USAID/MCHIP 2nd QUARTERLY REPORT (MCHIP PY4 Quarter 2 Country Program Report)

MADAGASCAR

Q2, FY12: January 1, 2012 – March 31, 2012

Submitted by: Jean Pierre Rakotovao
April 30, 2012

MCHIP- Madagascar 2nd Quarterly Report (FY 2012)

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 (MNH), USAID/Madagascar provided funding to MCHIP at the beginning of Fiscal Year (FY) 2010. One of MCHIP's primary roles has been to provide technical assistance to USAID bilateral programs, donors, professional associations and other collaborating partners for introduction and scale up of high impact interventions.

Since achieving registration status in December 2010, MCHIP has accomplished several key objectives in this first active year of the program. Some notable achievements include the development of a cadre of 37 clinical trainers well versed in clinical training techniques and in key aspects of MNH/Basic Emergency Obstetric and Newborn Care. Since project inception, MCHIP has increased the capacity of 539 physicians and midwives to provide quality care for women and newborns experiencing complications related to Postpartum Hemorrhage (PPH), Pre-eclampsia/Eclampsia (PE/E), infections, and neonatal asphyxia.

Complementing the efforts of the Santenet2 project, MCHIP has also increased the capacity of 330 Community Agents (CA) to provide essential maternal and newborn care, in particular their ability to respond appropriately to women and newborns with complications, through training on community-level maternal and neonatal health in the three demonstration districts of Fenerive Est, Taolagnaro, and Ambatondrazaka.

2. MCHIP Program Objectives and Key Activities

Objectives:

The program has three primary objectives as follows:

1. Provide support and technical leadership in MNCH;
2. To contribute nationally relevant program learning on integrated health approaches to MNH based on demonstration activities in three districts (Fenerive Est, Ambatondrazaka and Tolagnaro)
3. To increase uterotonic coverage to prevent PPH through professional association members and community agents in the district of Fenerive Est

Key Activities:

1. 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)
- Social Franchises (Networks of private health clinics) including PSI's "Top Reseau" and MSM's "Blue Star";
- USAID bilateral programs such as RTI's Santenet2, JSI's MAHEFA and other INGOs such as PSI;
- Other collaborating partners, such as UNICEF and UNFPA;

Regarding objective 1, 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 information sharing on targeted evidence-based globally approved best practices. For community level interventions related to objective 2, 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 is led by Field Coordinators in 3 demonstration districts who conduct data collection and analysis, assist with tool development, and help train and supervise community health workers (CHW) and other local partners. Also at the community level in the district of Fenerive Est, MCHIP is pursuing objective 3 by continuing to advocate for the rollout of the Introductory PPH Prevention Program to demonstrate that misoprostol is a feasible and effective alternative when oxytocin is not available as part of a comprehensive strategy to strengthen AMSTL.

3. Results for the Quarter

- MCHIP has strengthened the pool of qualified maternal and newborn (MNH) trainers in Madagascar by evaluating and qualifying three candidate trainers, which will ensure that efforts to improve the quality of MNH care are felt long after the project ends.

- MCHIP introduced and reinforced key supervision approaches and tools to ensure that transfer of learning takes place by providers in clinical sites after training in MNH skills.

- MCHIP has laid the groundwork for improving the quality of maternal and neonatal health care by conducting a dissemination workshop for the Quality of MNH Care (QoC) study. The goal of the January 24, 2012 workshop was to encourage key stakeholders to implement study recommendations in a coordinated fashion to address gaps in health care service delivery.

- During the QoC Study dissemination workshop, MCHIP raised awareness about neonatal resuscitation, the second leading cause of newborn death in Madagascar, and obtained commitment from key decision-makers to include this topic in pre-service EmONC training curricula.

- In this quarter, MCHIP increased the capacity of 54 physicians and midwives (539 total since project inception) to provide quality care for women and newborns experiencing complications related to PPH, PE/E, infections, and neonatal asphyxia through trainings in targeted MNH knowledge and skills in 6 provinces throughout Madagascar.

- MCHIP has also increased the capacity of an additional 121 Community Health Workers (CHW) (330 total since project inception) to provide essential maternal and newborn care, in particular their ability to respond appropriately to women and newborns with complications, through training on community-level maternal and neonatal health in the three demonstration districts of Fenerive Est, Taolagnaro, and Ambatondrazaka.

4. Narrative about Major Accomplishments

Objective 1: Support and national leadership in MNCH

Qualify three candidate trainers, January 30-February 3:

At the MNH supplemental training workshop for trainers (TOT) held in November, 2011, Jhpiego Master Trainer Cecile Somda helped the MCHIP training team identify the 3 strongest trainers- a midwife and two pediatricians- so they could then co-train with Jhpiego MNH Senior Technical Advisor Patricia Gomez in a January 30-February 3 MNH cascade training. During this MNH training, Gomez worked with MCHIP/Madagascar staff to evaluate and qualify the three candidate trainers. This process took these three trainers from "candidate" to "fully qualified" trainers. Now that they are fully qualified, they will be able to carry out training of professional association members independently, thus strengthening the pool of maternal and newborn health trainers in Madagascar.

Reinforce Supervision Approaches, January 25-27
Led by Patricia Gomez, MCHIP training staff conducted a 3-day supervision activity visit at sites which involved follow-up visits of professional association members to assess whether they are improving Emergency Obstetrical and Neonatal Care (EmONC) in their own sites and addressing the issues raised in the QoC study. She oriented trainers on objectives, methodology, and tools for follow-up of skilled providers after training in MNH and helped the MCHIP team strengthen supervision approaches and activities to ensure that MCHIP training participants are correctly using newly acquired skills and knowledge.

It is important to note that the three newly "qualified" trainers discussed above- along with several local MCHIP trainers- also participated in the 3-day supervision activity and are now better equipped to conduct required follow-up visits of training participants after MCHIP MNH trainings.

Quality of Care (QoC) Study and Dissemination Workshop, January 24, 2012 at the Hotel Carlton: A pioneer in the area of quality assurance, MCHIP undertook the QoC study with the goal of measuring the quality of and access to MNH health care in Madagascar. Importantly, MCHIP learned from the study about the gaps in newborn care, specifically high rates of newborn infection and lack of equipment and skill in newborn resuscitation, so we have included those themes in our MNH trainings. Other study findings similarly influenced our MNH trainings, which now include more emphasis on the use of the partograph, as well as prevention, recognition, and treatment of PPH and PE/E.

The QoC study dissemination workshop was a "working meeting," in which local stakeholders at different levels discussed and developed action plans to address the identified gaps in health care service delivery. Approximately 30 participants were in attendance as MCHIP and Tandem staff presented the goals and objectives of the study; key findings to date from the five countries where the study has been carried out; and specific findings from Madagascar. After questions and discussion four small groups worked on implementation plans to address the identified gaps in service delivery in the areas of infection prevention; prevention, identification and management of postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E); and newborn resuscitation.

In April 2011, MCHIP will share the report on this dissemination workshop with workshop participants and other key stakeholders, in addition to the the action plans or "pathways" for scale-up of interventions to address the service delivery gaps in maternal and newborn health. MCHIP applied this proven MCHIP methodology known as the "pathway" for scaling up evidenced based approaches, in which globally approved evidence based interventions are piloted in-country for eventual scale-up as appropriate. By developing these pathway documents, workshop participants were able to elaborate a useful guide for effectively reinforcing and implementing elements of the existing National MNCH Action Plan, namely in the core areas of PE/E, PPH and neonatal resuscitation.

Discussions will continue with partners to arrive at specific ways that they and MCHIP can work together to improve the quality of care provided at all levels of the health care system. These pathways or action plans were also shared at the February Safe Motherhood technical Working Group (TWG) Meeting with key decision makers, including TWG members JICA, USAID, UNFPA, UNICEF, OMS, World Bank, and the French Cooperation, to advocate for an integrated approach to achieve greater impact, especially in the 4 primary areas of MCHIP's focus (infection prevention, PPH, PE/E, neonatal resuscitation). Finally, the results of this QoC study will be included in the next TWG quarterly newsletter or "bulletin," published by the United Nations.

Objective 2: Integrated health approaches to MNH based on demonstration activities in three districts (Fenerive Est, Ambatondrazaka and Tolagnaro)

Training CHWs on Community Level maternal and neonatal health in the 3 demonstration districts: In the 2nd quarter**,** MCHIP trained 121 CHWs on community- level maternal and neonatal health interventions, with a special focus on reinforcing capacity of CHWs to respond appropriately to women and newborns with complications. This activity was undertaken with professional associations and NGOs working in close proximity to and collaborating with partner Santenet2. Training content included how to prevent the spread of disease through hand washing ; how to recognize danger signs for women who have just given birth and for newborns; the actions to take when complications arise, especially related to facilitating referral and transport to health facility; and manual extraction of breast milk when the baby is not properly suckling. In this same quarter, 102 CHW were supervised by trainers in follow-up visits to ensure that CHW are correctly using newly acquired skills.

Objective 3: To increase uterotonic coverage to prevent PPH through professional association members and community agents in the district of Fenerive Est

Several issues related to both John Hopkins IRB and in-country approvals have hindered progress on the implementation of this introductory PPH prevention program. MCHIP received USAID approval in October 2011 and then Malagasy Ethics Committee approval in December 2011 to implement an introductory PPH prevention program to increase the use of uterotonics at facility and home births. MCHIP submitted the research plan for this program to the JHSPH Institutional Review Board (IRB) in November, and has received three rounds of questions (Jan 6, Feb. 15, and March 21). MCHIP resubmitted the revised research plan April 12 and is waiting to hear back from the JHSPH IRB. Initial questions revolved around storage and dispensing of Misoprostol as the drug is being bought by Jhpiego and distributed by the MCHIP program. Safety measures are a recurrent theme and most recently, the IRB board raised the issue of a Drug Safety Monitoring Board (DSMB) to monitor safety and effectiveness. The Principle Investigator (PI) provided arguments for why this is not necessary as it is an operations research proposal, not a clinical trial. At this time there has been no resolution, or comment back, from the IRB.

Challenges related to in-country approval stem from a Feb. 27 letter from the national drug regulatory agency (DAMM), signed by the minister, indicating that they do *not* support the use of misoprostol for community-based distribution (or at HF level) for PPH prevention, apparently reversing their earlier position. For us to proceed with this activity as planned, it is essential that we receive government approval superseding the recent letter from DAMM. MCHIP Country Support Program Manager Steve Hodgins and Country Support Coordinator Jeff Smith will be in Geneva the week of April 16th and will

take advantage of the opportunity to discuss this matter with key counterparts from WHO/Geneva, seeking their advice and possibly their involvement with WHO/Madagascar counterparts.

As discussed with the USAID mission, intervention by USAID with the minister could conceivably be useful. MCHIP COP will also liaise with Dr. Josee, the MoH Director of District Health Care, with whom he participated in a JSI/MEHEFA project Nepal Study Tour to see community-based service delivery there, on how best to proceed with government, as she appears favorably disposed to proceeding with the use of misoprostol for Reproductive Indications (RIs), including the proposed PPH Prevention Program.

Through his participation in the Nepal Study Tour, MCHIP COP Dr. Rakotovao can take specific lessons learned from the Nepal experience and apply them here for the implementation of the proposed PPH introductory program. In particular, he witnessed first- hand how Nepal was able to implement innovative community- level programs using misoprostol in spite of current WHO guidance which recommends against similar community based programs. Additionally, he learned that one key strategy for moving the PPH prevention program forward in Nepal was to make misoprostol available only through the official government supply system, and not in private pharmacies, in order to minimize fears about the mis-use of misoprostol. Finally, he learned practical tips about how to package and distribute misoprostol for a community based program.

5. Way Forward

This past quarter, MCHIP had several notable successes, such as qualifying three of the top trainers from the first cadre of 18 to be independent trainers, which will go a long way toward ensuring that improvements in the quality of care are sustainable. These three trainers, in addition to several of the original cadre of 18 and the Jhpiego/MCHIP training team, are now well versed in effective supervision approaches and will use these skills in the required follow-up visits to providers they have trained. Trainers and training participants are now better able to improve Emergency Obstetrical and Neonatal Care (EmONC) in their own sites and to ensure that they are addressing the issues raised in the QoC study.

Having developed action plans with key MNH stakeholders at the Jan. 24 Dissemination Workshop for the QoC study, MCHIP will continue working closely with partners to address the gaps in health care service delivery and link study recommendations to action. MCHIP plans to build on workshop achievements by seeing to it that neonatal resuscitation is eventually included in the national training curriculum as agreed upon during the workshop, and will continue to raise awareness about the other 3 primary areas of MCHIP's focus (infection prevention, PPH, PE/E). Already, professional association members MCHIP has trained have been integrated into a beneficiary list who will be recipients of key maternal, equipment, medicine and infrastructure support financed by UNICEF/UNFPA.

MCHIP has trained 330 CHW to date on community level maternal and neonatal health so that they will be able to appropriately respond to women and newborns with complications. In the coming months, MCHIP will take this a step further by compiling and facilitating the adoption of best practices on community-level management of maternal and newborn complications in the 3 demonstration districts. This intervention will teach women- with the assistance of their families and the communities- to plan in advance for potential complications and ensure that systems are in place to provide necessary logistical support and immediate transport to the nearest health facility.

MCHIP Field Coordinators based in the three districts will also pre-test revised registers which now include key interventions that MCHIP targets in trainings, such as AMTSL (Active Management Third Stage of Labor), and the use of magnesium sulphate to treat PE/E. This will enable MCHIP to accurately measure the impact of trainings in targeted MNH skills and knowledge and more importantly, will help ensure that providers practice these new skills so that clients can receive quality MNH care. Ultimately, MCHIP will advocate that these registers be adopted nationwide if appropriate.

Similarly, so that clients receive the best quality care possible, MCHIP will distribute job aids to MNH cascade training participants which will reinforce their newly acquired competency and skill on the following three proven high impact interventions: treatment of PE/E through the use of magnesium sulphate; flow chart or guide for the treatment of PPH; and finally a guide on neonatal resuscitation.

For the PPH Prevention program, the next steps are for Dr. Rakotovao and other strategic partners, including JSI, PSI and MSM to continue to convince key decision-makers about the importance of misoprostol for RIs and particularly the need to move forward with MCHIP's proposed PPH Prevention Program, to satisfy the need for "further studies" mentioned in the recent letter issued by the DAM. That said, if MCHIP is not successful in getting a new dispensation from the government and/or if the DAM fails to approve the miso importation request, we will need to enter into discussions with USAID/Madagascar concerning significant revision to this planned activity, to bring it into line with GoM requirements.

6. Annexes

- **ANNEX I : Success Story: Community Health Workers Teach Women to Prepare for Birth**

Annex I: Success Story

Community Health Workers Teach Women to Prepare for Birth

By Susan Moffson

Community Health Worker (CHW) Madame Rasoa described how Manampy gave birth at home and the baby got stuck in the birth canal. "After many hours when the baby would not come out, the matronne (traditional birth attendant) went to look for the ambulance but it was too late. Manampy was saved but her baby did not make it." From this experience and many others, Rasoa embraced the guidance she received at the USAID-funded MCHIP (Maternal and Child Integrated Program) training held in September, 2011, in Fort Dauphin, Madagascar, to always encourage women to give birth in health facilities so they may avoid the fate of women like Manampy and her baby, who depend on unskilled "matronnes" when they give birth at home. Raymond Rakatomanga, one of the MCHIP trainers at this September CHW training, cautioned "women take a big risk when they give birth at home with a matronne since they are not trained to deal with complications."

Erline, a nineteen year old new mother, learned about some of these risks from CHW Rasoa while she was pregnant with her first child, Priscilla, now 4 months. Erline said "my family wanted me to give birth at home because it is cheaper." But after Rasoa described some of the dangers of giving birth at home, "my family did not want to be responsible in case something went wrong so they were willing to let me go to a health facility." Erline worried especially about her baby suffering complications and explained "if the baby has trouble breathing, there wouldn't be anyone at home to help her."

In Madagascar, fewer than 2 in 5 women deliver in a health facility. Some key barriers to health facility access include a lack of transport, and poor or nonexistent roads. Some communities are inaccessible by car or motorcycle and are as far as two days of walking from the closest health facility. In addition, giving birth in a facility is more expensive than at home, where the traditional birth attendant will charge the family a $5 fee for her services, the equivalent of 1 week of pay for a day laborer earning the standard $1 per/day. Facility births can cost more than 4 times this amount, since there are many expenses including transport, medicine, and food for the 2-3 days spent at the facility. Yet, Erline was not deterred by the costs of a facility birth: "I did not look at the cost; I looked at the dangers (of a home birth)."

MCHIP trainers not only stress the importance of giving birth in a facility, but they also teach CHWs how to help women and their families plan in advance for the upcoming birth so they are prepared in case problems arise. For example, they learn to set aside money for birth related expenses or unforeseen emergencies, and they designate family members to take care of the house and any older children, as well as to donate blood in case of excessive bleeding or other complications. Though Rasoa was not able to accompany Erline to the facility for the birth of Priscilla, Rasoa was proud that Erline was prepared when the time came. "She had money set aside for the seven kilometer journey to the health center." Erline lives in a rural area without roads or available transport, so she was carried by two men on a stretcher made of tree trunks and cloth. According to Erline, the birth went smoothly at the health center.

Since traditional birth attendants are available in the community there is little perceived benefit to give birth in health facilities when the journey is often long and the cost much greater than a home birth. Yet with about 10 women dying per day in Madagascar due to complications from pregnancy and childbirth, MCHIP efforts to convince women to plan in advance for the birth and give birth in a facility with skilled providers are essential for combatting the high rates of maternal and newborn deaths, at around 498/100,000 live births and 32/1000 live births per year, respectively. AS CHW Rasoa discussed, "before this MCHIP training, I didn't know about all the dangers of giving birth at home. Now I can explain these dangers to women to encourage them to prepare for the upcoming birth and especially to give birth in a facility."

Like the other 41 CHW that attended the September USAID-funded MCHIP training on community-level maternal and newborn health, Rasoa will continue to build awareness in her community - through weekly village meetings and daily home visits to her 40 female clients - about the importance of planning in advance for the birth, giving birth in a facility, good hygiene and proper-hand washing, and other life-saving practices that she has learned.

CHW Rasoa with her client Erline and 4 month old baby Priscilla after a recent visit in Fort Dauphin, Southern Madagascar. Photo taken by MCHIP Field Coordinator, Raymond Rakatomanga.

Two men transport a woman who is about to give birth to the local health facility in Fort Dauphin, Madagascar. Photo taken by MCHIP Field Coordinator, Raymond Rakatomanga.