

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

ACCESS

YEAR THREE ANNUAL IMPLEMENTATION PLAN – PART B

FIELD SUPPORT WORKPLANS Final Version 02/15/07

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Submitted by:

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

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

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Status of Field Support Workplans

Approved Workplans

1. Afghanistan
2. Bangladesh
3. Kenya
4. Guinea
5. Haiti
6. Madagascar
7. Nepal
8. Nigeria
9. South Africa
10. Tanzania

Afghanistan
ACCESS Field Representative: Hannah Gibson, Service Support Project (SSP) COP
US-based ACCESS Contact Person: Deirdre Russo, Program Officer ACCESS
Year 3 Funding Amount and Sources: ACCESS Field Carry Forward \$441,621
ACCESS Partners: JHPIEGO, SC
Other Collaborating Organizations: IMC

Program Approach

The objective of USAID's health care program in Afghanistan is to reduce the mortality and morbidity of women and children. ACCESS contributes to this objective by building capacity of the nascent Afghan Midwives Association; supporting the Ministry of Public Health in the area of safe motherhood and newborn health strategies; piloting a community-based prevention of postpartum hemorrhage initiative and assessing the feasibility of maternity waiting homes in the province with the world's highest recorded maternal mortality.

USAID has built and renovated health centers in needy areas to increase women and children's access to basic health care. Grants are provided to NGOs to operate clinics and train new community health workers, midwives, and clinic staff. USAID is helping build Ministry of Public Health (MOPH) capacity at the national and provincial levels.

USAID has just developed a new 5-year (2005-2010) strategy for Afghanistan with three main strategic objectives and a fourth that supports the program and links the first 3 together:

- SO 1: A thriving economy led by the private sector
- SO 2: A democratic government with broad citizen participation
- SO 3: A better educated and healthier population
- SO 4: Program Support System: Synergistic use of linkages and tools to support cross-program components.

Achievements PY02

- AMA office established within the Institute of Health Sciences building, Kabul. Furnishings and equipment donated by UNICEF.
- Second annual AMA Congress held May 2006 with co-funding provided by WHO and UNFPA. International Day of the Midwife celebrated nationally on May 5th.
- National advocacy group for Safe Motherhood established under auspices of AMA.
- Completion of national Maternal and Newborn Health Strategy and MOPH endorsement of 4- year strategy which falls under the newly endorsed Reproductive Health strategy. Translation in progress. National dissemination to follow.
- Obtained MOPH Ethical Review board approval for demonstration project in prevention of PPH at homebirth in Afghanistan.

- Sub-agreement to IMC awarded for implementation of PPH project in 2 districts of Kabul.
- Misoprostol distribution to pregnant women and monitoring and evaluation commenced.
- Feasibility study on use of Maternity Waiting Homes report completed and results disseminated to MOPH.
- Guidelines on the establishment of Maternity Waiting Homes developed; awaiting endorsement by MOPH.

Summary of Activities Program PY03

- Ongoing support to AMA and strengthening of board.
- Strengthening of national advocacy group.
- Ongoing monitoring and evaluation of the PPH field implementation process.
- Initiate development of plans to scale up the project intervention for national expansion.

PY03 Outputs

- Leadership skills of AMA board members.
- Obtain results of the Prevention of PPH demonstration project and disseminate to a wide audience.
- Maternal and Newborn and Reproductive health strategy translated and distributed nationally.
- Maternity Waiting home guidelines endorsed and distributed.

ACTIVITY 1: SUPPORT THE ORGANIZATION OF THE AFGHAN MIDWIVES ASSOCIATION (AMA)

Activity Lead: Midwifery Advisor: Pashtoon Afzar

Activity Location(s): Kabul, Afghanistan

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Strengthen AMA Capacity: <ul style="list-style-type: none"> • Provide general mentoring, training and support to local ACCESS Midwifery Advisor in Afghanistan. • Increase # provincial representatives of AMA by 20%. 	JHPIEGO/ ACNM	Ongoing December 2006

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 2: Develop the leadership capacity of AMA Board Members: <ul style="list-style-type: none"> • Provide technical assistance to build leadership and management capacity of AMA Executive /Governing Body members. • Provide TA to prepare and conduct a leadership and management skills work shop for Governing Board & Exec Board members. 	JHPIEGO/ ACNM	September/October 2006 November/December 2006
Task 3: Conduct one Governing Body meeting <ul style="list-style-type: none"> • Review of progress of AMA workplan to date. 	JHPIEGO	September 2006
Task 4: Continue advocacy efforts through National Advocacy Group to build alliances for Safe Motherhood <ul style="list-style-type: none"> • Celebration of first Afghanistan Safe Motherhood Day. 	JHPIEGO	Ongoing October 2006

ACTIVITY 2: IMPLEMENTING PREVENTION OF PPH DEMONSTRATION PROJECT AT HOMEBIRTH IN AFGHANISTAN.

Activity Lead: Dr Shams Begana Project officer and Training and Performance Manager,
Dr Nasratullah Ansari

Activity Location(s): Kabul city, Kabul Province and Faryab and Jawzjan Provinces.

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Continue advocacy and consensus building in project communities: <ul style="list-style-type: none"> • Including presentations on the nature and use of Misoprostol to an audience of clinicians, university figures, women's advocates and others 	JHPIEGO	Ongoing January – August 2007
Task 2: Hold follow-up implementation meetings to address specific issues such as: <ul style="list-style-type: none"> • Joint planning with implementing partner NGOs • Monitoring and evaluation of PPH activities • Conduct PPH TAG meeting at the MOPH 	JHPIEGO/SAVE/IMC	January – May 2007
Task 3: Ongoing support to implementing NGO partners	JHPIEGO/SAVE	January – May 2007

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 4: Data entry and ongoing data analysis including field monitoring including TA through follow-up visit.	JHPIEGO	January – June 2007
Task 5: Conduct follow-up technical assistance visits in coordination with MOPH and observe community-based Misoprostol distribution; collect success stories.	JHPIEGO	January – May 2007
Task 6: Review efforts to date and develop a plan for scaling up the intervention for national expansion with the MOPH.	JHPIEGO	March-August 2007
Task 7: Develop report on project findings and disseminate to national audience	JHPIEGO	June-August 2007

Program Management

Overall program management of the ACCESS program will be carried out by the SSP COP (previously the ACCESS program manager). Management of day to day activities of Activity 1 will be carried out by the AMA President and an administrative assistant. Activity 2 will be led by the PPH officer who will receive technical oversight and guidance from the Training and Performance Manager who has been involved with the project since its inception (this post is funded by the new Associate Award, SSP). Monthly meetings with PPH implementing partners (Save-US, IMC and 2 national NGOs STEP and MOVE) will be held to address key field implementation issues and at the MOPH, the specially formed PPH Technical Advisory Group will receive quarterly progress updates. To monitor project results, a database is being developed and a dedicated project data entry assistant has been hired. Additional activities such as ensuring completion of the translation and distribution of the maternal and newborn health strategy and maternity waiting home guidelines will be managed by the SSP COP.

Bangladesh
ACCESS Field Representative: Lubana Ahmad
US-based ACCESS Contact person: Pat Daly
PY03 Funding Amount and Sources: \$3,061,152
ACCESS Partners: Save the Children, JHPIEGO
Other Collaborating Organizations: ICCDR,B and Shimantik

Introduction

ACCESS program is a three year, USAID sponsored global program aimed at reducing maternal and newborn deaths and improving the health of mothers and newborns. The long term goal of this program is to improve maternal and neonatal outcomes. The overall objective of this activity is to increase the practice of healthy maternal and neonatal behaviors in a sustainable and potentially scalable manner. The ACCESS lead partner in Bangladesh is Save the Children USA. The project is implemented in seven upazillas of Sylhet districts with a population of 1.5 million. ACCESS/Bangladesh will collaborate with ICCDR,B and two local NGOs to implement this program at field level. Strategic Project Design includes **Home Practices, Counseling and Utilization of Services** to ensure four home visits by ACCESS counselors including pregnancy identification; **Community Mobilization** to support and facilitate the work of counselors; **System Strengthening** of the implementing NGOs to support services and counseling, community mobilization and leadership; **Advocacy** to build commitment to mobilize and leverage resources and to ensure ultimate sustainability and scaling up and appropriate **Communication Strategy**.

One of the major components of the project is to improve the household level behavior for healthy maternal and neonatal practices with appropriate messages and counseling strategies. Through an Intervention Design Workshop a Home visit strategy has been developed. The key aspects of the strategy include:

A. Household visit

1. ACCESS Counselor Home Visit Strategy

ACCESS Counselor (AC) will conduct four home visits for each pregnant/postpartum woman for education and negotiation with the woman and her family members and also orient the TBA/FBA and the newborn care person to practice behaviors that will contribute towards improved maternal and newborn outcomes in the home. The content of the household visits is:

Table 1: Contents of ACCESS Counselor Home Visit

Visit	Time of Visit	Contents of Visit
First visit P 1 (Pregnancy-1)	As soon as pregnancy is identified (preferably before 5 th month)	<ul style="list-style-type: none"> • Calculation of EDD • Counseling on nutrition and extra food • Help in preparing birth and complication readiness plan • Advice on self care • Referral for 4 ANC visits (TT & iron/folate) • Referral for danger sign • Negotiation on notification about delivery • TBAs/FBA & family members will inform AC • Community Action Group member will inform AC
Second visit P 2 (Pregnancy-2)	7-8 months of pregnancy	<ul style="list-style-type: none"> • Confirmation of TT & ANC • Review & update birth & complication readiness plan • Counseling on: <ul style="list-style-type: none"> • clean delivery • immediate newborn care • immediate & exclusive breastfeeding • delay bathing • cord care & resuscitation (stimulation only) • EPI • Referral for danger sign • Orientation to TBA/FBA & NC person • Negotiation on notification about delivery
Third visit (Mother & Newborn Care-1) MNC 1	Within 24 hours of delivery or as soon as possible	<ul style="list-style-type: none"> • Referral for PNC visit • Counseling on: <ul style="list-style-type: none"> • cord care • delay bathing • drying & wrapping • immediate & exclusive breastfeeding • Referral for danger sign (mother & newborn)
Fourth visit (Mother & Newborn Care-2) MNC 2	Between 5 to 7 days of delivery	<ul style="list-style-type: none"> • Referral for PNC visit • Counseling on: <ul style="list-style-type: none"> • exclusive breastfeeding • EPI • Birth spacing (focus on health of mother and baby) • Referral for danger sign (mother & newborn)

2. Pregnancy Identification Strategy

Initially each AC will make a list of all married women of reproductive age (MWRA) and list all pregnant women in her assigned area through household mapping. During this initial mapping she will also make a list of all TBAs/FBAs working in the area. Later the AC will update the list of pregnant women through FWA/HA, self reporting, CRPs (including TBAs), Female Community Supervisor Mobilizer (CSM), Male Community Mobilizer (CM) and other NGO workers at an ongoing basis. The AC will repeat household mapping in every 3 months.

3. Identification of Modern Health Services Facilities

The Upazila Team Leader (UTL) and Field Support Officer (FSO) will conduct an initial union-wide resource mapping (e.g. existing health facilities, governmental and non-governmental services, NGO programs, etc.) to identify health facilities. Based on that mapping as well as on information obtained from key officials at the Upazila level each facility will be assessed to identify facilities where pregnant/postpartum mothers and the newborns can be referred for appropriate health care. Based on the facility assessment the ACCESS intervention areas will be divided into three categories:

1. Area with adequate ANC & PNC service facility
2. Area with limited/inadequate ANC & PNC service facility
3. Area with no ANC & PNC service facility

This information will then be incorporated to ACCESS Counselor home visit strategy.

4. TOT and Basic Training of ACCESS Counselors

There will be two Training of Trainers (TOT) in which Technical Coordinator (TC), UTLs and FSOs from FIVDB and Shimantik (in mixed groups) will participate. DPM M&E, DPM MNH, DPM FO and PO from ACCESS will also participate in the TOT. National level resource persons will provide this TOT. The staff who will receive the TOT will be the ACCESS Master Trainers. Through this TOT the capacity within each partner NGO will be developed and they will roll out training to ACCESS Counselors (AC). The ACs will receive basic training in batches of 20 in basic maternal and neonatal health, assessment and counseling skills (with an emphasis on negotiation for behavior change), monitoring and improvement, and other project systems. Training will be competency-based, with an emphasis on practical learning in community situations.

B. Community Mobilization

Community mobilization is another major component of the ACCESS project. It supports and facilitates the work of the ACCESS Counselor to change the household level behavior for healthy maternal and neonatal practices and focuses on the implementation of the **Community Action Cycle (CAC)** at the community level for sustainable, appropriate and effective actions to achieve healthy maternal and neonatal outcomes.

Through an Intervention Design Workshop a detailed **Community Mobilization (CM)** strategy has been developed. The key aspects of the strategy include:

1. Selection of villages and selection criteria:

Both potential “champion villages” (with experience in community-based interventions and well-organized) and those most disadvantaged will be considered during the selection of villages.

At least 60% of the villages selected initially should be potential “champions”. The remaining villages will be selected among those most disadvantaged, with little or no maternal and neonatal health (MNH) programs and particularly high maternal and neonatal mortality rates.

210 villages/Paras will be selected for project start up. The initial selection will therefore include at least two villages from each union. To prepare ACCESS counselors’ (AC’s) entry to the communities, UTLs and FSOs will conduct an initial union-wide resource mapping (e.g. existing health facilities, governmental and non-governmental services, NGO programs, etc.). Based on that mapping as well as on information obtained from key officials at the Upazilla level and following the above-mentioned criteria, UTLs and FSOs will do a preliminary selection of villages. They will then conduct meetings at the union level with the Union Council (UP) Chairman and members (male & female), and health and FP staff. They will present them the ACCESS project and get additional information for the pre-selected villages. Based on the results of these meetings, UTLs and FSOs will do the final selection of villages.

2. TOT on Community Mobilization

There will be two TOT workshops (8 days each) in which UTLs and FSOs from both organizations (in mixed groups) will participate. Gathering together participants from both PNGOs during the TOT workshops will facilitate exchange and coordination between them.

3. Basic training on Community Mobilization for CSM/CM

Three to four batches of Basic training on Community Mobilization for CSM/CM will be conducted simultaneously by each organization over a short period of time (3 to 4 batches per organization; 13-18 participants each). Each training batch will last for 6 days.

4. Community Entry

During or prior to their training, CSMs and CMs will be assigned the villages they will be working in. After the training, CSMs and CMs will be ready to officially “enter the villages” on behalf of ACCESS—which is a crucial CAC phase. Following a pre-established format and content, they will present the project to the village gatekeepers by individual contacts and/or group meetings. During those meetings CSMs and CMs will identify potential zones for CAC implementation, get additional information on services and community-level organizations.

CSMs and CMs will combine transect walks with community mapping. These will be conducted with women and men separately. Specific modalities for transect walks and mapping will be explained in the training manual.

5. Initiation of Community Action Cycles and scaling up strategy

210 villages or Paras/groups of Paras will be selected at project onset for the implementation of CACs. All female and male mobilizers (105 total) will be recruited by September’06. Each

CSM will conduct 3 CAC in different villages/Paras. Each CM will support the work of 2 CSM and therefore conduct 6 CACs (with male participants) in 6 villages/Paras.

70 CSM x 3 CAC = 210 villages/Paras
35 CM x 6 CAC = 210 villages/Paras

A CAC will be completed within six months. By the fifth month, CSMs and CM will start new CACs in a new batch of (of approx. 210) villages. It is expected that on the fifth month the first villages will have already developed an action plan and started its implementation. At that time, the CSM and CM will be able to move on to the next set of villages and provide support to the first ones on a less regular basis.

The total anticipated number of villages covered by September 2008: 840 (app. # of villages in the 7 Upazillas: 1,637)
70 female Community Supervisors-Mobilizers (CSM) and 35 male Community Mobilizers will facilitate the Community Action Cycle in the selected villages/Paras.

6. Role of CRP

Community Resource Persons (CRPs) will be recruited in the villages to support the CSMs and CMs in the implementation of CACs. The CSM and CM will orient and strengthen the capacity of CRPs to carry out CM/CACs. It is hoped that CRPs will be able to continue CM processes for MNH independently after the project ends.

Both CRPs and CSM/CM will be recognized for their contribution to CM for MNH during public meetings/events. An annual event to recognize and reward CRPs will be organized at the village level.

7. Formation of Community Action Group (CAG)

Community Action Groups (CAGs) will be formed in each village. With the guidance of CSMs/CMs, the CAGs will become the main driving force/engine of the overall CAC. In addition to the CAGs' members, other villagers will be involved at different levels and in specific phases of the CAC.

CAG Composition

In most cases, the CSM and the CM will work separately with female and male participants respectively. Whenever possible, mixed CAGs will be formed.

Each CAG will have 10 to 15 members. If there are 10 to 15 members in a CAG, the same number of households should be represented.

Functioning of female and male CAGs in the same village

The female and male CAGs operating in a village will carry out separate CACs. However, they both will work on one action plan. To assure coordination and agreement between the male and female groups, the following process is suggested:

- The female CAG will develop an action plan, which will be shared with the male CAG for consultation and endorsement
- The initial action plan will be complemented with input from the male CAG
- Tasks, roles, and responsibilities will be divided between male and female groups. Female and male CAGs will coordinate their action through the CMS and CM or using community-based channels (e.g. female/male village leaders meetings)

This procedure is not cast in stone. It will be adapted to specific contexts. **Frequency of CAGs meetings**

It is recommended that CAGs meet at least bi-weekly initially. Once the action plan is developed and shared with the broader village, tasks and responsibilities divided, and sub-groups/committees formed (as needed), the CAGs will probably need to meet less frequently (once a month). The CAGs will probably meet more often and as needed. They should also be active during emergencies.

8. Integration of AC and CM components

The issues discussed within CM activities will be consistent with those raised by ACs at the household level. Villagers' mappings (which will be periodically updated as part of village-level monitoring of action plans) will complement the ACs' lists/maps for the identification and follow up of pregnant women. As far as possible, ACs will participate in *key* community meetings (as/when requested by the villagers or CAGs). They could also encourage some of the women they visit to share their stories (particularly successes) with other villagers during CAGs meetings or village-wide activities.

C. Monitoring and Supervision

CSMs and CMs will supervise the activities of ACs while FSOs will mentor CSMs and CMs and accompany them in the various CAC phases. Monthly staff meetings (UTL, FSO, CSM/CM, ACs) will be conducted to review accomplishments and take corrective actions as needed. Apart from a formal performance review of CSMs/CMs carried out by the FSOs quarterly, CSM/CM will be invited to conduct periodic self-assessments and identify their CM capacity strengthening needs. Self-assessments will be conducted twice a year and revised with FSOs during the regular monthly staff meetings. Refresher trainings will be organized according to the results of self-assessments.

CSMs and CMs will keep a register with information regarding the activities facilitated in each village (per CAC phase), their duration, number and characteristics of participants, key topics discussed, and decisions made, and anticipated follow-up. They will also keep a register of CRPs recruited and their involvement in CAC/CM activities.

To effectively monitor the activities under this project an M & E plan has been developed. Indicators have been selected to monitor and evaluate the project performance. A baseline survey will be conducted by ICDDR,B at the beginning of the implementation of the project

and the findings of the survey will be disseminated to all stakeholders. The project will develop a computerized MIS system. The partner NGOs will be oriented on how to enter and analyze data in computer. They will send their Monthly Performance Report (MPR) using the computerized MIS system. The PNGO Monthly Performance Report will routinely be analyzed in ACCESS Dhaka and Sylhet Office and necessary feedback will be given to them on a regular basis for improvement of the activities. The project will also conduct quarterly Program Review Meeting with partners.

Bangladesh Workplan (October 1, 2006 to September 30, 2007)

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4						
	O	N	D	J	F	M	A	M	J	J	A	S				
Startup Objective: To establish the ACCESS Project and initiate activities.																
A. Recruit staff for Dhaka and Sylhet level (SC-B Staffs)																
i. 2 Staff recruitment in process	x													Director HPN, PM-ACCESS	ACCESS HQ	Recruitment completed
ii. HR Orientation to new staff to project, policies, systems of SC	x													PM ACCESS, HR		All ACCESS /B staff complete orientations
B. Negotiate and sub grant to ACCESS Partners																
i. Prepare SOW agreement with ICDDR,B	x													PM ACCESS,	ACCESS HQ to review the SOW and deliverables	Agreement to proceed
ii. Contract signed with ICDDR,B	x													PM ACCESS Director F & A	ACCESS HQ nd HO	Three sub grants completed and signed
C. Program Management activities																
i. Set up communications with ACCESS HQ for technical and management issues	x	x	x	x	x	x	x	x	x	x	x	x	x	Country Director PM ACCESS	Biweekly calls with HQ	Project communication process specified.
ii. Bi-Monthly meeting with USAID/B		x		x		x		x		x		x		PM ACCESS	Country Director, SC-USA	Meeting held
iii. Monthly Team Meeting with Partner NGOs	x	x	x	x	x	x	x	x	x	x	x	x	x	Project Management Team		Meeting held
iv. Attend routine Monthly coordination Meeting with GOB/Stakeholders at Sylhet	x	x	x	x	x	x	x	x	x	x	x	x	x	FM and PNGOs	PM ACCESS	Meetings held
v. Prepare Annual and Midterm report for ACCESS HQ/ USAID Bangladesh	x						x						x	PM ACCESS and DPM M & E	Country Director, SC-USA	Report prepared

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs
	Q1			Q2			Q3			Q4					
	O	N	D	J	F	M	A	M	J	J	A	S			
vi. Establish contact with FHI for coordination with WG	x												PM ACCESS		Established contact with FHI
vii. Coordinate with USAID/Bangladesh for Corporate Steering group approval of the Work plan for Y 2		x											PM ACCESS	Country Director, SC-USA	Work Plan approved by CSG
D. Establish connection in Sylhet and Orient district leadership to ACCESS project and activities															
i. Upazilla Orientation (7) with Health, FP, UP Chairman, Religious leaders, Community leaders	x												PNGOs	FM and DPM FO and DPM CM	Upazilla level stakeholders oriented
ii. Sensitization of religious leaders on MNH issues through incorporation of a session in their routine training curriculum through Islamic Foundation at Sylhet	x			x			x					x	FM & DPM MNH	PM ACCESS	Religious leaders oriented on basic MNH issues and supportive at the village level
E. Coordination with other SC Health Sector activities															
i. Prepare monthly work plan and activity report for HPN sector	x	x	x	x	x	x	x	x	x	x	x	x	PM, ACCESS,	Director HPN	Monthly report prepared
ii. Participate in HPN bimonthly coordination meeting	x		x		x		x		x		x		PM ACCESS	Director HPN,	Shared program performance and plan
iii. Participate in SC-USA routine Quarterly Program review Meetings			x			x			x			x	PM ACCESS and DPM M & E	Country Director, SC-USA and Director HPN	Participated in QPRM and report prepared
iv. Prepare Annual/ midterm report for SC-USA HQ /HPN sector	x						x					x	PM ACCESS and DPM M & E	Director HPN,	Report prepared
F. Conduct detailed implementation planning (DIP) with NGO partners in Sylhet															

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs
	Q1			Q2			Q3			Q4					
	O	N	D	J	F	M	A	M	J	J	A	S			
i. Share DIP with ACCESS HQ	x												PM ACCESS	ACCESS HQ	DIP shared
ii. Synthesize inputs from QPRM with Partners for adjusting in FY 08								x	x				ACCESS /B team and PNGOs	ICDDR B	Inputs documented
iii. Annual work planning for Year 3										x			ACCESS /B team and PNGOs	ACCESS HQ	Work plan developed
iv. Y 3 Work plan reviewed by ACCESS HQ and USAID/B											x		ACCESS HQ and USAID/B CTO		Work plan reviewed and approved
G. Manual/Curriculum development on Technical MNH and CM component															
i. Manual/Curriculum Development on CM	x												ACCESS/B Team	Local Consultant SNL 2 Team	Manual/Curriculum drafted
ii. Manual/curriculum Editing after TOT	x	x											PM/FM	Local Consultant SNL 2 Team	Manual/Curriculum drafted
iii. PB/Technical Advisory Committee/ACCESS HQ Review		x											PM ACCESS, Director HPN	ACCESS HQ SNL 2 Team	Manual/Curriculum drafted
iv. Training Manual /Curriculum finalization		x											PM ACCESS	Local Consultant SNL 2 Team	Manual/Curriculum drafted
v. . Manual Printing and distribution			x										PM ACCESS/ FM		Manual printed and disseminated
vi. Adaptation and production of BCC/ counseling materials	x												ACCESS/B Team	ICDDR,B Imteaz Mannan /SNL 2 Team	BCC Materials adapted and reproduced
H. M&E / MIS															
i. Develop program MIS	x												DPM M & E	ICDDR B, ACCESS HQ M & E	MIS in place

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4						
	O	N	D	J	F	M	A	M	J	J	A	S				
ii. Establish standardized MIS and monitoring guidelines for all program staff/NGO partners	x													Partner NGOs	DPM M & E	MIS and monitoring tasks incorporated in staff job descriptions and NGO subawards; Use of tools and procedures incorporated into training of field staff; application of the MIS and monitoring tools reviewed as part of program reviews.
iii. Conduct Baseline Survey	x	x	x	x										ICDDRDB	PM ACCESS and DPM M & E and ACCESS HQ	Baseline survey conducted
iv. Share Baseline Survey findings at program area					x									ACCESS/B team	ICDDRDB	Base line findings disseminated
v. Periodic Monitoring Visit and Monthly Supervision		x	x	x	x	x	x	x	x	x	x	x	x	ACCESS/B team		Periodic monitoring and monthly supervision visits conducted
vi. Establish Surveillance System (Birth/Death/Pregnancy identification)	x	x	x	x	x	x	x	x	x	x	x	x	x	PNGOs	DPM M & E	Surveillance system in place
vii. Introduce uniform referral systems and forms into program management systems	x													Partner NGOs	DPM M & E	Referrals documented
viii. Develop Reporting Mechanism	x													DPM M & E	PM ACCESS, SNL 2, ICDDRDB, ACCESS HQ	Reporting mechanism in place
ix. Prepare Follow-up Skills Assessment Checklist and review periodically implementation of training for continuous improvement				x				x					x	DPM MNH DPM CM	DPM M & E	Check list available
x. Develop Supervision Checklist	x													DPM M & E	PM ACCESS	Checklist prepared

Key Activities	Year 2													Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4							
	O	N	D	J	F	M	A	M	J	J	A	S					
I. Implement regular support to operations focused on improvement																	
i. Quarterly Program Review meetings with Partners	x					x							x	ACCESS /B team and PNGOs	ICDDRDB every six months	Meetings held	
ii. Mid stream adjustments in program planning and systems based on partner consultation and results of program reviews													x	ACCESS /B Program Management Team	ICDDRDB, ACCESS HQ Director HPN	Flexibility maintained to adjust to program learning and incorporate monitoring data (or new research from other Bangladesh experiences)	
J. Establishment of regular monitoring and improvement system among appropriate groups or subgroups																	
i. Develop community-based HIS to be used by the community groups for activity monitoring and evaluation	x	x													DPM CM /PNGOs	DPM M &E Marcela	Community-based HIS developed for use by core community groups
YEAR 2: Objective 1: To increase knowledge, skills and practice of healthy maternal and neonatal behaviors in the home.																	
A. Recruitment of ACCESS counselors																	
i. Recruitment of ACCESS Counselors															FM and Technical staff at Sylhet, NGO Partners		At least 210 ACCESS counselors recruited
ii. Establish supervisory/support system for counselors	x	x	x												PM, DPM- M&E		Supervision system and process documented and in place
B. Establish a pregnancy identification system																	
i. Complete initial MWRA and pregnancy registration	x	x													PNGOs	DPM, M & E	MWRA & pregnant women identified
ii. Update pregnancy registration			x	x	x	x	x	x	x	x	x	x	x		PNGOs		Pregnancy registration updated
iii. Update MWRA registration						x						x			PNGOs		MWRA updated
C. Train ACCESS Counselor																	

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs
	Q1			Q2			Q3			Q4					
	O	N	D	J	F	M	A	M	J	J	A	S			
i. Conduct MNH TOT (2 batches) including MCP issues	x	x											ACCESS/B Team, PNGOs Core Staff	Local Consultant SNL 2 Team / USAID	TOTs trained / Field testing findings documented
ii. Implement ACCESS counselor training including monitoring and project systems		x	x	x									The UTL and FSOs (Master trainer) of the partners NGOs	ACCESS /B team	210 ACs trained and in place
D. Plan a home visiting schedule and system for ACCESS Counselors															
i. Mapping of households	x												UTL, FSOs and ACs	DPM M & E	Household Mapped
ii. UTLs/FSOs meeting to review mapping information and adapt schedule for their area	x	x											UTL and FSOs	Sylhet FM, Technical Coordinators	Proposed schedules for AC HH visit
iii. Procurement of Job Aids for ACs and other logistics (dolls, birth kits, bag, flip chart etc)	x	x	x										Partner NGOs	PM and FM ACCESS	Job Aides procured
E. Identify and provide orientation to high volume home birth attendants (TBAs, FBAs, TTBA)															
i. Identification of high-volume TBA, FBAs and TTBA	x	x											DPM FO and PNGOs	FM	TBA/FBA resources identified
ii. Develop a data base for the TBAs		x	x										DPM M & E	PM	Database developed
iii. Orientation of TBAs						x	x	x	x	x	x	x	FSOs/AC/CSM	DPM MNH	TBA/FBA resources oriented
F. ACCESS Counselors conduct home visits for education and negotiation with family to practice behaviors															
i. Home visits by ACCESS Counselor		x	x	x	x	x	x	x	x	x	x	x	ACCESS Counselor		Home visits conducted
YEAR 2 : Objective 2 : To increase appropriate, timely utilization of home and facility-based essential MNH services.															
A. Map care-seeking practices including use of modern, traditional, and alternative healing systems.															

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4						
	O	N	D	J	F	M	A	M	J	J	A	S				
i. Review of existing information	x	x												NGO Partners /UTLs/FSOs	ACCESS /B team	Maps by geographical area of health seeking practices and sources of services
ii. Participatory Rural Appraisal (PRA) Village Level				x	x	x	x	x	x	x	x	x	x	FM /DPM CM	ACCESS HQ	PRA done, Care seeking practices documented
B. Identify modern health service resources, review relevant health services supply and utilization information, and identify the most appropriate linkages by community/ACCESS coverage areas.																
i. Map service delivery points and outlets, locations and & providers														DPM FO and Partner NGO	FM	Maps of available services completed
ii. Develop Health Facility Assessment tool														DPM M &E	FM, ACCESS	Tool developed
iii. Assess Health Facility	x													UTL/FSOs	DPM FO/PO	Facility assessed
iv. Analyze Health Facility Assessment data	x	x												DPM M &E		Data analyzed
v. Identify Health Facility for referral by location		x												DPM M &E		SDPs identified by location
C. Incorporate linkage information into home visit and community mobilization meeting messages.																
i. Micro plans for AC home visit and CM interventions by type of area		x	x	x										UTL and FSOs	FM and DPM FO and DPM CM	Operational plans for field activities
D. ACCESS Counselors conduct home visits where service utilization messages and negotiation take place.																
i. Initiation of home visits				x	x	x	x	x	x	x	x	x	x	ACs	FM and DPM FO and DPM CM	HH visited
E. ACCESS field staff establish and utilize contacts with community influentials to support and problem solve danger signs and complications referrals.																
i. AC attend CAG meeting as needed					x	x	x	x	x	x	x	x	x	CSM/CMs	PM ACCESS DPM-CM	CAG attended
F. CSMs facilitate community action groups to provide support to utilization of services including key aspects of birth preparedness (emergency transport and funds), and access to supplies that can be used in the home (iron folate, clean delivery kits).																

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs
	Q1			Q2			Q3			Q4					
	O	N	D	J	F	M	A	M	J	J	A	S			
i. CSMs/CMs attend meetings of target communities						x	x	x	x	x	x	x	CSM/CMs	DPM-CM	Meetings held
YEAR 2 : Objective 3: To improve key systems for effective service delivery, community mobilization and advocacy.															
A. Identify and design key systems for the project in the context of NGO and MOH/FW operations															
i. Provide technical assistance to strengthen selected NGO systems as planned	x	x	x	x	x	x	x	x	x	x	x	x	ACCESS /B team	SC/B F & A Team	TA provided
B. Orient, train and equip partners to put systems in place															
i. Work planning	x	x								x	x		Partner NGOs	ACCESS /B team	Planning conducted jointly with NGOs
ii. Finalize performance/supervision systems	x												Partner NGOs	ACCESS /B team	Consistent approach to supervision established for ACCESS/Bangladesh program
YEAR 2 : Objective 4: To mobilize community action, support and demand for the practice of healthy MNH behaviors															
A. Recruitment and training of female and male community supervisor/mobilizers (CSMs).															
i. Recruit CSMs/CMs	x												Partner NGOs	ACCESS /B team	At least 105 CSM recruited (70 female and 35 male CSMs)
ii. Design training to include communication skills, facilitation of CAG, appraisal techniques, monitoring and evaluation	x												Project Mangement Team	ACCESS HQ CM International Consultant	6 day training package developed
iii. Conduct CM TOT		x	x	x									ACCESS/B Team, PNGOs Core Staff	CM International Consultant SNL 2 Team	Local TOTs trained / Field testing findings documented

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4						
	O	N	D	J	F	M	A	M	J	J	A	S				
iv. Implement basic training for CSM/CMs			x	x	x									Partner NGOs	DPM - CM	At least 105 CSMs trained and ready to implement community mobilization and other program activities
B. Community entry and initial inventory of resources																
i. Initial meetings with UPs, any existing committees, village leaders to invite community participation at the village level	x	x												Partner NGOs	DPM-CM	Communication channels opened with community leaders
ii. Assessment of community resources (rolling implementation)	x	x												Partner NGOs	DPM-CM	First phase in community mobilization completed
C. Participatory assessment and planning including linkages between resources.																
i. Facilitation of Participatory assessment and planning within community groups			x	x	x	x	x	x	x	x	x	x		CSM/CMs	DPM-CM	
D. Establish or engage current community groups or committees (health committees, management committees)																
i. Identify and negotiate revision of membership and roles with existing active groups				x	x	x	x	x	x	x	x	x		CSM/CMs	DPM-CM	Existing community groups activated if any, to establish community action cycle
ii. Facilitate the establishment of new core community groups in areas with no active groups				x	x	x	x	x	x	x	x	x		CSM/CMs	DPM-CM	Core community groups established in areas that previously did not have them
iii. Initiation of community action cycles (roll in by community)				x	x	x	x	x	x	x	x	x		CSMs/CMs	DPM-CM	CAG initiated

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs						
	Q1			Q2			Q3			Q4											
	O	N	D	J	F	M	A	M	J	J	A	S									
iv. Process documentation of the CM activities for refining the strategies for improvement (This activity was identified during the Intervention design workshop)						x		x	x							Local Consultants and DPM CM	International CM TA and ICDDRDB	Initial process documentation completed and findings fed forward in program			
E. CSMs facilitate community action groups to provide support to utilization of services including key aspects of birth preparedness (emergency transport and funds), and access to supplies that can be used in the home (iron folate, clean delivery kits).																					
i. CSMs/CMs attend meetings of target communities					x	x		x	x		x	x		x	x				CSM/CMs	DPM-CM	2470 meetings
F. Identify and orient community resource persons (CRPs).																					
i. Identify potential CRPs by discussion with community groups and ACCESS counselor recommendations	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				CSM/CMs	DPM-CM	CRPs identified.
ii. Develop a list of CRPs by village					x	x													DPM M & E	FM	CRP list available
iii. Orientation of CRPs								x	x		x	x		x	x				CSM/CMs	DPM-MNH and DPM CM	2496 CRPs oriented
G. Design and engage community group(s) in an ongoing action cycle based on NGO partners' experience (leadership, male, female, influentials)																					
i. Develop/Adapt curricula and training manual for community action cycle	x																		CSM/CMs	DPM-CM	Manual for training core community groups developed
ii. Train/orient select members of the group on the community action cycle								x	x		x	x		x	x				CSM/CMs	DPM-CM	Executive members of core community groups trained on the community action cycle
H. Link to governance structures (UPs), other development management groups, and to MOH/FW or NGO offices as appropriate.																					

Key Activities	Year 2												Responsibility	Technical Assistance	Milestones/Outputs	
	Q1			Q2			Q3			Q4						
	O	N	D	J	F	M	A	M	J	J	A	S				
YEAR 2: Objective 5: To increase key stakeholder leadership, commitment and action for these MNH approaches.																
A. Preparation of advocacy strategy and detailed work plan.																
i. Conduct national Workshop for developing national advocacy strategy	x													WRA ACCESS/B team	ACCESS HQ/ USAID/B and SNL 2	Workshop conducted
ii. Developing the national advocacy startaegy		x	x											WRA ACCESS/B team	ACCESS HQ/ USAID/B and SNL 2	Advocacy strategy linking community level to Upazila, district and national levels
B. Conduct Key Working Groups and meetings																
i. Establish national Technical Advisory Group	x													PM ACCESS	Director HPN	TAG established
ii. TAG holds regular meetings		x				x						x		PM ACCESS	Director HPN	3 meetings held
iii. Establish Sylhet district working group and hold regular meetings				x					x				x	FM and PNGOs	PM ACCESS	3 Meeting held
iv. Orient UP, Journalist, Non Partners NGO staff on th program to generate support	x	x										x	x	FM and PNGOs		Orientation completed
v. Collaboration with key stakeholders including professional associations	x	x	x	x	x	x	x	x	x	x	x	x	x	PM ACCESS	Director HPN	
C. Ensure cross learning, documentation and dissemination throughout the life of the project.																
i. Support to GoB events such as Breastfeeding Week, Vit A Day				x									x	PM ACCESS / FM	Director HPN	Events supported
ii. Exchange visits by the UP Chair/Female member/RL to see MNH program in country and abroad (7 m)													x	PM ACCESS	USAID/B	Exchange visits conducted

Guinea
ACCESS Field Representative: Yolande Hyjazi
US-based ACCESS Contact Person: Amy Rial
Carry forward field funding of \$27,000
ACCESS Partners: JHPIEGO
Other Collaborating Organizations: PRISM Project – Management Sciences for Health

Program Approach

In FY06, JHPIEGO supported the USAID Guinea 1998-2005 Country Strategic Objective of increased use of FP/MCH and STI/AIDS prevention services and practices, through expansion of postabortion care (PAC) services to Guinea's Forest Region. With these interventions, ACCESS addressed intermediate results I and II of this plan: increased access to and improved quality of FP/MCH and STI/AIDS prevention services and products. These efforts were in essence the final leg of postabortion care programming initiated under the Training in Reproductive Health in 1999, funded by USAID's office of Population and Health. Ongoing efforts were also supported by the Maternal and Neonatal Health Program with field support funding from USAID Guinea. From the initial introduction of postabortion care to two teaching hospitals in Conakry in 1999, TRH and MNH, in collaboration with the USAID Guinea bilateral project, PRISM, expanded services to two regional hospitals, seven prefectural hospitals, and one district health center in Upper Guinea. With the expansion of PAC services to six sites in Forest Guinea, the total number of sites supported by USAID is currently 17.

Using carry forward funds from FY06 field support, JHPIEGO will visit a subset of these sites to evaluate the quality of PAC services. This succinct evaluation will examine availability of all aspects of PAC services including counseling, family planning services, manual vacuum aspiration, linkages to other essential RH services, and community mobilization. It will provide information on the number of providers at each site who are able to provide PAC services as well as the caseload.

PY02 Outputs

- Brief evaluation of USAID-sponsored PAC services completed

Program Management

Evaluation activities will be conducted by a national PAC trainer in Guinea, Dr. Bademba Diallo, and JHPIEGO technical staff from the West Africa Region. The JHPIEGO ACCESS contact, Pr. Yolande Hyjazi will provide on-site coordination with PAC stakeholders

ACTIVITY 1 EXPANSION OF PAC SERVICES TO FOREST GUINEA

Activity Lead: Yolande Hyjazi

Activity Location(s): PAC sites in the Kankan and Faranah Regions; Conakry

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Conduct brief evaluation of USAID-sponsored PAC services in Guinea	JHPIEGO	October 2006

Timeline

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 1												
Task 1: Conduct brief evaluation of USAID-sponsored PAC services in Guinea	X											

Haiti
ACCESS Field Representative: Dr. Lucito Jeannis
US-based ACCESS Contact person: Nancy Ali
Year 3 Funding Amount and Sources: ACCESS \$400,000; PEPFAR,\$350,000 (\$100,000 (USD) from FY05 and \$250,000 (USD) from FY06)
ACCESS Partners: JHPIEGO
Other Collaborating Organizations: INHSAC, MOH, MSH/HS2007, PEPFAR
Dates: January to September, 2007

Strategic Statement

In Haiti, the contraceptive prevalence rate for all methods is 24.8 % - one of the lowest in the Western Hemisphere. Although the fertility rate fell from 4.7 children per woman in 2000 to an average of 4 children per women in 2005 (DHS 2005), this drop in fertility does not correspond with any increase in contraceptive use.

The data suggest use of modern contraceptive methods nationwide is stagnant and that new users are choosing less reliable traditional methods as often or more often than modern methods. Unmet need for family planning in Haiti is at 57.3%. Over 82% of Haitian women surveyed either do not want a child in the coming two years (30.4%) or do not want any more children (51.7%).

The Ministry of Health of Haiti (MSPP) has recently shown strong political will to respond to this unmet demand. The initiative *Repositionnement du Planning Familial en Haiti* launched at the end of 2006, aims to provide universal access to family planning for all women and men of reproductive age who want to space or limit their families.

With high unmet demand, renewed interest by the new government and strong commitment among NGO and civil society groups, USAID/Haiti is presented with an opportunity to revamp family planning in Haiti.

USAID assistance will support a broad mix of family planning methods including natural family planning, long lasting methods and permanent surgical contraception. In order to achieve the ambitious goal of the MSPP of 40% CPR in the next 5 years, attention to clinical methods for men and women will be a major component of Haiti's Repositioning FP initiative.

This workplan is submitted to the USAID/Haiti Mission as a contribution to its country strategy 2006 – 2009. It is consistent with the *New Strategic Framework for U.S. Foreign Assistance* which recognizes that investing in people and strengthening human capacity promotes and sustains democratic states that respond to the needs of their people. This proposal focuses on two of the five program elements of the Mission's Health portfolio: a) Family planning; and b) HIV/AIDS (prevention of mother to child transmission).

Program Approach

JHPIEGO will develop institutional capacity and increase human capacity in health facilities to provide family planning services and prevention of mother to child transmission of HIV/AIDS (PMTCT) services to vulnerable populations in Haiti. Assistance will be targeted to seven (7) departments through 23 service delivery sites managed either by non-governmental organizations (NGOs) or by the Government of Haiti (i.e. Zones Ciblees). The Zones Ciblees represent marginalized segments of the population which have little or no access to health services and have been strategically selected by the Government of Haiti as priority public sector sites to receive USAID health sector assistance.

By focusing on family planning and PMTCT, this workplan proposes interventions to improve health services for the three vulnerable demographic target groups prioritized in the new USAID strategy. These are: 1) children and youth under 25; 2) women; and 3) special concerns groups, such as persons living with HIV/AIDS (PLWAs).

The specific interventions outlined in this document and the use of remaining ACCESS funds has been discussed with USAID/Haiti and the HS2007 Project. As a result of these discussions, it was agreed that:

- Resources will be allocated to strengthen NGOs service delivery sites, and public sites located at hard-to-reach areas (Zones Ciblees).
- JHPIEGO will concentrate its efforts on building human capacity and strengthening institutional capability of the selected health sites to provide long-term reversible and non-reversible FP methods.
- All sites will be strengthened to provide long-term reversible FP methods (IUD, Norplant). Some sites will be strengthened to provide long-term non reversible FP methods (tubal ligation and vasectomy). Those sites that do not have the capacity to provide non-reversible methods will become part of a referral network, and/or the population will be served by mobile teams composed of experienced service providers based at the departmental levels.
- Regarding PMTCT/PEPFAR activities, JHPIEGO will provide support for strengthening services in 12 public sites and 11 service delivery sites of the HS2007 Project.

In addition to the above, ACCESS-FP, through support from USAID's Office of Population and Reproductive Health, will be implementing a new youth initiative in Haiti. JHPIEGO will replicate a successful youth reproductive health model from Nepal in Haiti. The model focuses on increasing young women's (<24) use of family planning, maternal, and neonatal services, through community based initiatives that are closely linked with available health services. This initiative will be implemented at Jacmel. A separate workplan detailing ACCESS – FP activities will be submitted to the Mission.

In summary, the ACCESS partnership in Haiti will continue to implement a strategic program that meets the needs of USAID/Haiti, the USG team, Haiti's Ministry of Health, and the women, men, young people, and children of Haiti through the provision of family planning with a focus on long term and permanent methods, PMTCT services, and a youth

initiative providing comprehensive youth-friendly reproductive health services to young mothers and girls. All interventions will be undertaken to achieve short-term visible and measurable results while still developing the capacity of Haitian institutions to sustain results beyond the life of this plan.

Summary of Activities

Family Planning Activities

Building on experience and strength of two ACCESS partners, JHPIEGO and AED last year, and past successes of JHPIEGO's collaboration under the MNH and TRH programs, ACCESS will strengthen family planning (FP) services at 11 HS2007 sites and 12 public sites (Zones ciblées). Given past challenges and lesson learned, ACCESS will modify its approach this year to provide more on-site technical assistance and expand training of service providers to new sites. In addition, a referral system will be set up at sites that do not have the capacity to offer non-reversible FP methods. FP clients requesting non-reversible methods will be referred to the nearest sites that provide permanent contraception.

Planned Outputs:

- Twenty three (23) sites offering long term and where feasible permanent family planning services according to quality standards.
- Referral system linking FP clients requesting long term non-reversible methods to sites that offer permanent contraception established
- Six (6) previously trained Technical Regional Coordinators providing supervision, technical support and follow up to trainees at all project sites
- Importance of the national family planning program reinforced at all departmental levels.

Implementation needs and constraints

The activities outlined in this workplan can only be conducted under the following conditions:

- The socio-political situation is such that consultants and staff can safely travel throughout Haiti.
- The institutions in which JHPIEGO plans to work are operational, amenable, and have the appropriate human resources to support the proposed interventions.

ACTIVITY 1: CONDUCT DESK ASSESSMENT TO GATHER BASELINE DATA ON TARGET SITES

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 will conduct 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 will be carried out jointly with HS2007/MSH. A needs assessment tool for this activity has already been developed in

collaboration with MSH and most of the assessment activities will be conducted with staff at the HS2007 Office.

Specific Tasks	Date
Task 1: Review secondary data collected by HS2007 and the results of the MOH and USAID-led assessments for the <i>Repositionnement du Planning Familial en Haiti</i> initiative	January – February 07
Task 2: Summarize the results by health facility and regions	February 07

ACTIVITY 2: STRENGTHEN FAMILY PLANNING SERVICES AT 11 HS2007 SITES AND 12 PUBLIC SITES (ZONES CIBLÉES).

Building on investments made to date and lessons learned about group based training and staff turnover, ACCESS will bring its technical assistance closer to each site to increase impact, reach and chances of sustainability. This process is based on a two-pronged approach of cascade training for the provision of long term (reversible and non-reversible) FP methods, and subsequent on-the-job supervision and mentoring through mobile technical coordinators based regionally.

JHPIEGO will build the capacity of trainers and in turn providers to provide long term (reversible and non-reversible) FP services at all 23 sites. Key project staff including the regional technical coordinators and other qualified trainers will complete an ACCESS-supported Clinical Training Skills (CTS) or Advanced Clinical Training Skills (ATS) course on long term FP (IUD, Norplant and tubal ligation) These courses will be conducted using recently updated JHPIEGO training packages and materials that are based on the latest WHO standards and guidelines on FP. JHPIEGO will also continue to provide technical assistance and support to INHSAC on all subsequent training and monitoring and supervision activities planned for FY 2007. These activities will be conducted in close coordination with the HS2007 Training Unit.

In addition, JHPIEGO will provide expendable supplies to all sites for the provision of long-term (reversible and non-reversible) FP services. Some sites (those that are in greatest need) will also receive equipment (instruments, medications, furniture etc.) through a donation from IMA.

JHPIEGO will also coordinate closely with MSH's procurement staff to ensure that adequate supplies of FP commodities are provided to the 23 sites .

Activity Location(s): At departmental level throughout Haiti

Name of sites		Location/Department
HS 2007 sites		
1- Clinique St Paul		West
2- FONDEPH Martissant		West
3- Pierre Payen		Artibonite
4- SADA Matheux		West

5- Hopital Ste Croix	West
6- Hopital Lumière	South
7- Centre de santé Lumière	South
8- Hopital Mirebalais (MARCH)	Center
9- Hop Berraca	North West
10- Hopital Claire Heureuse	Artibonite
11- AEADMA	Grande Anse
<i>Public sites (zones ciblées)</i>	
12- Centre de La Tortue	North West
13- Centre de Anse à Foleur	North West
14- Centre de Borgne	North West
15- Centre de Belladère	Center
16- Centre de Cerca La source	Center
17- Centre de Cornillon	West
18- Centre de Mobin Crochu	North
19- Centre de St Michel de l'Attalaye	Artibonite
20- Centre de Corail	Grande Anse
21- Centre de Abricot	Grande Anse
22- Centre de l'Asile	South
23- Centre de Anse à veaux	Nippes

Specific Tasks	Date
Task 1: Translate updated JHPIEGO training package into French	Feb 07
Task 2: Identify and prepare four sites for training in long term FP methods	Feb 07
Task 3: Identify regional coordinators	Feb 07
Task 4: Elaborate regional operational plans with regional coordinators	Feb 07
Task 5: Conduct a training of providers in IUD insertion	March 07
Task 6: Coordinate and conduct training of providers (2 per site) at each of the 23 sites in IUD insertion	March – April 07
Task 7: Conduct refresher TOT on implants and tubal ligation (minilaporotomy)	May – June 07
Task 8: Coordinate and conduct training of providers (2 per site) on implants and tubal ligation (minilaporotomy)	May – June 07
Task 9: Provide remaining 19 sites with supplies to offer long term FP methods	April 07
Task 10: Coordinate closely with MSH to ensure that FP commodities are provided to the 23 sites through MSH's procurement system	March – September 07
Task 11: Provide ongoing and on-the-job technical assistance/supervision to the trainees to ensure quality services -	April – September 07
Task 12: Work closely with HS2007 counterparts to develop and implement a M&E plan and assist the regional coordinators in data collection and monitoring	March – September 07

ACTIVITY 3: ESTABLISH REFERRAL SYSTEM LINKING FP CLIENTS REQUESTING NON-REVERSIBLE FP METHODS TO SITES THAT PROVIDE PERMANENT CONTRACEPTION SERVICES.

Specific Tasks	Date
Task 1: Develop referral tools/cards	February
Task 2: Orient/train staff at relevant sites on referral system	March
Task 3: Collect service statistics and referral data at sites to provide feedback on referrals and to ensure adequate follow-up of FP clients	March – September 07

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 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 family planning 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 family planning program to the government, in late 2006, the Prime Minister and US Ambassador hosted a national conference, Repositionnement du Planning Familial en Haiti.

ACCESS will work closely with the National Family Planning Committee to ensure that family planning issues are addressed at targeted departments.

Specific Tasks	Date
Task 1: Work with stakeholders and counterparts at targeted departments to review, elaborate or finalize the departmental plans within the context of Repositioning FP	January – February
Task 2: Elaborate the National plans	February
Task 3: Assist the National Family Planning Committee in following up on the implementation of the national plan	March – September 07

COMPLEMENTARY ACTIVITY

To ensure that family planning standards and guidelines are updated and in line with international standards at the departmental levels, with additional funding ACCESS can

provide technical assistance to the MSPP and the National Family Planning Committee to update and disseminate the national protocols and service delivery guidelines developed in 1997. ACCESS will also work closely with MSPP, HS2007 and the National Family Planning Committee to ensure that family planning issues are addressed at all departmental levels

II - PMTCT ACTIVITIES (FROM PEPFAR COP 06) 1 JANUARY 2007 TO 30 SEPTEMBER 2007

Building on experience and strengths of JHPIEGO during the last year under the PEPFAR COP 05 program, JHPIEGO will focus on providing technical assistance to sites delivering PMTCT services. This technical assistance will be delivered by JHPIEGO staff or consultants and will involve frequent visits by technical experts to 23 sites. JHPIEGO will provide technical assistance to all designated PMTCT/PEPFAR sites in close coordination with Care and Treatment and PEPFAR site managers. Technical assistance will involve coaching providers in PMTCT and its integration into MNH activities, problem solving, analyzing patient flow, supporting counseling and testing services 24/7, creating an adherence plan for ARV treatment and prophylaxis for each patient, linking HIV (+) support groups to the clinical sites, data collection and monitoring and other aspects of effective service delivery to ensure sustainable quality services. Capacity will also be built at all PMTCT/PEPFAR sites to provide family planning services.

JHPIEGO/Haiti staff will continue to work with relevant MOH officials to facilitate/expedite the approval and implementation of the revised patient register system. In the interim, JHPIEGO will develop data collection tools that will be used by the regional technical coordinators and staff at project sites to collect essential PMTCT statistics and data..

The following specific activities are proposed for the period from January to September 2007:

- Establish integrated quality PMTCT services at 23 sites and coordinate provision of external assistance from PEPFAR and other partners at each site
- Collaborate with MSPP to validate PMTCT register and disseminate them to all PMTCT sites
- Advocate for integration of PMTCT into residency training curricula for physicians and nurses
- Assist INHSAC in the provision of quality PMTCT training for 300 new service providers

JHPIEGO will implement all activities except those related to PMTCT training. INHSAC will support the PMTCT trainings with JHPIEGO's assistance.

Outputs

- Quality PMTCT services established at 23 sites (public and HS2007 sites)

- PMTCT registers disseminated in all ten sanitary departments
- Coordinated inputs from USAID partners to selected PMTCT sites
- Quality PMTCT training for 300 services providers delivered by INSHAC
- PMTCT integrated in the curricula of OBGYN residency programs and follow-up of newly graduated midwives

Activity Location(s): At departmental level throughout Haiti

Name of sites	Location/Department
Public sites	
1- HUEH	West
2- MIJ	West
3- Hopital de la Paix	West
4- Maternité de Carrefour	West
5- Hopital St Michel de Jacmel	South East
6- Hopital Ste Thérèse de Miragoane	Nippes
7- Hopital Immaculée Conception des Cayes	South
8- Hopital St Antoine de Jérémie	Grande Anse
9- Hopital La Providence des Gonaives	Artibonite
10- Hopital Justinien	North
11- Hopital Immaculé Conception de Port de Paix	North West
12- Hopital de Jean Rabel	North West
HS 2007 sites	
13- Clinique St Paul	West
14- FONDEPH Martissant	West
15- Hopital Ste croix	West
16- SADA Matheux	West
17- Centre de Pierre Payen	Artibonite
18- Hopital Claire heureuse	Artibonite
19- Hopital Lumière	South
20- Centre Lumière	South
21- March Mirebalais	Center
22- Hopital BERACA	North West
23- AEADMA	Grande Anse

ACTIVITY 1: ESTABLISH INTEGRATED QUALITY PMTCT SERVICES AT 23 SITES (PUBLIC AND HS2007 SITES)

Specific tasks	Date
1.1- Technical assistance to all sites	January to September 07
1.1. 1- Assist the sites in service organization and patient flow analysis, coaching providers in PMTCT and its integration into MNH activities, problem solving, analyzing patient flow, supporting counseling and testing services 24/7, creating an adherence plan for ARV treatment and prophylaxis for patients	
1. 2- Create link with the community for client follow-up	January to September 07
1.2.1- Link HIV (+) support groups and other community-based organizations to clinical sites to ensure wrap-around services for PMTCT clients and their families	
1.2.2- Coordinate provision of external assistance from PEPFAR and other partners at each site	
1. 3- Conduct monitoring activities	January to September 07
1.3.1- Assist the MSPP in the dissemination of the new PMTCT registers	
1.3.2- Orient services providers in data collection and monitoring	

ACTIVITY 2: COORDINATE PROVISION OF EXTERNAL PMTCT ASSISTANCE AT 23 SITES (PUBLIC AND HS2007 SITES) TO PROVIDE QUALITY SERVICES

Specific tasks	Date
2.1- Conduct trimester task force meetings with all stakeholders	January to September 07

ACTIVITY 3: ADVOCATE FOR INTEGRATION OF PMTCT INTO THE CURRICULA OF RESIDENCY TRAINING PROGRAMS FOR PHYSICIANS AND NURSES

Specific tasks	Date
5.1- Conduct advocacy meeting with l'Ecole des Infirmières and Faculté de Médecine to promote integration of PMTCT into their clinical training/clinical rotations	March 07
5.2- Follow-up on agreed activities	April – September 07

ACTIVITY 4: ASSIST INHSAC TO PROVIDE QUALITY TRAINING FOR 300 SERVICE PROVIDERS IN PMTCT. (PLANNING, COACHING, AND CONDUCTING TRAINING SESSIONS AND FOLLOW-UP

Specific tasks	Date
3.1 Assist INHSAC to conduct Departmental PMTCT training in the West, South-East, and South	January to September 07
3.2 Assist INHSAC to conduct Departmental PMTCT training in the North, North East, and North West	
3.3 Assist INHSAC to conduct Departmental PMTCT training in Nippes, Artibonite, Grande Anse and Center	

III. PROGRAM MANAGEMENT

Dr. Jeannis will continue in his role as the overall Program Director for ACCESS. To support. Dr. Jeannis, ACCESS hired the following additional staff:

- Technical Coordinator
- Technical Advisor/PAC/PMTCT
- Technical Advisor PMTCT
- Administrative and Finance Officer
- Drivers (2)

In addition to the ACCESS management team, six regional coordinators will be hired on a consultancy basis to provide oversight of the ACCESS program at the department levels. Technical assistance from JHPIEGO for the implementation of the activities discussed above. The ACCESS program proposes to develop specific Task Orders with INHSAC for training sessions that will include detailed deliverables and expected LOE based upon available resources and SOW.

IV. MONITORING AND EVALUATION

The ACCESS M&E framework and implementation strategies in Haiti will follow the program implementation lines laid out above, with details to be determined as the key program activities are agreed with USAID/Haiti. Potential indicators in the areas in which the ACCESS Program proposes activities will be discussed with USAID and also with partners and collaborators in order to assess complementary data requirements and potential areas for cost efficiencies in data collection efforts. Illustrative indicators are listed and defined in the table below.

Monitoring and Evaluation Framework for the ACCESS/Haiti Program

Illustrative Indicator	Definition/Calculation	Data Source/Collection Method	Frequency of Data Collection
Family Planning indicators			
Number of trainers trained in long term family planning methods		Training participant tracking sheets and training database	Quarterly
Number of providers trained in FP by method		Training participant tracking sheets and training database	Quarterly
Number of sites strengthened and offering long term FP methods		Program records	Annual
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
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
<i>PMTCT indicators</i>			
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
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

Illustrative Indicator	Definition/Calculation	Data Source/Collection Method	Frequency of Data Collection
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
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
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
Number/% of pregnant women at target facilities who have been tested for HIV	<u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT target facilities who have been tested for HIV <u>Denominator:</u> Total number of pregnant women (ANC and Maternity) at the PMTCT target facilities	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly
Number/% of pregnant women (ANC and Maternity) at target facilities who received pre test counseling	<u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT target facilities who received pre test counseling <u>Denominator:</u> Total number of pregnant women (ANC and Maternity clients) tested for HIV at the PMTCT target facilities	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly
Number/% of pregnant women (ANC and Maternity) at target facilities who received post test counseling	<u>Numerator:</u> Number of pregnant women (ANC and Maternity clients) at PMTCT target facilities who received post test counseling <u>Denominator:</u> Total number of pregnant women (ANC and Maternity clients) tested for HIV at the PMTCT target facilities	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly

Illustrative Indicator	Definition/Calculation	Data Source/Collection Method	Frequency of Data Collection
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
Number/% of pregnant women (ANC and Maternity) HIV (+) who received ARV prophylaxis	<p><u>Numerator:</u> Number of ANC clients HIV (+) at target facilities who received ARV prophylaxis</p> <p><u>Denominator:</u> Total number of ANC clients HIV (+) at the PMTCT target facilities</p> <p style="text-align: center;">AND/OR</p> <p><u>Numerator:</u> Number of Maternity clients HIV (+) at target facilities who received ARV prophylaxis</p> <p><u>Denominator:</u> Total number of Maternity clients HIV (+) at the PMTCT target facilities</p>	ANC and Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly
Number/% of pregnant women HIV (+) who are enrolled in the PMTCT program	<p><u>Numerator:</u> Number of pregnant women HIV (+) enrolled in the PMTCT program</p> <p><u>Denominator:</u> Total number of pregnant women HIV (+) at target facilities</p> <p>(Limited to ANC clients only)</p>	ANC PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly
Number /%of pregnant women who received single dose of Nevirapine at time of delivery	<p><u>Numerator:</u> Number of pregnant women HIV (+) who received single dose of Nevirapine at time of delivery</p> <p><u>Denominator:</u> Number of pregnant women HIV (+) who delivered at target facilities</p>	Maternity PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly
Number /%of HIV (+) pregnant women who received HAART	<p><u>Numerator:</u> Number of pregnant women HIV (+) women who received HAART</p> <p><u>Denominator:</u> Total number of HIV (+) pregnant women VIH (+) at target facilities</p>	PMTCT registers, Monthly PMTCT monitoring form, PMTCT database	Quarterly

Illustrative Indicator	Definition/Calculation	Data Source/Collection Method	Frequency of Data Collection
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
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
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 with RPR (+) test target facilities	ANC PMTCT register, Monthly PMTCT monitoring form, PMTCT database	Quarterly
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

Kenya
ACCESS Field Representative: Elaine Roman
US-based ACCESS Contact Person: TBD
PY03 Funding Amount and Sources: PEPFAR: ART- \$401,592; CT- \$500,000; PMTCT- \$250,000. POP: DRH Central Support- \$250,000. Malaria - \$250,000
ACCESS Partners: JHPIEGO
Other Collaborating Organizations: MOH Kenya – NASCOP,, DRH, DOMC

Program Approach

JHPIEGO/ ACCESS will provide direct support to the Ministry of Health (MoH)/ Division of Reproductive Health (DRH) to strengthen DRH's capability at the central level. JHPIEGO/ ACCESS will build on programming efforts to date in safe motherhood and maternal and newborn health aiming to improve DRH's ability to directly support provincial level programs.

With decentralization in effect and the start up of the USAID APHIA II projects throughout Kenya, it is not only important but also a priority for DRH at the national level to provide overarching and guiding support for provincial level initiatives. This includes making sure materials and supplies are available at the provincial and district level and emerging evidence for RH services is disseminated to national level and provincial level trainers and managers.

In addition, JHPIEGO/ ACCESS will build on programming efforts in HIV/AIDS prevention and care; specifically, strengthening DRH's and the National AIDS STI program (NASCOP) Programs ability to address HIV/AIDS priorities for Kenya. This will result in stronger linkages and improved collaboration between DRH and NASCOP.

Achievements PY02 (FY05)

DTC

- 450 service providers trained on DTC in Eastern, Nairobi and Central provinces
- Baseline survey conducted in sample 13 sites in the three provinces
- 60 NASCOP staff and PHMT teams orientated to DTC
- DTC Orientation package developed
- Support supervision conducted
- Lessons learned and results documented.

ART

- 250 service providers trained on ART
- Baseline survey conducted in sample 9 sites in two provinces
- 40 NASCOP staff and PHMTs oriented to ART

- Support Supervision conducted
- Results and lessons learned documented

Summary of Activities PY03 (FY 06)

DTC

- Planning and advocacy meeting with PHMTs and APHIA II Consortia
- Development of DTC learning resource package,
- Reproduction of materials
- Conduct TOT course for NASCOP staff and PHMTs
- Conduct supervision course for health care managers, at NASCOP and PHMT,
- Monitoring and Evaluation to document Program results

ART

- Planning and Advocacy meeting with ART TWG, APHIA II Consortia and PHMTs
- Development of orientation materials on clinical mentorship for adult/pediatric ART
- Train 50 trainers/clinical mentors on IMAI-ART, Pediatric -ART and supervision
- IMAI-ART and Pediatric -ART training for 200 health workers
- Support 50 clinical mentors to conduct facilitative supervision
- Monitoring and end of program review to document program results

PMTCT

- Planning and Advocacy meeting with APHIA II Consortia and PHMTs
- Adapt / produce PMTCT supervision manual for integrated services
- Train DRH & provincial teams on PMTCT supervision
- Support DRH/NASCOP to conduct quarterly facilitative supervision
- Conduct 2 semi-annual PMTCT supervision review meetings
- Stakeholder workshop on PMTCT Communication Strategy
- Finalize/reproduce PMTCT Communication Strategy document
- Monitoring and end of program review to document program results

DRH Direct Technical Support

Support collaboration between DRH and Kenya Clinical Officers Association (KCOA).

- Two Technical Updates- Emerging RH issues.
- Procurement and orientation to use of essential equipment for RH.
- 2 Technical Training Workshops.

Malaria

Dissemination of ACT regimen for case management of clinical malaria

- Planning and Advocacy meeting with DOMC & PHMTs and APHIA consortium
- Development of orientation materials
- Conduct TOT course for DOMC and PHMTs
- Develop a training plan with DOMC, PHMTs and APHIA Consortium on roll out

Documentation of information on IPTp 1 and IPTp2

- Conduct an assessment to identify appropriate sentinel sites or districts
- Conduct one day meeting to develop /adapt tools
- Conduct 3 day M&E training to strengthen M&E systems (specifically data collection) at DOMC
- Data analysis & Report writing

Limited Behavior Change Communication (BCC) intervention for community buy in indoor residual spraying

- Develop IRS training materials
- Community Planning & Advocacy meeting
- Train CORPS on IRS
- Support supervision
- One day meeting to document results

PY03 Outputs

DTC

- 100 participants PHMT (PASCOs and PARTOs) in each province updated
- Training approach and TOT incorporate these profiles
- 100 trainers trained in training methodology, supervision
- 250 sets of orientation materials for trainees reproduced
- 155 sets of DTC Learning Resource Package
- 250 DTC counseling job aid produced
- Program evaluation report, including lessons learned
- Dissemination meeting report

ART

- The ART TWG, PHMTs and APHIA II Consortia for target provinces sensitized and supportive of efforts to decentralize and strengthen ART via training and clinical mentorship
- Clinical mentorship curriculum and orientation package developed for adult and pediatric ART
- 25 Trainers/clinical mentors on IMAI-ART,
- 25 trainers/Clinical mentors trained Paediatric -ART and facilitative supervision

- 200 health workers trained on adult/IMAI-ART and Paediatric -ART
- 50 clinical mentors supported to conduct facilitative supervision for ART in target provinces
- Improved ART service delivery and linked with other HIV care, treatment and prevention services
- Dissemination of results of clinical mentorship program for ART

PMTCT

- PMTCT TWG, PHMTs and APHIA II Consortia for all provinces sensitized and supportive of DRH/NASCOP efforts to strengthen PMTCT supervision
- PMTCT supervision manuals adapted and developed
- 8 provincial DRH/NASCOP Teams trained on PMTCT Supervision
- DRH/NASCOP supported to conduct quarterly facilitative supervision in all provinces
- Two semi-annual review meetings on PMTCT supervision conducted
- PMTCT Communication Strategy developed
- Dissemination of results on PMTCT supervision

DRH Direct Technical Support

- Action plan developed between DRH and KCOA outlining RH linkages and collaborative support.
- 50 central and provincial level managers and trainers with improved knowledge and understanding of emerging RH issues.
- 150 total- Madam zoes, implant arm models, IUCD handheld models, breast models, penile models and African baby models procured and provincial level trainers orientated to their use.
- 50 central and provincial level trainers updated in core technical areas.

Malaria

- 100 participants updated on ACT- DOMC, PHMT and APHIA consortium
- ACT dissemination orientation materials developed
- 500 ACT orientation materials reproduced
- 100 trainers trained in training methodology
- ACT dissemination plan developed for DOMC
- 10-15 appropriate sentinel sites or districts identified
- Assessment tools developed/adapted
- 50 DOMC staff and provincial staff trained on M&E
- Training materials for IRS developed
- 100 IRS materials reproduced
- 50 Community leaders updated on IRS
- 80 CORPS trained on IRS
- Monitoring & Evaluation to document results

Program Management

JHPIEGO/ Kenya will manage the project and have overall responsibility for meeting the project goals and objectives, monitoring implementation, tracking the budget and reporting to USAID/ Kenya. and the ACCESS Program. JHPIEGO/ Kenya will work in close collaboration with the Ministry of Health – National Aids STI control program and Division of Reproductive Health (DRH) and APHIA II team to plan for roll out of activities to the provinces.

PEPFAR SUPPORT

ACTIVITY 1: STRENGTHENING COUNSELING AND TESTING SERVICES FOR HIV IN CLINICAL SETTINGS

JHPIEGO will use its past training experiences from FY05 to extend Diagnostic Counseling & Testing (DTC) services through training of NASCOP staff and PHMTs and assisting them to train health workers from the Ministry of Health (MOH) facilities in Western, Coast and Nyanza Provinces. In order to increase awareness on the new guidelines on HIV testing in clinical and medical settings and ensure that there will be ***no missed opportunities for HIV testing in Kenya***, JHPIEGO will directly **train NASCOP staff and provincial health management teams (PHMTs)**. Through the APHIA II Consortia , the PHMTs will be provided support to orientate 600 health workers in 32 districts in three additional provinces namely; Western, Nyanza and Coast, Rift Valley using the MOH/NASCOP guidelines for HIV testing in Kenya, thereby enhancing knowledge and competency in HIV testing and referral of HIV positive patients for care and treatment. This activity will result in **3,200** health workers orientated by colleagues in cascade approach (*ref. FHI evaluation of JHPIEGO cascade approach August 2001*) during FY06. JHPIEGO will also assist NASCOP staff and Provincial Health Management Teams (PHMT) to develop an implementation plan for rollout in the provinces.

In order to train the target numbers of providers in DTC, and to make the training sustainable, and ongoing, JHPIEGO will train trainers and supervisors, who will be involved in strengthening and continuing the services. JHPIEGO will also conduct ongoing supportive supervision and follow up to ensure that the trainings and orientations are of good quality and sustainable. Practical orientation on diagnostic counseling and testing with development of action plans and supervision during DTC implementation will promote health worker motivation and compliance with guidelines for testing in clinical settings. This activity will result in increased human resource capacity to provide both diagnostic and voluntary counseling and testing and subsequently increase access to diagnostic counseling and testing services as well as ART provision in clinical settings.

Program goal

Increase availability of Counseling & Testing in clinical and medical settings

Objectives

1. Train 100 NASCOP staff and PHMT on Diagnostic Counseling & Testing
2. Develop a learning resource package for DTC
3. Develop a national DTC implementation plan for roll out in the 4 provinces

Activity Lead: Nancy Koskei

Activity Location(s): NASCOP, 32 districts in Western, Rift Valley, Coast and Nyanza Provinces

Specific Tasks	ACCESS Partner(s)
Task 1: Conduct central level advocacy/planning meetings for DTC scale with NASCOP staff and PHMT team and APHIA II representatives for Western, Coast, Rift and Nyanza provinces	JHPIEGO
Task 2: Develop a DTC learning resource package (Trainer, Participants notebook and reference manual)	JHPIEGO
Task 3: Reproduction of DTC training materials	JHPIEGO
Task 4: Conduct TOT for 100 PHMT (PASCO, PARTO, PTLC, and NASCOP staff)	JHPIEGO
Task 5: Train 100 health care managers on supervision	JHPIEGO
Task 6: Monitoring and evaluation to document lessons learned	JHPIEGO

ACTIVITY 2: SCALING UP ART SERVICES

In FY05 JHPIEGO supported the training of 250 health workers in ART across 20 districts in Eastern and Nairobi province, thereby strengthening the delivery of ART services in existing ART sites. In this program JHPIEGO will produce competency-based tools for training in comprehensive care, increase the number of skilled ART trainers and support NASCOP to advance the ART skills of health workers in Eastern, Central and Nairobi Province. In addition to coordinating all proposed activities with the NASCOP ART unit, Provincial ART Officers (PARTOs), links will be established with Elizabeth Glazer Paediatric Aids Foundation (EGPAF) programs, APHIA II consortia, IMPACT and AMREF's ART activities, to assure long term capacity building and minimize duplication of efforts.

This program will use a multi-pronged approach toward scaling up ART service provision; directly supporting NASCOP at the central level to strengthen provincial level support. This will include the development of coordinated training and clinical mentorship plans through advocacy and planning meetings with 50 stakeholders from NASCOP's ART TWG, PHMTs and APHIA II Consortia. Production orientation materials for clinical mentorship

of adult and adolescent ART will be produced, possibly based on WHO's IMAI (Integrated Management of Adult Illnesses) handbook for HIV/AIDS and comprehensive care and materials for treatment & prevention for HIV exposed and infected children. These materials will help facilitate delivery of practical training and supervision of lower cadre staff in ART. JHPIEGO/ACCESS will support NASCOP to strengthen the knowledge and skills of 50 selected provincial clinical mentors (primarily PARTOs and expert clinicians) in critical technical areas including management of CCCs and M&E. The program will support NASCOP's efforts to decentralize HIV related services to lower cadres This will result in increased referrals of HIV infected adults, adolescents and exposed children to comprehensive care centers (CCCs) where services will be strengthened through activation of HIV facility committees. Finally, an end of program review meeting will be held in collaboration with 60 stakeholders from the NASCOP ART TWG, PHMTs, relevant APHIA II partners and supervisors of target health facilities to confirm whether JHPIEGO's multi-pronged approach has increased access for HIV infected adults, adolescents and exposed children to comprehensive care, prevention and treatment services with provision of ART for 4,000 HIV infected patients in the target provinces.

Activity Lead: Saade Abdallah

Activity Location(s): Eastern, Central and Nairobi Provinces

Specific Tasks	ACCESS Partner(s)
Task 1: Conduct advocacy/planning meeting on ART training & clinical mentorship	JHPIEGO
Task 2: (A) Develop orientation materials for clinical mentorship on adult and adolescent ART based on IMAI approach.	JHPIEGO
Task 2: (B) Produce orientation materials for clinical mentorship for paediatric ART	JHPIEGO
Task 3: Support NASCOP to train provincial clinical mentors and healthcare providers	JHPIEGO
Task 4: Monitoring and end of program review to document lessons learned	JHPIEGO

ACTIVITY 3: ENHANCING SUPERVISION AND INTEGRATION OF PMTCT SERVICES

The Ministry of Health's (MOH) Division of Reproductive Health (DRH) is responsible for overall leadership and coordination to the National PMTCT program in partnership with the National AIDS and STI Control Program (NASCOP). In 2006, JHPIEGO will support the central level Division of Reproductive Health to strengthen its supervisory function and quality assurance program and system to ensure the delivery of high quality PMTCT services in public sector and faith-based facilities. JHPIEGO will work with the PMTCT Technical Working Group to finalize guidelines and tools for PMTCT supervision and then adapt a simple, easy to use PMTCT Supervision Manual for integrated services using its Supervision for HIV training materials (developed jointly with CAFS and USAID REDSO) to conduct

this training. The DRH with support from JHPIEGO will integrate RH and HIV training and supervision schedules then build capacity of 8 provincial DRH/NASCOP training and supervisory teams (each team comprising of 2 central and 2 provincial DRH/NASCOP representatives) to manage comprehensive PMTCT, Safe Motherhood and Child Survival services. JHPIEGO in consultation with PHMTs and APHIA II partners will organize quarterly PMTCT supportive supervision visits for the 8 provincial DRH/NASCOP supervisory teams to monitor delivery of PMTCT and provide mentorship to PMTCT facility supervisors and service providers in selected districts. Finally, two PMTCT supervision review meetings will be organized semiannually by DRH/NASCOP for all PHMTs and APHIA II consortia to assess progress and effectiveness of facilitative supervision in improving the delivery and outcomes of PMTCT services. Lessons learnt will be documented and disseminated to concerned stakeholders.

DRH and NASCOP have an important role of raising general awareness and increasing the demand for better PMTCT services through advocacy, social mobilization and interactive communication using traditional and multi-media channels. In addition to enhancing PMTCT supervision, JHPIEGO will support the DRH and NASCOP to convene one consultative meeting for 50 key PMTCT stakeholders to develop a much needed national PMTCT communication strategy based on other country experiences.

It is expected that by the end of the program, the DRH will have capacity to supervise and coordinate the scale up of integrated family planning/PMTCT services and support the establishment of effective linkages between PMTCT, PMTCT plus services and HIV treatment services for HIV positive women, their infants and family members at both public and faith based facilities. In addition, DRH will be ready to launch the first National PMTCT Communication Strategy that will eventually lead to positive attitudes and behavior change towards PMTCT. It is assumed that central-level DRH and NASCOP, as well as the PHMTs and APHIA II Consortia will facilitate subsequent PMTCT support supervision and dissemination of the communication strategy to increase resource mobilization and delivery of quality PMTCT services.

Activity Lead: Saade Abdallah

Activity Location(s): Primarily central level support extended to all provincial headquarters

Specific Tasks	ACCESS Partner(s)
Task 1: Planning and Advocacy Meeting	JHPIEGO
Task 2: Adapt/produce PMTCT supervision manuals	JHPIEGO
Task 3: Train 8 provincial DRH/NASCOP training & supervision teams	JHPIEGO
Task 4: Support DRH/NASCOP to conduct facilitative supervision	JHPIEGO
Task 5: Conduct semi-annual PMTCT Supervision review meetings	JHPIEGO
Task 6: Organize 2-day PMTCT Communication Strategy Workshop	JHPIEGO
Task 7: Finalize/Reproduce PMTCT Communication Strategy document	JHPIEGO

PEPFAR Timeline:

Complete list of activities and tasks based upon above workplan. Fill in "X" for planned month in which the activity will take place.

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 1: Strengthening Counseling and Testing services for HIV in clinical setting												
Task 1: Conduct Central level advocacy and planning meeting for DTC scale up with NASCOP staff and PHMT team	X	X										
Task 2: Develop a DTC learning resource package (Trainer notebook, Participants notebook and Reference manual)	X											
Task 3: Reproduction of DTC training package		X	X									
Task 4: Conduct TOT for 100 NASCOP staff and PHMT team					X	X						
Task 5: Train 100 health care managers on Supervision							X	X				
Task 6: Provide support and TA to NASCOP CT working group	X		X		X		X		X		X	
Task 7: Monitor and Evaluate to document program results											X	X
Activity 2 : Scaling up ART services												
Task 1: Conduct advocacy/planning meeting on ART training & clinical mentorship	X											
Task 2: (A) Develop orientation materials for clinical mentorship on adult and adolescent ART based on IMAI approach.		X										
Task 2: (B) Produce orientation materials for clinical mentorship for pediatric ART		X										
Task 3: (A) Train 25 trainers/clinical mentors from 3 provinces on IMAI-ART and facilitative supervision			X									
Task 3: (B) Train 25 trainers/ clinical mentors from 3 provinces on pediatric -ART				X								
Task 4: (A) Train 100 health workers from 3 provinces on IMAI-ART					X							
Task 4: (B) Train 100 health workers from 3 provinces on pediatric- ART						X						
Task 5: Support 50 provincial clinical mentors to conduct facilitative supervision for adult, adolescent and pediatric ART							X	X	X			
Task 6: Monitoring and end of program review to document lessons learned			X			X			X		X	X

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 3 : Enhancing PMTCT supervision and Integration with other RH and HIV services												
Task 1: Planning and Advocacy Meeting	X											
Task 2: Adapt/produce PMTCT supervision manuals		X										
Task 3: Train 8 provincial DRH/NASCOP training & supervision teams			X									
Task 4: Support DRH/NASCOP to conduct facilitative supervision			X			X			X			
Task 5: Conduct semi-annual PMTCT Supervision review meetings					X					X		
Task 6: Organize 2-day PMTCT Communication Strategy Workshop						X						
Task 7: Finalize/Reproduce PMTCT Communication Strategy document							X					
Task 8: Monitoring and end of program review to document lessons learned.			X			X			X		X	

DRH DIRECT TECHNICAL SUPPORT

ACTIVITY 1: SUPPORT COLLABORATION BETWEEN DRH AND KENYA CLINICAL OFFICERS ASSOCIATION (KCOA).

DRH has specifically requested JHPIEGO's support to bring together the newly qualified Clinical Officers trained in RH. Clinical Officers play an important role in bridging the gap where there are no Medical Officers in Kenya. DRH would like to initially hold a one-day meeting with these trained COs to share experiences and challenges in order to better inform program planning and any gaps that may exist in the current training program for COs.

Activity Lead: Elaine Roman

Activity Location(s): Kenya

Specific Tasks	ACCESS Partner(s)
Task 1: Plan for meeting	JHPIEGO
Task 2: Hold meeting	JHPIEGO

ACTIVITY 2: TWO TECHNICAL UPDATES- EMERGING RH ISSUES

JHPIEGO/ACCESS began a technical update series in collaboration with DRH under its malaria in pregnancy program. This series provided an important opportunity to update central and provincial level managers and trainers in key technical areas. The technical updates are set up as a 1 day workshop to orientate key stakeholders to important issues affecting RH implementation. JHPIEGO/ ACCESS will work with the DRH Safe Motherhood Working Group in this program year to identify the most appropriate and needed technical updates for DRH staff. Possible topics, already discussed with DRH, may include fertility, emergency obstetric care and malaria/HIV interactions among pregnant women.

Activity Lead: Elaine Roman

Activity Location(s): Kenya

Specific Tasks	ACCESS Partner(s)
Task 1: Continued participation in Safe Motherhood Working Group	JHPIEGO
Task 2: Selection of Technical Update Topics	JHPIEGO
Task 3: Preparation for Technical Update	JHPIEGO
Task 4: Technical Update 1	JHPIEGO
Task 5: Technical Update 2	JHPIEGO

ACTIVITY 3: PROCUREMENT AND ORIENTATION TO USE OF ESSENTIAL EQUIPMENT FOR RH

Use of anatomic models in RH training and service provision is essential to establish and strengthen service providers' skills in client provision and counseling support. DRH has been using these anatomic models to train trainers and service providers in competency based skill provision for years. However, many of these models are old and ineffective for actual practicum use. DRH has requested models for its 13 training sites and clinical sites. JHPIEGO/ACCESS will procure the following models and conduct a one day orientation for central and provincial level staff on how to use these models correctly. While many staff have been trained previously to use these models, refreshing these skills is essential for maintaining the knowledge and skills they already have.

1. Madam Zoe- 25
2. Arm model for implants- 25
3. IUCD handheld model- 25
4. Breast model- 25
5. Penile model- 25
6. African Baby Model- 25

Activity Lead: Elaine Roman
Activity Location(s): Kenya

Specific Tasks	ACCESS Partner(s)
Task 1: Procure Models	JHPIEGO
Task 2: Plan one-day orientation	JHPIEGO
Task 3: Conduct orientation	JHPIEGO
Task 4: Distribute models to DRH	JHPIEGO

ACTIVITY 4: TWO TECHNICAL TRAINING WORKSHOPS

DRH has already taken steps to strengthen its capacity in new technical areas including gender integration, post-rape care and cervical cancer. DRH has requested support from JHPIEGO/ ACCESS to provide technical support to central level staff to strengthen the knowledge and skills of provincial level trainers and managers in these technical areas. JHPIEGO/ ACCESS will support 2 Technical Training workshops to co-train with DRH targeting provincial level trainers and managers in 2 select technical areas.

Activity Lead: Elaine Roman
Activity Location(s): Kenya

Specific Tasks	ACCESS Partner(s)
Task 1: Select technical training area	JHPIEGO
Task 2: Prepare for technical training	JHPIEGO
Task 3: Conduct Technical Training 1	JHPIEGO
Task 4: Conduct Technical Training 2	JHPIEGO

DRH Timeline

Complete list of activities and tasks based upon above workplan. Fill in "X" for planned month in which the activity will take place.

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 1: Support collaboration between DRH and Kenya Clinical Officers Association (KCOA).												
Task 1: Plan for meeting	X	X										
Task 2: Hold meeting			X									
Activity 2: Two Technical Updates- Emerging RH issues.												
Task 1: Continued participation in Safe Motherhood Working Group	X	X	X	X	X	X	X	X	X	X	X	X
Task 2: Selection of Technical Update Topics		X					X					

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Task 3: Preparation for Technical Update			X	X				X	X			
Task 4: Technical Update 1						X					X	
Task 5: Technical Update 2												
Activity 3: Procurement and orientation to use of essential equipment for RH.												
Task 1: Procure Models	X	X	X									
Task 2: Plan one-day orientation				X								
Task 3: Conduct orientation					X							
Task 4: Distribute models to DRH					X							
Activity 4: 2 Technical Training Workshops.												
Task 1: Select technical training area			X	X								
Task 2: Prepare for technical training					X	X						
Task 3: Conduct Technical Training 1								X				
Task 4: Conduct Technical Training 2											X	

ACTIVITY 5: SUPPORT TO THE DIVISION OF MALARIA CONTROL AND DIVISION OF REPRODUCTIVE HEALTH

Background

Malaria is one of the leading causes of morbidity and mortality in Kenya. It accounts for 32% of outpatient visits and causes an estimated 5% of total deaths with about 26,000 deaths per annum. The National malaria strategic plan (GOK 2001) estimates that more than 20 million Kenyans are regularly affected or at risk of the disease with about 70% of the population living in malaria endemic areas. Pregnant women living in endemic areas are at increased risk as malaria lowers their immunity. Maternal malaria increases a woman's risk to spontaneous abortion, still births and low weight babies. The government estimates that 170 million working days are lost each year as a result of the disease (Ibid)

In 2001, Kenya developed a ten year national malaria strategic plan indicating the interventions that would be implemented to address the problem of malaria. Four strategic approaches were identified: Clinical management through the provision of effective and prompt treatment. This includes ensuring adequate supply of drugs, appropriate case management by service providers and monitoring of drug efficacy. The second strategic approach is prevention of malaria in pregnancy. Key to this aspect is ensuring the free provision of SP to pregnant women, emphasis on prevention of malaria through the use of insecticide treated nets and ensuring effective treatment of malaria during pregnancy. This is in line with the WHO recommendation of using Intermittent Preventive Treatment for pregnant women with at least two doses of an effective antimalarial (currently sulfadoxine-pyrimethamine - SP) during antenatal clinic visits. The third key strategic approach is the use of insecticide treated nets and other vector control measures. This is based on creating an enabling environment, provision of subsidized nets to the vulnerable and creating demand for nets and epidemic preparedness and response. The supporting structures include IEC and M& E.

In 2004, Kenya changed its case management policy to the current first line treatment for malaria from SP to artemether-lumefantrine (*Coartem*) while the recommendation for IPT still remains SP. This of necessity requires the development of guidelines and training materials for service providers. One of the needs identified by the Division of Malaria Control (DOMC) is support in dissemination and training. JHPIEGO will use its technical experience in capacity building to support the DOMC in dissemination of the treatment guidelines and training service providers in selected areas in Coast, Rift Valley and Eastern Provinces. This will entail the development of orientation materials for the dissemination of the National guidelines for diagnosis, treatment and prevention of malaria and training of service providers. JHPIEGO's experience in the dissemination of guidelines shows that service providers are better able understand information on expected practice if it is shared through a simplified process such as orientation materials.

Over the last five years, JHPIEGO in collaboration with the MOH has developed materials on Focused Antenatal Care and Malaria in Pregnancy and trained service providers. Since 2003, these activities have been undertaken with the support of USAID. More recently, JHPIEGO has supported the MOH to develop materials and in the training of Community Own Resource Persons (CORPs) in implementing malaria in pregnancy and reproductive health interventions. Malaria during pregnancy has been associated with anemia in the mother as well as impairment of fetal nutrition, which contributes to low birth weight (LBW), and is a leading cause of poor infant survival and development in Africa. Each year, more than 30 million African women become pregnant in malaria-endemic areas and are at risk for *Plasmodium falciparum* malaria infection during pregnancy. In the majority of these settings, over 70% of pregnant women attend an antenatal care clinic (ANC) at least once during pregnancy, making a clinical-based intervention feasible.

However, despite the major achievements in the implementation of FANC/MIP which has now been scaled up in at least 23 districts with the support of JHPIEGO, there is inadequate documentation on the use of IPTp1 and IPTp2. The use of IPTp 1 and 2 are important RBM indicators and also important in contributing to the Millennium Development Goals. The Division of malaria control has requested support to document and capture information on the coverage of IPT in malaria endemic districts. JHPIEGO will support the DOMC in the process of documenting IPT especially in the sentinel districts and any other districts as appropriate. One of the challenges anticipated will be the lack of documentary evidence especially where this information is not recorded in the ANC registers. The DOMC is also keen to establish the availability of SP in ANC clinics especially against the backdrop of change in the first line drug. JHPIEGO will work with the division to collect this information.

As noted earlier, Kenya has been implementing various interventions in the control of malaria. In the recent past, there have been concerted efforts by the DOMC to strengthen Integrated Vector Management with an emphasis in Indoor Residual Spraying. In 2005, WHO supported Kenya to develop capacity for IRS in 16 districts with a total of 85 supervisors and 1700 spray men have been trained. JHPIEGO will work with the DOMC building on JHPIEGO's community experience with RH/MIP to ensure community buy-in into indoor residual spraying through Behaviour Change Communication (BCC) approaches.

Activity Lead: Kaendi Munguti
Activity Location(s): DOMC, DRH

Specific Tasks	ACCESS Partners (s)
Task 1: Dissemination of national ACT regimen for case management of clinical Malaria	JHPIEGO
Task 2: Documentation of information on IPTp 1 and IPTp 2	JHPIEGO
Task 3: Building on Community work with the CORPs, establish community buy in for Indoor residual Spraying	JHPIEGO
Task 4: Monitoring and Evaluation to document results	JHPIEGO

Timeline

Complete list of activities and tasks based upon above workplan. Fill in “X” for planned month in which the activity will take place.

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 1: Support to the Division of Malaria Control (DOMC) and Division of Reproductive Health (DRH)												
Task 1: Planning and advocacy meeting with DOMC & PHMTs and APHIA consortium	X											
Task 2: Develop ACT orientation package		X										
Task 3: Conduct TOT course for 100 DOMC and Provincial staff			X									
Task 4: Develop a training plan with DOMC, PHMTs and APHIA consortia			X									
Task 5: Conduct an assessment to identify appropriate sentinel sites or districts				X								
Task 6: Conduct one day meeting to develop / adapt tools			X									
Task 7: Conduct a 3 day M&E training to strengthen M&E systems at DOMC						X						
Task 8: Strengthen system for data collection at DOMC						X	X					
Task 9: Data analysis and Report writing							X					
Task 10: Conduct community planning & advocacy meeting								X				
Task 11: Develop IRS training materials								X	X			
Task 12: Train CORPs on IRS									X			
Task 13: Conduct Support supervision											X	
Task 14: Conduct one day meeting to document results												X

**Performance Monitoring Plan:
ACCESS/Kenya Monitoring and Evaluation Framework (* indicates a required PEPFAR indicator)**

Indicator	Definition / Calculation	Data Source / Collection Method	Frequency of Data Collection	Responsible Party
<i>USAID/Kenya I.R.3.2: Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS</i>				
<i>ACCESS Kenya Program Result : Strengthening Counselling & Testing services for HIV in clinical setting.</i>				
Number of trainers trained in Clinical training skills	Trained trainers are those who were trained in clinical training skills through ACCESS-supported training events or by ACCESS developed trainers.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff
Number of Supervisors trained in supervision skills	Trained supervisors are those who were trained in supervision skills through ACCESS supported training events or by ACCESS developed trainers.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff
*Number of individuals trained in counseling and Testing according to national & International standards	Trained individuals are those who are trained through ACCESS-supported training events or by ACCESS developed trainers. Data will be disaggregated by job function (e.g trainer, supervisor and provider)	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff
<i>ACCESS/ Kenya Program Result : Scaling up ART services</i>				
*Total number of health workers trained to deliver ART according to national and international standards, in the provision of ART treatment.	Trained individuals are those who are trained through ACCESS-supported training events or by ACCESS developed trainers. Data will be disaggregated by job function (e.g trainer, supervisor and provider)	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff
Number of trainers trained in clinical training skills	Trained trainers are those who were trained in clinical training skills through ACCESS-supported training events or by ACCESS developed trainers.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff

Number of supervisors of ART services trained in clinical mentorship skills	Trained supervisors are those who were trained in ART clinical mentorship skills through ACCESS supported training events or by ACCESS developed trainers.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	Trainers, Kenya Program staff
*Number of service outlets providing ART	Trained service providers are those who were trained in CT through ACCESS-supported training events or by ACCESS developed trainers.	Support Supervision report, MOH/NASCOP-726/727 forms	Quarterly During support supervision visit (Once) End of project evaluation	Support Supervision team, Kenya Program staff MOH – DASCO,PASCO, PARTO
Number of individuals newly initiating antiretroviral therapy during the reporting period	Data will be disaggregated by age, sex and type of SDP	Support Supervision report, MOH/NASCOP-726/727 forms	During monthly support supervision visit last 3 months End of project evaluation	Support Supervision team, Kenya Program staff MOH – DASCO,PASCO, PARTO
Number of individuals who ever received ART by the end of the reporting period	Data will be disaggregated by age, sex and type of SDP	Support Supervision report, MOH/NASCOP-726/727 forms	During monthly support supervision visit last 3 months End of project evaluation	Support Supervision team, Kenya Program staff MOH – DASCO,PASCO, PARTO
Number of facilities that receive at least one supervisory visit for ART, every 3 months	Facilities will be randomly selected among total facilities in target provinces providing ART using service providers trained through ACCESS-supported training events If used quarterly, at least 1 supervisory visit should be noted per facility every 3 months	Support Supervision report, MOH/NASCOP-726/727 forms	During monthly support supervision visit last 3 months End of project evaluation	Support Supervision team, Kenya Program staff MOH – DASCO,PASCO, PARTO

*USAID Kenya Intermediate Result: (3.1) Improved enabling environment for the provision of health services and (3.13) Quality of health services in health facilities improved
ACCESS Program Result: Partnerships initiated towards increasing community support for birth planning*

Number of trainers and managers (central and provincial) whose knowledge has been updated in key RH technical areas.	Trainers and managers are from the central and provincial levels. Community groups are organizations working to improve local conditions, e.g., the White Ribbon Alliance, FBOs, etc. Targeted stakeholders will utilize their knowledge and skills in the implementation of their programs. Evidence-based RH knowledge will be informed by technical assistance from the ACCESS Program, international standards, and other stakeholders.	Technical Update Action Plans	Per Technical Update (twice/year)	ACCESS, Elaine Roman
Number of equipment procured for DRH implementation support.	Equipment refers to: 1. Madam Zoe (pelvic model)- 25 2. Arm model for implants- 25 3. IUCD handheld model- 25 4. Breast model- 25 5. Penile model- 25 6. African Baby Model- 25	Procurement Statements	Annual	ACCESS, Elaine Roman
Number of trainers, managers and tutors oriented to use of essential RH equipment.	Trainers, managers and tutors will be oriented to use of essential equipment (see above).	Orientation records	Annual	ACCESS, Elaine Roman
Number of individuals trained in key technical RH areas	ACCESS-supported training events include ACCESS technical assistance, training materials, and approved staff. Trained persons are those who complete a training event satisfactorily according to the criteria established for each course.	Training database and/or other training records	Compiled from training database raw data semi-annually	ACCESS, Elaine Roman

ACCESS/ Kenya Program Result: Enhanced and Integrated PMTCT with RH and HIV Services

<p>Number of individuals who have been trained in PMTCT supervision according to national and international standards</p>	<p>Focal points are mid-level managers coordinating and gathering quarterly reports on RH and HIV service delivery on behalf of the DRH and NASCOP activities. Trained focal points are those who complete a PMTCT supervision training event satisfactorily according to the criteria established for the course. The number will be calculated as an annual count of provinces that have sent at least one person to an ACCESS-supported PMTCT supervision course and who satisfactorily completed that training as recorded in program records. Data will be disaggregated by affiliation of focal point (e.g., DRH or NASCOP, and also specify which province,).</p>	<p>Program records including training database and/or other training records</p>	<p>Training records reviewed to compile relevant information annually ACCESS</p>	<p>Support Supervision team, Kenya Program staff MOH – DRHT&S TEAMS,</p>
<p>Number of service delivery points providing the minimum package of PMTCT services according to national and international standards</p>	<p>Service delivery points are medical facilities where clinical care is provided for clients. The Prevention of Mother to Child Transmission package of services aims to prevent HIV+ transmission through the provision of ANC including a number of HIV related interventions. The provision of integrated PMTCT, ANC and HIV services at ACCESS target sites will be determined through follow-up and supportive supervisory review. Data will be disaggregated by affiliation of SDPs (e.g., public, FBO, private).</p>	<p>Support Supervision reports Records review to compile targeted SDPs that reach service provision goals</p>	<p>Annual</p>	<p>Support Supervision team, Kenya Program staff MOH – DRHT&S TEAMS,</p>

Number of facilities that receive at least one supervisory visit for PMTCT, every 3 months	Facilities will be randomly selected among total facilities in target area that provide PMTCT services If used quarterly, at least 1 supervisory visit should be noted per facility every 3 months	Support Supervision reports Records review to compile targeted SDPs that reach service provision goals	Annual	Support Supervision team, Kenya Program staff MOH – DRHT&S TEAMS,
Number of facility, zonal and regional managers who have received the national PMTCT supervision guidelines		Program activity records	Summary information will be compiled at the end of the reporting year.	Program technical staff with ACCESS M&E review

ACCESS Kenya Program Result : Strengthening malaria support to DOMC and DRH .

Number of trainers and managers (central and provincial) whose knowledge has been updated on ACT regimen.	Trainers and managers are from the central and provincial levels. .	Training data base and other records	Immediately after training)	Kenya program staff
Number of trainers trained in Clinical training skills	Trained trainers are those trained in clinical training skills	Training data base	Immediately after training	Trainers, ACCESS, Kaendi Munguti
Number of sentinel sites or districts identified	Sentinel sites are target sites that have been identified through an assessment	Assessment report	Done once and report compiled after assessment	ACCESS, Kaendi Munguti
Number of trainers and managers (central and provincial) trained on M&E	Trainers and managers are from central level- DOMC and provincial level-PHMT	Training data base, participant registration form and other records	Immediately after training	ACCESS, Kaendi Munguti
Number of community own resource persons (CORPs) trained on IRS	Community owned resource persons (CORPs) are community resource persons trained on IRS.	Self-administered Training Participant Registration forms as part of TIMS	Immediately after training	ACCESS, Kaendi Munguti

Madagascar
US-based ACCESS Contact Person: Rebecca Dineen
Year 3 Funding Amount and Sources: \$102,000 (\$50,000/USAID Madagascar Mission and \$52,000/pipeline from MAC Madagascar JHPIEGO field funds)
ACCESS Partners: JHPIEGO
Other Collaborating Organizations: MOH Madagascar, bilateral project Santénet

Background

Madagascar has a population of 16.5 million people, with 80% living in rural areas with limited or no access to public health services because of the extreme geographic diversity of the island. Malaria is the major cause of morbidity and mortality. The Ministry of Health and Family Planning has been working to establish a national malaria policy, including strengthening Focused Antenatal Care (FANC) and providing Intermittent Preventive Treatment (IPT) with Sulfadoxine Pyrimethamine (SP) to all pregnant women after the first trimester at all levels of the health system. The national policy has been validated and is in the process of dissemination and stipulates that IPT/SP should be provided to all pregnant women after the first trimester.

Program Approach

JHPIEGO/ACCESS worked in partnership with the Malaria Action Coalition (MAC) from FY04 to FY06 to strengthen Malaria and Pregnancy (MIP) work and improve quality of services in Madagascar. JHPIEGO/ACCESS has received \$50,000 in additional funding for FY07 from the USAID Madagascar Mission to continue to expand these efforts in collaboration with the Madagascar Ministry of Health National Malaria Control Program and the bilateral project Santénet. The Program will build on the work of MAC to strengthen services to prevent and control malaria. At least one local consultant in Madagascar will be contracted to coordinate and implement activities in country.

Project Goal

Strengthen and improve the quality of service provision to prevent and control malaria

Intermediate Result 1

Develop appropriate policies for the treatment of malaria and the control of MIP

Widespread resistance to chloroquine has prompted countries in Africa to revise their antimalarial treatment and MIP prevention and control policies in favor of more effective drugs. It is estimated that many of the one million deaths from malaria illness could be saved each year with effective first-line treatment. JHPIEGO helped to develop the national policy under the MAC partnership and now will work to develop the norms and protocols to help service providers institute standardized quality service provision.

ACTIVITY 1 DEVELOP NORMS AND PROTOCOLS FOR THE PREVENTION AND CONTROL OF MALARIA. FACILITATE VALIDATION AND DISSEMINATION FOR IPT AND ACT.

The Madagascar Ministry of Health has identified a need for norms and protocols. JHPIEGO can help the Ministry close this gap by covering the costs of developing the norms and protocols and printing them. JHPIEGO proposes that the dissemination plan be a collaborative effort supported by Santénet through a cascade approach.

Specific Tasks	ACCESS Partner(s)
Task 1: Organize a workshop with MOH and all stakeholders to develop norms and protocols	JHPIEGO
Task 2: Validate the norms and procedures, develop dissemination plan and advocate with partners to disseminate the plan	JHPIEGO

Intermediate Result 2

Strengthen national level capacity to improve access to and use of commodities and services

Under IR2, JHPIEGO will conduct the activities listed below. Most of the activities will be done in collaboration with the Ministry of Health and the bilateral Santénet.

ACTIVITY 2.1 DEVELOP AND PRINT JOB AIDS TO SUPPLEMENT NORMS AND PROTOCOLS FOR MALARIA (IPT AND ACT).

JHPIEGO has generic materials that could be adapted for service providers. The job aids would be for both IPT and ACT.

Specific Tasks	ACCESS Partner(s)
Task 1: Meeting to develop job aids	JHPIEGO
Task 2: Review and come to consensus on the job aids	JHPIEGO
Task 3: Print the job aids	JHPIEGO

ACTIVITY 2.2 IMPLEMENT THE PQI PROCESS FOR MIP AND MALARIA CASE MANAGEMENT USING ACT IN SELECTED HEALTH CENTERS.

JHPIEGO proposes to implement the PQI standards for both case management and malaria in pregnancy in health centers selected by the MOH and the Santenet project. The

Santenet project will use the lessons learned from these model sites to scale up the combined PQI standards in their remaining sites.

Specific Tasks	ACCESS Partner(s)
Task 1: Orientation to performance standards in malaria in pregnancy and malaria case management	JHPIEGO
Task 2: Identify actual performance in selected sites	JHPIEGO
Task 3: Analyze gaps and develop action plans	JHPIEGO
Task 4: Implement action plans	JHPIEGO

ACTIVITY 2.3 COLLABORATE WITH WHO TO DESIGN AND IMPLEMENT AN EVALUATION OF THE MALARIA IN PREGNANCY PROGRAM FUNDED BY USAID/MAC

IR1 Develop appropriate policies for the treatment of malaria and the control of MIP			
Activities	Products	Outputs	Outcomes
1.1 Develop norms and protocols for management and prevention. Facilitate validation and dissemination for IPT and ACT.	Norms and protocols for malaria prevention and control Report	Appropriate FANC, MIP, and malaria case management service protocols	Improved FANC, MIP, and malaria health services
IR 2 Strengthen national level capacity to improve access to and use of commodities and services			
2.1 Develop and print job aids to supplement norms and protocols for malaria (IPT and ACT).	Job aids for MIP and malaria case management services	Job aids are available for service providers	Improved FANC, MIP, and malaria health services
2.2 Implement PQI process for MIP and malaria case management using ACT in selected health centers.	Actual performance defined Action plan developed	Service providers and supervisors competent in PQI process	Improved quality of FANC, MIP, and malaria health services
2.3 Support evaluation of the MIP USAID/MAC activities	Evaluation report	Lessons learned from four years of MAC program interventions	Improved FANC, MIP, and malaria health services

Nepal
ACCESS Field Representative: Ms. Chandra Rai, SC US
US-based ACCESS Contact person: Ms. Patricia Daly
Year 3 Funding Amount and Sources: \$2,150,000.00 over 2 years
ACCESS Partners: JHPIEGO, Save the Children USA
Other Collaborating Organizations: NFHP (Nepal Family Health Program), Family Health Division (FHD), Child Health Division (CHD), NHTC (National Health Training Center), CTEVT (Center for Technical Education and Vocational Training), IOM (Institute of Medicine), District Public Health Office, Kanchanpur district, WHO, UNFPA.

Program Approach

ACCESS partners will work together to strengthen maternal and newborn health services in Nepal. Interventions are selected to be complementary to the USAID bilateral Nepal Family Health Project's (NFHP's) on-going capacity building and service delivery efforts for maternal and newborn care. The plan emphasizes program and policy support in the following areas:

- Strengthening skilled attendance at birth by upgrading the skills of key providers to provide skilled maternal and newborn care in the community
- Improving access to and coverage of community-based maternal and neonatal care
- Inform the policy and program agenda on approaches to increase coverage and access to skilled birth attendance in the community
- Support national policy on maternal and newborn care through: a) support to the National Neonatal Technical Advisory Committee (NNTAC) on developing implementation guidelines for managing low birth weight infants and b) supporting the policy agenda relating to community based skilled attendance

This strategy contributes to USAID's overall Strategic Objective #2 of 'Reduced fertility and protected health of Nepalese families' and specifically,

- Intermediate Result 2.2 'Increased use of selected maternal and child health services'.

The USAID will be contributing to the development of a 5 year country Operating Plan (OP) to be completed by Dec 2006. The mission has expressed its interest in pursuing practical models to provide community-based maternal and neonatal care (CB-MNC).

Achievements PY02

Skilled Birth Attendants Learning Resource Package (SBA LRP) development

- Documents, curricula and learning package collected and reviewed
- Job description of SBA and list of SBA skills finalized

- Meeting conducted and consensus built with major stakeholders on SBA LRP development
- Technical Advisory Group (TAG) formed to support SBA LRP development
- Plan of action and review process for SBA LRP developed
- Course design completed
- Workshop conducted to adapt international SBA material for Nepal
- First Draft of Generic SBA LRP produced
- Pre service education sites and in service training institutions for pre testing selected.
- Participants hand book translated into Nepali
- Detailed pre testing plan developed
- 2nd draft of SBA LRP reviewed by TAG
- Pre testing conducted
- Final draft produced after incorporating the pre testing findings

Low Birth Weight

- Developed district level detailed implementation plan for the project period in collaboration with district health authorities and NFHP
- Formative research conducted to identify the perceptions of low birth infants and their care at home
- Hired district level and field level supervisors to strengthen community based volunteers in carrying out family based care of low birth weight infants
- The detailed components of the LBW project design completed
- Preliminary list of indicators to be tracked by the project identified
- Oriented 64 health workers of different health facilities of Kanchanpur on project activities in relation to community based maternal and neonatal care including LBW infants care at home and in the facilities.
- Formed district level advisory group to support the implementation of community based maternal and neonatal care program in the district. The technical advisory group has met two times since establishment two months ago.
- Trained 30 health workers on Community based postnatal care training to enable them to conduct training of volunteers on identification of LBW infants and PNC care to both mother and infants.
- Training of volunteers on identification of LBW infants using weighting scale and postnatal care to both mother and neonates initiated. Forty batches will be trained this fiscal year 2005 – 2006
- Supplied logistic support to the trainers and to the volunteers
- Completed district and village development committee level profile
- Developed a social mapping system to register pregnant women and postnatal mothers in-order to ensure their access to the services provided by the project
- Monitoring and evaluation plan is on process and partially implemented, mainly for PNC visit by the volunteers
- Developed Community Health Workers' training package on PNC care and LBW
- Collaborated with NFHP to conduct a baseline survey

Study of Critical Factors Affecting the Enabling Environment for Skilled Birth Attendance

- Local study team identified and contracted
- Study design completed with input from all relevant stakeholders
- Review of relevant papers and documents completed
- Tools for study finalized
- Training of surveyors and data collection completed

Summary of Activities PY03

Skilled Birth Attendants Learning Package development

- Develop and test of SBA LRP in selected pre-service education sites and in in-service training program i.e. BEOC and MRT and develop roll out plan of SBA LRP.
- Support the development of policies associated with Skilled Birth Attendant (SBA) training issues surrounding registration, legal frameworks in which they operate, job descriptions, entry requirements, maintenance of quality of training, deployment and issues associated with their career structure.
- Plan for next step on future utilization of the package.

Low Birth Weight

- Develop Health Workers' training packages for management of LBW infants home and in health facilities
- Conduct Training of trainers on management of LBW infants at home and in the facilities
- Capacity building of health workers in dealing with referred cases for treatment
- Selection of volunteers for special care of LBW infants
- Conduct training on management of LBW infants for volunteers to enable them to strengthen the family's skill in taking care of LBW infants and seeking care in time from appropriate health institutions
- Home visit by the volunteers to the family of LBW infants as per standard guide line
- Supervision and monitoring of CBMNC including LBW infants using standard formats
- Conduct mid term evaluation
- Dissemination of the progress to stakeholders at the district and in the central level
- Support to develop the standard guidelines and protocol on management of LBW infants at the national level

Study of Critical Factors Affecting the Enabling Environment for Skilled Birth Attendance

- Preliminary data analysis
- National workshop with key stakeholders to review findings of study and to develop model recommendations
- Final report write up
- Printing and dissemination of final report

PY03 Outputs

Skilled Birth Attendants Learning Package development

- Collaborated with MOHP, SSMP to formulate an implementation strategy for SBA policy (Carry on PY 2)
- Printed the SBA LRP (including participant hand book in Nepali). (Carry on PY 2)
- Developed guidelines and recommendations for roll out (Carry on PY 2)
- Disseminated the SBA LRP and guideline for roll out plan. (Carry on PY 2)
- Developed/adapted at least two in-service training curricula based on SBA/LRP in collaboration with NHTC and other stake holders (New activity)
- Defined SBA training site criteria and developed standards (New activity)
- Upgraded up to 6 training sites to SBA training site using standards (New activity).
- Supported and provided TA to other stakeholders for SBA training site upgrading (New activity).

Low Birth Weight

- Developed training package on LBW for health workers and prepared core trainers
- Trained Health workers on management of LBW infants at health facilities
- Trained volunteers to provide PNC and LBW care at homes
- Supported volunteers for their role in the program
- Conducted monthly meetings of volunteers and health workers to review progress
- Conducted mid-term evaluation
- Conducted semiannual meeting of health workers and volunteers
- Completed final evaluation
- Disseminated final evaluation reports
- Developed National guidelines and strategy for the care of LBW infants

Study of Critical Factors Affecting the Enabling Environment for Skilled Birth Attendance

- Completed data collection
- Analyzed data collected

- Conducted National workshop with key stakeholders to review findings of study and to develop model recommendations
- Completed final report
- Report printed and disseminated

ACTIVITY 1: DEVELOPMENT OF GENERIC SKILLED BIRTH ATTENDANTS (SBA) LEARNING RESOURCE PACKAGE

Over the past 15 years, Nepal has made significant improvements in the health outcomes of women and children; however, maternal and neonatal mortality and morbidity rates remain high. Working towards achieving the Millennium Development Goal of reducing maternal mortality by 75% by 2015, His Majesty's Government of Nepal has made recent policy commitments to increasing access to skilled attendance at birth for Nepali women. Currently, only 13% of women in Nepal are attended by a skilled birth attendant (SBA) during delivery. The government's objective is to increase the level of skilled attendance to 60% in the next ten years.

Several players are active in Nepal in support of the government. USAID has asked ACCESS to help the Government of Nepal realize these goals, in close collaboration with the USAID bilateral Nepal Family Health Program as well as with SSMP/OPTIONS which has DFID funding to support the Nepal government on human resource issues. The Ministry of Health led SBA policy has been endorsed by the government. It has identified 27 skills required to be a Skill Birth Attendance. At present Family Health Division and National Health Training Center have been conducting training on Midwifery Refresher Training (MRT) to ANMs and registered nurses and BEOC to registered nurses and doctors. More specifically, ACCESS has been tasked with supporting the development of a generic SBA learning resource package for creating SBAs. In the year 2 the generic a draft SBA package developed jointly with Family Health (FHD), National Health Training Center (NHTC), Institute of Medicines, professional bodies and other stakeholders. The SBA generic package included normal maternal and neonatal health care, complication and its management components. The MoH has planned to train numbers health workers on SBA in the coming year. According to the targeted number, the NHTC will train the health workers on SBA coordinating with FHD. The FHD will select/nominate participants from the health facilities and ensures that they are providing the services as per SBA policy. The purpose behind keeping the package generic is so that it may be adapted to accommodate the competency levels of various cadres already existing in-country (i.e., ANMs, MBBSs, SNs) as well as the diversity of skill levels within each cadre. It will also ensure consistency and standardization of SBA skills and avoid the development of numerous different courses. Furthermore, depending on availability of funds, ACCESS will be engaged in the process of developing and strengthening training sites where SBA candidates can practice and hone their skills. Relevant findings from the SBA study being conducted by the ACCESS project will be taken into concern in this process. From 2006 WHO has committed to piloting SBA IST for ANMs in BPKIHS as well as working with Nepal Nursing Council (NNC) to develop SBA IST site accreditation standard and process. ACCESS is collaborating with WHO and other partners in these activities to ensure that national training system is

strengthened and efforts are not duplicated. For e.g. SBA IST standards will be consistent with any national accreditation system.

Activity Lead: ACCESS Human Resource Program Officer

All of these sub - activities related to SBA package development will be done in close collaboration with MoHP , SSMP, SMSC, NNTAC, NFHP and other key stakeholders

Activity Location(s): Kathmandu and training site locations TBD

Specific Tasks	ACCESS Partner(s)	Completion Date
Development of SBA LRP		
Task 1: Collaborate with MOHP, SSMP to formulate an implementation strategy for the SBA policy	JHPIEGO	Pending tie-up with SSMPs work
Task 2: Print the Learning Resource Package	JHPIEGO	November 2006
Task 3: Prepare/ develop guidelines and recommendations for roll out	JHPIEGO	December 2006
Task 4: Dissemination of generic SBA Learning package	JHPIEGO	December 2006
Develop/Adapt at least two in-service curricula based on SBA/LRP in Collaboration with NHTC, other stake holders		
Task 1: Form cadre specific working groups to adapt/revise/develop IST curricula based on the SBA LRP	JHPIEGO	January 2007
Task 2: Conduct workshop for working groups to review current curricula and the SBA package and make recommendations on required changes	JHPIEGO	February 2007
Task 3: Adapt/revise IST curricula to use CBT and the LRP for each cadre	JHPIEGO	March 2007
Task 4: Review each revised curricula by a technical team to insure adequate to produce SBA	JHPIEGO	April 2007
Task 5: Finalize curricula for each cadre	JHPIEGO	May 2007
Task 6: Orient NHTC, Stake holders and potential SBA training sites to new curricula	JHPIEGO	June 2007
Define SBA in-service training site criteria and develop standards		
Task 1: Define SBA training site criteria with FHD/NHTC and other stake holders	JHPIEGO	December 2006
Task 2: Based on SBA IST site criteria develop a national plan for site upgrading	JHPIEGO	January 2007
Task 3: Develop/adapt national standards for SBA IST sites	JHPIEGO	January 2007
Upgrade up to 6 IST sites to SBA training sites using standards		
Task 1: Select site for upgrading based on plan	JHPIEGO	January 2007
Task 2: Conduct orientation for SBA IST sites on standards, SBM and PI process	JHPIEGO	February 2007

Task 3: Support sites to Conduct self assessment using standards and develop an action plan to work towards to meet standards	JHPIEGO	March- May 2007
Task 4: Compile site strengthening needs across all selected sites and coordinate with stakeholders to provide support for SBA training site upgrading	JHPIEGO	May 2007
Task 5: Provide TA for training/Clinical Skills Standardization as needed	JHPIEGO	June to August 2007
Task 6: Assist sites to be reassessed, recognized and/or accredited as a national SBA IST sites.	JHPIEGO	August-September 2007

ACTIVITY 2: DEVELOP AND TEST A COMMUNITY STRATEGY TO IDENTIFY AND MANAGE LOW BIRTH WEIGHT INFANTS

Nepal as with other countries in South East Asia has a high rate of low birth weight (LBW) infants, which contribute to a substantial proportion of all neonatal deaths. Few programs globally have been successful in demonstrating an effective method of managing these low birth weight infants at the community level. This pilot would seek to develop such a method, specifically for the Nepal context, which could be scaled up by the MOHP. This along with the activities at the national level for developing LBW policies would assist the MOHP in operationalizing a key component of the National Neonatal Health Strategy. The community model will identify LBWs for targeted care at the home level by families and community workers and assist referral if necessary for more intensive care at a suitable referral facility. Other projects and research studies will be examined along with assessing the current situation in the pilot district to design the package of interventions which may include such approaches as supporting exclusive breast feeding (BF) with attention to the special problems LBW babies may encounter, preventing infection which may include identifying conditions such as sepsis and initiating prompt treatment, modifications of skin to skin care to prevent hypothermia/encourage feeding/reduce infection levels, supplementation with Vitamin A and supporting improved knowledge and care by health workers at referral facilities. This neonatal and LBW issues and contents have been incorporated in the Generic SBA Learning Resource Package (ACTIVITY 1) as well. This activity will be carried out in one of the existing NFHP districts, Kanchanpur and will be closely linked managerially and integrated as part of the existing CB-MNC project framework. The purpose of the Kanchanpur activity is to determine whether the standards of LBW care at each level (home, community, sub health post/health post) are appropriate, acceptable, feasible and effective—in order to inform national policy and develop and finalize LBW protocols. The Community Health Workers' training package for Female Community Health Volunteers (FCHV) developed jointly with FHD and NHTC. Similarly the Essential Newborn Care and LBW management training manual will be developed for health workers jointly with FHD, NHTC and Institute of Medicine. With these manuals, the ACCESS/Nepal will train health workers and FCHVs coordinating with District Health Office (DHO) and District Public Health Office (DPHO). Through this activity, it is envisioned ACCESS/Nepal will be able to determine appropriate regional best practices in

the Nepal context, effective ways to identify LBW infants, appropriate LBW care protocols for each level, and effective referral mechanisms between levels of care. The CB-MNC baseline study and other monitoring mechanisms will collect data on these issues. Training will be incorporated into the overall training strategy and SC and NFHP staff will have combined oversight of the activities. This activity will also be closely linked and feed information into **Activity # 3** (see below).

Activity Lead: ACCESS Nepal Program Manager with Save the Children US TA

Activity Location(s): Kathmandu and Kanchanpur District

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: In collaboration with FHD/NHTC/IOM develop training curriculum for health workers on management of sick newborns including LBW infants	SC/US	October 2006
Task 2: Recognition of volunteers by celebrating special day in collaboration with district public health office and local authority	SC/US	October 2006 & 2007
Task 3: Monthly meeting with the volunteers in all VDCs	SC/US	September 2006 to September 2007
Task 4: Observation visit by two project staffs to Bangladesh for Low Birth Weight Newborn care and management	SC/US	October 2006 to September 2007
Task 5: Conduct training for health workers to enable them to handle referred newborn with problems.	SC/US	November 2006
Task 6: Mid-term and end-line evaluations	SC/US	December 2006 & August 2007
Task 7: Semi annual review meeting with health workers /volunteers	SC/US	December 2006 & August 2007
Task 8: Observation visit of other model program within the country for volunteers and for the district level ACCESS team	SC/US	February 2007
Task 9: Dissemination of final report	SC/US	September 2007

ACTIVITY 3: ASSIST THE MOHP TO DEVELOP NATIONAL GUIDELINES FOR LOW BIRTH WEIGHT INFANTS TO BE INCLUDED IN THE NATIONAL NEONATAL HEALTH STRATEGY AND IMPLEMENTATION PLAN

Focusing on one of the major underlying contributing factors to neonatal mortality, Low Birth Weight, develop through the National Neonatal Technical Advisory Committee

practical, effective guidelines for use in Nepal at all service delivery levels, utilizing information from other country models, global recommendations and information gained from relevant studies in Nepal (Mother and Infant Research Activities (MIRA), Morang Innovative Neonatal Infection (MINI) project, UNICEF, Saving Newborn Lives (SNL) Behavior Change and Communication (BCC) and Birth Preparedness Package (BPP) program, Bangladesh Population Council KMC Community study etc.)

These guidelines would be a part of the implementation plan of the National Neonatal Health Strategy and training package and material could be developed.

Activity Lead: ACCESS Nepal Program Manager with Save the Children US TA

Activity Location(s): National

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Dissemination of baseline and formative study conducted in Kanchanpur	SC/US	December 2006
Task 2: Conduct desk and research reviews and potential site visits both within and outside of Nepal (Bangladesh, India)	SC/US	December 2006
Task 3: Form a working group and drafting of technical 'position' papers	SC/US	December 2006
Task 4: Develop draft guidelines based on Kanchanpur studies, monitoring data, desk review and technical 'position' papers	SC/US	January to August 2007
Task 5: Disseminate guidelines for review and submit to MOHP for endorsement process	SC/US	September 2007

ACTIVITY 4: CONDUCT A STUDY OF THE FACTORS AFFECTING SKILLED BIRTH ATTENDANCE AND MAKE RECOMMENDATIONS ON FEASIBLE MODALITIES FOR INCREASING COVERAGE, PROVIDING QUALITY SERVICES AND SUSTAINABLE MECHANISMS OF SERVICE DELIVERY.

The issue of skilled birth attendance is a critical one in Nepal, considering that more than nearly 90% of women deliver at home and skilled attendance only in 8% of cases. This results in very high rates of maternal and neonatal mortality.

Activity 1 addresses the issue of increasing the supply of skilled providers, but of equal, if not greater importance is the environment and system of delivering that care. Many problems have been experienced with young unmarried birth attendants working in remote regions with little support and the retention of staff and effectiveness of such systems have been questioned. Despite renewed attention on reducing maternal and neonatal mortality in the past few years, very little progress has been made in increasing the coverage of skilled birth attendance which is only 18% at present. Since Nepal is extremely diverse

geographically, culturally, economically and demographically, different models may need to be developed to suit different situations. Some projects have started service delivery projects such as 'birthing center' with mixed results. A thorough review of the successes and failures of such projects, the investigation of the perceptions and needs of the community *and* the service providers, and exploration of public/private partnerships, incentives, fee for service etc. would really contribute to any future planning for increasing and sustaining SBA coverage. Underlying this whole issue is the present conflict which is also an important factor to take into consideration when conducting this assessment. It is envisaged that this activity would be extremely thorough and involve high level external TA to evaluate the situation and make specific recommendations for the current situation in Nepal.

Activity Lead: Save the Children US and JHPIEGO in collaboration with MOHP and all Safe Motherhood Sub-committee member organizations and other relevant NGOs

Activity Location(s): Kathmandu and extensive field site visits

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Conduct preliminary analysis of findings	SC US JHPIEGO	December 2006
Task 2: Conduct National workshop with key stakeholders to review findings of study and to develop model recommendations	SC US JHPIEGO	December 2006
Task 3: Provide TA for data analysis, workshop conduction and report writing	SC US JHPIEGO	Nov- Jan 2006
Task 4: Draft final report, including description of models and recommendations	SC US JHPIEGO	February 2007
Task 5: Print and disseminate report of study	SC US JHPIEGO	March 2007

ACTIVITY 5: PASS THROUGH FUNDING FOR CEDPA ADOLESCENT PROGRAM

Girls in Conflict Affected Districts of Nepal (BuD for RH) Program by CEDPA

In Program Years 1 and 2, USAID/Nepal requested ACCESS assistance in facilitating the continuation and expansion of a CEDPA program called *"Building Reproductive Health Awareness Among Adolescent Girls in Conflict Affected Districts of Nepal"*. The primary goal of the BuD for RH program (4/1/05-3/31/06) is to improve the ability of girls aged 10-19 in conflict areas to make informed decisions regarding reproductive health and to access health services.

The specific objectives of the project are to:

- Improve RH The current phase of awareness and knowledge among adolescent girls/boys in conflict areas,
- Increase literacy among out-of-school adolescent girls participating in the program in conflict areas,
- Increase girls/boys' adoption of behaviors that lead to improved RH outcomes,
- Create an enabling family and community environment to support girls/boys' program participation and access to health services.

The current phase of the program, "Putting Learning into Action" (PLA) is based on feedback received from girls who participated in the project's National Girls' Congress, held in February 2006. During the Girls' Congress at the end of the BuD for RH project, participants expressed their desire to build on their knowledge and enthusiasm to reach out to their communities around the issue of STI and HIV/AIDS awareness and the reduction of menstrual taboos. During this new phase, CEDPA will support the greater inclusion of youth in civic society and their collective efficacy as agents of change.

October-December 2006

Peer educators will continue to meet with their discussion groups to cover the remaining Choose A Future! curriculum. The peer educations and participants are also organizing and carrying out public awareness activities surrounding reproductive health, HIV/AIDS, and menstrual taboos. Program staff are currently preparing for the end-line survey. A dissemination and lessons learned workshop will be held in December.

Achievements to Date

- Thirty-four Resource Centers were established in the communities and schools where the CAF programs were implemented. The centers are managed by a local Management Committee formed to oversee the center and receive guidance from CEDPA/Nepal. The resource centers offer a place for youth to meet as well as contain a small library.
- Nearly 45% of the girls who participated in the literacy and CAF program transitioned into formal schooling (mostly grades 3 and 4) after successfully completing the program.
- Reproductive health knowledge on the five focus areas of the CAF curriculum (puberty, pregnancy, family planning, STIs/HIV, and optimal birth spacing interval) witnessed increases of 30 percent or more. There was also an improvement in positive attitudes towards gender-based violence and empowerment issues.
- Girls who reported visiting a health facility when they experienced a RH problem improved by 65% as a result of program participation.
- Local-level Reproductive Health Coordination Committees (RHCC) were created to identify ways of increasing the use of health clinics and youth friendly services. They conducted regularly monthly meetings in 15 villages.
- Three district girls' congresses held in November and December were organized by the girls themselves. Participants included district stakeholders, media representatives and parents of the girls. This was a significant accomplishment, reflecting the

enhanced organizational, communication and knowledge skills of out-of-school, formerly illiterate adolescent girls.

Activity Lead: CEDPA Country Representative; ACCESS Headquarters

Activity Location(s): Kathmandu and selected conflict affected districts

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Administer the subagreement established with CEDPA	JHPIEGO	December 2006

ACCESS NEPAL PROGRAM MANAGEMENT

Save the Children will take the lead in managing the Nepal program on behalf of ACCESS. The Country Program Manager (PM) will be a SC US staff and will be supervised in country by the SC Health Team Leader. The PM will directly supervise the ACCESS Nepal staff members and will be responsible for providing oversight to all their activities including performance appraisals. The PM will be in direct link with USAID/Nepal and ACCESS Headquarters (HQ) for technical and management directions for the overall program. A three member Program Management Team comprising of the ACCESS Country PM, JHPIEGO Team Leader and the SC US Health Team Leader will be formed to oversee the overall implementation of the ACCESS program. This team will meet at least once a month or more often as necessary.

SC will hire the LBW program team whereas the HR team will be hired by JHPIEGO. Both organizations as well as USAID/Nepal and ACCESS/HQ will be involved in and approve the selection of the senior-level staff candidates. Administratively and financially each organization will be responsible for staff hired for ACCESS program. Office space for full time ACCESS hires will be set up within the NFHP compound. JHPIEGO Nepal will be responsible for the finances related to the HR work. SC will be responsible for the finances related to the LBW and the SBA study work.

As the ACCESS lead globally, JHPIEGO will be responsible to USAID for the Program's overall results. ACCESS HQ will ensure SC accountability for overall program management and implementation. ACCESS/JHPIEGO will provide USAID/Nepal with periodic financial and program reports that reflect the contributions and activities of all ACCESS partners. ACCESS HQ will also assure appropriate and quality technical assistance either from ACCESS HQ staff or short-term technical experts. ACCESS HQ is responsible for ensuring that partner services are of exceptional technical quality and adhere to stated schedules and budgets. ACCESS HQ will:

- Maintain regular, close communication with the field program, Save the Children Nepal as well as JHPIEGO field staff, other partners and subcontractors;

- Establish agreed upon expectations and requirements prior to project start up;
- Hold regularly scheduled reviews of progress to date, problems encountered and their estimated impact on costs and schedule, and plans for the upcoming review period;
- Require submission of comprehensive progress reports;
- Enforce quality assurance procedures that include a technical review of all deliverables and proven mechanisms for incorporation of changes, and maintenance of regular, documented communication; and
- Use internal tracking and monitoring systems to ensure that we deliver high-quality products to USAID.

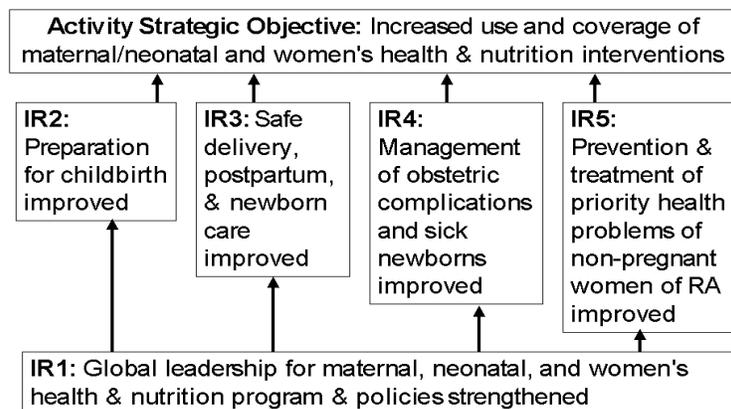
ACCESS HQ will assign appropriate program and finance staff to facilitate coordination, partner management, efficient reporting and financial accountability

PERFORMANCE MONITORING PLAN

I. Strategic and Conceptual Approach

M&E information will measure ACCESS progress towards results relating to Intermediate Results (IRs) 2.2 of USAID/Nepal's Strategic Objectives. Program markers (benchmarks, milestones, or indicators) are tied to the USAID Mission IRs as appropriate to the ACCESS program design and component activities agreed between USAID and ACCESS partners. This Performance Monitoring Plan (PMP) presents the frameworks within which these markers have been developed, and provides details on indicators, data systems and sources, and roles/responsibilities for monitoring implementation.

ACCESS Strategic Framework



While the ACCESS strategic framework above applies globally, country-level ACCESS programs have individually-tailored indicators agreed with the USAID Mission and linked to the respective USAID Mission strategic framework. The ACCESS M&E system relies on appropriate field and program staff to fulfill M&E responsibilities in order to maximize implementation efficiencies, partners and stakeholder collaboration, and cost-effectiveness.

Critical Assumptions

- That implementation will not be unduly disrupted by significant changes in funding levels, nor by events interrupting ability to travel freely or significant alterations in donor expectations
- That the respective local and global partners will cooperate, collaborate, and meet their commitments to contribute to the improvement of maternal and neonatal health initiatives
- That the Government of Nepal will remain stable with a continuing commitment to improving maternal and newborn
- That security challenges will not prohibit implementation as relevant

II. Performance Indicators and Results

The ACCESS Program and USAID/Washington recommend all countries with maternal, newborn, and women's health concerns establish systems track at least a minimum set of outcome- and impact-level indicators. Those indicators should consolidate key information for all stakeholders working in maternal and newborn health programming. Such a system should be designed to provide information crucial to the USAID Mission, host governments, and other stakeholders for understanding the relevant context in that country and how it changes over time, which is vital for appropriate programmatic decision-making. The ACCESS Program will not track essential reproductive health, safe motherhood, or newborn information at the impact or population/national level, in any country, unless specifically tasked and fully funded by the appropriate USAID Mission to do so. The ACCESS Program may, if requested, accept tasks and funding to collaborate in ensuring that information appropriate to safe motherhood and newborn health will be collected and appropriately analyzed or interpreted. Indicators for annual reporting on ACCESS Nepal Program results are provided below.

Indicator	Definitions and Calculation	Data source	Collection method/frequency	Responsible party	BASELINE (AND TARGET)	USE OF DATA
<i>USAID/Nepal Intermediate Result 2.2: Increased use of selected maternal and child health services.</i>						
Number of Generic Skilled Birth Attendant (SBA) Learning Resource Package developed and tested and provided to HMG and key partners to be adapted and incorporated curricula of various cadre of SBA	This generic SBA Learning Resource Package will accommodate the competencies and skills of Skilled Birth Attendants as defined by SBA policy of Nepal.	Program records SBA Learning Package	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0 <i>Target: 1</i>	-Standardize skills set and training package - Provide a national standard to contribute to future activities
Number and type (by cadre) of curricula adapted using SBA LRP	Existing in-service training curricula for various cadres will be adapted to ensure they now cover all SBA competencies to produce competent, skilled SBAs	Program records New curricula	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0 Target: 2	
Number of SBA In-service Training Site Standards developed for use by NHTC and/or national accreditation systems	A set of performance-based standards will be developed / adapted from Afghanistan midwifery school standards for Nepal SBA IST sites.	Program records Standards	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0 <i>Target: 1</i>	
Number of SBA IST sites assessed according to standards and working towards meeting them	Some current IST sites conducting BEOC and/or MRT training will be selected for upgrading to SBA IST sites, according to the newly-defined standards.	Program records Site assessment reports	Records review	ACCESS Nepal Program Manager and Program Officer (HR)	Baseline: 0 <i>Target: 6</i>	

Indicator	Definitions and Calculation	Data source	Collection method/frequency	Responsible party	BASELINE (AND TARGET)	USE OF DATA
Number of Community Strategies to identify and manage Low Birth Weight (LBW) Infants developed, tested and provided to GON 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, Annual	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
Number of LBW infants identified and managed as per protocol	Newborn infants who are less than 2.5 Kg will be identified in all VDCs in Kanchanpur. Cared for at home and community health facilities as per the protocol developed	CB MNC forms and data collection system	CB MNC reporting systems, Monthly	CB MNC Kanchanpur team	Baseline: 0 Target: TBD based on expected pregnancy and percentage of LBW	- Determining effectiveness of community based LBW intervention and protocol
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 the used at all service delivery levels and these guideline will be incorporated into national standards and protocols	LBW Guidelines	Records review, Annual	ACCESS Nepal Program Manager and Program Officer (LBW)	Baseline: 0 Target: 1	-Contributes to National Standards and Protocols

Indicator	Definitions and Calculation	Data source	Collection method/ frequency	Responsible party	BASELINE (AND TARGET)	USE OF DATA
Number of studies conducted to assess factors affecting skilled birth attendance and provide recommendations to HMG and other stakeholders	Study will be conducted thorough review of successes and failures of projects and investigates the perceptions and needs of community and the service provides, explore public private partnership and other factors affecting skilled birth attendance.	Program records Study report	Records review, Annual	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

NIGERIA
ACCESS Field Representative: Emmanuel Otolorin
US-based ACCESS Contact Person: Nancy Caiola
Year 2 Funding Amount and Sources: \$3 million
ACCESS Partners: JHPIEGO, ACNM, Constella Futures,
Other Collaborating Organizations: Federal and State MOHs, Nigerian medical Association, National Association of Nigerian Nurse Midwives, Nigeria Private Nurses & Midwives Association, COMPASS Project, Pathfinder International, SOGON, PATHS, WHO, and UNICEF

Program Approach

The key program approach to achieving this goal is the implementation of an integrated community and facility-based essential maternal and newborn care (EMNC) interventions focusing on ANC, emergency obstetric and newborn care,¹ and postpartum care including family planning (FP), along with the Household-to-Hospital Continuum of Care (HHCC). The HHCC approach recognizes the importance of a successful EMNC program to systematically address maternal and newborn issues of the community and facility together using evidence-based interventions and best practices. Addressing facility-based challenges and neglecting community/social issues and vice versa will not lead to the desired effects of reduction in maternal mortality rate and newborn mortality rate.² The HHCC addresses all three delays³ associated with maternal and newborn deaths by improving household and care-seeking practices, empowering the community to create and maintain an enabling environment for increased utilization of EMNC services, whether public or private, and improving the quality of care provided at the peripheral and district (LGA) levels. As stated in the proposal, the main technical intervention is the improvement of emergency obstetric and newborn care (EmONC), but recognizing that preparation for management of obstetric and newborn complications starts in the antenatal period and continues through childbirth and the newborn and postpartum periods.

ACCESS/Nigeria interventions will cover all components of maternal and newborn care: ANC, childbirth, newborn care, postpartum care (PPC) including postpartum FP. In the conservative North West, where demand seems largely confined to birth spacing, a

¹ Basic Emergency Obstetric Care includes: administration of antibiotics, oxytocics, anticonvulsants; manual removal of the placenta; removal of retained products following miscarriage or abortion; and assisted vaginal delivery with forceps or vacuum extractor. Basic newborn care includes: diagnosis and management of asphyxia, hypothermia, infections; diagnosis, stabilization and referral of LBW babies (or management where KMC is available); diagnosis, stabilization and referral of newborns with other illnesses or conditions (e.g., jaundice, tetanus, sepsis, birth defects/injuries). Comprehensive emergency obstetric care, typically delivered in district hospitals includes: all basic functions, plus Caesarean section and safe blood transfusion. Comprehensive newborn care includes: all the basic newborn function, plus management of LBW babies including use of Kangaroo Mother Care (KMC)

² ACCESS 2005. Household-to-hospital continuum of maternal and newborn care.

³ The 3 delays are: 1) delay in recognizing complications; 2) delay in reaching a medical facility; and 3) delay in receiving good quality care at the facility.

postpartum family planning approach may provide an opportunity to increase access for underserved populations.

Achievements PY01

ACCESS Nigeria is a new project which is currently at startup level. The period Jan-June 2006 witnessed a few activities leading to the submission of the ACCESS proposal, draft results framework and workplan in June 2006. A draft PMP was also submitted while noting that targets for program indicators will be assigned after completion of the baseline survey, which is planned for September 2006. Since the workplan was submitted at the end of June, it is anticipated that it will be approved in July. However, during the startup period, the following were achieved:

- Facilitated a 2-day national stakeholders meeting on Emergency Obstetric and Newborn Care in Abuja
- Conducted an advocacy trip to Kano and Zamfara states
- Participated in MEMS training activity for M&E and produced first draft of PMP for the ACCESS program.
- Supported participation of a five-person Nigeria team at the Africa Regional PPH Conference in Entebbe, Uganda. The Nigeria team included a physician and midwife from Zamfara state, one Lagos-based OB-GYN from the private sector, Deputy Director of the RH Unit and the Principal of Gwagwalada School of Midwifery. (Funded by ACCESS Core)
- Prepared for ACCESS Nigeria baseline survey, including developing a draft study protocol that was shared with stakeholders during the visit to Kano state in June, and draft data collection instruments
- Initiated and/or completed office start-up activities
- Finalized ACCESS Nigeria proposal, results framework, workplan, budget and PMP and submitted to USAID

Anticipated Results PY02

- Completed program start-up processes
- Improved enabling environment for and scale-up of best practices for EmONC at National and state level
- Improved availability of EmONC trained health care workers in selected LGAs
- Improved quality of EmONC services in selected LGAs
- Improved quality of family planning services in selected LGAs
- Increased demand for maternal and newborn services, including family planning, in selected LGAs
- Improved management of maternal and newborn services in selected LGAs

Program Management

JHPIEGO will take the lead in managing the Nigeria program on behalf of ACCESS. Professor Emmanuel Otolorin will serve as ACCESS Chief of Party (COP) and will directly supervise ACCESS/Nigeria staff members. He will be the direct link with USAID/Nigeria

and ACCESS Headquarters for technical and management directions for the overall program. The ACCESS COP will be seconded by a senior Program Manager with responsibilities for planning, managing and implementing activities. The Program Manager will supervise administrative and finance staff as well as program support staff in Abuja and in the field, although the ACCESS COP will have overall oversight and approval responsibilities. In addition, the ACCESS COP will supervise senior technical staff, who will themselves have oversight of trained Nigerian youth corpsers in the field.

ACCESS partners,⁴ will provide technical assistance, but all local staff will be hired through JHPIEGO. JHPIEGO is currently working to register in Nigeria to allow for this recruitment. The field office will submit work plans and reports to both USAID/Nigeria and to ACCESS headquarters for consolidation and submission to AID/Washington.

PROGRAM START UP

ACCESS/Nigeria will complete its start-up and initial M&E processes. These include such tasks as conducting a baselines study and preparing the final report, developing a SBM-R database in order to monitor performance, and instituting the necessary M&E systems.

Activity Lead: ACCESS COP

Activity Location(s): Abuja, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 1: Design and implement program monitoring and evaluation systems					
i. Enter and analyze baseline survey data and prepare study report	X				ACCESS/B M&E Specialist, ACCESS/N M&E Advisor, Research Agency, ACCESS COP
ii. Review and revise LGA HMIS forms and registers	X				Health facility in-charge
iii. Produce new community-based EmONC and FP HMIS forms and registers (see section 6.5)	X				ACCESS COP
iv. Develop database to monitor service statistics from ACCESS- supported facilities and CHEWS		X			ACCESS/B M&E Specialist, ACCESS/N M&E Advisor, MIS Staff
v. Develop database to monitor SBM-R performance of ACCESS-supported facilities to identify those meeting set accreditation criteria		X			ACCESS/B M&E Specialist, ACCESS/N M&E Advisor, MIS Staff
vi. Collect and synthesize routine monitoring data from ACCESS -supported facilities and communities working with target LGAs using new facility and community data analysis and decision-making forms developed under section 6.5	X	X	X	X	ACCESS/N M&E Advisor, LGA M&E Officers, Technical Officer
vii. Prepare routine results reports for donors (USAID/Nigeria and USAID/Washington)				X	LGA M&E Officers, Technical Officer, ACCESS COP, ACCESS/B M&E Specialist, ACCESS/N M&E Advisor

⁴ ACCESS Partners are: ACNM, AED, Constella Futures, IMA, and Save the Children

RESULT 1: IMPROVED ENABLING ENVIRONMENT FOR AND SCALE UP OF BEST PRACTICES FOR EMONC AT NATIONAL AND STATE LEVELS

Having the necessary national policies, standards, and guidelines for the provision and supervision of EmONC is essential for ensuring a program environment that provides the necessary training, supplies, deployment of trained health workers, appropriate remuneration and incentives that enable the provision of quality care in an equitable manner. Supportive and explicit policies related to maternal and newborn health already exist and are consistent with international efforts (see above). However, there remain issues in the area of human resources, health financing issues and others that have a direct bearing on Nigeria's ability to successfully implement and roll out high quality emergency obstetric and newborn care. Working with FMOH, the Nigerian Medical Association (NMA), the National Association of Nigerian Nurse Midwives (NANNM), the Nigeria Private Nurses & Midwives Association (NPNMA), SOGON, and the UN agencies in collaboration with the two bilateral programs, ENHANSE and Partnership for Transforming Health Systems (PATHS), ACCESS will implement strategies at national and state level to make certain that the appropriate policies, clinical standards and guidelines are in place to support the provision of quality EmONC services at state and LGA levels.

Activity Lead: ACCESS COP, Program Manager, Technical Advisor

Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 1.1: Establishment of structures for preparing and facilitating scale up of EmONC					
i. Meet with state SMC to discuss scaling up of evidence-based EmONC interventions				X	WHO, NPHCDA, PATHS, NYSC
ii. Meet with national SMC to review progress of ACCESS Project	X	X	X		USAID/N, WHO, NPHCDA, PATHS, NYSC
Task 1.2: Explore alternative financing mechanisms for the poor to access EmONC services (from ACCESS Core funds)					
i. Develop conceptual framework and protocol/tools for studying EmONC financial barriers	X				ACCESS COP, Technical Advisor, Program Manager, Community Mobilization Specialists, ACCESS Baltimore
ii. Present conceptual framework and protocol/tools at national SMC meeting	X				FMOH, ENHANSE, Program Manager
iii. Identification and training of study team	X				FMOH, ENHANSE, Program Manager
iv. Implementation of alternative financing mechanisms project	X	X	X		FMOH, ENHANSE, Program Manager
v. Data collection and analysis		X	X		FMOH, ENHANSE, Program Manager
vi. Finalize study report				X	FMOH, ENHANSE, Program Manager, ACCESS Baltimore
vii. Disseminate study report at national and selected state SMC meetings				X	FMOH, ENHANSE, Program Manager
Task 1.3: Define national EmONC performance standards for SBM-R					

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
i. Field test draft standards in ACCESS program site	X				Program Manager, Program Officers, M&E advisor, State RH Coordinators, PATHS
ii. Finalization of EmONC performance standards		X			Program Manager, Finance/Admin Manager, FMOH, WHO, PATHS

RESULT 2: INCREASED AVAILABILITY OF EMONC HEALTH CARE WORKERS IN SELECTED LGAS

In order for EmONC services to be available and function, the following are key building blocks: trained manpower available in sufficient number to provide 24-hour/7-day coverage; infrastructure and equipment available, including operating rooms and laboratory facilities at CEmONC facilities; a drug logistics system that ensures dependable supply of essential drugs and supplies; strong management systems including supervision; and a functioning referral system. These issues are each covered under separate areas of the ACCESS program: infrastructure and equipment under result 3, supplies and drugs as well as management systems under result 5, referral systems in both results 4 and 5. This result focuses on the first of these building blocks: the human resources. This is an area where there are critical shortages and gaps, especially in the rural areas and in particular in the North of the country.

Activity Lead: Program Manager

Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 2.1: Pre-placement BEmONC training for NYSC physicians					
i. Development of multimedia teaching aids (e.g. video segments)	X	X			Multimedia Consultant, PSE Faculty
Task 2.2: Advocacy for employment and rational deployment of HR in selected LGAs					
i. Meet State MOH and LGA leadership to develop a workplan to rationalize employment and deployment of HR for EmONC services		X			RH Coordinator, LGA Commission Representative
Task 2.3: Strengthen preservice midwifery education in Zamfara and Kano states					
i. Review content of existing preservice curricula for EmONC content and training methodologies	X				Program Manager, Program Officers, PSE Faculty
ii. Meet with FMOH and WHO to determine need to strengthen preservice midwifery education in Zamfara and Kano states	X				Program manager, Program officers, PSE faculty
iii. Meet with nursing and midwifery council to develop a plan for strengthening PSE curricula with EmONC content	X				Program Manager, local NANNM officials, Nursing and Midwifery Council
iv. Conduct training needs assessment for selected midwifery PSE institutions in Kano and Zamfara states		X			Program Manager, local NANNM officials, Nursing and Midwifery Council
v. Develop a plan for ACCESS to provide technical assistance to the selected PSE institutions		X			Program Manager, local NANNM officials, Nursing and Midwifery Council

vi. Support PSE institutions to implement plan			X		Program Manager, local NANNM officials, Nursing and Midwifery Council
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RESULT 3: IMPROVED QUALITY OF EMONC SERVICES IN SELECTED LGAS

To achieve this result, ACCESS will examine all the factors affecting the quality of services. The FMOH and partners have already made commendable efforts and dedicated resources to strengthening provider competence with Life Saving Skills training for doctors, midwives and CHEWS, although as noted above only a small proportion of all potential providers have been reached to date. The National Study on EOC Facilities also discusses the persistent lack of basic equipment and supplies that limit the extent to which EOC skills can be applied. These are some of the issues that ACCESS will tackle under this result as well as providing providers and facilities with standards-based tools to make their own strides wherever possible in addressing gaps in quality of care, and involving communities in defining and improving quality (linked with Result 4). Another aspect of quality ensuring appropriate linkages and coordination between communities is primary health and referral facilities. Where quality improvement approaches can address this, these will be covered here.

Activity Lead: ACCESS COP, Program Manager, Technical Advisor, Program Officers

Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 3.1: Upgrade facilities of selected LGAs to provide EmONC services					
i. Establish a Health Facility Management Committee (HFMC) in each health facility			X		Technical Advisor, NYSC doctors, Facility in-charges
ii. Prepare tender papers for supply of necessary equipment, training materials for EmONC, and renovation of facilities				X	Technical Advisor, Program Manager, ACCESS/Baltimore Program Officer, Facility in-charges
iii. Select vendors and award equipment supply and renovation contracts				X	Technical Advisor, Program Manager, ACCESS/Baltimore Program Officer, Facility in-charges
iv. Renovate selected facilities				X	Technical Advisor, Program Manager, Program Officer, Facility in-charges
v. Distribute necessary equipment and training materials for EmONC				X	Technical Advisor, Facility in-charges, Facility Stores Officer
vi. Monitor renovation of health facilities and installation of equipments				X	Finance/Admin Officer
vii. Work with health facilities to establish a maintenance policy including an inventory of equipment supplied				X	Program Officers, Facility in-charges, Stores Officers
viii. Strengthen blood transfusion system at the CEmONC facilities based on health facility needs assessment report	X	X	X	X	Program Officers, Finance/Admin Officer, Technical Advisor, Facility Laboratory Scientist/Technician

ix.	Strengthen infection prevention practices based on findings from health facility assessment exercise	X	X	X	X	Program Officers, Facility in charges, Infection Control Officers
x.	Identify a room/space at CEmONC and training sites for use as KMC ward			X		Program Officer
xi.	Needs assessment of KMC rooms to identify needs for renovation			X		Program Officer, Facility in-charges
xii.	Renovate room for KMC				X	ACCESS COP, Technical Advisor, Program Officer, Facility in-charges
Task 3.2: Strengthen the performance of health care workers (physicians, nurses, anesthetists, midwives) in EmONC services in both public and private sectors						
i.	Train NYSC doctors to provide BEmONC services		X		X	Technical Advisor
ii.	Train CHEWs to provide BEmONC services	X	X	X	X	Technical Advisor
iii.	Conduct on-the-job CEmONC training for facility teams (doctors, midwives, anesthetists) from selected health facilities	X	X	X	X	ACCESS COP, Technical Advisor, Consultant
iv.	Train nurses, midwives and CHEWS to provide KMC services		X		X	Technical Advisor
v.	Meet with state branches of SOGON to agree terms of an MOU to mentor NYSC doctors to perform Caesarean sections (CS)	X				ACCESS COP, Technical Advisor
vi.	Place selected NYSC doctors in CEmONC facilities to learn to perform CS	X	X	X	X	ACCESS COP, Technical Advisor
vii.	Orient SOGON members to mentorship of NYSC doctors	X	X	X	X	Technical Officer
viii.	Mentorship of NYSC doctors by SOGON	X	X	X	X	Technical Officer
Task 3.3: Introduce standard based management (SBM-R) tools and approaches at ACCESS-supported facilities						
i.	Orient facility in-charges/managers and SMOH/LGA supervisors to SBM-R approaches and national EmONC performance standards	X				Technical Advisor, Program Manager, Program Officers, Social Mobilizers, M&E Advisor
ii.	Establish an SBM-R coordinating body in each selected facility	X				Program Officers
iii.	Train teams of coaches and technical advisors	X	X	X		Program Officers
iv.	Conduct SBM-R baseline survey at facilities and discuss results	X				Program Officers
v.	Develop and implement practical SBM-R operational plans	X	X			Program Officers
vi.	Organize quality improvement teams by areas	X	X			Program Officers
vii.	Mobilize resources for quality improvement (including from the private sector e.g. GSM operators)	X	X	X	X	Program Officers
viii.	Measure progress through monitoring assessments and benchmarking	X	X	X	X	Program Officers

RESULT 4: IMPROVED QUALITY OF FAMILY PLANNING SERVICES IN SELECTED LGAS

While the services established through the program will be made available to all types of clients, the family planning portion of this program will specifically focus on meeting the needs of postpartum women for contraception. In this way, a maternal care service, which

includes EMNC, will serve as an entry point for family planning activities. This will be done in several key ways:

- No missed opportunities: The program will maximize counseling and service delivery contacts provided at PHC units and hospitals. Antenatal care, delivery care and postnatal care—all present opportunities to provide quality family planning information and services.
- Community health extension workers/volunteers will visit the women within three days and thus have the opportunity to counsel on LAM, return to fertility and healthy timing and spacing of pregnancies as well as screening for complications.
- Creating additional opportunities: Another possible entry point is fistula screening at the six-week postpartum visit. ACCESS will explore the possibility of screening for fistula which may encourage more women to return for the six week visit and give them the opportunity to access family planning services.
- Expansion of method mix: In collaboration with DELIVER, ACCESS will examine expanding the method mix to include Norplant and other long acting methods. In addition, counseling on LAM may be seen as expansion of contraceptive options with an emphasis on transitioning to modern methods.

Activity Lead: Program Manager, Program Officers

Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 4.1: Upgrade facilities of selected LGAs to provide FP services					
i. Conduct FP needs assessment for selected health facilities (using appropriate checklists) as part of baseline assessment described in Section A of the workplan	X	X	X		State SM coordinators, Program Manager, Facility and MCH in-charges,
ii. Strengthen facilities as needed to provide FP services	X	X	X	X	State SM Coordinators, Program Manager, Facility and MCH in-charges,
iii. Meet with DELIVER to develop an MOU on supply of FP commodities and logistic management training	X	X	X	X	Technical Advisor, Program Manager, DELIVER Staff
iv. Distribute FP commodities to ACCESS project LGA sites	X	X	X	X	Technical Advisor
Task 4.2: Strengthen the performance of health care workers (physicians, nurses, anesthetists, midwives) in FP services					
i. Conduct contraceptive technology updates for CHEWs, midwives and doctors	X	X	X	X	Program Officers, Program Managers, RH/SM Coordinators, ACCESS-FP
i. Train NYSC doctors to provide long-term contraceptive methods (IUD, Norplant/Jadelle, Tubal Ligation)		X		X	Program Officers, Master Trainers, Consultant, ACCESS-FP
ii. Train CHEWs to provide LAM including transition, pills, injectables, spermicides and condoms and counsel on long-term methods		X	X	X	Program Officers, Master Trainers, Consultant, ACCESS-FP
Task 4.3: Improve supervision of FP services					
i. Meet with SMOH/LGA to adapt supervision tools for FP and agree on supervision schedules	X				Supervision tools adapted
ii. Conduct joint ACCESS/LGA supervision visits	X	X	X	X	Joint supervision visits conducted

RESULT 5: INCREASED DEMAND FOR MATERNAL AND NEWBORN SERVICES

For EmONC interventions to be successful, pregnant women mothers and newborns with complications must be identified early and appropriate care sought in an opportune manner. For women and their families to detect obstetric and newborn danger signs early, educating them on these signs must begin prior to pregnancy or as soon as conception is established. This means educating women and communities on complications and actions to take beginning in the antenatal period through childbirth to the postpartum period. To ensure that women and their families are well educated on danger signs and seek care appropriately, ACCESS will utilize a number of evidence-based BCC and community mobilization (CM) approaches to increase demand for ANC and PNC services, and delivery by skilled birth attendants. For women who chose to deliver at home without skilled birth attendants, ACCESS will equip them with first aid obstetric skills to stabilize and keep the women alive during their transportation to a facility that could manage their complications. Another area for outreach education is the importance of adequate spacing between pregnancies. The program will raise awareness with regard to LAM, return to fertility and the healthy timing and spacing of pregnancies through community level activities.

Activity Lead: ACCESS COP, Program Manager, Technical Advisor, Program Officers

Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 5.1: Strengthen community capacity in planning and implementing EMNC activities					
i. Translate ACCESS/Nigeria CM training manual into Hausa		X			Program Manager, Program Officer
ii. Conduct training of CM trainers workshop	X				State Program Officers, State CM Specialists, ACCESS/B CI Specialist, consultant, COMPASS CM Trainer
iii. Conduct CM training for selected community groups	X	X	X	X	State Program Officer, M&E Officer, Program Manager, Finance & Admin Officer
iv. Community groups implement community mobilization activities including establishment of emergency transport, community finance schemes, etc	X	X	X	X	State Program Officer, M&E Officer, LGA PHC CM Officers
Task 5.2 Strengthen linkages between community, primary and secondary health facilities					
i. Train project clinical and CM trainers on EmONC & FP PDQ	X	X	X	X	State CM Specialists, M&E Officer, State RH Coordinators
ii. Conduct PDQ training for HFMCs	X	X	X	X	State Program Officer, M&E Officer, Finance & Admin Officer
iii. HFMCs implement PDQ at their respective health facilities	X	X	X	X	State Program Officer, State CM Specialists, M&E Officer, LGA PHC Directors, LGA PHC CM Officers
Task 5.3: Implement evidence-based behavior change interventions to increase community recognition of maternal and newborn danger signs and the importance of healthy timing and spacing of pregnancies					
i. Purchase or produce copies of translated identified existing appropriate BCC materials	X				Finance and Admin Officer

ii. Draft new BCC materials based on identified gaps	X				ACCESS COP, State CM officers, State RH Coordinators
iii. Translate draft new BCC materials into Hausa		X			Technical Advisor, CM Specialists, RH Coordinators, LGA PHC CM Officers
iv. Field test translated BCC materials		X			Local consultant, Technical Advisor, State Program Officers, State RH Coordinator
v. Finalize new BCC materials		X			Technical Advisor, State RH Coordinators, LGA PHC CM Officers
vi. Print new BCC materials and distribute to project LGAs		X			Finance and Admin Officer
vii. Develop tools for monitoring BCC activities including a adaptation of FCI's Kenya and Zambia birth preparedness and complication readiness card	X				Program Manager, CM Specialists, Technical Advisor
viii. Train project clinical trainers, LGA PHC CM Officers and community mobilization corpers on the use of the BCC materials (existing and newly developed)		X			Program manager, Program Officers, RH Coordinators
ix. Train facility-based service providers in the use of the relevant BCC materials			X		Program Officers, RH Coordinators, CM Specialists
x. Service providers initiate use of BCC materials in counseling clients at the facilities				X	Health facility service providers
xi. Train CHEWS, community group facilitators, and other community volunteers on use of relevant BCC materials	X	X	X	X	Program Officers, RH Coordinators
xii. CHEWS and community volunteers provide group and individual counseling in the community	X	X	X	X	LGA PHC CM Officers
xiii. Provide supportive supervision to Service providers, CHEWS, group facilitators and other community volunteers	X	X	X	X	Program Officers, RH Coordinators, M&E Officer
xiv. Conduct orientation with local leaders and wives	X				State CM Officers, FMOH, COMPASS, ACCESS FP B/C Advisor
xv. Training volunteers in HTSP, LAM return to fertility	X				State CM Officers, FMOH, COMPASS, ACCESS FP B/C Advisor

RESULT 6: IMPROVED MANAGEMENT OF MATERNAL AND NEWBORN SERVICES IN SELECTED LGAS

This result focuses on support and mentoring for local government health officials as well as support at this level to ensure effective implementation of ACCESS interventions. ACCESS mandate in health system strengthening is fairly limited and will focus on ensuring LGA health staff ownership and direct involvement in efforts to address EmONC in their area.

Activity Lead: Technical Advisor, Finance/Admin Officer, Program Officers
Activity Location(s): Kano and Zamfara states, Nigeria

Specific Tasks	Q1	Q2	Q3	Q4	ACCESS Staff/Partner(s)
Task 6.1: Strengthen leadership, managerial and advocacy skills of LGA Health Management Team					
i. Conduct a rapid assessment of LGA PHC capacity in program planning, implementation, monitoring and evaluation				X	Technical Advisor, Finance and Admin Officer
ii. Develop capacity plan for LGA PHC based on identified needs				X	CM Specialists, Technical Advisor, RH Coordinators, Finance and Admin Officer
iii. Provide targeted technical assistance to improve LGA HMT managerial skills	X	X	X	X	Finance and Admin Officer, Technical Advisor, ACCESS COP
iv. Meet with SMOH and LGA leadership to define criteria for identify high performing LGAs		X			SM/RH Coordinator, Program Officer, M&E Advisor, Technical Advisor, LGA PHC Directors
v. Identify existing high performing LGA HMTs in Kano and/or Zamfara			X		CM Specialists, RH Coordinators\SMOH
vi. Support exchange visits for selected members of Project LGA HMTs to identified high performing LGA HMTs		X	X		RH Coordinator\SMOH, LGA PHC Directors, ACCESS COP, Technical Advisor
vii. Project LGA HMT members who participated in exchange visit share "best" managerial practices or systems with colleagues		X	X	X	M&E Officer, Program Manager, CM Officers, RH Coordinators\SMOH
viii. Support LGA HMTs to implement recommended "best" managerial practices and/or systems	X	X	X	X	Technical Advisor, M&E Officers, CM Officers, RH Coordinators\SMOH
ix. Hold joint quarterly management meetings with LGA health management team	X	X	X	X	Community Mobilization Specialist
Task 6.2: Strengthen the necessary logistics, transport and communication systems for EmONC and FP					
i. Meet with LGA leadership to review logistic systems e.g. drugs, supplies, transport and communication	X				Finance/Admin, Technical Advisor, Program Officers, DELIVER Consultant, RH/SM Coordinator
i. Meet with LGAs and SMOH to discuss establishment of transport referral system between health facilities (including refurbishment of ambulances)	X			X	Finance/Admin, Technical Advisor, Program Officers, DELIVER Consultant, RH/SM Coordinator
ii. Support the LGA to implement the recommended emergency transport systems between facilities (e.g. ambulance revolving fund system- ARF)	X	X	X	X	Finance/Admin, Technical Advisor, Program Officers, RH/SM Coordinator
iv. Support the LGA to implement the recommended emergency communication systems between facilities (e.g. allow mobile phone vendors for 24/7 in facilities; two- way radios)	X	X	X	X	Finance/Admin, Technical Advisor, Program Officers, RH/SM Coordinator
Task 6.3: Improve supervision and support of standards-based management and recognition (SBM-R) of EmONC and FP services					
i. Meet with SMOH/LGA to adapt supervision tools for EmONC and FP and agree on supervision schedules	X				Technical Advisor, Program Officers, LGA Health Department Supervisors
ii. Update SMOH/LGA health department supervisors and facility in-charges in supportive supervision				X	Technical Advisor, Program Officers, LGA Health Department Supervisors
iii. Meet with LGA and SMOH officials to agree on mechanisms for strengthening transportation for supervision				X	Technical Advisor, Program Officers, LGA Health Department Supervisors

iv.	SMOH/LGA implement agreed supervision transport plan	X	X	X	X	LGA PHC Community Mobilizers, Program Officer
v.	Conduct joint ACCESS/LGA supervision visits	X	X	X	X	RH/SM Coordinators, LGA PHC Community Mobilizers
Task 6.4: Recognize high performing EmONC and FP champions, communities and facilities						
i.	Meet with FMOH, SMOH and LGA officials to set the minimum EmONC and FP standards for recognition and accreditation of health facilities as centres of quality service	X				Program Officers, Program Manager, SMOH/LGA Health Department Supervisors
ii.	Participate in State SMC meeting to set criteria for recognizing individuals as champions of quality improvement in EmONC and FP	X				Program Officers, Program Manager, SMOH/LGA Health Department Supervisors
iii.	Monitor SBM-R performance of ACCESS supported facilities to identify those meeting set accreditation criteria	X				Program Officers, Program Manager, SMOH/LGA Health Department Supervisors
iv.	Meet with SMOH and corporate bodies (MTN, Globacom etc) and NGOs to leverage resources for rewarding high performing facilities and individuals	X				Program Officers, Program Manager, SMOH/LGA Health Department Supervisors
v.	Design and produce reward certificates and plaques for high performing sites	X				Program Officers, SMOH/LGA Health Department Supervisors
vi.	Support public recognition events to reward high performing facilities and individuals	X				Program Officers, Social Mobilizers, SMOH/LGA Staff, Corporate organizations
Task 6.5: Strengthen health management information system relevant to EmONC and FP						
i.	Review of LGA EmONC and FP HMIS including forms and registers to identify gaps	X				Program Manager, Program Officer, Technical Advisor, CM Officer, RH Coordinator/SMOH, SMOH M&E Officer, LGA PHC Director, FMOH
ii.	Meet with LGA HMT and hospital management team to discuss HMIS, review results and suggested recommendations	X				Program Officers, HSDP staff, SMOH and LGA M&E Officers, RH Coordinator, LGA PHC Director
iii.	Revise LGA HMIS forms and registers [What about federal facilities which must report to the State, not the LGA?]		X			Health Facility in-charge
iv.	Produce new EmONC and FP HMIS forms and registers		X			ACCESS COP
v.	Orient health facility in-charges and unit heads to the new forms and registers {Will this included non-ACCESS facilities as well/}			X		Technical Advisor
vi.	Distribute new forms and registers to health facilities {Will this included non-ACCESS facilities as well/}			X		SMOH and LGA M&E Officers
vii.	Provide on-job training to other facility staff on use of new forms and registers		X	X	X	SMOH and LGA M&E Officers
viii.	Review/develop existing community based data collection tools	X				SMOH and LGA M&E Officers, Technical Advisors
ix.	Develop simple data analysis and decision-making form for health facilities	X				SMOH and LGA M&E Officers, Technical Advisor
x.	Train health facility management committee members on use of the analysis and decision-making form	X				SMOH and LGA M&E Officers, Technical Advisor
xi.	Produce new community-based EmONC and FP HMIS forms and registers		X			ACCESS COP

xii. Orient ward and village health committee members to the new forms and registers		X			Technical Advisor
xiii. Distribute new community-based forms and registers to health facilities			X		SMOH and LGA M&E Officers
xiv. Provide on-job training to CHEWS and community volunteers on use of new forms and registers			X		SMOH and LGA M&E Officers
xv. Develop simple data analysis and decision-making form for community				X	SMOH and LGA M&E Officers, Technical Advisor
xvi. Train ward, village and community groups on use of the analysis and decision-making form				X	SMOH and LGA M&E Officers, Technical Advisor

ACCESS Program Results Framework

SO15: Increased use of child survival and reproductive health services
Program Objective: Increased utilization of EmONC services by pregnant women, mothers, and newborns at selected LGAs in two states
Key Indicators:

- % of births attended by skilled health personnel [C 33.1]
- % of caretakers seeking care from skilled care providers for sick newborns
- % of pregnant women who received at least 4 antenatal care visits [C 33.2]
- Couple-years of protection (CYP) [C 34.1]
- # /% of postpartum women using contraception (including LAM) 6 weeks postpartum

IR 15.1: Improved quality of child survival and reproductive health services

IR 15.2: Strengthened enabling environment

IR 15.3: Expanded demand for improved child survival and reproductive health services

IR 15.4: Increased access to child survival and reproductive health services

ACCESS Result #4 Sub-IR.1
 Improved quality of family planning services in selected LGAs

Indicators

- # / % of women delivering in ACCESS-supported facilities receiving postpartum FP counseling
- % of providers trained in FP who are performing according to standards

ACCESS Result #3 Sub-IR.2
 Improved quality of EmONC services in selected LGAs

Indicators:

- # of buildings (clinics) rehabilitated/built [C 20.9]
- % of health facilities using SBM-R approach for performance improvement
- % of births at ACCESS-supported facilities with active management of the third stage of labour
- % of women with eclampsia managed according to protocol in ACCESS-supported facilities
- % of births at ACCESS-supported facilities for which the partograph was used

ACCESS Result #1 Sub-IR.3
 Improved enabling environment for scale-up of EmONC best practices at national and state levels

Indicators

- Training curricula and strategy for pre-service midwifery education revised and implemented in Kano and Zamfara states
- Operational performance standards for EmONC developed and distributed
- National KMC policy and guidelines developed and distributed in ACCESS-supported facilities

ACCESS Result #6 Sub-IR.4
 Improved management of maternal and newborn services in selected LGAs

Indicators

- % of BEmONC facilities experiencing no stockouts of essential EmONC drugs in the last 3 months

ACCESS Result #5 Sub-IR.5
 Increased demand for maternal and newborn services in selected LGAs

Indicators

- # of beneficiaries of community activities [C 20.10]
- # of community committees that have work plans that include activities to reduce maternal and newborn deaths, including promoting birth spacing.
- # of communities with plans that include emergency funds and/or a transport system for maternal and newborn complications

ACCESS Result #2 Sub-IR.6
 Increased availability of EmONC and FP health care workers in selected LGAs

Indicators

- % of births in target LGAs delivered by Caesarean section
- # of health facilities per 500,000 population in ACCESS-supported LGAs providing essential obstetric and newborn care
- % of births with complications treated at EmONC facilities
- # of persons trained in maternal and newborn care [C 33.5]
- # of ACCESS-supported health facilities providing postpartum FP counseling and services
- # of women reached through postpartum FP counseling and services

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)
USAID/Nigeria SO 15: Increased use of child survival and reproductive health services							
ACCESS LOP Objective: Increased utilization of quality EmONC services by pregnant women, mothersnewborns at selected LGAs in two Nigeria states, Kano and Zamfara							
1. <i>Births attended by skilled health personnel [C 33.1]</i>	<p>Definition: Number of births in past 12 months attended by a skilled health professional / Total number of live births in past 12 months</p> <p>Unit of measurement: Percentage</p>	Baseline and endline survey reports	Population-based survey	Baseline, and End-of-Program (September 2006 and June 2009)	SO 15 Team	Baseline, and End-of-Program	SO 15 Team ACCESS State and LGA stakeholders
2. <i>Caretakers of sick newborns who sought care from a skilled provider</i>	<p>Definition: Number 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)	SO15 Team	Baseline and End-of-Program survey	SO15 Team ACCESS State and LGA 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)
3. <i>Pregnant women who received at least 4 antenatal care visits [C 33.2]</i>	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 15 Team	Baseline and End-of-Program Annual	SO 15 Team ACCESS State and LGA stakeholders
4. Couple Years of Protection	Definition: An estimate of the protection against pregnancy provided by ACCESS-supported FP services during a period of one year, based upon the volume of all contraceptives sold or distributed free of charge to clients during the year Unit of measurement: Number	ACCESS Program Annual Report	Service statistics/facility record review	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
5. <i>Postpartum women using contraception (including LAM) 6 weeks postpartum</i>	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)	SO15 Team	Baseline, and End-of-Program	SO15 Team ACCESS State and LGA stakeholders
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.							

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)
1. Women receiving postpartum FP counseling at ACCESS-supported facilities	<p>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</p> <p>Unit of measurement: Percent</p>	ACCESS program reports	Service statistics/ facility record review	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
2.Trained providers performing FP services to standards	<p>Definition Number of providers trained in FP observed to be performing to standard/ Total number of providers trained in FP observed</p> <p>Standard here refers to (National FP protocol , international FP standards (e.g., WHO) and SBM/R standards once developed)</p> <p>Unit of measurement: Percent</p>	ACCESS program reports	Facility survey Supervisory/Observation checklist	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
Sub-IR 2 (ACCESS Result 3): Improved quality of EmONC services in selected LGAs							
1.Buildings (clinics) rehabilitated/built [C 20.9]	<p>Definition: Number of buildings rehabilitated/built (for ACCESS this refers to clinics/health facilities rehabilitated/rennovated, not built)</p> <p>Unit of measurement: Number</p>	ACCESS program reports	Review of program records Certification/ documentation issued for rehabilitated buildings	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA 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)
2. Health facilities using SBM-R approach for performance improvement	Definition: Number of health facilities using SBM-R approach Unit of measurement: Number	ACCESS Program reports	SBM Observation checklist	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
3. Use of active management of the third stage of labor (AMSTL)	Definition: Number of births in the past month at ACCESS-supported facilities where active management of the third stage of labor (AMSTL) was applied/Total number of births at ACCESS-supported facilities in the past month Unit of measurement: Percent	ACCESS Program reports	Service statistics/facility record review	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
4. Management of women with eclampsia in ACCESS-supported facilities	Definition: Number of eclamptic women seen in ACCESS facilities in the past month managed according to protocol/ Total number of eclamptic women seen in ACCESS facilities in the past month Unit of measurement: Percent	ACCESS Program reports	Service statistics/facility record review	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
5. Births at ACCESS-supported facilities where a partograph was used	Definition: Number of births with partograph in the past month / total number of births in the past month Unit of measurement: Percent	ACCESS Program reports	Service statistics/facility record review	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
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.							

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)
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	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
2. Operational performance standards for EmONC developed and distributed	Definition: Number of Operational Performance Standards for EmONC distributed to ACCESS-supported facilities Unit of measurement: Number	ACCESS Program reports	Operational performance standards document, Distribution list	Once	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
3. National KMC policy and guidelines developed and distributed in ACCESS-supported facilities	Definition: Number of National KMC policy and guidelines developed and distributed to ACCESS-supported facilities Unit of measurement: Number	ACCESS Program reports	KMC policy and guidelines	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
Sub-IR 4 (ACCESS Result 6). Improved management of maternal and newborn services in selected LGAs							

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)
1. Stockouts of essential EmONC drugs in BEmONC facilities	<p>Definition: Number of BEmONC facilities that reported no stock out on essential drugs in the previous three months/Total number of BEmONC facilities</p> <p>Essential EmONC drugs include: oxytocin, magnesium sulfate, gentamycin, SP, TT</p> <p>Unit of measurement: Percent</p>	ACCESS Program reports	<p>Review of facility records, SBM-R/Supervision reports,</p> <p>Also Facility survey (baseline and endline)</p>	Annual	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
USAID/Nigeria IR 15.3: Expanded demand for improved child survival and reproductive health services							
Sub-IR 5 (ACCESS Result 5): Increased demand for maternal and newborn services in selected LGAs.							
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	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA 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)
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	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
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	SO15 Team	Annual	SO15 Team ACCESS State and LGA stakeholders
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							

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)
1. <i>Caesarean sections as a percentage of all births</i>	Definition: Number of caesarean sections in LGA CEmONC facilities / total number of all expected births in LGA (Recommended: between 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	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
2. <i>Health facilities per 500,000 population providing essential obstetric and newborn care</i>	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 15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
3. <i>Births with complications treated at EmONC facilities</i>	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	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
4. Maternal Health Capacity Building [C 33.5]	Definition: Number of people trained on maternal (and newborn) disaggregated by type of training Unit of measurement: Number	ACCESS Program reports	Training information monitoring system (TIMS®)	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA 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)
5. Health facilities providing postpartum FP counselling and services	<p>Definition: Number of ACCESS-supported health facilities providing postpartum family planning counseling and services</p> <p>Unit of measurement: Number</p>	ACCESS Program reports	ACCESS program record review Service statistics/Facility record review	Quarterly	SO15 Team	Quarterly	SO15 Team ACCESS State and LGA stakeholders
6. Women reached through postpartum FP counseling and services	<p>Definition: Number of women who delivered (in the past 12 months) who received postpartum family planning counseling and services</p> <p>Unit of measurement: Number</p>	Baseline and endline survey reports	Population-based survey	Baseline, and End-of-Program (September 2006 and June 2009)	SO 15 Team	Baseline, and End-of-Program	SO15 Team ACCESS State and LGA stakeholders

South Africa
ACCESS Field Representative: Lunah Ncube
US-based ACCESS Contact Person: Amy Rial
Year 3 Funding Amount and Sources: PEPFAR \$600,000
ACCESS Partners: JHPIEGO
Other Collaborating Organizations: South African National Department of Health, Johns Hopkins Health and Education in South Africa (JHESA)

Program Approach

As the first country in Africa to attempt to provide life-saving anti-retroviral therapy (ART) to those eligible, South Africa is faced with the enormous task of providing treatment, care and support to more than 5.3 million persons living with HIV/AIDS (PLWHA) and their family members. More than 120 partners, mostly South African entities, along with the support of the international community, contribute to the efforts of the President's Emergency Plan for AIDS Relief (PEPFAR) as administered by the Office of the Global AIDS Coordinator (OGAC) and United States Government (USG) bodies operating in South Africa. As a PEPFAR contributor since 2003, JHPIEGO has been supporting the rollout of ART and other HIV/AIDS services, and will continue to do so under ACCESS Program Year Three. Working in close collaboration with the South African National Department of Health (NDOH) and Provincial Departments of Health (PDOHs), JHPIEGO will build on interventions that were implemented from FY04 to the present. These include dissemination of National HIV/AIDS related Guidelines, introduction of Standards-Based Management and Recognition (SBM-R) approach to improve quality of ART services, in support for Training Information Monitoring Systems (TIMS).

Achievements PY02

This is a new program in PY03.

Summary of Activities PY03

PY03 Planned Outputs

- Standards Based Management and Recognition in place and functioning at 5 ART sites in the Gauteng Province of South Africa
- TIMS functioning at three Regional Training Centers (RTC) in South Africa (Northern Cape, Mpumalanga, and Limpopo Provinces)
- Orientation Packages for National Health Care worker Guidelines and Continuum of Care Guidelines developed
- National Health Care Worker Guidelines and Continuum of Care Guidelines disseminated to the provincial level

Program Management

Lunah Ncube, JHPIEGO's Country Program Manager in South Africa, will be responsible for day-to-day management of field activities including coordination with USAID South Africa and National/Provincial Departments of Health and for capturing of program results. She will be backstopped by Amy Rial, JHPIEGO's Senior Field Program Manager for South Africa

JHPIEGO will contract to the Johns Hopkins Health and Education in South Africa (JHHESA) to support implementation of activities in South Africa. JHHESA is a fully registered and recognized South African NGO representing several Johns Hopkins Institutions in South Africa including JHPIEGO, the Johns Hopkins Center for Communications Programs (JH/CCP) and the Johns Hopkins Bloomberg School of Public Health. JHHESA will handle all human resource, contractual, and logistical implications of project implementation.

ACTIVITY 1 USING STANDARDS-BASED MANAGEMENT TO IMPROVE THE QUALITY OF ART SERVICES IN GAUTENG PROVINCE

Activity Lead: Lunah Ncube

Activity Location(s): Gauteng Province, South Africa

In 2005 and 2006, JHPIEGO worked with the Foundation for Professional Development (FPD) in South Africa and personnel of ART facilities in the Gauteng Province to develop performance standards for ART. These standards are the foundation for implementation of the SBM-R approach for ensuring quality and sustainability for the rollout of ART in South Africa.

With completion of the standards, JHPIEGO and FPD will work to complete a baseline measurement of actual performance and use this measurement to identify performance gaps in the services provided. Working with site personnel and ART stakeholders, including representatives of PLWHAs groups, JHPIEGO will lead this group through the process of root cause analysis and design of interventions to remedy performance gaps.

Throughout FY07, JHPIEGO will support continuous measurement at each site to determine changes in the level of improvement in performance standards at all sites to track progress over time. JHPIEGO will also work to integrate this process into site supervision, both through self-assessments, internal assessments and external assessments. This process ensures sustainability of quality services as it acknowledges a multi-dimensional supervision system starting with self, clients, peer and site, as well as external supervision.

As this process proceeds, JHPIEGO will work with FPD to implement interventions and will begin the process of discussing recognition systems to reward high-performing sites.

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Baseline measurement of actual performance	JHPIEGO	October 2006
Task 2: Conduct root cause analysis and design of interventions	JHPIEGO	January 2007
Task 3: Implement Interventions to improve quality of services	JHPIEGO	July 2007
Task 4: Support ongoing measurement of actual performance	JHPIEGO	September 2007

ACTIVITY 2: BUILD A FOUNDATION FOR DISSEMINATION OF NATIONAL HIV/AIDS GUIDELINES

Activity Lead: JHPIEGO

Activity Location(s): National Coverage

Using the model previously employed in 2005 and 2006 in dissemination of National ART and Palliative Care guidelines, JHPIEGO will build the foundation for dissemination of National Health Care Worker Guidelines for HIV/AIDS and Continuum of Care for HIV/AIDS. These guidelines are particularly important at this time as they support South Africa's move to integrate ART with primary health care at the PHC level. This approach includes development of user-friendly orientation packages that facilitators and service providers use as a tool for orienting themselves to the content of the guidelines. It includes practical exercises related to content and encourages providers to examine their values and judgments as they relate to HIV/AIDS care.

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Develop Orientation Packages for Health Care Worker Guidelines for HIV/AIDS and Continuum of Care	JHPIEGO	December 2006
Task 2: Orient Provincial teams and build facilitation skills for dissemination of National Guidelines.	JHPIEGO	September 2007

ACTIVITY 3: INSTALL AND SUPPORT TRAINING INFORMATION MONITORING SYSTEMS (TIMS) IN THREE REGIONAL TRAINING CENTERS

Activity Lead: JHPIEGO

Activity Location(s): Northern Cape, Limpopo, and Mpumalanga

TIMS is a computer-based tool that permits program managers to collect and analyze data on training activities. As most training activities in South Africa occur within decentralized settings, it is currently difficult to calculate both the number of training activities and their geographical reach. TIMS allows program managers to capture these data, and use it to improve allocation of resources and provider deployment, as well as inform policy decisions. Since 2003, JHPIEGO has been working with the NDOH, *Hope Worldwide*, and the Eastern Cape RTC to improve analysis of training information by installation and use of TIMS.

In FY07, JHPIEGO will roll out the installation and support TIMS at three additional regional training centers including the RTC in Northern Cape, Mpumalanga, and Limpopo, assisting provinces to track the TB/HIV training for provincial health providers. JHPIEGO will assist the sites to move from data collection for reporting only, to use of data for deployment, determining training needs and program management as well.

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Orient personnel at Regional Training Centers in Northern Cape, Mpumalanga, and Limpopo to TIMS and prepare them for day-to-day use and management (identification of equipment and personnel).	JHPIEGO	December 2006
Task 2: Work with site personnel to customize TIMS forms and to install the system	JHPIEGO	March 2007
Task 3: Provide on-going support and trouble shooting for newly installed TIMS at Regional Training Centers in Northern Cape, Mpumalanga, and Limpopo.	JHPIEGO	September 2007

ACTIVITY 4: SUPPORT TO THE SOUTH AFRICAN NDOH

Activity Lead: JHPIEGO

Activity Location(s): National Coverage

Since 2003, JHPIEGO has been providing support for a senior HIV/AIDS specialist seconded to the NDOH's Treatment Care and Support Unit. In 2006, a similar request was made to support a PLWHA coordinator. In FY07, JHPIEGO will continue to support these two HIV/AIDS experts

as consultants to the TCS Sub-directorate to help with the transfer of learning in treatment, care and accreditation of sites to provide ARV services, and to develop national programs that support PLWHA.

Specific Tasks	ACCESS Partner(s)	Completion Date
Task 1: Support a senior technical advisor at the NDOH Treatment, Care, and Support and a national coordinator for PLWHA.	JHPIEGO	September 2007

Timeline

Timeline of Activities	Months											
	O	N	D	J	F	M	A	M	J	J	A	S
Activity 1: Using SBM-R to improve quality of ART services												
Task 1: Baseline measurement of actual performance	X	X	X									
Task 2: Conduct root cause analysis and design of interventions				X	X	X						
Task 3: Implement Interventions to improve quality of services							X	X	X			
Task 4: Support ongoing measurement of actual performance										X	X	X
Activity 2: Dissemination of National HIV/AIDS Guidelines												
Task 1: Develop orientation packages for Health Care Worker Guidelines for HIV/AIDS and Continuum of Care	X	X	X	X	X	X						
Task 2: Orient provincial teams and build facilitation skills for dissemination of national guidelines.							X	X	X	X	X	X
Activity 3: Support for TIMS												
Task 1: Orient personnel at Regional Training Centers in Northern Cape, Mpumalanga, and Limpopo to TIMS and prepare them for day-to-day use and management (identification of equipment and personnel)	X	X	X									
Task 2: Work with site personnel to customize TIMS forms and to install the system				X	X	X						
Task 3: Provide on-going support and trouble shooting for newly installed TIMS at Regional Training Centers in Northern Cape, Mpumalanga, and Limpopo.							X	X	X	X	X	X
Activity 4: Support to the South African NDOH:												
Task 1: Support a senior technical advisor at the NDOH Treatment, Care, and Support and a national coordinator for PLWHA	X	X	X	X	X	X	X	X	X	X	X	X

Performance and Monitoring Plan

Indicator	Definition/Calculation	Data source/Collection Method	Frequency of data collection	Responsible party
<i>USAID/South Africa (PEPFAR): Support anti-retroviral therapy for 2 million HIV-infected individuals</i>				
<i>USAID/South Africa (PEPFAR): Support care for 10 million individuals infected and affected by HIV/AIDS, including orphans and vulnerable children</i>				
<i>ACCESS Program Result: Prevention and treatment of priority health problems of non-pregnant women of reproductive age</i>				
Total number of health workers trained to deliver ART services, according to national and/or international standards (PEPFAR)	Health Care workers are those individuals involved in management or delivery of HIV/AIDS services at the provincial, district, or service delivery level (nurses, doctors, HIV/AIDS managers, etc). These services will include any aspect of HIV/AIDS care and continuum of care. Standards are set by the South Africa NDOH	Participant registration forms	Semi-annual	Lunah Ncube - ACCESS
Number of local organizations provided with technical assistance for strategic information activities (PEPFAR)	Local organizations include regional training centers operating in any one of four targeted provinces in South Africa (Eastern Cape, Mpumalanga, Northern Cape, and Limpopo) and National TB and PMTCT units. In this instance, strategic information refers to the capture of training data.	Activity reports/ Consultant reports	Semi-annual	Lunah Ncube – ACCESS
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS) (PEPFAR)	Individuals refer to those individuals involved in the management and use of TIMS at Regional Training Centers and the National PMTCT and TB units at the NDOH. Training involves data entry, cleaning, running reports, trouble shooting, and analyzing training data.	Activity reports/ Consultant reports	Semi-annual	Lunah Ncube - ACCESS
Proportion of ART facilities targeted for SBM-R achieving 85% of performance standards	This is the number of ART facilities targeted for SBM-R achieving 85% of performance standards divided by the total number of ART facilities using the SBM-R approach	Performance standards	Semi-annual or annual	Lunah Ncube - ACCESS

Tanzania
ACCESS Field Representative: Emmanuel Rwamushaija, Country Director
US-based ACCESS Contact Person: Natalie Kuzmerski, Program Officer
Ministry of Health and Social Welfare Partners: Reproductive and Child Health Section, National Malaria Control Program, National AIDS Control Program, Human Resources Directorate Department, Health Services Inspectorate Unit
Other Collaborating Organizations: White Ribbon Alliance, Christian Social Service Commission and other Tanzanian Faith-Based Organizations delivering ANC/MIP services

Background

According to the most recent DHS survey, maternal and newborn health remains a critical public health concern in Tanzania with a maternal mortality ratio of 578/100,000 and an infant mortality rate of 68/1,000 live births (2005 DHS). Malaria specifically has been singled out as a major contributing element to this high maternal and neonatal morbidity and mortality. In 2003, there were over 10 million reported cases of malaria in Tanzania and every year, an estimated 1.7 million pregnant women suffer from malaria. Approximately 20% of maternal deaths in Tanzania are linked to malaria. As a result, Tanzania was selected as one of the first countries of intervention for the Presidential Malaria Initiative (PMI) which began in Fiscal Year 2006 and is administered by the USAID mission in Tanzania.

Having worked in partnership with the Ministry of Health and Social Welfare (MOHSW) of Tanzania for the past two years on developing and implementing Focused Antenatal Care (FANC) as a best practice, ACCESS is in a unique position to assist the MOHSW and USAID in meeting their objectives of addressing malaria prevention and control and have significant impact on malaria in pregnancy. FANC is the WHO-supported strategy of utilizing the antenatal care platform in order to integrate key interventions such as the prevention of malaria in pregnancy through intermittent preventative treatment (IPT) and promoting use of insecticide treated nets (ITNs), testing and treatment of syphilis in pregnancy, infection prevention, and creating links to PMTCT services.

Achievements to date

Beginning 2004/5 the main focus of ACCESS activities in Tanzania has been supporting the MOHSW to institute the national policy of providing all pregnant women with Focused ANC services. ACCESS has supported the MOHSW to use a cascading approach for developing trainers who can effectively disseminate knowledge and skills in FANC to other in-service providers. In Year 2004/5 training was targeted to providers working in facilities where PMTCT training was occurring, but in Year 2005/6 the implementation strategy shifted to ensure complete coverage of each region entered. Furthermore, ACCESS in collaboration with the MOHSW updated trainers from ten districts in the Arusha and Manyara Regions on FANC at the request of CEDHA and RCHS. In a complementary program, ACCESS has been working with pre-service educational programs (both nurse-midwifery schools and their affiliated clinical sites) to institute FANC as part

of the curricula so that new midwives emerge with these essential skills for addressing MIP and providing quality antenatal care. Training at both levels, in-service and pre-service, was followed up using an ANC quality improvement approach. In addition, at the request of the MOHSW/RCHS, ACCESS supported the development of a standardized Facilitator's Guide on training for FANC which is in its final stages. To increase coordination among efforts to address malaria in Tanzania, ACCESS also worked with CEEMI (Center for Enhancement of Effective Malaria Interventions) last year, providing technical assistance to CEEMI's objective of developing District-level Malaria/IMCI Focal Persons. Finally, ACCESS both supports and houses the Tanzania chapter of the White Ribbon Alliance which was created in 2004. The list below gives specific achievements under each activity:

Training of in-service providers to address Malaria in Pregnancy through FANC

- Comprehensive coverage of all districts in four regions with training of FANC/MIP trainers (Morogoro, Pwani, Kagera, and Dar es Salaam regions), plus 24 scattered facilities from Year 2004/5. Two ANC service providers from each hospital in the district along with the District Reproductive and Child Health Coordinator (D-RCH Coord.) were updated to the FANC/MIP content as well as developed as trainers. A total of 21 districts in the four regions mentioned above have at least four FANC/MIP trainers. These trainers have trained providers in their own facilities as well as from selected surrounding facilities targeting all hospitals, all health centers and selected dispensaries in each district.
- A total of 90 FANC/MIP trainers have been developed to implement the cascade approach to training of ANC providers on FANC/MIP
- Currently, 364 Reproductive Health providers out of approximately 6000 nationally have been updated by ACCESS in IPT/ITN/FANC skills

Training for pre-service diploma level nurse-midwifery schools to address Malaria in Pregnancy through FANC

- 25 certificate-level schools—50 tutors and 50 clinical preceptors—updated programs to include FANC (100% coverage)
- 15 diploma, advanced diploma and degree schools have been introduced to FANC (50% coverage).
- Developed FANC curriculum draft for learning resource package for diploma and higher schools

Implementation of a standards-based ANC quality improvement approach for performance and quality improvement of FANC to address Malaria in Pregnancy

- Facilitated baseline assessments in 64 facilities and conducted follow-up assessments in 15 facilities which showed improvements in quality care

Technical Assistance to CEEMI in the training of District Malaria/IMCI Focal Persons (DMIFPs)

- Supported CEEMI to organize a 10-day workshop for CEEMI trainers to improve their training skills for application in training of District Malaria/IMCI Focal Persons (DMIFPs)
- Supported CEEMI in conducting a performance assessment of the DMIFPs and to recognize gaps for improving training
- Supported CEEMI to organize instructional design workshop for CEEMI trainers to develop the Malaria in Pregnancy portion of the DMIFP training curriculum

Support to the White Ribbon Alliance for Safe Motherhood

- Supported WRA activities to develop advocacy package on human resources
- White Ribbon Day for mobilizing stakeholders and national community to address Safe Motherhood

Limitations

While ACCESS and the MOHSW have been able to achieve much success over the last two years, there are still a number of barriers that may cause delays in full scale up of FANC. Examples of these barriers include the shortage of skilled providers in Tanzania and the lack of adequate ANC equipment and supplies at some health facilities. Both of these challenges hinder implementation of the service standards according to national guidelines. Additionally, there was limited initial involvement of some technical groups in the program approach, such as gynecologists, which resulted in inadequate support to the focused ANC approach. Over the course of the program period (until 2009), the MOHSW and ACCESS will retain a certain degree of flexibility in their programming in order to address these and other barriers to implementation as they arise.

Summary of Planned Activities for Program Year 2006/7

With an increase of about 50% in funding this year, ACCESS is supporting the MOHSW to implement a strategy to comprehensively scale-up interventions to improve the quality of antenatal care services with a major focus on the prevention and control of malaria in pregnancy. The ultimate objective, over the next three years, is to achieve national coverage. Consistent with PMI and the MOHSW's Mid-Term Strategic Plan goals, ACCESS and the MOHSW expect Tanzania to achieve increased utilization of FANC services nationally, including 85% uptake of IPT in ACCESS-supported facilities by 2009.

The MOHSW in partnership with ACCESS has developed a comprehensive plan to address Malaria in Pregnancy in the area of service delivery in public and private sites including FBOs. Providers will be targeted with training on the correct administration of IPT with SP through FANC training and continuous supportive supervision. In addition, pre-service midwifery institutions will be strengthened to effectively integrate FANC into their educational curricula and clinical practice. Finally, ACCESS will continue to partner with the White Ribbon Alliance to advocate for change at a policy level for Safe Motherhood and support the WRA in their activities bringing national awareness to issues such as malaria in pregnancy.

Year 2006/7 Planned Outputs

- All Zonal and Regional RCHS Coordinators oriented to the FANC Training Package and the FANC Facilitator's Guide
- About 300 existing FANC trainers will receive updates in FANC clinical and teaching skills
- At least 15 Zonal and Regional RCHS Coordinators and FANC trainers affiliated with FBO developed as supervisors for FANC
- Regional Medical Officer, District Medical Officers, Regional Nursing Officers, District Nursing Officers, Hospital Medical Officer-in-Charge, Matrons, District Malaria and IMCI Focal Persons, District Planning Officers, District Pharmacist, Zonal MSD Coordinator and other stakeholders from the 12 regions oriented on FANC/MIP and the ANC quality

improvement approach. These will include Arusha, Manyara, Iringa and Ruvuma representatives for CEDHA, PHCI ZTCs

- The table below highlights the estimated numbers of providers, facilities, and districts/regions that ACCESS plans to support the MOHSW to cover with FANC training over 2006 to 2007. Some of this work may span into 2007/8.

Estimated Number of Providers trained in FANC	Estimated Number of Facilities (both public and private including FBO)	Estimated Number of Regions covered with FANC training	Estimated Number of Districts covered with FANC training
1585	550	13 = (4 Y2 + 6 Y3 + Arusha, Manyara, Iringa)	90

- 90 districts x 4 trainers = 360 plus other FANC/MIP trainers to be identified by RCHS trained to implement ANC quality improvement process
- Baseline assessments completed for all hospitals newly trained in FANC
- Action plans and solutions to be developed through ANC quality improvement process based on gaps identified during quarterly assessments and meetings held for at least 60 facilities from Years 2004/5 and 2005/6
- Development of ANC quality improvement database for the facilities to record quarterly assessment results and service statistics
- Development of quality improvement tools for assessing and improving quality of pre-service teaching
- At least 40 pre-service tutors, Zonal Training Center representatives and national representatives oriented on quality improvement tools for pre-service teaching
- All Medical Officer In-charges/hospital matrons and principals of diploma, advanced diploma and degree nurse-midwifery schools oriented to methods of strengthening clinical and classroom linkages in pre-service education for conducive learning environments
- 30 pre-service tutors and 30 clinical preceptors for diploma and higher level institutions trained in FANC; 60 pre-service tutors and 30 clinical preceptors for diploma and higher level institutions provided with updated classroom teaching skills and or clinical instruction and coaching skills
- Situational report on stock outs of SP and other essential ANC supplies based on quarterly facility data including a list of recommendations and strategies for addressing identified gaps
- Advocacy meetings in 6 districts with White Ribbon Alliance Core Committee members and CHMTs on human resources
- National White Ribbon Day event

Program Management

ACCESS/Tanzania has been steadily growing over the past two years. Year 2006/7 is the largest program to be implemented to date. In order to address the needs of this program, ACCESS will continue to expand its staff and operations. In 2005/6, ACCESS outgrew its office space and

moved to a new, larger building. In addition, to supplement the vehicle donated by USAID, ACCESS purchased a second vehicle to assist in transporting staff and materials out to the field. The vehicles have been very useful in reducing overall transport costs and time spent traveling to implementation sites.

For Year 2006/7, ACCESS has developed a staffing plan to address the significant increase in activities to be implemented in order to achieve our objectives. This staffing plan relies heavily on joint planning and joint implementation of activities with RCHS, NMCP, HSIU, HRDD and NACP. ACCESS proposes filling the following positions: Midwifery Advisors, Faith-based Coordinator, Monitoring & Evaluation Officer, Data Collection and Evaluation Specialist, 2 Finance Officers, and Driver. The Midwifery Advisors will work with the MOHSW at all levels including CHMTs in planning and managing all training and follow-up quality improvement activities for in-service FANC/MIP services. In addition, they will support other activities such as the pre-service or other clinical training work, as needed. The Faith-based Coordinator will be hired by IMA, one of the ACCESS partners, but will sit with the rest of the ACCESS staff in the JHPIEGO office. The Faith-based Coordinator will be responsible for all activities dealing with faith-based organizations and networks, and will also ensure that the ACCESS IPT/ITN/FANC activities are reaching FBO facilities as planned. The Faith-based Coordinator will also lead activities directly related to leveraging FBO networks for increased awareness regarding Malaria in Pregnancy. The Monitoring & Evaluation Officer will be based at the MOHSW but will be supported by ACCESS. Serving both the NMCP and the RCHS data reporting needs, the Monitoring and Evaluation Officer will offer technical assistance to both sections on monitoring FANC training and service activities as well as serve as a daily link between the MOHSW and the ACCESS Tanzania office. The Data Collection and Evaluation Specialist will lead all ACCESS-specific data collection to facilitate quarterly reporting to USAID for PMI. The Data Specialist will also have oversight on the current Training database and will collect and analyze information on quality improvement assessments from participating facilities. ACCESS has identified the need for two additional Finance Officers to provide accounting assistance to the current Finance Manager. Due to the large number of trainings and activities that will be occurring simultaneously, additional financial staff is needed to ensure adequate accounting. Finally, ACCESS plans to acquire one additional vehicle this year and will need to hire a Driver, accordingly.

Finally, the number of trainings needed to effectively scale up Focused ANC in Year 2006/7 is a major undertaking. In discussions with the MOHSW, it was agreed that ACCESS will closely collaborate with Zonal, Regional and District RCH Coordinators and other national FANC trainers, who will serve as point persons for FANC training within their geographic areas. Other key partners in training will be the Zonal and Regional CSSC (Christian Social Services Commission) trainers and staff at the Zonal Training Centers (ZTCs).

ACTIVITY 1: BUILDING NATIONAL CAPACITY FOR FANC/MIP TRAINING, INCLUDING IPT AND PROMOTION OF ITNS

This activity is the continuation of efforts to bring current service providers throughout the country up-to-date on providing Focused ANC services to all pregnant clients including IPT, promotion on the use of ITNs, testing and treatment for syphilis in pregnancy, infection prevention, and creating a link to PMTCT.

Recent changes and new evidence on malaria in pregnancy have led the MOHSW with ACCESS support to revise and update its current FANC/MIP Orientation Package which will be used in all FANC/MIP training. Since the bulk of the revision work took place in Year 2005/6, the revised package will be printed and made available for use by December 2006. Utilizing the updated FANC/MIP package and other materials, ACCESS will support the MOHSW to begin Year 2006/7 by building partnerships. More specifically, to organize coordination and advocacy meetings with representatives from the MOHSW –NMCP, RCHS, ZTCs, Local Government at District level as well as CSSC at varying levels and ACCESS. The coordination meetings lead by the MOHSW will bring together all FANC/MIP scaling up partners who will complement each other in achieving a national program.

Training and supervision of antenatal care are part of the Zonal, Regional and District RCH Coordinators scope of work hence the MOHSW/ACCESS partnership will work with these key personnel to update their knowledge and skills on FANC/MIP content and develop their training skills, qualifying them to lead further FANC training. In addition, there are currently approximately 300 FANC trainers in need of updates given the revised guidelines. With the list of these trainers provided by the MOHSW/RCHS, ACCESS and MOHSW will work collaboratively to ensure that all of these trainers are updated as well. Finally, understanding that approximately 48% of healthcare facilities in Tanzania are operated by faith-based organizations, MOHSW/ACCESS will partner with largest of the faith-based networks, the Christian Social Services Commission (CSSC) and other Tanzanian Faith-Based Organizations delivering ANC/MIP services in order to reach as many ANC clinics as possible. The number of FBO facilities reached in 2006/7 will be determined in collaboration with CHMTs and local FBO networks. Representatives from FBO networks identified as trainers will also be developed to lead FANC/MIP training.

Activity Lead: MOHSW: Assist. Director, RCHS & Program Manager, NMCP

ACCESS: Gaudiosa Tibajuka, Senior Midwifery Advisor

Activity Location(s): National

Specific Tasks	Participating Institutions	Completion Date
Task 1: Share and incorporate feedback on the revised ANC FANC Training Package, Quality Improvement Process, Facilitator's Guide	NMCP,RCHS, NACP,ACCESS	20 th to 25 th Nov 2006

Task 2:	Finalize FANC/MIP facilitator's guide and revised FANC Orientation Package. Print documents	NMCP,RCHS, NACP,ACCESS, ZTC	24 Dec 2006
Task 3:	Development of FANC/MIP Advocacy Package and printing	NMCP,RCHS, NACP,ACCESS, ZTC	2 nd Week Feb 2007
Task 4:	Coordination meeting with Zonal Training Centers (CEDHA, PHCI, Kigoma) and HRDD on FANC training	RCHS, HRDD, NMCP, ZTC	1st week Dec 2006
Task 5:	Meet with CSSC team (national and zonal levels) to advocate for strengthening ANC to address MIP, IPT, ITNs and to identify Zonal CSSC trainers	NMCP,RCHS, NACP,ACCESS, ZTC, HSIU	Dec 2006
Task 6:	Quarterly ACCESS/MOHSW Programme progress review meetings with IPT scale-up partners: NMCP, RCHS, HSIU, HMIS, ZTCs, CSSC, and districts representatives	NMCP,RCHS, NACP, ACCESS, ZTC, HSIU	Nov, Feb, May, Aug
Task 7:	FANC Update for all Zonal, Regional and District RCH Coordinators and the estimated 300 MOHSW FANC/MIP trainers on the revised FANC Orientation package and FANC facilitators' guide.	NMCP, RCHS, NACP, ACCESS, ZTC,	On going activity

ACTIVITY 2: COMPREHENSIVE COVERAGE OF ANC PROVIDERS WITH FANC/MIP BY REGION

While building capacity at the national level, ACCESS will simultaneously work with the MOHSW to implement more comprehensive training in selected regions. Over the next three years, following the geographic divisions of the country, ACCESS and MOHSW will move from zone to zone, covering all regions within the zone and all districts within each region. In Year 2006/7, the intervention areas will be six regions which will supplement the four comprehensively covered in Year 2005/6. Continued funding in Years 2007/8 and 2008/9 will address the remaining eight regions.

In each region, after initial advocacy meetings to introduce key stakeholders such as Regional and District Medical and Nursing Officers and hospital management teams to the FANC training materials, MOHSW and ACCESS will support the implementation of the cascading approach to FANC training by updating two trainers from an average of two hospitals per district and supporting the training for at least 50 peripheral level providers in each district (targeting all hospitals, all health centers and selected dispensaries in a district). ACCESS will support organization of the advocacy meetings with RCHS and NMCP staff. Following the Regional TOTs, the FANC trainers will be supported as they conduct FANC trainings at their hospitals for

the hospital ANC staff as well as ANC providers from health centers and dispensaries within the district. Each hospital will hold training for at least 25 providers from approximately 15 more peripheral facilities. In addition, the facilities from Year 2005/6 (the 4 regions) will be supported to hold additional trainings for another 25 providers from health centers and dispensaries within the district. In this way, MOHSW and ACCESS will ensure widespread coverage of FANC training down to the most peripheral facilities complementing CHMTs' efforts.

Activity Lead: MOHSW: MOHSW: Assist. Director, RCHS & Program Manager, NMCP
ACCESS: Gaudiosa Tibaijuka, Senior Midwifery Advisor

Activity Location(s): Year 2005/6 regions: Morogoro, Kagera, Pwani, and Dar es Salaam
Year 2006/7 regions: Kilimanjaro, Tanga, Ruvuma, Mwanza, Mara, and Shinyanga,

Specific Tasks	Participating Institutions	Completion Date
Task 1: Support for hospital-based FANC training for ANC providers from Year 2006/7 facilities (health centers and dispensaries- 6 regions). Train an additional 25 providers from 15 facilities in each district of the 4 regions of Year 2005/6	RCHS, NMCP, ACCESS, R &D –RCH Co	Ongoing
Task 2: Develop Zonal and Regional RCH Coordinators and CSSC Coordinators for selected regions as Supervisors for ANC quality improvement, (FANC/MIP clinical, teaching, supervision skills as appropriate)	RCHS, NMCP, ACCESS, R &D –RCH Co	March, May, July 2007
Task 3: Advocacy meetings in each region with Regional Medical Officer, District Medical Officers, Regional Nursing Officers, District Nursing Officers, Hospital Medical Officer-in-Charge, Matrons, District Malaria and IMCI focal persons, district planning officers, pharmacists, zonal MSD Coordinators and other stakeholders on FANC/MIP	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Ongoing
Task 4: Regional TOTs in FANC for facility-based midwife trainers	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Ongoing
Task 5: Follow-up activities of FANC/MIP trainers to document their performance and coverage in training after receiving teaching skills guided by their individual action plans	Z, R &D –RCH Co	Ongoing

ACTIVITY 3: SUPPORTIVE FOLLOW-UP OF PROVIDERS OFFERING FANC/MIP SERVICES USING AN ANC QUALITY IMPROVEMENT APPROACH

Since 2004, ACCESS has been working with the MOHSW to implement a monitoring and performance improvement methodology that emphasizes the use of standards in assuring quality care. In Year 2004/5, ACCESS and the MOHSW worked with key stakeholders to set FANC/MIP standards and develop appropriate assessment tools. In Year 2006/7, these tools will be revised to integrate updates on technical material and feedback from two years of utilization.

All FANC/MIP providers are introduced to the tool during training, but in order to better develop their capacity for carrying out assessments, ACCESS and MOHSW has supported the development of a separate four-day training where trainers are coached in the standards-based ANC quality improvement process as they conduct baseline assessments. Developing their capacity in this way ensures that they will continue to conduct self assessments for their own facilities and external assessments for others on a quarterly basis. ACCESS in consultations with RHMT and CHMT will select and strengthen model practicum sites three per region in 15 regions which will be used by FANC trainees. These should be facilities that already have some elements of quality ANC services and ACCESS will only strengthened them by adding basic equipment such as BP machines. As facilities conduct the quality improvement assessments, typically, they are quickly able to identify gaps. Providers are encouraged to focus on action and begin with simple interventions to address these gaps, achieve early results, and create momentum for change. However, once the simple gaps are addressed and remedied there frequently remain some that are more complicated. In order to tackle some of these complicated issues, facilities will be brought together to discuss their common problems and share solutions. Joining the discussions will be CHMT, RHMT representatives and other decision-makers who can offer assistance on larger systemic issues. These “lessons learned” sharing meetings are critical for collaboratively finding resolutions and keeping motivation for the quality improvement process high.

Data from the quality improvement assessments will be key in monitoring the FANC scale-up project and evaluating its effectiveness. Regional RCH Coordinators will take on the role of compiling assessment results and bringing it to annual meetings at the Zonal level, from which it can be gathered for national level results. All assessment results and service statistics will be contained within the MOHSW and ACCESS database systems.

Furthermore, examination of health facility registries and discussions with ANC providers have shown that stock outs of commodities such as SP, TT, iron and folate, and syphilis test kits continue to act as barriers to quality antenatal care. Recent GIS mapping of CSSC facilities also demonstrates that IPT is not available in the CSSC facilities. In order to better understand the issues surrounding stock outs, ACCESS will draw information from ANC quality improvement assessments conducted in 2004/5 and 2005/6 facilities. Analyzing the gaps, ACCESS will collect further information as needed and prepare a report discussing the weakest links of the logistics chain. This report will be presented to stakeholders including DMOs, RMOs, and representatives from the Medical Stores Division, Hospital In-charges and FBOs, to evaluate the results and develop solutions.

Activity Lead: MOHSW: Assist. Director, RCHS & Program Manager, NMCP
ACCESS: Gaudiosa Tibaijuka, Senior Midwifery Advisor & Data Collection and Evaluation Specialist, TBD

Activity Location(s): Year 2005/6 regions: Morogoro, Kagera, Pwani, and Dar es Salaam
Year 2006/7 regions: Kilimanjaro, Tanga, Ruvuma, Mwanza, Mara, and Shinyanga

Specific Tasks	Participating Institutions	Completion Date
Task 1: Conduct 4-day ANC quality improvement trainings for FANC/MIP trainers, in-charges and providers at health centers and dispensaries in all the targeted regions.	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Ongoing
Task 2: Support baseline quality improvement assessments by FANC/MIP trainers in their own facilities	ACCESS, RCHS, Z, R &D –RCH Co	Ongoing
Task 3: Support Zonal, Regional and District RCH Coordinators to facilitate ANC quality improvement assessments at the targeted facilities	ACCESS, RCHS, Z, R &D –RCH Co	Ongoing
Task 4: Collect facility assessment results and service statistics on a quarterly basis (Year 2004/5 – 2006/7 facilities) in collaboration with CHMTs	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Ongoing
Task 5: Compile ANC quality improvement assessment results and service statistics in database	RCHS, NMCP, ACCESS,	Dec 2006, Mar, June, Sept. 2007
Task 6: Participate and support regional quality improvement sharing meetings among FANC/MIP implementing facilities twice a year	RCHS, NMCP, Z, R &D –RCH Co	Feb , Aug 2007
Task 7: Coordinate bi-annual Quality Improvement meetings with HSIU and HMIS units in collaboration with other CAs	ACCESS, HSIU	March, Sept 2007
Task 8: Analyze and prepare report of ANC quality improvement assessment results from Years 2004/5, 2005/6 and 2006/7 facilities to determine the extent of stock outs and origins of problem	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Dec 2006, Mar, June, Sept 2007
Task 9: Organize stakeholders meeting to discuss ANC quality improvement assessment results and way forward	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Mar and Aug 2007

Task 10: Facilitate communication between District Medical Officers and FBO facility in-charges through meetings	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Ongoing
Task 11: Select and strengthen model practicum sites three per region in 15 regions	RCHS, NMCP, ACCESS, Z, R &D –RCH Co	Dec 2006 to March 2007

ACTIVITY 4: INCREASING QUALITY AND CAPACITY FOR PRE-SERVICE CERTIFICATE, DIPLOMA AND HIGHER LEVEL NURSING AND MIDWIFERY PROGRAMS RELATED TO FANC/MIP

ACCESS began working on this activity in Year 2004/5 following the request of the MOHSW as part of their overarching goals of strengthening pre-service education (PSE). ACCESS began addressing the issue by introducing FANC into 21 certificate-level nurse-midwifery schools. In 2005/6, ACCESS expanded into 15 of the 30 diploma and higher-level nurse-midwifery schools. ACCESS will complete coverage of all pre-service institutions with FANC/MIP in 2006/7 by addressing the remaining 15 schools. Following the same successful strategy used previously, ACCESS will target both institution-based tutors and facility-based clinical preceptors with technical knowledge in FANC/MIP as well as PSE teaching skills. ACCESS will also introduce both cadres to the ANC quality improvement process including the assessment tools for FANC, which will form the basis of their follow-up and support in performance improvement.

A new initiative for the pre-service sector will be the expansion of our quality improvement tools to improve teaching skills. Responding to a demand for standardization and quality improvement in teaching following a recent advocacy meeting with Principals and Hospital In-charges from clinical practicum sites, ACCESS in partnership with MOHSW/HRDD will work with a core committee of midwifery educators to develop standards for teaching. Following pre-testing, these standards will be incorporated into the current set of assessment tools for FANC/MIP.

Activity Lead: MOHSW/HRDD: Assistant Director – Training Unit

ACCESS: Lucy Ikamba, Pre-service Education Advisor

Activity Location(s): 15 remaining Diploma and higher-level Nursing-Midwifery schools (scattered throughout the country)

Specific Tasks	Participating Institutions	Completion Date
Task 1: Finalization and printing of the Pre-service Resource Learning Package	HRDD, ACCESS,	Jan 2007
Task 2: Adaptation of quality improvement tool for use in improving pre-service teaching	HRDD, ACCESS,	Jan 2007

Task 3: PSE Advocacy workshop for 15 Diploma and higher-level schools	HRDD, ACCESS, Midwifery Schools and Hospitals (practicum sites)	Jan 2007
Task 4: Training of 30 midwifery tutors on FANC/MIP clinical skills	HRDD, ACCESS,	Feb 2007
Task 5: Orientation of midwifery tutors along with Zonal Training Centers and national representatives on use of ANC quality improvement tool for pre-service education	HRDD, ACCESS, Midwifery Schools, ZTCs	Feb 2007
Task 6: Training 60 midwifery tutors in Pre-service Education Training Skills (PETS)	HRDD, ACCESS,	April, May 2007
Task 7: Participate in the finalization of the RCH preceptorship training curriculum	RCHS, ZTCs, ACCESS	
Task 8: FANC orientation and modified Clinical Training Skills (CTS) for clinical preceptors	HRDD, ACCESS,	May 2007
Task 9: ANC quality improvement trainings for tutors and preceptors.	HRDD, ACCESS,	June 2007
Task 10: Follow-up support for both certificate and diploma nurse-midwifery schools	HRDD, ACCESS,	Feb to Sept. 2007 Ongoing

ACTIVITY 5: IMPROVE ENABLING ENVIRONMENT FOR SAFE MOTHERHOOD ISSUES SUCH AS MALARIA IN PREGNANCY

As a global leader in maternal and newborn health, ACCESS desires to improve the enabling environment for safe motherhood interventions worldwide. Specifically, in Tanzania, ACCESS in partnership with other WRA members plans to continue advocating for such issues by participating in high-level policy meetings on safe motherhood. In addition, the White Ribbon Alliance is emerging as an influential force in Tanzania for bringing attention to Safe Motherhood issues. ACCESS will continue supporting the WRA operationally as well as programmatically. WRA plans for Year 2006/7 include targeting policymakers at the district level with an advocacy package designed to encourage allocation of greater human resources for maternal and neonatal health. The

WRA of Tanzania also met great success in Year 2005/6 with the National White Ribbon Day. A second high-profile event is planned for Year 2006/7 with the prevention and control of malaria in pregnancy as the overarching theme. Simultaneously, ACCESS will work with FBO networks to sensitize religious leaders to the pressing health needs of women. The objective is for religious leaders to pass on such messages to their congregations. In this way, ACCESS will be helping to create demand among the community to access the services that are being improved.

Activity Lead: MOHSW WRATZ: Rose Mlay, WRATZ Coordinator
 IMA: FBO Coordinator, TBD

Activity Location(s): National

Specific Tasks	Participating Institutions	Completion Date
Task 1: Support operational costs for WRA of Tanzania	ACCESS, WRATZ	Ongoing
Task 2: Support for WRA Annual member meeting, Working Group meetings, and Core committee meetings	WRATZ Coordinator, Core Committee members	September Dec, Mar, June and September 2007
Task 3: Implementation of advocacy package for increasing human resources for health in four districts (Babati, Sumbawanga, Monduli and Geita) which had least human resources during the 2005/6 manning levels assessment	ACCESS, WRATZ Coordinator, Core Committee members and District Focal persons	Ongoing form Jan to Aug 2007
Task 4: Organization of National White Ribbon Day to be held in Morogoro region with focus on prevention and control of Malaria in Pregnancy	ACCESS, WRATZ - Coordinator, Core Committee members & Morogoro Focal persons	March 2007
Task 5: Participation of WRA-TZ Coordinator and key ACCESS staff in national and regional level policy meetings related to safe motherhood, especially malaria in pregnancy	ACCESS, WRATZ Coordinator,	TBD

Specific Tasks	Participating Institutions	Completion Date
Task 6: Organize advocacy meetings with religious leaders on importance of managing malaria in pregnancy and other safe motherhood issues in Morogoro District council, Mvomero,, Babati, Sumbawanga, Monduli and Geita)	ACCESS, WRATZ	Ongoing form Jan to Aug 2007

ACCESS/Tanzania Monitoring and Evaluation Framework for Malaria Activities

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
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	Quarterly	Program country staff with ACCESS M&E review
<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	Quarterly	Program country staff with ACCESS M&E review
<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	Quarterly	Program country staff with ACCESS M&E review

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
<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 1st ANC clients 	HMIS	Quarterly	Program country staff with ACCESS M&E review
<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; Records kept by MEDA (implementing organization of the Tanzania National Voucher Scheme)	Quarterly	Program country staff with ACCESS M&E review
<p>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.</p>				

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
<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). 	<p>Program records including training database and/or other training records</p>	<p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>
<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. 	<p>Program records including training database and/or other training records</p>	<p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
<ul style="list-style-type: none"> • Number of facilities 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). 	<p>Program records including training database and/or other training records</p>	<p>Semi-annual</p>	<p>Program country staff with ACCESS M&E review</p>
<p>ACCESS Program Result: A continuous quality improvement process for ANC is implemented in all regional and district hospitals offering FANC</p>				

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
<ul style="list-style-type: none"> Number of ACCESS-targeted facilities with ANC Quality Improvement initiatives contributing to compliance with international standards 	<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 SBM-R assessments Records review	Annual	Program country staff with ACCESS M&E review
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

Indicator	Definition/Calculation	Data source/ Collection Method	Frequency of data collection	Responsible party
<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
ACCESS Program Result: Improved enabling environment to address Safe Motherhood issues.				
<ul style="list-style-type: none"> Number/% of 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. 	HMIS Program ANC quality improvement assessments	Semi-annual	Program country staff with ACCESS M&E review
<ul style="list-style-type: none"> Number of target districts with increased allocation of funds in district health budgets for hiring of skilled providers 	<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 with ACCESS M&E review