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Maternal and Child Health Integrated Program

## **USAID/MCHIP 2nd QUARTERLY REPORT**

### **MADAGASCAR**

Q2, FY02: January 1, 2011 – March 31, 2011

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# MCHIP Madagascar 2<sup>nd</sup> Quarterly Report (2011)

## 1. Introduction

Madagascar's maternal mortality ratio (MMR) is high at 498 per 100,000 live births, and it has not changed significantly since 1997. As part of USAID's expanded MCH programming to include a more significant focus on maternal and neonatal health, USAID/Madagascar provided funding to MCHIP at the end of Fiscal Year 2009. In the first year of the program, MCHIP conducted assessments of the current MNCH situation in the country, including the community health services, to enable us to design relevant program activities and lay the groundwork for MCHIP MNH improvement efforts.

In the first half of year 2 of the program, MCHIP launched activities at the national level by developing MOUs and workplans with relevant partners and stakeholders to address gaps in public and private sector MNCH policies, practices, services and support systems. At the end of April, when MCHIP will have finalized the needs assessment/planning exercise in the three selected demonstration districts of Fenerive Est, Ambatondrazaka, and Tolagnaro, MCHIP will use the results to develop detailed implementation plans and launch community level activities in the three districts. MCHIP is also in the process of finalizing the Quality of MNH Care (QoC) study begun in 2010, the results of which will also feed into Year 2 and 3 program interventions. A pioneer in the area of quality assurance, MCHIP undertook the study with the goal of measuring the quality and content of health care in Madagascar. Additionally, MCHIP plans to disseminate and use the study findings to influence national MNH policies and programs.

## 2. MCHIP Program Objectives and Key Activities

### Objectives:

The program has two primary objectives as follows:

1. Provide support and technical leadership in MNH at the national level;
2. To contribute nationally relevant program learning on integrated community and peripheral health facility approaches to MNH based on demonstration activities in three districts (Fenerive Est, Ambatondrazaka and Taolagnaro).

### Key Activities:

#### 1. National Level Activities for this quarter are as follows:

- **MCHIP/USAID Addis Workshop on EONC:** Participation in the MCHIP Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care (EONC). Attendees from the MCHIP Madagascar team included Jean Pierre Rakotovao, COP, Susan Moffson, DCOP, Claudine Razafarisoa, Midwifery and Training Advisor, Dr. Heritania Randrianjafinimpanana from SoMaPed (Madagascar's Pediatric Society), and Jocelyne Andriamanana from USAID/Madagascar. The three primary objectives of conference participation for the MCHIP-Madagascar team were:
  - Objective 1: Present Madagascar Poster on PPH/PEE Prevention and Treatment and learn about interventions and policy environment in other MCHIP countries.
  - Objective 2: Develop 5 priority interventions that are appropriate to be introduced or expanded in Madagascar.
  - Objective 3: Increase knowledge of current best practices in PPH/PEE prevention and treatment, and Helping Babies Breathe to be able to cascade knowledge to partners and program beneficiaries.
- **Participation in MNH Task Force Working Group:**

This MNH Working Group, comprised of donor organizations including Unicef, UNFPA, USAID, WHO, and JICA, had worked closely with the MCHIP team to evaluate where Madagascar is at with PPH/PEE Prevention and Treatment. More specifically, the MNH working group helped MCHIP develop the content of a poster on the current state of PE/E and PPH policy and practice in Madagascar for this Addis EmONC conference. The MNH working group members therefore agreed that the MCHIP team would distribute conference PPH and PE/E tools and information at the next MNH working group meeting.

On Tuesday, March 15, at the monthly MNH working group, Jean Pierre Rakotovoao presented the key highlights from the conference in a comprehensive 20 minute PowerPoint presentation (attached as annex). In addition, the MCHIP team disseminated the PPH and PE/E toolkits (files) and the conference presentations; demonstrated “Baby Nathalie;” presented the Helping Babies Breath guide; and distributed printouts of compiled group work on the “Interventions for Reduction of Morbidity and Mortality from PEE” and “Interventions for Reduction of Morbidity and Mortality from PPH.” Finally, since the MNH Working group had previously showed keen interest on appropriate dosages of MgSO<sub>4</sub>, the MCHIP team distributed an Addis presentation worksheet called “Managing Severe Pre-Eclampsia and Eclampsia with Magnesium Sulphate.”

- **Mercy Ministry Workplan and MOU:** MCHIP finalized both a workplan and MOU with Mercy Ministries, a Swiss NGO that works in community health in Eastern Madagascar. This MOU and workplan outline collaboration on essential maternal and newborn care activities, notably MCHIP participation in training, monitoring, and supervision of Community Health Workers (CHW) working within Mercy Ministries in Fenerive Est and Toamasina II.
- **Mercy Ministry Training for Community Health Workers (CHW):** In collaboration with Mercy Ministry medical staff, Claudine Razafiharisoa, the Midwifery and Training Advisor and Jean Pierre Rakotovoao, the COP, developed and adapted training tools and counseling card or job aids and conducted a 2-day training for Community Health Workers (CHW) from Mercy Ministries, Toamasina on March 8 and 9. Seventeen CHW participated. The primary objective of the training was to train CHW to assist women carry their pregnancies to term.
- **MNH Curriculum for Training of Trainers (ToT):** Claudine Razafiharisoa, the Midwifery and Training Advisor, led a 4-day workshop with 7 selected members of SoMaPed (Madagascar’s Pediatric Society) and FSF (Midwives Federation), two professional associations with whom MCHIP collaborates closely. The goal of this workshop was to develop the MNH curriculum for the MCHIP Training of Trainers scheduled for May 2011. The ToT curriculum, agenda, and tools will be finalized with input from Jhpiego’s technical team of MNH trainers.
- **Quality of Care Survey (QoC):** The consulting firm Tandem, who conducted the survey on behalf of MCHIP, presented the preliminary results of the QoC survey for Madagascar. The presentation was well attended by Directors and Representatives of the Ministry of Public Health, in addition to donor representatives, such as from the World Bank. While previous studies like the UNFPA/MOH 2009 Assessment of Emergency Obstetrical and Neonatal Care evaluated only the availability of care, MCHIP undertook this study to also assess the quality of care. In spite of numerous studies measuring the accessibility of care, there was a glaring lack of data available on the quality of these health services. Having obtained the input and buy-in of the MOH on this assessment, MCHIP is now well positioned to influence national MNH policies and programs, especially when final results are presented and disseminated in the summer of 2011. In addition, QoC survey final results will feed into workplan activities.

- **MOUs:** After lengthy discussions, MOUs and workplans where appropriate were developed with collaborating partners, including Unicef, UNFPA, SoMaPed, FSF, and ONM (National Order of Doctors). MCHIP has finalized MOUs with SoMaPed and FSF. After lengthy discussions with remaining partners Unicef, UNFPA and ONM, MCHIP has submitted final drafts to partners, which await signatures.

## 2. Community Level Activities for this quarter are as follows:

- **Needs Assessment/Planning Exercise:** MCHIP finalized recruitment of the three Field Coordinators in mid-February, who began working intensively on developing questionnaires, indicators, and related tools for the March 28- April 30 needs assessment/planning exercise. This needs assessment will be used to assess gaps in MNH health care service delivery in the 3 districts MCHIP will work and will serve as a basis from which to plan specific field activities related to training, monitoring and supervising CHWs. In keeping with MCHIP Madagascar's approach to complement the efforts of existing MCH partners, the needs assessment team, led by Serge Raharison, MCHIP Child Health Technical Officer, is working closely with key counterparts from Santenet2, UNFPA, and UNICEF wherever possible. The team is using data collection methods which include focus groups and semi-structured qualitative interviews to obtain rich, informative data.

## 3. Results for the Quarter

### National Level Results

- During the Addis EmONC Workshop, MCHIP was able to develop 4 priority interventions to be introduced and/or developed in Madagascar (see annex). One such intervention includes piloting the use of Misoprostol for Post Partum Hemorrhage (PPH) and USAID has given MCHIP approval to move forward with this intervention starting in fiscal year 2012. The goal of this project is to demonstrate that the use of misoprostol is feasible, acceptable, and effective for the reduction of maternal mortality caused by post partum hemorrhage.
- Through presenting and disseminating materials and information from the Addis EmONC workshop with the MNH Task Force Working Group, MCHIP has been able to share the latest research, tools, and best practices in MNH with important local partners, all of whom play a large role in influencing MNH policy and practice in Madagascar.
- By participating in the Mercy Ministries training for CHW on prenatal care, specifically on how to assist women achieve full term pregnancies, MCHIP is helping to ensure that women in rural zones have access to vital maternal health care. Recent studies have shown that one key factor in the high maternal mortality rates is that many rural women live in inaccessible areas distant from reliable transportation and health services. In fact, the 17 CHW who participated in the Mercy Ministry trainings all live in hard to reach rural zones where woman do not have access to even the most basic health facilities. Therefore, the training MCHIP is providing to CHW, who will in turn provide quality maternal health care to rural women, is critical for reducing maternal mortality in Madagascar.

### Results Narrative

One of MCHIPs pivotal roles here is to bring its expertise to the national level by sharing new and innovative evidenced based interventions that can greatly influence the adoption of improved practices. Partner stakeholder meetings, such as the MNH Task Force Working Group, provide a forum for sharing and influencing policy and practice in a way that is consistent with Jhpiego

philosophy and experience. The Addis Conference on EONC served to broaden the MCHIP team's level of expertise on the latest research, practices and policy in MNC. Knowledge and experience acquired have enhanced the capacity of partner (SoMaPed) and MCHIP technical staff to fulfill their numerous training and supervisory responsibilities as outlined in the MCHIP implementation plan. Perhaps just as important, MCHIP shared the relevant conference findings with key stakeholders at the MNH Task Force Working Group, who can then cascade the information within their respective organizations.

MCHIP felt it essential to develop MOUs to help ensure that the associations and stakeholders continue to work closely and collaboratively on the most pressing maternal and neonatal health issues. MOUs with SOMAPED and Federation des Sage Femmes (National Association of Midwives or FSF) are particularly important because MCHIP cannot work directly with the Ministry of Health (MOH), or other entities at the national level due to the Brook Amendment. We have therefore had to find creative ways to provide support and technical leadership at the national level without directly engaging with government entities. Though the majority of members of these two associations are government employees, MCHIP is able to work with them because they are voluntary members of these associations. With invaluable technical input and participation of Jhpiego MNH expert trainers, MCHIP will conduct a Training of Trainers for members of the FSF and SoMaPed, on key technical areas of MNH and they will cascade the training to other members and/or personnel at the national and district level, for whom we cannot provide direct technical assistance.

#### **4. Way Forward**

MCHIP faced some contextual challenges initially that have caused some delays in program start up and implementation. Madagascar has a particularly difficult political environment; the government is not stable and has experienced a number of coups or attempted coups in recent years, creating legitimacy issues and causing the U.S. government to put restrictions on NGO interactions with government entities. Notably, under the Brook Amendment, MCHIP is not permitted to provide financing, technical support or materials to the government, which has complicated our program objective "1" related to providing support and technical leadership in MNH at the national level. We are overcoming this challenge by finding creative ways in which to work with key government entities and staff influential in the MNH sector, such as through our close working relationships with SoMaPed and FSF. All that said, we will share information with and seek the involvement of key Central MOH counterparts whenever possible because we view their support as crucial for strategic and technical backup and for achieving program objectives.

As a USAID grantee, we face similar restrictions on working with the government at the community level, so we are not in a position to be directly involved in supporting health facilities. We have therefore prioritized close coordination with agencies like UNICEF and UNFPA, through regular meetings, MOUs and collaboration on key workplan activities, including the needs assessment and planned trainings, for example of midwifery faculty in selected universities. Our engagement with UN organizations allows us an opportunity to be meaningfully engaged at both at the national level and especially the health facility level, which is important, as we are committed to an approach reflecting the continuum of care from household through health facility.

In spite of slow registration process which took many months to complete due to bottlenecks at the ministry and their numerous ad hoc requests for information, MCHIP successfully registered at the end of the first quarter and has completed the majority of recruitment in this second quarter. Several key staff started work, including the Deputy Chief of Party in late January and several others in mid.-February, including the Midwifery and Training Advisor, the three Field Coordinators, and most recently the M&E Advisor, who will join the team April 18. MCHIP is in the process of

recruiting a Finance Officer in order to devolve financial management from a firm to the MCHIP office.

In the next quarter, we will finalize the needs assessment/planning exercise and use those results to develop detailed implementation plans for each of the three districts. In addition, we will conduct a Training of Trainers in April/May for members of SoMaPed and FSF on MNH, which will be followed up with a cascade of that training in the 6 provinces, slated for May through September.

## **5. Annexes**

- **Country Team Discussions: Poster Review (Addis EONC Workshop)**
- **Success Story: Mercy Ministries Training**
- **Presentation of Addis Conference Materials to MNH Working Group**

## Country Team Discussions: Poster Review

**COUNTRY NAME:** Madagascar

- I. 5 priority interventions that are appropriate to be introduced or expanded in your country:**
  1. To ensure there is facility level quality improvement in PE/E and PPH.
  2. Advocacy and early program implementation for use of misoprostol on demonstration basis.
  3. Work to reduce financial barriers to access intrapartum care.
  4. Strengthening the logistics systems for these commodities.
  
- II. 2 immediate steps that your country can take to disseminate information from this meeting to your colleagues.**
  1. Disseminate PPH and PE/E tools at next MNH working group.
  
- III. 2 challenges that might delay or interfere with introducing/expanding the 5 priority interventions.**
  1. Getting proper government approval and buy in from stakeholders to use misoprostol.

## **SUCCESS STORY: MERCY MINISTRIES TRAINING, Toamasina, March 7, 8, 2011**

In collaboration with medical staff from a Swiss NGO (Mercy Ministries), two key technical staff from the USAID funded MCHIP-Madagascar program, including the Midwifery and Training Advisor Claudine Razafiharisoa and Chief of Party (COP) Jean Pierre Rakotovao, developed and adapted training tools and job aids and conducted a 2-day training for Community Health Workers (CHW) from Mercy Ministries, Toamasina on March 8 and 9. Seventeen CHW participated, of which 10 were women and 7 were men. The primary objective of the training was to train CHW to assist women carry their pregnancies to term.

*The Community Health Worker (CHW) Lang Wai Mei, walked 4 hours on foot on the decrepit dirt road, unusable by cars, to catch the "taxi brousse" or "bush taxi" for another few hours before arriving at the Mercy Ministry Center in Salazamay, Toamasina. Another CHW, Jimmy Andrianantenaina, a fisherman, did his morning work and then paddled 1.5 hours in his wooden, hand-carved canoe-like "piroque," which serves as the local river transport, before reaching a bush taxi that took him to the same training. Lang and Jimmy, along with 15 other CHW, arrived at the center exhausted from the journey and uncertain about what to expect, though they hoped to acquire the tools to help women carry their pregnancies to term.*

*Often the sole health providers in distant rural areas without even basic health facilities, these CHW generally work alone, with only the most essential equipment and medicines, such as anti-diarrheal and anti-malaria medicine. So they value any kind of training that will help them help others. Though 2 CHW in the group of 17 had attained the equivalent of a high school education, most have only primary school education. Therefore it is not surprising that one of the initial fears they expressed in the opening session was that they would not be able to follow the training or teach their clients what they had learned, such as how to help women detect dangerous conditions during pregnancy, like high blood pressure or pre-eclampsia. MCHIP facilitators taught CHW to look out for danger signs for this condition, like severe headaches and swollen face and hands. Having come so far, CHW were also nervous about being away from their families, about possible health issues during the training, and especially about getting their transport reimbursed, because taxi drivers often do not have the materials or capacity to issue receipts.*

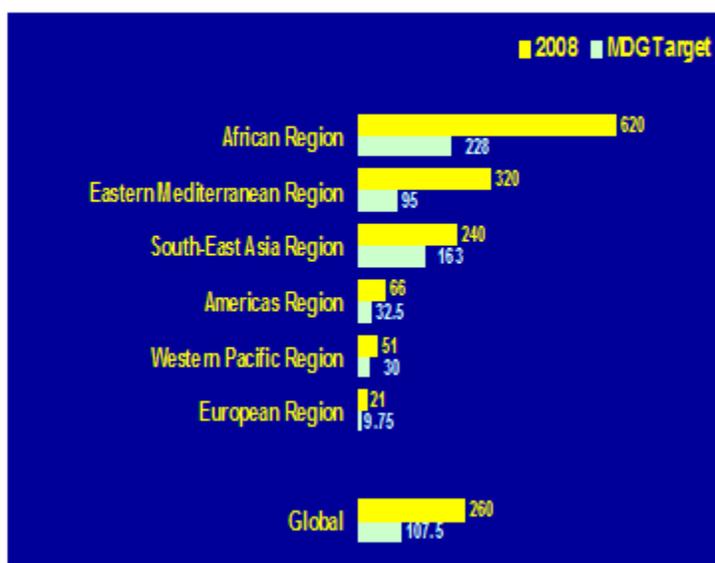
*In the end their fears were allayed. The training went smoothly, with attendees generally expressing satisfaction with the overall content and management of the conference, many even very satisfied. But the training was not without challenges! Some found it particularly difficult to calculate due dates, since this requires some math skill. For others, what proved highly challenging was demonstrating the use of counseling cards or job aids, which they will utilize when helping pregnant women. These counseling cards show pictures depicting women at various stages of pregnancy and illustrate the recommended practices they should follow. When asked why there were no written instructions on the card, Claudine, MCHIP's Midwifery and Training Advisor explained that "the women the CHW will help are from the country and have very little education." In the end, though, conference facilitators, including MCHIP's COP, Jean Pierre, were very proud of the CHW performance and found them to be highly motivated and capable. And despite the long journey to get to the training, attendees felt strongly that they had not wasted their time in coming. One more vocal participant, Cesarine Vololonirina, said that the "fatigue from the journey immediately went away" because they had learned to help women and newborns on vital MNH practices with increased confidence and skill.*

By participating in this training for CHW on prenatal care, specifically on how to assist women achieve full term pregnancies, this USAID funded MCHIP program is helping to ensure that women in rural zones have access to essential maternal health care. Recent studies have shown that one key factor in the high maternal mortality rates is that many rural women live in inaccessible areas distant from reliable transportation and health services. In fact, the 17 CHW who participated in this training all live in hard to reach rural zones where woman do not have access to even the most basic health facilities. On average, they will see about 30 beneficiaries per month, which when multiplied by 17, will impact a sizable group. This is particularly important here in Madagascar where, according to the Madagascar Demographic and Health survey from 2009, only 44% of all births were attended by a skilled health provider and only 35% of babies were born in a hospital setting. The CHW from this training are now trained to identify prenatal warning signs such as high blood pressure, a preventable condition and one of the three primary causes of maternal death. Therefore, the training USAID's funded MCHIP program is providing to CHW, who will in turn provide quality maternal health care to rural women, is critical for reducing maternal mortality in Madagascar.

African Regional Meeting on Interventions for impact in  
Essential Obstetric and Newborn Care.  
Addis Ababa, Ethiopia February 21, 2011.

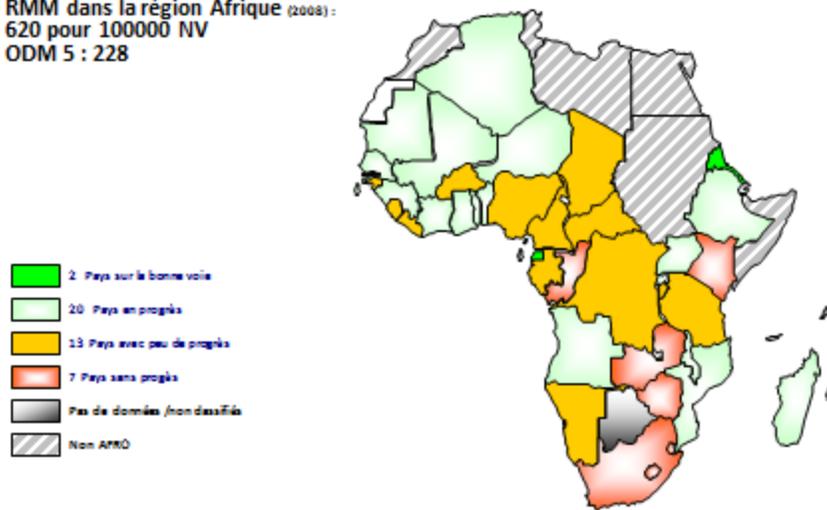
## Résumé

## Réalités



# Très peu de progrès pour atteindre l'ODM 5

RMM dans la région Afrique (2008) :  
620 pour 100000 NV  
ODM 5 : 228



## Chemin à prendre

**Nous savons...**

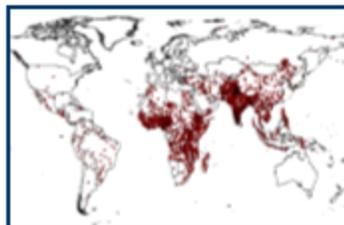
...Qui est à risque

...

...Où ils vivent...



...Ce que nous devons faire...



...et comment le faire.

## Les défis

- Gouvernance et Leadership
- Faible système de santé
  - Crise en ressources humaines.
  - infrastructure, médicaments et équipements inadéquats.
  - Pas assez de fonds pour une couverture universelle des interventions.
  - Mauvaise gestion et utilisation des informations de santé.
- Faible Coordination



### Exemple d'Initiative pour la prevention de l'HPP

- Développement d'un plan national
- Inclusion de GATPA dans les protocoles
- Mobilisation des ressources financières
- Développement de stratégies de formation
- Validation de matériels de formation
- Intégration de GATPA dans les outils de supervision
- Conduite des études

## **Rôle des Associations Professionnelles**

- Offre un leadership sur les questions concernant l'HPP
- Fait un plaidoyer sur les initiatives de contrôle de l'HPP
- Participe aux recherches pour la mise à jour des pratiques cliniques
- Fait la promotion des bonnes pratiques pour les protocoles et les politiques de soins
- Facilite le transfert des connaissances et des compétences
- Participe aux efforts pour l'assurance de la qualité

## **Niveau Politique**

- Engagement pour protéger tout accouchement de la survenue de HPP partout où la naissance survient
- Allocation de ressources humaines et financières
- Mise à échelle des interventions
- Travaille à travers un paquet complet de services de santé maternelle incluant la distribution à base communautaire du misoprostol

## Bonnes pratiques

- Changement des attitudes obstétricales concernant le GATPA (CAMBIO)
- Auto Apprentissage (SAIN)
- Intensive supervision post formation
- Formation informelle en pairs

### **Stratégies pour l'utilisation au niveau communautaire du Misoprostol Programmation & Mise en œuvre**



- Connait la communauté
- Campagne de Prise de conscience
- Intégration de la distribution misoprostol dans les interventions de santé maternelle à base communautaire
- Amélioration des services en salle d'accouchement

## Nouvelles Technologies pour traiter HPP



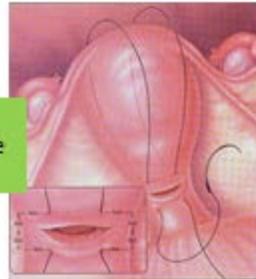
BRASS-V  
DRAPE

Vêtement  
antichoc



Condom/ballon  
tamponnade

Suture  
hémostatique  
de B Lynch



## Mama Nathalie



| Intervention/ Technologie                          | Lieu d'utilisation  | Niveau des prestataires                                 |
|--|---|---|
| <i>Compétences en soins d'urgence domiciliaire</i> | Communautaire   | Formation minimale                                      |
| <i>Injection conventionnelle d'utérotoniques</i>   | Formation sanitaire<br>Communautaire                            | qualifié<br>qualifié                                    |
| <i>Misoprostol</i>                                 | Formation sanitaire<br>Communautaire                            | qualifié<br>Formation minimale &<br>Auto Administration |
| <i>Oxytocine-Uniject</i>                           | Formation sanitaire<br>Communautaire (?)                        | qualifié<br>Formation minimale                          |
| <i>Vêtement Anti-choc</i>                          | Formation sanitaire<br>Communautaire (utilisation<br>seulement) | qualifié<br>Formation<br>minimale(utilisation)          |
| <i>Perfusion et Transfusion</i>                    | Formation sanitaire   | qualifié  |
| <i>Balloon/condom Catheter</i>                     | Formation sanitaire   | Hautement qualifié                                      |
| <i>Interventions chirurgicales</i>                 | Formation sanitaire   | Hautement qualifié                                      |

## Mises à jour (OMS)

- Application pour l'inclusion du misoprostol pour la prévention et traitement du HPP dans la liste modèle de l'OMS sera revue par le comité des experts en mars 2011
- Prochaine mise à jour des recommandations sur la prévention et traitement de l'HPP planifiée pour 2012

## Prévention PE/E

- Intérêt renouvelé sur l'importance de l'interrogatoire et les conseils mais non pas seulement l'examen physique et les tests pendant le CPN
- Il faut aussi mettre l'accent aussi bien sur la logistique que sur les formations et les supervisions

### Supplement en Calcium la prevention pré-éclampsie/éclampsie

- Association épidémiologique de régime calcique avec une grande différence avec le taux pré-éclampsie/éclampsie
- Supplémentation en calcium dans la deuxième moitié de la grossesse réduit:
  - pré-éclampsie (pas un grande étude)
  - Sévère morbidité (environ 20%)
- Ceci est suffisant pour justifier un programme pour la supplémentation des femmes enceintes avec un régime pauvre en calcium
- Recherches sont en train de se faire pour déterminer si une supplémentation avant la grossesse peut entraîner une différence

## L'idéal agent hypertensif pour la zone rurale et les régions éloignées

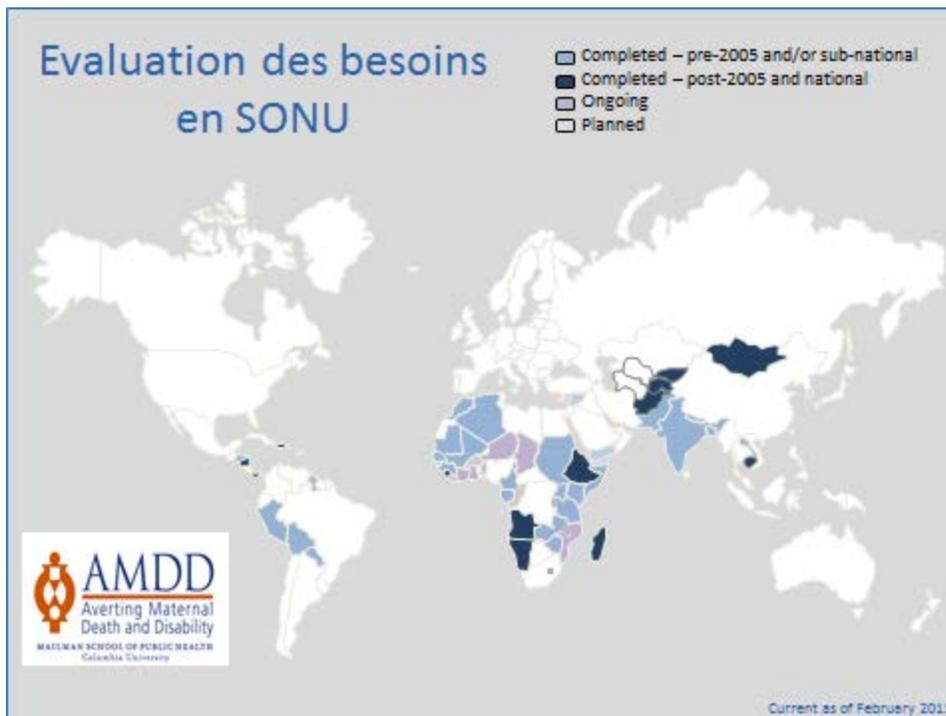
- Administration orale
- Réduction certaine de la TA
- Réduction lente de la TA
- Prise en charge rapide
- Changement minime de la TA
  - TA systolique: 130-160mmHg
  - TA diastolique: 80-110mmHg

### En fait

- Un paquet d'intervention doit inclure 1 - 3 agents antihypertensives
- Le choix d'une seule antihypertensive se fait entre methyldopa, nifedipine, et un autre beta-bloquant, probablement atenolol
  - labetalol n'est pas sur la LME
- Raisons théoriques et pratiques, avoir:
  - Un agent qui combine le contrôle du système nerveux central, beta bloquant et une vasodilatation
  - Un deuxième agent efficace pour les femmes dont la TA résiste avec un autre antihypertensif
- Reserve i.v. hydralazine pour la femme comateuse

## Modèle d'intervention

- Pour pré-éclampsie/ éclampsie:
  - Prévention
    - calcium pendant la grossesse à partir de 20 SA
    - aspirine à partir de 15 SA
  - Traitement: MgSO4 dose de charge
- Pour complément, inclure:
  - FAF à partir de 20 semaines
  - ocytocine routinière pendant le 3<sup>rd</sup> stade, pour prévenir HPP



## En général...

Outcomes pour HPP & PE/E, et RMM ne s'améliorent pas de façon significative s'il n'y a pas de changement pour :

- **sévère et chronique manque de personnel qualifié dans tout Afrique**
- **Infrastructure inadéquate**
- **Absence de lien entre les différentes parties du système de santé**
- **Système de référence mal organisé, inexistant ou seulement de fortune**
- **Environnement politique favorisant**

### QoC-MNC évaluation dans 5 pays en 2009-2010

- Ethiopie
- Kenya
- Tanzanie & Zanzibar
- Rwanda
- Madagascar
  
- Zimbabwe pour 2011
- Disponible pour assister d'autres pays



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## En résumé

- Faible pratique de prévention/dépistage en CPN (22% - 46%)
- Faible connaissance (39-46%)
- Existence de pratiques nuisibles qui doivent être nulles
- De la politique à la pratique pour GATPA:
  - Assez fréquent très haut niveau d'intervention
  - Mais faible traduction dans la pratique .
- Il existe des points forts mais d'autres cas ont besoin d'être renforcés

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## Mesurer qualitativement la santé maternelle et néonatale de façon routinière

| Technique   | Sources des données   | Données collectées  |
|---|---|---|
| Observation clinique structurée de l'interaction client - prestataire | Checklists cliniques remplis par les pairs et/ou évaluateurs externes (ex., checklists utilisés pour les initiatives d'amélioration de la qualité, checklists de supervision)   | Compliance avec les protocoles cliniques et normes  |
| Inventaire des FS/ infrastructure/approvisionnement /équipement       | Checklists des audits des FS, rapport de supervision  | Rupture des médicaments clés , équipement cassé ou inexistant, organisation de services   |
| Revue des registres   | Rapport du SGIS; registres ; dossiers médicaux ; audits basés sur les critères; audits des near miss; audits de décès maternels et néonataux; systèmes de surveillance sentinelle, système de gestion et d'information logistique | Utilisation de service ; fréquence des offres de service basé sur les évidences (ex pour fer pendant CPN, antitétanique, TIP); gestion des complications; nombre des décès et complications |

# Suggestions

- **5 interventions prioritaires qui sont appropriées pour être introduites ou mises à échelle dans votre pays:**
  - S'assurer de l'existence d'amélioration de la qualité dans la prise en charge de PE/E et HPP.
  - Plaidoyer et commencement d'un programme d'utilisation du misoprostol sur la base de démonstration.
  - Travailler pour réduire les barrières financières pour l'accès aux soins intrapartum.
  - Améliorer le système logistique pour les produits de PE/E et HPP.
- **Prochaine étape que votre pays puisse faire pour disséminer les informations de ce meeting à vos collègues .**
  - Disséminer les outils de HPP et PE/E au prochain groupe de travail de SMN.
- **Défis qui peut retarder ou interférer sur l'introduction/expansion des 5 interventions prioritaires**
  - Avoir l'accord du gouvernement et des parties prenantes pour l'utilisation du misoprostol.

## Basic Model

### with Standard Accessories

- Simulation squeeze bulbs with tubing and connectors
- Umbilical cord with connector and two ties
- Two sheets to simulate towels
- Head cap
- Tube for topping body filling
- Directions for use
- Transport/storage bag

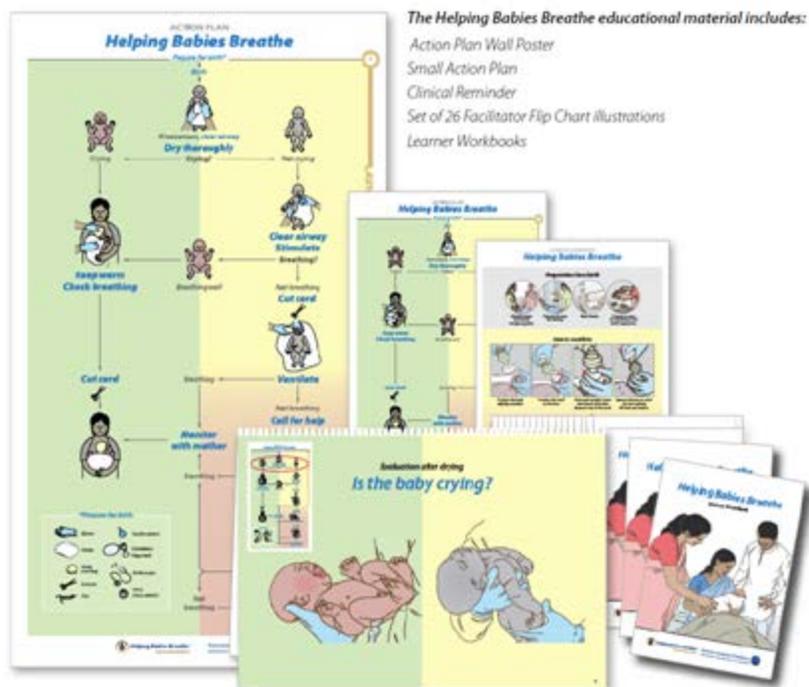


## Complete Model

### with the following additional items

- NeoNatalie Resuscitator
- NeoNatalie Suction
- Stethoscope





**Guide for Implementation and Scale-Up of *Helping Babies Breathe*® (HBB)**  
**A global educational program in neonatal resuscitation**

- I. Purpose, Audience, and Objectives of the Implementation Guide
- II. Developing a Sustainable HBB Program
  - A. Neonatal Resuscitation in the Context of Essential Services for Mother and Baby
  - B. Building Consensus and Planning for Sustainability
  - C. Conducting a Situation Analysis of Neonatal Resuscitation
  - D. Developing a Strategic Plan for Neonatal Resuscitation
- III. Implementation of Training in *Helping Babies Breathe*
  - A. Strategic planning
  - B. Training implementation
  - C. Monitoring the process and quality of training
  - D. Scale-up and sustainability of training
- IV. Monitoring and Evaluation
  - A. Monitoring the process and quality of training
  - B. Monitoring and evaluating the rollout of a program
  - C. Collecting neonatal outcome measures and vital statistics
- V. Scale-Up and Sustainability
  - A. Strengthening the health system
  - B. Extending advocacy into the community
  - C. Dealing with challenges and unintended consequences
- VI. Conclusion