USAID/MCHIP 3rd QUARTERLY REPORT

MADAGASCAR

Q3, FY11: April 1, 2011 – June 30, 2011

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July 29, 2011

MCHIP- Madagascar 3rd 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, MCHIP finalized the needs assessment/planning exercise in the three selected demonstration districts of Fenerive Est, Ambatondrazaka, and Tolagnaro, and used the results to develop detailed implementation plans and initiate community level activities in the three districts. MCHIP has nearly finalized the Quality of MNH Care (QoC) study, the results of which will be disseminated in late summer 2011. 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.

MCHIP is now fully staffed and operational, and has launched a MNH Training of Trainers (ToT) and most recently a series of MNH cascade trainings in the 6 provinces throughout Madagascar, which will be followed by three more waves of MNH cascade trainings from July- September, 2011. Perhaps most significant, MCHIP has successfully advocated to pilot the use of misoprostol for PPH prevention when oxytocin is not available.

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 Tolagnaro).

Key Activities:

1. At the national level, MCHIP provides technical assistance to the following partners:

- local professional associations, such as the Federation of Midwives (FSF), Madagascar Pediatrics Society (SOMAPED), and the National Order of Doctors (ONM)
- USAID bilateral programs such as Santanet2, PSI, JSI;
- Other collaborating partners, such as UNICEF, UNFPA, and Swiss NGO Mercy Ministries;

Technical assistance at the national level includes participation in the Safe Motherhood Working Group; training, curriculum, and proposal development in collaboration with organizations listed above; and finally national level advocacy on targeted evidence-based globally approved best practices.

2. At the community level, MCHIP provides technical assistance to USAID bilateral programs and other collaborating partners mentioned above for introduction and scale up of high impact interventions.

   Technical assistance at the community level is led by Field Coordinators in 3 demonstration districts who will conduct data collection and analysis, assist with tool development, and help train and supervise community health workers (CHW) and other local partners.

3. Summary of Major Accomplishments

- Used the results from a comprehensive needs assessment/planning exercise to develop detailed workplans- validated by local implementing partners- for the three demonstration districts of Fenerive Est, Tolagnaro, and Ambatondrazaka.
- Reached agreement with Mary Stopes Madagascar (MSM) and Population Services International (PSI) that MCHIP would support the private sector in the development of Emergency Obstetric and Newborn Care (EmONC) components to existing health clinic networks, namely MSM's Blue Star and PSI's Top Reseau.
- Trained 19 clinical trainers in MNH/Basic Emergency Obstetric and Newborn Care.
- Conducted 6 simultaneous Cascade Trainings in targeted MNH knowledge and skills for about 120 physicians and midwives in 6 provinces throughout Madagascar.
- Reviewed and revised the MCHIP Performance Monitoring Plan (PMP) as a result of a technical assistance trip from Dr Eva Bazant, MCHIP M&E Advisor.
- Created a training participant recording form and Access database of trained participants, which will be updated after each training.
- Successfully advocated to have MOH consider registration of misoprostol for use in post-abortion care (PAC) as well as for PPH prevention at health facility (only when oxytocin is not available) and community levels.
- After extensive advocacy efforts, obtained MOH approval to move forward with a district-level demonstration project to increase use of uterotonics at facility and home births. This project will emphasize training of providers in AMTSL (Active Management of Third Stage of Labor) using oxytocin as well as misoprostol for prevention of PPH to demonstrate that misoprostol is a viable alternative for PPH prevention when oxytocin is not available at health facilities, and will also test the program effectiveness of distributing misoprostol to women for use at home birth when they are not able to access care at a facility.

Narrative about Major Accomplishments

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

- **Finalize Performance Monitoring Plan (PMP)-** Having finalized the district workplans after the comprehensive needs assessment/planning exercise, the MCHIP team solicited the help of Dr. Eva Bazant, Senior M&E Advisor, to both orient the new MCHIP M&E Officer, as well as to evaluate whether the proposed indicators related to program objectives and proposed activities at both the national and community (district) level. Additionally, MCHIP worked with Dr. Bazant to ensure that the MCHIP indicators reflected the USAID OP Indicator Core Set on MCH Interventions and MCH health systems. Since one of MCHIP's key roles is to provide

technical assistance to other USAID supported NGOs, MCHIP also sought to address concerns raised about double-counting the same individuals/beneficiaries reached in reporting to USAID. Dr. Bazant led discussions with Santanet2 about these concerns and worked with MCHIP M&E Advisor, Erick Rakotomavo, to determine how MCHIP can get information on the number of community health workers (CHW) trained; the number of community members reached by CHWs; the referrals to health facilities; the number of key MNH interventions offered at the facilities; and number of complications, without double-counting.

- **Participation in MNH Task Force Working Group:**
  COP Jean Pierre Rakotovao worked in close collaboration with the MNH Working Group, comprised of donor organizations including Unicef, UNFPA, USAID, WHO, and JICA, on an 11 million euro European Union Proposal to improve maternal and child health in 5 zones in northern Madagascar. MCHIP provided key input on proposal design, including site choice and detailed activities to be undertaken.

- **MNH Training of Trainers (TOT), May 2-6:** Claudine Razafiharisoa, the Midwifery and Training Advisor, and Jean Pierre Rakotovao, led this 5-day training of 19 MNH clinical trainers, all of whom are selected members of SoMaPed (Madagascar's Pediatric Society) or FSF (Midwives Federation), two professional associations with whom MCHIP collaborates closely. This training helped update trainers on targeted maternal and newborn health knowledge and skills as well as on how to become effective trainers so that they could then teach their colleagues these same skills through a series of "cascade" trainings, from June-September 2011.

- **MNH Training of Trainers Team Building Workshop, June 14-16**: With support from Patricia Gomez, Jhpiego MNH Senior Technical Advisor, Claudine Razafiharisoa, the MCHIP Midwifery and Training Advisor, and Jean Pierre Rakotovao, COP, conducted a 3-day workshop for half of the newly-trained trainers (one from each of the six teams) from the original group of 19 Maternal and Newborn Health (MNH) Clinical Trainers that MCHIP trained from May 2-6. The goal of this Team Building Workshop was to enable trainers to review and revise training materials for the planned MNH "cascade" trainings and to ensure that documents and approaches were high quality and consistent with Jhpiego standards. Additionally, this Team Building Workshop gave MCHIP staff an opportunity to coach new trainers. The trainers returned to their respective sites on 17 June and met over the weekend with their co-trainers to share and finalize the plans made in Antananarivo for the first wave of cascade trainings, which took place simultaneously in 6 provinces from June 20-24.

- **Misoprostol Advocacy**: Given existing opposition to the inclusion of misoprostol on Madagascar's list of essential medicine for PAC and PPH uses, MCHIP has actively lobbied for consideration of misoprostol on this list at two key national level meetings as follows:
  - To ensure our proposed demonstration project to increase coverage of uterotonics at facility and community levels would not be blocked by the Ministry of Health or other key stakeholders, the MCHIP COP, Jean Pierre Rakotovao was a key participant in a May 31 workshop to discuss the use of misoprostol in Madagascar for prevention of PPH and for use in PAC. He worked closely with workshop organizers, in particular Dr. Rahelinirina, the Head of Service for Safe Motherhood, on vital workshop content, including a presentation of the results from the Venture Strategies International (VSI) Workshop in Tanzania on Postpartum Hemorrhage, during which the team representing Madagascar had developed a Madagascar Action Plan. The MCHIP COP himself presented on the use of misoprostol

around the world (See Annex III, "Misoprostol dans le Monde"), in which he effectively showed that there is a body of evidence proving the success of misoprostol in combatting PPH when oxytocin is not available. Additionally, he gave a compelling presentation about why Madagascar needs misoprostol (see Annex IIII). During workshop Q&A sessions and discussions, he successfully argued that the use of misoprostol for prevention of PPH could be successfully managed and further was able to obtain assurances that the MOH would approve the proposed MCHIP demonstration project which will introduce a PPH prevention strategy that reinforces AMSTL in health facilities and also assesses whether misoprostol is a viable alternative for PPH prevention when oxytocin is not available.

- The MCHIP COP played a crucial role in helping spearhead a June 16 workshop sponsored by Marie Stopes Madagascar (MSM), to discuss the registration and use of misoprostol in Madagascar and to formulate recommendations to send to the Minister of Health. He provided essential input during the workshop planning phase, as well as presented at the meeting on established uses, corresponding dosages and administration methods of misoprostol, and actively participated in meeting discussions. A key result of this workshop was that key partners came to the table ready to support the registration and use of misoprostol in the country for management of complications of abortion and for prevention of PPH at facility level (only when oxytocin is not available) and at home birth. The recommendations that will be forwarded to the MOH favor rapid action to register misoprostol in the country for use in post-abortion care (PAC) as well as for PPH prevention at health facility and community levels.

- **Quality of Care Survey (QoC):** During her May visit, Dr. Eva Bazant and the MCHIP team met with the consulting firm Tandem, who conducted the survey on behalf of MCHIP, to discuss next steps on finalizing the QoC report. When final results are presented and disseminated in the summer of 2011, MCHIP will be well positioned to influence national MNH policies and programs. In addition, QoC survey final results will feed into FY 2012 (Year 3) workplan activities.

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

- **Needs Assessment/Planning Exercise:** This needs assessment was used to assess gaps in MNH health care service delivery in the 3 districts in which MCHIP is working and has served 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, especially USAID bilateral programs, the needs assessment team, led by MCHIP Child Health Technical Officer Serge Raharison, worked closely with key counterparts from Santenet2, PSI, UNFPA, UNICEF, and local professional associations wherever possible.

  After the data collection phase, Serge facilitated a 2-day workshop in Antananarivo ("Tana"), attended by decision-makers within these organizations, where participants evaluated program gaps and achieved consensus on overall activities to support the MNH program in the three districts and MCHIP's specific roles and responsibilities. After this workshop, MCHIP Field Coordinators finalized district workplans with the buy-in of district level stakeholders. Perhaps most interesting, another beneficial outcome of the Tana planning workshop was that MCHIP finalized discussions with PSI staff about MCHIP's proposed role in assisting PSI with the development of an Emergency Obstetric and Newborn Care (EmONC) component to their network of health clinics, known as "Top Reseau, " which currently offer an array of family planning and child survival services.

- **Cascade Trainings, June 20-24:** MCHIP conducted this first wave of simultaneous MNH cascade trainings for about 120 physicians and midwives in 6 provinces throughout Madagascar, including Antananarivo, Antsiranana, Toamasina, Toliara, Fianarantsoa, and Mahajanga. Patricia Gomez assisted the team with preparations and roll-out as well as co-facilitated a cascade training in Antananarivo. Main topics covered included PE/E, PPH, and Neonatal resuscitation. Didactic sessions, role-plays, case studies and practice of clinical skills on models were all incorporated per the usual Jhpiego approach. MCHIP will roll out 3 more waves of cascade trainings from July through September, after which more than 400 midwives and physicians will be trained in targeted MNH interventions. (See Annex II, Cascade Training Schedule "ORGANISATION DES FORMATIONS EN CASCADE EN SMN PAR PROVINCE.").

- **District Level Activities:** Having validated district workplans in early May with local partners, the MCHIP Field Coordinators launched data collection and analysis at health facilities in their respective districts, where they are evaluating accessibility of centers and availability of staff; the existence of essential medicines and equipment; the qualifications of staff, in particular whether they are trained in Emergency Obstetric and Neonatal Care (EmONC), etc. By the end of July, 2011, close to half the health facilities or CSB (and Hospitals) have been evaluated. Additionally, Field Coordinators attended the Tana MNH Cascade Training from June 20-24 to reinforce their own MNH knowledge and skills and to enable them to more effectively conduct training and supervision activities in their own districts. They are working with MCHIP trainers to organize cascade trainings in their respective districts during July, when they will co-facilitate these trainings.

4. Way Forward

In the next quarter, MCHIP will build upon recent achievements at both the national and community level, which include the establishment of an effective M&E system, the roll-out of MNH Training of Trainers and first wave of MNH cascade trainings, the launching of district level activities, and the authorization to move forward with the demonstration project to increase coverage of uterotonics at all births.

Patricia Gomez, Senior MNH Technical Advisor, will continue to assist the MCHIP Training team standardize the training tools and methodology so that we can rapidly extend high quality technical updates on high impact maternal and newborn health interventions to the maximum number of providers. Having worked with the clinical training teams and co-facilitated a cascade training this past June, she is well positioned to provide feedback to the new trainers and MCHIP training team in order to strengthen their training skills for the upcoming cascade trainings from July-September. Additionally, she is assisting the team with planning a schedule of follow-up visits for the trained providers by each trainer to ensure transfer of newly-learned knowledge and skills and to assess needs for basic equipment to carry them out.

Given the presently favorable environment to demonstrate program effectiveness of using misoprostol at both facility and community levels,, MCHIP will move forward rapidly to design a district-level intervention that will introduce a PPH prevention strategy promoting increased use of correct active management of third stage of labor (AMTSL) in health facilities as well as the distribution of misoprostol to pregnant women through ANC visits and in the community by trained community health

agents. This proposal will then be submitted to USAID in-country and Washington for input and approval and ultimately to respective Madagascar and JHU IRBs.

3. Annexes

- **ANNEX I : Success Story: Saving Lives During Childbirth**
- **ANNEX II: Cascade Training Schedule (ORGANISATION DES FORMATIONS EN CASCADE EN SMN PAR PROVINCE)**
- **ANNEX III: Presentation on the Use of Misoprostol around the World (MISOPROSTOL DANS LE MONDE).**
- **ANNEX IIII: Presentation on Why Madagascar Needs Misoprostol**

ANNEX I: SUCCESS STORY

SAVING LIVES DURING CHILDBIRTH

The seasoned mid-wife student trainer, Eliane Rabary, was surprised to learn at the USAID funded training of trainers that the way to get a newborn baby to breathe did not involve holding the baby upside down by the feet and slapping it's rear-end, or vigorously patting the baby's back. During this May 2011 training held in Madagascar's capital, Antananarivo, USAID-financed trainers showed the 19 doctor and midwife trainers how to use ventilation masks and effective resuscitation techniques to help newborn babies breathe, all part of a comprehensive training package developed by USAID's MCHIP (Maternal and Child Health Integrated Program) project. While practicing these new skills on the life-sized baby mannequin, Eliane explained, "I need to forget what I learned in midwifery school 20 years ago."

This MCHIP training of trainers helped Eliane and 19 other trainers- all midwives or physicians- update their maternal and newborn health knowledge and skills. This program also taught them how to become effective trainers so that they could then teach their colleagues these same skills through a series of "cascade" trainings. This first "wave" of trainings took place in 6 provinces from June 20 – 24. In 2011 alone, these 20 trainers will have trained over 400 health care providers in the 6 provinces throughout Madagascar, covering nearly the entire country from North to South in areas with high rates of maternal and newborn deaths.

After undergoing intensive training and supervised practice on mother and baby mannequins to consolidate their new skills, these doctors and midwives are now better equipped to assist women and their babies throughout pregnancy, child birth, and the first weeks of the baby's life. Onjalalaina Andrianjatovo ("Onja"), a young midwife from the outskirts of Madagascar's capital, Antananarivo, is one such participant who is benefitting from this USAID funded "cascade" training. Since the three leading causes of maternal death in Madagascar include hemorrhage (excessive bleeding), eclampsia (high blood pressure and convulsions) and infections, this MCHIP program targets these three areas in their trainings. Onja was particularly impressed by the lesson on bi-manual compression of the uterus, a simple technique to treat excessive bleeding after childbirth. She told the story of one of her clients, a 36 year old woman giving birth to her 4th child, who was unresponsive to all their attempts at stopping uncontrolled bleeding after the birth of her stillborn baby. They had referred her to a hospital but sadly, she passed away during the journey there. Onja lamented "had I known about this easy procedure, maybe I could have saved this woman's life."

Like Eliane above, who had to refresh her out- of- date midwifery skills, both Onja and another participant, Nivo Andriamparany, a doctor at the Hospital for Mothers and Children in Tsaralalana, were equally impressed by MCHIP's innovative approaches to helping babies breathe, especially techniques and equipment used to remove secretions from the baby's mouth and nose. At the 4 poorly equipped health centers she works at- alternating with 10 other midwives- Onja said they normally use their hands to extract fluid from babies. Nivo confessed that while their hospital was relatively well equipped, they were not aware of some of these innovative methods and equipment for helping babies breathe, so she was pleased to learn something new.

What is most encouraging, though, is that these midwives and doctors will also act as role models in their own facilities and will demonstrate these simple yet vital skills to their colleagues, saving the lives of potentially many women and newborn babies. Onja confirmed that she has already agreed to transmit these modern teachings to the other 10 midwives she works with, likely when they are completing their required weekly night shifts at the maternity ward. Similarly, Nivo said she would be sharing these new approaches with the other doctors at her hospital. So while over 400 health providers will have been trained in the latest skills to help pregnant women and their babies, many more health providers and more importantly their patients stand to benefit from this invaluable, USAID funded MCHIP program.

Along with 19 other midwifes and doctors, midwife Onja and doctor Nivo look on while the pediatrician and trainer, Heritiana Randrianjafinimpanana, demonstrates how to use a ventilation mask during the Maternal Neonatal Health Cascade Training held in Madagascar's Capital, Antananarivo, from June 20-24.

ANNEX II : Cascade Training Schedule : ORGANISATION DES FORMATIONS EN CASCADE EN SMN PAR PROVINCE

ANTANANARIVO

DESIGNATION	**F1 : 20- 24 Juin**	**F2 : 18 – 22 juillet**	**F3 : 01 - 05 AOÜT**	**F4 : 05 -09 SEPT**	**OBSERVATIONS**
Effectif des participants	20	24	20	20	* participants Antsirabe
Lieux de formation	Antananarivo : INTH	Antsirabe : à préciser	Antananarivo : INTH	Antananarivo : INTH	
Equipe de co-formation	**Mme Myrta** Mme Suzette	**Mme Suzette** Mme Dorette	**Mme Myrta** Mme Suzette	**Mme Myrta** Mme Suzette	Mme Dorette pourra compléter l'équipe en fonction de son état de santé
Liste des participants	communiquée	communiquée	Non communiquée	Non communiquée	

FIANARANTSOA

DESIGNATION	**F1: 20- 24 Juin**	**F2 : 11- 15 JUILLET**	**F3 : 01- 05 AOUT**	**F4 : 05 – 09 SEPT**	**OBSERVATIONS**
Effectif des participants	20*	20	20	20	* participants FNR + Ambalavao ** participznts Manakara
Lieux de formation	Fianarantsoa	Manakara	Fianarantsoa : à préciser	Fianarantsoa : à préciser	

Equipe de co-formation	**Mme Eliane** Dr Yvonne Mme Lydia	**Mme Eliane** Mme Myrta Mme Lydia	**Mme Eliane** Mme Myrta Mme Lydia	**Mme Eliane** Dr Yvonne Mme Lydia	
Liste des participants	communiquée	communiquée	communiquée	communiquée	

TOAMASINA

DESIGNATION	**F1: 20- 24 Juin**	**F2 :25 – 29 juillet**	**F3 : 8- 12 JUILLET**	**F4 : 05- 09 SEPT**	**OBSERVATIONS**
Effectif des participants	20	40	20	20	
Lieux de formation	Toamasina	Fénérive Est Ambatondrazaka	Toamasina	Toamasina	
Equipe de co-formation	**Mme Olivée** Dr Arthur	**Mme Olivée** Dr Benja	**Mme Olivée** Dr Arthur	**Mme Olivée** Dr Arthur	Personne ressource : Dr Jean Pierre Mme Claudine
Liste des participants	Non communiquée	communiquée	Non communiquée	Non communiquée	

MAHAJANGA

DESIGNATION	**F1: 20- 24 Juin**	**F2 : 11 – 15 JUILLET**	**F3 : 01- 05 AOUT**	**F4 : 05- 09 SEPT**	**OBSERVATIONS**
Effectif des participants	20	20	20	20	
Lieux de formation	Mahajanga	Mahajanga	Mahajanga	Mahajanga	
Equipe de co-formation	**Mme Noro** Dr Noro Mme Agnès	**Mme Noro** Dr Noro Mme Agnès	**Mme Noro** Dr Noro Mme Agnès	**Mme Noro** Dr Noro Mme Agnès	Personne ressource : M.RAKOTOMAVO Eryck MCHIP PHPIEGO
Liste des participants	Non communiquée	communiquée	Non communiquée	Non communiquée	

TOLIARA

DESIGNATION	**F1: 20- 24 Juin**	**F2 : 11 – 15 JUILLET**	**F3 : 01 – 05 AOUT**	**F4 : 19-23 SEPT**	**OBSERVATIONS**
Effectif des participants	20	20	20	20	
Lieux de formation	Toliara	Taolagnaro	Toliara	Anosy	
Equipe de co-formation	**Mme Eudoxie** Dr Valikara	**Mme Eudoxie** Dr Heritiana	**Mme Eudoxie** Dr Valikara	**Mme Eudoxie** Dr Valikara	Equipe renforcée par Pr BLAMI

Liste des participants	Non communiquée	Non communiquée	Non communiquée	Non communiquée	

ANTSIRANANA

DESIGNATION	**F1: 20- 24 Juin**	**F2 : 25 – 29 JUILLET**	**F3 : 29 AOUT- 02 SEPT**	**F4 : 26 – 30 SEPT**	**OBSERVATIONS**
Effectif des participants	20	20	20	20	
Lieux de formation	Antsiranana	Sambava	Antsiranana	Antsiranana	
Equipe de co-formation	Dr Zoly Mme Jeanne Mme Laingo	Dr Zoly Mme Jeanne Mme Laingo	Dr Zoly Mme Jeanne Mme Laingo	Dr Zoly Mme Jeanne Mme Laingo	Personne ressource : Mr Herinjaka
Liste des participants	Non communiquée	Non communiquée	Non communiquée	Non communiquée	

ANNEX III: Misoprostol around the World: "Misoprostol Dans Le Monde"
Presented by Jean Pierre Rakotovao, May 31, at the Ministry of Health

Misoprostol

- Analogue E1 de la Prostaglandine
- *Agit sur l'utérus: ramollissement, contraction du myomètre ⇨ expulsion du contenu*
- Comprimé (orale, sublinguale, buccale, vaginale)
- *Thermostable*
- Cout faible

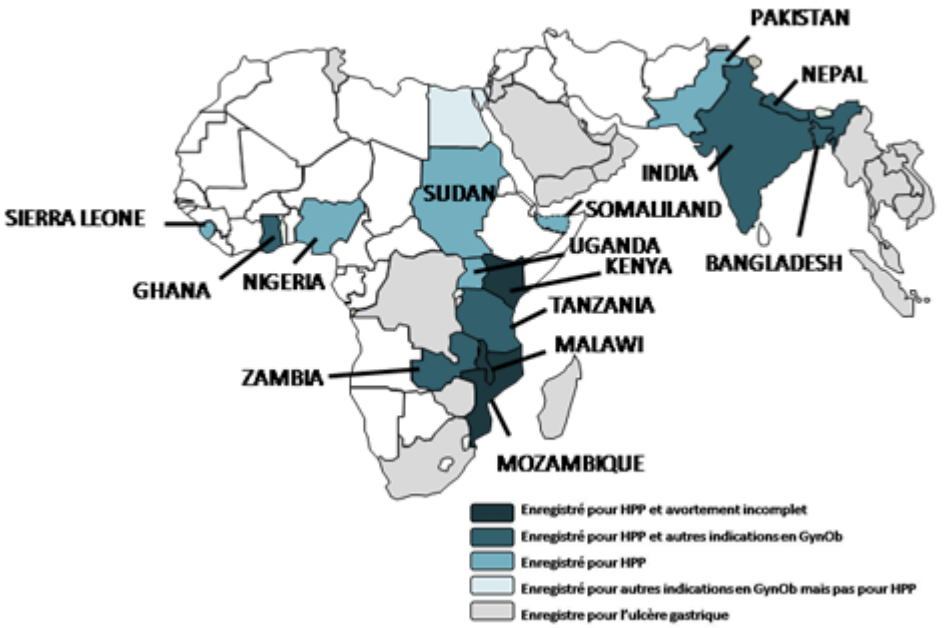
Misoprostol

Dosage (cp : 200µg)	1er Trimestre	2nd Trimestre	3ème Trimestre	Post partum
800µg (4cp)	Interruption de grossesse : voie vaginale toutes les 12h (max : 3)			
	Grossesse arrêtée : vaginale toutes les 3h (max : 2)			
600µg (3cp)	Grossesse arrêtée : voie sublinguale toutes les 3h (max : 2)			Prévention ou traitement HPP: voie orale ou sublinguale en dose unique
	Avortement incomplet : voie orale dose unique			
400µg (2cp)	Avortement incomplet : voie sublinguale dose unique	Interruption de grossesse (13-22 S) : voie vaginale toutes les 3h (max :>5)		
200µg (1cp)		Mort in utero (13-17 S) : voie vaginale toutes les 6h (max/ 6)		
100µg (1/2cp)		Mort in utero (18-26 S) : voie vaginale toutes les 6h (max/ 6)		
50µg (1/4cp)			Mort in utero (27-43 S) : voie vaginale toutes les 4h (max/ 6)	
25µg (1/8cp)			Mort in utero (27-43 S) : voie vaginale toutes les 4h (max/ 6)	
			Induction de travail : voie vaginale toutes les 4h (max : 6)	
20 µg			Induction de travail : solution orale toutes les 2h (max : 12)	

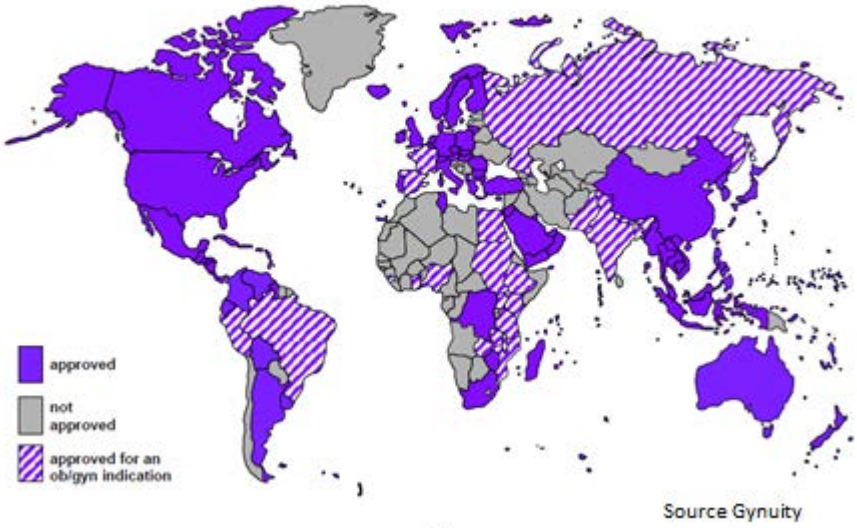
Source: Weeks A & Faundes A. *International Journal of Gynecology and Obstetrics* 2007;99:S156-9.

3

Pays : enregistrement du misoprostol



Situation des pays



Le Misoprostol dans la Prévention de l'Hémorragie Post-partum: Conclusions de l'Essai Clinique Mené à Chitral, au Pakistan

- **Objectif** : *déterminer l'efficacité et l'innocuité du misoprostol en traitement préventif de l'hémorragie post-partum (HPP) lors de naissances à domicile*
- **Nature** : *double-aveugle, contrôlée aléatoirement, a été menée sur environ 1400 femmes*
- **Hypothèse** : *600 µg de misoprostol administré par voie orale, réduit l'incidence de l'HPP quand administré au cours de la troisième phase du travail, par des accoucheuses traditionnelles formées*
- **Résultat**:
  - Comparé au placébo, le misoprostol par voie orale a réduit l'incidence d'HPP (≥ 500 ml) de 24%.
  - Comparé au placébo, les femmes ayant reçu du misoprostol ont subi une baisse plus réduite du taux d'hémoglobine (> 2g/dL) constatée après accouchement

THE 18th EXPERT COMMITTEE ON THE SELECTION AND USE OF ESSENTIAL MEDICINES (21 to 25 March 2011 Accra, Ghana)

Section 22.1.

- **Misoprostol tablet**: 200 micrograms was added, based on evidence of safety and efficacy for the prevention of post-partum hemorrhage, *where oxytocin is not available or cannot be safety used.*
- **Misoprostol tablet**: 200 micrograms; vaginal tablet: 25 micrograms, moved from complementary list to core list.
- Note for 200 micrograms tablet **amended** to specify it is for management of incomplete abortion and miscarriage and for prevention of post-partum hemorrhage *where oxytocin is not available or cannot be used safety.*

Population: 162.2 M
Risque de décès maternel: 1/51
RMM: 570 /100000 NV
Taux de fertilité: 2.5
Accouchement par personnel qualifié: 13%
Besoin non satisfait en PF: 11%
Misoprostol : G-Misoprostol®; Cytomis®, Isovent®

- **Formation**: 600 AT de 6 districts en prévention de l'HPP.
- *Intégration du misoprostol dans le **KIT d'accouchement** propre: plus de 70000 femmes avaient reçu misoprostol*
- Engagement du gouvernement par le ***développement de politique*** pour permettre l'accès des femmes au misoprostol, suivi de ***l'enregistrement*** du misoprostol

1 July 2011 9

Population: 27.5 M
Risque de décès maternel: 1/31
RMM: 830/100000 NV
Taux de fertilité: 3.1
AC assisté par PQ: 19%
Besoins non satisfaits en PF: 24%
Misoprostol: Isovent®, Misoprost®, Zitotec®

- 2008 : **Enregistrement** du misoprostol pour prévention HPP;
- **Formation des agents communautaires** sur Matri Surakchya Chakki, ou la pilule sauveuse des mères;
- ***Formation des pharmaciens*** *pour distribuer le misoprostol aux femmes enceintes pour la prévention de HPP*;
- Dans les villages éloignés des montagnes, les **partenaires** travaillent avec pour augmenter l'accès au misoprostol pour la prévention HPP.

1 July 2011 10

Population: 180.8 M
Risque de décès maternel: 1/74
RMM: 276 /100000 NV
Taux de fertilité: 4.0
Accouchement Assisté: 39%
BN en PF: 33%
Misoprostol: ST Mom®

- 2009 : **Enregistrement** du misoprostol
- *Secteurs publique et privé ensemble : facilite l' accès au misoprostol là où les mortalités maternelles sont très élevées à travers*:
  - Promotion **d'approches efficaces et sans risque** pour la prévention HPP,
  - Etablissement de système de **formation et d'éducation** des Agents communautaires,
  - **Conscientisation** à travers de campagne media et activités mobiles,
  - **Mobilisation** des décideurs politiques, des officiers du gouvernent, des ONGs et communautés pour **plaider** à l'utilisation du misoprostol .

Population: 82.8 M
Risque de décès maternel: 1/27
RMM: 720 /100000 NV
Taux de fertilité: 5.3
Accouchement Assisté: 10%
BNS en PF: 34%
Misoprostol: Misotac enregistré

- **Formation**: prestataires dont médecins, sage femmes, infirmiers, pharmaciens, autres agents de santé, et AC sur la prévention et traitement de HPP
- *E**ngagement** de gouvernement par le développement des **politiques** qui permettent l'accès au misoprostol aux mères dont l'inclusion du misoprostol dans la **liste des médicaments essentiels** en 2007*

Population: 23.8 M
Risque de décès maternel: 1/45
RMM: 830/100000 NV
Taux de fertilité: 4.0
AC assisté par PQ: 50%
Besoins non satisfaits en PF: 34%
Misoprostol: Misotac®

▪Septembre 2008: Food and Drugs Board **enregistre** le misoprostol pour les indications en obstétrique dont l'HPP;
▪*Octobre 2009: Ministère de la Santé approuve les **protocoles** de la maternité sans risque qui permettent l'utilisation du misoprostol pour la gestion de l'HPP au niveau communautaire;*
▪ **introduction de l'utilisation** du misoprostol en prévention de HPP au niveau communautaire dans 4 districts;
▪ ***Formation** à travers les ordres professionnels des infirmiers et sages femmes du personnel de santé pour donner le misoprostol lors des CPN dans les cas où la femme ne pourra pas venir accoucher dans les centres.*

1 July 2011 13

Population: 39 M
Risque de décès maternel: 1/39
RMM: 560/100000 NV
Taux de fertilité: 4.9
AC assisté par PQ: 42%
Besoins non satisfaits en PF: 24%
Misoprostol: Isovent® Misoclear®

▪ Juliet 2009**: Enregistrement** du misoprostol pour prévention et traitement de l'HPP, traitement de l'avortement incomplet et grossesse arrêtée;
▪***Introduction** du misoprostol pour la prévention de l'HPP dans 2 districts en partenariat avec le Ministère de la Santé Publique et Sanitation, Département de la Santé Reproductive et la Société des Gynécologues et Obstétriciens : **éducation** de la communauté sur le rôle du misoprostol en maternité sans risque et **formation** des agents communautaires pour donner le misoprostol aux femmes qui ne peuvent pas venir accoucher aux centres.*

1 July 2011 14

Population: 19,4 M
Risque de décès maternel: 1/45
RMM: 440/100000 NV
Taux de fertilité: 5.0
AC assisté par PQ: 51%
Besoins non satisfaits en PF: 23%
Source: PRB, 2010 and WHO, 2010
Misoprostol: neant

- 2006: **Inclusion** du misoprostol pour PAC dans les normes et procédures en SR
- 2008: Présentation des dossiers pour l'**enregistrement** du misoprostol pour ses indications en SR auprès de la DAMM
- MSM: formation des agents de santé (médecins et sages-femmes) des cliniques MSM et des CSB publiques dans six régions dans l'utilisation du misoprostol et ainsi que des agents communautaires pour la sensibilisation dans le cadre d'une étude

15

Population: 14.2 M
Risque de décès maternel: 1/18
RMM: 1100/100000 NV
Taux de fertilité: 6.3
AC assisté par PQ: 54%
Besoins non satisfaits en PF: 27%
Misoprostol: Misoprost®

- 2010: **enregistrement** de *deux types de misoprostol* pour la prévention et le traitement de l'HPP, avortement incomplet et grossesse arrêtée;
- **Intégration du** misoprostol dans les programmes de maternité sans risque des ONG locales.
- ***Inscription*** *dans la liste des Médicaments essentiels,* ***intégration*** *dans les guides et les curricula de formation*

1 July 2011 16

Population: 21.9 M
Risque de décès maternel: 1/45
RMM: 520/100000 NV
Taux de fertilité: 5.4
AC assisté par PQ: 44%
Besoins non satisfaits en PF: 19%
Misoprostol: Misotac®; Isovent®

- **Formation** des prestataires (médecins, sages femmes, infirmiers, et AC) pour la prévention et le traitement de l'HPP;
- Engagement du gouvernement pour le **développement de document de politique** => **enregistrement** de misoprostol;
- Oter tout obstacle à l' accès en **formant** les distributeurs de médicaments et les assister pour atteindre les agents communautaires et les femmes (misoprostol disponible dans le secteur publique et privé) ;
- **Formation** des infirmiers et sage femmes pour combler les manques en soins essentiels spécifiquement pour les soins après avortement en utilisant le misoprostol.
- ***Collaboration*** *Ministère de la Santé, association des Obstétriciens et Gynécologues (AMOG), PSI, distributeurs pharmaceutiques et d'autres organisations non-gouvernementales pour faciliter l'accès au misoprostol pour la prévention de l'HPP*

1 July 2011 17

Population: 156.2 M
Risque de décès maternel: 1/18
RMM: 1100/100000 NV
Taux de fertilité: 5.7
AC assisté par PQ: 35%
Besoins non satisfaits en PF: 17%
Misoprostol: Misoprostol®

- **Formation** des prestataires (médecins, sages femmes, infirmiers, et AC) sur l'utilisation du misoprostol pour la prévention et le traitement de l'HPP;
- Appui aux décideurs politiques pour **développer les documents de politique** pour s'assurer de l' accès des mères au misoprostol => inclusion dans la **liste des médicaments essentiels , dans les guides cliniques nationales;**
- *Encourage l'**enregistrement** de plusieurs types de misoprostol pour rendre les prix accessibles aux utilisateurs.*

1 July 2011 18

Misoprostol enregistré: Ummal Gargaar®

- Février 2009: appui technique au Ministère de la Santé et du Travail qui a franchi les étapes pour **enregistrer** le misoprostol pour la prévention et le traitement de l'HPP;
- *Somaliland est le premier pays où VSI et PSI ont développé une nouvelle marque de misoprostol qui est localement et culturellement acceptable: Ummal Gargaar traduit comme "aide pour une nouvelle mère qui vient juste de donner la vie."*
- **Orientation** des médecins, infirmiers et des accoucheuses communautaires de Hôpital maternité de Edna Adan, la société Red Crescent et l'Institut de sciences et de santé pour s'assurer que les femmes aient accès au misoprostol.

1 July 2011 19

Population: 43.7 M
Risque de décès maternel: 1/24
RMM: 950/100000 NV
Taux de fertilité: 5.3
AC assisté par PQ: 43%
Besoins non satisfaits en PF: 22%
Misoprostol: Misotac®, Misoprost®

- **Formation** des sage femmes, infirmiers et des médecins à l'utilisation du misoprostol pour la prévention de l'HPP comme complément dans la formation en soins après avortement;
- ***Intégration*** *du misoprostol comme un élément de l'initiative maternité sans risque => inclusion dans* ***les guides cliniques nationales****;*
- Une **recherche opérationnelle** avec Ifakara Health Institute et Bixby Centre à Université de Californie, Berkeley a démontré la faisabilité de donner aux femmes pendant le CPN le misoprostol pour prévenir l'HPP dans les cas où elles ne peuvent pas accoucher dans les formations sanitaires.

1 July 2011 20

Population: 30.7 M
Risque de décès maternel: 1/25
RMM: 550/100000 NV
Taux de fertilité: 6.7
AC assisté par PQ: 42%
Besoins non satisfaits en PF: 41%
Misoprostol: Misotac®

- Juin 2008: **enregistrement** de misoprostol pour prévention et traitement de l'HPP;
- Décembre 2008: Ministère de la Santé a approuvé le **guide clinique de l'utilisation** du misoprostol pour la prévention et le traitement de l'HPP comme directive pour les prestataires de soins;
- *Juin 2009: Lancement du misoprostol pour HPP avec Ministère de la Santé et PACE en **formant** médecins, infirmiers et sage femmes pour l'utilisation, et distribution du misoprostol dans les hôpitaux et centres de santé de 11 districts.*

1 July 2011 21

Population: 12.5 M
Risque de décès maternel: 1/27
RMM: 730/100000 NV
Taux de fertilité: 6.2
AC assisté par PQ: 47%
Besoins non satisfaits en PF: 28%
Misoprostol: Misotac®

- May 2008: **enregistrement** de misoprostol pour la prévention et traitement de l'HPP;
- **Structuration** du système de distribution du misoprostol et **formation** des prestataires sur l'utilisation du misoprostol en prévention de l'HPP;
- *Un projet de 9 mois est étendu sur 5 districts et aide le secteur publique pour la **mise à échelle de la distribution** du misoprostol pendant les CPN pour prévenir l'HPP dans les cas où les femmes ne peuvent pas accoucher dans les formations sanitaires.*

1 July 2011 22

ANNEX IIII: Why Madagascar Needs Misoprostol

Presented by Jean Pierre Rakotovao, May 31, at the Ministry of Health

Statistiques

- Avortement incomplet: 15 à 20% des grossesses déclarées échouent spontanément
- Un taux supplémentaire de 22% finit en avortement provoqué (spontanée ou provoquée, la fausse couche peut donner lieu à un avortement incomplet).
- HPP contribue à la survenue de 34% des décès maternels en Afrique Sub Saharienne et 22,5% à Madagascar**

* Abou Zahr 2003 * *EB SONU

Statistiques

- Infections dont post avortement : 15,5% **
- CPN : 49% des femmes ont fait au moins 4 CPN ***
- 64 % des femmes accouchent en dehors des formations sanitaires***

** EB SONU *** EDS 2008 - 2009

Réalités/Défis

- Limitation de l'accès aux prestataires qualifiés et aux établissements bien équipés
- Insuffisance des services existants de soins après avortement:
  - curetage : technique invasive
  - aspiration manuelle intra-utérine: offre limitée
- Disponibilité de produit actif (ocytocine): limitée pour la prévention de l'HPP

Réalités/Défis

- Chaque femme qui accouche est à risque de décès pour HPP
- Disponibilité du misoprostol sur le marché local (misoprost- cytotec – misoclear)
- Incrimination du misoprostol par rapport avortement illicite

Solutions

- Misoprostol:(évidences +++)
  - Alternative pour les soins après avortement
  - Bonne option pour la prévention de HPP dans les situations auxquelles le syntocinon n'est pas disponible
  - Facile à mettre à échelle et respecte l'équité d'offre de service de soins