

<p>STANDARD SECTOR INDICATOR CODE: HE-084</p>	<p>Mothers Reporting they Had a Birth Plan: Number of mothers with infants <12 months reporting they had a birth plan that included arrangements for HIV testing, giving birth with a skilled birth attendant, exclusive and immediate breastfeeding and emergency transportation.</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment Project Area: Maternal, Neonatal and Child Health Project Activity Area/Training Package: Maternal and Neonatal Care</p> <p>Project Area: HIV Mitigation Project Activity Area/Training Package: HIV Prevention</p>	
<p>Type: Intermediate-term Outcome</p>	<p>Unit of Measure: Mothers</p>	<p>Disaggregation: Sex: Female Age: 10-14 years, 15-17 years, 18-24 years, 25+ years</p>

To be counted for this indicator the following criteria must be met:

- The women must have had a live birth in the past 12 months **and**
- The women must have had a birth plan that included arrangements for HIV testing, and birthing at a birth facility with a skilled attendant. She must have been provided with information on: when to seek emergency medical care during pregnancy; point of contact for transportation to the hospital or other appropriate facility for emergency obstetric care and delivery, and importance of immediate and exclusive breastfeeding
- During her pregnancy, the woman received training on the essential maternal care services and/or participated in a group that was facilitated by a PCV or their partner and must have been encouraged to create a birth plan as a result of being in the group.
- The training must have been provided by the PCV or their partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. PC/Post staff determines what comprises a small group setting.
- Attendance at educational session/s must be documented by the Volunteer or their partner

Definitions:

Birth Plan contains at minimum information on: when to seek emergency medical care during pregnancy, where to get HIV testing and counseling service, where and when to seek care for labor and delivery. Also, it will include a plan for immediate breastfeeding and a point of contact for emergency transportation to the hospital

A skilled birth attendant is defined by WHO as an accredited health professional who has been educated and trained to proficiency in the skills needed to manage normal uncomplicated pregnancies, child birth and immediate post natal care, and in the identification, management and referral of complications in women and newborns.

Immediate breastfeeding is defined as the infant put to the breast within one-hour of birth.

Rationale: Making a plan for a safe birth is vital to the health and wellbeing of mothers and their infants. Maternal mortality is unacceptably high. About 800 women die from pregnancy- or childbirth-related complications around the world every day. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support after childbirth. It is particularly important that all births are attended by skilled health professionals, as timely

management and treatment can make the difference between life and death.

Measurement Notes:

- 1. Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.
- 2. General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outputs of the activities and then later at the appropriate time, measurements of specific outcomes (see the bullet on “frequency of measurement”).
- 3. Activity-Level Baseline Data Collection:** This indicator builds off of indicator **HE-079: *Educated Women on Essential Maternal Care Services***, which measures, as one component, the knowledge and attitudes of currently pregnant women regarding the creation of birth plans. Therefore, baseline data collected in the form of a pre-test for HE-079 would apply to this indicator as well.

Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the “unit of measure” above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at “0.” It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have been able to do some relationship and trust-building with the person/people the Volunteer is working with, and developed an understanding of cultural norms and gender dynamics.

- 4. Frequency of Measurement:** After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same women, to assess if they actually developed a birth plan during their pregnancy. This measurement is typically taken after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. In the case of this indicator the follow-on measurement can only be taken once the woman has delivered and up to one year following the live birth. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time. Once Volunteers have measured that at least one woman has achieved the indicator, they should report on it in their next VRF.

Volunteers may determine to take more than one baseline and one follow-on measurement with the same individual (or group of individuals) for the following valid reasons:

- Volunteers may want to measure whether or not any additional individuals initially reached with activities have now achieved the outcome in the indicator, particularly for any activities that are on-going in nature (no clear end date);

- Volunteers may want to enhance their own learning and the implementation of their activities by using the data collected as an effective monitoring tool and feedback mechanism for the need to improve or increase their activities;
- A Peace Corps project in a particular country may choose to increase the frequency of measurement of the indicator and Volunteers assigned to that project will be required to follow in-country guidance.

In all cases, any additional data collection above the minimum expectation should be based on the time, resources, accessibility to the target population, and the value to be gained versus the burden of collecting the data. Following any additional measurements taken, Volunteers should report on any new individuals achieving the outcome in their next VRF.

- 5. Definition of Change:** The minimum change to report against this indicator is a woman with an infant <12 months had a birth plan during their last pregnancy that included arrangements for HIV testing, giving birth with a skilled birth attendant, exclusive and immediate breastfeeding and emergency transportation as compared to what was measured initially at baseline. In the case of this indicator, if the woman the Volunteer/partner works with has already created a birth plan before beginning to work with the Volunteer/partner, then the Volunteer would not be able to count her for this activity because the Volunteer's work did not actually lead to the desired change. However, if as a result of working with the Volunteer/partner, the woman decided to create a birth plan during her pregnancy that would count because the Volunteer's work influenced this change.
- 6. General Reporting in the VRF:** The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRFs is the number of women with infants < 12 months who, after working with the Volunteer/partner, created a birth plan during their pregnancy that included arrangements for HIV testing, giving birth with a skilled birth attendant, exclusive and immediate breastfeeding and emergency transportation. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of individuals who participated in the activities designed to meet this indicator.
- 7. Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by "Sex" and "Age. When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by 1) male and female, and 2) 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years.

Data Quality Assessments (DQA): DQA are needed for each indicator selected to align with the project objectives. DQAs review the validity, integrity, precision, reliability, and timeliness of each indicator. For more information, consult the Peace Corps MRE Toolkit.

Alignment with Summary Indicator: Behavior Change to Improve Health