



Prevention of Postpartum Hemorrhage Initiative (POPPHI) Project Semi-annual Report

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Prevention of Postpartum Hemorrhage Initiative (POPPHI) Project

Semi-annual Report

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States government.

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1. Progress

Progress is being defined according to activities completed in the work plan.

1.1 Summary of Activities

The Prevention of Postpartum Hemorrhage Initiative (POPPHI) Project has continued to play a key role in initiating and facilitating activities that accelerate the uptake and use of PPH prevention strategies to save lives. From the acceptance and recommendation for use of a uterotonic by all women giving birth (in addition to a recommendation that all skilled birth attendants practice AMTSL) at the WHO Technical Consultation in October 2006, to the launch of the second Joint Statement by the International Federation of Gynaecologists and Obstetricians (FIGO) and the International Confederation of Midwives (ICM), to Indonesia's initiating activities to scale up AMTSL, there has been a leap forward in global activity on PPH prevention with significant progress in moving from advocacy to action. POPPHI has played a catalyst or primary role in many of these activities.

As part of the movement forward, POPPHI's work during the six months from August 2006 through January 2007, focused on preparation and initiation of "scale-up" activities, completion of global surveys, finalizing global indicators and support, completing the translation of the CD-ROMs into Spanish and French, dissemination of the research findings on misoprostol and pushing forward with oxytocin in Uniject™. Five "scale-up" countries are identified with a potential sixth country: Mali, Ghana, Benin, Indonesia, Uganda and Bangladesh. During the past six months, POPPHI has worked to ensure ministry of health and USAID mission buy-in to the scale-up process and begin the preparation for national meetings. The national meetings will review the evidence, identify barriers and plan activities to expand or scale-up country efforts to decrease postpartum hemorrhage through the use of active management of the third stage of labor (AMTSL) and community-based interventions, such as misoprostol. Five additional AMTSL countries have completed the survey, including data collection, analysis, and draft reports: El Salvador, Guatemala, Honduras, Nicaragua and Indonesia. A sixth country, Benin, is currently analyzing its data and will soon begin report writing. After much work with partners and USAID, the indicators are finalized and include a new community-based indicator. Indicator 1 has been included in the new USAID FACT. These are listed below:

Indicator 1: Number and Percentage of women in facilities and home where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs)¹ within a specified time period

¹ <http://www.who.int/healthinfo/statistics/inbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Indicator 2: Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL).

Indicator 3: Number and percentage of women in the home where the woman received community PPH prevention within a specified time period.

The data on the effectiveness of misoprostol from the Belgaum study has allowed POPPHI, through the Uterotonic Drugs and Devices Task Force (UDDTF) to move forward with strategy development on the use of misoprostol. POPPHI has monitored and tracked the activities leading to the production of oxytocin in Uniject by Instituto Biologico Argentino (BIOL) in Argentina. The Mali matrone project will include the use of oxytocin in Uniject™. Highlights of POPPHI activities over this period include:

- Increased global acceptance, agreement and willingness to actively address PPH prevention as seen through 1) the outcomes of the WHO Technical Consultation—recommending that all skilled birth attendants (SBAs) should practice AMTSL and moving the agenda forward by recognizing that all women should receive a uterotonic—oxytocin or misoprostol; 2) the saturation and significant emphasis placed on PPH at the FIGO Congress; and 3) the interest of countries to include PPH prevention as a major strategy to reduce maternal mortality.
- National meetings on PPH prevention strategies, focused on AMTSL, have taken place in Pakistan, Mali and Indonesia. The Ministries of Health have made commitments to scaling up AMTSL in Mali and Indonesia with strategic partners including USAID, its bilateral projects and specifically POPPHI assisting in this effort. Both of these countries are very committed to ensuring that all women giving birth (vaginal deliveries) with an SBA receive AMTSL.
- The “cutting edge” work in Mali to train auxiliary providers- *matrones*- to practice AMTSL is going well and there are plans for the inclusion of oxytocin in Uniject™ to occur in March/April 2007.

A summary table of performance is included below, in table 1. The table illustrates that POPPHI has again met or exceeded all of its targets for this reporting period.

Task 1: Expand AMTSL Through Non-Training Approaches to Improve Provider Practice

During this reporting period, the effects of POPPHI and its partners’ work are more evident in the field. During an in-county visit, the AMTSL posters were found in a Mopti, Mali clinic as well as clinics in Ghana. The Ethiopian and Tanzanian surveys are being widely quoted and are being used by policy makers to determine next steps for action. Recent correspondence from Ethiopia ob/gyn society indicates that they are focusing on increasing AMTSL practice in the regions where the survey found AMTSL practice absent. Additionally, POPPHI is receiving increasing requests to provide materials, give presentations and TA or requests to translate materials already developed. Organizations, such as JSI, are including training in AMTSL in their maternal health programs,

requesting to translate the CD-ROM into Ukrainian and providing POPPHI with data on their activities. The list-serv and toolkits continue to be used and the website, posters and fact sheets are very popular and requested. To date, 2779 English factsheets, 2679 English posters, 2117 French factsheets, 2242 French posters, 921 Spanish factsheets, and 945 Spanish posters have been requested and these have been distributed in 42 countries.

Task 2: Improve the Quality and Availability of AMTSL at the Facility Level

- The global AMTSL survey to assess current practices regarding AMTSL and to identify major barriers to its use has been completed in eight countries to date: Ethiopia, Tanzania, El Salvador, Guatemala, Honduras, Nicaragua, Indonesia and Benin. The final reports for Ethiopia and Tanzania have been sent out in hard copy and electronically, and are available on the POPPHI website. A dissemination plan was developed by Eastern, Central, and Southern Africa (ECSA) to ensure that the data from the surveys were adequately shared in both countries. From recent correspondence, it appears that the official dissemination workshops are currently being planned. The Uganda survey has been on hold until funding is received from African 2010/ECSA.

A data analysis workshop was held in Baltimore from December 5-10, 2006, in which the four Central American countries and Indonesia participated. A draft report was produced as the outcome from this workshop. These reports are currently being finalized and translated. Benin is currently analyzing its data. Indonesia has moved ahead quickly and conducted a national dissemination meeting on January 30, 2007.

In addition to the global survey, POPPHI's work in Latin America continues to focus on two areas: 1) small grants to Bolivia, Peru, and the Dominican Republic (the Paraguay grant has been withdrawn); and 2) work with three midwifery/nursing associations from Bolivia, Ecuador, and El Salvador for follow-up to the International Confederation of Midwives (ICM) Trinidad conference which was held in April 2002. POPPHI consultant, G. Metcalfe, traveled with R. Quiroga to Bolivia to assist with an AMTSL training conducted by the ob/gyn and nursing associations, November 7-22, 2006. See Appendix K for the trip report. Given the lack of response from the associations to submit a proposal, the funds will be used to support G. Metcalfe to assist the associations to complete the selected activities.

The POPPHI indicators were finalized during this reporting period after significant work with partners and USAID. Another activity completed and submitted to USAID during this period was the training evaluation. A request was made by USAID to make some additions and this will be completed and resubmitted in April, 2007.

The training manual is completed, revised and was pre-tested in Pakistan. It will be sent to reviewers and provided to countries who have requested it in draft form, e.g., Bangladesh. The training of trainers manual is currently under review. We have

completed a post-training evaluation worksheet that we are starting to disseminate with grantees.

Task 3: Improve the Quality and Availability of AMTSL at the Community Level

Pakistan bilateral activities were completed during this period with the national dissemination meeting on AMTSL held on January 16, 2007, followed by three provincial workshops attended by 25 – 35 participants at each workshop. Balochistan joined the Karachi workshop due to a travel ban to that area. Six to eight local facilitators assisted at the training and these facilitators had participated in the small grants' training conducted by D. Beck that was held in August, 2006. All workshops were very well-received with numerous comments on their success in generating interest and knowledge about PPH and AMTSL. Correspondence from small grants recipients indicate that “Encores” are requested for more training.

In **Bangladesh**, EngenderHealth (**EH**) has developed a work plan and continues to support the national PPH working group. A national PPH prevention work plan has also been developed which includes the intention to conduct an ATMSL survey, using the POPPHI tools, and EH is contributing \$20,000 to the effort. They are seeking additional funding at this time. Plans are being made to incorporate AMTSL into three hospitals where EH has ongoing fistula activities. D. Armbruster visited Bangladesh from Jan. 21-25, 2007, and participated in a national PPH task force meeting, met with National Support Development Project (NSDP) and initiated the small grant process with the Bangladesh nursing association and the ob/gyn association (to replace Paraguay?). The associations will develop their proposal and submit within the month.

Bangladesh is maintaining the momentum created by their national PPH prevention meeting (convened August, 2006) with continued PPH task force meetings and the creation of a national action plan. POPPHI will provide its draft training manual to Bangladesh. Bangladesh is working actively to register misoprostol and talking with a pharmaceutical manufacturer, Novartis, on producing a 25 mcg. and 600mcg. misoprostol tablet.

Mali has completed its baseline and has begun training matrones. S. Engelbrecht traveled to Mali in late January, 2007, to conduct supervision visits and to plan for the February 12, 2007, national scale-up of PPH prevention meeting. M. Greeley and D. Armbruster will visit Mali in early February, 2007, to participate in the launch and work with the Ministry of Health (MOH) on next steps for the AMTSL scale-up. Additionally, two regional launches will be held after the national launch in the Mopti and the Kourikouro regions. M. Greeley and D. Armbruster will attend the Mopti launch while S. Engelbrecht assists with the national training of trainers from February 13 - 19, 2007, followed by the Kourikouro launch. POPPHI will work with the MOH, USAID and its partners to determine its follow-up activities but anticipates that it will have a role in monitoring and evaluation, particularly an evaluation in 1-2 years time. In **Indonesia**, the national AMTSL survey was completed, data analyzed and draft report written by early January

2007. The national dissemination workshop was held on January 30, 2007, and was well attended by national and provincial leaders. The ownership of the process and commitment to using the data to make changes and improvements within the Indonesian health system was apparent from the MOH, particularly the Director and deputy director of the maternal health department, as well as the hospital department. Follow-up meetings with the MOH, USAID, Health Services Program (HSP) and other stakeholders showed continued commitment to follow-up activities, with POPPHI playing a significant role. Decisions are currently being made by USAID on POPPHI's role and the activities for which it will take the lead. Additionally, USAID is determining whether additional funding will be available for POPPHI, in addition to the \$100,000 it will contribute.

The Community-based PPH Prevention Task Force has completed the community-based literature review and it is under final review.

Task 4: Make UDD Available at Low Cost to Countries

POPPHI has focused on follow-up to the issues and activities suggested during the *Practical Guidance for use management and storage of oxytocics* meeting, March 21, 2006, during this reporting period. US Pharmacopeia (USP) has provided POPPHI with a draft of the revised oxytocin monograph that removes the temperature guidance on 2-8 degrees C and allows use of plastics (versus glass) for the container. The request to increase the specifications has been questioned by the Food and Drug Administration (FDA) and USP is seeking guidance from WHO and other advisors. The final monograph is expected to be available during the next quarter. The global discussion on this issue, combined with website information and the technical briefs by RPM Plus appear to be increasing understanding in the field. Discussions at the field level indicate better use and understanding of the storage issues than previously found.

This six months has also seen milestones achieved by the producer of oxytocin in Uniject™, BIOL, with the Health Tech team. The stability studies are completed and an initial filling of oxytocin into Uniject™ has occurred, January, 2007. This will be sent to Mali for the matrone study. A meeting is planned for February, 2007, with Dr. Hans Hogerzeil, director of the Essential Drug Division at WHO. POPPHI continues to support efforts by the HealthTech program to develop a Vaccine Vial Monitors (VVMs) for oxytocin.

1.2 Looking to the Future

POPPHI will have a very busy next six months as it continues its strategic focus on scale-up in the 5-6 countries and providing assistance to achieve 50% coverage of AMTSL in those countries. Mali and Indonesia have begun the process of scaling-up and POPPHI is finalizing plans developed with the MOH, USAID and bilateral partners in each country. Benin and Ghana are likely to complete their surveys and national dissemination meetings in the next six months. These meetings will help define POPPHI's role and the

activities it will pursue in these countries to assist with the scale up of AMTSL. It is anticipated that Uganda will complete its survey but may not complete the follow-up activities during this next reporting period. The reports of the 6 surveys should be completed and disseminated through national dissemination meetings. G. Metcalfe will represent POPPHI at these meetings and provide guidance as the countries plan small interventions to increase use of AMTSL in Honduras, Nicaragua, Guatemala and El Salvador. The expansion of misoprostol activities will also be an important focus for POPPHI. The PPH Working Group and the four task forces will continue to meet and provide additional guidance on POPPHI activities in the upcoming six months. Global advocacy activities will continue but will be more focused on WHO and international bodies who can have a significant impact on the expansion of AMTSL globally.

1.3 Activities Completed by Task

General

Under this category, all activities listed in this period are either ongoing or completed. Activities include the following:

POPPHI website, www.pphprevention.org, continues to be a very active site with numerous additions and updates made during the last six months. The new items include: updated information on PPH prevention indicators, including a new community based indicator and some reference data collection forms; the French and Spanish AMTSL CD-ROMs, and the second Joint Statement by FIGO and ICM—“*Prevention and Treatment of Post-partum Haemorrhage: New Advances for Low Resource Settings*”.

- POPPHI continues to support the list-serv on PPH prevention with questions and topics on uterotonics being the primary topics.
- Maintain master calendar of events.
 - This calendar is available online and is an ongoing activity with participation by all partners. The majority of the following conferences and meetings are listed and have been initiated or attended by POPPHI staff:
 - All Task Forces on first interventions, training, community-based PPH prevention, and uteronic drugs and devices (UDD), met during this period. (See Appendix L for the most recent minutes from the first interventions, community-based PPH prevention and UDD task forces. The training task force minutes will be posted to the POPPHI website during March, 2007)
 - USAID hosted an indicator meeting to review indicators for the new FACT system. POPPHI indicator #1 on AMTSL is included in the system.
 - POPPHI initiated and provided funding for the WHO Technical Consultation on *Postpartum Hemorrhage Prevention Strategies in Low Resource Settings*. This meeting was held October 18 – 20, 2006, in

Geneva, Switzerland. Global experts in obstetrics/gynecology and midwifery joined WHO staff to review the evidence on controversial topics on AMTSL such as use of AMTSL by non-skilled attendants, use of misoprostol for PPH prevention, immediate versus delayed cord clamping. The results are likely to recommend the use of AMTSL for all skilled birth attendants (with a slightly expanded definition – see Appendix G); use of a uterotonic, including misoprostol and oxytocin, for non-SBAs who are trained to competence to use the uterotonic; and delayed cord clamping.

- FIGO Congress in Kuala Lumpur, Malaysia (November 5-10, 2006) provided a venue for the presentation of the data on the Ethiopian and Tanzanian surveys and a forum for extensive dialogue with ob/gyn leaders on their work on PPH prevention and treatment. The approval of a second Joint Statement of FIGO and ICM on *Postpartum Hemorrhage Prevention Strategies in Low Resource Settings* by their respective Boards of Directors/ Management was announced at this meeting. FIGO's focus and special initiative on PPH was evident with a significant number of large fora, presentations, posters and materials distributed on PPH.
- Collected data and contributed to the POPPHI Portfolio Review (November, 2006) and Operational plan (December, 2006)
- A Data Analysis workshop for the AMTSL surveys was held in Baltimore, Maryland from December 5-10, 2006. Participants included D. Jarquin, LAC/ COMIN coordinator and the in-country coordinators from Honduras, El Salvador, Nicaragua and Guatemala. Indonesia and Benin were also represented. All participants except Benin analyzed their survey data and wrote draft reports on their data.
- A national meeting on *Reducing Maternal Mortality: Evidence-based Interventions and Strategies to Prevent Postpartum Hemorrhage* was held in Pakistan, in collaboration with the PAIMAN/ USAID bilateral project, on January 18, 2007. This meeting was followed by three provincial workshops held in Peshawar (North West Frontier province), Karachi (Sindh province – and included participants from Balochistan province), and Lahore (Punjab province) between January 20 and February 3, 2007, for 2½ days each.
- The Indonesian Ministry of Health hosted a national meeting to disseminate the results of the national survey on AMTSL and to identify the steps forward.
- Facilitate the exchange of information and coordinate with implementing partners (IPs).
 - The POPPHI partners (RTI, EH, and PATH, with FIGO as a regular contributor) continue to hold monthly teleconferences where they share

information on project activities, discuss issues and concerns, and plan future activities.

- RTI staff, N. Darcy, continues to work with the IPs to collect data on the indicators. John Snow, Inc., and its projects in Ukraine, Georgia has become an active participant in data collection with provision of data to POPPHI. The Quality Assurance (QA) Project continues to share data from their collaborative work in Benin, Ecuador, Honduras, Niger and Nicaragua.
- N. Darcy also maintained contact, dialogue and follow-up with the participants of the Cooperating Agency (CA) meeting held in June, 2006. The POPPHI indicators to collect data on the summary outcome indicators have been finalized, including the community based indicator.
- POPPHI has provided 1000 French posters and fact sheets to ACCESS for their use in country programs. ACCESS/JHPIEGO assisted POPPHI with the French and Spanish CD-ROMs on AMTSL by reviewing and providing feedback on the translations.
- Health Tech and POPPHI continue to collaborate on the manufacture of oxytocin in Uniject™ and plans are finalized for providing oxytocin in Uniject™ to the matrone project in Mali.
- RPM Plus staff and POPPHI are continuing collaboration on the surveys in Benin, and Ghana. RPM Plus is also participating in the national workshop on scaling up AMTSL in Mali. It is anticipated that the workshop will identify technical assistance to be provided by RPM Plus to the MOH in Mali.
- Identify and track current and ongoing research and country implementation related to AMTSL.
 - A list of ongoing research on misoprostol for preventing PPH is available on the POPPHI Web site. The information was updated in July 2006.
- Convene a PPH Working Group Meeting.
 - The PPH Working Group meeting is planned for March 26, 2007, and a Save the Date notice has been sent to participants.

Reporting

- POPPHI Performance Monitoring Plan was updated, submitted and accepted, on January 24, 2007 (based on the finalized indicators)
- POPPHI submitted its February 1 to August 31, 2006, semi-annual report to USAID on schedule.

Task 1: Expand AMTSL through Non-training Approaches to Improve Provider Practice

Provide technical assistance to FIGO and ICM to promote the use of AMTSL

1. Continue dissemination of FIGO/ICM Joint Statement

- Assist FIGO and ICM staff to facilitate dissemination of joint statement through their meetings.
 - POPPHI provided PPH toolkits, FIGO/ICM joint statements, briefing papers, and job aids for the FIGO Congress in Malaysia, Pakistan national AMTSL meeting, and the Bangladesh national PPH task force and the Indonesia national dissemination meeting received FIGO/ICM joint statements, briefing papers and job aids.
 - POPPHI was informed by a number of Pakistani, Bangladeshi and Indonesian obstetricians/gynecologists during visits to their respective countries that the FIGO presentations or “launches” at Cairo and in Malaysia were effective in getting support from in-country providers as to the importance of PPH as a problem and to motivate them to address PPH in their countries.

2. Provide technical assistance (TA) to associations for workshops on PPH

- Use AMTSL training materials and practica appropriate for workshop settings.
 - CD-ROMs are translated into Spanish and French and available on the website. There is currently a request to translate the AMTSL CD-ROM into Ukrainian.
 - Technical assistance has been provided to Bolivia, Pakistan and Indonesia during this reporting period. Workshops to standardize the practice and training of AMTSL were held in Bolivia and Pakistan. Additionally, POPPHI staff assisted in the facilitation of national meetings on AMTSL; the dissemination of findings from the AMTSL survey in Indonesia; and a national PPH task force in Bangladesh.
 - POPPHI has been asked to assist Pan-American Health Organization (PAHO) and ICM in at the 2nd Regional Conference in Argentina to hold three 4-hour sessions on PPH for the participants. G. Metcalfe and C. Kramer are planning these sessions for mid-March 2007.
- Identify and adapt non-training approaches to increasing provider skills on AMTSL.
 - POPPHI’s Web site, www.pphprevention.org, is live and updated regularly. Numerous in-country colleagues have indicated that they have used it. POPPHI has been informed by numerous national association colleagues that the website is used routinely, easy to use, and informative.
 - POPPHI has been working with the PAHO to distribute the translated AMTSL posters and fact sheets as well as the condensed version of the PPH toolkit.

- Identify and utilize representatives and experts from countries in each region with experience in AMTSL to take leading roles and to assist small grant recipients and other countries interested in introducing AMTSL.
 - Dr. S. Gbangbade, Benin, is assisting RPM Plus in conducting the surveys in Benin and Ghana. He will also serve as a consultant to assist the Uganda AMTSL survey team in data analysis and report writing
 - G. Metcalfe, consultant and Chilean midwife, has agreed to be the LAC team leader to oversee and coordinate the work in Latin and Central America.
 - S. Ahsan Pal, Pakistan ob/gyn, served as a consultant to the national and three provincial trainings in Pakistan.
- Link with regional experts trained by the Maternal and Neonatal Health (MNH) program and with national associations.
 - POPPHI continues to link with MNH regional experts whenever possible.
- Provide association leadership with evidence supporting the use of AMTSL to ensure commitment to AMTSL. Provide training as needed.
 - Reference material provided to all association leadership. Ongoing updates provided.
- Facilitate and assist associations to implement, evaluate, and follow up on workshops/practice, using expertise from a master resource list and IPs.
 - This work is ongoing.

3. Provide assistance, monitoring, and evaluation of small grants

- Awarded grants to 15 country associations during 2006. The Paraguay grant was withdrawn due to the inability of the associations of ob/gyn's and midwives to coordinate the effort. Peru has received the award but has not provided any information on their activities yet. Changes in leadership of the midwifery association have exacerbated the problem; POPPHI staff is in frequent contact with them. Visit http://www.pphprevention.org/small_grants.php for more information.
 - Bangladesh will be a new small grant recipient. Discussions were held with leadership of the nursing (includes midwives) association and ob/gyn society during D. Armbruster's recent visit, January 2007. Both associations agreed that they are interested in working with POPPHI on expanding the use of AMTSL. There was agreement that the nursing association will receive the funding and provide the direction (per guidance from USAID and EH). An advisory group, consisting of 2-3 ob/gyn's and 2-3 nurses will oversee the grant. Explanations were given on the baseline and endline survey documents.
 - Baseline surveys have been received from 12 countries– Benin, Cameroun, Ghana, Tanzania, Burkino Faso, Uganda, Nepal, Bolivia, DR, Pakistan,

Malawi and Indonesia. Nepal has sent in their endline surveys during this reporting period.

- Monitor progress of grants, in collaboration with FIGO and ICM.
 - The baseline/endline data collection tool has been greatly simplified and closely resembles the new data collection form developed for country and project use (see Appendix A)
 - N. Darcy, M&E specialist, and M. Torok intern, completed the input of the baseline data for all of the small grant awardees/ national associations received to date February 15, 2007. See Appendix J to review the data.
 - N. Darcy and M. Greeley set up appointments with many of the associations and are in constant communication with them to get answers to questions raised by the input and analysis of the baseline data.
- Provide materials and selective TA to grantees to ensure high quality and competence in AMTSL training.
 - See Task 1, number 2, bullet 1, dash 2 for additional information.

4. Promote the publication of the FIGO/ICM joint statement in 25 association newsletters or other mechanisms

- Ensure ICM and FIGO publish joint statements in 25 national newsletters (or other mechanisms).
 - Completed.

5. Distribute PPH toolkit

- Distribute toolkits through international, regional and national meetings, including medical, midwifery, and nursing professional meetings. Last reporting period POPPHI distributed most of the toolkits so it was not necessary to distribute as many this period. The numbers of job aids has markedly increased, however.
 - POPPHI continued to distribute PPH Toolkits at conferences, meetings, and at the request of interested parties. During this period, 123 (plus previous 1,735, for a total distribution of 1,858) condensed PPH Toolkits, 46 (plus previous 585, for total distribution of 681) PPH Toolkit reference manuals, and 225 (plus previous 1000, for a total distribution of 1,225) CD-ROMs were distributed in Bolivia, Pakistan and to numerous countries that attended the FIGO international Congress (See Appendix M for the distribution list).

6. Link or collaborate with other organizations to expand the use of AMTSL

- Work with UNFPA, UNICEF, and WHO to develop a joint statement in support of AMTSL
 - WHO and UNFPA agreed to continue to work on a joint statement. Unicef was not in attendance but it is anticipated that they will also agree to complete this effort.

- A WHO Technical Consultation, supported by POPPHI and USAID, was held from October 18-20, 2006, on *Prevention of Postpartum Hemorrhage in Low Resource Settings*. While the final document has not been published to date, important outcomes include:
 - WHO will recommend that all Skilled Birth attendants (SBAs) perform AMTSL for all vaginal births. (The definition of SBA will include both the new and older versions of the WHO/UNICEF/UNFPA/ FIGO/ICM definition of SBA. (See Appendix G for the earlier definition of a SBA.) Health providers who are not SBAs but are trained to competency on AMTSL can also perform ATMSL.
 - The drug of choice for AMTSL is oxytocin but misoprostol will be recommended if use of oxytocin is not feasible.
 - WHO will recommend that all births (with non-SBAs) receive a uterotonic: oxytocin or misoprostol.
 - WHO will recommend delayed cord clamping
- Making Pregnancy Safer division published a Technical Update on AMTSL which was widely distributed at the FIGO conference
- A meeting of cooperating agencies was held on June 27, 2006, with participation of USAID and ten organizations to increase the use of the AMTSL indicators for tracking AMTSL data.
- M. Greeley participated in the fall CORE meeting, specifically to share information on the POPPHI/AMTSL indicators and to ask the participating organizations to use these indicators and for the Safe Motherhood/Reproductive Health (SM/RH) Working Group of CORE to support and promote these indicators.
- D. Armbruster provided consultation to Dr. A. Degregorio, Save the Children in Aceh, Indonesia on the potential use of misoprostol in their program.

7. Monitor activities of professional associations in promoting AMTSL

- Assist FIGO and ICM to track member association information dissemination activities to promote AMTSL policies and practices.
 - FIGO presented data from its survey of ob/gyn associations and a number of midwifery associations during the FIGO Congress. See http://www.sogc.org/figosurvey/index_results.asp for available results.
 - The report from FIGO (June 2006 to September 2006) is found in Appendix E.
- ICM and FIGO have joined the monthly POPPHI teleconferences to update all parties on project accomplishments and address issues as they arise. FIGO regularly joins the meetings.

- FIGO received a donation to support the publication of a book on PPH. This book utilized the expertise of many ob/gyn's in the field and was distributed at the FIGO Congress. It was a very popular item and all copies were rapidly distributed.
- N. Darcy completed an assessment of the FIGO web-based data collection tool, and determined that we cannot use this data for AMTSL reporting because the data collection does not match the POPPHI indicators
- USAID and others may refer to the POPPHI web site to get periodic updates and current information on the status of POPPHI's work promoting AMTSL.

Task 2: Improve Quality and Availability of AMTSL at the Facility Level

1. Evaluate training and non-training approaches designed to improve provider skills in AMTSL

- Document and evaluate traditional and nontraditional skill-building approaches to measure their effectiveness in ensuring essential competencies related to AMTSL.
 - Ongoing
- Develop an evaluation report of training strategies.
 - The training evaluation was submitted to USAID in October, 2006. USAID asked for additional data and POPPHI will deliver this updated information during April 2007.
- Hold a training TF meeting.
 - Training TF met on January 4, 2007, via telecom. The training manual was reviewed, as well as suggestions for the revised toolkit. The next Training TF will meet on March 26, 2007, just after the PPH Working Group.
- Evaluate the self-study module.
 - The self-study module is on hold until the training module is completed. We will then evaluate the need for the self-study, particularly given the amount of material that is available on the Web.
 - Intrahealth: Mali and Bangladesh have both indicated interest in pursuing the development of a mentoring system as an alternative training strategy. This would likely use self-study material and then practitioners would obtain clinical experience at a designated “mentoring” facility.
- Share training materials.
 - The draft training module for participants was pre-tested in Pakistan during the provincial workshops. A draft Training of Trainers component has been completed. Selected components of the module, e.g., the skills checklist, is being pre-tested in Pakistan during a standardization meeting held with the small grant awardees. Additionally, the module, combined with materials previously developed by IntraHealth, is being used for training *matrones*. The

matrone training is a 5 day training class due to the low level of education and training of this health cadre.

- Job Aids have been distributed widely: 2,679 English posters; 2,779 English fact sheets; 2,242 French posters; 2,117 French fact sheets; 945 Spanish posters; and 921 fact sheets have been distributed during this reporting period. Countries who have received hard copies of the job aids include: Argentina, Bahamas, Barbados, Belice, Benin, Bolivia, Brazil, Burkina Faso, Cameroon, Chile, Columbia, Costa Rica, Cuba, Dominican Republic, DRC, Ecuador, El Salvador, Ethiopia, Ghana, Guatemala, Guyana, Haiti, Honduras, India, Indonesia, Jamaica, Malawi, Malaysia, Mali, Mexico, Nepal, Níger, Nicaragua, Pakistan, Panama, Paraguay, Peru, Suriname, Tanzania, Uganda, Uruguay, Venezuela.
- The job aids are also available to download on the website.
- The job aids were translated into Urdu and distributed in Pakistan.

2. Develop monitoring plan; measure implementing partners' progress toward achieving benchmarks and measure availability and coverage of AMTSL services

- Finalize M&E plan to monitor IP programs' progress toward achieving benchmarks and measure availability and coverage of AMTSL services in five countries.
 - Reporting forms were developed for use by IPs and countries/organizations interested in collecting data on the indicators. (See Appendix A).
 - The reporting forms (translated to French) are being used in the matrone pilot in Mali and in the Senegal bilateral project.
- Revise M&E plan as needed, based on input from USAID and IPs.
 - The two outcome indicators have been finalized and the Performance Monitoring Plan (PMP) revised, submitted and approved by USAID, January, 2007.
 - A community based indicator has also been finalized and approved by USAID, January, 2007
 - Information on the indicators are available on the website at <http://www.pphprevention.org/Indicators.htm>
- Collect needed data on benchmarks and indicators and provide periodic progress reports to USAID and IPs.
 - N. Darcy, RTI, continues to facilitate data collection on indicators from IPs. POPPHI staff collect data from the small grant recipients.
 - POPPHI has been diligently completing work on the indicators (now finalized and approved) and reporting forms. A network of projects and organizations active in maternal/child health and that include active management of the third

stage of labor, has been created through the process of meetings, indication of interest and communication by POPPHI's M&E specialist, N. Darcy. This network is regularly updated on the indicators and contacted for data when POPPHI reports are due.

- POPPHI is in dialogue with WHO to collaborate on the development of global indicators for PPH prevention. The intended outcome would be a global indicator for inclusion in national health/management information systems. A meeting is set for February 19, 2007, with the leadership of the Making Pregnancy Safer division.

3. Provide TA to missions and regional bureaus upon request

With support from the LAC Bureau, POPPHI is continuing to support the Central American Society of Ob/Gyn's and El Salvador, Guatemala, Nicaragua and Honduras completed their surveys and data analysis during this reporting period. The teams are currently revising and editing the reports and planning the dissemination of findings in their respective countries. Additionally, G. Metcalfe became the team leader for the POPPHI LAC work and has focused on moving the Trinidad follow-on countries forward. G. Metcalfe, with R. Quiroga, visited Bolivia to conduct a training of trainers and to plan the follow-on development of training centers in Sucre.

POPPHI continued collaboration with REDSO-East, Africa Bureau, the Support for Analysis and Research in Africa SARA Project, ECSA, and the Regional Centre for Quality Health Care (RCQHC). The AMTSL surveys in Ethiopia and Tanzania were completed and the reports distributed in hard copy and electronically.

Uganda has been prepared since October/ November, 2006, to conduct the survey but has not received its funding from Africa 2010 and ECSA. When funds are provided to the MOH, the Ugandan team will complete the AMTSL survey.

The AMTSL surveys were conducted in Indonesia, Benin, and are in the planning stages in Ghana. The AMTSL surveys have the support of the MOH and USAID missions in these three countries. The Benin and Ghana surveys are being funded by RPM Plus. Indonesia also participated in the Baltimore data analysis workshop and has submitted a draft report. Benin is currently analyzing its data and plans a dissemination meeting in April 2007. Ghana plans to start data collection in May, 2007.

- Conduct dissemination workshops on AMTSL survey in each country in partnership with key stakeholders.
 - El Salvador, Guatemala, Nicaragua and Honduras completed data collection for the AMTSL survey and attended the data analysis workshop held in Baltimore from December 5-10, 2006.
 - Indonesia also participated in the data analysis workshop.
 - With oversight from C. Stanton, Principal Investigator, the LAC teams and Indonesia analyzed their country data using the STATA statistical package

and wrote draft reports during the data analysis workshop. The teams are currently editing and revising the reports and planning the dissemination of the data.

- Dissemination workshops are currently being planned for the LAC teams.
- Indonesia conducted its national dissemination workshop on January 30, 2007.
- Conduct small scale interventions to increase support for the use of AMTSL by skilled providers
 - The dissemination workshops will present the survey data, provide a forum for discussion of issues and challenges and create action plans to include activities that will form the basis for the small scale interventions needed to maximize the use of AMTSL in the Central American countries.
- Identify countries with significant opportunity and supportive environment* to expand or scale-up PPH prevention activities.
 - POPPHI, its partners, and USAID have identified 5 scale up countries and have confirmation from the USAID missions and ministries of health in 4 of the countries: Mali, Ghana, Benin, Uganda and Indonesia.
 - Bangladesh was not originally identified as a scale-up country but great interest has been generated, with a national meeting on scale up of PPH prevention held August, 2006, and the creation of a national PPH task force. Bangladesh has plans for an AMTSL survey funded locally and an action plan. Bangladesh has requested to be officially recognized as a “scale-up” country for POPPHI and this is under consideration.
- Provide additional support (TA and funding) for implementation and M&E activities.
 - POPPHI will work with national teams of MOH, USAID and partners to determine its role in supporting scale-up in the 5-6 countries. Activities will likely include M&E activities such as use of POPPHI indicators, data collection system development and evaluation of the success of scale-up at 1-2 years after startup of the program. Other possibilities for technical assistance include behavior change interventions, development of alternative training methodologies and use of misoprostol.
 - Indonesian national meeting developed an action plan based on the following topic areas: policy, providers/practice, drugs and logistics and monitoring and evaluation. Based on the action plans and meetings with important stakeholders, POPPHI identified activities and areas where its support would be most valuable, including developing tools for monitoring performance and outcomes. These suggestions and recommendations are currently being evaluated by the USAID mission in Indonesia.

- Ongoing support and monitoring to ob/gyn and midwifery/nursing associations to expand AMTSL
 - Through association small grants
 - See Task 1, bullets 3 and 7
 - Through Trinidad follow-on small grants
 - Due to the lack of response for submission of proposals, the small grants will not be provided. The funding that would have been used for the small grants will be used to hire G. Metcalfe, consultant, to assist in implementing the programs.
- Dissemination of materials and lessons learned on prevention of PPH, with a focus on AMTSL
 - See Task 1, #2, bullet 2, dash 2; Task 1, #5 and Task 2, #1, bullet 5, dash 2
- Regional dissemination workshop in collaboration with PAHO, Centro Latinoamericano de Perinatología y Desarrollo Humano (CLAP), INCLAN, Quality Assurance Project (QAP), National Institute for Child Health and Human Development (NICHD).
 - This activity is not in the work plan for this reporting period.

Task 3: Improve the Quality and Availability of AMTSL at the Community Level

Important contributions were made this reporting period towards PPH prevention efforts at the community level. The second Joint Statement, ***Postpartum Hemorrhage Prevention Strategies in Low Resource Settings***, was finalized, approved and disseminated and can be found on POPPHI's website. The Mali matrone pilot project is underway and findings to date are quite positive on the matrone's ability to use AMTSL effectively. Misoprostol continues to be a topic of discussion at all country visits with a variety of issues discussed and registration of the drug continuing to be a major issue. POPPHI is facilitating the effort to move misoprostol forward and into use for PPH prevention. The Community-based TF is also making contributions to this effort.

- The Uterotonic Drugs and Devices Task Force (UDD TF) made an important decision to move forward in support of misoprostol for prevention of PPH at the community level and for use in AMTSL when oxytocin is not feasible. With its partners, a strategy was outlined and will be further developed. (See Appendix L for the UDD TF minutes).
- POPPHI agreed to follow-up with WHO to encourage prompt release of the October 2006, Technical Consultation document on AMTSL. WHO staff stated that the document has been approved by the Director General (DG)'s office and is getting ready for printing.
- POPPHI is also discussing the status of adding misoprostol into the Essential Drug List (EDL) for PPH indications with WHO Making Pregnancy Safer staff.

- Visits to Bangladesh and discussions with NSDP staff indicate that AMTSL can be safely provided in the home by the paramedical staff. NSDP agreed to send evaluation data to POPPHI.
- An article on community-based PPH prevention strategies (changed from solely AMTSL) is being published in the next MotherNewborNet newsletter.
- The literature search on community-based prevention of PPH activities is completed and in its final stages of editing. See Appendix N for a summary of the literature search.

1. Develop monitoring plan; measure implementing partners' progress toward achieving benchmarks and measure availability and coverage of AMTSL services

- Collaborate with IPs on indicators, sources of data, reporting procedures, etc.
 - Completed.
- Revise M&E plan as needed, based on input from USAID and IPs.
 - Completed.
 - Two outcome indicators have been reviewed and revised, and approved by USAID; The follow-up CA meetings in November, on, 2006, provided valuable feedback and interest from CAs and NGOs to finalize the AMTSL indicators. Ongoing comments are being solicited through the list-serve. Several CAs have committed to collecting data based on the updated indicators.
 - The community-based indicator has been finalized and is on the website.
- Collect needed data on benchmarks and indicators and provide periodic progress reports to USAID and IPs.
 - Ongoing.

2. Provide TA to missions and regional bureaus upon request

POPPHI has identified four countries with bilateral programs that are interested in receiving TA from POPPHI to total US\$100,000 per country: Bangladesh, Indonesia, Mali, and Pakistan.

POPPHI's work with the LAC Bureau continues as reported above (see "Provide TA to missions and regional bureaus upon request" under Task 2).

- Pakistan: POPPHI conducted the national dissemination workshop on PPH prevention on January 16, 2007, in collaboration with the USAID bilateral program, PAIMAN, USAID, UNICEF, UNFPA and WHO. It was very successful, generated much interest and developed action plans for the four areas of policy, practice, drugs and logistics and monitoring and evaluation/ documentation. See Appendix C for the action plans and recommendations. Additionally, three provincial workshops were conducted to give a more hands-on

training to midwives and physicians at the district hospital and health center level. Four provincial workshops were originally planned but travel to Balochistan was prohibited so participants from Balochistan participated in the Karachi workshop. D. Armbruster visited Pakistan from January 13 – 20, 2007. American Collect of Nurse Midwives ACNM consultant, D. Beck, worked with numerous Pakistani ob/gyn's who served as co-facilitators for the workshops. These facilitators had been trained in the professional association trainings held in late 2006. The posters and fact sheets are translated into Urdu and were widely distributed. D. Beck visited Pakistan from January 14 – February 3, 2007. J. Litch, PATH, assisted with the Karachi workshop from January 21 – 25, 2007.

- Mali: POPPHI continues its collaboration with the bilateral program, Assistance Technique Nationale (ATN), IntraHealth/The Capacity Project, and CARE/Keneya Ciwara to complete a pilot project that trains *matrones* in the use of AMTSL. S. Engelbrecht is the team leader for the Mali program and has participated in training of trainers, training of matrones, supervision visits as well as development of the indicators and M&E plan. Plans are made for the national “launch” of the scale-up activities to be held on February 12, 2007.
- Indonesia: The national AMTSL survey is completed, data analyzed and draft report written. With support from the USAID mission, the bilateral project, Health Systems Project (HSP) and MOH, a national meeting was held on January 30, 2007, to disseminate the findings of the survey and make plans for next steps and was facilitated by the MOH, its partners, with assistance by POPPHI and the PATH office. S. Hermijanti Junizarman, Director of Maternal Health, MOH-Indonesia actively participated, as well as her deputy, Dr. Lukman and the director of hospitals. Plans of action were developed. Misoprostol was a major topic of discussion with the maternal health division in support but with prominent ob/gyn's and midwives expressing vocal opposition. It was agreed that the registration effort will move forward, possibly with the efforts of Venture Strategies. D. Armbruster participated in the national meeting.
- Bangladesh: A national PPH scale up meeting was held at the end of August, 2006, in Bangladesh with over 220 people in attendance. POPPHI posters were hung around the large conference room and local and international speakers, including POPPHI's director, gave presentations and updates to the participants. (See Appendix B for the meeting agenda). A national PPH task force has been formed and had already met prior to the meeting. The recommendations from the meeting would form the basis for a work plan for the PPH task force. The use of a simple QA process with computer-based data was previously discussed with Bangladesh EH but the suggestion was withdrawn at the request of USAID. D. Armbruster traveled to Bangladesh from August 29 - 31, 2006, to participate in the national meeting and work with the Bangladesh team on PPH prevention strategies. January 21 – 26, 2007, was another trip to Bangladesh by D. Armbruster to review the national strategy, the EH plans to support scale up

and to meet with the professional associations to initiate a small grant to Bangladesh.

Task 4: Make Uterotonic Drugs and Devices Available at Low Cost to Countries

- Task 4 activities for the past six months have included significant activities of oxytocin in Uniject, with BIOL completing their stability studies with no problems and filling of oxytocin in Uniject for the matrone pilot going according to plan. Application for registration for oxytocin in Uniject in Argentina is planned for April 2007. Glandpharma is planning or has just begun their stability data collection for oxytocin in Uniject. With the positive results from the Belgaum misoprostol study, activity has increased around misoprostol with POPPHI developing a strategy through the UDD Task Force. Additionally, USP's has revised the oxytocin monograph to remove the temperature requirements and allow manufacturer's to determine the temperature requirements based on their stability data. Plastic containers are permitted. There was general agreement by the advisory group for these suggested changes. The suggestion to increase the specifications from 90-110% to 80-120% was questioned by FDA and further advice is being sought by USP from WHO. WHO is also developing a monograph for *The International Pharmacopoeia*. Oxytocin is in the list of drugs for prequalification but is not at the top of the list at present. A visit to Dr. H. Hogerzeil and Dr. S. Koop at WHO is planned for February, 2007, that will provide an update on the prequalification process. POPPHI continues to work closely with HealthTech on oxytocin in the Uniject™ issues and with RPM Plus. RPM Plus is supporting the Benin AMTSL survey and has had planning meetings with the Ghana MOH to initiate the ATMSL survey. RPM Plus will not conduct a survey in Mali at the request of the MOH. Mali states that the funding for the survey can be better spent on other technical assistance.

Convene the UDD TF

- A UDD TF meeting was held December 18, 2006.
- Detail barriers that affect international and national action.
 - Awareness of the importance of PPH to maternal mortality: The FIGO Congress was a watershed of plenaries and presentations on PPH. The ob/gyn community spoke eloquently to this critical issue that is in their realm to address. While the need to more effectively address PPH prevention and treatment was a frequent topic, the global AMTSL surveys are clearly indicating that physicians do not regularly practice AMTSL.
 - The use and availability of oxytocin: The issue of stability and storage of oxytocin continues to be a barrier at the periphery. USP and WHO continue to move forward with activities that will assist in getting oxytocin used, managed and stored appropriately: changes in the USP monograph and a WHO system for prequalification of oxytocin.

- Misoprostol: Major hurdles for the use of misoprostol for PPH indications have been overcome during the last six months. With the Belgaum study published in the Lancet, there is now solid data to support its use for PPH prevention. Additionally, the WHO Technical Consultation held in October 2006, solidly supported the use of a uterotonic in the community – both oxytocin and misoprostol. The UDD TF created an action plan to increase the use of misoprostol for PPH prevention and treatment. But other hurdles remain. WHO has not yet issued its official endorsement; misoprostol is not on the EDL for PPH indications yet; lack of country registration of misoprostol for PPH indications; and overcoming the concern about abuse of the drug in communities are the largest obstacles at this time.
- Detail barriers that affect lower-level implementation.
 - Training: The lack of simple training materials that are competency-based impedes the ability of MOHs or NGOs to provide training in AMTSL for their health care providers. The draft two-day training module was pre-tested in Pakistan and is being requested by Bangladesh. The TOT manual is available in draft. The CD-ROMs are very popular in the field and a request for translation into Ukrainian has been received from the JSI program in Ukraine.
 - Local logistics: Concern over the quality of oxytocin available was raised in Pakistan. One physician stated that he had concerns in his hospital about the oxytocin and when he went and looked in the pharmacy, it was bovine oxytocin. Differences in brands and manufacturers were also noted. Indonesia was concerned about the cost of oxytocin in the private sector, since many ob/gyn's and midwives also have private practices. Both of these issues were addressed at the national meetings and included in the action plans.
 - Provider and community acceptability: The use and abuse of oxytocin and misoprostol by both providers and communities is evident from discussions across many countries. This issue needs to be addressed directly.

2. Conduct global survey on AMTSL

See Task 2: Improve Quality and Availability of AMTSL at the Facility Level; 3. Provide TA to missions and regional bureaus upon request; bullets 1-4

3. Convene a first intervention TF

- The first intervention TF met at the FIGO Congress in Kuala Lumpur, Malaysia on November 10, 2006. A. Lalonde has asked S. Arulkumaran to chair the committee going forward.

4. Estimate and compare costs of uterotonics, injection equipment and devices, and cold chain storage of oxytocin

- Conduct a cost analysis.

- This task was deleted from work plan after discussion with USAID during 2006.

By partnering with RPM Plus in a small number of countries, POPPHI hopes to collect information on costs of uterotonics and injection equipment and devices and to identify ways to provide cold chain storage for oxytocin.

POPPHI awaits the final report from national level surveys from five West African countries conducted by an RPM Plus consultant.

- Develop a policy brief, which UDD TF will lead, on cost-comparison of uterotonics, injection equipment and devices, and cold chain storage of oxytocin.
 - Additional policy briefs are under discussion.
 - With the data on the effectiveness of misoprostol available as well as cost data, POPPHI will work with Health Tech and RPM Plus to develop a policy brief on cost-comparison of uterotonics. Either a separate brief or in combination, injection equipment and devices and cold chain storage of oxytocin will also be included.

5. Provide TA and advocacy to get drugs/devices registered for use in AMTSL in at least three countries

- POPPHI, through Health Tech and BIOL, is providing oxytocin in Uniject™ to the Mali matrone project. There will be an evaluation of the feasibility and acceptability of Uniject compared to oxytocin in standard syringes.
- H. Hogerzeil stated that oxytocin in the Uniject™ device would not be included on the WHO Essential Drug List since Uniject is a delivery device. Oxytocin is already on the Essential Drug List.
- D. Armbruster and S. Brooke received funding to collaborate with P. Buekkens, Tulane and J. Belizan, IECS/Argentina to evaluate whether the use of oxytocin in Uniject™ will increase the practice of AMTSL due to “ease of use.” Additional funds are being sought through Becton Dickinson.
- POPPHI plans to assist Bangladesh in registering misoprostol through assistance in collecting the necessary documents for the dossier.
- POPPHI is working with USAID to focus on scale up in five countries that will include work on topics such as drugs, devices, registration, and regulatory legislation.
- POPPHI will utilize regional experts and consultants to provide TA and advocacy for drug registration and other drug-related issues.

1.4 Performance Standards Completed

The majority of the performance standards are discussed and covered under the narrative description of activities. We are still collecting data for our two outcome indicators, and

when the global AMTSL survey is completed, we expect to have more detailed data for these two indicators. Table 1 summarizes the Performance Monitoring Report.

Table 1. Performance Standards Completed By Task

| Task | Performance Standard | Year 3 Quarter | | | | Actual; Date Completed | Target |
|------|--|---------------------------------------|---|---|---|--|--|
| | | 1 | 2 | 3 | 4 | | |
| 0.1 | Subcontracts with ICM and FIGO finalized | X (for August 6, 2006) | | | | Year 3 Amendment August 6, 2006 - FIGO | Yes – FIGO Year 3 No-ICM |
| 0.2 | PPH Working Group (WG) meets 1–2 times a year | | | | | Third PPH WG planned for March 26, 2007 | WG meets 1–2 times |
| 0.3 | Number of skilled birth attendants who attend training in AMTSL | | | | | 1037 trained (January 31, 2007) | 1754 |
| 1.1 | Number of FIGO and ICM regional conferences where the Joint Statement on Prevention of PPH was disseminated | 1 – in Malaysia (November 5-10, 2006) | | | | 1 conference for 2006; Dec 2004 May 2005 July 2005 Sept 2005 | Total of 4 conferences |
| 1.2 | Number of small grants to national professional associations for activities in support of increasing provider awareness and skills of AMTSL (See “Develop small grants mechanism” section) | | | | | 15 issued through Jan. 2007 | Total of 15 issued (1 grant retracted and another in progress) |
| | Small grants effectively measure two or more of the agreed upon indicators | | | | | Baseline survey to associations 12 completed | 16 countries |
| 1.3 | Disseminate the FIGO/ICM joint statement in 25 association newsletters or by other mechanisms | | | | | FIGO & ICM Total of 53 statements disseminated; Jan 2006 | 25 newsletters or other mechanisms |

| Task | Performance Standard | Year 3 Quarter | | | | Actual; Date Completed | Target |
|------|---|----------------|-----------------------------|---|---|--|--|
| | | 1 | 2 | 3 | 4 | | |
| 1.4 | 1,200 toolkits distributed to professional associations Provide distribution list to ACCESS | | | | | 1,858 condensed total, 681 reference total, and 1225 CD-ROM total; Distribution list developed sent to ACCESS; August 2006 | Distribution strategy completed List of recipients developed |
| 1.5 | Number of workshops where TA is provided to associations' | | 7 TAs provided to workshops | | | | 4 workshops |
| 1.6 | WHO, UNICEF and UNFPA joint statement in support of AMTSL | | | | | | Joint statement developed |
| 2.1 | Evidence of joint work planning among implementing partners. Evidence in work plans of mutual agreements between the contractor and each of the implementing CA about roles and required nature and scope of support services | X | X | | | Third annual work plan; November 2006 PPH WG meets once; March 2007 M&E plan revised; Approved Jan, 2007 | 3rd annual work plan of POPPHI PPH WG meets 1–2 times M&E plan finalized |
| 2.2 | Evidence of mechanism of coordination and collaboration among implementing partners | X | X | | | See above, 2.1, PPH WG | PPH WG meets 1-2 times |
| 2.3 | Evaluation report of training strategies | | | | | Completed and submitted. Revisions to be made by July, 2007 | Evaluation scope of work complete |
| 2.3a | Training TF meets 2–4 times a year | X | | | | In progress Has met in January 4, 07 | Meets 2–4 times a year |
| 2.3b | Job Aids developed | X | X | | | Completed and 2,679 Eng posters; 2,779 Eng factsheets; 2,242 Fr posters; 2,117 Fr | Poster, provider, and policy job aids |

| Task | Performance Standard | Year 3 Quarter | | | | Actual; Date Completed | Target |
|------|--|-------------------|---|---|---|---|--|
| | | 1 | 2 | 3 | 4 | | |
| | | | | | | factsheets; 945 Span posters; 921 Span factsheets distributed to 42 countries, including associations and numerous conferences | |
| 2.4 | Evidence of functional monitoring system to measure progress of all implementing partners toward achieving benchmarks and to measure availability and coverage of AMTSL services | X | X | | | M&E plan revised; Approved, January 2007 | Finalized M&E plan with agreed upon indicators |
| | Number and Percentage of targeted Districts providing active management of the third stage of labor (AMTSL). | | | | | In progress – see Figure 4 | No targets agreed upon |
| | Number and Percentage of women within a specified time period in facilities and homes where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs). | X | X | | | In progress – see Figure 3 | No targets agreed upon |
| | Results of survey available and used to develop intervention to increase support and use of AMTSL in Central American countries | | | | | Global AMTSL survey completed in 8 countries – data analysis -1; reports completed for 2 with dissemination; draft reports for 5 countries | Completed survey and intervention initiated |
| 3.1 | Evidence of mechanism of coordination and collaboration among IPs | X | X | | | See above, 2.1 | See above, 2.1 |
| 3.2 | Evidence of functional monitoring system to measure progress of all IPs toward achieving benchmarks and availability and coverage of AMTSL | X | X | | | Consensus on performance monitoring plan and indicators among IPs M&E plan revised; Approved January, 2007 | Finalized M&E plan with agreed upon indicators |

| Task | Performance Standard | Year 3 Quarter | | | | Actual; Date Completed | Target |
|------|--|-------------------|---|---|---|---|--|
| | | 1 | 2 | 3 | 4 | | |
| | | | | | | Outcome indicators revised and finalized 1/07 | |
| 3.3 | Submit performance monitoring report | | X | | | Semi-Annual Report consistently submitted on time | Submit semi-annual report |
| 3.4 | USAID receives information on all IPs' progress toward achieving benchmarks and information on availability and coverage of AMTSL services | | X | | | Semi-annual Report; Jan. 2007 | Submit semi-annual report |
| 3.5 | Provide TA to missions and regional bureaus | X | X | | | In progress | Provide TA |
| 4.1 | Critical pathway report completed | | | | | Yes; Dec 2004 | Yes |
| 4.2 | UDD TF meets 1--3 times a year | | X | | | UDD Task Force scheduled to meet March 2007 | Meets 1--3 times a year |
| 4.2a | First Interventions TF meets 1--2 times a year | | X | | | FI TF meets once; Scheduled for March 2007 | Meets 1--2 times a year |
| 4.3 | Number of countries where drugs/devices are registered (i.e., approved for use) for the indication of AMTSL in the correct dosage by government regulatory or policy-making bodies | X | X | | | Global AMTSL survey is providing this data for 10 countries – 8 to date | Report on work required to register drugs & devices |
| 4.4 | Number of countries with adequate cold chains established for storage of oxytocics | X | X | | | In progress—survey data will provide | Number of countries identified for year 1 |
| 4.5 | Number of countries with adequate supplies of uterotonics in the drug procurement pipeline for routine use in all facility deliveries | X | X | | | In progress—survey data will provide | No targets agreed upon |
| 4.6 | Negotiation for field support or TA with at least two missions | | | | | In progress; Indonesia, scheduled for Q3 | Negotiation for field support or TA with at least two missions |

| Task | Performance Standard | Year 3 Quarter | | | | Actual; Date Completed | Target |
|------|---|-------------------|---|---|---|---------------------------|------------------------|
| | | 1 | 2 | 3 | 4 | | |
| 4.7 | Report on the cost-comparison of uterotonic choices | | | | | In progress | No targets agreed upon |

Figure 1. Performance Monitoring Report

1.5 Additional AMTSL Performance Information

Problems Solved or Still Outstanding

Initiation of misoprostol activities

- The data from the Belgaum study and the decision of the UDD task force to begin work on increasing use of misoprostol will add a new dimension to POPPHI's work. While this is not a problem, and is in fact an exciting new focus, it will require strategic planning and effort.

Small grants

- The Paraguay ob/gyn and midwifery associations were unable to finalize the grant agreement. The grant was never issued.
- The Peruvian grantee, Decana Nacional Colegio de Obstetricas del Perú, changed leadership since the grant was issued. The current leadership is unaware of activities that may have or have not begun. POPPHI is currently trying to determine how much progress has been made.

Global AMTSL Survey

- The global AMTSL survey remains a challenge but significant progress has been made in completing 8 surveys. Finalizing reports and then completing the final paper on the combined data will take significantly longer than anticipated.

Data collection

- Collection of data remains a challenge but N. Darcy does an outstanding job of trying all ways possible and with all partners working on maternal health to collect data. POPPHI continues to focus on collecting data but there is still very little data being provided by partners at this time. With the two AMTSL indicators changing definition, and final approval received January 2007, partners will now also need to modify their data collection tools and this will be an evolving process.

1.7 Proposed Solutions to Ongoing Problems

- See above

1.8 Compelling Success Stories

1. BIOL is producing oxytocin in Uniject™ and has filled its first batch. Registration is planned for April submission to Argentina authorities.
2. The small grant awardees in the Dominican Republic continue their excellent public/ private partnership and an agreement with the MOH to provide training to additional hospital staff in the DR.
3. The commitment of the Mali MOH and the Indonesian MOH to expanding AMTSL throughout the country is strong. Mali is focusing its efforts to get all providers trained and there is great enthusiasm for this effort. The regional support for the effort is also great and discussions held during the latest trip to Mali indicate that the use of misoprostol will be revisited when the WHO Technical Consultation document is released. The size of Indonesia means that other types of strategies are needed but there is also significant commitment from the MOH and other partners to markedly expand the use of AMTSL, particularly by the *bidan de desas* (midwives).
4. In Pakistan and the Ukraine, POPPHI and CAs have collected information that shows the outcome on PPH prevalence (which reduces) when AMTSL practice is increased. Refer to Appendix F for more details.

1.9 Documentation of Best Practices That Can Be Taken to Scale

AMTSL is a best practice, and this project seeks to take this best practice to scale.

1.10 AMTSL Indicator 1 and 2, Community PPH Indicator POPPHI and Partner Summary Information

Detailed country level information was submitted to USAID, in November, 2006, when collecting data for the Portfolio Review. The information summarized below, is information collected after the Portfolio Review.

The following table summarizes information for the two AMTSL indicators and the Community PPH indicators from our CAs, and their plans for tracking data for these indicators over the remainder of 2007.

Figure 2. POPPHI Partner AMTSL and Community PPH Indicator Status and Plans

| Country | Project/Partner | Status |
|------------|-----------------|--|
| Bangladesh | NSDP/PI | NSDP have 21 facilities with AMTSL. They are planning in the next 6 months to go from 21 to 59 facilities - using AMTSL as home-births with 'SBA' which is a paramedic. They will be able to track our AMTSL indicator 1 and indicator 2 |
| Bangladesh | EngenderHealth | AMTSL data has not begun to be collected yet, as the work is just getting started following the national stakeholders' meeting (Jan, 2007). Refer to Appendix E for more details. |

| Country | Project/Partner | Status |
|-------------|--------------------|---|
| Rwanda | JHPIEGO/ACCESS | They will be doing a baseline assessment in Rwanda, starting in about 2 months. Once this is completed, will work to improve the record keeping system. They will be working in four districts: Gasobo, Kicukiro, Kayonza, and Kirehe. Since these were just selected, the province data is not available at this time. They will be able to report on Indicators 1 and 2, starting in Oct, 2007. |
| Nigeria | JHPIEGO/ACCESS | Completed the baseline assessment. There is currently nothing in records about AMTSL. They will be able to report on Indicators 1 and 2, starting in Oct, 2007. They plan their work in Kano State and Zamfara States in Northwest Province. In Kano state, the selected local government authorities (LGAs or districts) are Dawakin Tofa and Gezewa while in Zamfara state, the LGAs selected are Gusau and Kaura Namoda. |
| Afghanistan | JHPIEGO | They should be able to report on the Community PPH indicator for Afghanistan for their semi-annual report in April, 2007. |
| Niger | URC-Macro/QAP | They are monitoring an average of about 2,000 births a month in the 28 QAP targeted facilities in Niger and so will be able to look at mortality over time in addition to PPH hemorrhage rates. A couple of large hospitals in Niger have contacted our team just this week to let us know that they are independently taking on AMTSL training for all of their providers and associated primary care maternities using the training protocol we developed. See Figure 3 and Figure 4 below, and Appendix D. |
| Benin | URC-Macro/QAP | See Figure 3 and Figure 4 below, and Appendix D. |
| Ecuador | URC-Macro/QAP | See Figure 3 and Figure 4 below, and Appendix D. |
| Honduras | URC-Macro/QAP | See Figure 3 and Figure 4 below, and Appendix D. |
| Nicaragua | URC-Macro/QAP | See Figure 3 and Figure 4 below, and Appendix D. |
| Ukraine | JSI | See Figure 3 and Figure 4 below, and Appendix D. |
| Georgia | JSI | See Figure 3 and Figure 4 below, and Appendix D. |
| Senegal | Population Council | We have just started work on a new bilateral in Senegal which will cover safe motherhood services including PPH. At this time, we have not collected any new data on this topic to contribute to POPPHI. |

Indicator 1: Number and Percentage of women in facilities and home where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) within a specified time period.

Figure 3. AMTSL Indicator 1 Data

| Country | Total # of Vaginal Deliveries | # of AMTSL | % of AMTSL |
|--|--|--|--|
| Georgia | 3,957 | 2,849 | 72% |
| | <u>Time Period:</u> Jan 01- Dec 30 2006 | <u>Time Period:</u> Jan 01- Dec 30 2006 | <u>Time Period:</u> Jan 01- Dec 30 2006 |
| Ukraine | 44,800 | 35,840 | 80% |
| | <u>Time Period:</u> Jan 01- Dec 30 2006 | <u>Time Period:</u> Jan 01- Dec 30 2006 | <u>Time Period:</u> Jan 01- Dec 30 2006 |
| Benin | Data not consistently reported second half 2006 due to staff turnover (QAP) Data available from Acquire, from 66 facilities | | 71.5% <u>Time Period:</u> End of Sept, 2006 |
| Ecuador | This is using # of births (older indicator definition) <u>Time period:</u> November 2006 | <u>Time period:</u> November 2006 | 79 % (total # births: data pending) <u>Time period:</u> November 2006 |
| Niger | This is using # of births (older indicator definition) 13,217 births total <u>Time period:</u> Aug-Dec 06 | <u>9,781 births</u> <u>Time period:</u> Aug-Dec 06 | 74 % (of 13,217 total births) <u>Time period:</u> November 2006 |
| Honduras | This is using # of births (older indicator definition) <u>Time period:</u> October 2006 | <u>Time period:</u> October 2006 | 100% (total # births: data pending) <u>Time period:</u> November 2006 |
| Nicaragua | This is using # of births (older indicator definition) <u>Time period:</u> September 2006 | <u>Time period:</u> September 2006 | 99%(total # births: data pending) <u>Time period:</u> November 2006 |
| Pakistan (POPHI follow-up in 3 hospitals in Karachi – practice after training) | 6540 <u>Time period:</u> | 5925 <u>Time period:</u> | 90% <u>Time period:</u> |

| Country | Total # of Vaginal Deliveries | # of AMTSL | % of AMTSL |
|---------------------------------------|-------------------------------|---------------------|---------------------|
| | Sept 2006-Dec 2006 | Sept 2006-Dec 2006 | Sept 2006-Dec 2006 |
| Nepal Endline (full version of AMTSL) | 6862 | 3575 | 52% |
| | <u>Time period:</u> | <u>Time period:</u> | <u>Time period:</u> |
| | Sept 2006-Dec 2006 | Sept 2006-Dec 2006 | Sept 2006-Dec 2006 |

Indicator 2: Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL).

Figure 4. AMTSL Indicator 2 Data

| Country | Number | Percentage |
|-----------|---|------------------|
| Georgia | 3 (targeted 4 districts) | 75% |
| Ukraine | Data Unavailable | |
| Benin | 2 out of 36 zones | 6% |
| Ecuador | 76 health areas out of 168 | 45% |
| Niger | Coverage expanding to primary care facilities in 2007 | 0% in 2006 |
| Honduras | 5 out of 20 departments | 25% |
| Nicaragua | 136 out of 151 municipios | 91% |
| Pakistan | Data Unavailable | Data Unavailable |
| Nepal | Data Unavailable | Data Unavailable |

1.11 Additional M&E Information from Small Grants Activities

(1) Benin:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 11 | 3 | | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 11 | 4 | | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 11 | 4 | | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 11 | 4 | | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 10 | 4 | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ² within a specified time period: | AMTSL (with pre-training self reported definition) at 92%, in 12 facilities, in 9 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 10 out of 13 facilities had AMTSL rates greater than 50%. | | | | | | | |

² <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(2) Cameroun:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 5 | 3 | 7 | 15 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 4 | 0 | 8 | 12 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 4 | 0 | 7 | 11 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 6 | 2 | 2 | 10 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 8 | 3 | 13 | 24 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ³ within a specified time period: | AMTSL (with pre-training self reported definition) at 15%, in 7 facilities, in 5 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 2 out of 7 facilities had AMTSL rates greater than 50%. | | | | | | | |

³ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(3) Ghana:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | <input type="checkbox"/> Yes *no national baseline data received yet <input type="checkbox"/> No | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 55 | | 3 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 56 | | 3 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 55 | | 3 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 54 | | 2 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | | | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁴ within a specified time period: | AMTSL (with pre-training self reported definition) at 59%, in 43 facilities, in 27 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 39 out of 43 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁴ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(4) Tanzania:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 34 | 4 | 1 | 39 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 24 | 2 | 1 | 27 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 18 | 2 | 1 | 21 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 30 | 3 | 0 | 33 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 20 | 2 | 1 | 23 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁵ within a specified time period: | AMTSL (with pre-training self reported definition) at 80%, in 18 facilities, in 4 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 16 out of 18 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁵ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(5) Malawi:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input checked="" type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 35 | 3 | 2 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 34 | 3 | 2 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 30 | 2 | 2 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 30 | 3 | 2 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 30 | 2 | 2 | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁶ within a specified time period: | AMTSL (with pre-training self reported definition) at 92%, in 25 facilities, in 11 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 11 out of 25 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁶ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(6) Uganda:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 7 | | | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 3 | | | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 2 | | | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 2 | | | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 2 | | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁷ within a specified time period: | AMTSL (with pre-training self reported definition) at 9%, in 7 facilities, in 2 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 2 out of 7 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁷ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(7) Burkino Faso:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|---|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [] Yes *no national level baseline data received [X] No | | | | [] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 8 | | 0 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 0 | | 0 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 0 | | 0 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 1 | | 0 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 1 | | 0 | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁸ within a specified time period: | AMTSL (with pre-training self reported definition) at 75%, in 11 facilities, in 5 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 1 out of 11 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁸ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(8) Bolivia:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | <input type="checkbox"/> Yes *This question was not answered <input type="checkbox"/> No | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 21 | 57 | 14 | 92 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 6 | 28 | 2 | 36 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 6 | 26 | 2 | 30 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 11 | 36 | 7 | 54 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/iCM components in routine care or as part of their protocol: | 10 | 29 | 3 | 42 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ⁹ within a specified time period: | AMTSL (with pre-training self reported definition) at 30%, in 45 facilities, in 26 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 12 out of 45 facilities had AMTSL rates greater than 50%. | | | | | | | |

⁹ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(9) Pakistan:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|--|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [X] Yes [] No | | | | [] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 61 | 55 | 19 | 135 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 43 | 41 | 17 | 101 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 34 | 29 | 16 | 79 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 38 | 33 | 15 | 86 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 30 | 31 | 16 | 77 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁰ within a specified time period: | AMTSL (with pre-training self reported definition) at 44%, in 28 facilities, in 13 districts | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 16 out of 28 facilities had AMTSL rates greater than 50%. | | | | | | | |

¹⁰ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

(10) Nepal:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|--|---------------------|-------------------|-------------------|--|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [X] Yes [] No | | | | [X] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 56 | 3 | 11 | 70 | 46 | 1 | 2 | 49 |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 32 | 2 | 4 | 38 | 46 | 1 | 2 | 49 |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 24 | 2 | 4 | 30 | 45 | 1 | 2 | 48 |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 55 | 2 | 8 | 65 | 44 | 1 | 2 | 47 |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 54 | 3 | 9 | 66 | 44 | 1 | 2 | 47 |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹¹ within a specified time period: | AMTSL (with pre-training self reported definition) at 91%, in 41 facilities, in 5 districts | | | | AMTSL (with pre-training self reported definition) at 52%, in 26 facilities, in 5 districts | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 22 out of 41 facilities had AMTSL rates greater than 50%. | | | | Calculation pending more information on total number of maternal facilities in each district. For the facilities targeted by the small grant, 18 out of 26 facilities had AMTSL rates greater than 50%. | | | |

¹¹ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

We will continue to collect baselines and endlines from our small grant participants. We have baseline information for the Dominican Republic, and Indonesia – which was not available to be entered into EpiInfo for this reporting period due to outstanding data quality questions. This will be entered into EpiInfo and be available during the next reporting period. Peru have just started their trainings, so their baseline information will be available during the next reporting period, and will use the simplified data collection tool which is used to collect data for the two POPPHI indicators. Baseline information was not collected for initial trainings in Mali.

Refer to Appendix J for the more complete data tables for each country. In order to be consistent with data entry, the POPPHI team developed a set of decision rules to be used for all paper based surveys as the data was entered into EpiInfo. Refer to Appendix I for the guidelines used when interpreting the data written on the paper based surveys and how this interpretation was used when entering data into EpiInfo.

1.12 Additional Training Information

Note: Pass rate will be 90% for all programs conducting post-training assessments

Figure 5. POPPHI Training Data

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of Jul 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sep 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|----|----------|---|---|---|--|--|--|--|
| 7. | Malawi | Train or update 29 SM trainers | See Appendix H | 37 total 5 key persons in health training institute 1 SM trainer | 134 | | | |
| 9. | Tanzania | Train 75 | See Appendix H | 34 | 75 | | | |
| 2 | Nepal | Train 80 | See Appendix H | 82 | 80 | | | No post training pass-rate data available (Target 75); AMTSL rate 52% at endline |
| 1 | Pakistan | Small grants: Train 150 Bilateral: Train 100 | See Appendix H | 108 | 175 | 201 | 75 | No post training pass-rate data (Target 100); However, in JPMC, Kharader and Lady Dufferin, AMTSL rates at 90% |
| 3 | Bolivia | Train 75 | See Appendix H | 101 | 75 | | 50 | |
| 5 | Uganda | Train 50 | See Appendix H | 74 | 50 | | | |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of Jul 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sep 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|----|--------------------|---|---|--|--|--|--|--|
| 14 | Paraguay | Train 140 | See Appendix H – small grant transferred | NA | 140 | | | |
| 15 | Dominican Republic | Train 200 | See Appendix H | 190 | 150 | | 50 | |
| 11 | Mali | Train 150 | See Appendix H | | 75 | 134 | 75 | Target 125; Post Knowledge evaluation: 68 Post skills evaluation: 55 |
| 10 | Benin | Train 90 | See Appendix H | 15 ¹² | 90 | | | |
| 11 | Burkino Faso | Train 25 midwives | See Appendix H | 12 | 25 | | | |
| 12 | Cameroun | Train 25 providers | See Appendix H | 25 | 25 | | | |
| 4 | Peru | Train 200 | Training is just beginning | | 200 | | | |
| 6 | Ethiopia | Train 20 tutors and 10 heads of schools | See Appendix H | 0 | 30 | | | Target 30 |

¹² We do not have full training information. We have received 15 member surveys to date that we can enter into EpiInfo

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of Jul 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sep 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|-------------|-------------|--------------------------------------|---|--|--|--|--|---|
| 8 | Ghana | 100 trainers | See Appendix H | 87 | 100 | | | Target 100; will track in endline survey AMTSL rate (not available yet) |
| 16 | Ecuador | Train 50 nurses and nursing teachers | Training has not started yet | | | | 50 | For 50 |
| 17 | El Salvador | Train 30 health providers | Training has not started yet | | | | 30 | |
| 18 (new) | Indonesia | | See Appendix H | | | 71 | 0 | |
| Total | | | | 765 (Target 1424) | | 406 (Target 330) | | |
| Grand Total | | | | 1171 (Target 1754) | | | | |

Appendix A: Indicator Definition and Data Collection

1. AMTSL Indicator 1 definition sheet
2. AMTSL Indicator 2 (coverage) definition sheet
3. Community Based PPH prevention Indicator
4. General AMTSL data collection form for Indicators 1 and 2
5. Community Based PPH prevention data collection form

AMTSL INDICATOR REFERENCE SHEET – V10 Dec 12th 2006

Indicator 1: Number and Percentage of women in facilities and home where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs)¹ within a specified time period

DESCRIPTION

Precise Definition: Number and percent of women in facilities and homes where the woman received AMTSL by skilled birth attendants (SBAs) in targeted areas in a specified time period. This includes vaginal deliveries only². Targeted areas are those where the United States Agency for International Development partner and Cooperating Agency (CA) maternal and child health projects are implementing AMTSL interventions – these include public and private health facilities, rural and urban health facilities, as well as home births with SBAs. AMTSL is defined as the following three elements:

- a. Use of uterotonic drug within one minute of birth (oxytocin is the drug of choice, preferred 10 IU/IM)
- b. Performance of controlled cord traction.
- c. Performance of uterine massage after the delivery of the placenta.

Unit of Measure: Number and percentage

DATA ACQUISITION

Data Collection Method: AMTSL data can be collected in two ways:

- (1) When AMTSL is included in the facility records (e.g., delivery register, partograph, patient chart), , or where logbooks are used for SBAs for home deliveries, the data recorded during the specified time period can be collected
- (2) In cases where AMTSL is not part of routine data collection, the number of women receiving AMTSL is determined by surveys, (self-administered or interviewer-administered), as a proxy for what actually happens.

Data Quality:

1. Where data are collected through routine data collection, validation checks should be performed by supervisory visits that include observation of births. In a low-birth rate facility or for home deliveries, this can be accomplished by implementing demonstration of births and inspecting supplies of uterotonic (preferred oxytocin) in the facility or home. In the cases where patients procure their own uterotonic (preferred oxytocin) and there are no births currently happening during the supervisory visit, provision of AMTSL can be determined by surveying staff at the facility or home.
2. Where there is no routine data collection, supervisory visits should still be performed, observational where possible and then demonstration in the cases where observation is not possible due to lack of deliveries during the supervisory visit (for facility and home).

Supervisory visit frequency will be determined by the ministry of health (national, district in the cases where this is decentralized) when AMTSL is included in routine data collection. For instances where AMTSL is not included in routine data collection, supervisory visits should occur once during the site specified period.

Data Source(s) - Timing/Frequency of Data Acquisition: Facility registers, logbooks or surveys (primary) - semi-annually

DATA ANALYSIS AND REPORTING

Method of Calculation: For facility and home births, the percentage is calculated by dividing the number of women who received AMTSL recorded in the past time period where AMTSL is recorded (numerator) by the total number of women with vaginal deliveries recorded in the past time period (denominator). **Site specified time period includes during the past zero to twelve months, and can be set at fixed intervals for different locations. For example, some sites may record data during one month, and some during three months.**

Data Reporting: Facility registers, logbooks or surveys reported by USAID partners to POPPHI semi-annually

¹ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

² Does not include Caesarean -Section or abortion

DATA QUALITY AND OTHER ISSUES

Known Data Limitations and Significance (if any): When data is collected via survey, (when the data is not available in the facility records), there are limitations because the data is being recorded based on individual recall of health care staff and is subject to error. The supervisory visits provide some validation of the recall but again only occur once during the time period of data collection. Also, there is usually turnover of health care staff, so we cannot guarantee during baseline and final that the same staff will be interviewed (will try to do this but in some cases it is not possible), which means that someone may be part of the final survey who has not been present all the time during the CA or partner projects so for this person we will not be able to compare baseline and final.

Actions Taken/Planned to Address Data Limitations: Work to include AMTSL in routine data collection.

Indicator Significance and Management Utility: This indicator is used to measure whether AMTSL occurred at facility births or home births with SBAs. This is consistent with the project providing training in AMTSL for facility-based births and determining pre- and post-training if there is an improvement in the use of AMTSL for births.

Location of data storage: Data will be kept with the project team and reported to POPPHI semi-annually.

AMTSL INDICATOR REFERENCE SHEET – V8 January 10th 2007

Indicator 2: Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL).

DESCRIPTION

Precise Definition: This indicator is reported only by countries where programs implement AMTSL in facilities in targeted districts. This indicator is calculated based on Indicator 1 (number and percentage of women receiving AMTSL within the reporting period) in targeted facilities where the woman received AMTSL.

A targeted district provides AMTSL if more than 20% of facilities in the targeted district provide AMTSL. *A facility provides AMTSL* when at least 50% of the women receive AMTSL for vaginal deliveries in the facility.

Facilities means maternal health facilities including hospitals, maternal health centers, and other maternal health delivery facilities that are designated by the country government as maternal health facilities. Government health facilities that do not provide any maternal health services are not included in the total number of facilities.

Unit of Measure: Number and percentage

DATA ACQUISITION

Data Collection Method: Take the summary information for each facility in the AMTSL indicator (see Indicator 1) using the POPPHI data collection form, which includes facility name, number of women delivering babies, number of women receiving AMTSL, and district name. For each targeted district, verify the percentage of facilities providing AMTSL. If this is equal to or greater than 20%, then this district should be included in the numerator.

Data Source(s): Secondary

Timing/Frequency of Data Acquisition: Semi-annually

DATA ANALYSIS, REVIEW, & REPORTING

Method of Calculation: Numerator: number of targeted districts where at least 20% of facilities are providing AMTSL. Denominator: total number of targeted districts.

Review of Data: Review calculations based on AMTSL Indicator 1 summary data.

Data Reporting: Reported by U.S. Agency for International Development (USAID) partners to POPPHI semi-annually. POPPHI will also work with USAID partners to get the number of government health facilities in the countries that the USAID partners are working in.

DATA QUALITY ISSUES

Known Data Limitations and Significance (if any): This only shows districts where the USAID maternal and child health projects are being implemented and AMTSL is being provided. This cannot be used as a national-level coverage indicator.

Actions Taken or Planned to Address Data Limitations: None

OTHER NOTES

Indicator Significance and Management Utility: This indicator is used to measure if AMTSL is being provided for births in districts. This indicator is also used to track information at a country level, which can be used to determine expansion country status (defined as countries that have at least 20% of facilities [maternal health] providing AMTSL).

Location of data storage: Data will be kept with the project team. The contractor will maintain a copy as well as maintain all records for this indicator.

COMMUNITY PPH PREVENTION INDICATOR REFERENCE SHEET – V3 Jan 11th 2007

Indicator 3: Number and percentage of women in the home where the woman received community PPH prevention within a specified time period.

DESCRIPTION

Precise Definition: Number and percentage of women in the home where the woman received community PPH prevention in targeted areas in a specified time period. This includes vaginal deliveries only.¹ Targeted areas are those where the U.S. Agency for International Development (USAID) partner and Cooperating Agency (CA) maternal and child health projects are implementing community PPH interventions – these include home births with non-skilled birth attendants (SBAs).² Community PPH prevention is defined as the following two elements:

- a. External uterine massage after the delivery of the placenta
- b. Use of a uterotonic drug after vaginal delivery and before the placenta is delivered

Unit of Measure: Number and percentage

DATA ACQUISITION

Data Collection Method: Community PPH prevention data can be collected in two ways:

- (1) When community PPH prevention is included in the non-SBA logbooks for home deliveries.
- (2) In cases where community PPH prevention is not part of routine data collection, and logbooks are not used, the number of women receiving community PPH prevention is determined by surveys, (self-administered or interviewer-administered), as a proxy for what actually happens.

Data Quality:

1. Where data are collected through routine data collection, validation checks should be performed by supervisory visits that include observation of home births. For home deliveries, this can be accomplished by implementing demonstration of births and inspecting supplies of uterotonic in the home. In the cases where patients procure their own uterotonic and there are no births currently happening during the supervisory visit, provision of community PPH prevention can be determined by surveying the non-SBA during home visits.
2. Where there is no routine data collection, supervisory visits should still be performed, observational where possible and then demonstration in the cases where observation is not possible due to lack of deliveries during the supervisory visit (for home).

Supervisory visit frequency will be determined by the ministry of health (national, district in the cases where this is decentralized) when community PPH prevention is included in routine data collection. For instances where community PPH prevention is not included in routine data collection, supervisory visits should occur once during the site specified period.

Data Source(s) - Timing/Frequency of Data Acquisition: Logbooks or surveys (primary) - semi-annually

DATA ANALYSIS AND REPORTING

Method of Calculation: For home births, the percentage is calculated by dividing the number of women who received community PPH prevention recorded in the past time period where community PPH prevention is recorded (numerator) by the total number of women with vaginal deliveries recorded in the past time period (denominator). **Site specified time period includes during the past zero to twelve months, and can be set at fixed intervals for different locations. For example, some sites may record data during one month, and some during three months.**

Data Reporting: Logbooks or surveys reported by USAID partners to POPPHI semi-annually

¹ Does not include C-Section or abortion

² This includes all people that are not SBAs (WHO definition) includes TBA, family members, non SBA community health workers etc

DATA QUALITY AND OTHER ISSUES

Known Data Limitations and Significance (if any): When data is collected via survey, (when the data is not available in logbooks), there are limitations because the data is being recorded based on individual recall of health care staff and is subject to error. The supervisory visits provide some validation of the recall but again only occur once during the time period of data collection. Also, there is usually turnover of health care staff, so we cannot guarantee during baseline and final that the same staff will be interviewed (will try to do this but in some cases it is not possible), which means that someone may be part of the final survey who has not been present all the time during the CA or partner projects so for this person we will not be able to compare baseline and final.

There is no information in this indicator definition about timing of massage as there is insufficient evidence based recommendations on when to start, how frequent to give the massage and when to stop. For administering a uterotonic, there is no restricted timing (e.g. within one minute of birth) because getting the uterotonic after the baby is delivered, even if after 1 minute still has health benefits. The project has determined that using the delivery of the placenta is a reasonable cut-off for this time window and will be easier for women to remember (even though administering the uterotonic after the placenta delivery can have some health benefits).

Actions Taken/Planned to Address Data Limitations: Work to include community PPH prevention in routine data collection.

Indicator Significance and Management Utility: This indicator is used to measure whether community PPH prevention occurred at home births with non-SBAs. This is consistent with the project providing training in community PPH prevention for home-based births and determining pre- and post-training if there is an improvement in the use of community PPH prevention for home births.

Location of data storage: Data will be kept with the project team and reported to POPPHI semi-annually.

**Active Management of the Third Stage of Labor (AMTSL)*
Reporting Form**

| | |
|--|--|
| 1. Project and organization name | Project Name: Organization Name: |
| 2. Country | Country Name: |
| 3. Reporting Period | Start date: |
| | End date: |
| 4. Total Number of facilities in targeted district | List the number of maternal health facilities per district (i.e., number of facilities, district name). Note: This includes all maternal health facilities in the district, and not just targeted facilities. |
| 5. Total number of women delivering babies attended by skilled birth attendants in your project area in this reporting period | For each district, fill out the number of facility-based women delivering babies by facility, including facility and district names (i.e., number of women, facility name, district name) |
| | For each district, fill out the number of home births and list district name. |
| 6. Total number of women that received AMTSL by a skilled birth attendant in this reporting period | For each district, fill out the number of facility-based women that received AMTSL by facility including the facility and district names (i.e., number of women, facility name, district name) |
| | For each district, fill out the number of home births and list district name. |
| 7. Remarks | |

*Definition of AMTSL is attached.

Facility Data Collection Form

| | |
|--|---|
| 1. Name of facility and district | Name of facility: District: |
| 2. Total number of women delivering babies attended by skilled birth attendants in your project area in this reporting period | Number of women delivering babies at this facility: |
| | Number of home births: |
| 3. Total number of women that received AMTSL by a skilled birth attendant in this reporting period | Number of women delivering babies that received AMTSL at this facility: |
| | Number of home births: |
| 4. How is the data collected? Mark all that apply | Facility/skilled birth attendant records – Yes/No Survey – Yes/No Observation – Yes/No |
| 5. Are supervisory checks performed? How often are these performed? | Observation – Yes/No Demonstration – Yes/No Monthly – Yes/No; Quarterly – Yes/No; Semi-Annually – Yes/No; Annually – Yes/No |

*AMTSL includes all three components:

- a. Use of uterotonic drug within one minute of birth (oxytocin preferred, 10 IU/IM).
- b. Performance of controlled cord traction.
- c. Performance of uterine massage after the delivery of the placenta.

**Community Postpartum Hemorrhage (PPH) Prevention*
Reporting Form**

| | |
|--|--|
| 1. Project and organization name | Project Name Organization Name |
| 2. Country | Country Name |
| 3. Reporting Period | Start date: |
| | End date: |
| 4. Total number of women delivering babies at home by non-SBAs in your project area in this reporting period | For each district, fill out the number of women delivering babies at home, listing district name |
| 5. Total number of women that received community PPH prevention in the home by a non-SBA in this reporting period | For each district, fill out the number of women delivering babies that received community PPH prevention, listing district name. |
| 6. Remarks | |

*Definition of community PPH prevention is attached.

Home-Based Data Collection Form

| | |
|---|--|
| <p>1. Name of non-skilled birth attendant (non-SBA) and district</p> | <p>Name of non-SBA: District:</p> |
| <p>2. Total number of women delivering babies that you attended during delivery at home in your project area in this reporting period</p> | <p>Number of women delivering babies that you attended during delivery:</p> |
| <p>3. Total number of women that received community PPH prevention that you attended during delivery in the home in your project area in this reporting period</p> | <p>Number of women delivering babies that received community PPH prevention that you attended during delivery:</p> |
| <p>4. How is the data collected? Mark all that apply</p> | <p>Non-SBA records – Yes/No Survey – Yes/No Observation – Yes/No</p> |
| <p>5. Are supervisory checks performed? How often are these performed?</p> | <p>Observation – Yes/No Demonstration – Yes/No Monthly – Yes/No; Quarterly – Yes/No; Semi-Annually – Yes/No; Annually – Yes/No</p> |

Community PPH prevention is defined as both of the following two elements:

- a. External uterine massage after the delivery of the placenta.
- b. Use of a uterotonic drug after vaginal delivery and before the placenta is delivered.

Appendix B: National Stakeholders' Meeting on Scaling Up of Prevention of Post Partum Hemorrhage in Bangladesh

**Bangladesh-China Friendship Conference Center
Media Room # 2, First Floor
Agargaon, Dhaka
23-24 August, 2006**

Objectives:

- To share national and international experiences on prevention and management of PPH
- To discuss issues, strategies and activities related to scaling up of prevention of PPH

Day – 1

| Date & Time | Topic/Activity | Facilitator/Responsibilities |
|------------------------|---|--|
| 9:00 am | Registration | |
| 9:30am-10:30am | Inaugural Session | |
| | Chairperson | DG, Directorate General of Health Services |
| | Chief Guest | Secretary, Ministry of Health & Family Welfare |
| | Guests take seat | |
| | Quran Telewat | Moulana Mohiuddin |
| | Welcome address (context, objectives and expected outcome of the meeting) | Dr. A. J. Faisel, Country Representative, EngenderHealth Bangladesh Country Office |
| | The need for appropriate strategies to address PPH | Dr. Monir Islam, Director, Making Pregnancy Safer, WHO Geneva |
| | Remarks by Special Guest | Ms. Debbie Armbruster, Project Director, POPPHI |
| | Remarks by Special Guest | Ms. Lynn Gorton, Director, PHN, USAID Dhaka |
| | Remarks by Special Guest | Ms. Duangvadee Sungkhobol, WR, WHO |
| | Remarks by Special Guest | Prof. Dr. Jubeida Khatoon, senior most retired Ob/Gyn Specialist |
| | Remarks by Chief Guest | Mr. A.K.M. Zafar Ullah Khan Secretary, MOHFW |
| | Speech by Session Chairperson | Prof. Dr. Md. Shahadat Hussain, Director General, Directorate General of Health Services |
| 10:30 am | Tea Break | |
| 11.00am-1:30pm | Session - I: Organizational/Institutional experiences | |
| | Session Chairperson | Prof. Maliha Rashid, Chairman, PPH Task Force & Prof. of Ob/Gyn, SSMC & Mitford Hospital |
| | Panelists | • Mrs. Tahera Ahmed, Asstt. Representative, UNFPA |
| | | • Prof. Anowara Begum, Past President, OGSB |
| | | • Prof. A. B. Bhuiyan, Past President, OGSB |
| | Key note presentation | Prof. A. B. Bhuiyan |
| | Global overview of PPH, AMTSL and community based approach | Dr. Harshad Sanghvi, Medical Director, JHPIEGO |
| | Addressing PPH at the Maternal and Child Welfare Center | Dr. Jafar Ahmad Hakim, Director (MCH-RH), DGFP |
| | Experiences of managing PPH in the hospitals of Bangladesh | Program Manager, RH, DGHS |
| | Training of community based skilled birth attendants | Dr. Abdul Halim, NPO, WHO, Bangladesh |
| | Question-Answer-Comments-Observations, remarks by the participants | |
| | Discussion by the Panelists | Panelists |

| Date & Time | Topic/Activity | Facilitator/Responsibilities |
|------------------------|--|---|
| | Wrap up by Session Chairperson | Prof. Maliha Rashid, Session Chairperson |
| 1:30 pm | Lunch & prayer break | |
| 2:30 pm-4:30 pm | Session – II: Community based experiences | |
| | Session chairperson | Dr. Merge Koblinsky, Head, Public Health Science Division, ICDDR |
| | Panelists | • Dr. Monir Islam, Director MPS, WHO, Geneva |
| | | • Prof. Sayeba Akhter, Head of Ob/Gyn, DMCH |
| | | • Ms. Lauren Pessa, EngenderHealth, New York |
| | Belgaum, India experience of PPH prevention activities | Dr. Shivaprashad Saha, J. N. Medical College, Belgaum, India |
| | Community based management of PPH | Dr. Christine Edward, Medical Director, LAMB Hospital, Parbatipur |
| | Experiences of NGO clinics of addressing PPH at community level | Dr. Umme Salma Jahan Meena, Advisor, NSDP |
| | Addressing PPH: Rural perspective | Dr. Kaiser Afsana, Program Manager, BRAC |
| | Misoprostol: experiences in rural Bangladesh | Dr. Ndola Prata, Gonoshayastha Kendra, Dhaka |
| | Question-Answer-Comments-Observations -and remarks by the participants | |
| | Discussion by the panelists | Panelists |
| | Wrap up by Session Chairperson | Dr. Merge Koblinsky, Head, PHS Division, ICDDR |
| 4:30 pm | Evening Tea and close of Day's activities | |

Day -2:

| Date & Time | Topic/Activity | Facilitator/Responsibilities |
|------------------------|--|---|
| 8:30am-10:45am | Session – III: Clinical experiences on management of PPH | |
| | Session chairperson | Prof. Sultana Jahan, Chairman, BSMMU & President, OGSB |
| | Panelists | • Dr. Jean Ahlborg, Regional Medical Advisor, EngenderHealth, Asia Regional Office, Bangkok |
| | | • Line Director, PHC, DGHS |
| | | • Chief, Health & Nutrition, UNICEF |
| | | • Director Hospital, DGHS |
| | QAP model and its application in Bangladesh. | Ms. Debbie Armbruster, Project Director, POPPHI |
| | Condom temponade: Important technique for management of PPH | Prof. Sayeba Akhter, President Elect, OGSB |
| | AMTSL experience in hospital setting | Prof. Kohinoor Begum, Prof. of Ob/Gyn, DMCH |
| | Misoprostol as a preventive measure of PPH | Dr. Rokhsana Ivy, Consultant, MCHTI, DGFP |
| | Sharing experiences of a PPH study of ICDDR, B | Dr. Md. Quayum, Team Leader, HSID, ICDDR, B |
| | Question-Answer-Comments-Observations -and remarks by the participants | |
| | Discussion by the panelists | |
| | Wrap up of the session by Chairperson | Prof. Sultana Jahan, Chairman, BSMMU & President, OGSB |
| 10:45 am | Tea Break | |
| 11:15am-1:15pm | Session – IV: Technical/Policy recommendations on PPH | |
| | Session Chairperson | Prof. T.A. Chowdhury, Head of Ob/Gyn deptt. BIRDEM |
| | Guests | Prof. A.B. Bhuyian, Past President, OGSB |
| | | Prof. Dr. Md. Shahadat Hossain, DG, DGHS |
| | | Mr. Abdul Mannan, DG, DGFP |
| | | Joint Secretary, WHO & Public Health, MOHFW |
| | | Ms. Lynn Gorton, Director, PHN, USAID, Dhaka |

| Date & Time | Topic/Activity | Facilitator/Responsibilities |
|------------------------|--|--|
| | | Ms. Debbie Armbruster, Project Director, POPPHI |
| | Mainstreaming PPH prevention activities in the Health and FP service delivery of Bangladesh (summary of issues identified during the 2 days) | Dr. A. J. Faisel, EngenderHealth, BCO |
| | Comments by WHO | Dr. Monir Islam, Director MPS, WHO, Geneva |
| | Comments by Guests | |
| | Wrap up of the session by Chairperson | Prof. T.A. Chowdhury, Head of Ob/Gyn deptt. BIRDEM |
| 1:15 pm | Vote of thanks | Dr. Setara Rahman, Sr. Program Officer, EH,BCO |
| 1:30 pm | End of the Stakeholders' meeting & Lunch | |

Appendix C: Pakistan PPH Recommendations from the National Workshop

January, 2007

[Compiled from participants comments at the national level workshop]

Annexure 10

Policy

- Awareness and endorsement of the *national expansion* in terms of policies, guidelines, protocols and standards in new places
- *Male doctors* need to be involved in obstetric/gynecological trainings
- Hold national, provincial and *district* meetings among policy/decision makers, ensuring their sensitization
- Ensuring availability of *life saving* staff, drugs and equipment in DHQs, RHCs, THQs etc.
- Revision of the *essential drug lists* at different levels
- Sensitization of policy makers about the *cost affectivity* of AMTSL
- Standardization of *messages/policies*
- Sharing of *best practices* by holding seminars, workshops and meetings
- Review all the *existing training manuals*, specifically focusing on Obstetrics/Gynecology
- *Operational research* of relevant areas
- In-built system of *monitoring and evaluation*

Annexure 11

Providers

- Enough evidence regarding practices for AMTSL project in Pakistan
- Available standardize evidence – base protocol and checklist
- Disseminate these protocols through
 - a. Training
 - 1. Information
 - 2. Hands on
 - b. Tools
 - c. Seminars
 - d. Small groups with role models
 - e. Feedback
- Survey
 - a. Before
 - b. After
- Address provider barriers

Trainings:

- Public teaching institutions
 - a. Pre-service
 - b. In-service
- Midwifery Schools
- SOGP Member
- Private Sector
- Community based – AKHSP
- Refresher courses
- Provider motivation
 - a. Recognition/publishing good results
 - b. Support

Annexure 12

Logistics for Drugs and Supplies

- *Integration* of health services
 - a. Infrastructure (linked)
 - b. Piggyback with EPI
- *Oxytocin* – procurement, storage, distribution (cold chain maintenance)
- *Manufacture* to be encouraged
- *Availability* at all levels
- *Government* should help in procurement and distribution at all levels
- *Donor agencies* cooperation is needed
- *Misoprostol* – registering, licensing, availability

Annexure 13

Monitoring and Evaluation

Methods of monitoring and evaluation:

- Use of AMTSL should be noted in patient charts and pantographs
- Those patients receiving AMTSL should be well identified by making stamp
- Make sure Oxytocin is always available and not out of stock

Indicators:

- Number of patients receiving AMTSL by skilled birth attendants should be identified
- Identify the districts providing AMTSL
- Percentage of providers trained in AMTSL
- Percentage deaths in number of PPH cases

Annexure 14

Operations Research

Community based strategies (PPH):

- TBAs
 - a. Training
 - b. Support
 - c. Supervision
- Options where no qualified girls are available
- CMWs
 - a. Training
 - b. Support
 - c. Supervision
- Pairing of LHWs and TBAs
- Who is the provider of Mesoprostol?
 - a. CMWs
 - b. LHWs
 - c. TBAs
 - d. Mothers
- Working from the community
 - a. Training the families
 - b. Training the communities
- Empowerment of women in labour – education and training about labour
- Currently practicing midwives
 - a. Identify
 - b. Supervise
 - c. Establish birthing stations

Appendix D: AMTSL Data from POPPHI CAs

February 24, 2007
Reporting Period 2006/partial 2007

JSI Research & Training Institute, Inc
USAID Funded Healthy Women in Georgia (HWG) Program
USAID Ukraine Program

Indicator 1: Number and Percentage of women in facilities and home where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) within a specified time period.

| Country | Total # of Vaginal Deliveries (Jan 01- Sep 30 2006) | # of AMTSL (Jan 01- Sep 30 2006) | % of AMTSL (Jan 01- Sep 30 2006) |
|---------|---|----------------------------------|----------------------------------|
| Georgia | 3,957 | 2,849 | 72% |
| Ukraine | 44,800 | 35,840 | 80% |

Indicator 2: Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL).

| Country | Number | Percentage |
|---------|--------------------------|------------|
| Georgia | 3 (targeted 4 districts) | 75% |
| Ukraine | Pending feedback JSI | |

Maternal Facility Coverage Indicator

| Country | Total Number in Country | Number |
|---------|-------------------------|--------|
| Georgia | Pending feedback JSI | 5 |
| Ukraine | Pending feedback JSI | 20 |

Intrahealth – USAID Funded Acquire Project, Benin, Ended Sept 2006

Note: This project was using the older POPPHI definitions for Indicator 1 and Indicator 2.

Indicator 1: Number (and Percentage) of births within a specified time period in facilities and homes where the woman received active management of third stage of labor (AMTSL) by skilled birth attendants (SBAs).

| Benin 66 Facilities | Districts (11) | Total # of Vaginal Deliveries (Sep 2005 - Sep 2006) | # of AMTSL (Sep 2005 - Sep 2006) | % of AMTSL (Sep 2005 - Sep 2006) |
|--|---|---|----------------------------------|----------------------------------|
| 66 facilities – this covers 11 districts total (out of 77) | Covè-Zagnando-Ouinhi-Savè-Ouèssè-Adjohoun-Bonou-Dangbo- Pobè-Adja Ouère-Kétou | 9934 | 7103 | 71.5% |
| TOTAL | NA | 9934 | 7103 | 71.5% |

Calculation: We are waiting for feedback from Acquire to determine how many districts are represented by these 66 facilities. There are 12 départements (equivalent to provinces or regions) which are separated into 6 health units (2 départements combined together from a health management perspective). There are 77 communes underneath these departments (which I think would be our districts). It seems from Acquire, that they use the 6 health units across the country. These 66 facilities are in 2 departments (out of the 6 departments), and in 2 areas within each department. For the first department, they are covering 5 communes. For the second department, they are covering 6 communes. So, this data represents a total of 11 districts, within a national total of 77 districts. They are covering 13-16 facilities in each district with these numbers, so I would think this is over 25% of the district, but cannot know for sure. The project is targeting 15 districts in total out of the country, with a total of 79 facilities, 66 of which have some level of detail for AMTSL records.

Indicator 2: Number and percentage of districts providing active management of the third stage of labor (AMTSL).

Precise Definition: This indicator is reported only by countries where programs implement AMTSL in facilities in targeted districts. This indicator is calculated based on Indicator 1 (number and percentage of births within 1 month to 1 year) in targeted facilities where the woman received AMTSL. A district is considered to provide AMTSL if more than 25% of facilities in the targeted districts provide AMTSL.

Calculation: With the current data provided from Acquire, we can extrapolate a value for Indicator 2. Number of districts providing AMTSL (with more than 25% of facilities in the targeted district providing AMTSL) = 11.

Given that this project is only targeting these 15 districts, with data for 11 districts, and there is a total of 77 districts, Indicator 2 percentage = $11/77 = 14\%$.

Note: She is trying to get us this information by the end of this week, Friday, Nov 17th.

Implementation of AMTSL as part QAP EONC Improvement Collaboratives In Ecuador, Honduras, Nicaragua, Benin, and Niger

| Country: | Start-up Date: | # facilities reporting: | Prevention of PPH Outcome Indicators: | | |
|-----------|----------------|-----------------------------------|--|--|---|
| | | | POPPHI indicator # 1: # and % of births within a specified time period in which AMTSL was implemented in targeted facilities | % of country districts providing AMTSL in at least one facility as part of QAP collaborative | POPPHI indicator # 2: # and % of targeted districts providing AMTSL (at least 20% facilities in district) |
| Ecuador | Aug. 2003 | 41/60 | 79 % (total # births: data pending) <u>Time period:</u> November 2006 | 45% | 45% (76 health areas out of 168) |
| Honduras | Nov 2003 | 99/114 | 100% (total # births: data pending) <u>Time period:</u> October 2006 | 25% | 25% (5 out of 20 departments) |
| Nicaragua | Sept. 2003 | 43/ 142 | 99%(total # births: data pending) <u>Time period:</u> September 2006 | 91% | 91% (136 out of 151 municipios) |
| Benin | February 2005 | 15 | <i>Data not consistently reported second half 2006 due to staff turnover</i> | 6% (2 out of 36 zones) | 6% |
| Niger | January 2006 | 25/28 (District Hospitals) | 74 % (of 13,217 total births) <u>Time period:</u> Aug-Dec 06 | 63 % (District Hospital level only as of first phase) | 0% in 2006; Coverage expanding to primary care facilities in 2007 |

Brief Comments on QAP AMTSL program in individual countries:

Ecuador: The EOC Collaborative began in August 2003 in one province, Tungurahua. However, at the time, QAP was also working with the MOH to implement continuous quality improvement (CQI) processes focused on obstetric and newborn care in 14 demonstration health areas in 8 provinces (including Tungurahua) through the national Free Maternity Program. In the three subsequent years, the EOC collaborative incorporated new health areas and provinces, such that the collaborative now involves 13

provinces, 76 health areas, and 8 hospitals, with a total of 84 improvement teams in the country as a whole.

Key Results: The percent of normal deliveries in which oxytocin was administered to prevent PPH increased from 15% in August 2003 to 79 % in 60 sites in November 2006. The EOC Collaborative played a critical role in achieving the spread of AMTSL, even in the absence of a formal MOH decision to incorporate AMTSL as part of national norms.

As the practice of AMTSL expanded in the provinces participating in the collaborative, QAP's advocacy efforts with central MOH authorities were intensified in order to achieve the necessary legitimacy for the spread of active management throughout the entire country. While ideally this legitimacy should be reflected in a complete revision of the current maternal care guidelines, given the difficulty of achieving such a revision in a short time, it was decided instead to work toward an addendum to the guidelines which would endorse the practice of AMTSL.

The restructuring process that has been underway within the MOH, coupled with the country's political instability, have led to frequent changes in key MOH staff and resulted in delays in efforts to formalize AMTSL within the national maternal care guidelines. However, in December 2005, MOH representatives and QAP staff resumed discussion on the subject, and the MOH decided to move ahead with the addendum. In January 2006, the MOH convened a working group of expert obstetrician-gynecologists with QAP support to write the addendum, which was completed in February. The Addendum was officially launched as part of national policy on April 20, 2006.

Honduras: QAP has provided assistance to the Secretariat of Health (SOH) of Honduras since November 2003 to apply CQI methods to improve essential obstetric care, initially in one health region (#5) but by late 2005 in five departmental health regions (following a re-drawing of the health system into departmental health regions). By the end of 2005, 52 facilities in 5 departmental regions were involved in the EOC Collaborative, and by the end of 2006, this had increased to 71 facilities out of the 99 facilities in the 5 departmental regions. The 71 facilities include all 5 departmental hospitals, all 12 maternity clinics, and 54 out of 82 health centers. CQI facilitators within the SOH departmental offices provide training and coaching support to facility-based CQI teams in each departmental area. The national QA unit of the SOH has begun introducing the CQI program focused on maternal and child health in additional departmental regions beyond the 5 assisted by USAID. In October 2006, workshops began in 5 additional departmental regions to initiate facility-based CQI activities. Active management of the third stage of labor is part of the MCH standards that are the focus of CQI efforts.

Key Results: AMTSL increased from 92% when the collaborative was launched in January 2004 to 100% of all deliveries in QAP-assisted sites in October 2006.

Nicaragua: QAP is now working with the Ministry of Health SILAIS leadership and facility teams in 91% of the country's municipalities, covering 15 of the 17 SILAIS in the country. Key changes implemented include dissemination of clinical evidence, local

training in referral hospitals (in particular on cord traction), use of local champions to promote AMTSL, the MOH's addition of AMTSL to official norms, and monthly monitoring and posting of results. Overall, teams have demonstrated strong and sustained performance for key indicators of EOC quality.

Key Results: AMTSL increased from 69% when the collaborative was launched in September 2003 to 99% of all deliveries in QAP-assisted sites in September 2006.

Benin: The MOH and QAP/USAID are collaborating in the implementation of an EONC collaborative in two zones, Pobe/Adja-Ouere/Ketou (PAK) and Aplahoue/Djakotamey/Dogbo (ADD). The Benin EONC collaborative has targeted a continuum of care at the facility level and includes 10 primary health facilities, 2 zonal (district) hospitals, and 3 regional hospitals.

Activities Implemented in the EONC Collaborative:

- Stakeholder meeting in Nov 2004 to introduce collaborative
- Provider orientation to the EONC collaborative goals (Feb 2005)
- Expert meeting to finalize baseline document and tools
- Training of regional coaches (Jul 2005)
- Regular Learning Sessions to share best practices (Feb & May 2005, Jan 2006)
- Implementation of 'action plans' at site level & 6 coaching supervision site visits

Key Results: % of deliveries in which AMTSL was implemented increased from 2% to 70% from Feb. 2005 to June 2006. *Data collection has been irregular in the second half of 2006 due to program staff turnover in Benin.*

Niger: Building on QAP LAC EOC Collaborative gains and an established pediatric care collaborative in Niger, QAP/URC and the Nigerien MOH launched an EONC collaborative in 28 maternities in the spring of 2006, in established pediatric collaborative sites. Two expert meetings (Dec 2005 and Mar 2006) reviewed and adapted international evidence-based best MNH practices including AMTSL. A first set of 7 regional Learning Sessions (June 2006) began implementation of collaborative objectives at the local level, including introduction of AMTSL in all participating maternities. An aggressive training program focused on AMTSL and Essential Newborn Care (ENC) was launched on-site in all participating facilities in June 2006 using a combination of national expert and local trainers. To date 239 providers have been trained in AMTSL, ENC, and basic Infection Prevention as part of an integrated training package using national and regional expert trainers. On-site AMTSL/ENC training has fully integrated CQI content to train site team local member experts to operationalize AMTSL on the ground. Upon completion of training and demonstrated proficiency on 5 mannequins and 5 live patients, provider trainees are granted a certificate of training. Regular on-site coaching/supervision by MOH/QAP staff, participation in regional learning sessions, and regular monitoring of shared indicators has continued to reinforce AMTSL gains on the ground.

AMTSL: Results June-Dec: 2006:

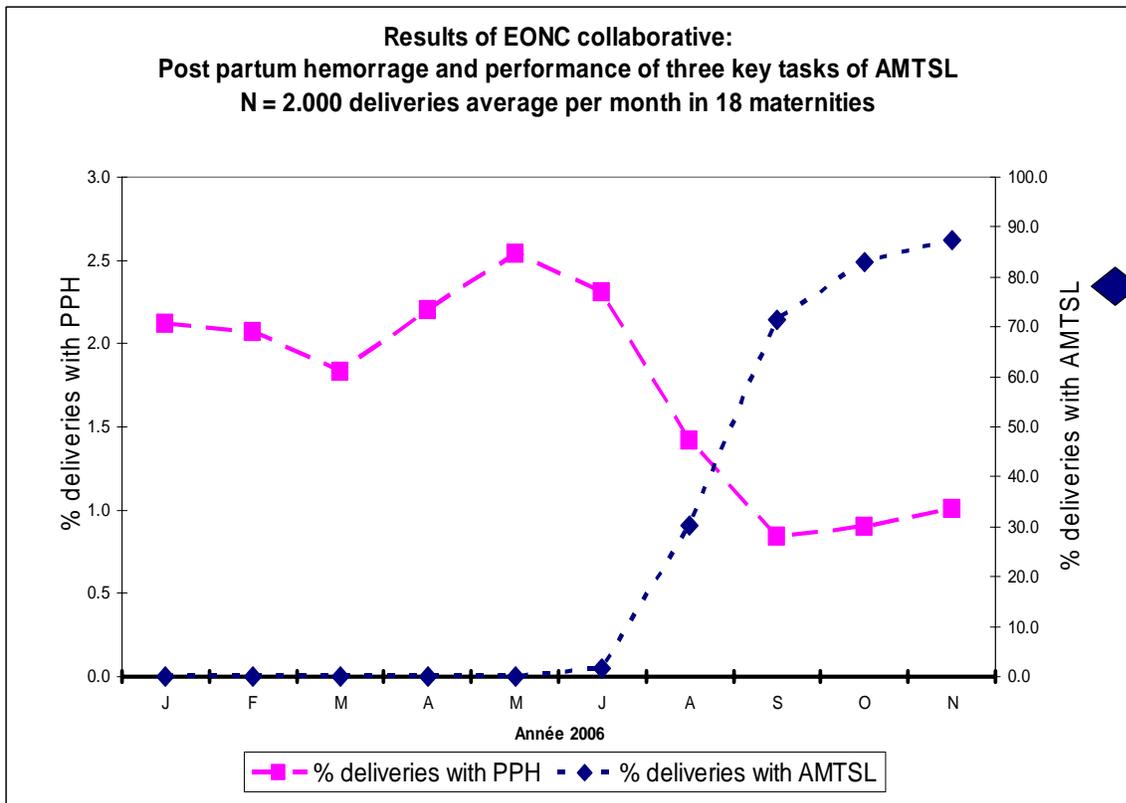
Process and Outcome Results in 25 facilities in which AMTSL intervention has been introduced in Niger since June 2006:

Coverage: % live births in which AMTSL has been applied in 25 targeted facilities has increased from 0% at baseline (Jan-June 06) to 95% by December 2006. Since introduction of the AMTSL intervention in 25 facilities, an average 74 % of 13,217 total births in a five month period (Aug-Dec 06) have received AMTSL, with 95% of 2,520 births in December benefiting from AMTSL.

Process: Compliance with AMTSL standards (3 elements) increased from 0% at baseline to 97 % by end of 2006 in 25 EONC facilities in which AMTSL package has been implemented.

Outcome: > 50% reduction in PPH from 2.1 % (Jan 06) to 0.7 % (Dec 07) of 2,369 average births per month in 25 targeted EONC sites since AMTSL training/implementation in May/June 2006. See Figure 1 for results as of November 2007.

Figure 1:



Challenges/Innovations:

- Inadequate national health information system to monitor AMTSL indicators (frequent stock-out of partograms and partograms do not include AMTSL)

standards). *QAP Niger has introduced partogram AMTSL/ENC rubber “stamps” into partograms to improve compliance with standards and monitoring. National partogram record is currently being revised by national MOH, WHO, and QA. QAP advocating strongly for inclusion of AMTSL elements in new partogram.*

- *Poor baseline provider competence for AMTSL. Training strategy a major challenge due to lack of quality training sites in Niger. On-site training being implemented to reduce training costs and increase competence and motivation for entire site team to cooperatively implement AMTSL as part of routine delivery care*
- *Lack of oxytocin inputs and cold-chain capacity: Regular participation in Regional Learning Sessions allow sites to problem solve at regional local level with support of regional MOH authorities, sharing resources and innovations.*

Appendix E: Engenderhealth Prevention of PPH Project Semi-annual Report for Bangladesh and FIGO Report

[August 2006 – January 2007]
Lauren Peso

Following are the achievements of the reporting period:

- National stakeholders meeting on scaling up of prevention of postpartum hemorrhage with 236 local and expatriate participants held at Dhaka.
- National Action Plan of the PPH Task force developed following the recommendations of the National Stakeholders' meeting.
- Till now six meeting of the National PPH task Force organized and conducted.
- Scope of Work (SOW) for the PPH Task Force revised under six broad headings namely coordination, developing policy and strategy guidelines, provide technical support, support capacity development, strengthening supervision and monitoring and undertaking advocacy for scaling up of programs.
- As an outcome of the national stakeholders meeting, it was decided to conduct an assessment on the availability and routine use of active management of third stage of labor for prevention of post partum hemorrhage in Bangladesh. This will provide us the base line data and also find out the practice gaps of the providers.
- A sub committee has been formed by the members of the National PPH Task Force. The subcommittee has been assigned the function to develop the concept paper of the national assessment on AMTSL, develop the materials related to AMTSL training and to develop the scaling up strategy of AMTSL. All the materials developed by the sub-committee have been presented in the National PPH task Force meeting, received comments which has been incorporated and are further being reviewed. Scaling up strategy of AMTSL is further being revised following the draft paper shared with Ms. Deborah Armbruster.
- A District model of replication of AMTSL training has been proposed by the sub committee in the scaling up strategy. The TOT courses on AMTSL will be conducted after the scaling up strategy and the curriculum are finalized.
- A Job aid on AMTSL has been translated in to Bangla, shared with National PPH Task Force for review and is in the process of finalization for printing. This translated AMTSL poster will be circulated to all levels of facilities conducting deliveries throughout the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP).

- Regarding the registration of Misoprostol, a series of meetings held with different Pharmaceutical companies (Gonoshaystha Pharmaceuticals and Nuvista Pharma)
- EH, BCO staff visited one district to review the existing status of AMTSL record keeping. It was found that AMTSL is practiced sporadically at district level hospitals including medical colleges but at the sub district level, the providers were not received orientation on AMTSL. It was found that no body is recording AMTSL even at the district level hospital. Following this visit work is underway to recommend ways and means of proper record keeping on AMTSL

**Semi Annual Progress Report
For the period from June 2006 – September 2006**

Subcontract no: RTI.1171-02-01713- CRT (Code: 1171-02-00-00)

Recipient: International Federation of Obstetricians and Gynaecologists of Canada
FIGO Secretariat, FIGO House
Suite 3, Waterloo Court, 10 Theed Street
London, UK SE1 8ST

Purpose: To assist POPPHI to expand and improve the quality and availability of AMTSL at the facility level and community level through their work with through their member associations around the world.

Progress on Activities:

1. Maintain a data bank tracking FIGO and ICM member societies and associations involvement in AMTSL related activities

Some new information was added to the tracking data as a result of a small member survey conducted of FIGO associations. The feedback gathered through that process confirmed that the 80/110 FIGO associations are aware of the Joint Statement. Of those 35 have confirmed that they have taken an active role in disseminating the statement to their membership, and through other means within their countries. As in the past, these numbers represent only those reported to us, and therefore it is estimated that the number of associations that have disseminated the statement is likely higher.

2. Continue to disseminate joint ICM/FIGO joint statement (and evidence supporting its use)

The Joint Statement continued to be dissemination through the respective websites of FIGO and ICM. Furthermore, agreement was reach with the SOGC that POPPHI would be provided with space at the SOGC Booth at the FIGO World Congress in order to distribute materials including the Joint Statement and the Job Aids. SOGC planned to distribute a textbook on Postpartum Haemorrhage which was sure to attract attention to the issue.

In addition, in preparation for the FIGO World Congress in the November 2006, it was ensured that the Joint Statement and other POPPHI activities were included in a number of presentations given by FIGO officials (Dr. Andre Lalonde, Dr. Arnaldo Acosta and Dr. Arulkumaran).

3. ICM/FIGO meetings re: need to revise/update ICM/FIGO Joint Statement

Representatives from the two organizations worked collaboratively to update the statement, which ultimately resulted in the preparation of a second Joint Statement

entitled *Prevention and Treatment of Post-partum Haemorrhage: New Advances for Low Resource Settings*. (POPPHI Resources were not used for the development of this second statement).

4. Support POPPHI Project's focus on select countries for intensified effort on the use of AMTSL and other

As there was never any agreement on how to proceed with this element of the work plan, it was agreed that this portion of the work plan would be differed until year three.

5. Participate to other meetings of relevance (e.g., Geneva Meeting, Entebbe Meeting)

No such meetings took place during this reporting period.

6. Participate to POPPHI's Working Group and First Intervention Task Forces

Dr. Andre Lalonde participated in two First Intervention Task Force meetings during this reporting period. Both took place via teleconference, one on August 31, 2007 and the other on September 11, 2007. A subsequent meeting also took place at the FIGO World Congress, but that fell outside the specific dates of this reporting period.

7. Submit semi annual and annual progress reports, including work plan for Year 3

Work took place during Year 2 to prepare the work plan for Year 3 and to plan for the transfer of the responsibility for the project back to the FIGO Secretariat in London.

Appendix F: POPPHI Semi-annual AMTSL Data— August Training-Pakistan

Pakistan follow-up (Lahore and Karachi)
AMTSL percentages and PPH incidence
D. Beck

Data collected August 2006 to December 2006

Trickle Down Training Since August 2006

Karachi

| | Doctors | Midwives | Medical Students | Midwifery Students |
|----------------|------------|----------|------------------|--------------------|
| Total by Cadre | 79 | 28 | 7 | 27 |
| Total | 141 | | | |

Lahore

| | Doctors | Midwives | Medical Students | Midwifery Students |
|----------------|-----------|----------|------------------|--------------------|
| Total by Cadre | 22 | 3 | - | - |
| Total | 25 | | | |

Clinical Data from September – December 2007

3 Karachi Hospitals: JPMC, Kharader and Lady Dufferin

| Hospital | Number of Vaginal Deliveries | Number of Case Given AMTSL | Number Requiring Added Uterotonic | Number Retained Placenta | Number PPH in Spite of AMTSL |
|---------------------------|------------------------------|----------------------------|-----------------------------------|--------------------------|------------------------------|
| JPMC | 3500 | 2903 | 67 (2.3%) | 7 | 14 |
| Kharader General Hospital | 1695 | 1695 | - | 1 | 8 |
| Lady Dufferin Hospital | 1345 | 1345 | 422 (31%) | 9 | 43 |
| Total | 6540 | 5925 (90%) | 489(8.2%) | 17(0.2%) | 65(1%) |

Lahore Hospital

| Hospital | Number of Vaginal Deliveries | PPH due to Uterine Atony |
|------------------------------------|------------------------------|--------------------------|
| Services Hospital Units I, II, III | 3285 | 193 (5.8%) |

Questions to Imtiaz Kamal 30 January 2007:

- Do the number of providers trained (as noted above) include those who were in the August training?
- Do we have baseline figures from each hospital in Karachi, perhaps from 2005, for the following, so we can compare the PPH rate in 2005 and then from September to December 2006?
 - Number with retained placenta
 - % PPH
- At JPMC, not all women with vaginal deliveries are receiving AMTSL. It would help to have some sort of explanation to clarify why 10% are not receiving AMTSL.
- It is very curious about the number of patients receiving additional uterotonics at Lady Dufferin Hospital – 31%. In the Bristol and Hinchingsbrooke trials that included over 6000 women, somewhere between 3.2 – 6.4 % needed additional oxytocics to manage PPH. One thought is that providers are not trusting that AMTSL will work and are automatically giving

additional uterotonics for anyone they think is higher risk. Do you think that could be happening?

- Also in the Bristol and Hinchingsbrooke trials the rate of PPH with active management was between 6 – 7 %. The rate noted above is only about 1%. Am wondering if we are actually picking up everyone with PPH or is the amount of bleeding being underestimated, as we know is so common... or is there another reason for the low PPH rate? Have included the data from the Bristol and Hinchingsbrooke trials for comparison.

| Factors | Study | Management | |
|-------------------------------|-----------------|------------|-------------|
| | | Active | Physiologic |
| Postpartum | Bristol | 5.9% | 17.9% |
| Hemorrhage | Hinchingsbrooke | 6.8% | 16.5% |
| Oxytocic Needed to Manage PPH | Bristol | 6.4% | 29.7% |
| | Hinchingsbrooke | 3.2% | 21.1% |

Responses from Imtiaz Kamal 31 January 2007:

Now to answer your Qs and Os:

- In Karachi the providers are those who were trained by the trainers who attended the August Workshop with you. You would recollect that they had committed to give trickle down training and with Arjumand ensuring follow up, the training was done as follows by:
 - Razia and Talat in JPMC
 - Leila, with a bit of help from MAP, in Lady Dufferin Hospital
 - Azra and Farah in Kharadar Hospital
 - Farah and Saadia as a mobile team (their training activities have been reported in the quarterly report)
- Regarding the base line information. We again think alike. MAP felt that just having figures for AMTSL will not stand alone. We must have some data to compare it with.

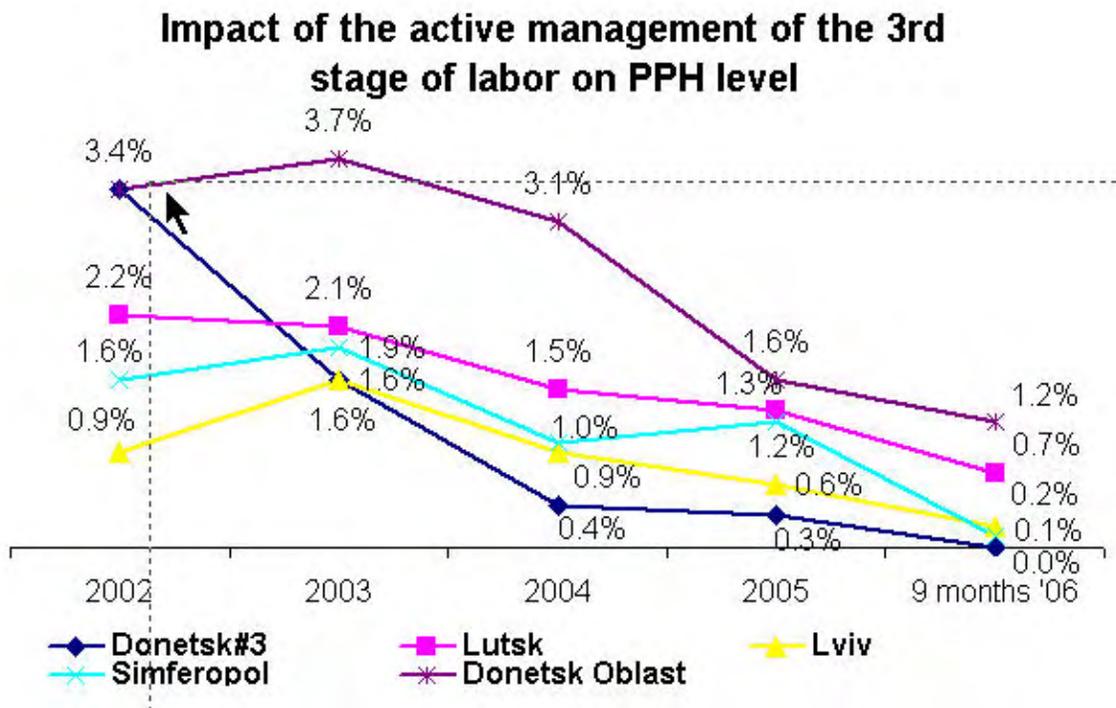
As I told you I have some say in Lady Dufferin Hospital so when requested they obliged. Also Dufferin has good records of each patient, maybe not excellent but good enough for essential information. Leila got the "Three months just before AMTSL" information and then the quarterly report of the three months when AMTSL was introduced. We have those figures. We have often referred to those in our meetings. PPH was cut down to almost half. I will check with Arjumand . If she did not Annex that table to the quarterly report, then we will forward it to you.

Yes. The base line information is needed. I am afraid I cannot promise that it will become available. I told you last night 95% of the Ob/Gyns I know are fond of "Knives and needles".

Only 5 % like to use a pen. I can try but no promises.

3. JPMC not giving AMTSL to all. Yes the question did come up. If I recollect, they called ALL deliveries," vaginal deliveries" even when they were C Sections. I will check on that.
4. Re Lady Dufferin (LDH) giving extra uterotonics in addition to AMTSL. That was also questioned by Arjumand. We checked on that. Your observation is correct. Extra uterotonics are given to every woman considered at risk of PPH. The area served by LDH is overpopulated, high fertility, low Hb levels and lower middle class clients. LDH is almost a charitable institution. They do not want any one at risk to lose any more blood than absolutely necessary. This time you had Dr. Biqis from LDH in the training sessions(The one with a covered head). With her there we can expect a change.
5. Yes the PPH rate was low. I can attribute it to three things: (1) Extra uterotonics (2) Not being able to measure blood loss accurately, and (3) Not recording accurately. We can follow up on that.

Impact of AMTSL on PPH levels in 5 cities in Ukraine (post 2005)



Appendix G: Proposed WHO SBA (2006) Definition and Original (2004) SBA Definition

**(REFER TO
HTTP://WWW.WHO.INT/HEALTHINFO/STATISTICS/INDBIRTHSWITHSKILLEDHEALTHPERSONNEL/EN)**

Proposed updated SBA definition discussed in October, 2006 meetings:

“SBAs are health professionals who have been educated and trained to proficiency in skills needed to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral for mother and baby for interventions that are beyond their competence or are not possible in the particular setting. SBA includes medically trained doctor, nurse, or midwife. Depending on the setting, other healthcare providers, such as auxiliary nurse-midwives, community midwives, village midwives and health visitors, may also have acquired appropriate skills if they have been specially trained. It does NOT include traditional birth attendants (TBA).”

2004 WHO SBA definition

The term ‘skilled attendant’ refers to “an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (WHO, 2004).

Note:

Traditional birth attendants (TBA) either trained or not, are excluded from the category of skilled health workers. Strictly, the term TBA refers only to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period (WHO, 2004).

Appendix H: POPPHI Training Summary Information for 2006, 2007

Pass rate will be 90% for all programs conducting post-training assessments

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|----|----------|---|---|--|---|--|--|-------------------------|
| 7. | Malawi | Train or update 29 SM trainers; 5 key persons in health training institute/ 100 clinical officers = 134 | <p>Program 27th July 2006</p> <p>Trained Nurse Midwife Tutor (1) , Midwifery Lecturer (2) , RN/M Assistant Lecturer, RN/M - Deputy Director (3), Clinical Services (RHU), RN/Midwife - Tutor, Clinical Officer – Tutor (4), RN/M - Assistant Lecturer, RN/M - Safe Motherhood Coordinator, RN/M - Chief Nursing Officer Q.A. (5)</p> | <p>37 total</p> <p>5 key persons in health training institute 1 SM trainer</p> | 134 | | | |
| 9. | Tanzania | 15 participants per municipality x 5 municipalities = 75 | <p>[Participants for these workshop were drawn from city hospitals namely Temeke, Mwanjamala, Ilala and some from selected health centers both private and public which has high numbers of deliveries]</p> <p>34 service providers were updated on the</p> | 34 | 75 | | | |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|---|---------|--|---|--|---|--|--|--|
| | | | current practice of Active Management of Third stage of Labour - 21 st to 22 nd June 2006 and 12 th to 13 th July 2006 at Muhimbili National Hospital | | | | | |
| 2 | Nepal | 4 regions x 20 participant per region = 80 | <p>Two days of trainer's training workshop for preparation of trainers on Active management of Third Stage of Labor was organized at Kathmandu on 16-17th March at training hall of Kathmandu Medical College. There were 20 participants altogether, of which 10 gynecologists and 10 nurses representing NESOG and NAN respectively. This training was facilitated by the trainers who attended the Asia region workshop held in Delhi.</p> <p>Two days Training on "Active Management of Third Stage of Labor" was organized and conducted on 26 and 27th march 06 at Pokhara. Altogether 23</p> | 82 | 80 | | | No post training pass-rate data available; Will track with AMTSL percentages = 52% at endline [51 endline surveys] |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|---|----------|--|--|--|---|--|--|--|
| | | | <p>participants attended the training.</p> <p>Two days training on AMTSL was conducted at Bheri Zonal Hospital on 26-27 March, 06. A total of 21 participants participated with full energy and enthusiasm.</p> <p>Eastern region Inaruwa, Sunsari, March 26th and 27th 2006. A total of 18 participants.</p> <p>Two days training on AMTSL in Dhulikhel Kavre, was organized and conducted in Dhulikhel community Hospital on March 26-27, 2006. There were 20 participants in number comprising from the hospital, various PHC, HP and SHP as well as DHO of Kavre District.</p> | | | | | |
| 1 | Pakistan | <p>Small grants: 10 hospitals x 15 trainees = 150</p> <p>Bilateral: 4 provincial trainings = 100</p> | <p>Training of Health care Providers on AMTSL protocol:</p> <p>14th Sept 2006 - Kharader General Hospital Karachi</p> | 108 | 175 | 201 | 75 | No post training pass-rate data; However, in JPMC, Kharader and Lady Dufferin, |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|---|---------|----------------------|--|--|---|--|--|-------------------------|
| | | | <p>Trained 17 people total</p> <p>12th Sept 2006 – OMI Hospital Karachi</p> <p>Trained 18 people</p> <p>8th Sept 2006 – Dr. Ziauddin University Hospital</p> <p>Trained 23 people: 4 doctors provided follow-on training</p> <p>22nd Sept 2006 – Lady Dufferin Hospital Karachi</p> <p>Trained 22 midwives</p> <p>27th Oct 2006 – Lady Dufferin Hospital Karachi</p> <p>Trained 26 midwifery student</p> <p>27th Oct 2006 – Lady Duffering Hospital Karachi</p> <p>Trained 9 junior house doctors</p> | | | | | AMTSL rates at 90% |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|---|---------|------------------------------------|--|--|---|--|--|-------------------------|
| | | | <p>1st Sept 2006 – Jinnah Post graduate medical hospital Karachi</p> <p>Trained 28 people (post graduate medical students and house officers)</p> <p>August-Dec 2006, there was additional trickle down training:</p> <p>In Karachi, 79 doctors, 28 midwives, 7 medical students and 27 midwifery students (141 total)</p> <p>In Lahore, 22 doctors and 3 midwives (25 total)</p> | | | | | |
| 3 | Bolivia | 3 workshops x 25 participants = 75 | <p>6-7 April 2006, AMTSL training</p> <p>34 people trained</p> <p>2 Other trainings completed during 2006</p> <p>67 Trained</p> | 101 | 75 | | 50 | |
| 5 | Uganda | Train health workers in 2 | <p>March 15-18 2006, They trained 39 in</p> | 74 | 50 | | | |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|----|--------------------|---|--|--|---|--|--|--|
| | | districts/ 2 x 25 = 50 | Kiboga (5 health centres), 35 people in Kibaale (4 health centres) | | | | | |
| 14 | Paraguay | Train at 7 hospitals x 20 | Small grant cancelled; Moving to B'desh in 2007 | | 140 | | | |
| 15 | Dominican Republic | 10 hospitals x 20 providers = 200 | Trained in 9 hospitals (one was removed due to lack of compliance) Bogart, 17 Mar 2006, 24 Salcedo, 4 Apr 2006, 21 Macoris, 11 Apr 2006, 18 Marza, 27 Apr 2006, 25 Limardo, 21 Apr 2006, 13 Pina, 21 Feb 2006, 26 Maguana, 4 Apr 2006, 19 Higuey, 4 Apr 2006, 24 Montecristi, 16 Mar 2006, 20 | 190 | 150 | | 50 | |
| 11 | Mali | 25 x 3 groups of matrones trained in bilateral; 75 trained with small grant | Sikasso, 18 – 21 Sep, 2006; 20 Gao, 13 – 16 Nov, 2006; 22 Gao, 19 – 22 Nov, 2006; 31 Gao, 23 – 26 Nov 2006; 18 Koulikoro, 6 – 9 Nov, 2006; 22 | | 75 | 134 | 75 | Target 125; Post Knowledge Evaluation, 68; Post skill evaluation, 55 |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|----|--------------|--|--|--|---|--|--|-------------------------|
| | | | Koulikoro, 6 – 9 Nov, 2006; 21 Trained Nurse (16), Obstetrical Nurse (22), Midwife (14), Doctor (15), Matrone (46), CPM (17) and Monitrice (1) and 3 additional | | | | | |
| 10 | Benin | Train 90 providers | We do not have the final training report; We have received 15 member surveys so at a minimum 15 have been trained | 15 | 90 | | | |
| 11 | Burkina Faso | Train midwives in Ougadougou that aren't trained in AMTSL = 25 | From the member surveys, have data on 12 people who were trained. No final training report available. | 12 | 25 | | | |
| 12 | Cameroun | Train 25 providers | Did pre-post, will have this information once received all surveys. Received 25 baseline surveys. | 25 | 25 | | | |
| 4 | Peru | Train 200 | Training just beginning | | 200 | | | |
| 6 | Ethiopia | Train 20 tutors and 10 heads of schools | We do not have this information as they ended up not doing training | | 30 | | | Target 30 |

| # | Country | Small Grants Country | 2006 Training Overview, Dates, Participants (end of July 2006) | Actual Number Trained 2006 (end of Sep 2006) | Target Number Trained 2006 (end of Sept 2006) | Actual Number Trained 2007 (end of Jan 2007) | Target Number Trained 2007 (end of Sep 2007) | Post Training Pass Rate |
|--------------------|-------------|--------------------------------------|--|--|---|--|--|---|
| 8 | Ghana | 100 trainers | We have not received the final training report yet. We have received 59 member surveys we can use in EpiInfo | 87 | 100 | | | Target 100 (will track at endline AMTSL rate) |
| 16 | Ecuador | Train 50 nurses and nursing teachers | Not started yet | | | | 50 | For 50 |
| 17 | El Salvador | Train 30 health providers | Not started yet | | | | 30 | |
| 18 | Indonesia | | Trained 71 health care workers July, 2006 | | | 71 | 0 | |
| Total | | | | 765 (Target 1424) | | 406 (Target 330) | | |
| Grand Total | | | | 1171 (Target 1754) | | | | |

Appendix I: Data Consistency Decisions

August 2006 – January 2007

Niamh Darcy

This outlines the data decisions used in entering data into EpiInfo from the handwritten and electronic baseline and endline surveys.

Decision: For now, collect answers to both #3 (uterotonics available) and #9 (uterotonics using) as is. We are really more interested in what they are using and that is what we will be reporting on. [Question: #3 asks what uterotonics are available at facility and #9 asks which are they currently using. Shouldn't #9 include all or a subset of #3? What if they are different? Should we create a rule or leave it as is?]

Decision: If they respond No to #2b (a), then we should ignore entries for (2b) [b-f] as these are not valid. If they respond no to #2, then should ignore answers to (2a) and (2b).

Decision: Leave this as is (#4-#8). If they respond that they have not been formally trained in AMTSL and they are practicing it, this is ok. We are really looking at use here and they may have not had a separate AMTSL specific training but received this as part of their overall curriculum [Question: what if a person responds that he/she has not been trained in AMSTL (#4) and/or does not use it (#5 and 6) but then responds yes to #8? Should we leave this as is?]

Decision: If parent question is answered as No, then even if they answer the other components you can leave these as blank as they are not valid. [Question: If parent question was answered “no”, all components were skipped. But what should I do if parent question is skipped but component questions have responses?]

Decision: We will just have to leave it as is when entering into EpiInfo (if number of births in facility less than number that receive AMTSL). We can see what the results are in the endline. When we compute a percentage for this entry, it cannot be more than 100%. [Question: For a couple surveys, the total number of births recorded was less than the number of births that received AMSTL. What should I do in these cases?]

Decision: If Yes/No hard to read, then leave as blank. If Yes/NO are both selected, then leave blank, or select both.

Decision: If answer to any question is not legible, leave blank. We will just ask the grantees to review the data collection forms in more detail for us. If answer is blank, then also leave blank.

Decision: If the date field is blank or illegible. Enter in the date the grantee says the training occurred, you can enter this (assuming before date from grantee) as some grantees sent out surveys ahead of the training]

Decision: For Question 11, where a group (like Malawi) use district protocols, we cannot track this as it is not asked so leave as blank.

Decision: 2 #11 circled “national” and wrote in “safe motherhood”. Leave selection as national. We do not need to enter in safe motherhood as we didn’t ask in the survey what kind of detailed protocols were used.

Decision: Section 1 #5: >2000. I think for now we just write in 2001 – that is the best we can do here.

Decision: Section 1#5 and #6, if answer Yes, then leave blank. Must be a numeric answer.

Decision: If the answer is NO for a composite question, and if the respondent has checked the subsequent part of the composite question this is interpreted as a NO for the whole question.

Decision: For hand written surveys, where they differ from the electronic version, use the hand written one as the correct information.

Decision: Some member surveys do not say whether they are an OB/GYN or Midwife – do we assume Midwife if not selected – just select Unknown for this for now.

Decision: If different people surveyed in the same facility have different answers for the number of births and number that received AMTSL we have decided to use the average. If someone does not answer these two questions (5, 6) or only answered one of these, then do not factor their answer into the average for this facility.

Decision: If not marked baseline or endline, then assume baseline for all surveys received to date – this is consistent with small grant timelines.

Decision: Leave empty if not completed, Section 2, #9, 10.

Decision: If a page of a survey is missing, leave this as blank and then determine if we can recover this page from the site.

Decision: s2#2b: more than 1 response – then just leave as blank as these answers are mutually exclusive.

Decision: skipped 10, responded to 10a-c, skilled 10d – do not enter any data here as it is inconsistent and should not be counted.

Decision: Member replied No to question 10, and answered remainder – use the overall No as the response. If question 10 not filled out, leave as blank

Decision: When Yes and No selected, either enter both into the survey or neither. Do not enter just one or the other.

Decision: For +/- 400 to 450 we have chosen 425. Also, for 25-30 we have chosen 28 (rounded up to the nearest whole number as can’t have halves for babies)

Decision: For illegible or blank leave these as blank in EpiInfo.

Decision: If someone writes in ‘No’ and then writes a comment the comment field will not be entered into EpiInfo.

Decision: Allow Section I, Q5 and Q6 to be blank. This means they do not know. This means we will not include this in our summary report.

Decision: If enter <100 then leaving as blank. If enter approx 2000 then enter as 2000.

Decision: If enter #5 2500/year -This should be ok if they answered #6 as /year. If #6 is per 3 months, then divide 2500 by 4 to get per 3 months.

Decision: Several baseline surveys from DR reply "yes" to the question "Have you been trained in AMSTL"? and write in "ahora" (now). We will assume this is really No as they are only being trained in the intervention (which is why they answer now).

Appendix J: Small Grant Survey Detailed Information (Baseline and Endline)

August 2006 – January 2007

Niamh Darcy

The following set of details, shows the summarized output from EpiInfo for the survey data received and entered into EpiInfo from all the small grant countries as follows:

- (1) Benin
- (2) Bolivia
- (3) Burkino Faso
- (4) Cameroun
- (5) Ghana
- (6) Malawi
- (7) Nepal (baseline and endline)
- (8) Pakistan
- (9) Tanzania
- (10) Uganda

Benin

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 11 | | 4 | | | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 10 | | 4 | | | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 9 | | 4 | | | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 1 | | 0 | | | | | |
| (b) Available less than 3 months | 0 | | 0 | | | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | 0 | | | | | |
| (d) Available more than 6 months and less than 9 months | 0 | | 0 | | | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | 0 | | | | | |
| (f) Continuously available | 10 | | 3 | | | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 10 | | 4 | | | | | |
| (b) Injectable ergometrine | 3 | | 1 | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | | | | |
| (e) Oral ergometrine | 4 | | 1 | | | | | |
| (f) Oral misoprostol | 2 | | 2 | | | | | |
| (g) Rectal misoprostol | 4 | | 2 | | | | | |
| (h) Other (specify):__ _____ | 0 | | 0 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 11 | | 4 | | | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 11 | | 4 | | | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 11 | | 4 | | | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 11 | | 4 | | | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 11 | | 4 | | | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 11 | | 4 | | | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 0 | | 0 | | | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 1 | | 0 | | | | | |
| (b) No payment by patient for uterotonic drugs | 3 | | 1 | | | | | |
| (c) Not included in clinical protocols or guidelines | 0 | | 0 | | | | | |
| (d) Lack of training in active management of the third stage of labor | 1 | | 1 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 2 | | 1 | | | | | |
| (f) No supervisory support | 2 | | 1 | | | | | |
| (g) Other (specify): _____ _____ | | | | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 11 | | 4 | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 11 | | 4 | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 10 | | 4 | | | | | |
| d. Immediate clamping of cord? | 11 | | 4 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 10 | | 4 | | | | | |
| (b) Injectable ergometrine | 0 | | 0 | | | | | |
| (c) Injectable combined Oxytocin/ergometrine | 0 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | | | | |
| (e) Oral ergometrine | 0 | | 0 | | | | | |
| (f) Oral misoprostol | 0 | | 1 | | | | | |
| (g) Rectal misoprostol | 0 | | 1 | | | | | |
| (h) Other (Specify):____ _____ _____ | | | | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 9 | | 4 | | | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 8 | | 3 | | | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 9 | | 4 | | | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 9 | | 3 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 9 | | 4 | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 9 | | 4 | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 9 | | 4 | | | | | |
| d. Immediate clamping of cord? | 9 | | 4 | | | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 9 | | 4 | | | | | |
| (b) Injectable ergometrine | 0 | | 0 | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | | | | |
| (e) Oral ergometrine | 0 | | 0 | | | | | |
| (f) Oral misoprostol | 0 | | 1 | | | | | |
| (g) Rectal misoprostol | 0 | | 1 | | | | | |
| (h) Other (Specify): | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|--|---|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 11 | 3 | | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 11 | 4 | | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 11 | 4 | | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 11 | 4 | | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 10 | 4 | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹³ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (1) The number of facilities where [c] in item 5 is greater than 50% (2) The total number of facilities in this district involved in maternal deliveries (3) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (4) The number of targeted districts (5) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹³ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Bolivia

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 30 | | 57 | | 14 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 21 | | 57 | | 14 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 20 | | 56 | | 14 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 8 | | 1 | | 0 | | | |
| (b) Available less than 3 months | 0 | | 0 | | 0 | | | |
| (c) Available more than 3 months and less than 6 months | 1 | | 4 | | 0 | | | |
| (d) Available more than 6 months and less than 9 months | 1 | | 0 | | 0 | | | |
| (e) Available more than 9 months and less than 12 months | 14 | | 39 | | 11 | | | |
| (f) Continuously available | 4 | | 9 | | 2 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 19 | | 48 | | 14 | | | |
| (b) Injectable ergometrine | 18 | | 44 | | 9 | | | |
| (c) Injectable combined oxytocin/ergometrine | 3 | | 16 | | 2 | | | |
| (d) Oral/buccal oxytocin | 4 | | 5 | | 0 | | | |
| (e) Oral ergometrine | 15 | | 42 | | 10 | | | |
| (f) Oral misoprostol | 15 | | 15 | | 4 | | | |
| (g) Rectal misoprostol | 2 | | 2 | | 0 | | | |
| (h) Other (specify):__ _____ | | | 2: duratocin | | 4: cervical misoprostal | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 7 | | 27 | | 1 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 6 | | 27 | | 1 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 7 | | 26 | | 1 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 7 | | 27 | | 1 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 6 | | 21 | | 1 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 12 | | 20 | | 7 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 1 | | 6 | | 0 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 1 | | 7 | | 2 | | | |
| (b) No payment by patient for uterotonic drugs | 0 | | 1 | | 0 | | | |
| (c) Not included in clinical protocols or guidelines | 1 | | 7 | | 2 | | | |
| (d) Lack of training in active management of the third stage of labor | 19 | | 21 | | 9 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---|--------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 13 | | 12 | | 9 | | | |
| (f) No supervisory support | 5 | | 15 | | 6 | | | |
| (g) Other (specify):____ ____ | | | 1: coordinacion con todo personal 3: falta de capacitacion | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 19 | | 44 | | 5 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 10 | | 33 | | 3 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 14 | | 49 | | 3 | | | |
| d. Immediate clamping of cord? | 12 | | 44 | | 5 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 18 | | 46 | | 5 | | | |
| (b) Injectable ergometrine | 10 | | 11 | | 3 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 1 | | 1 | | 2 | | | |
| (d) Oral/buccal oxytocin | 3 | | 1 | | 0 | | | |
| (e) Oral ergometrine | 6 | | 5 | | 5 | | | |
| (f) Oral misoprostol | 0 | | 2 | | 1 | | | |
| (g) Rectal misoprostol | 0 | | 0 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 8 | | 26 | | 2 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 7 | | 15 | | 1 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 7 | | 18 | | 1 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 7 | | 22 | | 2 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 6 | | 24 | | 2 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 7 | | 16 | | 2 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 7 | | 21 | | 0 | | | |
| d. Immediate clamping of cord? | 5 | | 17 | | 0 | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 7 | | 26 | | 2 | | | |
| (b) Injectable ergometrine | 2 | | 9 | | 2 | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | 4 | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 1 | | | |
| (e) Oral ergometrine | 3 | | 0 | | 1 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 0 | | | |
| (g) Rectal misoprostol | 0 | | 0 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|---|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *This question was not answered [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 21 | 57 | 14 | 92 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 6 | 28 | 2 | 36 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 6 | 26 | 2 | 30 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 11 | 36 | 7 | 54 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 10 | 29 | 3 | 42 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁴ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (6) The number of facilities where [c] in item 5 is greater than 50% (7) The total number of facilities in this district involved in maternal deliveries (8) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (9) The number of targeted districts (10) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁴ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Burkina Faso

Section III – Member Survey Summary Data Form. *This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).*

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 8 | | | | 4 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 8 | | | | 0 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 8 | | | | 0 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 0 | | | | 4 | | | |
| (b) Available less than 3 months | 1 | | | | 0 | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | | | 0 | | | |
| (d) Available more than 6 months and less than 9 months | 0 | | | | 0 | | | |
| (e) Available more than 9 months and less than 12 months | 1 | | | | 0 | | | |
| (f) Continuously available | 5 | | | | 0 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 8 | | | | 0 | | | |
| (b) Injectable ergometrine | 6 | | | | 0 | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | | | 0 | | | |
| (e) Oral ergometrine | 1 | | | | 0 | | | |
| (f) Oral misoprostol | 0 | | | | 0 | | | |
| (g) Rectal misoprostol | 0 | | | | 0 | | | |
| (h) Other (specify):__ _____ | | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 0 | | | | 0 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 0 | | | | 0 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 0 | | | | 0 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 0 | | | | 0 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 0 | | | | 0 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 1 | | | | 0 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 1 | | | | 0 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 2 | | | | 0 | | | |
| (b) No payment by patient for uterotonic drugs | 2 | | | | 0 | | | |
| (c) Not included in clinical protocols or guidelines | 0 | | | | 0 | | | |
| (d) Lack of training in active management of the third stage of labor | 5 | | | | 0 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 1 | | | | 0 | | | |
| (f) No supervisory support | 3 | | | | 0 | | | |
| (g) Other (specify): _____ _____ | | | | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 3 | | | | 0 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 2 | | | | 0 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 7 | | | | 4 | | | |
| d. Immediate clamping of cord? | 7 | | | | 4 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 5 | | | | 0 | | | |
| (b) Injectable ergometrine | 3 | | | | 0 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 0 | | | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | | | 0 | | | |
| (e) Oral ergometrine | 1 | | | | 0 | | | |
| (f) Oral misoprostol | 0 | | | | 0 | | | |
| (g) Rectal misoprostol | 0 | | | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 1 | | | | 0 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 0 | | | | 0 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 0 | | | | 0 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 0 | | | | 0 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 0 | | | | 0 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 0 | | | | 0 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 1 | | | | 0 | | | |
| d. Immediate clamping of cord? | 1 | | | | 0 | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 1 | | | | 0 | | | |
| (b) Injectable ergometrine | 1 | | | | 0 | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | | | 0 | | | |
| (e) Oral ergometrine | 0 | | | | 0 | | | |
| (f) Oral misoprostol | 0 | | | | 0 | | | |
| (g) Rectal misoprostol | 0 | | | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input checked="" type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 8 | | 0 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 0 | | 0 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 0 | | 0 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 1 | | 0 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 1 | | 0 | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁵ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (11) The number of facilities where [c] in item 5 is greater than 50% (12) The total number of facilities in this district involved in maternal deliveries (13) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (14) The number of targeted districts (15) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁵ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Cameroon

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|---------------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 8 | | 3 | | 14 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 5 | | 3 | | 7 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 4 | | 3 | | 5 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 4 | | 0 | | 8 | | | |
| (b) Available less than 3 months | 0 | | 0 | | 0 | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | 0 | | 1 | | | |
| (d) Available more than 6 months and less than 9 months | 0 | | 0 | | 0 | | | |
| (e) Available more than 9 months and less than 12 months | 1 | | 0 | | 0 | | | |
| (f) Continuously available | 1 | | 3 | | 0 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 6 | | 3 | | 6 | | | |
| (b) Injectable ergometrine | 5 | | 3 | | 4 | | | |
| (c) Injectable combined oxytocin/ergometrine | 1 | | 1 | | 2 | | | |
| (d) Oral/buccal oxytocin | 1 | | 1 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 2 | | 3 | | | |
| (f) Oral misoprostol | 2 | | 1 | | 2 | | | |
| (g) Rectal misoprostol | 3 | | 2 | | 1 | | | |
| (h) Other (specify):__ _____ | | | | | 1: achete par la patiente | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 4 | | 0 | | 8 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 4 | | 0 | | 8 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 4 | | 0 | | 7 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 4 | | 0 | | 8 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 4 | | 0 | | 7 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 6 | | 2 | | 2 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 2 | | 1 | | 6 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 4 | | 1 | | 6 | | | |
| (b) No payment by patient for uterotonic drugs | 6 | | 1 | | 7 | | | |
| (c) Not included in clinical protocols or guidelines | 3 | | 1 | | 3 | | | |
| (d) Lack of training in active management of the third stage of labor | 4 | | 1 | | 4 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|-------------------------------|---------------------|---------------------|--------------------|--|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 2 | | 0 | | 3 | | | |
| (f) No supervisory support | 1 | | 1 | | 2 | | | |
| (g) Other (specify): _____ _____ | 1: refus de certaiX gyneco | | | | 1: refus de certains gynecologue | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 8 | | 3 | | 13 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 8 | | 3 | | 14 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 8 | | 3 | | 14 | | | |
| d. Immediate clamping of cord? | 8 | | 3 | | 13 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|---------------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 7 | | 2 | | 10 | | | |
| (b) Injectable ergometrine | 3 | | 3 | | 9 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 4 | | 0 | | 4 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 3 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 1 | | | |
| (g) Rectal misoprostol | 0 | | 0 | | 1 | | | |
| (h) Other (Specify):____ _____ _____ | | | | | 1: achete par la patiente | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 4 | | 0 | | 3 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 3 | | 0 | | 1 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 4 | | 0 | | 1 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 4 | | 0 | | 1 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 4 | | 0 | | 3 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 4 | | 0 | | 3 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 4 | | 0 | | 3 | | | |
| d. Immediate clamping of cord? | 4 | | 0 | | 3 | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 4 | | 0 | | 3 | | | |
| (b) Injectable ergometrine | 3 | | 0 | | 1 | | | |
| (c) Injectable combined oxytocin/ergometrine | 1 | | 0 | | 3 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 1 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 1 | | | |
| (g) Rectal misoprostol | 2 | | 0 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|---|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [] Yes *no national level baseline data received [] No | | | | [] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 5 | 3 | 7 | 15 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 4 | 0 | 8 | 12 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 4 | 0 | 7 | 11 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 6 | 2 | 2 | 10 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 8 | 3 | 13 | 24 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁶ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (16) The number of facilities where [c] in item 5 is greater than 50% (17) The total number of facilities in this district involved in maternal deliveries (18) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (19) The number of targeted districts (20) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁶ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Ghana

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 56 | | 3 | | | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 56 | | 3 | | | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 55 | | 3 | | | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 1 | | 0 | | | | | |
| (b) Available less than 3 months | 2 | | 0 | | | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | 0 | | | | | |
| (d) Available more than 6 months and less than 9 months | 1 | | 0 | | | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | 0 | | | | | |
| (f) Continuously available | 51 | | 3 | | | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 57 | | 3 | | | | | |
| (b) Injectable ergometrine | 50 | | 2 | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 13 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | | | | |
| (e) Oral ergometrine | 0 | | 0 | | | | | |
| (f) Oral misoprostol | 0 | | 0 | | | | | |
| (g) Rectal misoprostol | 1 | | 0 | | | | | |
| (h) Other (specify):__ _____ | | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 56 | | 3 | | | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 55 | | 3 | | | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 55 | | 3 | | | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 56 | | 3 | | | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 51 | | 3 | | | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 54 | | 2 | | | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 1 | | 0 | | | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 7 | | 0 | | | | | |
| (b) No payment by patient for uterotonic drugs | 4 | | 0 | | | | | |
| (c) Not included in clinical protocols or guidelines | 2 | | 0 | | | | | |
| (d) Lack of training in active management of the third stage of labor | 5 | | 0 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|---|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 7 | | 0 | | | | | |
| (f) No supervisory support | 4 | | 0 | | | | | |
| (g) Other (specify):____ ____ | 1: some patients do not take injections | | | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 57 | | 3 | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 57 | | 3 | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 57 | | 3 | | | | | |
| d. Immediate clamping of cord? | 53 | | 3 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 57 | | 3 | | | | | |
| (b) Injectable ergometrine | 32 | | 0 | | | | | |
| (c) Injectable combined Oxytocin/ergometrine | 10 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | | | | |
| (e) Oral ergometrine | 7 | | 0 | | | | | |
| (f) Oral misoprostol | 0 | | 0 | | | | | |
| (g) Rectal misoprostol | 0 | | 0 | | | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 53 | | 1 | | | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 45 | | 1 | | | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 45 | | 1 | | | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 45 | | 1 | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 51 | | 1 | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 52 | | 1 | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 52 | | 1 | | | | | |
| d. Immediate clamping of cord? | 49 | | 1 | | | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 52 | | 1 | | | | | |
| (b) Injectable ergometrine | 33 | | 1 | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 16 | | 0 | | | | | |
| (d) Oral/buccal oxytocin | 1 | | 0 | | | | | |
| (e) Oral ergometrine | 8 | | 0 | | | | | |
| (f) Oral misoprostol | 3 | | 1 | | | | | |
| (g) Rectal misoprostol | 3 | | 1 | | | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|---|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [] Yes *no national baseline data received yet [] No | | | | [] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 55 | | 3 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 56 | | 3 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 55 | | 3 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 54 | | 2 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | | | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁷ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (21) The number of facilities where [c] in item 5 is greater than 50% (22) The total number of facilities in this district involved in maternal deliveries (23) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (24) The number of targeted districts (25) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁷ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Malawi

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 35 | | 3 | | 2 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 35 | | 3 | | 2 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 32 | | 3 | | 2 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 1 | | 0 | | 0 | | | |
| (b) Available less than 3 months | | | | | | | | |
| (c) Available more than 3 months and less than 6 months | 1 | | 0 | | 1 | | | |
| (d) Available more than 6 months and less than 9 months | 6 | | 0 | | 0 | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | 1 | | 0 | | | |
| (f) Continuously available | 21 | | 2 | | 1 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 30 | | 3 | | 2 | | | |
| (b) Injectable ergometrine | 10 | | 1 | | 1 | | | |
| (c) Injectable combined oxytocin/ergometrine | 25 | | 3 | | 1 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 1 | | 0 | | 0 | | | |
| (f) Oral misoprostol | 0 | | 3 | | 0 | | | |
| (g) Rectal misoprostol | 0 | | 2 | | 0 | | | |
| (h) Other (specify):__ _____ | | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 34 | | 3 | | 2 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 33 | | 3 | | 2 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 33 | | 3 | | 2 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 31 | | 2 | | 2 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 31 | | 2 | | 2 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 30 | | 3 | | 2 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 2 | | 0 | | 0 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 9 | | 1 | | 0 | | | |
| (b) No payment by patient for uterotonic drugs | 1 | | 0 | | 0 | | | |
| (c) Not included in clinical protocols or guidelines | 3 | | 0 | | 0 | | | |
| (d) Lack of training in active management of the third stage of labor | 4 | | 0 | | 0 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---|-------------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 3 | | 1 | | 0 | | | |
| (f) No supervisory support | 8 | | 0 | | 1 | | | |
| (g) Other (specify):____ ____ | | | | | | | | |
| | | | 1: don't for c/s and patients delivered MSB | 1: syringes at times | | | | |
| | | | 1: erratic supply of uterotonic drugs | | | | | |
| | | | 1: shortage of staff and drugs | | | | | |
| | | | 2: home deliveries | | | | | |
| | | | 2: shortage of drugs | | | | | |
| | | | 1: no refresher courses | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 33 | | 3 | | 2 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 34 | | 3 | | 2 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 31 | | 2 | | 2 | | | |
| d. Immediate clamping of cord? | 34 | | 2 | | 2 | | | |
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 26 | | 3 | | 1 | | | |
| (b) Injectable ergometrine | 10 | | 1 | | 1 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 26 | | 2 | | 1 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 0 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 0 | | | |
| (g) Rectal misoprostol | 0 | | 1 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 29 | | 3 | | 2 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 7 | | 2 | | 1 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 23 | | 3 | | 2 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 4 | | 1 | | 0 | | | |
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 28 | | 3 | | 2 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 28 | | 3 | | 2 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 25 | | 3 | | 2 | | | |
| d. Immediate clamping of cord? | 24 | | 3 | | 1 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|-----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 26 | | 3 | | 1 | | | |
| (b) Injectable ergometrine | 18 | | 3 | | 1 | | | |
| (c) Injectable combined oxytocin/ergometrine | 24 | | 2 | | 2 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 1 | | 0 | | 1 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 1 | | | |
| (g) Rectal misoprostol | 0 | | 0 | | 1 | | | |
| (h) Other (Specify): _____ _____ | 1: if PPH we give (9) | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 35 | 3 | 2 | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 34 | 3 | 2 | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 30 | 2 | 2 | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 30 | 3 | 2 | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 30 | 2 | 2 | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁸ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (26) The number of facilities where [c] in item 5 is greater than 50% (27) The total number of facilities in this district involved in maternal deliveries (28) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (29) The number of targeted districts (30) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁸ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Nepal

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|----------------------------|---------------------|--------------------|-------------------|----------------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 62 | 48 | 3 | 1 | 12 | 2 | 77 | 51 |
| 2. Enter the number of respondents who have uterotonic drugs available: | 56 | 46 | 3 | 1 | 11 | 2 | 70 | 49 |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 51 | 44 | 2 | 1 | 11 | 2 | 64 | 47 |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | 6 | 3 | 0 | 0 | 1 | 0 | 7 | 3 |
| (a) Not available | 2 | 1 | 0 | 0 | 1 | 0 | 3 | 1 |
| (b) Available less than 3 months | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| (c) Available more than 3 months and less than 6 months | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| (d) Available more than 6 months and less than 9 months | 2 | 1 | 0 | 0 | 0 | 0 | 2 | 1 |
| (e) Available more than 9 months and less than 12 months | 47 | 40 | 3 | 1 | 9 | 2 | 59 | 43 |
| (f) Continuously available | | | | | | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 56 | 46 | 3 | 1 | 11 | 2 | 70 | 49 |
| (b) Injectable ergometrine | 39 | 27 | 3 | 0 | 6 | 1 | 47 | 28 |
| (c) Injectable combined oxytocin/ergometrine | 1 | 3 | 0 | 0 | 0 | 0 | 1 | 3 |
| (d) Oral/buccal oxytocin | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 2 |
| (e) Oral ergometrine | 10 | 12 | 1 | 0 | 2 | 2 | 13 | 14 |
| (f) Oral misoprostol | 6 | 2 | 1 | 0 | 1 | 0 | 8 | 2 |
| (g) Rectal misoprostol | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (h) Other (specify):__ _____ | 1: injectable | 1: injectable prostadin | 0 | 0 | 0 | 1: injectable prostadin | 1 | 2 |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| | prostadin | | | | | | | |
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 32 | 46 | 2 | 1 | 4 | 2 | 38 | 49 |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 27 | 46 | 2 | 1 | 4 | 2 | 33 | 49 |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 28 | 46 | 2 | 1 | 4 | 2 | 34 | 49 |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 30 | 45 | 2 | 1 | 4 | 2 | 36 | 49 |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 26 | 44 | 1 | 1 | 3 | 2 | 30 | 47 |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 55 | 44 | 2 | 1 | 8 | 2 | 65 | 47 |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 2 | 2 | 1 | 0 | 1 | 0 | 4 | 2 |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 25 | 7 | 0 | 0 | 3 | 0 | 28 | 7 |
| (b) No payment by patient for uterotonic drugs | 6 | 7 | 1 | 0 | 2 | 1 | 9 | 8 |
| (c) Not included in clinical protocols or guidelines | 7 | 2 | 0 | 0 | 2 | 0 | 9 | 2 |
| (d) Lack of training in active management of the third | 14 | 7 | 0 | 0 | 7 | 0 | 21 | 7 |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|--|---------------------|--------------------|--|------------------|-------------------|------------------|
| stage of labor | | | | | | | | |
| (e) Inadequate training in active management of the third stage of labor | 11 | 3 | 0 | 0 | 4 | 0 | 14 | 3 |
| (f) No supervisory support | 4 | 11 | 1 | 0 | 1 | 1 | 6 | 12 |
| (g) Other (specify):____ _____ _____ | 0 | 1: inavailability of labour service 2: lack of training to all staff -may need all midwives 2: new staff -no birthing center -no compt | 0 | 0 | 1: sometime lack of man... 1: continuity able | 0 | 2 | 5 |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 58 | 44 | 3 | 1 | 11 | 2 | 72 | 47 |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 57 | 45 | 3 | 1 | 10 | 2 | 70 | 48 |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 56 | 45 | 3 | 1 | 10 | 2 | 69 | 48 |
| d. Immediate clamping of cord? | 58 | 45 | 2 | 1 | 9 | 2 | 69 | 48 |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 59 | 48 | 3 | 1 | 10 | 2 | 72 | 51 |
| (b) Injectable ergometrine | 17 | 8 | 2 | 0 | 1 | 1 | 20 | 9 |
| (c) Injectable combined Oxytocin/ergometrine | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| (d) Oral/buccal oxytocin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (e) Oral ergometrine | 6 | 0 | 0 | 0 | 1 | 1 | 7 | 1 |
| (f) Oral misoprostol | 4 | 0 | 0 | 0 | 1 | 0 | 5 | 0 |
| (g) Rectal misoprostol | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (h) Other (Specify): _____ _____ _____ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 42 | 36 | 3 | 1 | 6 | 2 | 51 | 39 |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 28 | 24 | 1 | 0 | 6 | 1 | 35 | 25 |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 32 | 34 | 2 | 1 | 5 | 2 | 39 | 37 |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 28 | 24 | 3 | 0 | 1 | 1 | 32 | 25 |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|------------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 40 | 33 | 3 | 1 | 6 | 2 | 49 | 36 |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 38 | 32 | 3 | 1 | 6 | 1 | 47 | 34 |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 38 | 33 | 3 | 1 | 6 | 1 | 47 | 35 |
| d. Immediate clamping of cord? | 40 | 33 | 2 | 0 | 6 | 1 | 48 | 34 |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 40 | 34 | 3 | 1 | 6 | 2 | 49 | 37 |
| (b) Injectable ergometrine | 13 | 6 | 2 | 0 | 1 | 1 | 16 | 7 |
| (c) Injectable combined oxytocin/ergometrine | 5 | 3 | 1 | 0 | 0 | 0 | 6 | 3 |
| (d) Oral/buccal oxytocin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (e) Oral ergometrine | 5 | 3 | 1 | 0 | 0 | 1 | 6 | 4 |
| (f) Oral misoprostol | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| (g) Rectal misoprostol | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (h) Other (Specify): _____ _____ | 0 | 1: vaginal misoprostal | 0 | 0 | 0 | 0 | 0 | 1 |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|----------------------|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [X] Yes [] No | | | | [X] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 56 | 3 | 11 | 70 | 46 | 1 | 2 | 49 |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 32 | 2 | 4 | 38 | 46 | 1 | 2 | 49 |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 24 | 2 | 4 | 30 | 45 | 1 | 2 | 48 |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 55 | 2 | 8 | 65 | 44 | 1 | 2 | 47 |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 54 | 3 | 9 | 66 | 44 | 1 | 2 | 47 |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ¹⁹ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (31) The number of facilities where [c] in item 5 is greater than 50% (32) The total number of facilities in this district involved in maternal deliveries (33) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (34) The number of targeted districts (35) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

¹⁹ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Pakistan

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 61 | | 56 | | 22 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 61 | | 55 | | 19 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 48 | | 52 | | 18 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 4 | | 1 | | 3 | | | |
| (b) Available less than 3 months | 0 | | 0 | | 0 | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | 0 | | 0 | | | |
| (d) Available more than 6 months and less than 9 months | 3 | | 0 | | 7 | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | 0 | | 0 | | | |
| (f) Continuously available | 51 | | 55 | | 10 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 60 | | 56 | | 21 | | | |
| (b) Injectable ergometrine | 54 | | 52 | | 12 | | | |
| (c) Injectable combined oxytocin/ergometrine | 20 | | 20 | | 11 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 11 | | 12 | | 0 | | | |
| (f) Oral misoprostol | 26 | | 37 | | 0 | | | |
| (g) Rectal misoprostol | 42 | | 53 | | 0 | | | |
| (h) Other (specify):__ _____ | 6: PGF2alph | | 11: PGF2alpha | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|-----------------------|--------------------|-------------------|------------------|-------------------|------------------|
| | a | | 2:Prostein E2alpha | | | | | |
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 43 | | 41 | | 17 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 36 | | 31 | | 17 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 39 | | 39 | | 16 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 41 | | 39 | | 16 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 40 | | 40 | | 16 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 38 | | 33 | | 15 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 2 | | 15 | | 0 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 11 | | 2 | | 19 | | | |
| (b) No payment by patient for uterotonic drugs | 7 | | 0 | | 3 | | | |
| (c) Not included in clinical protocols or guidelines | 12 | | 18 | | 0 | | | |
| (d) Lack of training in active | 24 | | 11 | | 2 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---|--------------------|-------------------|------------------|-------------------|------------------|
| management of the third stage of labor | | | | | | | | |
| (e) Inadequate training in active management of the third stage of labor | 8 | | 16 | | 3 | | | |
| (f) No supervisory support | 5 | | 0 | | 0 | | | |
| (g) Other (specify): _____ _____ | | | 1: personnel manual restraints, risk of retained placenta | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 44 | | 38 | | 21 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 54 | | 52 | | 16 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 50 | | 50 | | 21 | | | |
| d. Immediate clamping of cord? | 54 | | 54 | | 21 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 61 | | 56 | | 22 | | | |
| (b) Injectable ergometrine | 40 | | 45 | | 16 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 14 | | 30 | | 15 | | | |
| (d) Oral/buccal oxytocin | 5 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 6 | | 0 | | | |
| (f) Oral misoprostol | 11 | | 18 | | 0 | | | |
| (g) Rectal misoprostol | 36 | | 50 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | 5: PGF2alpha | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 33 | | 29 | | 22 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 26 | | 12 | | 18 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 23 | | 13 | | 12 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 23 | | 24 | | 13 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 32 | | 16 | | 21 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 26 | | 26 | | 17 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 26 | | 28 | | 22 | | | |
| d. Immediate clamping of cord? | 25 | | 28 | | 22 | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 32 | | 29 | | 18 | | | |
| (b) Injectable ergometrine | 20 | | 23 | | 10 | | | |
| (c) Injectable combined oxytocin/ergometrine | 5 | | 18 | | 17 | | | |
| (d) Oral/buccal oxytocin | 1 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 1 | | 0 | | | |
| (f) Oral misoprostol | 1 | | 5 | | 0 | | | |
| (g) Rectal misoprostol | 17 | | 26 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | 1: F2 alpha prostaglandin | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|--|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 61 | 55 | 19 | 135 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 43 | 41 | 17 | 101 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 34 | 29 | 16 | 79 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 38 | 33 | 15 | 86 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 30 | 31 | 16 | 77 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ²⁰ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (36) The number of facilities where [c] in item 5 is greater than 50% (37) The total number of facilities in this district involved in maternal deliveries (38) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (39) The number of targeted districts (40) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

²⁰ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Tanzania

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 33 | | 4 | | 1 | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 33 | | 4 | | 1 | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 26 | | 4 | | 1 | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 0 | | 0 | | 0 | | | |
| (b) Available less than 3 months | 0 | | 0 | | 0 | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | 0 | | 0 | | | |
| (d) Available more than 6 months and less than 9 months | 0 | | 0 | | 0 | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | 0 | | 0 | | | |
| (f) Continuously available | 32 | | 3 | | 1 | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 25 | | 4 | | 1 | | | |
| (b) Injectable ergometrine | 28 | | 3 | | 1 | | | |
| (c) Injectable combined oxytocin/ergometrine | 6 | | 0 | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 0 | | | |
| (f) Oral misoprostol | 1 | | 0 | | 0 | | | |
| (g) Rectal misoprostol | 4 | | 1 | | 0 | | | |
| (h) Other (specify):__ _____ | 1: vaginal misoprost | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 24 | | 2 | | 1 | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 23 | | 2 | | 1 | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 21 | | 2 | | 1 | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 20 | | 2 | | 1 | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 20 | | 2 | | 1 | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 30 | | 3 | | 0 | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 3 | | 1 | | 0 | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 15 | | 1 | | 0 | | | |
| (b) No payment by patient for uterotonic drugs | 7 | | 1 | | 0 | | | |
| (c) Not included in clinical protocols or guidelines | 1 | | 0 | | 0 | | | |
| (d) Lack of training in active management of the third | 9 | | 2 | | 1 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| stage of labor | | | | | | | | |
| (e) Inadequate training in active management of the third stage of labor | 14 | | 2 | | 1 | | | |
| (f) No supervisory support | 3 | | 2 | | 1 | | | |
| (g) Other (specify): _____ _____ | | | | | 1: few facilities | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 28 | | 3 | | 1 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 31 | | 4 | | 1 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 24 | | 3 | | 1 | | | |
| d. Immediate clamping of cord? | 24 | | 2 | | 1 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|------------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 23 | | 4 | | 1 | | | |
| (b) Injectable ergometrine | 24 | | 4 | | 1 | | | |
| (c) Injectable combined Oxytocin/ergometrine | 4 | | 0 | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 0 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 0 | | | |
| (g) Rectal misoprostol | 2 | | 1 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | 1: vaginal misoprostal | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 18 | | 2 | | 1 | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 13 | | 1 | | 0 | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 14 | | 1 | | 0 | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 14 | | 0 | | 0 | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|------------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 16 | | 2 | | 1 | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 17 | | 2 | | 1 | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 17 | | 2 | | 1 | | | |
| d. Immediate clamping of cord? | 14 | | 2 | | 1 | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 12 | | 2 | | 0 | | | |
| (b) Injectable ergometrine | 14 | | 2 | | 0 | | | |
| (c) Injectable combined oxytocin/ergometrine | 5 | | 0 | | 0 | | | |
| (d) Oral/buccal oxytocin | 0 | | 0 | | 0 | | | |
| (e) Oral ergometrine | 0 | | 0 | | 0 | | | |
| (f) Oral misoprostol | 0 | | 0 | | 0 | | | |
| (g) Rectal misoprostol | 1 | | 0 | | 0 | | | |
| (h) Other (Specify): _____ _____ | | | | | 1: vaginal misoprostal | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|---|---------------------|-------------------|-------------------|---------------------|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [] Yes *no national level baseline data received [] No | | | | [] Yes [] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 34 | 4 | 1 | 39 | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 24 | 2 | 1 | 27 | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 18 | 2 | 1 | 21 | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 30 | 3 | 0 | 33 | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 20 | 2 | 1 | 23 | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ²¹ within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (41) The number of facilities where [c] in item 5 is greater than 50% (42) The total number of facilities in this district involved in maternal deliveries (43) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (44) The number of targeted districts (45) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

²¹ <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Uganda

Section III – Member Survey Summary Data Form. This section is an aggregation (summary form) using the information collected from the member survey tool (Part II) completed by midwife and OB/GYN members of your associations who will participate or have participated in the small grant activities. The item numbers on the Member Survey and this Summary Data section are matched. In each entry field, the aggregated data compiled from the same item number of the Member Survey. For each item, entries should be made for each of the three columns (Midwives, OB/GYNs, Other and Total).

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 1. Enter the total number of respondents who completed the member survey: | 8 | | | | | | | |
| 2. Enter the number of respondents who have uterotonic drugs available: | 7 | | | | | | | |
| 2a. Enter the number of respondents who had uterotonic drugs available at the time the survey was completed: | 5 | | | | | | | |
| 2b. Enter the number of respondents who had a supply of uterotonic drugs: | | | | | | | | |
| (a) Not available | 1 | | | | | | | |
| (b) Available less than 3 months | 1 | | | | | | | |
| (c) Available more than 3 months and less than 6 months | 0 | | | | | | | |
| (d) Available more than 6 months and less than 9 months | 0 | | | | | | | |
| (e) Available more than 9 months and less than 12 months | 0 | | | | | | | |
| (f) Continuously available | 6 | | | | | | | |
| 3. Enter the number of respondents who have the following uterotonic drugs available: | | | | | | | | |
| (a) Injectable oxytocin | 3 | | | | | | | |
| (b) Injectable ergometrine | 8 | | | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 0 | | | | | | | |
| (d) Oral/buccal oxytocin | 0 | | | | | | | |
| (e) Oral ergometrine | 1 | | | | | | | |
| (f) Oral misoprostol | 0 | | | | | | | |
| (g) Rectal misoprostol | 0 | | | | | | | |
| (h) Other (specify):__ _____ | | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 4. Enter the number of respondents trained in active management of the third stage of labor: | 3 | | | | | | | |
| 4a. Enter the number of respondents with training that included administration of an uterotonic drug (such as oxytocin, ergometrine, etc) within one minute of birth? | 2 | | | | | | | |
| 4b. Enter the number of respondents with training that included applying controlled cord traction and counter traction to the uterus to deliver the placenta? | 2 | | | | | | | |
| 4c. Enter the number of respondents with training that included massaging the fundus of the uterus through the abdomen after delivery of the placenta? | 3 | | | | | | | |
| 4d. Enter the number of respondents with training that also included immediate clamping of cord? | 3 | | | | | | | |
| 5. Enter the number of respondents who use active management of the third stage of labor in routine care for every birth: | 2 | | | | | | | |
| 6. Enter the number of respondents who use active management of the third stage of labor selectively for patients they think are at risk for postpartum hemorrhage (PPH): | 3 | | | | | | | |
| 7. Enter the number of respondents who report these barriers to their use of active management of the third stage of labor: | | | | | | | | |
| (a) Availability of uterotonic drugs | 2 | | | | | | | |
| (b) No payment by patient for uterotonic drugs | 0 | | | | | | | |
| (c) Not included in clinical protocols or guidelines | 1 | | | | | | | |
| (d) Lack of training in active management of the third stage of labor | 6 | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| (e) Inadequate training in active management of the third stage of labor | 5 | | | | | | | |
| (f) No supervisory support | 1 | | | | | | | |
| (g) Other (specify): _____ _____ | | | | | | | | |
| 8. Enter the number of respondents who currently provide these practices for every birth during the third stage of labor: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 5 | | | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 4 | | | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 6 | | | | | | | |
| d. Immediate clamping of cord? | 8 | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|---|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 9. Enter the number of respondents currently using the following uterotonic drugs for active management during the third stage of labor? (<i>circle all that apply</i>) | | | | | | | | |
| (a) Injectable oxytocin | 1 | | | | | | | |
| (b) Injectable ergometrine | 8 | | | | | | | |
| (c) Injectable combined Oxytocin/ergometrine | 0 | | | | | | | |
| (d) Oral/buccal oxytocin | 0 | | | | | | | |
| (e) Oral ergometrine | 1 | | | | | | | |
| (f) Oral misoprostol | 0 | | | | | | | |
| (g) Rectal misoprostol | 0 | | | | | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |
| 10. Enter the number of respondents who are using clinical protocols or guideline for maternal care in their clinic, hospital or workplace: | 4 | | | | | | | |
| 10b. Enter the number of respondents with the most current copy of the clinical protocols or guidelines available at their clinic, hospital or workplace? | 2 | | | | | | | |
| 10c. Enter the number of respondents who are using World Health Organization (WHO) or national clinical protocols or guidelines at their clinic, hospital or workplace: | 1 | | | | | | | |
| 10d. Enter the number of respondents who are using institutional clinical protocols or guidelines at their clinic, hospital or workplace: | 1 | | | | | | | |

| | Midwives Baseline | Midwives Endline | OB/GYNs Baseline | OB/GYNs Endline | Other Baseline | Other Endline | TOTAL Baseline | TOTAL Endline |
|--|----------------------|---------------------|---------------------|--------------------|-------------------|------------------|-------------------|------------------|
| 11. Enter the number of respondents using clinical protocols or guidelines that recommend: | | | | | | | | |
| a. Administration of an uterotonic drug within one minute of birth? | 4 | | | | | | | |
| b. Apply controlled cord traction and counter traction to the uterus to deliver the placenta? | 3 | | | | | | | |
| c. Massage the fundus of the uterus through the abdomen after delivery of the placenta? | 2 | | | | | | | |
| d. Immediate clamping of cord? | 3 | | | | | | | |
| 12. Enter the number of respondents using clinical protocols or guidelines that recommend use of: | | | | | | | | |
| (a) Injectable oxytocin | 3 | | | | | | | |
| (b) Injectable ergometrine | 4 | | | | | | | |
| (c) Injectable combined oxytocin/ergometrine | 2 | | | | | | | |
| (d) Oral/buccal oxytocin | 0 | | | | | | | |
| (e) Oral ergometrine | 1 | | | | | | | |
| (f) Oral misoprostol | 0 | | | | | | | |
| (g) Rectal misoprostol | 0 | | | | | | | |
| (h) Other (Specify): _____ _____ | | | | | | | | |

Section IV: POPPHI Outcome Indicators:

| | Midwives Baseline | OB/GYNs Baseline | Other Baseline | TOTAL Baseline | Midwives Endline | OB/GYNs Endline | Other Endline | TOTAL Endline |
|---|---|---------------------|-------------------|-------------------|---|--------------------|------------------|------------------|
| 1. Active management of the third stage of labor is included in country Safe Motherhood protocols. | [<input type="checkbox"/>] Yes *no national level baseline data received [<input type="checkbox"/>] No | | | | [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | | |
| 2. Enter the number of member midwives (MW) or obstetricians/gynecologists (OB/GYNs) that have uterotonics available in their clinic or workplace: | 7 | | | | | | | |
| 3a. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor : | 3 | | | | | | | |
| 3b. Enter the number of MWs or OB/GYNs trained in active management of the third stage of labor including all 3 FIGO/ICM components: | 2 | | | | | | | |
| 4a. Enter the number of MWs or OB/GYNs using active management of the third stage of labor in routine care or as part of their protocol: | 2 | | | | | | | |
| 4b. Enter the number of MWs or OB/GYNs using active management of the third stage of labor including all 3 FIGO/ICM components in routine care or as part of their protocol: | 2 | | | | | | | |
| 5. Number and Percentage of births in facilities where the woman received active management of the third stage of labor (AMTSL) by skilled birth attendants (SBAs) ²² within a specified time period: For each district, list by facility (a) Number of births in the previous 3 months at the facility (b) Number of births where the woman received AMTSL by SBA within the previous 3 months [c] Calculate the percentage from (a) and (b) per facility | | | | | | | | |
| 6. Number and percentage of targeted districts providing active management of the third stage of labor (AMTSL). For each targeted district, list by facility (46) The number of facilities where [c] in item 5 is greater than 50% (47) The total number of facilities in this district involved in maternal deliveries (48) The percentage of facilities in this district that provide AMTSL (divide (1) by (2)) For the small grant, list (49) The number of targeted districts (50) The percentage of targeted districts providing AMTSL (this is (3) divided by (4)) | | | | | | | | |

²² <http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/> - refer to WHO definition of SBA

Appendix K: Trip Report

Gloria Metcalfe, MNH –LAC/C Consultant

Nov 6- 18, 2006

Standardization of AMTSL BOLIVIA

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ABBREVIATIONS

| | |
|--------|---|
| POPPHI | Prevention of Postpartum Hemorrhage Initiative |
| AMTSL | Active Management of third stage of labor (MATEP in Spanish) |
| IU | International Units |
| LAC/C | Latin America and the Caribbean |
| OB/Gyn | Obstetrician and gynaecologist |
| CCT | Controlled Cord Traction |
| PPH | Postpartum Hemorrhage |
| SSS | Social Security System (Caja de Seguro Social in Spanish) |
| SUMI | Maternal and Child Universal Insurance (Seguro Universal Materno Infantil in Spanish) |
| MCH | Maternal, Child Health |
| MM | Maternal Mortality |
| NM | Neonatal Mortality |
| MOH | Ministry of Health |
| TA | Technical assistance |

EXECUTIVE SUMMARY

The POPPHI small grant in Bolivia supports the OB/Gyn and Nursing Associations to improve the use of AMTSL among their members throughout the country. A total of three, two-day workshops were planned to train 33% of the professional members (50 nurses and 50 doctors). Two nurses (one nurse midwife) and two OB/Gyns, who participated in the Lima workshop, facilitated the workshops. The first workshop was conducted in April 2006, in Sucre for 30 participants from Sucre and Potosi (Tarija

participants were unable to participate). In July 2006, G. Metcalfe, POPPHI consultant, travelled to Bolivia to conduct an assessment of the action plans developed by the Bolivian participants of the International Confederation of Midwives Trinidad Conference. Based on the findings of the assessment, POPPHI decided to combine both the small grant and Trinidad-follow-up activities. As a result, Ms. Metcalfe travelled to Bolivia in November 2006, to provide technical assistance to facilitate the two remaining AMTSL workshops (under the small grant activity), and to identify clinical sites for AMTSL practice with real clients during for subsequent trainings planned. The second workshop was in Cochabamba (Nov. 7-8) for 19 participants from Beni, Cochabamba, and Santa Cruz. The third workshop was in La Paz (Nov. 9-10) for 26 participants from Oruro, La Paz, and Pando.

Though most of the participants reported that they routinely use AMTSL during the practice with the anatomical models, it was evident that they did not have a standardized procedure. Most of participants identified the use of AMTSL with the routine use of oxytocin, but without CCT and counter-pressure to the uterus. Few of them knew about the three steps involved in the procedure. Some of the participants associated AMTSL with a procedure to manage PPH. Although the national protocols and norms promote the use of AMTSL, the description of the procedure is somewhat confusing. Practicing with anatomical models was very useful for participants to understand the need to standardize the procedure, and also to understand the reason for each step. POPPHI learning materials and job aids on AMTSL, such as the poster, checklists, fact sheet and the toolkit for providers, including the CD-ROM, were well accepted and highly demanded by participants, facilitators, and health authorities.

Three maternity hospitals were identified in Sucre as potential clinical sites to conduct follow-up training workshops. These workshops will include practice with real clients after completing competency training with anatomical models.

USAID Bolivia is interested in coordinating MCH projects in Bolivia to share technical materials and experiences. EngenderHealth is starting MCH activities, and is interested in using the POPPHI materials. Also, UNICEF is in discussions with the MOH about how to expand AMTSL in the country. UNICEF is interested in a possible collaboration with POPPHI, given that POPPHI has developed the necessary materials.

PURPOSE

1. To provide TA and support Bolivian facilitators – (2 nurses and 2 OB/Gyns) during two AMTSL trainings in La Paz and Cochabamba.
2. To review and improve learning materials for the training if needed.
3. To identify potential clinical sites to standardize AMSTL.
4. To finalize a proposal to support Bolivia's Trinidad conference action plan.

BACKGROUND

After the conference in Trinidad Tobago in 2002 conducted by ICM and JHPIEGO Baltimore, POPPHI carried out a workshop conducted in Lima/Peru in 2004, to promote the use of AMTSL. Participants included OB/Gyns and nurses of Latin-American countries who belong to their country's professional associations. Based on WHO international recommendations to decrease maternal and neonatal mortality, the POPPHI workshop provided information to support the use of AMTSL, included practice demonstrations, and consisted of discussions on how to support the implementation of the procedure in countries. The representatives of each association were invited to apply for a small grant to support an activity to expand AMTSL in their respective country. The Ob/Gyn association and the nursing association of Bolivia received a small grant to accomplish the following activities: 1. Development of a training module for AMTSL; 2. Dissemination of learning materials and models; 3. Three AMTSL workshops in La Paz, Sucre and Cochabamba; 4. Selection of three pilot health centers for the implementation of AMTSL; and 5. Development of action plans from participants to replicate training in their areas. POPPHI will monitor and evaluate the grant through baseline and endline surveys.

FINDINGS

1. The team of facilitators demonstrated a strong sense of responsibility to accomplish the training activities. They were open to receiving suggestions to improve trainings, and worked well as a team.
2. Planning this training through the nursing and OB/Gyn Associations allowed professional members who are working outside the public system, like the Social Security, private health facilities and NGOs, to participate. This was very welcome as participants do not typically have the opportunity to receive this kind of information and to share clinical experiences. Most trainings in Bolivia are for MOH staff.
3. The MOH presented the situation of MM and NM, including the PPH situation in Bolivia. Participants indicated that PPH is not as big a problem in hospitals as it is in rural health facilities and homes, where AMTSL should be implemented (according to their view).
4. The number of participants was around 25% less than expected- particularly from Cochabamba participants. Representatives from Tarija weren't able to attend any of the three traveling workshops (due to transport problems).
5. Though the MOH has included AMTSL in the national norms and protocols since 2001 (SUMI documents), participants from the SSS did not know about AMTSL, and most participants, including the facilitators, were not familiar with the legal framework as it relates to this procedure.
6. Although participants said they routinely use AMTSL, the practice with models revealed that either they did not know the steps or carried them out incorrectly. The general belief about AMTSL was that it only involved oxytocin, without standard doses and administration. Some participants use 5 IU; others use 10 IU; and either IM or IV. After administration of oxytocin they wait for signs of

placental detachment. Very few participants knew about CCT, counter-pressure, and uterine massage as steps in the procedure. And those who practiced CCT and counter pressure did it incorrectly (e.g., Credé instead of counter-pressure of the uterus). It was also necessary to emphasize examination of the placenta for completeness. Furthermore, in the Cochabamba training, it was necessary to clarify that AMTSL is a procedure to prevent, and not to treat PPH. because the reason being is that oxytocin has been used routinely for induction/augmentation of labor and for treatment of PPH.

7. Unfortunately, Health Policy Art. 20 says– “if the staff has not been trained in the AMTSL procedure, use only oxytocin”-.
8. There is no register for the use of AMTSL. The MOH added to the Perinatal form a YES or NO to register the use of oxytocin without specifying when, dose, and route.
9. The facilitator’s presentation of the procedure was confusing because it lacked a clear description of the procedure steps, with no emphasis on the objectives. Additionally, it included unnecessary information about physiology and complications of third stage.
10. Presentation and the learning package on AMTSL for the training was improved with the addition of the evidence-base and POPPHI material, which included the AMTSL CD ROM, a poster with the description of the steps, and the AMTSL fact sheet.
11. Use of anatomical models for both demonstration and practice of AMTSL were key activities for participants to standardize the procedure and for facilitators to make corrections as needed. However, time only allowed for practice, and not participant competency evaluation.
12. The POPPHI survey was filled out by participants as a pre- and post-test training. Facilitators did not understand its objectives; and hence, did not introduce it to participants.
13. Participants’ motivation to implement AMTSL in their facilities at the end of training was high and was reflected in their action plans.
14. SUMI assures the availability of oxytocin necessary to perform AMTSL for every woman during birth and at no charge.
15. Three maternities visited in Sucre (Chuquisaca) are potential clinical sites for further AMTSL trainings. Directors and staff are available for and interested in standardizing the procedure. There is an excellent training center with facilities, including a classroom, projector, computers, flipchart and space to practice with models, in addition to a rate of 10 births in 24 hrs.

CONCLUSIONS

1. The MOH supports the use of AMTSL, and is available to review and correct the national protocol and norms related to the procedure based on the POPPHI learning package.
2. To assure the correct implementation of AMTSL it is necessary to standardize the procedure in the national norms, and disseminate it countrywide. Dissemination of technical information from MOH to health facilities is a significant barrier in Bolivia.

3. Although AMTSL is an uncomplicated procedure, training needs to be carried out with supervised practice on models and on real clients, given that it is a change in the way to assist the third stage.
4. POPPHI Learning Package for AMTSL should include Toolkit for Providers, CD ROM, Poster, and fact sheet as these materials contain the necessary information to support providers to learn and implement AMTSL.
5. Planning trainings by nursing and OB/Gyn associations has the advantage of incorporating members from not only the public health system but also from the private health sector. It also helps to build a team work concept.
6. Registration of AMTSL is not included in the clinical records.
7. Nurses and OB/Gyns acknowledge that during their professional formation, practice is the weakest topic. For nurses this situation is worse. Most of them finish the pre service training without assisting births. Participants were very motivated in having supervised practice on models. Three maternity hospitals' staff is available to standardize the procedure and to become clinical training sites.

RECOMMENDATIONS

1. Organize the POPPHI learning material for AMTSL in Spanish in a standardized package that includes: Toolkit for Providers, AMTSL CD ROM, poster, and fact sheet. This package should also include the MOH documents that support the use of the procedure (norms and protocols); as well as some suggestions for recording the procedure in the clinical records.
2. It is highly recommended to include a list of supplies necessary to prepare a station of AMTSL practice with a model. Anatomical models (childbirth simulators) are key components of this practice also in addition to a cloth placenta model; kit to assist birth (Kochers, scissors and cord clamp), basin, oxytocin vials, disposable syringes, gloves, and three towels. This allows participants to practice in a more realistic scenario and helps them to standardize the procedure.
3. This POPPHI learning package in Spanish should be shared with the MOH, USAID, NGOs working in maternal health. Additionally, each professional trained should share this information with the executives and staff of their facilities. It's necessary to assure availability of this material in Bolivia.
4. Follow-up to the participants' action plan should be conducted within three months after training. Ideally the follow-up should be carried out by the same team of facilitators who conducted the training. During the follow-up facilitators can support and evaluate competency.
5. It is necessary to ensure AMTSL recording in the clinical documents in order to build indicators and measure the impact of the interventions. MOH can be encouraged to change the item in the clinical record from "use of oxytocin in the third stage: oxytocin – others –none" to "use of AMTSL YES - NO".
6. Given that the POPPHI objectives and target population of the small grants program and the Trinidad follow-up activities are the same, it is highly recommended to develop only one plan that ensures training and follow-up for all. (See proposal annex 2 and 3.)

7. Explore potential collaboration (e.g., USAID/Bolivia, MOH, EngenderHealth, UNICEF) and encourage coordination with projects in Bolivia that are carrying out maternal health activities, particularly AMTSL.

Appendix L: Task Force Meeting Notes

Teleconference Meeting Notes POPPHI First Intervention Task Force October 11, 2006

Attendees:

Harshad Sanghvi, Medical Director, Maternal & Neonatal Health JHPIEGO
Dr. Sabaratnam Arulkumaran, FIGO 2003-06, Secretary General
Joseph Ruminjo, Engender Health
Lauren Pessa, Engender Health
Yancy Seamans, Program for Appropriate Technologies in Health, PATH
Suellen Miller, Director, Safe Motherhood Programs, University of California, San Francisco (UCSF)
Liette Perron, Program Manager, International Women's Health Division, SOGC
Dr. André Lalonde, Executive Vice President, SOGC, Chair of POPPHI Task Force

Absent:

Dr. Ralph Hale, Executive Vice-President, the American College of Obstetricians and Gynecologists (ACOG)
Viven Tsu, Program for Appropriate Technologies in Health, PATH

Member Ex-Officio:

Deborah Armbruster, Director, Prevention of Postpartum Hemorrhage Initiative (POPPHI)

Attached:

Agenda
List of interventions by level of care

1. Status of Task Force in the next three years

This was not discussed to great length, and it will be brought back in the next meeting, which is hoped to be a meeting in person in Kuala Lumpur during the FIGO World Conference on Friday, November 10, 2006, during a breakfast session. Further details will be sent.

2. Proposal to POPPHI

2.1 Complete List of Intervention Task Force by Level of Care

This was discussed only very briefly. Suellen Miller was to look at this to clean up this area. Dr. Lalonde will also verify, and a copy will be sent to all of those attending the meeting so this document can be finalized in Kuala Lumpur.

2.2 Tamponade/Shock Garment

The Tamponade discussion was led by Harshad Sanghvi who spoke of the world's experience in this, and the need to have a registry or, as Professor Arulkumaran put it, an audit that would help different hospitals around the world to report on their experience with Tamponade, either using condom or using other urology or non-urology catheters. This will need to be centralized and Dr. Lalonde will ask Deborah Armbruster, the secretariat for this project, if the results can be centralized with POPPI. Dr. Arulkumaran prepared papers for such audits. POPPHI agrees to be the repository of responses.

Dr. Lalonde asked whether people were interested in submitting research projects, but it appears as though the research project would now mostly be a method to register or to keep on record all of the hospitals in the developing world, and developed world, that are using either condom or other instruments for uterine tamponade.

On the question of the Shock Garments, at this time it is not being produced except in the research country hospitals and Suellen Miller reported that they would need further funding to get a larger trial going. She will be speaking separately with Harshad Sanghvi on this issue.

2.3 Measured Blood Loss

The document prepared by Yancy Seamens from PATH was considered and found to be acceptable. The discussion ensured how this could be useful in different settings. A dialogue followed as to why this is being considered in the task force. Dr. Lalonde responded that this was being looked at because of the problems of estimated blood loss. Research conducted by WHO had found that clinical variations on estimated blood loss were close to 50%. Discussion followed and it was mentioned that training to estimate blood loss at the hospital level would be a good initiative that could be taken by POPPHI as part of the active management of the third stage of labor. When people are trained in a given hospital unit they perform much better in estimating blood loss. This led into the discussions of producing this blood measurement resource that would also be tagged behind the 8x11 page on the early signs of PPH. Harshad Sanghvi will send to Dr. Lalonde any information that he may have on this and we will take the information that was sent to us by Arulkumaran as to developing the early clinical signs and again possibly using the rule of 30 and other signs adapted to each level of care. This has been the overriding concern is to adapt tools to the level of care.

Task: Find information for Deborah Armbruster regarding new pads for blood loss measurement.

Four levels of care were identified:

- 1) household and/or community
- 2) local health unit
- 3) local hospital and/or regional or district
- 4) university hospital level

3. New Chair Needed

Dr. Lalonde confirmed that Dr. Arulkumaran will take over and lead the PPH First Intervention Task Force. Dr. Lalonde mentioned that a communication with Kathy Herscherderfer will be made in attempts of obtaining one midwife to embark on this task force. It will be confirmed with Ralph Hale if he wishes to continue and can delegate an alternate person for participation in these meetings. Dr. Lalonde will communicate with Dr. Pius Okong from Uganda to join the committee. There will also be need of a representative from Asia. Dr. Lalonde suggests Sherren Bhutta from Pakistan.

4. Other Topics

None

5. Next Meeting

In discussing the next meeting schedule, a suggestion was made that a meeting occur during the FIGO Kuala Lumpur World Congress. All of those on the committee will be attending. Dr. Lalonde suggested that a breakfast meeting be organized. It will be on Friday morning, 7 to 9am, at a location to be confirmed ASAP.

Respectfully submitted by

André B. Lalonde, MD, FRCSC, FRCOG, FSOGC, FACS, MSc
Executive Vice-President
The Society of Obstetricians and Gynaecologists of Canada (SOGC)
Chair, POPPHI Task Force

c.c.: Deborah Armbruster, Director, Prevention of Postpartum Hemorrhage Initiative (POPPHI)

Community-based Prevention of PPH Task Force
December 11, 2006
Meeting Minutes

Present: Joseph deGraft-Johnson, Mona Moore, Winnie Mbwesa, Deborah Armbruster, Jim Litch, Marcela Tapia, Niamh Darcy, Meghan Greeley

Additional items to add to the agenda:

(1) Feedback on Misoprostol – Friday have UDD TF meeting, India drop looks like 40-45% drop compared to placebo. Melodie Holden from Venture Strategies and Jill Durocher from Gynuity are going to come.

(2) Community PPH indicator for tracking.

Review the meeting minutes from March, 2006:

- How do we define Community: A decision that this is not in facilities, but includes core clinical practices that take place within the household.
- We did not get the confirmation whether they do AMTSL in Yemen for community midwives at home. *Niamh will follow up with Yvonne on this.* (Niamh followed up and found out that community midwives in Yemen do practice AMTSL.)
- Discussion on first meeting, WHO definition of the immediate post partum period. Were waiting to get feedback on this. *Debbie can send a note to Matthews to get this feedback.*
- Also discussions on amount of blood and PPH – Joseph does not remember the details.

Literature Review:

Need to change the 600,000 in the introduction paragraph. *Meghan will change.*

Overview of studies.

1. Community based AMTSL; NSDP Program; Oxytocin and Uniject – Indonesia and Vietnam
2. Breast Feeding and nipple stimulation – Malawi randomized control trial in 1989.
3. Use of misoprostol
4. Blood loss and recognition of PPH. The absorbent pad did not get on here as we are waiting for feedback. *Meghan is following up on this.* We did not have costing information – it is less than the drape, which is 1\$, maybe .3\$ to .4\$. Study in Tanzania using kangas.
5. Community mobilization and involvement – yet to be tested

Community-based AMTSL

- Create a table that has the summary findings in place so it would be easier to digest and compare, by intervention. Intervention – use category (devices,

medications), Recipient, Location of intervention, provider, level of evidence (literature review) and efficacy/result, issues (e.g. drug registration, supply, storage, lack of a referral centre etc), challenges in practice. Do we add in a column on issues of mis-use from the studies that are already documented?

- Debbie putting an article together on Community AMTSL for MotherNewbornNet, some of this information will feed over. Hunting for developing country examples. Discussions on whether just uterine massage and uterotonic is enough? *Debbie can share this information with CBTF to go into this table for AMTSL.*
- Replace ergometrine with misoprostol? Getting oral ergometrine or injectables will be much quicker in some countries than getting misoprostol.
- Can lower level cadres actually perform AMTSL or community PPH e.g. matrones in Mali, working in facilities with mid-wives as backup, and then see when they can work on their own.
- Could add a column on women's perspectives – what the beneficiaries think of these interventions. Also need community/family perspectives. Maybe combine into one column?
- We think some of the information is out there on the cadre of workers who implement AMTSL at the community but this is not published (just from program records). This is available in many developed countries. Should we include this published information from developed countries? Tell people that developed world is still doing this and it is effective. What is the skill level of the workers involved?
- This recent conference, WHO brought out two definitions of skilled, and used the ones they wanted. In their recommendations, they said it was ok to have trained health workers, trained to proficiency in the skill at hand (i.e. semi-skilled trained workers). This is a different direction from where they were before. There will be a long lag time in the field for this to get out.
- Using an uterotonic is effective. Something we do need to discuss in more detail. QAP uses this as a proxy as AMTSL.
- No mention in the literature on the use of misoprostol in AMTSL. Only place where this is covered is the WHO trial. In a hospital it does not make sense as misoprostol is so much more expensive on oxytocin.

Nipple Stimulation and Breast Feeding

- No evidence that these reduce PPH. We should actively communicate this?

Use of Misoprostol

- Where can you re-use (if drugs are un-used). Where are drugs mis-used? Always have to deal with potential abuse. There are operational guidelines are in place –

this does not really lead to full control, once people are aware of how they can use these drugs – e.g. oxytocin used to bring on delivery.

- Not just widely distributed to women – given to a trained community worker. This is an issue that has to come up – what is a country willing to do.
- Important to get some basic data from these 3 countries – how is it being provided. Debbie to contact ASHA? Indonesia, Nepal and Afghanistan. Trained community health workers give it to pregnant women in their 8th month. It is tied to the last ANC visit, pregnant women who comes in the 8th month? Could we give it earlier – do not want it to be with the pregnant woman for too long.
- Evidence is that it works, it does prevent CBPPH, and there are evidence out there in terms of programming.
- Is this the key intervention that we want to push? Do we use our resources to plan this out for one country only?
- WHO recommendation says uterotonic drug for community PPH. You can't just give the drug out, you need to give a package which includes education material as well as giving the drug. You get the community involved, the community leaders, and may have their own way of tracking how it is used in their community.
- For countries that don't have misoprostol, or can't have it, we need to research can oxytocin be used at the community level. Could make this uterotonic instead – as ergometrine can be used.
- Oxytocin promoted at all facilities – we should promote this. Oxytocin is used for inducement. Oxytocin is used by SBA. Joseph doubts that we will be able to promote oxytocin with not so skilled BA. Misoprostol in tablet form. This is some of the discussion on Friday.
- Our work with the small grants – most countries allow the use of oxytocin.
- ATMSL will be held as an example of getting away from a one-sized fits all intervention that can be effective. What we are going to find in time, we will need a drop down menu of interventions, depending on what facility or community, the type of country, etc. We need to get the facts out there about misoprostol. There will never be a single intervention that can be scaled across the world! Idea that just have to wait to find this single effective intervention.
- Maybe at the UDD – a write-up of drop-down menus – here are the various options. These are the advantages of using one intervention over the other.

Measurement of blood loss and PPH Prevention

- Some people see the measurement of blood as an intervention itself. Whether it is the kanga, the pad, or the drape, if the women in the family monitor this, then this is a way to know when to do a referral. The premise is that you will see increased activity.

Recognition and referral of PPH? Stabilization? What do we call this?

- Have a table that details this:
 1. What are the actual things that women use?
 2. How do they recognize PPH?
- Categorize the HBLSS as part of the recognition and referral, and not part of the Community mobilization/involvement. ***Meghan to move this up.***
- Anti-shock, could be moved as a potential also to this area – as it is used for stabilization. This could be used for the travel to the facility. It is a one time purchase (\$150!). No final decision made on whether to move this or not. Do see how this could be used at the community level. More than one hour away from a facility.
- Just before recognition, TBA training. May want to review this, and see if this was the pre-cursor to the Gambia study. ***Have to make this clearer*** – what does position of the placenta mean?
- Could convert this to women, her family members, and non-SBA to recognize PPH.
- Mona recommends removing – we did not get into TBA literature fully. Joseph – need to include it, what has the training done? Mona thinks there is an endless amount of literature on this. This is an intervention that can be effective – PPH recognition and referral is really important. The Gambia (Ghana?) study, found that the TBAs really did not refer, or referred too late. Do not think there are studies that have quality data on pre/post with TBAs and referrals. Do a more detailed lit review to see if we can find some real data on whether this training of TBAs really works, the impact of this training on referrals.
- HBLSS – as long as we are consistent. We do not have the detailed data. Main thing teaching is bi-manual compression in this. It is hard to single out HBLSS as creating results. The evidence in terms of studies are not there, we are not saying it is bad. We could decide interventions without evidence (goes into a table).
- Remove ‘In the project areas, the evaluation showed that 17 of the 20 women who reported this problem collectively implemented 61 of these steps’. As we do not understand what collectively means – and it does not make sense. ***Or rewrite this?***
- Giving fluids was one of the steps. Is this effective in terms of stabilization? Jim says that giving fluids can be a harmful practice for PPH – this is if IV only. For oral-rehydration this is not an issue.

Recommendations for updating Literature Review (including earlier comments also)

- Follow (1) AMTSL with (2) Use of Uterotonics, (3) Basic Routine care (includes recognition, nipple stimulation etc). Cross-cutting issue is the Community Mobilization and individual Education – it should be introduced this way in the Literature Review.

- We should add ‘Sreen Thaddesu’ paper reference – it is about perceptions and community mobilization (includes Indonesia). Community involvement measurement on behavioral change – this has not been done to the best of their knowledge.
- Marcela – put together a few paragraphs on sections on community mobilization
- Volunteer – put together a few paragraphs on the sections for the literature review – looking for volunteers!
- Want everyone to send their issues (from a programmatic perspective, like we saw from NDSP) to Joseph on the literature review content.

Review and Revise the work plan

Meeting to review Dec 11th, 2006 (held today)

(May not have enough facts for a Fact Sheet based on this finalized document)

1. Revise and finalize report on literature review, Jan 31st 2007
2. Two weeks to review this, Feb 15th, 2007
3. Hold discussions on the Fact Sheet/Matrix until after Feb 15th, 2007

Community PPH Indicator

- From the WHO Technical Consultation: "In the absence of AMTSL, a uterotonic drug (oxytocin or misoprostol) should be offered by a health worker trained in its use for prevention of PPH"
- Sustained (intermittent or continuous?) external Uterine Massage (after delivery of the placenta) every 15 minutes for a period of up to 2 hours or until bleeding stops (pads gone through, measurement of blood?) or woman is transferred and received at a health facility.
- Use of uterotonic drug within 1 minute AFTER delivery (should we mention misoprostol here specifically or give a list of drugs?).
- The WHO consultation did agree on non-SBA using uterotonic.
- Timeframe: After the delivery, before the placenta comes out? Want to get it as quickly as possible, but it is still helpful if get it before placenta comes out. There is still data out there that shows that administration of a uterotonic even in 4th stage can be beneficial. Want to give this as soon as possible. They are fine with uterotonic instead of a list of drugs.
- Uterine massage – this is going to be difficult to measure – unless measuring what first aid is given to the woman at home. How do you capture this purpose in the indicator. This is just for prevention – do uterine massage as part of practice. Every 15 minutes check for bleeding, and massage the uterus as they do this check. Do we want to do this just after the delivery of the placenta, for 5 minutes, another one for 30 minutes after?

- Better not to make any recommendations about timing or information on sustained. This is easier for us to measure if we do not measure timing or method of delivery of uterine massage.
- Include availability of uterotonics in the community and measure these. This is really a programmatic issue. Impact of community involvement in the use and supply of drugs.

**UDD Task force
December 15, 2006
Meeting Minutes**

Present: Claudia Morrissey, Jen Leopold, Emmanuel Nfor, Patricia Gomez, Mary Ellen Stanton, Robin Mardeusz, Melodie Holden, Jill Durocher, Deborah Armbruster, Nancy Moss, José Belizan, Martha Carlough, Stacie Geller, Steve Brooke

Present by phone: Metin Gulmezoglu, Diana Beck, Richard Derman

Presentations: (can be found at: <http://www.pphprevention.org/TaskForces.htm>)

Stacie Geller: *Oral misoprostol in preventing postpartum hemorrhage in resource-poor communities: a randomized placebo-controlled trial*

Melodie Holden: *In-country strategies on misoprostol for PPH*

Jill Durocher: *Misoprostol ongoing research—what else do we need to know?*

Steve Brooke: *Oxytocin in Uniject: where are we now and what is next?*

Misoprostol Strategy:

Suggested goal:

- Promote widespread availability of misoprostol for PPH prevention in the absence of a SBA

Discussion:

- What is a SBA? (WHO: Skilled attendant refers exclusively to people with midwifery skills who have been trained to proficiency to manage deliveries and manage complications. Depending on setting, other health care providers (ANMs, community midwives, etc.) may also have acquired appropriate skills, if they have been specially trained)
- Should the goal state “uterotonic” instead of “misoprostol” since both oxytocin (and oxytocin in Uniject) and misoprostol have potential use? (WHO Technical Consultation came to this conclusion)
- Auxiliary nurse-midwives are called “skilled” in Indian guidelines have misoprostol used for prevention, with oxytocin used for treatment.
- Should this be absence of availability of oxytocin, rather than absence of skilled birth attendant?

Suggested Framework for developing a strategy for misoprostol: (agreed that different countries will do this differently)

1. Policy/Advocacy:

- For product availability
 - Develop, revise or agree upon materials or documents that provide guidance to countries

- Encourage and work with WHO to get misoprostol included in the EDL for PPH indications
- Make information available on the registration process
- Country guidelines to include use of misoprostol for PPH: assist countries to get approval
 - Standard Treatment Guidelines, Formulary, MCH program
 - Identify who authorized to use and work to get lower level cadres able to use
- Professional associations: cannot overlook their role and they should be included in the process
- Affordability of the drug → does it matter since it saves a life! It is part of logistics to get the price down as low as possible. Need to convince officials and decision-makers that no matter what it costs, it's worth it. We can afford \$6 per woman over a lifetime
 - prevention doesn't get as much publicity but is incredibly important
- Educate policymakers on miso for prevention of PPH to encourage them to make it availability for PPPH programs, where there is no SBA, not so much whether or not misoprostol should be used (community level, home births, unskilled workers....)
 - this should include countries where it is already registered, because the registration is just the beginning...it's not over with registration
- Assist countries to update their EDL to reflect the PPH indication; (recognize that registration is a process led by manufacturers and distributors and is about supply but is not about the advocacy).
- Important to utilize governments with experience in registration—bring them into process to get assist other countries on how to move forward
 - start off with a global conference to get people knowledgeable about misoprostol
 - help people given their own country situation and identify what works with them
 - how do you help people to do that plan (where do you bring donors in)

2. Practice

- Integrate into existing programs
- Proper use
- Training/pre-service and in-service:
- Supervision
- Options for distribution
 - SAFE study

- Case studies
- alternatives

3. Logistics/Supplies:

- Registration: plan to make it integrated into the existing programs (public or private) registration in a country is not the tangible goal; we're talking about appropriate groups of MOH state that they want to do it and then take action
- Product Availability
- Pooled procurement
- Companies want to make money, get manufacturers connected to distributors, then get pharmacies to buy and have availability, then make connections so that everyone is on board.
 - quality: is there some sort of quality-assurance process?, need to think about this early on; need to make sure that there is a good product being sent out there. GMP approvals given by each country's own process; quite expensive for a company to get—not product specific, shows if your overall manufacturing and quality management processes are to good standards. Would be nice if WHO pre-qualified suppliers. Need to get this on EDL first. If working with manufacturer has US GMP, then it is much easier to get it approved locally.

4. Monitoring and Evaluation:

- Used appropriately
- How many births/what percentage of births
- Need indicators
- Know what happening → does it work?
- Conduct a baseline assessment before you start giving away misoprostol tablets to make sure that they are not being thrown away, that they are being used the correct way
 - Safety issues; monitor adverse effects
 - special concern with miso with shivering, pyrexia, etc. that when it is used women are made comfortable, etc, that this is done with a monitoring and done in a safe way
- Need to monitor awareness (big surveys), availability (stock-outs, etc), and use (have to figure out how to do this well)
 - Reducing PPH should be a victory for the MOH and the RH program—but in order to be able to show success and positive outcomes –there is a strong need for a baseline assessment to be able to say anything about outcomes.

5. Information, education, and communication/Increase demand

- Aware
- Available
- Used
- outcomes

Operationalizing misoprostol use: Question is no longer should we operationalize this, but how we should operationalize—putting it into existing program (MPS programs, training programs, etc)

- This is not a new process since we go through the same process with drugs every time. Keep coming back to meetings with MOH wanting to introduce drug, but operationalizing use is the issue:
 - what models are in place where you have logistics in place
 - what supervision system is in place?
 - how do you get it to the end user?
- India will be training by state, starting hospital level and going out to communities; coordinated by MOH and sent out from there
- In each country, we need to involve the MOH, Ministry of Education (pre-service), Ministry of Finance, drug purchasing (medical stores), local NGOs
- Use some of same successes from promotion of AMTSL: WHO's work, regional meetings, champions, coalitions, etc.

Ongoing Research questions:

- Study of 400 micrograms versus 600 micrograms should take place, but this is not the highest priority in misoprostol research. In ongoing studies, we should get more information on the side effects. If data shows that 400 micrograms is equally as effective as 600 micrograms, then we'll change recommendations.
- In terms of effectiveness,
 - Important to take into account how other components were practiced: for example, the Gambia study was with TBAs, AMTSL was practiced, and there was minimal difference in miso vs. oral ergo
 - can't lump all the studies together
 - Pakistan data will be able to support the findings of the Belgaum/India study
- Is it appropriate to look at a trial that incorporates oxy and miso w/ or w/out AMTSL to get a handle on the questions?
- Trial in Pakistan is tracking the use of other AMTSL components such as CCT and massage. : TBAs practice some components, CCT and cord clamping less common, but uterine massage practiced by about 60 percent of women.

LAC region issues related to misoprostol:

- Overall, LAC has high facility based births and availability of oxytocin though some places have low rate of hospital deliveries
- Argentina, religious issues—Catholic
- Oxytocin is already accepted but not used
- The suggestion is to focus on increasing use of AMTSL and that is higher priority than miso.
- Gynuity is doing work in Quito: misoprostol work for treatment and incomplete abortion; they suggest that their data (if found effective) can provide evidence to move forward with getting it approved

Getting misoprostol out to the community:

- We're thinking of this coming through providers in the health system—should that be the way it is? Provided to a TBA? Provided to woman/family through a clinic?
- All channels will serve some part and criss-crossing
- At the Goa meeting, there was agreement to provide miso through the antenatal clinic or a trained health worker—someone specifically trained to perform this task (this is a critical point for WHO). It does not have to be the SBA who attends the birth but can be a trained health worker in the country according to their own country's system; social marketing might be an important part to increasing demand. OTC was the most controversial in the Goa meeting, and we're not talking about that today
- If we agree that we can get it to women through clinic or trained health worker, (the Indonesian SAFE model), how do we back that up—how do we translate this controlled study into a program and manage this from a systems point of view—who has the drugs, how do they get distributed???
- How do we take the model and roll it out?
- This is a really good model in a country; most women visit some sort of community worker in a country—then how do those people get it? We need some short write-ups on how to do this in a country
 - what can we put together so that countries can see what to do?
- Everyone agrees that education is a key component to be included in safe distribution of the drug
 - important to involve some trained health workers, because that will allow us to collect data on what is happening (rather than OTC with education)
 - need to be able to evaluate how well this works
 - OTC with pharmacists providing education (and can track data) is a good option as well

Oxytocin in Uniject Update

- PATH collaboration with Argentine pharmaceutical producer ongoing
 - Good six-month results from stability testing
 - Will produce initial Oxytocin in Uniject for field trial use in January 2007 with second larger production planned for Q2 2007
 - Will apply for Argentine registration Q2 2007
 - Will provide Oxytocin in Uniject for use in Mali, Argentina, and South Africa field evaluations during 2007
- Progress of an Indian producer with Oxytocin in Uniject was delayed due to lack of availability of a Uniject filling machine, BD working to resolve this ASAP.
 - Could also be an Indian producer of Oxytocin in Uniject emerging by end of 2007

Overall Strategy for UDD in Prevention of PPH

Updates on oxytocin:

- USP is revising the monograph—looking at removing any USP storage temperature requirements (so they remove the 2-8 degrees C) so each manufacturers can use set storage temperature based on their own specific stability studies, changing the potency specifications (from 90%-110% to 80% – 120%) and including use of plastics (vs glass ampoules)
- RPM+ has put out some very well done and well received factsheets on oxytocin to address the confusion out there about oxytocin, particularly related to the recent (past few years) change in temperature requirements (the USP storage temp requirements changed to 2-8 degrees C versus the previous 15-25 degrees C).
- WHO has focused on replacing ergometrine with oxytocin (not completely successful). Ergometrine is the norm for a lot of the African countries (Anglophone especially)—with increased use at the periphery
- Why is there such variability in labeled storage temperatures and stability?
 - certain amount that oxy will degrade over time and the higher the heat, the quicker it degrades
 - other ingredients in their formula (pH, buffer) affect stability, so differences can exist between different producers oxytocin finished product
 - Drug regulations only allow a small number of, specified storage temperature ranges for drugs, such as 2-8 degrees C (refrigerated conditions) and 25 degrees C (controlled room temperatures—air-conditioned). If a producer can not achieve a desired shelf life (perhaps 2 or even 3 years) at 25 degrees, then their only option is to shift to the next lowest allowed storage temperature range, which is 2-8 degrees C. This is true even if their testing showed the drug would be stable at 20 degrees C.

- Difference between regulatory drug requirements, and can't go against labeling and requirements
 - the higher the temperature, the shorter the shelf life
 - drug producers know that customers do not want to buy drugs with short shelflife
 - need to come up with a system to allow it to be used quickly (good management of drug supply) or kept cool to increase shelf life

Action items/future work of UDD:

1. POPPHI will work with WHO-Making Pregnancy Safer to help facilitate getting misoprostol for the prevention of PPH indication on the Essential Drug List

- Monir said that he would put an application in to put misoprostol on the EDL for prevention of PPH (requires a sign-off from the secretary-general)
- Misoprostol is currently on the list for other indications, needs to get added for the prevention of PPH

2. Indicators:

- Critical that the use of misoprostol and oxytocin and AMTSL – the high-impact interventions – be carefully monitored. We need to know what is being done in terms of supply and provision of service—the successes, evaluated against the outcomes we want and lessons learned. Otherwise, this work will get lost or the excitement will taper off and another program will get attention
 - have to pay attention to collecting data on indicators of success
 - monitor:
 - used appropriately
 - no adverse health outcomes
 - disseminate into the community
 - how many births, what % of births are getting this...otherwise, not paying enough attention to this
- Community-based TF: looking to have a community-based indicator. Use of a uterotonic at birth, evaluate if it is misoprostol or something else

3. Documentation of program implementation of misoprostol use:

SAFE study: Sanghvi H, Wiknjastro G, Chanpong G, Fishel J, Ahmed S, Zulkarnain M. *prevention of postpartum hemorrhage study West Java, Indonesia*. Baltimore, MD: JHPIEGO. 2004. Available at:

http://www.jhpiego.com/scripts/pubs/product_detail.asp?product_id=561

4. Big Picture Action Items:

Ergo tabs→switch to misoprostol: in the Gambia (find out if this is an issue in other places)

Ergo injection→oxytocin injection

- need a plan of action of how to do
- issue paper (part of broader advocacy work—need to gather a succinct argument)
- issue of practice/habit (sustained contraction) (maybe need to find champions in a country for how to do)
- focus on champions

Achieving coverage

- who is authorized to use: need to make sure that midwives are authorized to use oxytocin for prevention of PPH (and miso)
- who is attending births
- drug supply (if you scale up intervention, then need to make sure the drugs are there)

5. POPPHI work in survey countries:

- In non–scale-up countries: need to find people to work there
- 5 scale-up countries: follow up with LQAS methodology in 2 years
- Have raised a lot of awareness on PPH, especially AMTSL, a lot of partners are here to work. Looking to identify and tackle what issues are country by country, and who is ready to tackle key policy issues to start and drug issues
 - look at who is working in each country or capability of working in a country and working together to see who can take on each issue
 - using early adopter countries to influence others
 - what are indicators of success?
 - writing up case studies on this

6. Venture Strategies: case studies on each countries:

Nigeria: approved for sale in pharmacies; government has not yet figured out how to get it to the pharmacies

- In order to buy it, needs a prescription
- People in country are interpreting miso approval as only for facilities or SBAs

7. Uniject:

Should we be looking for more countries in which to use oxytocin in Uniject?

Might be some avenues for programs/countries who in 18/24 months want to use oxytocin in Uniject

Appendix M: Toolkit and Jobaid Dissemination

Aug 2006 – January 2007
POPPHI

| Date | Requested By | Organization | Sent To | Organization | # of Condensed | # of Reference/ Library | # CD ROMS | Country/ Countries |
|--------------|-----------------------|--------------|------------------|----------------|----------------|----------------------------|--------------|-----------------------|
| 11/3/2006 | Deborah Armbruster | FIGO | FIGO Congress | many | | 1 | 55 | global |
| 11/6/2006 | Rebeca Quiroga | POPPHI | Bolivia | USAID mission | | | 2 | Bolivia |
| | | POPPHI | PAIMAN | JSI | 123 | 40 | 163 | Pakistan |
| | Niamh Darcy | RTI | Mary Segall | Abt Associates | | 5 | 5 | global |
| TOTAL | | | | | 123 | 46 | 225 | |

**Job-Aid Dissemination
August 2006 - Jan 2007
POPPHI**

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|-----------------------------|---|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|---------------------|
| Sept 06-Jan 07 | | | | | | | | |
| Kathleen Hill | URC | | | | 60 | | | Niger, Benin |
| FIGO Conference | | 50 | 50 | | | | | global |
| Rebeca Quiroga | Bolivia | | | | | 78 | 2 | Bolivia |
| Judith Standley | UNICEF | | | | | | 100 | Bolivia |
| Aamina Adham | POPPHI | 300 | 300 | | | | | Pakistan |
| Deb Armbruster | POPPHI | 100 | | | | | | Pakistan, Indonesia |
| Patricia Gomez | ACCESS | 500 | 500 | | | | | global |
| Carmela Cordero | EngenderHealth | 5 | 5 | 5 | 5 | 5 | 5 | Dominican Republic |
| Laurence Odounlami Monteiro | ASFB | 0 | 0 | 100 | 100 | 0 | 0 | Benin |
| Dr. Luis Zárate Pereira | Sociedad Boliviana de Ginecología y Obstetricia | 0 | 0 | 0 | 0 | 100 | 100 | Bolivia |
| Maimouna Foro | Association Burkinabé des Sages-femmes | 0 | 0 | 100 | 100 | 0 | 0 | Burkina Faso |

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|------------------------------|---|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|--------------|
| Souleymane Zan | Société des gynécologues et obstétriciens du Burkinabé | 0 | 0 | 100 | 100 | 0 | 0 | Burkina Faso |
| Dr. Kabuya Willy | MSH/RDC | 0 | 0 | 10 | 75 | 0 | 0 | DRC |
| Solomon Kumbi Hawas | Ethiopian Society of ob/gyns | 100 | 100 | 0 | 0 | 0 | 0 | Ethiopia |
| Kiros Kebede Gugesa | Ethiopian Nurse Midwives Association | 100 | 100 | 0 | 0 | 0 | 0 | Ethiopia |
| Kwasi Akyem Apea-Kubi | University of Ghana Medical School Department of Obstetrics and Gynecology | 100 | 100 | 0 | 0 | 0 | 0 | Ghana |
| Ms. Laurensia Lawintono | Indonesia Midwives Association | 100 | 100 | 0 | 0 | 0 | 0 | Indonesia |
| L. Kamwendo | | 100 | 100 | 0 | 0 | 0 | 0 | Malawi |
| Madame Dicko Fatoumata Maiga | Siège Bamako-Coura | 0 | 0 | 100 | 100 | 0 | 0 | Mali |
| Ms. Tara Pokharel | Nursing Council of Nepal | 100 | 100 | 0 | 0 | 0 | 0 | Nepal |

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|---------------------------|---|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|-----------|
| Ms. Intiaz Kamal | Maternity and Child Welfare Assoc. Pakistan | 100 | 100 | 0 | 0 | 0 | 0 | Pakistan |
| Wilfrida Sosa | Asociacion de Obstetras del Paraguay | 0 | 0 | 0 | 0 | 100 | 100 | Paraguay |
| Ms. Elena Lara Valderrama | Decana Nacional Colegio de Obstetrices del Perú | 0 | 0 | 0 | 0 | 100 | 100 | Peru |
| Richard S.M. Lema | MHS-Massana Hospital | 100 | 100 | 0 | 0 | 0 | 0 | Tanzania |
| Feddy Mwangi | Tanzania Midwives Association | 100 | 100 | 0 | 0 | 0 | 0 | Tanzania |
| Wasswa George Munganwa | The Association of Obstetricians and Gynaecologists of Uganda | 100 | 100 | 0 | 0 | 0 | 0 | Uganda |
| Sakina Kiggundu | Ugandan Private Midwives Association | 100 | 100 | 0 | 0 | 0 | 0 | Uganda |
| Meenu Ratnani | EngenderHealth | 10 | 10 | 0 | 0 | 0 | 0 | India |
| Dr. Rebecca Tonye | Hospital Central | 0 | 0 | 250 | 250 | 0 | 0 | Cameroon |

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|---|---|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|-----------|
| Deborah Armbruster | POPPHI (FIGO conference) | 500 | 500 | 500 | 500 | 300 | 300 | Malaysia |
| Laurence Odounlami Monteiro (for partner org.) | | 0 | 0 | 100 | 100 | 0 | 0 | Benin |
| Dr. Luis Zárate Pereira (for partner org.) | Sociedad Boliviana de Ginecología y Obstetricia | 0 | 0 | 0 | 0 | 100 | 100 | Bolivia |
| Kwasi Akyem Apea-Kubi (for partner org.) | University of Ghana Medical School Department of Obstetrics and Gynecology | 100 | 100 | 0 | 0 | 0 | 0 | Ghana |
| L. Kamwendo (for partner org.) | | 100 | 100 | 0 | 0 | 0 | 0 | Malawi |
| Madame Dicko Fatoumata Maiga (for partner org.) | Siège Bamako-Coura | 0 | 0 | 100 | 100 | 0 | 0 | Mali |
| Ms. Elena Lara Valderrama (for partner org.) | Decana Nacional Colegio de Obstetrias del Perú | 0 | 0 | 0 | 0 | 100 | 100 | Peru |
| David Burrows | JHPIEGO | 0 | 0 | 150 | 150 | 0 | 0 | USA |
| Cheick Toure | IntraHealth | 0 | 0 | 400 | 400 | 0 | 0 | Mali |
| Meghan Greeley | | 0 | 0 | 200 | 200 | 0 | 0 | Benin |
| Dr. Antonio Horacio Toro | PAHO | 2 | 2 | | | 2 | 2 | Brazil |

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|-------------------------------|--------------|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|--------------------|
| Dr. Pier Paolo Balladelli | PAHO | | | | | 2 | 2 | Columbia |
| Ana Cristina Nogueira | PAHO | | | | | 2 | 2 | Dominican Republic |
| Dr. Jorge Luis Prospero | PAHO | | | | | 2 | 2 | Ecuador |
| Dr. Joaquin Molina | PAHO | | | | | 2 | 2 | Guatemala |
| Dr. Juan Eduardo Guerrero | PAHO | | | | | 2 | 2 | El Salvador |
| Dr. Kathleen Israel | PAHO | 2 | 2 | | | | | Guyana |
| Dr. Beatrice Bonnevaux | PAHO | | | 2 | 2 | | | Haiti |
| Dr. Jose Fiusa Lima | PAHO | | | | | 2 | 2 | Honduras |
| Dr. Socorro Gross Galiano | PAHO | | | | | 2 | 2 | Nicaragua |
| Dra. Carmen Rosa Serrano | PAHO | | | | | 2 | 2 | Paraguay |
| Dr. Manuel Pena | PAHO | | | | | 2 | 2 | Peru |
| Dr. Renato d'Afonseca Gusmao | PAHO | | | | | 2 | 2 | Venezuela |
| Dr. Jose Antonio Pages | PAHO | | | | | 2 | 2 | Argentina |
| Ms Lynda Rae Campbell | PAHO | 2 | 2 | | | | | Bahamas |
| Dr. Bernadette Theodore-Gandi | PAHO | 2 | 2 | | | | | Barbados |
| Dr. Beverley Barnett | PAHO | 2 | 2 | | | | | Belize |
| Dr. Carlos Samayoa | PAHO | | | | | 2 | 2 | Costa Rica |

| Sent To | Organization | English Factsheets | English Posters | French Factsheets | French Posters | Spanish Factsheets | Spanish Posters | Countries |
|------------------------------------|--------------|--------------------|-----------------|-------------------|----------------|--------------------|-----------------|-----------|
| Dr. Juan Manuel Sotelo Figueriredo | PAHO | | | | | 2 | 2 | Chile |
| Dra. Lea Guido | PAHO | | | | | 2 | 2 | Cuba |
| Dr. Ernest Pate | PAHO | 2 | 2 | | | | | Jamaica |
| Dr. Jacobo Finkelman | PAHO | | | | | 2 | 2 | Mexico |
| Dr. Stephen Simon | PAHO | 2 | 2 | | | | | Suriname |
| Dra. Guadalupe Verdejo | PAHO | | | | | 2 | 2 | Panama |
| Dr. Jose Fernando Dora | PAHO | | | | | 2 | 2 | Uruguay |
| Dr Christian Daras | PAHO | | | | | 2 | 2 | Bolivia |
| TOTALS Aug-Jan 07 | | 2779 | 2679 | 2117 | 2242 | 921 | 945 | |

Appendix N: Community-based Prevention of PPH: A Review of the Literature

August 2006 – January 2007
Updated Feb 22, 2007
Prepared by Meghan Greeley

Introduction

The Prevention of Postpartum Hemorrhage Initiative (POPPHI) Project is focused on preventing postpartum hemorrhage (PPH), primarily through expanding the use of active management of the third stage of labor worldwide.

At least one quarter of all maternal deaths worldwide are due to PPH. It is estimated that as many as 14 million women experience pregnancy-related hemorrhage every year, and that almost 150,000 of these women die as a result. Most of these deaths occur within 24 hours of delivery. The majority of PPH is caused by uterine atony, failure of the uterus to contract.¹

Postpartum hemorrhage is unpredictable, with two-thirds of PPH occurring in women with no identifiable risk factors. Without proper management, PPH can rapidly progress to cause life-threatening blood loss, often within two hours. Because of this unpredictability and rapid progression, reducing the incidence of PPH, and improving PPH outcome when it does occur, remains a challenge. Community-level interventions, including home based, can be instituted routinely to prevent PPH, and community response systems can reduce the delay in reaching and receiving additional lifesaving care for PPH.

An important focus within PPH reduction overall is the prevention of PPH at the community level. Because not enough information is available centrally about community-based strategies for prevention and treatment of PPH, POPPHI is developing a factsheet to address the use of the following **interventions at the household and within the community**:

- **Active management of third stage of labor** by skilled service providers and/or trained community health workers.
- **Use of uterotonics** such as misoprostol, oxytocin, and ergometrine to prevent or manage PPH.
- **Use of basic routine care** such as uterine massage, bimanual uterine compression, bladder emptying, and nipple stimulation for prevention and/or treatment of PPH.
- **Other PPH prevention activities.**

In preparation for this factsheet, we have conducted a search for the interventions completed to date related to postpartum hemorrhage in the community. This included a literature search for relevant articles, presentations by groups currently involved in implementation, and a web search for related activities. This search was completed using PubMed and by collecting information from experts on articles and topics that they would like to see included. All articles and documents were included if they focused on prevention of postpartum hemorrhage outside of facilities.

I. Active management of the third stage of labor (AMTSL)

AMTSL involves three main components: 1) the use of a uterotonic agent within one minute following the birth of the baby, 2) delivery of the placenta with controlled cord traction, and 3) uterine massage after delivery of the placenta.² Clinical trials in developed countries have shown that the use of AMTSL (in contrast to physiologic management of the third stage of labor when oxytocic drugs are not used and the placenta separates spontaneously) significantly reduces postpartum hemorrhage. A Cochrane review of these trials recommends AMTSL for all women delivering in a hospital and anticipating the vaginal birth of a single infant.³ It is strongly recommended that AMTSL only be performed by a skilled birth attendant or those health workers trained to perform the skill.^w

Some programs have begun to practice AMTSL with providers working in the community.

Nongovernmental Organization (NGO) Service Delivery Program (NSDP)

The NSDP program in **Bangladesh** has trained nurse-midwives/family welfare visitors/paramedics in use of partograph, AMTSL, and newborn resuscitation. These providers were selected for participation in the program already having basic midwifery training as part of their basic education course, worked in NSDP clinics, and were already attending births in the community as part of their private practice. These providers were equipped with delivery kits containing injectable oxytocin and mobile phones and sent to perform home births in the community.

There is currently no published information on this work, and the information here comes directly from program staff. An International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) evaluation report found that 74 percent of paramedics practicing used oxytocin, 100 percent used controlled-cord traction, and 96 percent practiced uterine massage. Presently, according to monitoring data from the program, no client has required referral for PPH. Although this work is still at an early stage, the evidence reported thus far shows that AMTSL can be practiced effectively at the community level.⁴

^w WHO definition, October 2006.

Maternal Child Health Workers (MCHWs)

In **Nepal**, there has been a significant amount of work done related to the prevention of PPH, including training MCHWs in the practice of AMTSL. MCHWs are community health workers meant to function in remote areas, where other higher-level health workers are not willing to stay for extended periods of time. The MCHWs initially took a 15-week course with theoretical and clinical components. In 2000, an additional 6-week training in midwifery skills was added, which included training in AMTSL. An evaluation of the MCHWs completed in 2003 found that the MCHWs demonstrated between 60 and 80 percent of the desired knowledge and skills for a skilled birth attendant. Overall, they found that MCHWs, “on average, have an acceptable level of knowledge and skill, shown in a practice situation, to function as community-level skilled attendants.”⁵ No specific information was provided in the evaluation report on their use of AMSTL during home deliveries.

II. Use of Uterotonics

Much research has been done that shows that uterotonic drugs can be used effectively for preventing and treating PPH. Recent studies also show that misoprostol can be safely distributed to pregnant women to use at home immediately after the delivery of the placenta.

Prevention of PPH with oxytocic drugs

Prendiville, Elbourne, and Chalmers analyzed data from controlled trials in which an oxytocic drug was compared to a placebo or no routine prophylaxis. The review found that routine use of oxytocic drugs reduced the risk of PPH by 40 percent. The authors suggest that routine prophylactic use of oxytocics could significantly reduce the postpartum hemorrhage rate.⁶

AMTSL with oxytocin in the Uniject™ device (Uniject is a trademark of BD)

Use of the Uniject prefilled injection device can increase the ease of practice of AMTSL. As shown in a study completed in **Vietnam**, AMTSL is equally effective when performed with standard ampoule and syringe and with the Uniject device.⁷ Use of the Uniject device reduces the need for available syringes and needles and, as it is a single-use device, reduces the risk of transmission of blood-borne pathogens. In **Angola**, providers using the device and parturient women both reported favorable use of the device.⁸

Prevention of PPH with oral ergometrine:

In a study conducted in the Netherlands, in both facilities and at home births, oral ergometrine was shown to have only a small (5 percent) reduction in blood loss, as compared to placebo. The authors did not feel there was a reason to recommend the use of oral ergometrine in the third stage of labor.⁹

Prevention of PPH with misoprostol:

Although past research has shown that misoprostol is effective in the prevention of postpartum hemorrhage,¹⁰ only recent findings have shown misoprostol's effectiveness in a community home-birth setting. A study in the **Gambia** found a non-significant trend in reduction of PPH with misoprostol when compared to oral ergometrine (standard treatment).¹¹ In **Indonesia**, a study was conducted to demonstrate the safety, acceptability, feasibility, and program effectiveness of community-based distribution and use of misoprostol. This study demonstrated that, when supplied with misoprostol during the 8th month of pregnancy, women safely and correctly took the drug, were 25 percent less likely to perceive excessive bleeding after birth, 30 percent less likely to need an emergency referral for any complication, and were 45 percent less likely to need a referral for PPH.¹² The results of a placebo-controlled trial in rural **India** from 2002 to 2005 showed that misoprostol is effective in decreasing the rate of acute postpartum hemorrhage (12 percent to 6.4 percent) and mean blood loss (262.3 ml to 214.3 ml). This trial used auxiliary nurse-midwives to administer misoprostol, attend the birth, and measure blood loss.¹³

Treatment of PPH with misoprostol

In **Tanzania**, TBAs were trained in the recognition of PPH by using a standard cloth garment used by the community called a kanga. It was determined that two soaked kangas equaled 500 ml of blood, and the TBAs in the study were trained to recognize this. In the non-intervention area, the TBAs were trained to refer a woman once she had soaked two kangas of blood. The TBAs in the intervention area were taught to give 1,000 mg of misoprostol rectally after 2 kangas were soaked with blood. They were trained to refer the woman if the bleeding continued or the woman showed signs of shock. 2 percent of women in the intervention area were referred compared with 19 percent of women in the non-intervention area.¹⁴

III. Use of basic routine care

Uterine massage

Uterine massage is promoted as a component of AMTSL, but little research has been conducted to show its effectiveness as a stand alone intervention. A small randomized trial was completed in the Assiut University Hospital in **Egypt** in 2005, where women were randomized into one of two groups, the first of which received injection of 10IU oxytocin, immediate cord clamping, and controlled cord traction, and the second of which received these three interventions as well as intermittent uterine massage (described as “manual stimulation of the whole surface of the uterus using steady repetitive movements, as firmly as can be achieved without causing distress to the mother, till the uterus became contracted”) every 10 minutes for 60 minutes. Although the results are limited by the small sample size, persistent uterine massage was shown to reduce the amount of blood loss and the need for additional uterotonics.¹⁵

Breastfeeding and nipple stimulation

A randomized, controlled trial was completed in **Malawi**, in 1989, to determine whether or not early suckling reduced PPH. The subjects were all attended by TBAs. All TBAs involved in the trial received training on record keeping, physiology of the third stage of labor, causes of PPH, management of the third stage of labor, measurement of blood loss at delivery, reasons for referral for third stage complications, and, for the early suckling group only, immediate breast suckling after delivery. The results showed no significant difference between the two groups for frequency of PPH (blood loss greater than 500 ml) and mean blood loss.¹⁶ Despite the lack of research proving the effectiveness of immediate breastfeeding and nipple stimulation, Geller et al. report that in areas where oxytocics are not available, these might prove to be effective in reducing the incidence of PPH, although randomized trials are needed.¹⁷

Home-based life-saving skills (HBLSS)

Home-based life-saving skills is a program developed by the American College of Nurse-Midwives (ACNM) to teach pregnant women, their primary family caregivers, and home birth attendants the skills and knowledge for a safe and healthy pregnancy. This includes not only PPH, but the other most common life-threatening problems and/or complications of women and newborns.

Fullerton, Killian, and Gass report on the outcomes of using HBLSS in rural Uttar Pradesh, **India** during the Community Partnerships for Safe Motherhood project, a 36-month feasibility study to “promote the adoption of basic maternal and neonatal life-saving interventions within the home and community, to reduce delays in transport to referral units where life-threatening complications can be managed, and to increase use of postpartum and post-abortion family planning.”¹⁸ The Global Health Technical Brief, “First Aid for Women and Newborns Where Home Birth is Necessary or Common” also reports on the HBLSS approach, reporting that “‘Unskilled’ attendants can save lives through appropriate home-based management of maternal and neonatal complications such as postpartum hemorrhage and neonatal sepsis.”¹⁹

The HBLSS approach addresses the issue of “bleeding too much” by presenting six self-care actions: rub the womb, stimulate the nipple by breastfeeding, stimulate the nipple by hand, squat and pass urine, hold the womb between two hands, and press on the place from which the bleeding is coming. In the project areas, the evaluation showed that only 5 of the 20 women who reported excessive bleeding were referred by self or others to an emergency obstetric care facility and all survived.

A field test of the HBLSS program in **Ethiopia** showed improved performance in the management of postpartum hemorrhage. Using in-depth interviews and *complication audit forms*, all cases reported to have had signs of PPH were evaluated for appropriate case management. The average score for appropriate case management of cases attended by an HBLSS guide was 69 percent, as compared with 36 percent in cases attended by other unskilled attendant.²⁰

IV. Early recognition, first aid, and referral of PPH

Early recognition of excessive bleeding (PPH) after delivery of the baby, by the birth attendant, relative or the mother herself, is essential for initiation of prompt and appropriate actions to save the life of the bleeding mother. Early recognition of PPH, initiation of first aid, and prompt referral can reduce the delay in reaching and receiving additional lifesaving care for PPH. Various studies have been conducted to find an easy, effective and acceptable way for birth attendants, relatives and mothers to recognize excessive post-delivery bleeding. The results of some of these studies are discussed below.

Household measurement of blood loss

Different methods to measure the amount of postpartum blood loss during home births have been used in various settings where a large number of births take place outside of facilities, often without skilled attendance. In **Tanzania**, TBAs were trained to recognize PPH when two kangas (standard, locally produced, and pre-cut cloth garments common to that area) became soaked with blood. Measurement verifications showed that two kangas soaked with blood represented slightly more than 500 ml, the standard definition of PPH.²¹ In rural India, a specially-designed blood collection drape was used to estimate blood loss. Birth attendants reported that the drape was easy to use and allowed them to more easily recognize excessive blood loss.²²

Recognition of PPH

In the **Gambia**, TBAs were interviewed about recognition, prevention, and management of PPH. This study showed through semi-structured interviews that the TBAs have the potential to help manage PPH. Through their training, the TBAs learned to check the position of the placenta (by placing their hand on the uterus and pulling the cord gently) and refer to the nearest health facility if the placenta was not delivered in one hour. The TBAs indicated that they watched for blood loss carefully, using the number of *lappas* (local pieces of cloth) soaked with blood to make their determination. The TBAs knew that they had to refer the woman immediately if the blood loss was serious. The authors conclude that the TBAs could be trained in additional practices that could help prevent PPH in home settings.²³

V. Other Medical/ Clinical Interventions

Antishock garment

The non-inflatable antishock garment is a neoprene garment that, when placed on a woman, can apply 30 to 50 mm Hg of pressure to the lower body. This will cause a transfer of blood from the lower body and abdomen to the central circulation, stabilizing women with postpartum hemorrhage while they wait for surgical intervention or blood transfusion.²⁴ Thus far, the antishock garment has only been tested in facility settings, although there is potential for future use in the community. A pilot study in **Egyptian**

teaching hospitals found a statistically significant 50 percent decrease in measured blood loss with use of the antishock garment for treatment of PPH as compared with standard clinical management of PPH. This study is limited by the small sample size and the fact that the study is pre-post design and unblinded, allowing for provider bias.²⁵ The garment has not been tested in a community setting yet but it has the potential of being used to prolong the life of a woman with PPH long enough to get her to a health facility for appropriate treatment.

VI. Community mobilization/ behavior change communication (BCC) Interventions

Community mobilization (CM) has been defined as “a capacity-building process through which community individuals, groups and organizations plan, carry out, and evaluate activities in a participatory and sustained basis to improve their health and other needs, either on their own or stimulated by others.”²⁶ Community-based efforts to prevent and manage PPH include a variety of complementary activities, such as: awareness raising and community dialogue on safe motherhood and the prevention of PPH; training of TBAs and other community workers in PPH management; and the establishment of emergency evacuation/referral systems/plans. Each of those activities has an inherent value and, depending on the contexts and needs, can effectively contribute to prevent mortality due to PPH. They become part of a CM process when and to the extent that community members actively participate in their planning, design, implementation, and evaluation. For instance, community members (including representatives of those directly concerned by the issue, in this case, e.g. pregnant women) could decide to include some or all of the aforementioned activities in a local action plan to prevent PPH based on the results. They could organize teams or sub-committees for their implementation, set up a community-based monitoring system to verify whether they are being carry out as planned, and conduct participatory evaluations to assess whether or not those activities are helping to solve the problem (i.e. PPH and maternal mortality). As Howard-Grabman and Snetro point out, in CM processes, outside actors play an advising, facilitating and supporting role. They can help raise awareness of an issue that communities may not perceive as a priority and build momentum towards the development of endogenous, sustainable solutions. But when external actors begin to direct or manipulate the effort, the building of community capacity is compromised and sustainability is undermined.³¹ In CM processes, outside facilitators should be ready to gradually share or relinquish control as communities are enabled to make important decisions and play more active roles in the improvement of their health and quality of life.

Most national safe motherhood programs have a community mobilization/BCC component. Usually, these interventions do not single out PPH, but provide education and awareness creation on PPH as part of an overall campaign to improve recognition of a “package” of the most common obstetric and newborn danger signs. Improving timely household/community recognition and response to all of the danger signs, including PPH

is usually combined with community interventions for emergency transport and referral when complications occur.

One comprehensive review of studies of community and household perception of PPH states that it is critical to “ensure that women and their families accept that bleeding after birth is not desirable, that skilled care is preferable to traditional care, and that they make arrangements during pregnancy for the time of birth.”²⁷

Community mobilization for blood transfusion

In two communities in **Nigeria**, a main factor in maternal deaths due to PPH in these communities was the lack of blood for transfusions. Between April and December of 1993 an education and community mobilization campaign was held to increase community-wide blood donations that would be used for women suffering from PPH.

Contact was made with clan heads, village heads, male and female opinion leaders, and youth leader in order to inform them of the maternal mortality risk due to PPH in their communities. Activities included in the campaigns were posters, handbills, and a song about blood donation and transfusion, all of which promoted the message in English and the local language that blood transfusion can save lives, blood transfusions can only happen if blood is available, and blood is only available if people donate. These messages were promoted in markets, schools, and churches.

The results showed a significant increase in the blood availability for transfusion from 39.4 percent pre-intervention to 79.2 percent post-intervention. Although the blood donation and transfusion both took place in a facility setting, this study demonstrates that community-based behavior change interventions can improve quality of care and blood availability for transfusion at facility level.²⁸

Discussion

There is a significant opportunity to reduce the number of maternal deaths in the world through preventing PPH at the community-level. This literature review takes a look at the evidence that is available and the programmatic implementation of these interventions. These interventions are either currently being implemented at the community level or have the opportunity in the future to be able to move to the community level.

As a country or program makes a decision about the type of intervention(s) to implement, it will be important to look at the specific context and choose the options that work best for that setting. There is not currently one effective community-based prevention of PPH intervention that should be taken to scale everywhere. Factors to take into consideration will be the recipient (which could be the community itself), the person or organizer performing the intervention, the equipment needed (and its availability), the skills needed, and the political environment (concerning drug availability, level of cadre who performs intervention) and the motivation/commitment of the community.

Additional research is needed in many of these areas. Can lower-level cadres perform AMSTL? This is something that POPPHI is currently exploring through its work with matrones (midwifery assistants) in Mali. What is an effective strategy to scale-up the use of misoprostol in a community setting? Additional operations research is needed on implementation of misoprostol.

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