in FY06, then there is a possibility that additional field support funds will be available in FY08 to support the expansion of FP services.

KENYA

1. Major Accomplishments

- Contraceptive uptake increased on average 15% in three districts where ACCESS provided technical support aimed at facilities. This was a remarkable increase; the target was set at 5% by the MoH and the Implementing Best Practices consortium in Kenya.
- ACCESS supported the NASCOP in the development of provider-initiated counseling and testing training materials. NASCOP has adopted the materials as part of the national HIV training materials in Kenya.
- ACCESS-FP has supported the DRH to reinvigorate postpartum care services with an emphasis on FP. ACCESS-FP developed the first postpartum family planning orientation package for Kenya, which has been successfully used to train a limited number of providers.
- ACCESS is supporting the rollout of integrated management of adult illnesses (IMAI) for HIV. Since October, this has included a TOT to develop competency and advocacy and planning meetings with all target provinces. ACCESS has also supported the development of pediatric HIV training materials.
- ACCESS is working closely with DRH and NASCOP to strengthen supervision for PMTCT. ACCESS has supported DRH and NASCOP in the finalization of the supervision manual for PMTCT services.
- ACCESS has supported the development of TB/ANC materials, which build on the focused ANC package developed with support from JHPIEGO. Training sites have been identified for implementation.

2. Progress Summary

The ACCESS program in Kenya continues to strengthen capacity within the MOH. To date, ACCESS has worked in over 30 districts in six provinces in Kenya. ACCESS/ JHPIEGO technical support targets reproductive health (RH) and FP, safe motherhood (SM), malaria and HIV/AIDS. These comprehensive efforts aim to bring about positive change for women and their families in Kenya. Specifically, ACCESS:

- Improves FP services for women and their partners through international best practices
- Creates informed demand at the community level around comprehensive RH services targeting MIP
- Strengthens providers' capacity to deliver ART and CT services for HIV-positive Kenyans.

Implementing Best Practices

In 2005, DRH/Kenya formed the Implementing Best Practices Consortium in Kenya, which was made up of multiple supporting partners, including JHPIEGO. Through the ACCESS Program, JHPIEGO provided technical support through training and supervision to providers in four districts in Kenya. This targeted support focused on improving providers' knowledge and skills in contraceptive technology, counseling for patients and infection prevention practices. The MOH goal was to increase contraceptive uptake by 5%. An endline survey conducted in three of the four ACCESS-designated districts showed an average increase for contraceptive uptake of 15% surpassing the MOH targets. Targeted training and follow-up supervision among providers certainly contributed to this increase. During the endline, 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.

Postpartum Family Planning

The postpartum FP initiative is a collaborative program with the MOH/DRH, ACCESS FP and FRONTIERS aiming to reinvigorate postpartum care services including FP in Kenya. This program is based on the large unmet need for postpartum care services including FP in Kenya and will be implemented initially in two phases in the Embu district of Eastern province of Kenya. ACCESS FP is providing the implementation technical support and FRONTIERS is conducting the operations research component to examine changes in providers' knowledge, attitudes and practices and utilization of postpartum services including PP-FP among clients. Since October of 2006, a series of meetings was held with the MOH at the central and provincial levels to sensitize stakeholders to the program and to generate buy-in. A PP-FP orientation package was developed and pre-tested, and service providers were trained using the materials. Support supervision was conducted for each of the 25 service providers trained. Key findings from the support supervision include:

- The facility and district health management teams are supportive of this program.
- Most facilities have set aside a separate room for postnatal care.
- From the record registers it was noted that LAM is now a method being offered to postnatal mothers alongside historically popular methods like injectables.
- The postnatal visits schedule is being adhered to and mothers are now coming back after two weeks and six weeks.

TB/Antenatal Care

Despite initial problems getting the senior DRH and national TB and leprosy program officials to work as a team, this program is likely to advance quickly over the next two months because (i) the orientation package has already been developed and (ii) the number of activities and geographical coverage is quite limited. The unique nature of the program will be of interest to other stakeholders so it is important that ACCESS adopts an operations research approach.

ART

Despite delayed startup, significant progress has been achieved within a short time period. Due to excellent relations established with the MOH/NASCOP at the central and provincial levels, as well as by capitalizing on the development of the pediatric orientation package in November 2006, we are likely to achieve the program goals and objectives by September 2007. The MOH as well as the

WHO have expressed appreciation for JHPIEGO's continued responsiveness to NASCOP's needs and priorities.

PMTCT

Because program activities were formulated through close consultation with the DRH, they have remained among the DRH's top priorities. The PMTCT focal persons from DRH and NASCOP are very motivated and are working closely with ACCESS to ensure successful implementation of the consensus meeting for PMTCT supervision manual and tools. Many other stakeholders are anxious to see the PMTCT supervision system in place. Development of a PMTCT communication strategy will become the next top priority for the DRH and NASCOP from April 2007.

Counseling and Testing

The CT scale up program for FY06 provides technical assistance support to NASCOP at the central level and to the Provincial Health Management Teams (PHMTs) at the provincial level. Since October 2006, ACCESS has provided technical assistance to NASCOP's CT working group in the development of the CT learning resource package. As part of ACCESS' goal of building capacity within NASCOP, a five-day instructional design workshop was conducted to develop and repackage these materials; participants learned how to develop instructional training materials. The participants were drawn from all members of the CT working group including; Liverpool VCT, National Laboratories Kenya, Kenyatta National Hospital, the National TB and Leprosy program and the University of Nairobi. The materials were pre-tested in Nairobi through a five-day training for 15 service providers from nine health facilities and institutions; these included public, faith-based and pre-service institutions. Based on the feedback from the pre-test, the materials have now been updated and finalized for national training. The PHMTs have been sensitized to the program and they are ready to roll out trainings in their districts.

3. Challenges

ACCESS funding for Kenya was not received until mid-January 2007, even though program implementation was expected to begin October 2006. This delay has resulted in a late start for all programs and an added pressure for program teams to quickly implement to reach program goals and to satisfy national Kenyan targets. The late startup will be an ongoing challenge throughout the year. The ACCESS Kenya team has shown remarkable gains in a short amount of time.

For the ART program, clinical mentorship—as outlined in the ACCESS/Kenya workplan—is not a current priority for the MOH/NASCOP. NASCOP has requested that JHPIEGO continue to provide technical support for the a) newly launched IMAI; and b) rollout of the pediatric HIV orientation package, as outlined in the JHPIEGO/ACCESS workplan. Rather than training and supporting “clinical mentors” for IMAI and pediatric ART, JHPIEGO will train and support 50 trainers who will subsequently train service providers and conduct support supervision for IMAI and pediatric ART. This updated program approach has been approved by USAID/Kenya.

ACCESS' programs for the DRH Central Support and TB/ANC are moving forward. However, there have been delays due to the late arrival of funding and due to competing priorities within the DRH. However, plans for program implementation have been discussed with appropriate stakeholders and these projects are moving forward.

NEPAL

1. Major Accomplishments

Maternal and Newborn Care LRP for SBA for in-service and pre-service training for auxiliary nurse midwives, nurses and doctors finalized.

ACCESS completed a study at six facilities and surrounding communities on the enabling environment for SBA in Nepal and identified factors influencing use of delivery services in remote areas. Results revealed:

- Most women preferred a home delivery and reserved attendance at a facility only for complications. This was due to the high costs of transportation to the facility, facility fees and negative perceptions of facility staff.
- Facility staff said the lack of providers inhibited the availability of services and that they lacked training, equipment, drugs, decent housing, professional advancement opportunities and education for their children.
- Facility factors that may be associated with high volume of delivery services include “24/7” services/staffing, availability of basic emergency obstetric care; easy access; a referral system and/or ambulance; dynamic facility leader, energetic community collaboration; and employment of local personnel.

Development and implementation of a LBW identification and management intervention at the community level in Kanchanpur district by trained FCHVs. From January to February this year, a total of 176 newborns were identified as LBW (150) and very low birth weight (26) by LBW FCHVs. Of the FCHVs observed, 80% demonstrated proper use of KMC.

Initiation of national LBW management guidelines development with national technical advisory group.

Initiation of KMC at the health facility level: a baseline facility survey on KMC was conducted; a stakeholder sensitization workshop held; a KMC TAG formed; a KMC training manual drafted and reviewed by technical experts; and 17 providers were trained as KMC trainers.

2. Progress Summary

Skilled Birth Attendant Result Pathway

Maternal and Newborn Care Learning Resource Package for Skilled Birth Attendants

The ACCESS Nepal program, along with the Family Health Division (FHD), conducted a third TAG meeting on October 27, 2006. Findings and issues from the field testing of the Maternal and Newborn Care (MNC) LRP from this meeting were shared during the meeting; and additional adaptation of the package was also agreed upon during this time

In November 2006, a three-day workshop was conducted with 36 participants to modify and incorporate findings from the LRP field testing. During this workshop, the group agreed upon which findings to include from the field testing in the final version of the SBA LRP; this included materials, resources and the number of facilities needed to support the use of the SBA LRP and identified the most useful information, which was to be included in a “how to” guide for using the SBA LRP in both in-service and pre-service training programs. In addition to the “how to guide,” participants also recommended the development of pre-test questionnaires, as well as transparencies for each module. An international midwifery consultant helped the ACCESS Nepal program

develop a user's guide for trainer/managers, a pre-test questionnaire and transparencies. The newborn care portion of the guide, which included information on KMC, was reviewed by a local consultant and edited to reflect the national protocol and the curricula used by the Institute of Medicine. During this period, the LRP was formatted, reviewed and finalized for printing.

Nepal has many stakeholders working to improve maternal and neonatal health services including the existing SBA policy and national documents. The ACCESS Nepal Program team participated in various coordination meetings with different stakeholders to ensure integration of the LRP will be integrated with other, ongoing national and project-specific human resources activities, such as curricular reviews and policy-level discussions. One such example was the introduction of the package given at the UNFPA-organized workshop “Roadmap for achieving skilled care by every birth attendant.” Similarly, three SBA forum meetings, organized by National Health Training Center (NHTC) and with support of the Support to Safer Motherhood Programme, were attended by program staff members. The SBA forum mainly focused on SBA training strategies and in-service training site assessment and accreditation. During the meeting, the FHD and other stakeholders proposed to change the title Skilled Birth Attendant Learning Resource Package. The rationale for the change was shared with ACCESS HQ and a new name was given—the Maternal and Newborn Care Learning Resource Package for Skilled Birth Attendants.

ACCESS Nepal also supported the FHD and NHTC to begin immediate use of the MNC LRP for upcoming in-service training activities in 2007. ACCESS assisted in analyzing needs and developing the course outlines based on the MNC LRP to update participants who had received BEOC and Midwifery Refresher Training in the past. This activity was considered a priority for the Government of Nepal. ACCESS Nepal provided technical support and helped prepare trainers by conducting an orientation of the package and of the newborn care module. A total of 23 trainers were updated using the outline and the MNC LRP. These trainers will begin in-service training at four sites: Baglung Hospital in Baglung district; Koshi Zonal Hospital in Biratnagar; Bharatpur Hospital in Chitwan district; and Maternity Hospital in Kathmandu.

ACCESS further supported the NHTC to develop plans and a course outline for in-service training for a large numbers of ANMs, staff nurses and doctors with no previous MNC training. Thousands of providers will need a three-month refresher training to meet new SBA criteria. A rollout plan was developed jointly with NHTC to begin training those providers who have not yet received BEOC and Midwifery Refresher Training. Based on analysis of core skills defined by the National SBA Policy and existing pre-service and in-service curricula, gaps were identified and addressed in the course outline. This outline will be finalized by NHTC in the next quarter.

Building on national interest in accreditation of SBAs and the immediate need at hand to begin in-service training for SBAs, NHTC participated in ongoing discussions with ACCESS on SBA in-service training site assessments and accreditation. In February 2007, a JHPIEGO midwifery advisor shared experiences on MNC training successes in other countries including lessons learned and impacts—particularly on the usefulness of SBM-R. A workshop on SBM-R was conducted to review both the NHTC assessment and accreditation tools for their consistency with the MNC LRP. Discussions have continued between the NHTC and other stakeholders on how ACCESS will most effectively support NHTC SBA training sites in the final year of the ACCESS program in Nepal.

As a part of ACCESS technical support to NFHP, Harshad Sanghvi visited Nepal from March 4–11, 2007 for mid-term review of the “Preventing Post Partum Hemorrhage at Home Births under

Community Based Maternal and Newborn Care” program. He reviewed all aspects of field implementation, including quality of education, safety issues and adherence to protocol. After analyzing and reviewing the data to ensure that project aims are being met (i.e., coverage, safety, and acceptance); Dr. Sanghvi made recommendations for changes in program implementation. Additionally, he met with TAG members and presented his key findings during the CB-MNC TAG meeting on March 8 2007. Lastly, he met with government officials from the FHD and members from the larger development community (Support to Safer Motherhood Programme, WHO, UNFPA, UMN) to help them plan for national rollout of the project. He also worked closely with both Kathmandu- and Banke-based project staff of NFHP and made field visits to meet community volunteers and health workers in Banke.

Study on the Enabling Environment to Support Skilled Birth Attendants in Nepal

During the last program year, a study was conducted in six sites to identify the key factors that contribute to successful utilization of birth attendant services. Also studied were the barriers and constraints to effective use, and potential models that might be recommended for use in rural Nepal. Major findings of the study included that most women preferred and planned a home delivery and reserved attendance at a facility only as a back-up for complications. This was due to the perceived high costs of transportation to the facility and facility fees. Cost was especially important to dalit women, as were concerns regarding possible discrimination due to caste. Attitudes about facility staff among non-users were predominantly negative. Staff felt that the lack of providers inhibits the availability of services. They also felt constrained by a lack of training, equipment and drugs, decent residences, professional advancement opportunities and education for their children. Facility factors which may be associated with high volume of delivery services include “24/7” services and availability of BEOC; easy access; three or more trained staff available in primary healthcare (PHC) centers; a referral system and/or ambulance on site; dynamic leadership of the facility, energetic community collaboration; and employment of local personnel.

Since the beginning of this program year, the ACCESS Nepal team has conducted two workshops involving the Government of Nepal and stakeholders with support from an international and national consultant. The first workshop was organized on November 17, 2006 to share preliminary findings of the study with key stakeholders and to gain opinions, critical assessment and recommendations on the study. A second workshop was held on December 22, 2006 to review study results and collect appropriate recommendations for use. Based on the study findings, the stakeholders elaborated on the potential applications of study findings for 1) strengthening behavior change communication programs and approaches, 2) improving the management of ANC and delivery services, 3) identifying further research needed, and 4) addressing implications for health policies. The study findings were shared with the Government of Nepal and stakeholders in the annual program review meeting of the FHD.

Newborn Results Pathway

Community Based Management of Low Birth Weight Infants in Kanchanpur District

Late last year, a formative study was undertaken to identify local knowledge and perception of families and communities on LBW newborn care in the Kanchanpur district. Study results indicate that most families are still practicing home deliveries; high utilization of untrained birth attendants for home deliveries still exists; babies are kept on the floor, bed, straw mat or plastic while waiting for the placenta to be delivered; and babies are given a bath after birth. The study recommended developing and disseminating proper behavior change messages on these issues.

The LBW pictorial register was developed in Nepal and field tested in Kanchanpur. A total of 10 FCHVs were trained to use the tool. Feedback and comments received from the field testing were incorporated and the register finalized.

The ACCESS Nepal program conducted monthly meetings with NFHP and USAID to discuss the NFHP-implemented CBNMC program and ACCESS program in Kanchanpur. In December 2006, the FCHV subcommittee meeting chaired by the Director of Family Health Division presented information on the role of FCHVs and the LBW program in Kanchanpur. In Kanchanpur, an LBW TOT was conducted for 20 government and NFHP health workers and ACCESS staff members. A total of 138 FCHVs from the Kanchanpur municipality received the BPP/PNC training supported by ACCESS Nepal Program. In addition to the 200 FCHVs selected last year from Village Development Community (VDC), 20 more FCHVs were identified as LBW FCHVs from the municipality area. In total, 220 FCHVs in 11 sites received training on the identification and management of LBW infants. All 220 FCHVs were provided with a box, containing a scale, KMC wrappers, blouses, palliders, a registry, thermometer and IEC materials.

In addition, district development committee members received a one-day orientation on LBW infants, including the importance of the community's role in caring for LBW neonates. A total of 93 district development committee members, volunteers, stakeholders and journalists participated in the orientation.

At the national level the TAG was created with 18 technical experts from the Government of Nepal, Institute of Medicine, private institutions and ACCESS Nepal. The TAG guides and supports both working groups and the ACCESS team while developing national LBW guidelines and KMC introduction in Nepal. Thus far, three meetings have taken place. The ACCESS team developed a KMC training manual; likewise, a KMC intervention and sensitization workshop was developed. Both were shared among TAG members.

The ACCESS Nepal Program, with technical support from a local consultant, Save the Children US /Asia Area Office and ACCESS HQ, developed a database for monitoring the KMC and LBW program in Kanchanpur. The database helps project staff monitor data, progress and regular accomplishments. In January and February of this year, a total of 176 neonates were identified as LBW (150) and very low birth weight (VLBW) (26) by LBW FCHVs. Of the total LBW babies identified, 80% of FCHVs who were observed demonstrated proper use of KMC.

Kangaroo Mother Care at Health Facilities

The ACCESS core-funded intervention KMC initiative at health facilities has made good progress in this semi-annual period. The questionnaire on the LBW neonate from the baseline data collection was developed by the ACCESS Nepal Program, with input from a technical expert from ACCESS headquarters. The objective of the study was to assess the incidence of LBW babies, current care practices and survival status at the time of discharge. The baseline study was conducted in one zonal hospital, Mahakali Hospital, and three primary health care centers—Beldandi, Dodhara and Shreepur—in the Kanchanpur district. The study was also conducted by a team of medical consultants and in one zonal hospital, Seti hospital, in the Kailali district. In addition to the current care practices, information on selected health staff regarding knowledge of KMC, staffing levels and newborn-related equipment and medication were also collected. The study showed that both hospitals had one incubator each, with no incubators in the PHC centers. LBW babies are managed

either by use of an incubator or by asking the mother to wrap her baby skin-to-skin, using an extra cloth. Very little information on the LBW babies, including daily weight, was recorded in the available facility registers, which made it difficult to properly assess the care given.

Similarly, the two zonal hospitals and three PHCs were assessed by the ACCESS team to determine the feasibility and willingness to initiate KMC at their facilities. The team found that all health facilities showed interest in initiating KMC with minimal support, such as basic startup equipment and health worker training.

Two ACCESS staff members from Nepal visited two active KMC center at the All India Institute of Medical Sciences and King Edward Memorial Hospitals in Mumbai. The objective of the visit was to gain knowledge and understanding related to implementing KMC, understanding factors which contribute to success and identifying potential professionals who may be available to provide technical assistance and training in Nepal especially for the introduction of a KMC facility.

A two-day KMC sensitization workshop for policy makers, decision makers and stakeholders was conducted with the technical support of three consultants from India and a technical expert from ACCESS headquarters. The objective of the workshop was to build awareness of KMC as an intervention for improving newborn health in Nepal. The consultants presented the concept, practice, effectiveness, evidence and benefits of KMC. During the workshop, current practices of KMC in Mumbai, Malawi, Delhi and the ACCESS Nepal Program were shared with the participants. A total of 53 individuals participated in the workshop. At the end of the workshop, participants listed next steps and activities for implementing and scaling up of KMC activities in-country. The group recommended sharing this plan with the director of the general department of health services through both the director of the FHD and TAG members during the next TAG meeting.

3. Challenges

Maternal and Newborn Care Learning Resource Package for Skilled Birth Attendance and Other Components to Produce Qualified Skilled Birth Attendants

The development of the MNC LRP for SBAs by the ACCESS program was highly appreciated by the Government of Nepal and stakeholders. The demand for the LRP was high. However, ensuring consistency in utilization by different stakeholders is challenging for the ACCESS Nepal program and the NHTC. Therefore, training of a qualified SBA using the LRP is linked with the trainers and training site preparation, site assessment and accreditation.

In general, support for using the MNC LRP for SBAs as the national standard is strong and positive; however, there is considerable urgency to begin this training quickly. This is due to several factors, including government annual budgets/workplans 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 Government of Nepal supports SBA development, stakeholder coordination has waned during this period. This environment contributed to delays in the initiation and timing of ACCESS activities in early 2007.

Most mothers and family caretakers in the community do not go to the health facility when FCHVs referred neonates as very LBW and/or sick. Due to lack of financial resources or lack of awareness, the community still seeks services from LBW FCHVs or goes to its neighboring country India for

treatment. There is an urgent need to start essential newborn training for health workers and more advocacy activities on the importance of LBW care and KMC at the community level.

In the Kanchanpur district, certain ethnic groups have beliefs that giving birth is something dirty. Only lower caste women touch and take care of the recently delivered women and baby. The woman is later purified after several days postpartum, once the cultural ritual is completed. The FCHVs are local women and these practices hinder the provision of KMC to LBW neonates. Some FCHVs expressed their concerns of being social outcasts even though they would like to try KMC.

The Government of Nepal has made gentamicin available at the PHC level only; other health facilities such as sub health posts do not have gentamicin injections available. This is problematic since this is the next level of health facilities where the LBW FCHVs refer sick neonates.

4. Opportunities

Integrating the Maternal and Newborn Care Learning Resource Package into National Training Systems

In November 2006, WHO and UNFPA supported a workshop, which focused on accreditation of the MNH LRP and highlighted a number of key issues surrounding SBA training systems in Nepal. From this workshop resulted a greater understanding of these issues and a larger commitment to addressing them. To date, all Safe Motherhood partners are using the LRP in their programs. The Safe Motherhood Program and NSI have used the package to train health workers in their districts. Different forums, such as the SBA forum and UNFPA workshop were used to share the package. This level of stakeholder commitment has the potential to build consensus for quality training for SBAs, as well as other inputs such as training site standardization. It also provides a readily available package that can be easily incorporated into pre-service education for staff nurses and ANMs. It is also recognized that national trainings, site assessments and accreditations should be consistent with the contents of the MNC LRP.

Kangaroo Motherhood Care as New Initiative

The KMC sensitization workshop served as the fire to light a keen interest by policy makers, planners and stakeholder for implementing KMC in Nepal. The ACCESS Program Nepal generated interest of KMC initiation among the program implementers. There are many opportunities to expand KMC and work together with different donors and partners. ACCESS would like to build on this foundation and extend KMC to the national level.

NIGERIA

1. Major Accomplishments

Preliminary analysis of a baseline household survey of 414 women who delivered in the past 12 months conducted in Kano and Zamfara states found that:

- 48% of women in Kano and 35.3% 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 19% of the women received childbirth assistance from a nurse/midwife and 20% from a traditional birth attendant. 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. Less than 1% received assistance from a medical doctor.

A baseline survey of 18 government health facilities in four local government areas (LGAs) of Kano and Zamfara (five hospitals and 13 primary health centers/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.

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.

Performance standards for EmONC in hospitals and primary health centers were developed 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.

Maternity and newborn record forms and registers were finalized and 46 relevant health care providers were trained in their usage in Kano and Zamfara states.

Twenty-six community mobilizers in Kano and Zamfara states were trained. A TOT on KMC was conducted for 15 providers, including obstetricians, pediatricians, nurse/midwives and RH coordinators from the Kano and Zamfara MOHs. A workshop for 24 health care providers from both hospitals and primary health centers (PHCs) in the two states on use of the SBM-R quality improvement approach was also held.

Orientation on EmONC for 147 Nigeria Youth Service Corps medical and paramedical staff and sociology graduates in Kano and Zamfara orientation camps was conducted. Twelve Nigeria Youth Service Corps doctors, medical officers, nurse/midwives working in ACCESS-supported facilities in EmONC were trained.

2. Progress Summary

The ACCESS Nigeria program contributed to the SBA, ANC, PPH and newborn pathway through its introduction of the SBM-R approach for PQI at the hospitals and PHCs. The performance standards cover the following thematic areas:

- i. Focused ANC (16 standards)
- ii. Managing complications of pregnancy (16 standards)
- iii. Managing complications of labor, childbirth, immediate postpartum and newborn care (27 standards)
- iv. Further postnatal care for the woman and newborn (23 standards)
- v. Support services, including blood banking, laboratory and pharmacy (25 standards)
- vi. Information, Education and Communication services (5 standards)

- vii. Facility resources (26 standards)
- viii. Management systems (13 standards)
- ix. Infection prevention (34 standards)

During this period, the ACCESS program completed baseline facility and household surveys and qualitative formative research in the four program target LGAs in Kano and Zamfara states. The results are being used to inform the design of program interventions and provide baseline measures against which program success can be measured at the end of the program.

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 is working with the state Ministry of Health (SMOH) to revise maternity and newborn care record forms, antenatal clinic register, delivery register and family planning register. If necessary, ACCESS will print final forms and registers to fast-track their use in the ACCESS-supported facilities.

Political activities during the quarter made interaction with LGA chairmen and senior SMOH officials difficult. Hopefully, the signing of the tripartite MOU between the state government, local government authorities and ACCESS will be concluded in the next quarter. A draft MOU has been forwarded to relevant authorities for comments and negotiation.

The USAID Nigeria Mission redirected funds and as a result ACCESS funding was significantly reduced for fiscal year 2007.

TANZANIA

1. Major Accomplishments

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

ACCESS continued to develop clinical training, service delivery and quality improvement capacity for focused ANC/MIP in government- and FBO-affiliated health facilities and schools, including:

- A total of 178 in-service clinical trainers were trained: 152 providers from health facilities in six regions and 26 zonal and regional RCH coordinators from all the zones in Tanzania
- ACCESS trained 24 diploma nursing and midwifery pre-service educators in focused ANC/MIP, including 13 tutors and 11 preceptors
- ACCESS trained 362 providers from four regions in focused ANC/MIP clinical skills

ACCESS 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.

At ACCESS-supported facilities during this reporting period, over 10,000 ANC clients accessed IPT 1 (58%) and over 8,500 ANC clients received IPT 2 (50%), and close to 11,000 ANC clients received TT2 (63%), and close to 15,000 received ITN vouchers (86%).

ACCESS played a key role in organizing the National White Ribbon Day, which had the theme “advocating for home-based lifesaving skills.” More than 10,000 people marched in Morogoro, where the event was held, and a number of influential people attended.

ACCESS helped introduce a reporting format to facilities to report on the problem of sulfadoxine-pyrimethamine (SP) stockouts which are affecting the delivery of IPT, and is currently working on a monthly reporting system with RCHU and NMCP, tied to the Expanded Program for Immunization (EPI) reporting system, which will help assist in alleviating the problem of stockouts

2. Progress Summary

Scaling up Quality Focused Antenatal Care/Malaria in Pregnancy Services: Over the last six months, ACCESS Tanzania has continued to support the MOH to comprehensively scale up interventions to improve the quality of focused ANC services including prevention and control of MIP using SP for IPT, counseling for use of ITNs, prevention and treatment of syphilis during pregnancy, and IP and control. ACCESS scaled up focused ANC through in- and pre-service training and quality improvement interventions using the ANC quality improvement approach, detailed below.

In-Service Training and Capacity Building: ACCESS Tanzania continued to use the cascade strategy for in-service training in focused ANC/MIP. A total of 538 people were trained in clinical skills on focused ANC in both the in-service and pre-service setting, and including 152 TOTs in focused ANC training skills. The TOTs will now train providers based at their own facilities, as well as those from other hospitals and health centers in their districts. To help these TOTs provide a standardized training in improved focused ANC services throughout the country, a facilitator’s guide was developed.

Performance and Quality Improvement: As part of the program’s quality assurance work, ACCESS facilitated assessments at facilities with trained focused ANC/MIP providers through application of a standards-based quality assurance approach. During this reporting period, 40 health facilities (18 hospitals, 12 health centers and 10 dispensaries) conducted a total of 53 ANC quality assessments at their facilities on focused ANC/MIP using the ANC quality improvement tool. An overall trend of improvement was seen from baseline to subsequent assessments (see Table 1 below).

Table 1: Tanzania focused ANC/MIP Baseline and Follow-up Assessment Standards-based Quality Assurance Assessment Scores (Percentage) for October 2006–March 2007

	MEAN	MEDIAN	RANGE
BASELINE ASSESSMENT SCORE (N=8)	44.4	38	21-65
1ST FOLLOW-UP ASSESSMENT SCORE (N=31)	50.2	51	27-82
2ND FOLLOW-UP ASSESSMENT SCORE (N=9)	59.4	54	48-79
3RD FOLLOW-UP ASSESSMENT SCORE (N=5)	57.4	54	51-70

Advocacy: Leaders and policy makers in Mwanza, Ruvuma and Tanga regions were part of advocacy meetings to support focused ANC interventions and ensure that funds for ANC interventions are allocated in District Council plans. Participants ranged from regional and district medical officers, district planning and nursing officers, to representatives from both FBO and government hospitals. To standardize the structure and content of the advocacy meeting, ACCESS developed the “Focused ANC/MIP/SIP Advocacy Guide,” which outlines the contents of advocacy meetings that target leaders and policy makers at national, regional, district and health facility levels.

Learning Materials Development: The infection prevention and control English and Kiswahili pocket guides were finalized. 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 IP and control practices in a simple, readable and easily understandable format. The documents have been formatted for printing and after approval by the MOHSW, 2,000 copies of the Swahili version and 500 copies of the English version will be printed and disseminated to the service providers and policy makers.

Pre-Service Education: ACCESS supported the MOHSW’s Human Resource Development department to build the capacity of 11 midwifery tutors from five different midwifery schools and 13 preceptors from affiliated health facilities. The tutors are responsible for training nursing and midwifery students in focused ANC/MIP/SIP.

ACCESS developed a quality improvement tool for pre-service education in consultation with the MOH/Human Resource Development Department, Muhimbili University College of Health Sciences and the other diploma nurse midwifery schools, to be used for assessing the quality of teaching in the Nursing and Midwifery schools, based on performance standards taught in the ANC curriculum. The tool has been pre-tested in various schools in the country and will further be pre-tested during training of the tutors.

Advocacy meetings were held with stakeholders of pre-service education, including principals of the diploma and higher nursing midwifery schools, tutors, medical officers from affiliated hospitals and district medical officers. A total of 120 stakeholders in over four regions participated. Key accomplishments included a commitment to improve linkages between the schools and the clinical practical sites as well as the district council.

Service Uptake: Fifty-four ACCESS-supported facilities (21 hospitals, 18 health centers and 15 dispensaries) reported on their service statistics during this reporting period. Table 2 below shows the uptake of selected services in these facilities. The table demonstrates that IPT uptake at facilities

with ANC providers trained through ACCESS-supported training events is higher than among ANC clients in the general population, as measured by the most recent DHS (52.1% for IPT1 and 21.7% for IPT2 among all ANC clients surveyed).²

Table 2: Focused ANC/MIP Service Statistics for Selected ACCESS Facilities Compared to National Average (October 2006–March 2007)

SERVICE	NUMBER OF ANC CLIENTS RECEIVING SERVICE	PERCENT OF ANC CLIENTS RECEIVING SERVICES	NATIONAL AVERAGE (DHS 2004/05)
IPT 1	10,053	58% ³	52%
IPT 2	8,584	50%	22%
TT2	10,794	63%	56%
Iron	34,222	70%	61%
ITN Vouchers	14,841	86%	75% ⁴

In addition, ACCESS-supported facilities reported on syphilis screening. In ACCESS-supported facilities, 79% of ANC clients were screened for syphilis (see Table 3) using the rapid plasma regain (RPR) test.

Table 3: Syphilis Screening Statistics for Selected ACCESS Facilities

SCREENING FOR SYPHILIS	NUMBER OF ANC CLIENTS RECEIVING SERVICE	PERCENT OF ANC CLIENTS RECEIVING SERVICE
Tested	13,660	79%
Positive	459	3%
Positive and Treated	448	98%
Positive Partner Treated	370	81%

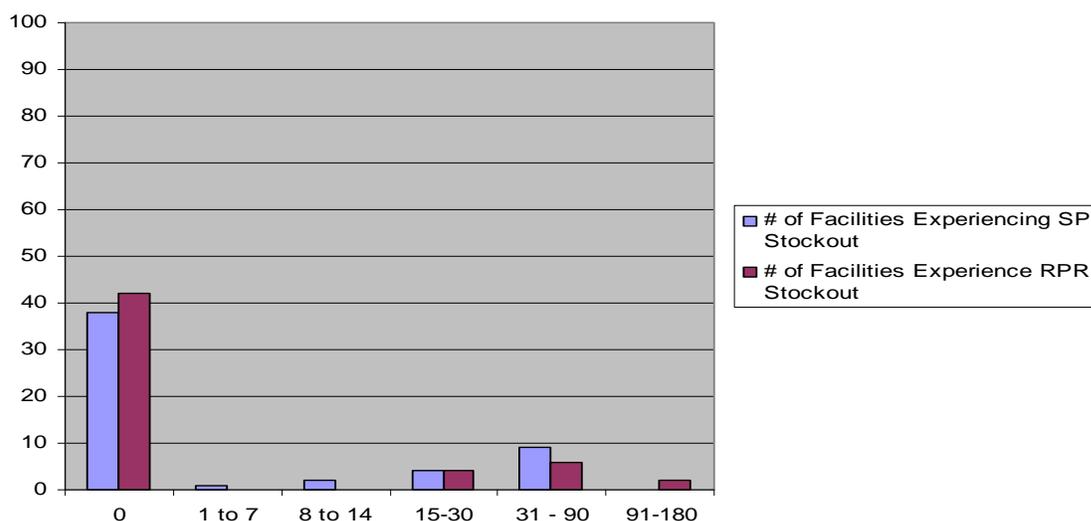
The ACCESS program was able to bring the problem of stockouts of SP to the attention of the NMCP by increasing documentation and presenting evidence of stockouts through an improved reporting system. ACCESS is in the process of working with RCHS and the NMCP to come up with a reporting system for SP and other key ANC supplies and drugs (such as RPR kits for syphilis testing) that will link in with the monthly EPI reporting system, in order to help facilities get a quicker response to the problem of SP stockouts. The graph in Figure 1 and Table 4 show some of the documentation of stockouts that have been presented to the NMCP and other agencies involved in supply of SP to facilities. In this graph, 54 facilities reported information about whether or not they had stockouts during the reporting period (21 hospitals, 18 health centers and 15 dispensaries).

² Tanzania Demographic Health Survey 2004-05. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.

³ Denominator is first visit ANC clients.

⁴ Report on 2006 TNVS, Hanson et al., IHDR and LSTMH, 2007.

Figure 1: Number of Days Selected Facilities Experienced SP and RPR Kit Stockouts (October 2006 –March 2007



In addition to documenting SP stockouts, ACCESS is also trying to solve the problem of stockouts of RPR kits for screening for syphilis. In the same 54 health facilities, the following stockouts for RPR kits were documented:

Table 4: Stockouts of SP in ANC delivery area

NUMBER OF DAYS	NUMBER OF FACILITIES	PERCENT OF FACILITIES
0	42	78%
1-7	0	0
8-14	0	0
15-30	4	7%
31-90	6	11%
91-180	2	4%
TOTAL	54	100

White Ribbon Alliance: The WRATZ launched a campaign to advocate for increasing qualified health workers as a strategy to reduce maternal deaths. During this reporting period, an assessment was conducted in the districts of Sumbawanga, Geita and Monduli. The most striking findings were in the Sumbawanga district, where some of the key results included:

Increased deployment of medical staff in over half of the dispensaries, with three dispensaries gaining a skilled attendant for labor and delivery

The Sumbawanga district council started a nursing/midwifery school, with its intake coming from the Sumbawanga secondary school, aiming to employ/deploy the graduates locally

Sumbawanga has planned and budgeted to upgrade some staff to have the skills and qualifications to be able to conduct cesarean sections at the two health centers

ACCESS is very proud to have been part of White Ribbon Day on March 25 when more than 10,000 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, some ministers, MPs and other UN representatives, such as UNICEF, WHO, etc. The guest of honor of the day was the 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.

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.

Recruiting and training new staff 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.

A strained relationship with the MOHSW Reproductive and Child Health Section and NMCP delayed the finalization of the 2006/07 workplan and the focused ANC training materials. Much effort has been directed to improving this relationship.

Frequent stockouts of SP, ferrous sulphate 200mg tablets, folic acid 5mg tablets and RPR kits was experienced in most 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 purposes.

IV. DETAILED PROGRAM ACHIEVEMENTS: REGIONAL INITIATIVE FIELD FUNDS

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
- Malaria Action Coalition
- West Africa

AFR/SD

1. Major Accomplishments

- ACCESS completed follow-up visits with the four Ghanaian participants from the May clinical training skills course in Ghana in order to assess retention of skills in essential maternal and newborn health practices. All Ghanaian participants were shown to be competent in key skills.
- In Ghana, Ethiopia, Tanzania and Malawi, ACCESS conducted a two-day computer-based course entitled “ModCal (Modified Computer Assisted Learning) for Clinical Training Skills,” for the midwifery educators participating in the Africa/SD initiative, as well as other interested partners. The ModCal course was in preparation for the Regional Clinical Training Skills/Curriculum Design course.
- ACCESS supported a six-day regional clinical training skills/curriculum design course in Ethiopia in January 2007 for 15 midwifery educators from the four target countries. Building on lessons learned through the ModCal course, participants honed their training skills and practiced curriculum design skills such as development of lesson plans. Fourteen out of 15 participants completed the course as candidate clinical trainers. The final participant left the course early due to illness.

2. Progress Summary

In 2003, the African Regional Reproductive Health Task Force, spearheaded by WHO/AFRO, called upon countries and partners to develop and implement the Africa Road Map for Accelerating the Attainment of the Millennium Development Goals related to MNH. One of the major challenges identified to achieving these goals was the “weak national human resources development and management” found in many African countries. To this end, the ACCESS program, in collaboration with WHO/AFRO and with funding from both the AFR/SD Bureau of USAID and ACCESS core funding from USAID, decided to strengthen pre-service midwifery education in order to build a sustainable strategy for meeting the need for greater numbers of SBAs—especially those with competencies in essential and emergency maternal and newborn care.

During the reporting period, ACCESS contributed to the SBA pathway by rejoining the midwifery educators who received technical updates in Year 2 for the development of their clinical training and curriculum design skills. The midwifery educators were first introduced to clinical training skills and competencies through a computer-based course. 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 will support these new trainers to hone their

skills in their home countries by supporting a technical update and clinical site strengthening for other midwifery/nursing educators at one model facility in each country.

Furthermore, ACCESS has developed a generic pre-service nurse/midwifery curriculum that will be pre-tested during the site strengthening and technical update activities in each country. This will serve as the basis for updating the curricula for the four Anglophone countries scheduled in Year 4 and will be customized based on each country's individual needs.

Also during the reporting period, ACCESS' AFR/SD workplan approval came in January 2007. Due to this late start date, few activities targeting the Africa Road Map have begun. The first activity—technical assistance to Mozambique—is scheduled for April–May 2007.

3. Challenges

The ministries of health in the four Anglophone countries have not been as engaged in the implementation of the pre-service activities as would be ideal. Therefore, ACCESS has been organizing teleconference meetings, including WHO/AFRO-Brazzaville, the AFRO country offices, and the ACCESS country teams to discuss ways in which to further gain buy-in of the MOH. To date, calls to Ethiopia and Malawi have taken place.

One of the participants of the CTS in Ethiopia became very sick and was evacuated to Nairobi for emergency surgery. The participant eventually returned home to Ghana and is recovering.

Identifying activities for supporting country efforts in moving forward the Africa Road Map has proven to be challenging. Reasons for these challenges include the fact that all countries are at different stages in implementing the Road Map, and there has been a lack of communication to governments that ACCESS is available to provide technical assistance. After lengthy conversations and meetings with WHO/AFRO and USAID, four activities were programmed for Year 3. All are scheduled to take place in the second half of the year.

MALARIA ACTION COALITION

1. Major Accomplishments

- ACCESS is providing technical guidance to countries in Africa as they work toward 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 President's Malaria Initiative.
- At the request of the Madagascar MOH/FP, JHPIEGO held a five-day workshop with key stakeholders to develop norms and protocols for malaria and MIP. 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.
- ACCESS supported the MOH in developing orientation materials and in the training of CORPs on comprehensive reproductive health services including MIP. To date, 439 CORPs have been trained.

2. Progress Summary

Madagascar

Following the validation of a national malaria policy, the Madagascar MOH/FP identified a need to develop norms and protocols for its implementation. 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. To respond to this request, in January, JHPIEGO held a five-day workshop with key stakeholders from the MOH/FP and completed the document for both malaria and MIP. During the workshop, the participants outlined a plan to have the document validated and disseminated.

In a second workshop in January, JHPIEGO worked with the NMCP to develop a job aid. The preliminary draft included the following content areas:

- The importance of a confirmatory test before giving ACT treatment to children under the age of 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

Finally, the JHPIEGO team worked with the NMCP and the DRH to combine the MIP and case management of malaria performance standards into one document. The domains include:

- Welcoming, patient-oriented reception services, community relations
- Focused ANC
- Malaria case management
- Management systems
- Human and material resources
- IP practices

The team then accompanied the NMCP to test this tool in two health centers. The final score in the centers were 4.76% and 12.2% of standards achieved. Together the NMCP and the JHPIEGO team outlined an activity plan to complete the quality assurance process in these and four other health facilities this year.

Kenya

ACCESS supported the MOH in developing orientation materials and in the training of 439 CORPs on focused ANC and MIP. This training is in line with the new MOH's 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.

3. Challenges

Kenya—Lack of funding to support the rapid scale-up from the initial three ACCESS/MOH districts

Kenya—Ensuring continued collaboration and active involvement of RH under the PMI initiative in order to address MIP

WEST AFRICA

1. Major Accomplishments

- ACCESS made follow-up visits to seven out of the 13 original providers from Kaedi district, Mauritania who had been trained in EmONC in November 2006. All seven midwives reported that they practiced AMTSL routinely.
- The Regional Hospital Center in Sokode District, Togo was selected to be developed as a clinical training site. Following a site assessment in October 2006, ACCESS helped equip the site with the necessary training materials and medical supplies to conduct an EmONC training.
- Social mobilization efforts are under way in 18 health zones of Ngaoundere district, Cameroon. In each zone, the community liaison teams conducted auto-diagnostic participatory sessions in which community members were able to analyze their own problems related to maternal and newborn health, formulate solutions and develop action plans.

2. Progress Summary

The main objective of the ACCESS/West Africa program has been to create the replication of best practices in MNC in non-USAID presence countries throughout the 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.

In Program Year 3, 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.

Cameroon

ACCESS has developed the Ngaoundere district hospital as a clinical training site and conducted two clinical courses at this site, training a total of 39 providers in Cameroon from two districts (Ngaoundere and Tibati). Furthermore, five strong providers from Cameroon were selected to participate in a Regional Clinical Training Skills course in Burkina Faso in September 2006. Having completed this course, these five providers are currently “candidate clinical trainers” and are in the process of organizing another clinical training course for which they will act as facilitators under the tutelage of a master trainer. In this way, ACCESS will have helped to build in-country capacity for training. Following the training, the next steps for this work in Cameroon is to have the Cameroon

trainers conduct follow-up visits of the newly trained providers, and to introduce and begin rolling out a quality improvement process using the SBM-R approach.

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. For example, in Boumdjere zone, problems identified included that pregnant women do not return to the clinic for ANC appointments and do not deliver at the facility. Activities to address these problems include: 1) making household visits to pregnant women; 2) organizing educational discussions; and 3) holding advocacy meetings with traditional leaders. For each activity, action plans included the timeframe for completion, the responsible persons and resource persons, an indicator for success and the source of verification of such data. The next step is to transfer communication tools and skills to the provincial pool (a group of representatives who serve as social mobilization trainers) so that they can assist communities to carry out their action plans.

Mauritania

In Mauritania, ACCESS continues to work to build the capacity of doctors, midwives and anesthetists in EmONC. To date, 20 providers from Mauritania have been updated in these best practices either through a clinical skills standardization course or through a clinical coaching course that was held in Burkina Faso. In addition, three providers completed the Regional Clinical Training Skills course. A follow-up visit was made to Mauritania by ACCESS and AWARE program staff and an ACCESS clinical consultant to: follow up and assess those providers who have already been trained; assess the status of the training site at Kaedi hospital; and advocate with regional and national level stakeholders—both MOH and UNICEF—for improved human resources. The visit elaborated many continuing challenges that providers in Mauritania face, but also revealed opportunities for improvements. Conditions at the training site, Kaedi hospital have significantly deteriorated. However, two other clinical sites—Kaedi Health Center and Toulde Health Center—had greatly improved. In both these sites, as well as with all the providers evaluated, AMTSL was reportedly systematically practiced. But use of vacuum extraction and the partograph remained low or not practiced at all at the facilities visited.

Niger

Using the same training site (Zinder), which ACCESS had strengthened with materials in Year 2, a clinical skills standardization training is currently underway for 20 providers from the Maradi district. This course is being led by candidate Nigerian trainers who participated in the Regional Clinical Training Skills 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. Approximately one to two months following this training, the team of Nigerian trainers will follow up these providers, assessing their retention of skills and implementation of best practices in their home facilities.

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. Training dates have yet to be finalized, but will include the providers who participated in the Regional Clinical Training Skills course as co-facilitators.

3. Challenges/Opportunities

This year, challenges remain in Mauritania. The follow-up visit conducted in January 2007 found that many of the trained providers are not able to implement the best practices, especially use of the vacuum extractor for assisted delivery. There were many cited barriers to implementation of these new best practices. Midwives at Kaedi Regional Hospital noted that they did not practice vacuum extraction as they did not feel competent in this skill and preferred to rely on forceps. Use of manual vacuum aspiration for post-abortion care was also not part of regular practice. The hospital only had one manual vacuum aspiration kit, which was defective. Other issues noted were the absence of a newborn respirator and the neglect of use of the partograph. It is important to note that all necessary equipment, including a giant partograph, were supplied by ACCESS in August 2005, prior to the initial training. It was also found at Kaedi hospital that many essential drugs, such as oxytocin, were locked in a warehouse, the only key with the gynecologist who had left his post approximately six months prior. Many of these medications were found to be expired.

As noted, conditions at the formerly developed training site, Kaedi hospital have significantly deteriorated. The gynecologist stationed at this hospital has left for unknown reasons and is yet to be replaced. In the interim, the hospital director has been taking over these responsibilities, but he is not highly engaged in the ACCESS/AWARE activities. Therefore, he is also not supportive of his trained staff to make changes. Past attempts to further engage him, such as implicating him in training work or attending clinical coaching in Burkina Faso have not been fruitful. Furthermore, Kaedi hospital has an additional dearth of human resources in the maternity. There are currently only three practicing midwives at the hospital and only two of whom are capable of conducting night duty. For these reasons, a decision was made among stakeholders that the training site should be relocated from Kaedi District Hospital to Aleg District Hospital which is in the neighboring region of Brakna. Providers from Aleg participated in the earlier clinical training in Kaedi. Furthermore, meetings were held with the regional health director, the hospital director and the hospital's ob/gyn who were engaged in transferring the intervention to their site. The gynecologist, Dr. Mahmud, assured the assessment team of his intention to stay in this region.

Overall, many of the issues in Mauritania stem from higher-level difficulties. For example, it became clear that the country does not have a strategic plan for deployment of human resources or good policies for assuring quality services. The MOH of Mauritania recognizes its limitations and asked UNICEF, AWARE and ACCESS for support to improve its national strategy. To this end, it was agreed that UNICEF will support a visit by Dr Ouedraogo Charlemagne, a renowned leader in West Africa on maternal and newborn health and a JHPIEGO/ACCESS master trainer, to travel to Mauritania and work with stakeholders to develop a new plan. This visit took place April 23–27, 2007.

ANNEX A: ACCESS PROGRAM COVERAGE MATRIX

ACCESS clinical (e.g., capacity building and service delivery) and community-based (e.g., demand generation) interventions reached women and families in Nepal, Afghanistan, Bangladesh, Ghana, Haiti, Kenya, Nigeria, Mauritania, Cameroon, Burkina Faso, Tanzania and Madagascar. **Table 7** below presents detailed information on the types of interventions being implemented in each country and the associated population coverage (those living in the intervention target communities and/or facility catchment areas). This matrix does not capture national-level policy work.

Table 7: ACCESS Program Coverage

COUNTRY INTERVENTION	# OF COMMUNITIES	# OF FACILITIES	# OF DISTRICTS/ DEPARTMENTS	% OF DISTRICTS/ DEPARTMENTS	# OF REGIONS/ PROVINCES	TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS)	# OF WOMEN OF RE-PRODUCTIVE AGE (15–49)
AFGHANISTAN							
Community-based PPH study: Counseling + misoprostol	N/A	6	3 out of 329	1%	2 out of 3	79,500	18,285
Community-based PPH study: Counseling alone	N/A	3	3	1%	2 out of 3	35,840	8244
BANGLADESH							
Prenatal/postnatal Community Outreach visits and referral	7 sub-districts (upazillas)	N/A	1 out of 64	1.6%	N/A	1,443,841	Not available
BURKINA FASO							
FANC/MIP service delivery scale-up		49	5 out of 53	9%	1 out of 11	3,849,335	798,737 (estimate)
CAMEROON							
EMNC (SBA) training and service delivery		26	2 (Ngaoundere and Tibati) out of 58 departments*	3%	1 out of 10	281,111	67,186 (estimate)
Social mobilization for quality maternal and newborn care	18 catchments areas	N/A	1 (Ngaoundere) out of 58 departments	2%	1 out of 10	244,009	58,318 (estimate)

COUNTRY INTERVENTION	# OF COMMUNITIES	# OF FACILITIES	# OF DISTRICTS/ DEPARTMENTS	% OF DISTRICTS/ DEPARTMENTS	# OF REGIONS/ PROVINCES	TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS)	# OF WOMEN OF RE-PRODUCTIVE AGE (15–49)
GHANA							
Technical Updates and Clinical Skills Standardization for Midwifery Educators		1	1 (Accra City) out of 138 districts	1%	1 out of 10 regions	2,029,143	515,402 (estimate)
HAITI							
PMTCT service delivery (ANC clinic and maternity)	N/A	23	7 out of 10	70%	N/A	2,797,200	668,531
PAC service delivery	N/A	11	8 out of 10	80%	N/A	1,978,800	472,933
KENYA							
Implementing Best Practices: Service delivery in FP, Contraceptive Tech. Update and IP, including facilitative supervision	N/A	Nakuru district-164 Nyeri district-100 Homabay district-35 Migori district-60	4 out of 76	6%	4 out of 7	Nakuru district 1.5 million Nyeri district-799,697 Homabay district-320,000 Migori district-35,818	Nakuru district-367,500 (estimate) Nyeri district 676,053 Homabay district – 78,400 (estimate) Migori district-8,775 (estimate)
Postpartum Family Planning (ACCESS-FP)	N/A	4 facilities	1 district- Embu	1.3%	1 out of 7	318,724	78,087

COUNTRY INTERVENTION	# OF COMMUNITIES	# OF FACILITIES	# OF DISTRICTS/ DEPARTMENTS	% OF DISTRICTS/ DEPARTMENTS	# OF REGIONS/ PROVINCES	TOTAL POP. (IN TARGET COMMUNITIES OR FACILITY CATCHMENT AREAS/DISTRICTS)	# OF WOMEN OF RE-PRODUCTIVE AGE (15–49)
Demand generation for RH/MIP services-scale-up of community RH/MIP package	2 divisions (Usigu & Madiany) in Bondo district 2 divisions (Wote & Kaiti) in Makueni district 2 divisions (Lunga Lunga, Msabweni & Kinango) in Kwale district		3 malaria-endemic districts out of a total of 45 malaria-endemic districts	7%	3 out of 7	-Bondo district-287,014 -Makueni district-887,266 -Kwale district-600,000	-Bondo district-70,318 (estimate) -Makueni district-217,380 (estimate) -Kwale district-13,679
MADAGASCAR							
FANC/MIP service delivery scale-up		76	4 out of 22	18%	2 out of 6	710,808	164,197 (estimate)
MALAWI							
Technical Updates and Clinical Skills Standardization for Midwifery Educators		1	1 out of 27 (Kasungu)	0.4%	3	480,659	106,706 (estimate)
MAURITANIA							
EmONC (SBA) service delivery		13	7 out of 44*	16%	6 out of 13	1,063,755	245,727 (estimate)
NEPAL							
SBA LRP pretest	3 sites	Pretesting: 2 hospital and 1 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	6 sites	6 IST sites	6 out of 75 districts	8%	4 regions out of 5	TBD	TBD
Mgmt. of LBW infants at community level	60,158 households	10 SHP, 8 HP, 3 PHCC,	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)
		1 zonal hospital					
Facility Based KMC	61 Village Development Committees, 3 municipalities	2 zonal hospitals and 3 PHCC	2 districts out of 75	3%	1 out of 5	1,016,204	197,103
NIGERIA							
Technical Updates and Clinical Skills Standardization for Midwifery Educators	N/A	5 Gen Hospitals 12 PHCs	4 LGAs (districts) out of 774 (Gusau and Kaura Namoda in Zamfara state and Dawakin Tofa Kano Municipal in Kano state)	.3%	1 out of 6	4,060,714	942,086 (estimate)
TANZANIA							
FANC/MIP service delivery scale-up		356	78 out of 128	48.4%	18 out of 21	27,948,513	5,581,318

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

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

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

ANNEX B: ACCESS GLOBAL M&E FRAMEWORK WITH RESULTS

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
ACCESS Program Result: Increased use and coverage of maternal/neonatal and women's health and nutrition interventions						
<p>A. Number of ACCESS countries demonstrating improvement in ACCESS target areas in the past year in indicators appropriate to areas of program activity as determined by country-specific M&E plan and budget agreed by USAID Mission</p> <p>(collection is field-dependent)</p>	<ul style="list-style-type: none"> ACCESS countries will be identified on an annual basis according to funding levels and scopes of work. Countries with funding under \$300K per year may be considered ACCESS countries if the SOWs are extensive enough, e.g., include activities under at least 4 ACCESS IRs. Indicators to track, appropriate to areas of program activity, will be determined from the final country M&E plans and budget agreed by USAID Mission, but potentially include: <ul style="list-style-type: none"> i. %/# of births attended by skilled attendants ii. %/# of mothers who report immediate and exclusive breastfeeding for last live birth iii. %/# of ANC clients in malaria-endemic areas who receive IPT and appropriate counseling on ITN use during pregnancy and for newborns iv. %/# of ANC clients who receive appropriate HIV/AIDS counseling for PMTCT vi. %/# of mothers who receive antenatal iron folate The number will be calculated as an annual count of countries meeting the definition criteria. 	<p>Program records and country reports, population-based surveys by ACCESS, HMIS</p>	<p>M&E review of country-level M&E indicators</p> <p>Annual</p>	<p>Program lead staff and M&E staff of ACCESS</p>	<p>Baseline: 0</p> <p><i>Target: selected ACCESS countries, including: Tanzania, Haiti, Nigeria, Bangladesh, Nepal, India, Cambodia, Rwanda</i></p>	<p>N/A-annual update only</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>B. Number of ACCESS countries demonstrating improvement since the last survey in appropriate impact/outcome indicators collected by other mechanisms (e.g., DHS, MICS, RAMOS, SPA, and others)</p> <p>(collection is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS countries: see above. • Indicators to track will be determined in conjunction with the country's USAID Mission considering planned data collection activities relevant to maternal, neonatal, and women's health and nutrition status and potentially include: <ul style="list-style-type: none"> • i. % of births attended by skilled attendants (national) • ii. % of mothers reporting breastfeeding within the first hour of birth for last child (national) • iii. immunization coverage rates • iv. ITN use rates for (a) population; (b) mothers/newborns • v. % of facilities offering maternal/neonatal services that provide integrated PMTCT services • The number will be calculated as an annual cumulative count of countries meeting the definition criteria. 	National or other project data (e.g., DHS, MICS, etc.)	M&E collaboration with other organizations and USAID Annual	M&E in collaboration with country USAID and other MNH stakeholders	Baseline: 0 <i>Target: selected ACCESS countries with relevant data that correspond with ACCESS intervention areas, incl.: Tanzania, Haiti, Nigeria and Bangladesh, Cambodia, India, Rwanda</i>	N/A-annual update only
<p>C. (Country-level) Estimated population of women of reproductive age living in communities or catchment areas of facilities targeted by ACCESS interventions</p>	<ul style="list-style-type: none"> • The number of reproductive age women is the female population estimated to be between the ages of 15–49. • Communities or catchment areas targeted by ACCESS will be determined at the country level. • The number will be calculated as country totals <i>where appropriate and available</i> and a global total for all of the countries meeting the definition. 	National census data, DHS data or other national sources as available	Program and M&E analysis and review of available national data per targeted areas Semi-annual	Program lead staff and M&E staff of ACCESS	Baseline: 0 <i>Target: all ACCESS countries with relevant data</i>	9,821,201

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>• ACCESS Program Intermediate Result 1: Global leadership for maternal, neonatal, and women's health and nutrition program and policies strengthened</p>						
<p>1a. Number of technical approaches and/or products being promoted for international use through ACCESS leadership roles</p>	<ul style="list-style-type: none"> • Technical approaches and products include those advocated by USAID. Some may be strengthened by ACCESS prior to promotion while other approaches that are already proven will simply be promoted by ACCESS. • Technical approaches and/or products strengthened by ACCESS are those where ACCESS review and improvement activities are reported to have been successfully completed. • Promotion for use occurs through many venues: meetings, collaboration, alliances and partnership implementation. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Semi-annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 1: 10 Year 2: 25 Year 3: 28</p>	<p>25</p>
<p>1b. Number of countries that implement and promote national policies, including service delivery guidelines, to increase access to high-quality maternal and neonatal health services</p>	<ul style="list-style-type: none"> • Policies, including clinical care and service delivery guidelines, are national instructions meeting international evidence-based quality criteria related to ACCESS goals. • Countries increasing access to high-quality EMNC services are those whose national leadership, MOH and/or others ensure dissemination of such standards in strategies that reach the point of service delivery and service providers. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> Year 1: 4 Year 2: 4 Year 3: 4 <i>Tanzania, Haiti, Nepal, India</i></p>	<p>4 countries:</p> <p>Tanzania – National Infection Prevention Guidelines</p> <p>Haiti – National PMTCT guidelines</p> <p>Nepal-Skilled Birth Attendance Polciy</p> <p>India-Skilled Birth Attendance guidelines</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>1c. Number of international and/or national policies, including service delivery guidelines, revised and/or strengthened to promote access to and coverage of integrated EMNC services</p>	<ul style="list-style-type: none"> • Policies and guidelines are international or national instructions to health system decision-makers (e.g., clinical service delivery points, managers, and service providers) meeting international evidence-based quality criteria related to ACCESS goals. • Policies and guidelines promoting access to integrated EMNC services are those whose focus includes expanding availability or coverage of service delivery covering the ACCESS-recommended package of EMNC and other services. • Revised or strengthened policies and guidelines are those where ACCESS review and improvement activities targeting EMNC service integration are reported to have been successfully completed. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of activity results per indicator criteria</p> <p>Annual</p>	<p>ACCESS technical staff and M&E</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 1: 3</i> <i>Year 2: 2</i> <i>Year 3:</i> <i>Afghanistan</i> <i>Nigeria,</i> <i>Malawi</i></p>	<p>Nigeria: National performance standards for maternal and newborn health developed</p>
<p>• ACCESS Program Intermediate Result 2: Preparation for childbirth improved</p>						
<p>2a. Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved birth planning</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-targeted communities are those identified social and geographic areas where program activities and alliances aim to enhance shared responsibility and collective action in birth preparedness/ complication readiness. • Achievement of improved birth planning is defined as having fulfilled birth preparedness goals of the community's self-developed action plan. • The number will be calculated as an annual count of targeted communities meeting the definition criteria. 	<p>Program reports and activity tracking</p>	<p>Program and M&E review of program reports</p> <p>Annual</p>	<p>Program staff in-country with ACCESS M&E review</p>	<p>Baseline: 0</p> <p><i>Targets:</i> <i>Year 1: 0</i> <i>Year 2: 4</i> <i>Year 3: 4 countries,</i> <i>Cameroon,</i> <i>Nigeria,</i> <i>Bangladesh</i> <i>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>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>2b. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received 2 tetanus toxoid (TT) injections</p> <p>(applicability is field-dependent)</p> <p>[Note: Tanzania definition: Number of ANC clients with 2 doses of TT/Number of 1st visit ANC clients]</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target TT as an area for improvement. Activities may target facilities, or home-based care. Percent of women delivering in facilities is according to facility records showing 2 TT injections having been given to the mother: Number of women's records that show a delivery in the past 6 months and 2 TT injections prior to that delivery (numerator)/ number of women's records that show a delivery in the past 6 months (denominator). Number delivering in communities will be calculated from home records if available (e.g., if the country uses cards the client keeps) or program records. 	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Annual</p>	Program country staff with ACCESS M&E review	<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>	Tanzania – 63% (54 facilities)

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>2c. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received iron/folate supplementation</p> <p>(applicability is field-dependent)</p> <p>[Note: Tanzania definition: Number of ANC clients who received iron (alone)/Total number ANC visits]</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target iron/folate supplementation as an area for improvement. Activities may target facilities, or home-based care. Percent of women delivering in facilities will be calculated from facility records that show iron/folate supplementation having been given to the mother: Number of women's records that show a delivery in the past 6 months and iron/folate supplementation prior to that delivery / number of women's records that show a delivery in the past 6 months (numerator/denominator). Number of women delivering in communities will be calculated from home records if available (e.g., if the health system uses cards that the client keeps) or program records. 	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: not known at country levels</p> <p><i>Target:</i> <i>Year 3: 2 countries, Tanzania, Bangladesh</i></p> <p><i>% TBD per final country workplans</i></p>	Tanzania – 70%% (54 facilities)
<p>2d. Percent/number of women who gave birth in the past 6 months who received counseling/information/materials for ITN use during pregnancy and with newborn</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target ITN use for improvement. Women delivering in communities in the past 6 months will be identified through program records or if appropriate facility-based records. Delivery/receipt of counseling, information and/or materials (including vouchers) for ITN use will be determined from program records or if appropriate facility-based records. The number will be calculated as a semi-annual count of women meeting the definition criteria. 	HMIS and/or home records	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: not known at country levels</p> <p><i>Target:</i> <i>Year3: 1 country, Tanzania</i></p> <p><i>% TBD per final country workplans</i></p>	Tanzania proxy indicator: 86% of ANC clients received ITN voucher (54 facilities)

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>2e. Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 1st 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"> Calculation: Number of pregnant women who receive IPT1 under observation/ Number of 1st ANC visits This indicator will be reported by country only where ACCESS activities target IPT with sulfadoxine-pyrimethamine (SP) as an area for improvement. Receipt of IPT with SP will be determined from facility records. These indicators will be measured in malaria- endemic countries only. 	HMIS	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: TBD country level</p> <p><i>Target:</i> <i>Year 3: 2 countries, Tanzania, Uganda</i></p> <p><i>%TBD per final country workplans</i></p>	<p>Tanzania – 58% (54 facilities)</p> <p>Uganda – 94% (5 facilities)</p>
<p>2f. Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 2nd dose of intermittent preventive treatment (IPT2) under direct observation</p> <p>(applicability is field-dependent)</p> <p>[Note: Madagascar used “all pregnancies” as the denominator for this indicator.]</p>	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT2 under observation/ Number of 1st ANC visits This indicator will be reported by country only where ACCESS activities target IPT with SP as an area for improvement. Receipt of IPT with SP will be determined from facility records. This indicator will be measured in malaria-endemic countries only. 	HMIS	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: TBD country level</p> <p><i>Target:</i> <i>Year 2: 2 countries, Tanzania, Madagascar</i></p> <p><i>%TBD per final country workplans</i></p>	<p>Tanzania – 50% (54 facilities)</p> <p>Uganda – 76% (5 facilities)</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>2g. Number of antenatal care providers trained through ACCESS-supported curricula or events in focused antenatal care and/or prevention of maternal to child transmission</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. • Training that targets focused ANC and/or PMTCT is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills to provide evidence-based ANC and PMTCT (CT for HIV). • Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. • Trained providers are those who complete a training course satisfactorily according to the course criteria. • The number is a semi-annual count of providers meeting the definition criteria. 	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: 0</p> <p><i>Target:</i></p> <p><i>Year 2: 4 countries:</i></p> <p><i>Year 3: 2 countries, Tanzania, Haiti,</i></p>	<p>Haiti – 129 providers trained in PMTCT</p> <p>Tanzania: -178 inservice clinical trainers (providers from 6 regions plus 26 Zonal and Regional RCH Coordinators from all the Zones in Tanzania) -24 Diploma Nursing and Midwifery preservice educators in FANC/MIP, including 13 tutors and 11 preceptors. -362 providers from four regions in FANC/MIP clinical skills. for a total of 564 health workers trained FANC/MIP.</p> <ul style="list-style-type: none"> • Global e-learning Antenatal Care course – 3257

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>2h. Total number of pregnant women provided with PMTCT services at target facilities, including counseling and testing⁵</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> Pregnant women include those attending ANC services and/or those delivering in the maternity at the PMTCT target facilities, as applicable to the country program. This indicator will be reported by country only where ACCESS activities target PMTCT as an area for improvement. 	HMIS, Centers for Disease Control and Prevention (CDC) Global AIDS program database	<p>Availability records TBD in context of developing the country-level M&E plan.</p> <p>Semi-annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: 0</p> <p><i>Target:</i> Year 2: 1 country Year 3: 1 country, Haiti</p> <p><i>Number/% TBD per final country workplans</i></p>	Haiti – 6072 pregnant women were counseled and tested (7 facilities)
<p>• ACCESS Program Intermediate Result 3: Safe delivery, postpartum care, and newborn health improved</p>						
<p>3a. Number of ACCESS-targeted facilities with PQI initiatives contributing to compliance with international standards</p>	<ul style="list-style-type: none"> ACCESS-targeted facilities are those identified service delivery points where program activities and alliances aim to enhance quality of care through PQI approaches. 	Program PQI records PQI database	<p>Records and document review</p> <p>Semi-annual</p>	Program technical staff with ACCESS M&E review	<p>Baseline: 0</p> <p><i>Target:</i> Year 3: 3 countries, Tanzania (FANC), Nigeria (EMONC), Rwanda (EMONC)</p> <p><i>Number of facilities TBD per final country workplans</i></p>	<p>Tanzania: During this reporting period, 40 facilities conducted 53 assessments. Baseline assessments were conducted by 8 facilities; first followup assessments by 31 facilities; second followup assessments by 9 facilities; and third followup assessments by five facilities.</p> <p>Nigeria: 24 providers were trained in SBM/R for EMONC.</p>

⁵ PEPFAR indicator

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>3b. Percent/number of births in ACCESS-targeted facilities in the past 6 months that occurred with a skilled attendant using a partograph</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator is reported by country only where ACCESS activities target correct use of a partograph as an area for MNH improvement. Women delivering in the past 6 months will be identified through facility records. Correct use of a partograph will be determined from facility records. Skilled attendants are those employed in skilled service provider categories according to the standards of the country. The percentage will be calculated by dividing the number of births recorded in the past 6 months that occur with a skilled attendant using a partograph (numerator) by the number of births recorded in the past 6 months (denominator). 	<p>Facility records, completed partographs</p>	<p>Records review</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target: Year 3 :1 country, Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Baseline data in Nigeria showed that the partograph is currently not used.</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>3d. Percent/number of births in the past 6 months in ACCESS-targeted facilities/communities with active management of third stage of labor</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator is reported by country only where ACCESS activities target AMTSL as an area for improvement, either in facilities, communities, or both. Births in the 6 months prior to data collection will be identified through facility records and/or program records at the community level. AMTSL is determined by information available in the records. For facility births, the percentage is calculated by dividing the number of births recorded in the past 6 months where AMTSL is recorded (numerator) by the number of births recorded in the past 6 months (denominator). For community or home births, the number is an annual count of the births in the 6 months prior to data collection meeting the definition criteria. 	<p>HMIS and/or program records where data are available</p>	<p>Records review, where data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: TBD country level</p> <p><i>Target:</i> <i>Year 3: 4 countries, Nigeria, India, Rwanda, Cambodia</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Data will be available for the Annual Report.</p>
<p>3e. Percent/number of newborns in the past 6 months in ACCESS-targeted facilities or communities dried and warmed immediately after birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. Newborns in the past 6 months are those whose births are recorded in the 6 months prior to data collection. Being dried and warmed immediately after birth is determined by information available in the records. This indicator is an annual count of newborns meeting the definition criteria. 	<p>Facility and/or program records if data are available</p>	<p>Records review, if data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3: 2 countries, Bangladesh and Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh baseline data will be available in July 2007.</p> <p>Nigeria HMIS data will be available for the Annual Report.</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>3f. Percent/number of newborns in ACCESS-targeted facilities or communities that are breastfed within one hour of birth</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. Breastfeeding within 1 hour of birth is determined by information available in the records or through exit interviews with new mothers at facilities or interviews with recent mothers in the community. This indicator is an annual count of newborns meeting the definition criteria. 	<p>Facility and/or program records if data are available</p> <p>Client exit interviews</p> <p>Community survey</p>	<p>Records review, if data are available</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3: 2 countries, Bangladesh and Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh baseline data will be available in July 2007.</p> <p>Nigeria HMIS data will be available for the Annual Report.</p>
<p>3g. Percent/number of providers with adequate knowledge of essential newborn care</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target newborn care as an area for improvement. Adequate knowledge will be determined. 	<p>Provider knowledge survey</p>	<p>Survey</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3: 5 countries, Nigeria, India, Cameroon, Mauritania, Nepal</i></p> <p><i>Target=100% of trained providers</i></p>	<p>Results for Nigeria baseline knowledge survey (18 facilities, 45 providers):</p> <ul style="list-style-type: none"> -first step in thermal care: 18% correct -maintaining babies temp.: 47% -immediate newborn care: 36% -Cord care: 9% -newborn resuscitation: 47% -breastfeeding initiation: 47%

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>3g. Percent/number of women in ACCESS-targeted facilities or communities who accept a contraceptive method by 6 weeks postpartum⁶</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target integrated family planning as an area for improvement. Women who accept a contraceptive method are those recorded in facility or community outreach records as receiving the contraceptives or a prescription for a method (if appropriate in context). The number is a semi-annual count of women recorded at ACCESS-targeted facilities or through community outreach as meeting the definition criteria. 	<p>Facility and/or program records</p>	<p>Records review</p> <p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: country level TBD</p> <p><i>Target:</i> <i>Year 3:</i> <i>2 countries, Nigeria and Kenya</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Data will be available from Kenya for the Annual report.</p>

⁶ This indicator will be collected through ACCESS-FP.

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>3h. Percent/number of women who delivered in past 6 months in ACCESS-targeted facilities/communities who received a postpartum visit within 3 days after childbirth</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target postpartum care as an area for improvement. Activities may target facilities, or home-based care. Percent of women delivering in facilities will be calculated from facility records that show the mother receiving postpartum care. Number of women's records that show a delivery in the past 6 months and postpartum care within 3 days/number of women's records that show a delivery in the past 6 months (numerator/denominator). Number of women delivering in communities will be calculated from home records if available (e.g., if the health system uses cards that the client keeps) or program records. 	<p>HMIS and/or home records or community survey</p>	<p>Availability of HMIS information or home records TBD in the context of developing the country-level M&E plan</p> <p>Annual</p>	<p>Program country staff with ACCESS M&E review</p>	<p>Baseline: not known at country levels</p> <p><i>Target:</i> <i>Year 2: 2 countries, Bangladesh, Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	<p>Bangladesh baseline data will be available in July 2007.</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<ul style="list-style-type: none"> ACCESS Program Intermediate Result 4: Management of obstetric complications and sick newborns improved 						
<p>4a. Percent/number of women attending ACCESS-targeted facilities with eclampsia who appropriately receive magnesium sulfate</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> This indicator will be reported by country only where ACCESS activities target facility-based eclampsia treatment as an area for improvement. Women with eclampsia attending targeted facilities are those recorded as presenting at the facility with clinical symptoms. Appropriate treatment with magnesium sulfate is determined according to the clinical record or aggregated records. The percentage is calculated by dividing the numerator (women recorded at ACCESS-targeted facilities with eclampsia and receiving magnesium sulfate) by the denominator (all women recorded at ACCESS-targeted facilities with eclampsia). 	Facility records	Records review	Program technical staff with ACCESS M&E review	<p>Baseline: TBD country level</p> <p><i>Target:</i> <i>Year 3: 1 country, Nigeria</i></p> <p><i>% TBD per final country workplans</i></p>	Data will be available for Nigeria for the Annual Report.

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>4b. Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in infant resuscitation</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> • ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. • Training that targets infant resuscitation is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills to treat infant asphyxia. • Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. • Trained providers are those who complete a training course satisfactorily according to the course criteria. • The number is a semi-annual count of providers meeting the definition criteria. 	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	ACCESS M&E	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 2:</i> <i>Providers in 4 countries, Cameroon, Mauritania, Nigeria, Nepal</i></p>	<p>Nigeria: 12 providers</p> <p>Ghana/ Ethiopia/ Tanzania/ Malawi: 14 midwifery tutors</p> <ul style="list-style-type: none"> • Global e-learning course on Essential Newborn Care – 2629 <p>Total: 2655</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<p>4c. Number of maternal/neonatal providers trained through ACCESS-supported curricula or events in management of LBW newborns/KMC</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> ACCESS-supported curricula and training events are those developed and managed by ACCESS staff or ACCESS-approved training staff. Training that targets KMC is a pre-service or in-service course or other learning experience that includes competency-based knowledge and skills related to management of LBW babies. Maternal/neonatal providers are service delivery staff whose core competencies and employment duties include pregnancy and birth-related health issues. Trained providers are those who complete a training course satisfactorily according to the course criteria. The number is a semi-annual count of providers meeting the definition criteria. 	Training records	<p>Compilation of totals from training records.</p> <p>Semi-annual</p>	ACCESS M&E	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 3:</i> <i>Providers in 2 countries, Nigeria and Nepal</i></p>	<p>Nigeria- 15 providers trained as KMC trainers</p> <p>Nepal-17 providers trained as KMC trainers</p>
<p>4d. Number of ACCESS-targeted communities with social mobilization approaches leading to achievement of improved complication readiness</p> <p>(applicability is field-dependent)</p>	<ul style="list-style-type: none"> ACCESS-targeted communities are those identified social and geographic areas where program activities and alliances aim to enhance shared responsibility and collective action in birth preparedness/ complication readiness. Achievement of improved complication readiness is defined as having fulfilled complication readiness goals of the community's self-developed action plan. The number will be calculated as an annual count of targeted communities meeting the definition criteria. 	Program reports and activity tracking	<p>Program and M&E review of program reports</p> <p>Annual</p>	Program country staff with ACCESS M&E review	<p>Baseline: 0</p> <p><i>Target:</i> <i>Year 3:</i> <i>Communities in 4 countries: Cameroon, Nigeria, Bangladesh, India</i></p>	<p>Kenya – 3 districts and 6 divisions</p> <p>Cameroon – one department</p> <p>Information for Nigeria, Bangladesh and India will be available for the Annual Report</p>

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPONSIBLE PARTY	BASELINE (AND TARGET)	PROGRESS FOR OCT. 2006-MARCH 2007
<ul style="list-style-type: none"> ACCESS Program Intermediate Result 5: Prevention and treatment of priority health problems of non-pregnant women of reproductive age improved (Targets of Opportunity) 						
5a. Number of linkages with international obstetric fistula networks initiated and technical assistance provided	<ul style="list-style-type: none"> International obstetric fistula networks are those organizations or groups of organizations who identify obstetric fistula as a key area of international concern and needed activism. Linkages are working relationships on identified tasks toward specified goals agreed between a network and ACCESS. Initiation of linkages is the agreement to develop such a working relationship, and the provision of technical assistance is the role ACCESS plays in the tasks to be pursued. The number will be an annual count of networks linking with ACCESS tasks, and a qualitative report of technical assistance may also be provided. 	Program records	Records review	ACCESS M&E	Baseline: 0 <i>Targets:</i> Year 1: 4 Year 2: 1 Year 3: 1	ACCESS is an active member of one international obstetric fistula network

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

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

ACCESS/AFGHANISTAN MONITORING AND EVALUATION FRAMEWORK- SERVICE SUPPORT PROJECT (SSP) ASSOCIATE AWARD

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 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 (See notes)	0 36 Health Facilities start the application of the integrated quality assurance process	0 Development of QA process as per workplan. Pilot and analysis planned for April/May with launch of baseline in 36 facilities planned in July.	Semi-annually	QA Database	1) Information is collected semi-annually from SSP Quality Assurance Database
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 (see note 1)	0 as above	Semi-annually	QA Database	1) For year one it will not be enough time to recognize any facility. It is expected that the unified quality approach will be ready between April and June 2007
3	No. of referrals from basic centers served in secondary facilities (annual)	No. of OPD patients referred into PPG supported BHCs, CHCs and District Hospitals (Section XX, HMIS MIAR) (see note 1)	107,000	120,000	55,901 (47% of target) (see note 2)	Quarterly	HMIS	1) Referrals served in BHCs is also included to include referrals from health posts. 2) Data belongs to Period of July - Dec, 2006.

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
Intermediate Result 2: Increased number and performance of BPHS and EPHS service providers, especially women in rural and underserved areas								
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) (see note 1)	28%	N/A	End of 2007 (see note 2)	PPG 2007 Household Survey	1) Value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007 2-) SSP relies on OPH/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.
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 (see notes 1 and 2)	338 (102% of target) (see note 3)	Quarterly	Training Database	1) Information is collected quarterly from SSP supported community midwifery grants 2) No. enrolled will be slightly higher that the target no. of graduates to make up for the dropouts and unsuccessful students. 3) Data as of March 2007. Since individual student data is not yet available through the training

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
								database, this information was extracted from the Grants Database.
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 (see notes 1 and 2)	Quarterly	Training Database	1) Information is collected quarterly from SSP supported midwifery grants. 2) The first round of graduations will not occur before September 2007.
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 99,237 Other visits 60,729 (68% of target) (see note 1)	Quarterly	HMIS	1) Data belongs to Period of July - Dec, 2006.
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	23386 (56% of target) (see note 1)	Quarterly	HMIS	1) Data belongs to Period of July - Dec, 2006.

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 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	53,902 (57% of target) (see note 2)	Quarterly	HMIS	1) Data belongs to Period of July - Dec, 2006.
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 HFs 470,000 HPs	227,000 HFs 485,000 HPs	New clients in HFs 66,457 Repeat clients in HFs 49,343 (total 51% of the target) 277,626 in HPs(57% of the target)(see note 1)	Quarterly	HMIS	1) Data belongs to Period of July - Dec, 2006.
Intermediate Result 3: <i>Improved capacity and willingness of communities, families and individuals to make informed decisions about their health and support and sustained health-seeking behavior</i>								
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) (see note 1)	23%	N/A	End of 2007 (see note 2)	PPG 2007 Household Survey	1) Value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007. 2) SSP 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.

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 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) (see note 1)	47%	N/A	End of 2007 (see note 2)	PPG 2007 Household Survey	1) Baseline value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007. 2) 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.
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) (see note 1)	59%	N/A	End of 2007 (see note 2)	PPG 2007 Household Survey	1) Baseline value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007. 2) 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.

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 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 (see note 1)	N/A	End of 2007 (see note2)	PPG 2007 Household Survey	<p>1) New questions for measuring this indicator will be added to next round of PPG Household Survey in October 2007. That value will serve as a baseline for the following years.</p> <p>2) SSP 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.</p>
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) (see note 1)	47%	N/A	End of 2007 (see notes)	PPG 2007 Household Survey	<p>1) Baseline value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007.</p> <p>2) 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.</p>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
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 (see notes)	50% (excludes Kabul City, only rural districts) (see note 1)	55%	N/A	End of 2007 (see note 2)	PPG 2007 Household Survey	<p>1) Baseline value provided from the REACH end-of-project household survey. Next measurement will occur in October 2007.</p> <p>2) 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.</p> <p>3) SSP may ask MOPH 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 targets will be defined and the progress will be measured accordingly.</p>

NO	INDICATOR	DEFINITION	BASELINE	TARGET - SEPT. 2007	STATUS - MARCH 2007	FREQUENCY OF REPORTING	SOURCE	NOTES
<i>Intermediate Result 4: Integrated gender awareness and practice into BPHS and EPHS service delivery</i>								
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	Information will be collected quarterly through SSP QA database.

AFR/SD MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
PRIORITY 1: Support advocacy to mobilize resources and improve the policy environment for maternal and newborn care AFR/SD Result: <i>Increased resources for maternal and newborn health programs at the country level</i> AFR/SD Result: <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	Forty one (41) master trainers (8 Anglophone, 9 Francophone and 24 Lusophone) coming from 14 African countries have been trained to provide support and guidance to the implementation of the Road Map.
Number/% of target countries receiving ACCESS support to implement the Road Map	Technical assistance will be provided using ACCESS funds.	Program records/reports	Semi-annual	ACCESS Program staff	No countries are currently receiving ACCESS support to implement the Road Map.
Number of (target) countries with Africa Road Map plans for maternal and newborn health	A plan, or implementation guidelines, for the Africa Road Map has been developed and is in place in target countries.	Actual plan Communication with trained facilitators	Semi-annual	AED/Berengere de Negri	21 countries have developed Africa Road Map plans for MNH (not with direct access assistance)
PRIORITY 2: Disseminate effective approaches to improve the quality of integrated MNH care AFR/SD Result: <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.
Number of tutors and clinical instructors trained in integrated	Trained individuals are those who were trained in EMNC through	TIMS	Semi-annual	Trainers, ACCESS	A training for a total of 19 tutors and clinical instructors was

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL STATUS
EMNC	ACCESS-supported training events or by ACCESS-developed trainers.			Program staff	conducted in May 2006. Four of the participants were from Nigeria and supported by ACCESS/Nigeria funds.
Number of target countries with core group of midwifery tutors able to train and develop midwifery curricula	These tutors and clinical instructors at pre-service midwifery education institutions are trained in integrated EMNC at ACCESS-supported training events. This will be addressed in Year 3.	TIMS	Semi-annual	Trainers, ACCESS Program staff	Tutors and clinical preceptors from 4 countries will be given skills to train and develop midwifery curricula.
<p>PRIORITY 4: African regional and national capacity to implement programs</p> <p>AFR/SD Result: African institutions actively engaged in supporting the implementation of the WHO/AFRO Road Map</p> <p>AFR/SD Result: Linkages strengthened among African Institutions and networks to coordinate with each other and strengthen their leadership in MNH</p> <p>AFR/SD Result: National-level capacity to implement Support to Safer Motherhood Programmes 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.
Number of midwifery schools with trained tutors and clinical instructors for EMNC	Trained tutors and clinical instructors include those trained in EMNC through ACCESS-supported training events or by ACCESS-developed trainers.	TIMS	Semi-annual	Trainers, ACCESS Program staff	The 19 midwifery educators trained in May 2006 are from 12 midwifery schools, 5 teaching hospitals, and 2 MOH offices. (includes Nigeria which was not funded by AFR/SD).

ACCESS/BANGLADESH MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
Goal: To improve maternal and neonatal health outcomes						
Neonatal mortality rate in ACCESS intervention area	Number of deaths of newborn 1-28 days in last year in <u>ACCESS intervention area, by upazilla</u> x 1000 Total number live births in last year	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
SO: To increase the practice of healthy maternal and neonatal behaviors in antenatal, childbirth, and postnatal periods in a sustainable and potentially scalable manner						
*Percent of recent mothers ⁷ who had a birth plan during their last pregnancy	Number of recent mothers who reported having a <u>birth plan during their last pregnancy</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*Percent of recent mothers whose birth was attended by a skilled ⁸ provider by type of provider, by place of delivery	Number of recent mothers attended at their last childbirth by a <u>skilled provider by type of provider, by place of delivery</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 2007.
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) <u>at birth</u> x 100 Total number of recent mothers who gave birth at home interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.

⁷ “Recent mother” defined as having given birth within the last year (12 months)

⁸ “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.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 <u>clean birth kit were used at their last childbirth</u> x 100 Number of recent mothers who gave birth at home interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*Percent of newborns who were breastfed within the first hour after childbirth	Number of recent mothers who reported initiating breastfeeding <u>within 1 hour of birth</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*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 <u>the last 24 hrs prior to the survey</u> x 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 survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*Percent of newborns whose first bath was delayed for 3 days	Number of recent mothers who reported delaying bathing their <u>newborn for the first time until 3 day after birth</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*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 <u>before the delivery of the placenta</u> x 100 Total number of recent mothers who delivered at home interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*Percent of newborns who had nothing applied on to their umbilical stump after birth [USAID]	Number of recent mothers who reported that their newborns <u>had nothing applied to their umbilical cord after birth</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
Percent of recent mothers who reported receiving two TT immunizations during their last pregnancy	Number of recent mothers who reported receiving two TT <u>immunizations during their last pregnancy</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who consumed iron/folate tablets during their last pregnancy	Number of recent mothers who reported consuming <u>iron/folate tablet during their last pregnancy</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>pregnancy for at least 2 years</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers whose recent births were delayed for at least 2 years	Number of recent mothers whose recent births were delayed <u>for at least 2 years</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who accepted a contraceptive method by 6 week postpartum	Number of recent mothers who accepted a contraceptive <u>method by 6 weeks postpartum</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
IR1: To increase knowledge, skills, and practices of healthy maternal and neonatal behaviors in the home						

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 x 100 Total number of recent mothers who gave birth at home interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who know to breastfeed their babies immediately after childbirth	Number of recent mothers who reported knowing to breastfeed <u>their babies within 1 hour of birth</u> $\times 100$ Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who know to exclusively breastfeed their babies for the first 6 months	Number of recent mothers who reported knowing to <u>exclusively breastfeed babies for the first six months of life</u> $\times 100$ Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>bathing of their newborns for 3 days</u> $\times 100$ Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who know to dry newborns immediately after childbirth	Number of recent mothers who reported knowing drying <u>newborns before the placenta is delivered</u> $\times 100$ Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who know to wrap newborns immediately after childbirth	Number of recent mothers who reported knowing <u>wrapping newborns before the placenta is delivered</u> $\times 100$ Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 <u>should be applied on to the umbilical stump of the newborn</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who can cite at least three danger signs of pregnancy	Number of recent mothers who cited 3 danger signs <u>of pregnancy</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who can cite at least three danger signs of childbirth	Number of recent mothers who cited 3 danger signs <u>of childbirth</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who can cite at least three danger signs postpartum	Number of recent mothers who cited 3 danger signs <u>postpartum</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who can cite at least three danger signs in newborn babies	Number of recent mothers who cited 3 danger signs <u>in newborn babies</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>PNC after delivery from a skilled provider</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
IR2: Increased appropriate and timely utilization of home and facility-based essential maternal and neonatal health services						
*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 <u>by type of provider</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 <u>skilled provider by type of provider</u> x 100 Total number of recent mothers who reported having developed a danger sign during their last pregnancy	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR B	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*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 <u>skilled provider by type of provider</u> x 100 Total number of recent mothers who reported having developed a danger sign during their last childbirth	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR B	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*Percent of recent mothers who received a PNC visit within 3 days after childbirth	Number of recent mothers who received a PNC visit within <u>3 days after childbirth</u> x 100 Total number of recent mothers interviewed	MIS Report; PBS survey report	AC visit record review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDR B	ACCESS Counselors have started home visits since April 7, 2007. Report will be available in June 2007.
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 <u>type of provider</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDR B	Information will be available after completion of baseline in June 07.
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 <u>by type of provider</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDR B	Information will be available after completion of baseline in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 <u>provider by type of provider</u> x 100 Total number of recent mothers who reported having developed a danger sign after their last childbirth	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>and sought care from a skilled provider by type of provider</u> x 100 Total number of recent mothers who reported their newborns developed a danger sign at birth or within 1 month after birth	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
IR3: Improved key NGO systems for effective intervention delivery						
*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	PNGO	Initial MWRA registration is going on. Report will be available in June 07.
*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	PNGO	Initial pregnancy registration is going on along with MWRA registration. Report will be available in June 07.
*Percent of recent mothers whose pregnancy was identified and registered at least 3 months before delivery	Number of recent mothers whose pregnancy was identified <u>and registered at least 3 months before delivery</u> x 100 Total number of recent mothers interviewed	MIS report; PBS survey report	Pregnancy Register review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	Initial pregnancy registration is going on along with MWRA registration. Report will be available in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 <u>last pregnancy</u> x 100 Total number of recent mothers interviewed	MIS report; PBS survey report	Pregnancy Register review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
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 <u>importance of 4 ANC visits by a skilled provider</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>pregnancy who were referred by an ACCESS Counselor</u> x 100 Total number of recent mothers with a danger sign during their last pregnancy	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 <u>importance of 2 PNC visits by a skilled provider</u> x 100 Total number of recent mothers interviewed	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
*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	PNGO	ACCESS Counselors have started distributing birth kits during their home visits in April 07. Report will be available in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 $\times 100$ Total number of recent mothers interviewed	MIS report; PBS survey report	Pregnancy Register Review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
*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 $\times 100$ Total number of recent mothers interviewed	MIS report; PBS survey report	Pregnancy Register Review; PBS survey	Quarterly; Baseline and end-line surveys	PNGO; ICDDRDB	ACCESS Counselors have started home visits in April 07. Report will be available in June 07.
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 $\times 100$ Total number of recent mothers with a postpartum danger sign after their last childbirth	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
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 $\times 100$ Total number of newborns with a danger sign	PBS survey report	PBS survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers satisfied with specified services (negotiation, counseling & referral) 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 $\times 100$ Total number of recent mothers interviewed	PBS survey report	In-depth interview	end-line survey	ICDDRDB	Information will be available after completion of end-line in 2011.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 <u>visits in the last month by Community Supervisor Mobilizer</u> x 100 Total number of ACCESS Counselors	MIS report	CSM visit record review	Quarterly	PNGO	Community Supervisor Mobilizers have started their supervisory visits in April 07. Report will be available in June 07.
IR4: 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)	<u>Number of villages that have a CAG by intervention union</u> x 100 Total number of villages in that union	MIS report	CM/CSM Register Review	Quarterly	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
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 <u>(if there are CAGs in the villages)</u> x 100 Total number of recent mothers interviewed (in CAG villages)	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
Percent of recent mothers who are members of Community Action Group (CAG)	Number of recent mothers who are members of Community <u>Action Group (CAG) (if there are CAGs in the villages)</u> x 100 Total number of recent mothers interviewed in CAG village	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
*Percent of Community Action Groups (CAG) that met at least once in the last 2 months	<u>Number of CAG that met at least once in the last 2 months</u> x 100 Total number of CAG	MIS report	CAG Register review	Quarterly	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
*Percent of Community Action Groups (CAG) with action plans to advocate for improved EMNC services	<u>Number of CAG with action plans</u> x 100 Total number of CAG	MIS report	CAG Register review	Semi annually	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
*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 <u>development of action plans</u> x 100 Total number of CAG with action plans	MIS report	CAG Register review	Semi annually	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
*Percent of Community Action Groups (CAG) with an emergency transport system	<u>Number of CAG with an emergency transport system</u> x 100 Total number of CAG	MIS report	CAG Register review	Semi annually	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
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 <u>of an emergency transport system</u> x 100 Total number of recent mothers interviewed in CAG village with emergency transport system	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 $\frac{\text{Number of recent mothers who experienced a pregnancy-related complication, or whose newborns experienced a complication, in CAG village with emergency transport system interviewed}}{\text{Total number of recent mothers who experienced a pregnancy-related complication, or whose newborns experienced a complication, in CAG village with emergency transport system interviewed}} \times 100$	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
*Percent of Community Action Groups (CAG) with an emergency financing system	$\frac{\text{Number of CAG with an emergency financing system}}{\text{Total number of CAG}} \times 100$	MIS report	CAG Register review	Semi annually	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
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 $\frac{\text{Number of recent mothers interviewed in CAG village with emergency financing system who are aware of the existence of an emergency financing system}}{\text{Total number of recent mothers interviewed in CAG village with emergency financing system}} \times 100$	PBS survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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 survey report	PBS Survey	Baseline and end-line surveys	ICDDRDB	Information will be available after completion of baseline in June 07.
*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 x 100 Total number of CAG	MIS report	CAG Register review	Semi annually	PNGO	The process of forming CAG has been started in April 07. Report will be available in June 07.
IR5: 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		Related to advocacy, which will be initiated once advocacy strategy is developed.
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 End line		Related to advocacy, which will be initiated once advocacy strategy is developed.

INDICATOR	DEFINITION	DATA SOURCE	DATA COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS
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"> • Corporate Working Group Meeting • Projahnmo Dissemination and Design Workshop • Meeting on Sepsis Management of Newborn at Community Level in Bangladesh • Consultative Meeting on Community based early postnatal care package • Consultation workshop on Community Based Postnatal Care (PNC) in Bangladesh
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/modifying maternal and neonatal health strategy/policy

ACCESS/HAITI MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS FOR OCT. 2006–MAR. 2007
Family Planning indicators				
Number of trainers trained in long term family planning methods		Training participant tracking sheets and training database	Quarterly	14 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	Not started yet
Number of sites strengthened and offering long term FP methods		Program records	Annual	Not started yet
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 started yet
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	Not started yet
PMTCT indicators⁹				
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	Not relevant to workplan for this period

⁹ 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 FOR OCT. 2006–MAR. 2007
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	129 (43%) INSAC has trained 129 out of 300 services providers in PMTCT as of February 2007
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: -counseling and testing for pregnant women -ARV prophylaxis to prevent MTCT -Counseling and support for safe infant feeding practices -family planning counseling or referral	PMTCT follow-up assessment , ACCESS program records	6 months after baseline assessment	7 (30%) ACCESS has been supporting a total of seven (7) PMTCT sites. During FY 2007 support will expand to an additional 16 sites bringing the total number of PMTCT sites covered to 23.
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	6072 pregnant women were counseled and tested
Number/% of Maternity clients at target facilities who received family planning counseling	<u>Numerator:</u> Number of Maternity clients at PMTCT target facilities who received family planning counseling <u>Denominator:</u> Total number of Maternity clients at PMTCT target facilities	PMTCT Maternity registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	This information will be available for the Annual Report

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS FOR OCT. 2006–MAR. 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>6072 (91.56%)</p> <p>Note Denominator Used: Total number of pregnant women (ANC and Maternity) counseled</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>6216</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	<p>5074 (83.56%)</p>
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	<p>233 (3.84%)</p>

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS FOR OCT. 2006–MAR. 2007
Number/% of pregnant women HIV (+) who are enrolled in the PMTCT program	<u>Numerator:</u> Number of pregnant women HIV (+) enrolled in the PMTCT program <u>Denominator:</u> Total number of pregnant women HIV (+) at target facilities (Limited to ANC clients only)	ANC PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	146 (62.66%) Number of pregnant women who tested positive and were enrolled in the PMTCT services
Number/% of pregnant women (ANC and Maternity) HIV (+) who received ARV prophylaxis	<u>Numerator:</u> Number of ANC clients HIV (+) at target facilities who received ARV prophylaxis <u>Denominator:</u> Total number of ANC clients HIV (+) at the PMTCT target facilities AND/OR <u>Numerator:</u> Number of Maternity clients HIV (+) at target facilities who received ARV prophylaxis <u>Denominator:</u> Total number of Maternity clients HIV (+) at the PMTCT target facilities	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	101 (43.34%) 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	<u>Numerator:</u> Number of pregnant women HIV (+) who received single does of Nevirapine at time of delivery <u>Denominator:</u> Number of pregnant women HIV (+) who delivered at target facilities	Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	101 (93.07%)
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%)

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	PROGRESS FOR OCT. 2006–MAR. 2007
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	No data available until new PMTCT register (developed with ACCESS assistance) is rolled out by the Ministry of Health
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 (03.86%)
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	5570 (89.61%)
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	213 (3..82%)
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	127 (59.62%)
Number/% of newborns with HIV (+) mothers who received ARV prophylaxis	<u>Numerator :</u> Number of newborns with HIV (+) mothers who received ARV prophylaxis <u>Denominator :</u> Total number of newborns with HIV (+) mothers	PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly	104 (92.86%)

ACCESS NEPAL MONITORING AND EVALUATION FRAMEWORK

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

INDICATOR	DEFINITIONS AND CALCULATION	DATA SOURCE	COLLECTION METHOD/ FREQUENCY	RESPON-SIBLE PARTY	BASELINE (AND TARGET)	USE OF DATA	STATUS
Number of guidelines developed for LBW infants to be included in the National Maternal and Neonatal standards and protocols	Based on recommendations and information gained from relevant studies a National Guideline/ Protocol for LWB will be developed for use at all service delivery levels and these guidelines will be incorporated into national standards and protocols.	LBW Guidelines	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 <i>Target:</i> 1	-Contributes to National Standards and Protocols	Implementing.
Number of studies conducted to assess factors affecting skilled birth attendance and provide recommendations to HMG and other key stakeholders	Study will be conducted thorough review of successes and failures of projects and investigate the perceptions and needs of community and the service provides, and explore public-private partnership and other factors affecting skilled birth attendance.	Program records Study report	Records review	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 <i>Target:</i> 1	- Review approaches to identify strengths and weaknesses toward improving successes -Guide resource allocation and contribute to effective planning for future activities	Study completed and under finalization.

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
<i>USAID/Nigeria SO 15: Increased use of child survival and reproductive health services</i>								
<i>ACCESS LOP Objective: Increased utilization of quality EmONC services by pregnant women, mothers, newborns at selected LGAs in two Nigeria states, Kano and Zamfara</i>								
1. Deliveries with a Skilled Birth Attendant [C 33.1]	<p>Definition 1: 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>Unit of measurement: Number & 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	1048 births in 5 hospitals in Kano and Zamfara states
2. Caretakers of sick newborns who sought care from a skilled provider	<p>Definition: 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>Unit of measurement: 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	ACCESS is revising HMIS forms to capture this data

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
3. Pregnant women who received at least 4 antenatal care visits [C 33.2]	Definition: 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 Unit of measurement: 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	419 women from 1354 live births (31%). Kano March data not included. Data generated from available service statistics- Not pop-based survey
4. Couple Years of Protection in USG-supported programs	Definition: 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 Unit of measurement: Number	ACCESS Program Annual Report	Service statistics/facility record review	Semi-annually, Annually	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	1797 (Kano service statistics for march not yet included). Note: The CYP is for all the health facilities, i.e. hospitals and PHCs. The CYP is for 6 months in Zamfara and 5 months in, Kano

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
5. Antenatal Care visits by skilled providers from USG-assisted facilities [C 33.2]	Definition: Number of pregnant women receiving antenatal care from skilled providers Unit of measurement: 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	7534 (Kano service statistics for march not yet included) Note: Includes 4 hospitals, excluding Murtala Mohammed hospital, Kano.¹⁰
6. Postpartum women using contraception (including LAM) 6 weeks postpartum	Definition: Number of women using a contraceptive method 6 weeks postpartum/ Total number of postpartum women with live births (If still breastfeeding appropriate methods include: LAM, IUCD or progestin-only method). Unit of measurement: Percentage	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	ACCESS is working on system to capture this data

¹⁰ Presently Murtala Mohammed hospital is not providing services because of renovations. This is the largest hospital in Kano.

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
7. Number of counseling visits for FP/RH as a result of USG assistance	<p>Definition: Number of people counseled on FP/RH disaggregated by gender</p> <p>Unit of measurement: 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	<p>2573 (Kano service statistics for march not yet included).</p> <p>122 Male 2451 Female</p> <p>Note: The service statistics are for 3 hospitals, 5 PHCs in Kano from October to February and for 2 hospitals, 7 PHCs in Zamfara from October to March</p>
8. Postpartum/Newborn visits within 3 days of birth in USG-assisted programs	<p>Definition: Number of postpartum women/newborn in USG-assisted program who received postpartum care within 3 days of delivery</p> <p>Unit of measurement: Number</p>	ACCESS program reports	Service statistics/ facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	1048

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
USAID/Nigeria IR 15.1: Improved quality of child survival and reproductive health services								
Sub-IR 1 (ACCESS Result 4): Improved quality of family planning services in selected LGAs.								
1. Women receiving postpartum FP counseling at ACCESS-supported facilities	Definition: 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 Unit of measurement: Number	ACCESS program reports	Service statistics/ facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	Not in HMIS. ACCESS working on system to capture data
2. Trained providers performing FP services to standards	Definition Number of providers trained in FP observed to be performing to standard/ Total number of providers trained in FP observed Standard here refers to (National FP protocol , international FP standards (e.g., WHO) and SBM/R standards once developed) Unit of measurement: Percent	ACCESS program reports	Facility survey Supervisory/Observation checklist	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	FP training not yet conducted
3. People Trained in FP/RH with USG-funds	Definition Number of providers trained in FP/RH Unit of measurement: Number	ACCESS program reports	Facility survey Supervisory/Observation checklist	Quarterly	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	Planned for next quarter

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
Sub-IR 2 (ACCESS Result 3): Improved quality of EmONC services in selected LGAs								
1. 1.Health facilities rehabilitated [C 20.9]	Definition: Number of health facilities rehabilitated Unit of measurement: 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	Planned for next quarter
2. Health facilities using SBM-R approach for performance improvement	Definition: Number and Percent of health facilities using SBM-R approach Unit of measurement: Number and Percent	ACCESS Program reports	SBM Observation checklist	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	Training in SBM-R completed in March, 2007. Providers trained came from 10 facilities, including the 5 hospitals.
3. Women receiving Active Management of the Third Stage of Labor (AMSTL)	Definition: 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 Unit of measurement: Number & Percent	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	8 of out 1295 SVDs (1%). ACCESS is revising HMIS forms to help in capturing this data in all facilities

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
4. Management of women with eclampsia in USG-supported facilities	Definition: 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 Unit of measurement: Number & Percent	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	None. ACCESS is working to include this data in HMIS forms and to increase access to Magnesium Sulphate
5. Births at USG-supported facilities where a partograph was used	Definition: Number of births with partograph in the past quarter / total number of births in the past quarter Unit of measurement: Number & Percent	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	None. Partograpgh has been included in new patient record forms to be distributed in next quarter
USAID/Nigeria IR 15.2: Strengthened enabling environment								
Sub-IR 3 (ACCESS Result 1): Improved enabling environment for and scale-up of EmONC best practices at national and state levels.								
1. Training curricula and strategy for preservice midwifery education revised and implemented in Kano and Zamfara states	Number of schools in Kano and Zamfara states that have adopted and used the preservice education curricula revised with ACCESS support Unit of measurement: Number	ACCESS Program reports	Review of training strategy document and program records	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	Not yet done

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
2. Operational performance standards for EmONC developed and distributed	<p>Definition: Number of Operational Performance Standards for EmONC distributed to ACCESS-supported facilities</p> <p>Unit of measurement: Number</p>	ACCESS Program reports	Operational performance standards document, Distribution list	Once	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	Performance standard for SBM-R developed and approved. 35 copies 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
3. National KMC policy and guidelines developed and distributed in ACCESS-supported facilities	<p>Definition: Number of National KMC policy and guidelines developed and distributed to ACCESS-supported facilities</p> <p>Unit of measurement: Number</p>	ACCESS Program reports	KMC policy and guidelines	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	Draft guidelines distributed for review by FMOH and state MOH stakeholders

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
Sub-IR 4 (ACCESS Result 6). <i>Improved management of maternal and newborn services in selected LGAs</i>								
1. USG-assisted Service Delivery Points experiencing Stockouts of specific tracer drugs	<p>Definition: 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>Unit of measurement: 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	Baseline survey revealed almost 90% of health facilities had stock-outs. ACCESS is planning LMIS training and provision of seedstocks of tracer drugs and FP commodities
USAID/Nigeria IR 15.3: <i>Expanded demand for improved child survival and reproductive health services</i>								
Sub-IR 5 (ACCESS Result 5): <i>Increased demand for maternal and newborn services in selected LGAs.</i>								
1. Beneficiaries of community Activities [C 20.10]	<p>Definition: 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>Unit of measurement: 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	Direct Community activities including service provision just starting

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
2. Community committees' activities to reduce maternal and newborn deaths	<p>Definition: 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>Unit of measurement: Number</p>	ACCESS Program reports	Review of VDC, WDC and PHCDC work plans	Annual	SO13 Team	Annual	SO13 Team ACCESS State and LGA stakeholders	Community activities just starting
3. Community with complication readiness plans	<p>Definition: Number of communities with plans that include emergency funds and/or a transport system for maternal and newborn complications</p> <p>Unit of measurement: Number</p>	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	Community activities are just starting
4. People that have seen or heard a specific USG-supported FP/RH message	<p>Definition: Number and Percent of people who heard or seen specific FP/RH message in past 12 months</p> <p>Unit of measurement: Number and Percent</p>	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	FP messages under development

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
USAID/Nigeria IR 15.4: Increased access to child survival and reproductive health services								
Sub-IR 6 (ACCESS Result 2): Increased availability and distribution of EmONC trained health care workers in selected LGAs								
1. Caesarean sections as a percentage of all births	Definition: 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) Unit of measurement: 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	0.05%
2. Health facilities per 500,000 population providing essential obstetric and newborn care	Definition: Number of health facilities per 500,000 population in ACCESS-supported LGAs providing essential obstetric care (basic and comprehensive) (Recommended 1 CEmONC and 4 BEmONC facilities per 500,000 population) Unit of measurement: Number	ACCESS Program reports	Health facility survey and estimates of LGA population	Quarterly	SO 13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	1 CEmONC 3 BEmONC

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)	SEMI-ANNUAL STATUS OCT, 06 – MARCH, 2007
3. Births with complications treated at EmONC facilities	Definition: Number of births with complications treated at EmONC facilities/Total number of births expected to have complications (estimated at 15% of all expected births) Unit of measurement: Percentage	ACCESS Program reports	Review of facility records	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	HMIS does not currently capture this data. ACCESS is revising form to assist in capturing the data
4. People trained in Maternal Health and/or newborn health [C 33.5]	Definition: Number of people trained on maternal (and newborn) disaggregated by Gender of people trained Unit of measurement: Number	ACCESS Program reports	Training information monitoring system (TIMS [®])	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	121 Female 73 Male 48 EmONC 11 KMC 15 HMIS 44 COM mobilization 26 SBM-R 22
5. USG-assisted service delivery points providing FP counseling and/or services	Definition: Number of USG-assisted service delivery points providing family planning counseling and services Unit of measurement: Number	ACCESS Program reports	ACCESS program record review Service statistics/Facility record review	Quarterly	SO13 Team	Quarterly	SO13 Team ACCESS State and LGA stakeholders	10 ACCESS supported facilities including 5 hospitals and 5 PHCs

ACCESS TANZANIA MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FOR OCTOBER 2006-MARCH 2007
ACCESS Program Objective: Increased utilization of focused ANC services nationally, to meet the PMI and the MOHSW/MTSP Goals of 85% uptake of IPT by 2009.					
<ul style="list-style-type: none"> Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 1st dose of intermittent preventative treatment (IPT1) under direct observation 	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT1 under observation/Number of 1st ANC visits Receipt of IPT with SP will be determined from facility records. 	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	58%
<ul style="list-style-type: none"> Percent/number of pregnant women who attended antenatal care services at ACCESS-targeted facilities who received 2nd dose of intermittent preventative treatment (IPT2) under direct observation 	<ul style="list-style-type: none"> Calculation: Number of pregnant women who receive IPT2 under direct observation/Number of 1st ANC visits Receipt of IPT with SP will be determined from facility records. 	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	50%
<ul style="list-style-type: none"> 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"> Calculation using HMIS data: Number of ANC clients that received 2 TT shots / number of 1st ANC clients 	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	63%
<ul style="list-style-type: none"> 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"> Calculation using HMIS data: Number of ANC clients that received iron/folate supplementation / number of all ANC clients 	HMIS; tally sheet	Quarterly	Program country staff with ACCESS M&E review	70%
<ul style="list-style-type: none"> Percent of 1st visit ANC clients who received an ITN voucher 	<ul style="list-style-type: none"> Number of 1st visit ANC clients given voucher / Total number of 1st visit ANC clients 	HMIS; tally sheet Records kept by Tanzania National Voucher Scheme	Quarterly	Program country staff with ACCESS M&E review	86%
ACCESS Program Result: 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.					

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FOR OCTOBER 2006-MARCH 2007
<ul style="list-style-type: none"> 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"> Providers may include midwives, nurses and are defined according to Tanzanian categories of instructors and care providers. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. Data will be disaggregated by affiliation of trainees (e.g., public, FBO, private). 	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	564 (362 providers And 202 trainers)
<ul style="list-style-type: none"> Percent/number of districts with at least 4 qualified FANC trainers 	<ul style="list-style-type: none"> Number of districts with at least 4 qualified FANC trainers / Total number of districts Qualified FANC trainers are those who complete the FANC training event satisfactorily according to the criteria established for the course. There are currently 128 districts in Tanzania mainland. 	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	16
<ul style="list-style-type: none"> Number of hospitals with at least 2 providers trained in focused ANC through ACCESS-supported training events; 	<ul style="list-style-type: none"> 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. Providers, such as nurse-midwives, are defined according to local (Tanzania) categories of care providers. Trained providers are those who complete a focused ANC training event satisfactorily according to the criteria established for the course. Data will be disaggregated by affiliation of service delivery points (SDPs) (e.g., public, FBO, private). 	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	23

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FOR OCTOBER 2006-MARCH 2007
<ul style="list-style-type: none"> 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"> 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. Providers, such as nurse-midwives, are defined according to local (Tanzania) categories of care providers. Trained providers are those who complete a focused ANC training event satisfactorily according to the criteria established for the course. Data will be disaggregated by affiliation of service delivery points (SDPs) (e.g., public, FBO, private). 	Program records including training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	215
ACCESS Program Result: A continuous quality improvement process for ANC is implemented in all regional and district hospitals offering FANC					
<ul style="list-style-type: none"> 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"> 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. Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private). 	Program ANC Quality Improvement assessment tools; Records review	Annual	Program country staff with ACCESS M&E review	5
ACCESS Program Result: All graduates of pre-service midwifery education programs from 2007 onwards are ready to practice FANC according to national standards					
<ul style="list-style-type: none"> 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"> Tutors and practicum site preceptors are defined according to local (Tanzania) categories of instructors and care providers. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. 	Training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	24

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	PROGRESS FOR OCTOBER 2006-MARCH 2007
<ul style="list-style-type: none"> 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"> Tutors and practicum site preceptors are defined according to local (Tanzania) categories of instructors and care providers. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course. 	Training database and/or other training records	Semi-annual	Program country staff with ACCESS M&E review	24
ACCESS Program Result: Improved enabling environment to address Safe Motherhood issues.					
<ul style="list-style-type: none"> 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"> 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. ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. 	Program ANC quality improvement assessments; tally sheets	Quarterly	Program country staff with ACCESS M&E review	6
<ul style="list-style-type: none"> 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"> Skilled providers include all cadres with a basic level of formalized health education, including doctors, nurse-midwives, nurses, midwives, clinical officers, matrons, MCHAs, etc. 	District Health Plans	Annual	Program country staff (WRATZ) with ACCESS M&E review	81% in Sumbawanga 86% in Monduli

ACCESS WARP MONITORING AND EVALUATION FRAMEWORK

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL REPORT
WARP MONITORING AND EVALUATION FRAMEWORK <i>West Africa IR1: Increased dissemination of best practices and use of cross border services region-wide</i> <i>West Africa IR3: Increased technical and management capacity of regional institutions and networks</i> ACCESS IR 3: Safe delivery, postpartum, and newborn care improved					
Number of providers trained in EMNC or EmONC in the past year through ACCESS-supported training courses	<p>ACCESS-supported training courses include ACCESS technical assistance, training materials, and approved staff.</p> <p>Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.</p>	Training participant tracking sheets and training database Training workshop summary reports	Annual	ACCESS consultant ACCESS staff	Currently ACCESS is in the process of training 20 providers in Niger. It is expected that another 20 will be trained in Niger, Cameroon, Mauritania and Togo.
% of providers trained in ACCESS-supported clinical training courses competent in key EMNC/EmONC skills (AMSTL and at least one other skill) 23 months after training	<p><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</p> <p><u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC/EmONC course</p>	Clinical observations during training follow-up site visits	2-3 months after training	ACCESS consultant ACCESS staff	11 out of 13 in Mauritania (the remainder were not followed up). These are providers who were trained in 2005 and this was their second follow up visit.
% of providers trained in ACCESS-supported EMNC/EmONC training courses that have implemented at least 2 action items (including or in addition to AMSTL)	<p><u>Numerator:</u> Number of providers completed an ACCESS-supported EMNC/EmONC course who have implemented at least 2 action items</p> <p><u>Denominator:</u> Total number of providers who completed an ACCESS-supported EMNC/EmONC course</p>	Review of service statistics and actual partographs during training follow-up site visits	2-3 months after training	ACCESS consultant ACCESS staff	4 out of 13 for Mauritania. At Kaedi hospital, where 3 of the providers practice, best practices have not been implemented. In Kaedi Health Center, Toulde Health Center, Bababe Health Center and Aleg Hospital at least 2 best practices have been implemented.

INDICATOR	DEFINITION/CALCULATION	DATA SOURCE/COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	RESPONSIBLE PARTY	SEMI-ANNUAL REPORT
Number of trainers trained in clinical training skills for EMNC/EmNOC 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 (September 2006).
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	N/A
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	N/A
Number of trained Social Mobilization trainers reporting having conducted advocacy activities using autodiagnostic tools in the last 3 months.	Trained SMAs are ACCESS-trained advocates through the workshops in targeted countries. Auto-diagnostic tools are a key focus of the training.	Program records/reports, completed auto diagnostic tools.	2-3 months after training	Mmwangaza Action ACCESS Staff	27
Number of individuals trained through Social Mobilization Advocacy workshops in target countries	Targeted 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	SEMI-ANNUAL REPORT
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