USAID FROM THE AMERICAN PEOPLE

MCHIP Maternal and Child Health Integrated Program

Prevention and Management of Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia:

National Programs in Selected USAID Program-Supported Countries

Status Report

March 2011

By:
Angeline Fujioka
Jeffrey Smith

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ABBREVIATIONS AND ACRONYMS

ANM	Auxiliary Nurse Midwife
AMTSL	Active management of the third stage of labor
DRC	Democratic Republic of the Congo
EDL	Essential Drugs List
E. Guinea	Equatorial Guinea
EmONC	Emergency obstetric and newborn care
LAC	Latin America and the Caribbean
MgSO4	Magnesium sulfate
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MMR	Maternal mortality ratio
NGO	Nongovernmental organization
PE/E	Pre-eclampsia/eclampsia
POPPHI	Prevention of Postpartum Hemorrhage Initiative
PPH	Postpartum hemorrhage
RH	Reproductive health
SBA	Skilled birth attendant
SBM-R	Standards-Based Management and Recognition
ToT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization

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We would like to express our sincere gratitude to our partners and colleagues in the field who are working to improve the lives of women and children. They have demonstrated commitment, creativity and attention to detail in their programs to reduce postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E). We acknowledge the generosity of their time and the importance of information shared through hard work—our colleagues responded to multiple requests and questions in the development and revision of this status report. Special thanks to the United States Agency for International Development (USAID), the Maternal and Child Health Integrated Program (MCHIP), and partner colleagues in Afghanistan, Angola, Bangladesh, Bolivia, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Ghana, Guatemala, Guinea, Honduras, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Paraguay, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe.

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- Management Sciences for Health
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- PATH
- USAID RBHS (Liberia)
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- USAID SHTP II (South Sudan)
- USAID MAISHA (Tanzania)
- USAID STRIDES (Uganda)
- USAID ZISSP (Zambia)

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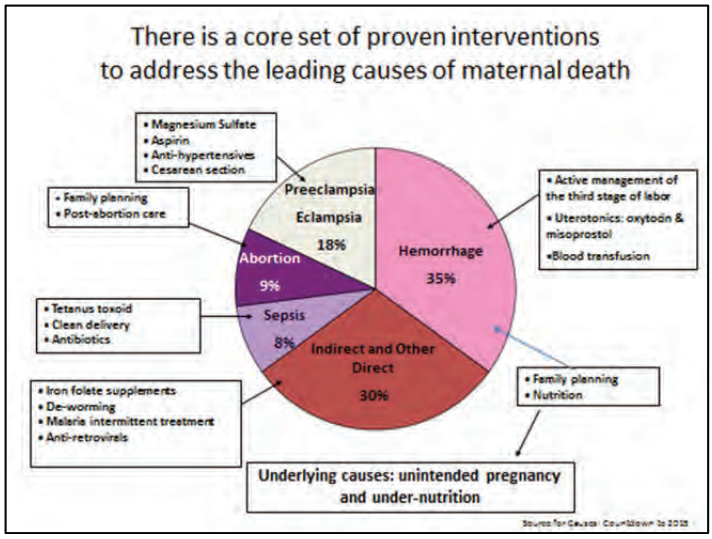
MCHIP is the USAID Bureau for Global Health flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in MNCH, immunization, family planning, malaria and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

INTRODUCTION

Maternal mortality persists at exceedingly high rates—with the World Health Organization (WHO) reporting a maternal mortality ratio (MMR) of 290 maternal deaths per 100,000 live births in developing nations.[1] Consequently, reducing maternal mortality is a global development priority for donors, and a global program priority for the United States Agency for International Development (USAID) and the Maternal and Child Health Integrated Program (MCHIP) as part of USAID efforts to support achievement of Millennium Development Goals 4 and 5.

Figure 1. Interventions to address maternal death



Source: Countdown to 2015 Decade Report 2000–2015: Taking stock of maternal, newborn and child survival

The WHO recently developed an elaborate classification system, which defines anemia and obstructed labor as contributing rather than direct causes of maternal mortality. Deaths previously categorized in these two areas are now classified as hemorrhage or sepsis. MCHIP is focused on advancing the uptake of evidenced-based, high-impact interventions appropriate for low-resource settings in which postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E) are of major concern. Further, MCHIP supports USAID and other donor programs to scale-up these interventions with the overall goal of reducing maternal mortality in the 30 priority countries with the highest mortality rates by 2013, a shared goal of USAID's Maternal Health Results Pathway.

USAID-supported programs have achieved significant momentum in the development and implementation of PPH-reduction activities globally. Programs to reduce mortality from PPH, and increasingly programs for PE/E, are in place in many countries around the world. USAID, with MCHIP support, is tracking the implementation and progress of these country programs. To this end, a database on PPH-reduction activities was developed in 2010 with input from multiple partners (based on, and using some, initial work done by PATH and the Prevention of Postpartum Hemorrhage Initiative [POPPHI]). A further update and analysis of that database is presented here for 31 countries worldwide. This exercise is a continuation of the MCHIP PPH Strategy for Accelerating Scale Up of Interventions to Prevent and Treat PPH, which was developed in 2010 through data collection and dissemination of key messages.[2] The database will track ongoing progress of programs that are scaling up PPH-reduction and PE/E-management activities in multiple countries around the world, including all countries in which

[1] World Health Organization (WHO). 2010. Trends in maternal mortality: 1990 to 2008. Accessed March 18, 2011 from http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

[2] Gomez, P. May 24, 2010. MCHIP Strategy for Accelerating Scale Up of Interventions to Prevent and Treat Postpartum Hemorrhage.

MCHIP is working. This enhanced database will better serve existing and new projects, and will be useful as a reference for USAID and partners as they advance program progress and scale-up.

METHODOLOGY

OVERVIEW

A country-level landscape analysis was conducted from January to March 2011 in 31 countries across Africa, Asia and Latin America, including 23 MCHIP priority countries facing the highest disease burden. The purpose of this analysis was to document progress in national scale-up of PPH- and PE/E-reduction programs in all MCHIP and MCHIP-affiliated programs around the world. It is anticipated that the questionnaire used in this analysis will be repeated on a semi-annual to annual basis in an effort to maintain current information.

SURVEY INSTRUMENTS

Data were collected through a national-level questionnaire with 45 short-answer questions that addressed six core components: policy, training, drug distribution and logistics, monitoring and evaluation, programming and opportunities for scale-up. (Questionnaire content is located in Appendix A. Responses by country are in Appendix B.) Development of the questionnaire was a collaborative effort between USAID and the MCHIP Maternal Health team; the questionnaire also underwent three extensive revisions. Country responses to this questionnaire are visually represented in color-coded conceptual maps (Appendix C) to indicate current national program progress in scaling up PPH-reduction and PE/E-management programs to reduce maternal mortality and morbidity. Four different colors were used to indicate: 1) MCHIP and/or USAID active programs, 2) active programs of other partners, 3) previously addressed, not currently active programs, and 4) government-only active programs (such as in India). Lighter shades of the specified colors were used to indicate partial coverage of a program component or a focus on a specific element of the program component (rather than the entire component). Key components of the conceptual maps include: global actions, national strategic choices, phased program implementation, and sustainability and institutionalization. All survey instruments were translated into French and Spanish using professional translation services. Back translation of responses into English was also performed.

DATA COLLECTION PROCEDURES

Data collection was coordinated by the MCHIP Maternal Health team at its Washington, D.C., headquarters. The questionnaire tools were not field-tested; however, data collection was conducted in two phases to account for feedback and revisions to documents after the first phase. The first round included 20 African countries. Detailed instructions were given (via e-mail) to USAID and MCHIP technical counterparts for conducting data collection. Each country was encouraged to hold a country

team meeting to gather input from key stakeholders, namely: maternal health program experts, ministries of health, collaborating nongovernmental organization (NGO) partners and USAID mission leadership. Support to each team was made available from MCHIP headquarters via e-mail and teleconferencing. Additional support was provided during in-depth, face-to-face meetings with representatives from the 20 countries that participated in the MCHIP-organized Africa Regional Meeting on *Interventions for Impact in Essential Obstetric and Newborn Care,* which was held in Addis Ababa, Ethiopia, from February 21–25, 2011.

Data collection instructions were modified based on feedback from phase one countries. Questionnaire instruments were not adjusted. Phase two regions included Latin America, Asia and Francophone Africa. Phase one countries received support from headquarters through e-mail and teleconference.

ANALYSIS AND DOCUMENTATION

Questionnaire responses were analyzed in English. Responses in French or Spanish from seven countries were translated into English by MCHIP translators, and entered into a Microsoft Excel spreadsheet. Conceptual maps were translated into English and maintained as PowerPoint slides.

Content analysis techniques were applied to questionnaire data by grouping responses according to five themes:

1. Expansion and scale-up of active management of the third stage of labor (AMTSL)
2. Education and training in AMTSL
3. Expansion and scale-up of PPH-reduction programs using misoprostol
4. Expansion and scale-up of use of magnesium sulfate (MgSO4)
5. Education and training in PE/E management principles

These five themes linked the components of national program scale-up that were assessed in the questionnaire: policy, training, drug distribution and logistics, monitoring and evaluation, and programming. Original data from the questionnaire and conceptual maps are housed on the internal MCHIP SharePoint site.

FINDINGS

These findings are a compilation of data collected from 31 countries in the regions of Africa, Asia and Latin America. The 21 African countries are: Angola, Democratic Republic of the Congo (DRC), Ethiopia, Equatorial Guinea (E. Guinea), Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe. Afghanistan, Bangladesh, India, Indonesia and Nepal are the five Asian countries. The five Latin American countries are Bolivia, Guatemala, Honduras, Nicaragua and Paraguay. Figures presented in this section compare three to four questions, grouped by one of five themes across all 31 countries. The five themes are:

1. Expansion and scale-up of AMTSL
2. Education and training in AMTSL
3. Expansion and scale-up of PPH-reduction programs using misoprostol
4. Expansion and scale-up of use of MgSO4
5. Education and training in PE/E management principles

Specific country responses to each question on the questionnaire, aggregated by the above-mentioned themes, are presented in Appendix B.

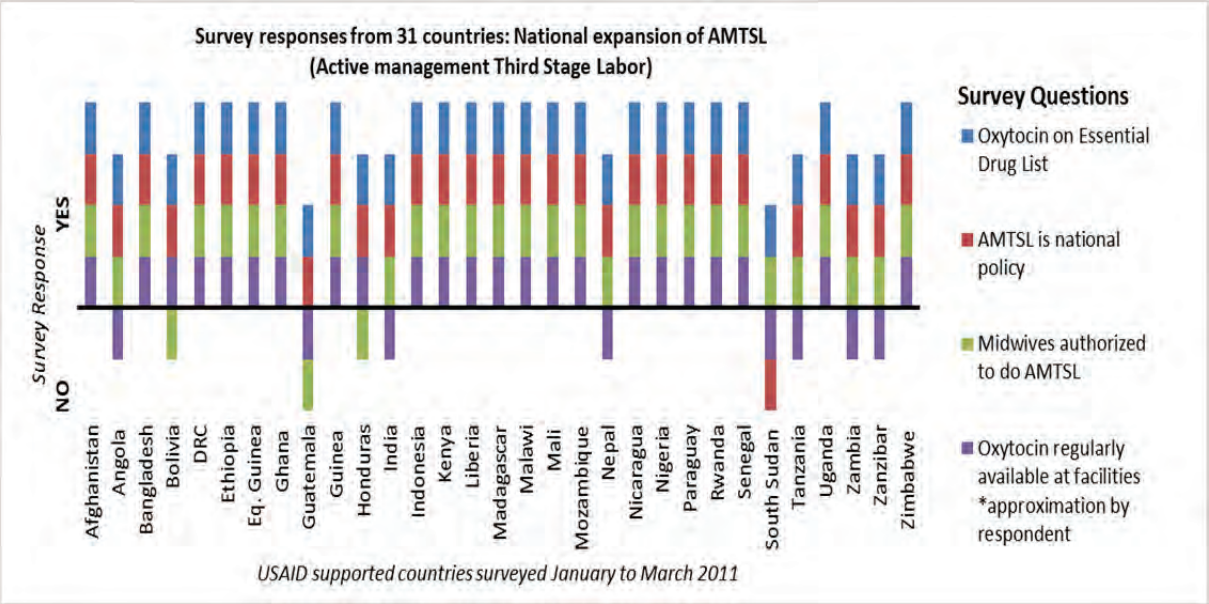
Conceptual maps developed by each country, coded to represent current state of progress in national scale-up of PPH and PE/E reduction and management programs, can be found in Appendix C. These conceptual maps were created for 27 countries in Africa, Asia and Latin America: Afghanistan, Angola, Bolivia, DRC, Ethiopia, E. Guinea, Ghana, Guinea, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Paraguay, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe.

Figure 2. Countries surveyed, by region

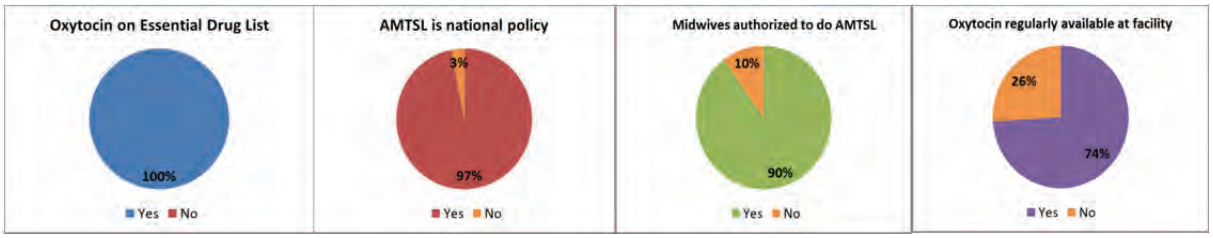
	Countries surveyed
AFRICA	Angola
	DRC
	Ethiopia
	Eq. Guinea
	Guinea
	Ghana
	Kenya
	Liberia
	Madagascar
	Malawi
	Mali
	Mozambique
	Nigeria
	Rwanda
	Senegal
	South Sudan
	Tanzania
	Uganda
	Zambia
	Zanzibar
	Zimbabwe
ASIA	Afghanistan
	Bangladesh
	India
	Indonesia
	Nepal
LATIN AMERICA	Bolivia
	Guatemala
	Honduras
	Nicaragua
	Paraguay

THEME 1: EXPANSION AND SCALE-UP OF AMTSL

Figure 3. Survey responses from 31 countries: National expansion of AMTSL



Aggregate responses by survey question



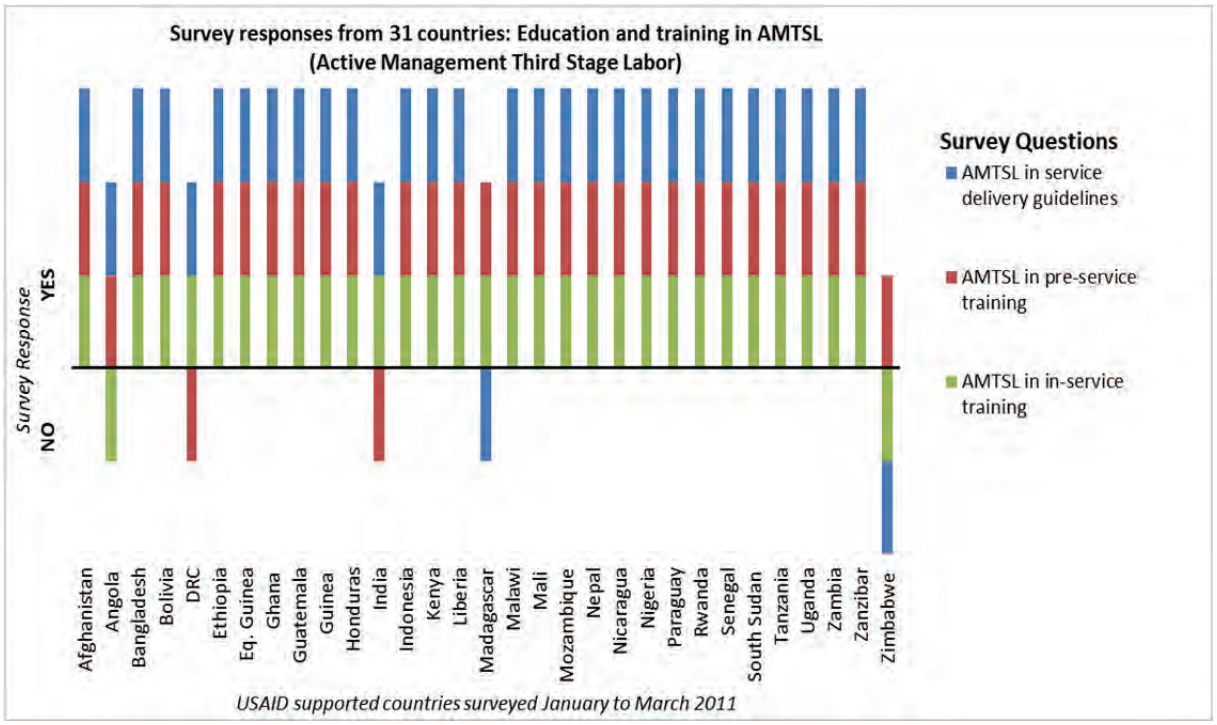
All 31 countries surveyed reported the presence of oxytocin on the Essential Drug List (EDL), and 97% of countries have incorporated AMTSL with national policy for PPH prevention. Although South Sudan does not have AMTSL approved as a national policy, it is included in the National Guidelines for Public Health Community Clinics and Hospitals and in other health policy documents. Midwife authority to perform AMTSL varied by region. One hundred percent of African and Asian countries surveyed stated that midwives are authorized to perform AMTSL, whereas only 40% of Latin America and the Caribbean (LAC) countries surveyed reported the same. Bolivia is one of three LAC countries that do not allow midwives to perform AMTSL—as midwifery is not yet a professional cadre in the country. Bolivia will, however, graduate its first group of midwives in 2012. Inconsistent availability of oxytocin in facilities that offer maternity services occurred in 26% of countries surveyed, while 74% reported oxytocin as regularly available. (This measurement was subjective according to respondents' best approximation.)

Theme 1: Expansion and Scale-Up of AMTSL

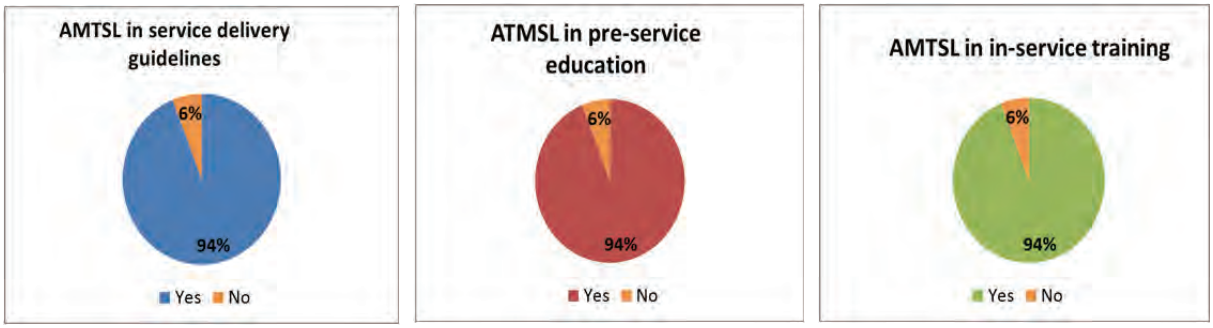
	Oxytocin on EDL		AMTSL Is National Policy		Midwives Authorized to Perform AMTSL		Oxytocin Available in Facility	
	YES	NO	YES	NO	YES	NO	YES	NO
Afghanistan	✓		✓		✓		✓	
Angola	✓		✓		✓			✓
Bangladesh	✓		✓		✓		✓	
Bolivia	✓		✓			✓	✓	
DRC	✓		✓		✓		✓	
Ethiopia	✓		✓		✓		✓	
E. Guinea	✓		✓		✓		✓	
Ghana	✓		✓		✓		✓	
Guatemala	✓		✓			✓		✓
Guinea	✓		✓		✓		✓	
Honduras	✓		✓			✓	✓	
India	✓		✓		✓			✓
Indonesia	✓		✓		✓		✓	
Kenya	✓		✓		✓		✓	
Liberia	✓		✓		✓		✓	
Madagascar	✓		✓		✓		✓	
Malawi	✓		✓		✓		✓	
Mali	✓		✓		✓		✓	
Mozambique	✓		✓		✓		✓	
Nepal	✓		✓		✓			✓
Nicaragua	✓		✓		✓		✓	
Nigeria	✓		✓		✓		✓	
Paraguay	✓		✓		✓		✓	
Rwanda	✓		✓		✓		✓	
Senegal	✓		✓		✓		✓	
South Sudan	✓			✓	✓			✓
Tanzania	✓		✓		✓			✓
Uganda	✓		✓		✓		✓	
Zambia	✓		✓		✓			✓
Zanzibar	✓		✓		✓			✓
Zimbabwe	✓		✓		✓		✓	

THEME 2: EDUCATION AND TRAINING IN AMTSL

Figure 4. Survey responses from 31 countries: Education and training in AMTSL



Aggregate responses by survey question



The majority (94%) of countries stated that AMTSL is currently included in education and training components through service delivery guidelines, pre-service education and in-service training for skilled birth attendants (SBAs). One hundred percent of LAC countries have AMTSL in all three training components. Zimbabwe does not currently have AMTSL in its service delivery guidelines, although the guidelines are under revision to include AMTSL. Zimbabwe does have partial in-service training in AMTSL but not for all cadres of SBAs. In India, the government is working with MCHIP to include AMTSL in pre-service education at schools for Auxiliary Nurse Midwives (ANMs). In DRC, training materials have been developed, and training has begun for teachers on AMTSL. However, AMTSL is not yet integrated with the pre-service education system in DRC. Angola and Madagascar did not provide additional information

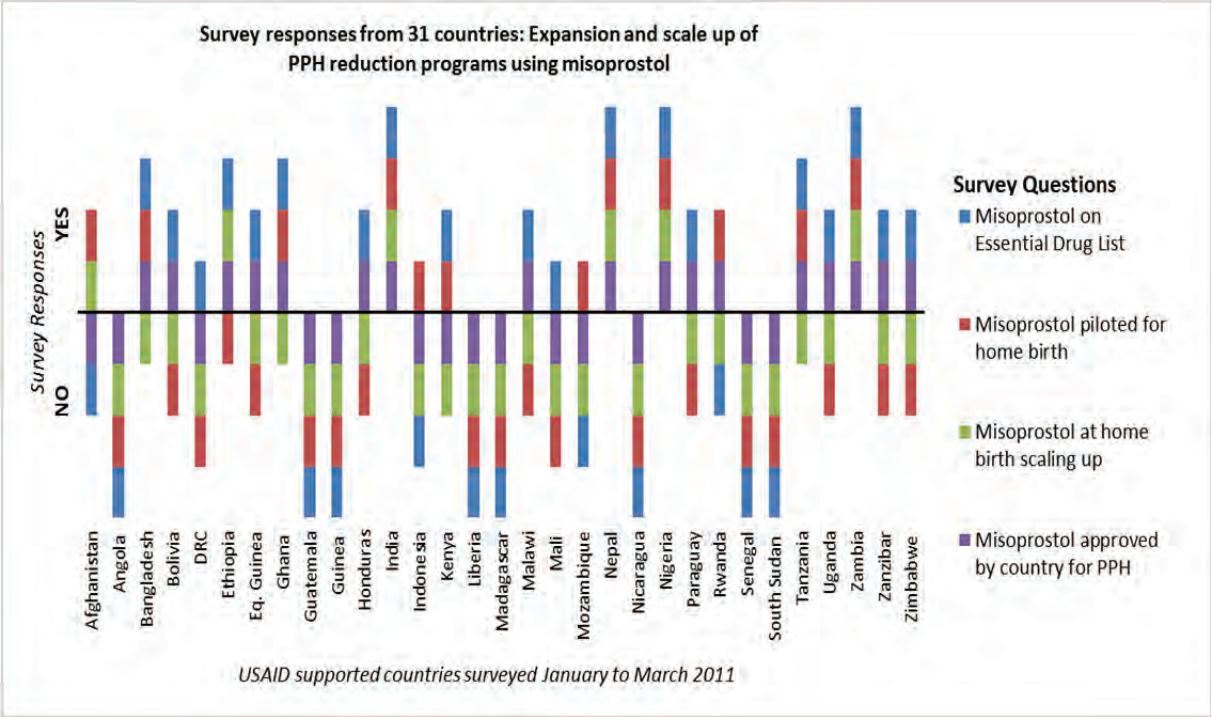
regarding AMTSL integration with education and training components, as it was not specifically requested in the question.

Theme 2: Education and Training in AMTSL

	AMTSL in Service Delivery Guidelines		ATMSL in Pre-service Education		AMTSL in In-service Training	
	YES	NO	YES	NO	YES	NO
Afghanistan	✓		✓		✓	
Angola	✓					✓
Bangladesh	✓		✓		✓	
Bolivia	✓		✓		✓	
DRC	✓			✓	✓	
Ethiopia	✓		✓		✓	
E. Guinea	✓		✓		✓	
Ghana	✓		✓		✓	
Guatemala	✓		✓		✓	
Guinea	✓		✓		✓	
Honduras	✓		✓		✓	
India	✓			✓	✓	
Indonesia	✓		✓		✓	
Kenya	✓		✓		✓	
Liberia	✓		✓		✓	
Madagascar		✓	✓		✓	
Malawi	✓		✓		✓	
Mali	✓		✓		✓	
Mozambique	✓		✓		✓	
Nepal	✓		✓		✓	
Nicaragua	✓		✓		✓	
Nigeria	✓		✓		✓	
Paraguay	✓		✓		✓	
Rwanda	✓		✓		✓	
Senegal	✓		✓		✓	
South Sudan	✓		✓		✓	
Tanzania	✓		✓		✓	
Uganda	✓		✓		✓	
Zambia	✓		✓		✓	
Zanzibar	✓		✓		✓	
Zimbabwe		✓	✓			✓

THEME 3: EXPANSION AND SCALE-UP OF PPH-REDUCTION PROGRAMS USING MISOPROSTOL

Figure 5. Survey responses from 31 countries: Expansion and scale-up of PPH-reduction programs using misoprostol



Aggregate responses by survey question

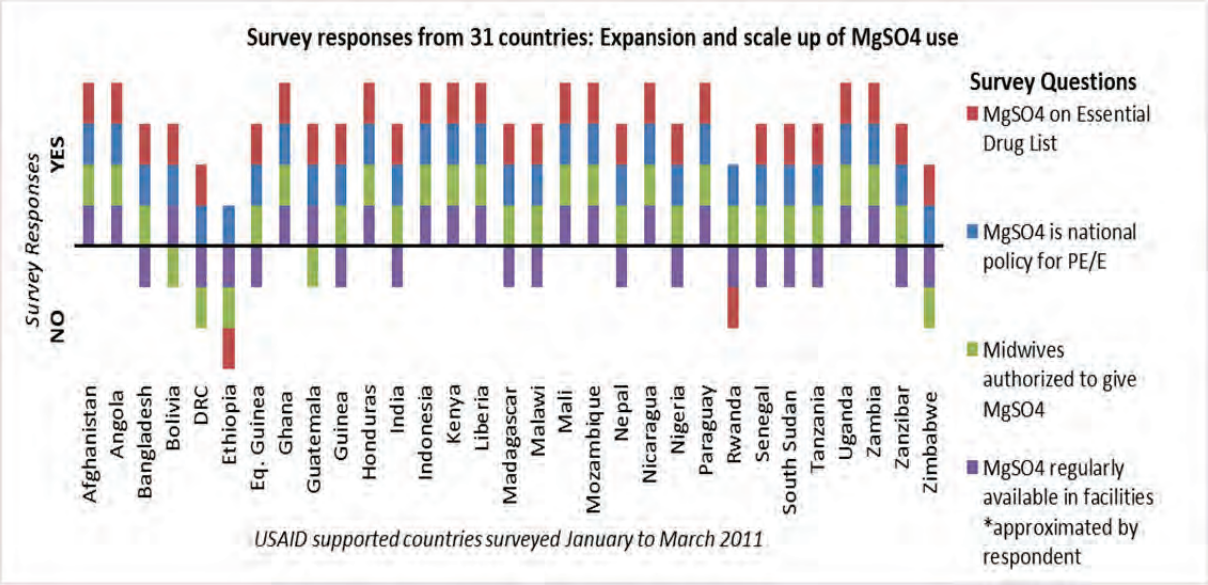
Existence of programs for the reduction of PPH using misoprostol varied by region. Misoprostol is on the EDL in most (61%) countries, although approved indications do not consistently include PPH prevention or treatment. Eight countries—Angola, Guatemala, Guinea, Liberia, Madagascar, Nicaragua, Senegal and South Sudan—answered "no" to all questions regarding use of misoprostol for PPH reduction. Conversely, all Asian countries surveyed have piloted misoprostol for PPH prevention at home births, and three of the five Asian countries (Afghanistan, India, Nepal) are scaling up these programs. Thirty-nine percent of countries surveyed are currently piloting or have piloted use of misoprostol for PPH prevention at home births in the past five years. Sixty-seven percent of countries piloting misoprostol have a national policy in place approving the drug for PPH prevention. Whereas, 75% of countries scaling up misoprostol in their PPH program have a national policy in place approving it for PPH prevention.

Theme 3: Expansion and Scale-Up of PPH-Reduction Programs Using Misoprostol

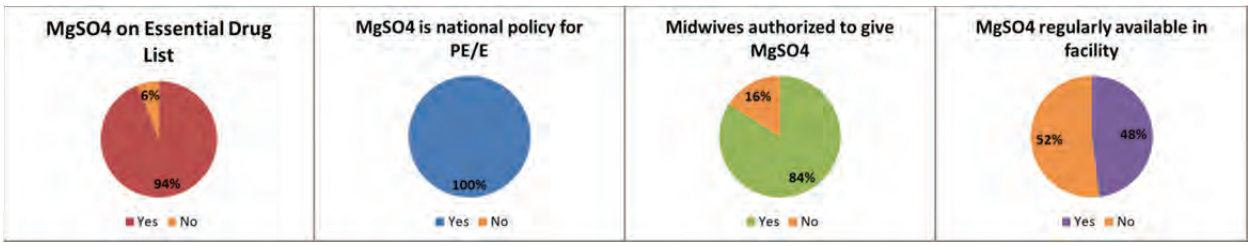
	Misoprostol on Essential Drug List		Misoprostol Piloted for Home Birth		Misoprostol at Home Birth Scaling Up		Misoprostol Approved by Country for PPH	
	YES	NO	YES	NO	YES	NO	YES	NO
Afghanistan		✓	✓		✓			✓
Angola		✓		✓		✓		✓
Bangladesh	✓		✓			✓	✓	
Bolivia	✓			✓		✓	✓	
DRC	✓			✓		✓		✓
Ethiopia	✓			✓	✓		✓	
E. Guinea	✓			✓		✓	✓	
Ghana	✓		✓			✓	✓	
Guatemala		✓		✓		✓		✓
Guinea		✓		✓		✓		✓
Honduras	✓			✓		✓	✓	
India	✓		✓		✓		✓	
Indonesia		✓	✓			✓		✓
Kenya	✓		✓			✓		✓
Liberia		✓		✓		✓		✓
Madagascar		✓		✓		✓		✓
Malawi	✓			✓		✓	✓	
Mali	✓			✓		✓		✓
Mozambique		✓	✓			✓		✓
Nepal	✓		✓		✓		✓	
Nicaragua		✓		✓		✓		✓
Nigeria	✓		✓		✓		✓	
Paraguay	✓			✓		✓	✓	
Rwanda		✓	✓			✓	✓	
Senegal		✓		✓		✓		✓
South Sudan		✓		✓		✓		✓
Tanzania	✓		✓			✓	✓	
Uganda	✓			✓		✓	✓	
Zambia	✓		✓		✓		✓	
Zanzibar	✓			✓		✓	✓	
Zimbabwe	✓			✓		✓	✓	

THEME 4: EXPANSION AND SCALE-UP OF USE OF MgSO4

Figure 6. Survey responses from 31 countries: Expansion and scale-up of MgSO4 use



Aggregate responses by survey question



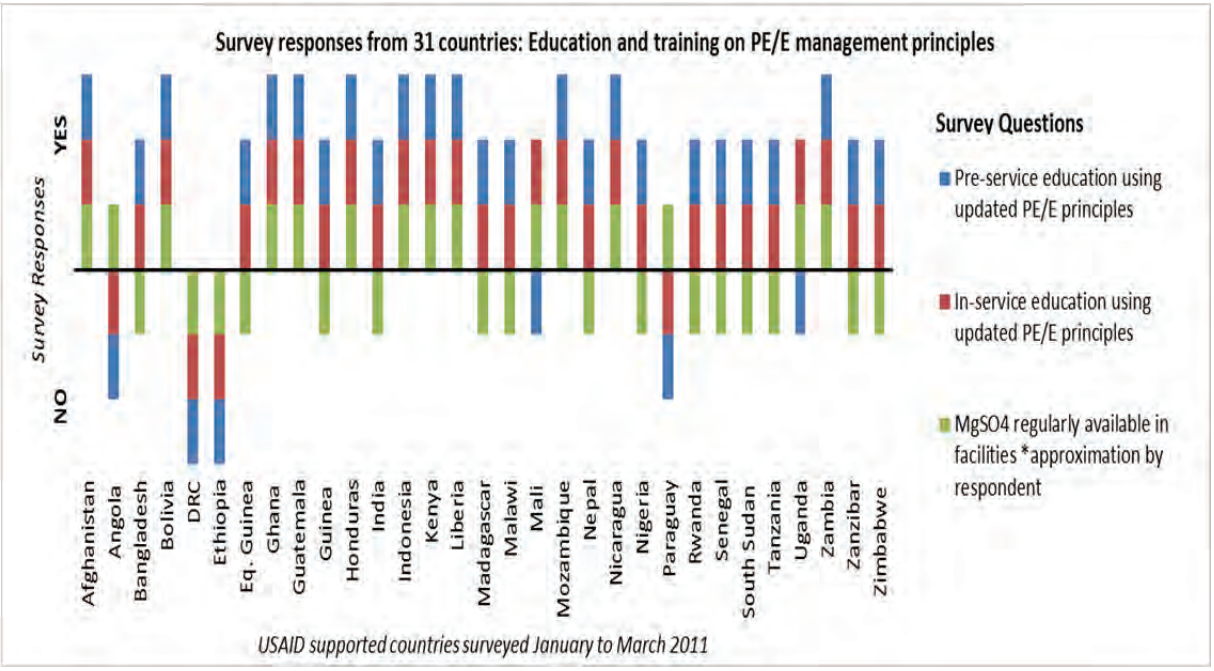
MgSO4 is the first-line anticonvulsant for severe PE/E in 100% of countries surveyed across all regions. Most countries—except Rwanda and Ethiopia—have MgSO4 on the EDL. Ethiopia reports that MgSO4 is under review and that there are plans to add it to the list soon. Bolivia, DRC, Ethiopia, Guatemala and Zimbabwe do not yet authorize midwives to diagnose severe PE/E or give the first dose of MgSO4 to prevent seizures. In Bolivia, there is not a professional midwifery cadre. Ethiopia plans to include midwife authorization in the scale-up training of MgSO4. In DRC, a prescription is required for MgSO4, but midwives are not authorized to write them. In Guatemala, MgSO4 can be given only by a midwife if no doctor is available, while in Zimbabwe, MgSO4 can be used only in hospitals. Although MgSO4 is endorsed by national policy in all countries surveyed, only 48% of countries reported MgSO4 as consistently available in facilities with maternity services, irrespective of region.

Theme 4: Expansion and Scale-Up of Use of MgSO4

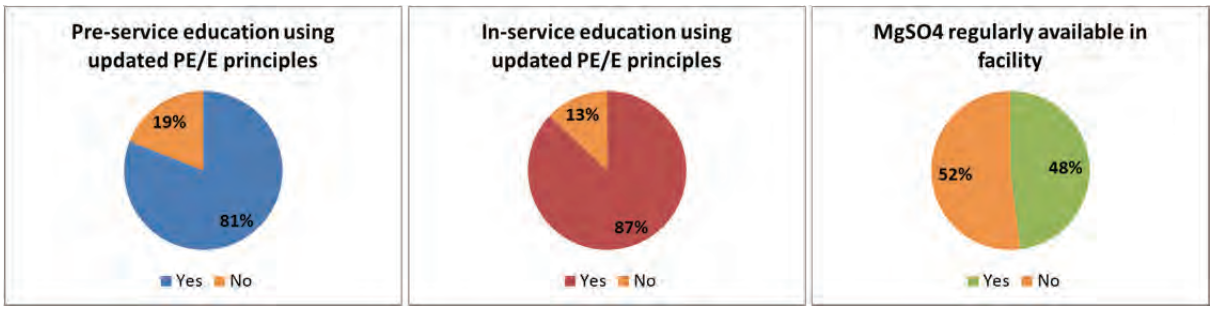
	MgSO4 Is National Policy for PE/E		MgSO4 on Essential Drug List		Midwives Authorized to Give MgSO4		MgSO4 Regularly Available in Facility	
	YES	NO	YES	NO	YES	NO	YES	NO
Afghanistan	✓		✓		✓		✓	
Angola	✓		✓		✓		✓	
Bangladesh	✓		✓		✓			✓
Bolivia	✓		✓			✓	✓	
DRC	✓		✓			✓		✓
Ethiopia	✓			✓		✓		✓
E. Guinea	✓		✓		✓			✓
Ghana	✓		✓		✓		✓	
Guatemala	✓		✓			✓	✓	
Guinea	✓		✓		✓			✓
Honduras	✓		✓		✓		✓	
India	✓		✓		✓			✓
Indonesia	✓		✓		✓		✓	
Kenya	✓		✓		✓		✓	
Liberia	✓		✓		✓		✓	
Madagascar	✓		✓		✓			✓
Malawi	✓		✓		✓			✓
Mali	✓		✓		✓		✓	
Mozambique	✓		✓		✓		✓	
Nepal	✓		✓		✓			✓
Nicaragua	✓		✓		✓		✓	
Nigeria	✓		✓		✓			✓
Paraguay	✓		✓		✓		✓	
Rwanda	✓			✓	✓			✓
Senegal	✓		✓		✓			✓
South Sudan	✓		✓		✓			✓
Tanzania	✓		✓		✓			✓
Uganda	✓		✓		✓		✓	
Zambia	✓		✓		✓		✓	
Zanzibar	✓		✓		✓			✓
Zimbabwe	✓		✓			✓		✓

THEME 5: EDUCATION AND TRAINING IN PE/E MANAGEMENT PRINCIPLES

Figure 7. Survey responses from 31 countries: Education and training in PE/E management principles



Aggregate responses by survey question



Most countries are teaching current PE/E principles in pre-service education and in-service training, including MgSO4 as the anticonvulsant of choice for women with severe PE/E. Angola, DRC, Ethiopia and Paraguay do not have updated PE/E principles in training and education programs. Ethiopia reportedly does not have a mechanism for national dissemination through pre-service education, as medical universities function autonomously regarding curricula. Ethiopia does, however, have an in-service PE/E training program. Despite MgSO4 endorsement in the education and training programs of 81% of surveyed countries, only 48% reported having it regularly available in facilities with maternity services.

Theme 5: Education and Training in PE/E Management Principles

	Pre-service Education Using Updated PE/E Principles		In-service Education Using Updated PE/E Principles		MgSO4 Regularly Available in Facility	
	YES	NO	YES	NO	YES	NO
Afghanistan	✓		✓		✓	
Angola		✓		✓	✓	
Bangladesh	✓		✓			✓
Bolivia	✓		✓		✓	
DRC		✓		✓		✓
Ethiopia		✓		✓		✓
E. Guinea	✓		✓			✓
Ghana	✓		✓		✓	
Guatemala	✓		✓		✓	
Guinea	✓		✓			✓
Honduras	✓		✓		✓	
India	✓		✓			✓
Indonesia	✓		✓		✓	
Kenya	✓		✓		✓	
Liberia	✓		✓		✓	
Madagascar	✓		✓			✓
Malawi	✓		✓			✓
Mali		✓	✓		✓	
Mozambique	✓		✓		✓	
Nepal	✓		✓			✓
Nicaragua	✓		✓		✓	
Nigeria	✓		✓			✓
Paraguay		✓		✓	✓	
Rwanda	✓		✓			✓
Senegal	✓		✓			✓
South Sudan	✓		✓			✓
Tanzania	✓		✓			✓
Uganda		✓	✓		✓	
Zambia	✓		✓		✓	
Zanzibar	✓		✓			✓
Zimbabwe	✓		✓			✓

CONCLUSION AND RECOMMENDATIONS

AMTSL is strongly represented in the policy, education and training components of national programs throughout the 31 countries surveyed, as indicated by questionnaire and visual pathway findings. Inconsistent availability of oxytocin was noted in facilities offering maternity services—an examination of causes for this unavailability will be crucial to addressing program needs. Potential factors to investigate are: oxytocin potency, cold chain availability, supplies for injection, adequate staffing at facilities, supervision and training needs. Community-based programs for the reduction of PPH using misoprostol are increasing, with multiple countries across Africa, Asia and Latin America initiating or expanding these programs. The analysis of the questionnaire demonstrated a clear need to support and expand these misoprostol programs given that the vast majority of countries have not yet achieved a national scale.

Across the 31 countries surveyed, programs for the prevention and management of PE/E are not as well-developed as PPH programs. Nonetheless, MgSO4 is recognized as the first-line drug for prophylaxis and treatment of eclamptic seizures across all regions, as shown by universal inclusion in national policies and broad inclusion in educational curricula. Program effectiveness is in question; when a minority of facilities has consistent availability of the drug, even fewer respondents report consistent use of the drug.

Findings from this survey indicate a disparity between nationally approved policies and education guidelines to reduce PPH and PE/E and actual services delivered. Multiple, creative approaches are needed—and are being implemented—to address this gap between policy and practice. Possible approaches include quality improvement initiatives, change management strategies and mHealth approaches—e.g., use of Standards-Based Management and Recognition (SBM-R) or improvement collaboratives, CAMBIO Interventions, and engaging clinicians through cellular and online networks, respectively. More emphasis must be placed on training and supervision to increase utilization of high-impact interventions, specifically use of AMTSL and MgSO4. This analysis also demonstrated the need to consider and address indirect utilization barriers for these high-impact interventions.

These data will be collected from national programs on an ongoing basis to continue documenting program progress and identifying opportunities to focus program attention. The survey instruments were formatted for use in other national programs and are available in English, French and Spanish.

Appendix A: Complete Questionnaire Content

Section I: Postpartum Hemorrhage (PPH)

1. Is AMTSL at every birth approved as national policy? *(YES/NO)*
2. Are the steps for correctly performing AMTSL incorporated with service delivery guidelines? *(YES/NO)*
3. Is misoprostol approved for prevention and/or treatment of PPH? *(YES/NO)*
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system? *(YES/NO)*
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system? *(YES/NO)*
6. Is pre-service education curricula updated to include AMTSL for all SBA cadres? *(YES/NO)*
7. If so, which cadres?
8. Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation? *(YES/NO)*
9. Is AMTSL included in in-service training curricula for all SBA cadres? *(YES/NO)*
10. Is distribution of misoprostol for PPH prevention during home births being piloted? *(YES/NO)*
11. Is distribution of misoprostol for PPH prevention during home births being scaled up? *(YES/NO)*
12. Is oxytocin on the Essential Drug List? *(YES/NO)*
13. Is misoprostol on the Essential Drug List? *(YES/NO)*
14. Is oxytocin regularly available at facilities that offer maternity services? *(YES/NO)*
15. Do stock-outs of oxytocin occur? *(YES/NO)*
16. If so, how frequently do stock-outs of oxytocin occur?
17. Is AMTSL included in the national HMIS? *(YES/NO)*
18. Where is AMTSL recorded? e.g., delivery logs, maternity chart, other registers.
19. What activities in PPH prevention and management are being undertaken by MOH? Briefly specify what is being done.
20. What activities in PPH prevention and management are being undertaken by United States government-sponsored programs? Briefly specify what is being done.
21. What activities in PPH prevention and management are being undertaken by other partners funded by other donors? Briefly specify what is being done.
22. What percentage of districts is covered by current national PPH programs?
23. What percentage of current SBAs are being reached by programmatic efforts of the current national PPH programs?
24. Please describe any potential opportunities that you see for program expansion or scale-up. e.g., champion exists who needs support to disseminate messages; national conference scheduled for next year and curriculum revision planned; MOH has policy in place and needs support for program roll-out.
25. What are the three most significant bottlenecks to scaling up PPH-reduction programs in your country? Briefly describe what is being done.
26. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.

Section II: Pre-eclampsia/Eclampsia (PE/E)

1. What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?
2. Is MgSO4 on the Essential Drug List for severe PE/E? *(YES/NO)*
3. What drugs are approved through national policy/service delivery guidelines for administration as first-line anti-hypertensives in severe PE/E?
4. What drugs are listed on the Essential Drug List, as anti-hypertensives in management of severe PE/E?
5. Are midwives authorized to diagnose severe PE/E and administer initial dose of MgSO4 at lowest level facility that they work at within the health system?
6. Have pre-service education curricula and teaching materials been updated to include current global management principles for PE/E for all SBA cadres? *(YES/NO)*
7. If so, which cadres?
8. Are current global management principles for PE/E included in in-service training courses for SBAs? *(YES/NO)*
9. Is MgSO4 regularly available at facilities that offer maternity services? *(YES/NO)*
10. Do stock-outs of MgSO4 occur? *(YES/NO)*
11. If so, how frequently do stock-outs of MgSO4 occur?
12. Is an indicator to monitor the quality of severe PE/E management included in the national HMIS? *(YES/NO)*
13. If so, what is this indicator and where is it recorded? e.g., delivery logs, maternity chart, other registers
14. What activities in PE/E prevention and management programming are being undertaken by the MOH? Please briefly specify what is being done.
15. What activities in PE/E prevention and management programming are being undertaken by United States government-supported implementing partners? Please briefly specify what is being done.
16. What activities in PE/E prevention and management programming are being undertaken by other partners funded by other donors? Please briefly specify what is being done.
17. What percentage of districts is covered by current PE/E programs?
18. What percentage of current SBAs are being reached by programmatic efforts of the current national PE/E programs?
19. Please describe any potential opportunities that you see for program introduction, expansion or scale-up, e.g., champion exists who needs support to disseminate messages; national conference scheduled for next year and curriculum revision planned; MOH has policy in place and needs support for program roll-out.
20. What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Please briefly describe what is being done.
21. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.

Appendix B: Analysis of PPH and PE/E, by Country

AFGHANISTAN

Is there an MCHIP presence in this country? *(YES/NO)*	NO
CONTACT PERSON (responsible for updates to this matrix)	Akmal Samsor, 0093-777 33 1512, asamsor@jhpiego.net
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO, it is not present in the EDL and we are advocating to include in the EDL.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, the midwifery students are assessed but not the doctors.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur? If so, how frequently?	YES, but rarely, so the patients buy oxytocin from the private pharmacies.
M&E	
15. Is AMTSL included in the national HMIS?	YES
16. Where is AMTSL recorded?	Maternity register and partograph

PROGRAMMING	
17. What activities in PPH prevention and management are being undertaken by MOH?	BBC activities on birth preparedness and complication readiness. Leading the piloting and scaling up of the community-based distribution of misoprostol.
18. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Supporting the community-based midwifery schools, from which more than 2,000 midwives have graduated in the last few years. Financially supporting the piloting and scale-up the community-based PPH prevention project with technical support from Jhpiego. Financially supporting the development of AMTSL e-learning module for the SBAs with technical support from Jhpiego. Financially supporting the in service EmONC training for SBAs.
19. Activities in PPH prevention/management undertaken by other partners?	UNICEF has financially supported: the EmONC needs assessment, renovating the EmONC training centers, developing a new EmONC LRP, and conducting training of trainers (ToT) for EmONC trainers with the technical support from Jhpiego.
20. % districts covered by national PPH programs?	90% of the districts but only 64% of the total population of the country. Distribution of misoprostol covers only 5–7% of the districts.
21. % SBAs reached by national PPH programs?	90% of the SBAs
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
22. Opportunities for program expansion/scale-up.	National reproductive health (RH) policy revised and misoprostol included as an uterotonic drug to be used for prevention of PPH. MOH new strategy to support the community-based distribution of misoprostol. Other partners like UNICEF and Gynuity are planning to started community-based distribution of misoprostol for the prevention of PPH.
23. Significant bottlenecks to scaling up PPH reduction programs in your country?	Policy gap regarding the use of misoprostol as an uterotonic agent. Misoprostol not in the EDL. Funds unavailability for the scaling up of the project more districts.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, all SBAs
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur? If so, how frequently?	NO

M&E	
10. Indicator of severe PE/E management in HMIS?	NO
11. What is indicator and where is it recorded?	
PROGRAMMING	
12. Activities in PE/E prevention and management undertaken by the MOH?	BCC activities for prevention of PE/E. EmONC training for management of PE/E.
13. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	BCC material development PE/E. Financially supporting EmONC training.
14. Activities in PE/E prevention and management undertaken by other partners?	BCC activities and EmONC activities.
15. % of districts covered by PE/E programs?	90% of the districts, but only 64% of the population of the country population is covered.
16. % of SBAs reached by national PE/E programs?	90%
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
17. Opportunities for program introduction, expansion, or scale-up.	Piloting community-based prevention of PE/E through calcium supplementation and proteinurea testing.
18. Significant bottlenecks to scaling up PE/E management programs in your country?	

ANGOLA

Is there an MCHIP presence in this country? *(YES/NO)*	NO
CONTACT PERSON (responsible for updates to this matrix)	Jhony Juarez jjuarez@jhpiego.net Phone 244-926079665
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, but is just used in some facilities.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, but the health providers doesn't use that.
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO, but same hospitals are using.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, but many health centers with room delivery have not conditions to do that. Some SBAs at health center are trained to do manual removal of the placenta (MRP), but conditions are not appropriate to do so; therefore it is only recommended to be done at the hospital level.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, it's in the curriculum but not actually being done because it needs to be developed further. Nurses, nurse-midwives, doctors
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO
8. Is AMTSL included in in-service training curricula for all SBA cadres?	NO
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	NO
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Depends, because before oxytocin was put on the EDL, each clinic/hospital had to procure and stock their own oxytocin, so there were many more stock-outs. It has recently been added to EDL, which will likely reduce stock-outs because it will be supplied.
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	Antenatal and delivery record

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Health provider training Equip health facilities
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Clinical guidelines Health providers' training
20. Activities in PPH prevention/management undertaken by other partners?	We do not have this information.
21. % districts covered by national PPH programs?	The country has no specific program for PPH.
22. % SBAs reached by national PPH programs?	
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	MCHIP is not working in Angola currently. However, I think we have a high opportunity to begin. The country needs a program like this.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	The country has no specific program for PPH.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	Angola has few medical doctors. The majority is technical nurses who receive 1–2 years training at nursing school. The midwives also are few. In health centers there is MgSO4, but the nurses have fear to use that. Just in hospitals MgSO4 is used.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	NO
7. Global management principles for PE/E in in-service training courses for SBAs?	NO
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	NO, because it is rarely used due to fear of MgSO4.
10. Frequency of MgSO4 stock-outs?	
M&E	
11. Indicator of severe PE/E management in HMIS?	Not currently, but is in discussion for inclusion.
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Training providers to take BP and to teach family and the woman danger signs (this is with a volunteer CHW).

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Clinical guidelines Health provider training
15. Activities in PE/E prevention and management undertaken by other partners?	Nothing
16. % of districts covered by PE/E programs?	We have not this information.
17. % of SBAs reached by national PE/E programs?	We have not this information.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	MCHIP is not working in Angola currently. However, I think we have a high opportunity to begin. The country needs a program like this: 1. Recent interest for MH advocacy to decrease MMR. 2. In 2010, the Vice President of Angola started municipal health committee with the main issue being maternal mortality.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	NO program as of yet.

BANGLADESH

Is there an MCHIP presence in this country? *(YES/NO)*	YES, through MaMoni and MCHIP.
CONTACT PERSON (responsible for updates to this matrix)	Imteaz Mannan +8801747905109 Imteaz@hotmail.com
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, all skilled attendants approved to use AMTSL.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, included in C-SBA, nursing, undergraduate and postgraduate (Gyn) doctor's curriculum, also in (the newly formulated) midwifery curriculum.
3. Is misoprostol approved for prevention and/or treatment of PPH?	Misoprostol is approved for PPH prevention (but not as treatment) by National Drug Authority since 2008. It is in the doctor's curriculum, and focuses on facility-based use. In limited projects: EngenderHealth, BRAC, MaMoni, ICDDR,B and Pathfinder have approval to distribute misoprostol at community level. The national approval for community-based distribution is not yet completed. The new operational plan (2011–2016) of MOHFW proposes misoprostol distribution through outreach services (Community Clinic and Satellite Clinic).
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	NO 1. Only gyn doctors trained on EmOC and anesthesia are authorized to perform MRP. 2. Bangladesh is in the process of developing a proper midwife cadre.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, C-SBAs, doctors and nurses are authorized and trained on AMTSL with oxytocin.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, for C-SBAs, nurses and doctors, also for upcoming midwives.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES, a national scale-up strategy has been developed, but not yet approved.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES, but not indicated for PPH, only for peptic ulcer disease.
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES, regularly
15. How frequently do stock-outs of oxytocin occur?	Quarterly, procurement may be delayed.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	In case files/records of the patient (in project area in delivery register).

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Included in the draft Operational Plan of the next sector program (2011–2016), a scale-up plan has been developed but not yet approved.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Mayer Hashi/EngenderHealth and MaMoni/MCHIP are two USAID projects distributing misoprostol at community level.
20. Activities in PPH prevention/management undertaken by other partners?	BRAC (community), Pathfinder International (community), ICDDR,B (community), UNICEF (through OGSB/MOHFW, facility only), POPPHI/OGSB/MOHFW (facility).
21. % districts covered by national PPH programs?	15 districts of 64 currently covered in the community program, another six planned. The OGSB/MOHFW/UNICEF training being rolled out to cover providers nationally from all health facilities, but not at community. Several initiatives may not cover the entire district, and instead work in several sub-districts.
22. % SBAs reached by national PPH programs?	1. Misoprostol distributed through outreach workers in aforementioned areas. 2. National PPH program only covers EmOC programs and not focused on community management. 3. Estimated 25% are oriented only, but not formally trained 4. Regular supervision and monitoring is lacking.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Director, Primary Health Care of DGHS/MOHFW is a champion. OGSB – Ob/Gyn Society and BPS (Bangladesh Perinatal Society) also champions. YES, champion exists who needs support to disseminate messages. National conference scheduled for next year; will have a practice session for PG trainees in O&G have. YES, MOH has policy in place and needs support for program roll-out and curriculum revision is not required. Its updated.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	- Community-based distribution not endorsed nationally yet. 15–20% of outreach worker positions are vacant, making community-based distribution difficult. - Essential drugs does not indicate misoprostol for use in PPH. - Supervision and monitoring needed, need to be included in MIS.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES, for referral center (Upazilla Health Complex).
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *NO* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *NO* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	The C-SBAs and nurses are authorized to diagnose PE/E, provide loading does and refer to hospital.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	C-SBA program, pre-service medical and nursing curricula includes the updated guidelines.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES

LOGISTICS	
8. MgSO4 regularly available at facilities?	Upazilla Health Complex and district level hospitals have MgSO4.
9. Do stock-outs of MgS04 occur?	YES, very common.
10. Frequency of MgSO4 stock-outs?	Procurement is done quarterly, and stock-outs occur regularly then.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	ANC check-up through satellite clinics identifies mothers-at-risk and refers them to Upazilla/subdistrict level. CSBA and C-EmOC services provide prevention and management.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	EngenderHealth and MaMoni are collaborating with OGSB, BSSMMU (tertiary hospital), DGHS and other stakeholders to define the intervention parameters.
15. Activities in PE/E prevention and management undertaken by other partners?	Through UNICEF/OGSB/MOHFW partnership limited number of health service providers at facility level are being trained (in conjunction with PPH training).
16. % of districts covered by PE/E programs?	At health facility level, all facilities nationally are targeted by OGSB. However, there are NO community-based programs at this point.
17. % of SBAs reached by national PE/E programs?	EmOC and C-SBAs are two programs addressing eclampsia management. They cover roughly 25% of facilities and 30% of communities (but together only 23% of all deliveries).
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	3 professional bodies: OGSB, BPS and BPA are champions Director-PHC of DGHS/MOHFW, Director-Hospital of DGHS/MOHFW, Director, MCH-DGFP/MOHFW, PM-IST of DGHS/MOHFW are also champions.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	- Quality of ANC at all levels particularly satellite clinics (detection), 50% mothers do not receive any ANC. - Low referral compliance. - Shortage of SBAs, high percentage of home deliveries.

BOLIVIA

Is there an MCHIP presence in this country? ***(YES/NO)***	YES, since October 2009. In coordination with the MOH and in accordance with the SAFCI policy (family, community and intercultural health). Strengthening the network of integrated services. Developing processes for quality of care and health worker training in maternal health, COEM (Emergency and Obstetric Care), training and family planning.
CONTACT PERSON (responsible for updates to this matrix)	Dra. Jackeline Reyes M., jreyes@jhpiego.net, 591-77210980
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, the standards exist and have been developed.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, it's found in the National Health Standards of Healthcare for Women and Newborns (page 169). In fact, we help implement this standard in the health facilities of the selected network of 4 departments (Beni, Chuquisaca, Santa Cruz y Tarija).
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, there is a MOH standard #142 called the standard and clinical protocol regarding the use of misoprostol in obstetrics and gynecology with "Ministry resolution 205." The MOH has started implementing this standard in the capital cities of Santa Cruz, Potosi, Tarjia, and Chuquisaca.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	There is NO health care professional profile of midwives in Bolivia. The UNFPA is helping with this and as soon as 2012 there will be the first cadre of this professional.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	The qualified provider of obstetric care is authorized at all levels of the health system.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, for nursing and medical internists and residents.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO, although the state universities are working on competency guidelines based on this standard (AMTSL standard).
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO, however home births are attended by SBAs. Only 4% of births were attended by traditional birth attendants (not formally trained in midwifery) in the ENDSA 2008 study.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES, since April 7, 2009 by "RM 0205" and "0426" approves its utilization.
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO
15. How frequently do stock-outs of oxytocin occur?	The biggest problem is related to the cold chain, depending on the manufacturer.
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	In the Basic Perinatal Clinical History (HCPB)

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	The Bolivian government has clear policies increasing postpartum services and those of "RN." In this regard, a "Bono Juana Azurduy" has been developed as a mechanism for transfer conditions. On the other hand there is a "SUMI" (Universal Maternal-Infant insurance), where women can receive free care for pregnancy, birth, postpartum and in cases when they present with obstetric complications such as hemorrhage. *The Juana Azurduy Incentive is a government incentive created to encourage women to attend antenatal care in each trimester of pregnancy, the birth, postpartum and newborn care until the child is 2 years old by giving the woman a certain amount of money for each trimester of pregnancy and for well-baby visits until the child is 2 years old to improve the health seeking indicators especially for skilled attendance at birth in facilities.*
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	All the organizations that receive USAID funding support the implementation of standards, protocols and policies of the MOH in their different fields of intervention, level of management in the review, editing, publication and dissemination of standards at the request of the MOH officials and the level of health facilities and the update of providers according to the national protocols and standards, scientific evidence and provision of basic equipment. This activity takes place in the geographical areas that is specific to an agency who then coordinates with SEDES (Health Service Department) and the MOH.
20. Activities in PPH prevention/management undertaken by other partners?	All the programs by other agencies and NGOs are in accordance with the policies of the MOH and help implement and disseminate the policies according to the conventions they have with the country and the area of intervention.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	There is NO such registry. Supposedly 100% of providers should use the standards, however in the majority of services the national guidelines are not followed because there is a lack of monitoring and evaluation of these services.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	The SBM-R method could achieve a high percentage of this goal. In addition, you could expand community work so that women recognize danger signs and make an appropriately timed decision to seek help. (Delayed access to care) is the primary cause of (maternal) death in Bolivia. One could also do a conference to present the results of applying the SBM-R methodology thus demonstrating how it has improved indicators and provider competency.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Scale up AMTSL to 100% of births attended by SBA under the monitoring of standards and the in-service training of providers. The construction of Centers for Skills Development.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	Although midwives do not exist in Bolivia, the first class will graduate in 2012.

TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, in the 3 levels of care, but although they are within our standards they don't meet our standards because the professionals in the 3rd level of care have different schools and make their treatment (decisions) based on that.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	NO, because there is a program through the SAMI/SIAL (SALMI=Distribution system of drugs and supplies and SIAL=Information system for the distribution (system).
10. Frequency of MgSO4 stock-outs?	In general there are not stock-outs because the programs are managed by SALMI/SIAL.
M&E	
11. Indicator of severe PE/E management in HMIS?	YES, it's in the SNIS (National Health Information System) but it does not give the quality of management. It is also in the HCPB (same indicator as in SNIS).
12. What is indicator and where is it recorded?	It's documented in the weekly epidemiology report. It reports the number of cases in each health care center. Other indicators are found in the variables of the HCPB.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	The antenatal care that is part of SUMI and free throughout the entire country provides medicine and supplies. The "Bono Juana Azurduy"—conditional transfers—encourages women to receive at least 4 ANC visits during pregnancy.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	All the organizations that receive USAID funding support the implementation of standards, protocols and policies of the MOH in their different fields of intervention, level of management in the review, editing, publication and dissemination of standards at the request of the MOH officials and the level of health facilities and the update of providers according to the national protocols and standards, scientific evidence and provision of basic equipment. This activity takes place in the geographical areas that is specific to an agency who then coordinates with SEDES (Health Service Department) and the MOH.
15. Activities in PE/E prevention and management undertaken by other partners?	All the programs by other agencies and NGOs are in accordance with the policies of the MOH and help implement and disseminate the policies according to the conventions they have with the country and the area of intervention.
16. % of districts covered by PE/E programs?	100%. There are some departments where the primary complication is eclampsia, for example Oruro.
17. % of SBAs reached by national PE/E programs?	100% of providers should promote the national programs of the MOH.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Helping the MOH with standards-based monitoring in 100% of the primary, secondary and tertiary health care services, with the supply of minor equipment; ToT.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Measuring the standards. Apparently it is the way to monitor and apply the standards.

DEMOCRATIC REPUBLIC OF THE CONGO

Is there an MCHIP presence in this country? ***(YES/NO)***	YES
CONTACT PERSON (responsible for updates to this matrix)	Lucie Zikudieka, 243818138835, e-mail: lucie_zikudiaka@yahoo.fr Dr. Kalume Tutu, tel:234999913011, kalumetutu@yahoo.fr
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy	YES, the standards and were reviewed, and the GAPTA was integrated with the national policy.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, see above.
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO, oxytocin was retained as a first-line uterotonic and metergine as second-line uterotonic.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	NO, integration with basic training program is not being applied as yet even though they have received the training materials and ISTM training division officers and teachers have been briefed.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, for the 57 USAID zones/4 UNICEF zones/certain IRC zones.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO, misoprostol is on the Essential Drug List for treatment of gastric ulcers but not as a uterotonic. Use of misoprostol is not authorized for prevention of PPH in home-based deliveries.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	Occasionally
15. How frequently do stock-outs of oxytocin occur?	They are infrequent.
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	It is found in the partograph, in delivery and postpartum registers and in data collection forms.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	GAPTA, reduction of cases of episiotomies, advice on preparation for delivery using the delivery plan, advising new mothers to health facilities where there are qualified health professionals, follow up with the partograph.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	In zones funded by USAID.
20. Activities in PPH prevention/management undertaken by other partners?	The Ministry has accepted the strategy and has integrated it with the standards; they have also reviewed data collection tools at the national level but scale-up continues to pose some challenges.
21. % districts covered by national PPH programs?	Around 19% (100/515) zones across the country.
22. % SBAs reached by national PPH programs?	Exact data not available; but believe approximately 10% of births in country are by birth attendants.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Create a pool of champions with a bigger number of partners; organize a conference on the benefits of the program.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Not all partners have integrated the program with their budgets. The country is vast and there is the problem of accessibility. Requirement that training be based on use of models to acquire competency, with models being very expensive.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES, if MgSO4 not available*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	NO, a prescription is required.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	NO
7. Global management principles for PE/E in in-service training courses for SBAs?	NO
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgS04 occur?	YES, MgSO4 is not available in the majority of health facilities in the country.
10. Frequency of mgso4 stock-outs?	YES
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	In the delivery register.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Not a lot; revision of standards have just been adopted.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Training materials have been reviewed.

15. Activities in PE/E prevention and management undertaken by other partners?	Do not know.
16. % of districts covered by PE/E programs?	Data not available.
17. % of SBAs reached by national PE/E programs?	Data not available.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Standards have been reviewed, as well as essential medicines list and training materials. The hope is that with the new bilateral, there will be opportunities for scale-up and dissemination of information about the program, with the help of champions.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	515 zones to cover. Lack of funds. Lack of tracers for medicines.

EQUATORIAL GUINEA

Is there an MCHIP presence in this country? ***(YES/NO)***	There is NO MCHIP presence in this country, but there is a maternal and neonatal health program of Jhpiego that is funded by Petrol company EG LNG, the Ministry of MINAS, and the Ministry of Sanitation and Social Welfare (MINSABS).
CONTACT PERSON (responsible for updates to this matrix)	Pastora Ndong Mikue, Regional Coordinator of Sexual and Reproductive Health, ndongmi@yahoo.es, 00240-222-27-8196
SECTION 1: POSTPARTUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, except the traditional birth attendants.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, in the University School of Sanitation (EUSA).
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES, especially after the site evaluations by Anne Davenport (Jhpiego) February 2011.
15. How frequently do stock-outs of oxytocin occur?	NO, it doesn't run out (see answer 14).
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	It's not documented in any register.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Give health talks at the focused antenatal visits.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Jhpiego is the only NGO working in this country. USAID is not here. Jhpiego just started here in 2011.
20. Activities in PPH prevention/management undertaken by other partners?	The Spanish NGOs work in training and buying materials.
21. % districts covered by national PPH programs?	Do not know
22. % SBAs reached by national PPH programs?	Do not know
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	1. Ongoing training of providers who attend births. 2. A conference for all those responsible from MINSABS and all the hospitals.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Training of staff and unavailability of materials like oxytocin and syringes.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
20. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *DON'T KNOW*
21. Is MgSO4 on the EDL for severe PE/E?	YES
22. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine *YES*
23. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine *YES* Methyldopa *YES if patient is ambulatory*
24. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
25. PSE curricula include global management principles for PE/E for all SBA cadres?	Medical faculty and licensed nurses of the University School of Sanitation.
26. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
27. MgSO4 regularly available at facilities?	NO
28. Do stock-outs of MgS04 occur?	YES
29. Frequency of MgSO4 stock-outs?	NO, it's not available in the hospitals.
M&E	
30. Indicator of severe PE/E management in HMIS?	Not in home births.
31. What is indicator and where is it recorded?	NO
PROGRAMMING	
32. Activities in PE/E prevention and management undertaken by the MOH?	Prenatal care in the health centers of the country including education talks.
33. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Training of personnel who are active in the ministry and maternity (centers).
34. Activities in PE/E prevention and management undertaken by other partners?	Nothing
35. % of districts covered by PE/E programs?	Do not know.
36. % of SBAs reached by national PE/E programs?	Do not know.

OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
37. Opportunities for program introduction, expansion, or scale-up.	A conference in sexual and reproductive health and education training.
38. Significant bottlenecks to scaling up PE/E management programs in your country?	1. Focused prenatal visits. 2. Managing pregnant women. 3. Education talks on the stages of labor.

ETHIOPIA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Alemnesh Tekleberhan, MNCH Team Leader, MCHIP/Jhpiego Ethiopia +251 1911156263, atekleberhan@jhpiego.net
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, national PPH prevention and treatment guidelines in place. As per the guideline, oxytocin is the drug of choice for AMTSL at the facility level.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, misoprostol is included in the Essential Drug List for PPH prevention. It is approved at the community level with community health workers (CHW).
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	Not clearly defined in their job description.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	AMTSL has been integrated in all pre-service training institutions including nursing midwifery and medical faculties.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	Varies across regions and schools. Competency-based education is scarce across the country. Some midwifery schools do assess for competency.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, AMTSL is also included in in-service BEmONC training course.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	Misoprostol is also being distributed to health extension workers (HEWs) who are frontline health workers at the community level. It is also included in their in service training of clean delivery course. HEWs are expected to provide home delivery as well as health post level delivery service.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES, for HEW. They are expected to deliver women at health posts as well as at home, this is at full scale. However TBAs or lay person at home birth do not receive misoprostol for PPH prevention, and at this stage it is not scaled up.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES, available in more than 90% of facilities as per MCHIP quality of care assessment conducted in 19 hospitals throughout all regions in 2009 or 2010.
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Hard to know.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Patient held card.

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Ensuring in-service training integrates PPH prevention and management; policy development as described earlier.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	MCHIP—in-service BEmONC training; under ACCESS training of HEW and clean and safe delivery. Essentially there does not seem to be a specific focus, rather ensuring its integration into ongoing in-service training.
20. Activities in PPH prevention/management undertaken by other partners?	Essentially there does not seem to be a specific focus, rather ensuring its integration with ongoing in-service training. Population Council/VSI: community-based distribution of misoprostol and training. UNICEF, WHO, World Bank UNFPA: AMTSL.
21. % districts covered by national PPH programs?	Depends what you mean by PPH programs – specific programs to address PPH prevention/management or ensuring it is integrated?
22. % SBAs reached by national PPH programs?	As above, but would hazard a guess and say around 15% to date.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	MOH needs support to ensure AMTSL recorded at facility level in HMIS.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Do not think there are any; issue is making sure all implementers follow the policy.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES as second-line*
2. Is MgSO4 on the EDL for severe PE/E?	Soon to be added
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO it is not in the list of the protocol* Hydralazine *YES first-line drug of choice for acute treatment* Nifedipine *(YES/NO) in the absence of hydralazine it is recommended* Methyldopa *(YES/NO) drug of choice for maintenance dose*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	Not clearly articulated yet in their scope of practice; but it is planned to include it in scale-up of MgSO4 training.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	Not sure as each university are autonomous do develop and use their own curriculum and the program is very new.
7. Global management principles for PE/E in in-service training courses for SBAs?	Program just started—for physicians; will then be rolled out for mid-level providers.
LOGISTICS	
8. MgSO4 regularly available at facilities?	Only at hospitals and only very recently.
9. Do stock-outs of MgSO4 occur?	Not yet, but drug has only in last three months been made available in country.
10. Frequency of MgSO4 stock-outs?	
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	NO

PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	UNICEF has funded Ob/Gyn Association to train doctors on MgSO4; Emory University initiated pilot MgSO4 project in one hospital. Procurement and distribution of MgSO4.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Essentially there does not seem to be a specific focus, rather ensuring its integration with ongoing in-service training.
15. Activities in PE/E prevention and management undertaken by other partners?	See #14.
16. % of districts covered by PE/E programs?	NO idea because the new program is just being rolled out now.
17. % of SBAs reached by national PE/E programs?	Would make a guess and say around 20%—focus is on hospitals.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Ensuring roll out of use in MgSO4 is integrated with PSE and in-service training, rather than a stand-alone training.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Ensuring sufficient supplies of MgSO4 for all appropriate facility levels. Availability of calcium gluconate. The latter is not yet available.

GHANA

Is there an MCHIP presence in this country? ***(YES/NO)***	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Gloria Quansah-Asare, *Director Family Health Division, Ghana Health Services*, gloasare1@yahoo.com, +233 244 281 732
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES • Pilot projects by Millennium Villages Project and Ventures Strategies Innovation. • Four districts in four different regions.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Infrequent in remote and rural areas.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Partograph
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	In-service training for SBAs, job aids, supervision.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	In-service training for SBAs, on-job training, creating job aids, supervision.
20. Activities in PPH prevention/management undertaken by other partners?	PATH/Oxytocin Initiative (Bill and Melinda Gates Foundation). Oxytocin in Uniject for home deliveries by CHOs. • Pilot project by PATH • More than 1,200 home deliveries targeted in four districts
21. % districts covered by national PPH programs?	National coverage.
22. % SBAs reached by national PPH programs?	National coverage.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	41% of deliveries without a SBA—scaling up misoprostol at household level would assist in preventing PPH in these deliveries. • Maintain quality implementation of AMTSL at national level. • Strengthen supportive supervision at facility level. • Strengthen logistics and supply. • Include indicators in District Health Information Management System (HIMS). • Operations research on quality of implementation and coverage.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Sufficient funds, supply chain and logistics management, supervision/change in attitudes and beliefs of service providers.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazapam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine *YES* Nifedipine *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine *YES* Nifedipine *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, midwives.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	Infrequently
10. Frequency of MgSO4 stock-outs?	Infrequently
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	Client folder/treatment sheet, labor ward register.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Training (pre-service, in-service and on-job), treatment protocols, job aids, supervision.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Training (pre-service, in-service and on-job), treatment protocols, job aids, supervision.

15. Activities in PE/E prevention and management undertaken by other partners?	Unknown
16. % of districts covered by PE/E programs?	National
17. % of SBAs reached by national PE/E programs?	National
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	• Maintain quality implementation at national level. • Strengthen supportive supervision at facility level. • Strengthen logistics and supply of MgSO4. • Include indicators in District HIMS • Operations research on quality of implementation and coverage.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Maintenance of practice when cases of PE/E are rare.

GUATEMALA

Is there an MCHIP presence in this country? ***(YES/NO)***	YES, although MCHIP is only working in a small area of technical assistance introducing oxytocin in Uniject as part of PPH prevention in Guatemala.
CONTACT PERSON (responsible for updates to this matrix)	Dr. Carlos Morales, Asesor Técnico del Ministerio de Salud/Programa de Salud Sexual y Reproductiva, E-mail: caremorales@hotmail.com Ph: +502-5414-8088
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, although it's not in the standard; midwives do it because there is so much work.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	NO, this (MRP) is only done by doctors, CAIMIS (Integrated Maternal Infant Health Centers) and hospitals. It's not done in the CAPS unless it's an emergency. This is not in the standard.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, it's promoted in the curriculum of medical and nursing students.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, this is done through the reproductive health facilitators during theoretical and practical training as part of the students' curriculum.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	NO
14. Do stock-outs of oxytocin occur?	YES, sometimes
15. How frequently do stock-outs of oxytocin occur?	It depends on the service. In Guatemala, the hospitals and health regions are autonomous in purchasing drugs. Sometimes the health regions don't have the resources to supply the primary and secondary health centers. In general the hospitals do not suffer stock-outs of drugs because they have a budget for them.

M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	In the medical record and partograph (in the maternity register).
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	YES, the activities include: implementation of the SBA guidelines of mother and baby in all delivery sites, including the use of AMTSL, partograph, and management and prevention of hemorrhage.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Training, technical and financial assistance for the implementation of the national guide to delivery care by HCI (Health Care Improvement) Project.
20. Activities in PPH prevention/management undertaken by other partners?	UNFPA, PAHO, OMS AGOG, OB/GYN Association of Canada and other NGOs.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	In 2009, 45 hospitals = 100% had skilled maternal newborn attendance and 100% of "CAPS"—all of the services related to delivery services were covered.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	With the National Commission of Birth Control Regulation, 15% of alcoholic beverage (sales) will go toward maternal and newborn activities. Additional resources to monitor the use of this standard. Guatemala is interested in introducing oxytocin in Uniject to prevent PPH. It would be good to increase technical and financial assistance for this process.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Finances are the most important challenge. In addition, the human resources with skills in attending births (is another challenge). Geographical access (is a challenge) because there are some departments so spread out and it's difficult to cover the entire population.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	The standard states that if a woman arrives to a permanent health center and there is NO doctor, then the patient should be stabilized and referred to a higher level facility. They can give the dose (of MgSO4) but only when there is NO doctor available.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, it's in the undergraduate obstetrics and gynecology and nursing curriculum.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES

LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgSO4 occur?	YES, it can happen but there is NO documentation regarding how frequently there are stock-outs.
10. Frequency of MgSO4 stock-outs?	In October and November, there are very few (MgSO4). This depends on the level of care and if it's the end of the year.
M&E	
11. Indicator of severe PE/E management in HMIS?	YES
12. What is indicator and where is it recorded?	It's documented in the medical record and partograph. The indicator is that 100% of women who present with severe pre-eclampsia must have a dose of MgSO4. In addition, they must document the dose and the blood pressure.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Training for graduated students and facilitators give support, training and supervision. In addition, the development of guidelines and standards.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	A technical person from HCI provides technical and financial support.
15. Activities in PE/E prevention and management undertaken by other partners?	Financial and logistics support, for example PAHO supports the development of guidelines and printing training material.
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	100%. The facilitators visit all the hospitals and places where births are managed.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Attend other activities in the Central American region to get updates of what other countries are developing.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Constant training and monitoring, constant change of personnel attending births. This does not permit continuity in training.

GUINEA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Dem Bokar, SBM-R Advisor, Dem_bokar@yahoo.fr, Tel: 67 54 81 14
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, doctors, midwives, obstetricians/gynecologists.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO, planned for next fiscal year.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO
15. How frequently do stock-outs of oxytocin occur?	N/A
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	In files and delivery registers

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	• Training of providers. • Systematic use of AMTSL in health facilities in the public sector.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	• Implementation of performance standards for EMOC that includes AMTSL for prevention of PPH and development of protocols for management of PPH.
20. Activities in PPH prevention/management undertaken by other partners?	*Questions 20 and 21 are the same.*
21. % districts covered by national PPH programs?	• Approximately 50% of district hospitals. • Very small number of health centers (N=10).
22. % SBAs reached by national PPH programs?	100% of qualified birth attendants who are in districts covered by the program.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	• Ministry of Public Health develops a policy and the means to support that policy. • Include all health centers who carry out deliveries, in the implementation of norms and EMOC training.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	• Government providing free deliveries without necessary needs, e.g., availability of oxytocin. • Limited funds for national coverage. • Limited number of partners work in this area (rezoning of the country into zones where donors are working).
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, doctors, midwives, ob/gyn in training
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	YES
M&E	
11. Indicator of severe PE/E management in HMIS?	NO

12. What is indicator and where is it recorded?	• Delivery registers • Performance standards analyses
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Interventions and programming exist but with very minimal structure.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Implementation of EMOC performance standards, which include use of MgSO4 for management of PE/E.
15. Activities in PE/E prevention and management undertaken by other partners?	Training of providers by the "Programme National de Maternite sans Risqué" funded by UNFPA.
16. % of districts covered by PE/E programs?	Around 50% of district hospitals and very small number (10) of health centers. The program for implementation of EmOC performance standards includes AMTSL as well as management of PE/E.
17. % of SBAs reached by national PE/E programs?	Difficult to quantify; data not collected; minimal intervention.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Ministry of Health should develop a policy for the formal introduction of a program on PE/E prevention and management, and a means to support that policy.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	

HONDURAS

Is there an MCHIP presence in this country? ***(YES/NO)***	NO, nevertheless MCHIP is facilitating technical assistance for a project introducing oxytocin in Uniject at the community level and facilities in Honduras.
CONTACT PERSON (responsible for updates to this matrix)	Dr. Ivo Flores, Director del Programa de Atención Integral a la Familia E-mail: floresfloresivo@yahoo.com, Ph: +504-2222-1257
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, AMTSL is part of the Secretary of Health of Honduras standards (SSH).
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, the steps are correctly explained in the national standards manual.
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, misoprostol is approved in the national guidelines for the treatment of PPH. It is not found to be approved for prevention.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, midwives are authorized to perform AMTSL in places where they attend and where they are trained (to do it).
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	NO, this procedure is only done at the hospital level and only authorized to be performed by doctor residents and specialists where there is "CONE" (Essential Obstetric Newborn Care) basic and comprehensive CONE.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, AMTSL is included in the curriculum for auxiliary nurse, doctor, and nurse programs. Nevertheless, there is NO coordinated effort between the SSH and the faculty of medicine and nursing to include the SSH standards in the curriculum.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, through the CONE strategy.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES, there are stock-outs.
15. How frequently do stock-outs of oxytocin occur?	Not frequently but they happen.
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	In the postpartum note, this is part of the medical record.

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	CONE Strategy—This strategy includes health service strengthening through theoretical and practical training of providers. The training is 100% based in the national standards of delivery care. The SSH is also working in a project to introduce oxytocin in Uniject for the prevention of PPH.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Financial assistance for projects for example the introduction of oxytocin in Uniject. USAID through HCI (Health Care Improvement Project) is implementing a program of quality assurance.
20. Activities in PPH prevention/management undertaken by other partners?	ChildFund trains midwives to recognize heavy bleeding and discern normal, moderate and severe bleeding. Child Fund provides training at the community level for diagnosing PPH and managing it at the community level.
21. % districts covered by national PPH programs?	100% of the regions are covered by the policy but because of budget restraints only six of the 20 total regions are covered to implement CONE.
22. % SBAs reached by national PPH programs?	There is NO database that records this information.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	• Strengthen quality assurance to better monitor national standards. • Budget to implement and disseminate the RAMNI policy. • Revise the nursing and medical curriculum of study. • Information, Education and Communication strategy (IEC), this strategy aims to strengthen facility based deliveries and promote family planning. The strategy is developed but there are not enough resources to implement it. • A community level strategy (individual family and community) to promote facility-based delivery and to improve transportation for women with complications. • Home-based maternity strategy to get women closer to facilities with skilled birth attendants.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	• Community births: there are a large number of women who die in the community because of retained placenta. Continue to work on promoting facility based deliveries. • Assure all maternal-infant clinic personnel correctly perform AMTSL. • Create the option of initial management of PPH in rural areas. How can they do initial management of PPH? With a protocol in place for initial management of PPH. • Increase the human resource capacity. • Harmonization and include monitoring of medical faculty so that everyone is in accordance to the strategies disseminated by the Secretariat of Health. • M&E of indicators. Implementation of this program needs to be accelerated.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*

5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES, they are authorized but at the maternal-infant clinic level they don't have adequate experience in managing a patient with pre-eclampsia, but at the hospital level they do have it (the experience).
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, at the nursing and physician level, but it should be aligned with the SSH standards.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES, because the standards are created based on the scientific evidence.
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	Sometimes, but very rarely because the drug isn't used very often.
10. Frequency of MgSO4 stock-outs?	Very rarely
M&E	
11. Indicator of severe PE/E management in HMIS?	Same as AMTSL, there is a checklist and instruments to monitor the diagnosis and management of PE/E.
12. What is indicator and where is it recorded?	It's documented in the medical record and the referral page. These are the minimum documents needed to refer a patient. The indicator used is the % women with a complication (severe PE/E) that have been managed according to the standard. There is a checklist that includes all the steps of treatment.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	The CONE strategy, RAMNI policy, national standards and guidelines, IFC (Individual Family and Community: for the detection of danger signs so that patients are referred in a timely manner to a hospital).
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	They provide financial and technical assistance to support SSH. The quality assurance program provides quality improvement technical assistance in monitoring.
15. Activities in PE/E prevention and management undertaken by other partners?	ChildFund provides community level training. Identifying danger signs and referral opportunities of the midwife. The UNDP supports the revision of standards as does PAHO. This is financed by the Spanish to expand the strategy of implementing CONE in hospitals and maternal-infant clinics.
16. % of districts covered by PE/E programs?	Six of the 20 regions.
17. % of SBAs reached by national PE/E programs?	There is NO such database.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	It goes hand in hand with the PPH prevention program though the quality assurance program. The training is to have quality management and referral at the maternal-infant clinic level.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Community education on the danger signs of PE. Also training and strengthening the peripheral level to know the signs of PE/E. Ensure facility-based deliveries (hospital births) for patients at increased risk of PE because the clinics do not have the ability to manage these complications. Strengthen maternal-infant clinic capacity to manage PE/E. Strengthen and scale up the CONE strategy.

INDIA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Somesh Kumar, +91 9717 29 7738; skumar@jhpiego.net
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	NO
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, except at the home deliveries, where the midwives are supposed to give misoprostol for AMTSL.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	NO, although AMTSL has not been included *per se* in the curriculum, the curriculum does state that the ANMs and GNMs should follow Government of India SBA Guidelines, which include AMTSL. But efforts are being undertaken, in collaboration with MCHIP, to include AMTSL in the curricula of ANM training centers.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	The students are supposed to be assessed for competency of AMTSL, but this is not practiced.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	This is being implemented.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	NO
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Frequently
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery logs and registers record oxytocin administration, but not all three steps of AMTSL.

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	1. In-service SBA training for all nurse-midwives and physicians. 2. Inclusion of oxytocin and misoprostol in EDL. 3. NO SEPARATE PROGRAM FOR PPH PREVENTION.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	1. In-service SBA training for all nurse-midwives in USAID focus states of UP and Jharkhand and Uttaranchal through Vistaar program. 2. Training of providers of select district hospitals and select super-specialty hospitals linked to nursing-midwifery institutions—in essential MNCH practices including AMTSL-MCHIP.
20. Activities in PPH prevention/management undertaken by other partners?	The other agencies are mainly supporting the implementation of government-sponsored in-service SBA training, which includes UN agencies, UNICEF, WHO and USAID-supported projects such as MCHIP, Vistaar, etc.
21. % districts covered by national PPH programs?	Roll out of in-service SBA training is being undertaken throughout the country.
22. % SBAs reached by national PPH programs?	N/A
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	The MOHFW already has the in-service training as a part of its overarching policy for improving maternal health; specifically, the intrapartum care. But there is a need to support the roll-out of these training activities in the state, both in terms of increasing numbers of trainings and improving the quality of these trainings.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine Nifedipine
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine Nifedipine
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES, midwives can give the first dose of MgSO4 before referring.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, all cadres
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	Reasonably frequently, NO such formal data are available though.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	Delivery register and case sheets.

PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	In-service SBA training for all nurse-midwives and physicians. Inclusion of MgSO4 in EDL. NO SEPARATE PROGRAM FOR PE/E.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	In-service SBA training for all nurse-midwives in USAID focus states of UP and Jharkhand and Uttaranchal through Vistaar program. Training of providers of select district hospitals and select super—specialty hospitals linked to nursing-midwifery institutions—in essential MNCH practices including management of PE/E MCHIP.
15. Activities in PE/E prevention and management undertaken by other partners?	The other agencies are mainly supporting the implementation of government-sponsored in-service SBA trainings, which includes UN agencies, UNICEF, WHO and USAID-supported projects like MCHIP, Vistaar, etc.
16. % of districts covered by PE/E programs?	Roll out of in-service SBA trainings is being undertaken throughout the country.
17. % of SBAs reached by national PE/E programs?	NA
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	The MOHFW already has the in-service trainings as a part of its overarching policy for improving maternal health-specifically the intra-partum care—but there is a need to support the roll out of these trainings in the state, both in terms of increasing numbers of trainings and improving the quality of these trainings.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Training capacity at the state level and below. Lack of HR in adequate numbers to supervise/follow up on the trained providers.

INDONESIA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Anne Hyre; ahyre@jhpiego.net; +62811880-918
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO, misoprostol is approved for other medical indications though.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, down to the community health center; village midwives do not do manual removal at home.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, as part of the normal birth process.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	Was piloted from 2003–2008.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES, but stored outside of the refrigerator.
14. Do stock-outs of oxytocin occur?	NO
15. How frequently do stock-outs of oxytocin occur?	
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Back of the partograph (delivery note).
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Training
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Inclusion of AMTSL in all performance standards; AMTSL training of midwives where needed.
20. Activities in PPH prevention/management undertaken by other partners?	Same as above.

21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	100%
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	I would actually argue that AMTSL has been scaled up nationally through the Normal Delivery Training course and pre-service education. Continued promotion of AMTSL is really the priority now (not letting it fall off the radar screen). Also, ensuring that all steps are conducted on a routine basis. Oxytocin use seems nearly universal in Indonesia, but we do see midwives waiting for signs of separation before doing controlled cord traction.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Midwives are providing AMTSL more frequently than ob/gyns. As with PE/E below, little is being done to ensure that doctors are complying with standards.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES, but rarely available* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	Technically, they are authorized down to the community health center level. However, none of them are doing it.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, it is—in midwifery curriculum since 2002. Not sure about medical education, but I suspect it has been updated, too.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES, but generally without calcium gluconate, which then makes providers reluctant to use MgSO4.
9. Do stock-outs of MgSO4 occur?	NO
10. Frequency of MgSO4 stock-outs?	
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	BEmONC and CEmONC training
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Inclusion of PE/E in performance standards; training and updates in PE/E management.
15. Activities in PE/E prevention and management undertaken by other partners?	Same.

16. % of districts covered by PE/E programs?	Perhaps 10%.
17. % of SBAs reached by national PE/E programs?	Perhaps 10%.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Good clinical guidelines have existed for years, but NO one is complying with them. We plan to develop a job aid that clarifies how to properly administer MgSO4. An online survey of ob/gyn practices will be sent out to all ob/gyns in April 2011 to determine their current practices.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Ob/gyns are not held accountable for complying with standards—they do whatever they want, even though good guidelines have existed for at least 15 years. We are trying to make the ob/gyn association more aware that people are not complying, and to take a stronger stance that compliance with guidelines is not optional. Asmuyeni (our midwifery advisor) suggests that there be an MOH decree saying that government hospital patients are patients of the midwives, with ob/gyns and pediatricians as consultants. She feels we would be more likely to be able to scale up best practices if midwives were able to make decisions (since doctors are rarely around).

KENYA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Nancy Kidula, nkidula@jhpiego.net
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO, not in policy but has been piloted in several sites.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Rarely
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery log
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Community BCC—knowledge of danger signs, emergency preparedness; in ANC iron supplementation, counseling of danger signs; during labor and delivery AMTSL; during PPC recognition of danger signs, review of mothers within 24 hours of delivery.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Training of service providers in AMTSL; piloting of misoprostol use at community level.

20. Activities in PPH prevention/management undertaken by other partners?	Same as above.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	80%
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	MNH technical working group in place. A lot of OR on misoprostol ongoing and reports submitted to the MOH; uterotonics already on the country's EDL; accelerated advocacy activities for reduction of MMR; commodity security being enhanced under the economic stimulus package; more health workers being hired; referral systems being strengthened; policy and guidelines and job aids in place; pre service curricula revised to incorporate PPH management; PPH part of EmOC in service training.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Reduced SBA Commodity security Pre-service training
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, all cadres
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Frequently
M&E	
11. Indicator of severe PE/E management in HMIS?	YES
12. What is indicator and where is it recorded?	Cases of PE/E; no alive/no dead. Delivery logs, maternity register, RH summary tools/
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Advocacy for early ANC attendance; BP measurement as routine part of ANC, delivery and PPC; MgSO4 for management of eclampsia; advocacy for SBA and PNC within 24 hours.

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Capacity building of service providers; procurement of BP machines.
15. Activities in PE/E prevention and management undertaken by other partners?	As above; some are also involved in infrastructure development.
16. % of districts covered by PE/E programs?	ALL
17. % of SBAs reached by national PE/E programs?	21% have MgSO4.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	MNH TWG in place; advocacy on reduction of MMR; commodity security being enhanced under the economic stimulus package; more health workers being hired; referral systems being strengthened; policy and guidelines and job aids in place; pre-service curricula revised to incorporate PE/E management; PE/E part of EmOC in-service training; MgSO4 and antihypertensive drugs are on EDL.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Late ANC attendance. Commodity security. Low skilled birth attendance.

LIBERIA

Is there an MCHIP presence in this country? ***(YES/NO)***	MCHIP is present and supporting family planning efforts; Rebuilding Building Basic Health services (RBHS) is the bilateral supporting MCH.
CONTACT PERSON (responsible for updates to this matrix)	Dr. Saye D. Baawo, Director of Family Health Division, MOHSW +231-651-2984, e-mail sdbaawo@gmail.com
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	1–2 weeks in some health facilities due to bad road conditions.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	On the back of the partograph form, IN maternity chart.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	MOHSW supports AMTSL; oxytocin at all facilities supporting. BEMONC and CEMONC training including PPH. In-service training of mid-level health care professionals in Basic Life Saving Skills (BLSS) and training of medical doctors in obstetric surgical emergencies.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	BEMONC and CEMONC training courses include AMTSL and management of PPH.
20. Activities in PPH prevention/management undertaken by other partners?	AMTSL, BEmONC, CEmONC and management of PPH. In-service training of mid-level health care professionals in BLSS.
21. % districts covered by national PPH programs?	100%of counties (equivalence of district) are covered by current PPH program.
22. % SBAs reached by national PPH programs?	100% SBA are being supported.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Development of the RH Policy, Maternal and Newborn Health Road Map, the Basic Package of Health Services (BPHS), protocols for maternal and newborn care. These documents ensure harmonization of care at all of levels of service delivery as well as mandate that all maternal and newborn deaths are reported within 24 hours and investigated within 48 hours. Strong political will from the office of the President of the Republic of Liberia.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Getting skilled attendants to all MOHSW facilities. 2. Supplies chain issues. 3. Putting knowledge into actions. The MOHSW has re-opened additional midwifery schools, strengthened supply chain and improving supervision.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, midwives, nurses, physician assistants, registered nurse midwives and instructors of various cadres.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	1–2 weeks due to bad road conditions in rural areas.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	

PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Supplying medications to facilities (essential drugs), including PE/E management in PSE curricula and in-service training of health professionals.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Supply chain management, capacity building of health care providers.
15. Activities in PE/E prevention and management undertaken by other partners?	Supplying medications to facilities (essential drugs), including PE/E management in PSE curricula and in-service training of health professionals.
16. % of districts covered by PE/E programs?	100% of all 15 counties.
17. % of SBAs reached by national PE/E programs?	
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Same as PPH above.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Same as PPH above.

MADAGASCAR

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Rakotovao Jean Pierre, jrakotovao@jhpiego.net,+261340263218
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	NO
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, future nurses (student nurses), midwives
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO, this is determined by communication and request from health center to the central supply and these requests reveal NO stock-outs.
15. How frequently do stock-outs of oxytocin occur?	
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery logs and register
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	ANC: sensitization on danger signs and delivery plan, iron and folic acid distribution. AMTSL during delivery.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	ANC: sensitization on danger sign and delivery plan, iron and folic acid distribution.

20. Activities in PPH prevention/management undertaken by other partners?	ANC: sensitization on danger sign and delivery plan, iron and folic acid distribution. Job aids for health agent.
21. % districts covered by national PPH programs?	NO specific PPH program but there is EmONC that covers 100% of districts.
22. % SBAs reached by national PPH programs?	
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Partner engagement Revision of norms and procedures Information sheet (bulletin)
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Not enough funds; misoprostol not registered; protocols not disseminated or used because providers have not been trained yet; guides not available at community level. • Advocacy, plan to update norms and procedures, to produce protocols and guidelines.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES, ongoing in that it is very near to being officially on the EDL.
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES (will be on EDL soon)* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, nurses, midwives, doctors and anesthetists
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	Four months out of a year
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	

PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	NO specific program but it is included in EmONC training and routine ANC.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	IEC: danger signs
15. Activities in PE/E prevention and management undertaken by other partners?	EmONC training
16. % of districts covered by PE/E programs?	Not concerned
17. % of SBAs reached by national PE/E programs?	Not concerned
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	National meeting on RH is held annually and would be an opportunity to disseminate information on PE/E at this meeting.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	As there no specific program, there are no bottlenecks.

MALAWI

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Luwiza Soko Puleni, lpuleni@jhpiego.net, 265 888894481
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, it is part of the National Reproductive Health Service Delivery Guidelines, Safe Motherhood National Protocols and Reproductive Health Standards.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, AMTSL is included in the Malawi National Reproductive Service Delivery Guidelines.
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, misoprostol was registered for use in PPH prevention and treatment and for obstetric use by the Malawi Poisons, Medicines and Pharmacy Board in January 2010. It has also been included in the Malawi National Obstetric Protocols for use in PPH prevention and treatment.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES. Previously, only registered midwives and clinicians were able to conduct the manual removal of placenta. However, under ACCESS in 2007, Jhpiego worked with Nurses and Midwives Council to update pre-service curriculum for nurse-midwifery technicians (the cadre that provides MNH services at health center level) to enable them to perform signal functions of BEmONC including manual removal of placenta.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES. All skilled birth attendants are authorized to practice AMTSL in facilities using oxytocin.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES. AMTSL is integrated with pre-service education programs for nurses, midwives, physicians and paramedics. All skilled birth attendants are authorized to practice AMTSL in facilities.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, checklists are also made for students adopted from the BEmONC manual to enable students practice AMTSL before clinical skills examinations.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, AMTSL is also integrated with in-service training programs, such as BEmONC.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO. MOH/MCHIP/VSI had planned to pilot misoprostol distribution in three MCHIP-supported districts; however, delays in approval of the IRB protocol led to expiry of funds from VSI.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	Not Applicable
LOGISTICS	
11. Is oxytocin on the EDL?	YES, oxytocin is an essential drug that is listed under Essential Health Package in Malawi. Oxytocin is now available for use in health centers, where ergometrine had been the norm.
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES, oxytocin is available in all hospitals and health centers that provide maternity services. There are occasional stock-outs due to some bottlenecks in the distribution system where Central Medical Stores (CMS) distributes directly to health facilities; the main challenge being lack of electronic system to feedback information from health facility to CMS and back.

14. Do stock-outs of oxytocin occur?	YES. With introduction of BEmONC, oxytocin availability is somewhat consistent however there have been reports of oxytocin stock-outs for two weeks or more at some health facilities (including district hospitals). In addition, the lack of refrigerators to store oxytocin and frequent power cuts especially at health centers and rural areas is problematic for storing of oxytocin.
15. How frequently do stock-outs of oxytocin occur?	Two weeks or more at some health facilities (including district hospitals).
M&E	
16. Is AMTSL included in the national HMIS?	NO, AMTSL is not yet included in the national HMIS but rather in selected programs (i.e., MCHIP has it as an indicator in the Performance Monitoring Plan).
17. Where is AMTSL recorded?	Partograph has components of AMTSL, but only includes oxytocin and controlled cord traction and not uterine massage. Efforts to introduce an addendum to be attached to the partograph in MCHIP focus districts have not been successful.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Supplying oxytocin to health facilities and advocating for establishment of additional BEmONC sites that include training of providers in PPH prevention and management among others. Another activity to promote PPH prevention and management is SBM-R in reproductive health in all districts and central hospitals including 13 health centers. Other than this, Malawi does not have a stand-alone PPH program.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Providing technical and financial assistance to BEmONC and SBM-R in reproductive health training, which includes prevention and management of PPH.
20. Activities in PPH prevention/management undertaken by other partners?	Providing technical and financial assistance to BEmONC training that includes management of PPH. This is to a small extend in comparison to the USG support through ACCESS and MCHIP.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	Approximately 80% of SBA in district and central hospitals through SBM-R and BEmONC training.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	1. The first lady, Her Excellence Madam Callista Mutharika, is Malawi's Coordinator for Safe Motherhood. She could be used as an advocate for PPH, where she can use opportunities during meetings on her Safe Motherhood Foundation to disseminate messages on PPH to the masses. 2. Continue lobbying with partners such as DfID and Maries Stopes to pilot misoprostol distribution at ANC for home births. 3. Potential to scale up SBM-R in RH from current 13 health centers to all health centers countrywide.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Shortage of SBAs. 2. Stock-outs of oxytocin. 3. Lack of funding to pilot misoprostol distribution. • Training of more midwives. • Updating knowledge and skills of midwives and clinicians by providing them with BEmONC knowledge and skills. • The Commodity Security Strategy has been developed and incorporated in the National Reproductive Health Strategy to manage all the maternity drugs and supplies. • Lobbying for financial support from other donors/partners.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES

3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *NO* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *NO* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, for all SBAs
7. Global management principles for PE/E in in-service training courses for SBAs?	Incorporated with pre-service and in-service training programs, such as BEmONC.
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO. It is mostly available at central and district hospitals; the majority of lower level care (health centers) with the exception of facilities in the MCHIP-supported districts, are scared to use MgSO4. They don't order it from CMS and if it is supplied to them, it expires on the shelf.
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Most of the time there are stock-outs for a month or more at some health facilities especially health centers. District and central hospitals have stock-outs for two weeks or more.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO, there is no indicator in HMIS and quality of care of severe PE/E management is hardly recorded.
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	NO stand-alone PE/E prevention and management program, however this is part of BEmONC training and SBM-R in RH.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Included in BEmONC training and SBM-R, where MCHIP supports MOH with funding and technical support.
15. Activities in PE/E prevention and management undertaken by other partners?	There isn't much focus from other partners on PE/E.
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	Approximately 80% of SBA in district and central hospitals through SBM-R and BEmONC training.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	1. Potential to scale up SBM-R in RH from current 13 health centers to all health centers countrywide.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	1. Stock-outs of MgSO4 and shortage of SBAs. 2. Lack of competence in using MgSO4. • The Commodity Security Strategy has been developed and incorporated in the National Reproductive Health Strategy; MgSO4 is one of the priority drugs. • Mentoring of SBAs on use MgSO4 although this is being done at a smaller scale.

MALI

Is there an MCHIP presence in this country? *(YES/NO)*	YES, ATN plus implemented by Abt Associates.
CONTACT PERSON (responsible for updates to this matrix)	Dr. Toure Cheick Oumar, Ctoure@intrahealth.org, +223 20 22 87 83/66 74 08 80
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, midwives, physician, ob/gyns
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Depend on the level of facility.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Partograph, delivery register
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Free cesarean section policy.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Introduced AMTSL and Essential Newborn Care (ENC) with in-service training curricula for nurses and midwives. Scaled up AMTSL/ENC in USAID Mali Geographic zones (35 districts). Conducted a demonstration project to allow matrons to practice AMTSL. Advocated to change policy to allow matrons to use uterotonics drugs. Conducted pilot project to test oxytocin (Uniject). Developed job aids for SBA and matrons to better practice AMTSL. Ensured inclusion of AMTSL/ENC in pre-service education programs for all SBAs.
20. Activities in PPH prevention/management undertaken by other partners?	Others partners include UNFPA, Canadian, Dutch cooperation, Aga Khan Foundation with Gynuity plan to test misoprostol by TBA.
21. % districts covered by national PPH programs?	70%
22. % SBAs reached by national PPH programs?	90%
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Matrons are responsible for attending most of the vaginal births in the rural areas. MOH allowed them to practice AMTSL in 2009. Uniject test succeed a lot of interest. It showed that 10 IU of oxytocin in a Uniject device with TTI can be successfully used by matrons and other birth attendants as part of an effective AMTSL program. In addition, the simplicity and ease of use of the device are preferred by providers to standard autodisable syringe.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Regular availability of uterotonics at rural level. Issues of uterotonic drugs conservation and quality control. Actual MIS doesn't include AMTSL indicators.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *NO* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *NO* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	NO
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	Depends on level of health pyramid. It's more frequent at rural district than urban, where private pharmacists are available.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO

12. What is indicator and where is it recorded?	NA
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Developed and disseminated protocols for PE/E prevention and management. Effort to make available essential drugs.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Supported training in procedures. Developed and disseminated job aids. Pilot project to improve the management of PE/E through the quality approach (Kayes region).
15. Activities in PE/E prevention and management undertaken by other partners?	
16. % of districts covered by PE/E programs?	10%
17. % of SBAs reached by national PE/E programs?	10%
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Essential drugs are on list of national drugs. PE/E prevention and management are includes the MOH "feuille de route" to achieve MDG. The pilot project in Kayes region showed interesting results and partners want to invest in scale-up.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Constant availability of essentials drugs at rural level. Issues of uterotonic drugs conservation and quality control. Actual MIS doesn't include AMTSL indicators.

MOZAMBIQUE

Is there an MCHIP presence in this country? ***(YES/NO)***	YES
CONTACT PERSON (responsible for updates to this matrix)	Jim Ricca, MCHIP Mozambique Chief of Party, jricca@jhpiego.net +258-82-305-3916
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	Not yet, but a pilot study using misoprostol for prevention of PPH has been conducted in some provinces of Mozambique and it's expected that the result of this study will contribute for this approval.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, maternal health nurses—intermediate and basic level.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, maternal health nurses—intermediate and basic level.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, maternal health nurses and physicians.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, but this kind of assessment needs to be improved.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES, supported by VSI.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	This is difficult to quantify, but in the Model Maternities Initiative health facilities, this does not occur often.
M&E	
16. Is AMTSL included in the national HMIS?	It has just started to be included in the new system, which is rolling out to all health facilities this year. National, regional and provincial trainings occurred last year. District level trainings are occurring now. It has been introduced in some health facilities and will be in all by June 2011.
17. Where is AMTSL recorded?	In the birth register

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Scale-up of Model Maternities Initiative based on SBM-R approach to 122 facilities by 2015—promotes the use of AMTSL and other evidence-based practices are part of this. Reinforce the training of human resource for health including MCH nurse and invest in the implementation of the integrated plan to accelerate the achievement of MDG 4 and 5.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Promotes the use of AMTSL in the Model Maternities Initiative currently in 34 health facilities accounting for 20% of institutional births.
20. Activities in PPH prevention/management undertaken by other partners?	WHO, UNFPA and some NGOs have been supporting Essential and Emergency Obstetric Care in-service training, that include AMTSL, in several provinces of the country.
21. % districts covered by national PPH programs?	100% of provinces (not all districts)
22. % SBAs reached by national PPH programs?	Data not available
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	The scale-up of the Model Maternities Initiative from 34 to 122 facilities over the next 4 years. This is a focal area for essential obstetric and neonatal care, as well as Basic EmONC services. Other potential opportunities are: the integrated in-service training package (under development), support to strengthening pre-service training, support to Ob/Gyn and Midwives Mozambique Associations to organize their national events.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	• Stock-outs of oxytocin • Sufficient human resources to cover births in health facilities • Low institutionalized delivery rate (about 50%) • Limited capacity to provide supportive supervision for MNH services
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES, all levels of maternal-child health nurse (ESMI)
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, maternal health nurses and physicians
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	Not that frequently in the Model Maternities facilities

M&E	
11. Indicator of severe PE/E management in HMIS?	It has just started to be included in the new system which is rolling out to all health facilities this year. National, regional and provincial trainings occurred last year. District level trainings are occurring now. It has been introduced in some health facilities and will be in all by June 2011.
12. What is indicator and where is it recorded?	% of severe PE/E treated with MgSO4, recorded in the birth register.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Scale-up of Model Maternities Initiative, reinforce the training of human resource for health including MCH nurse and invest in the implementation of the integrated plan to accelerate the achievement of MDG 4 and 5.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Help in scale-up of Model Maternities. Support to strengthen the training of human resource for health (in- service and pre-service).
15. Activities in PE/E prevention and management undertaken by other partners?	WHO, UNFPA and some NGOs have been supporting Essential and Emergency Obstetric Care in-service training that includes PE/E prevention and management, in several provinces of the country.
16. % of districts covered by PE/E programs?	100% of provinces (not all districts)
17. % of SBAs reached by national PE/E programs?	100%
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Through the Model Maternities, scale up quality attention for ANC and births. Other potential opportunities are: the integrated in-service training package (under development), support to strengthening pre-service training, support to Ob/Gyn and Midwives Mozambique Associations to organize their national events.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Lack of functioning sphygnomanometers in some health facilities. Stock-outs of MgSO4 and calcium gluconate. Insufficient cover of EmOC. Limited number of human resources in health facilities. Limited capacity to provide supportive supervision for MNH services.

NEPAL

Is there an MCHIP presence in this country? ***(YES/NO)***	YES, key implementers of PPH activities in Nepal are health sector support program (DFID); Nepal Family Health Project (USAID), UNICEF; then, MCHIP playing greater role in implementing activity for PPH prevention those are NHSSP (follow on of SSMP), UNICEF and Rural Health Development Project (RHDP). MCHIP is currently not working directly on PPH.
CONTACT PERSON (responsible for updates to this matrix)	**For NFHP,** Ram Chandra Silwal rsilwal@nfhp.org.np 5524313 (184) **For MCHIP,** Geeta Sharma gsharma@jhpiego.org.np 5524313 (360)
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES, AMTSL at every birth is approved as national policy. It has been cited in following national standards and clinical protocols: • National policy on SBA (2006) as one of the core skill among 27 core skills of SBA. • National Medical Standard for Reproductive Health volume III (2007). • Clinical protocols for medical officer (2007). • Clinical protocols for SN/ANM (2008). • MNH package.
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, the steps for correctly performing AMTSL are incorporated with service delivery guidelines.
3. Is misoprostol approved for prevention and/or treatment of PPH?	Misoprostol is approved for prevention of PPH at home birth (only) not for treatment of PPH.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, midwives/nurses (SN, ANM) are trained to perform manual removal of placenta at all levels of health facility (SHP, HP, PHC, hospitals). GON already endorsed clinical protocols followed by orientation on protocols. But legally nurses and midwifes are not protected/ authorized to perform MRP.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, they are authorized to perform AMTSL with oxytocin at all levels of health system. They must perform this skill where there is birthing facility or women come to deliver in those facilities.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, pre-service education curricula of ANM, SN, BN, BSc Nursing, MBBS and postgraduate medical and nursing program are updated to include AMTSL.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	During their clinical posting, students are assessed for competency in performing AMTSL as part of internal evaluation. It is not mandatory to assess their clinical skill in AMTSL prior to their graduation. In theory, the AMTSL skills are assessed prior to graduation, but in practice, some of the training institute does not meet these criteria and nurses are graduated without assessing these skills.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, it is included in in-service training curricula of SBA.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES, it was piloted in Banke (2005–2007) district, which covered 73% of total expected pregnancy in that district. Among them, 53% women had taken misoprostol after delivery.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES, after successful pilot results, it has been scaled up (2008–2010) in seven districts. Approval of national level phase wise expansion was received in April 2010. Sanghini franchise network with be doing the social marketing.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES

13. Is oxytocin regularly available at facilities with maternity services?	NO, still not regularly available at every health facility that offers maternity services especially in all birthing centers and in the facilities without system refrigeration support.
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	From time to time
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Maternity logs and patients charts
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	For PPH prevention: • Community level education on PPH prevention (BPP in all 57 districts). • Promotion of institutional or SBA assisted delivery. In SBA training, AMTSL is one the core skills taught for PPH prevention. • Distribution of misoprostol for PPH prevention at home birth For PPH management: • Manual removal of placenta if PPH is due to retained placenta (when assisted by SBAs). And in some tertiary and better equipped facilities: • Uterine tamponade • Uterine and utero-ovarian artery ligation
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	With USAID support: • Provide national level TA to GON and other partner for PPH prevention. • Piloted community-based distribution of misoprostol for PPH prevention. • Development of BBC IEC material for advocacy on PPH prevention. • Training of HW and FCHV on use of misoprostol for prevention of PPH at home birth.
20. Activities in PPH prevention/management undertaken by other partners?	• Joint involvement of partners at national level activity, i.e., TAG meetings, program reviews, material development. • Implementation of PPH prevention activities including distribution of misoprostol for prevention of PPH at home birth. • Along with the USAID funded program UNICEF, CARE, Rural Health Development Project also implemented the misoprostol distribution in their working district • BBP program training, SBA trainings. • MNH Updates by the Nepal Family Health Project.
21. % districts covered by national PPH programs?	• 100% districts covered for AMTSL. • 20% districts (15/75) for distribution of misoprostol for prevention of PPH at home birth. And eight district in planning phase.
22. % SBAs reached by national PPH programs?	SBAs are trained from all districts (similar to province), still need to reach the SBAs in peripheral health facilities.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	• National expansion of distribution of misoprostol for prevention of PPH at home birth. • Increase coverage oxytocin. • Quality assurance (SBM-R) approach for PPH prevention.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	• SBA coverage at delivery and immediately after delivery • Maintenance of temperature of oxytocin • Procurement of misoprostol for scale

SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 YES Diazepam *(YES/NO)* it is not recommended as it causes CNS depression in mother and neonatal hypothermia (according to national standard).
2. Is MgSO4 on the EDL for severe PE/E?	YES, it is recommended for use in severe pre-eclampsia and listed on the EDL.
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO (but the atenolol has been listed there)* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	Midwives (ANM, SN) are authorized to diagnose severe PE at lowest level of health facility, administer loading dose of MgSO4 and refer those cases to higher level health facilities where comprehensive emergency obstetric care is available. But such cases are infrequent; they might lose confidence in this skill as evidenced by ACCESS study in 2009. Even in the lowest level of health facilities (SHP and HP), we could not find urine test kits and sometimes BP apparatus is non-functional. In this situation, midwives might not be able to diagnose severe PE. Most severe PE cases are underdiagnosed and underreported in these facilities and they are managed as pregnancy induced hypertension only. Clinical protocols are also available for midwives.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, current global management of principles for PE/E is included in ANM, SN, BN, BSc nursing, MBBS and postgraduate courses. Currently, teachers/instructors are also invited for SBA trainings and there is policy to provide guidance to students by SBA trained teachers only.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	This drug is essential drug in Nepal. But not all health facilities have stocks of MgSO4. There is limited data to support this. The ACCESS study conducted in 2009 found most health facilities had the stocks of MgSO4 for loading dose only not for the full course.
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	There are limited data on this.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	

PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	PE/E prevention (conducted by MCHIP): • Two different forms of calcium (tablet and powder) were supplemented to 97 PW and identified consumer acceptability and compliance on these supplements with USAID support (FHD coordination). Now MOHP is planning for larger district scale-up with USAID support. PE/E detection (planned under MCHIP): • Routine blood pressure measurement to all PW at each ANC visit • Urine protein test where this facility is available PE/E management:(also conducted by ACCESS): • Antihypertensive • MgSO4 administration to SPE/E cases • Timely delivery
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Following activities are undertaken with USAID support: PE/E prevention: • Calcium supplementation has been piloted in one of the district of Nepal for identification of consumer acceptability and compliance. • MCHIP (USAID funded) with other partners are planning for larger district pilot of calcium supplementation during pregnancy. PE/E management: • ACCESS program (USAID-funded) supported GON to develop SBA learning resource package, PE/E management is one of the core skill in SBA training. • ACCESS program (USAID-funded) with NESOG conducted one intervention in 2009 to strengthen the use of MgSO4 in 22 health facilities across Nepal and advocated to use this live-saving drug. • MCHIP is supporting GON and other partners to disseminate evidences and job aids for PE/E management.
15. Activities in PE/E prevention and management undertaken by other partners?	• Community awareness on PE/E symptoms through BPP package. • Development and dissemination of simpler job aids for magnesium sulfate administration. • Support GON to develop national standards and protocols and training/orientation to service providers on PE/E screening and management. • Representation in national PE/E TAG meeting and discussion of innovative approaches for PE/E screening/management. • MNH updates. • Advocacy to use MgSO4 for SPE/E management.
16. % of districts covered by PE/E programs?	We can calculate the percentage according to the coverage of B/CEOC services. Management of PE/E through MgSO4 is one of the major services in B/CEOC centers. There are 45 CEOC sites till date, 33 are functioning. In these 12 sites, caesarean section facility is not available but BEOC services are available in all sites (45 districts). According to this, around 60% districts are covered by current PE/E programs.
17. % of SBAs reached by national PE/E programs?	N/A
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	• Limited data available on PE/E, mode of treatment, treatment outcome, etc. There are some possibilities to maintain PE/E register in all the health facilities where maternity services are offered to track PE/E incidence and services. • SPE/E management initiatives can be expanded to all SBA and Aama suraksha sites (sites that provide free maternity services) and pictorial job aids need to be disseminated. • Emphasize knowledge and skills in SPE/E diagnosis, management and monitoring in all SBA training. • Conduct regular drills in health facilities for refreshment of skills.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	• Ensure availability of MgSO4 and other drugs, equipment and supplies for PE/E management. • Updating the skill for service providers. • SBA at delivery.

NICARAGUA

Is there an MCHIP presence in this country? ***(YES/NO)***	There is NO MCHIP program. UNFPA: Global Maternal Health Program PAHO: Maternal Health Program UNICEF: Domestic Violence Component HCI/USAID: Quality of Service Standards DELIVER: Logistic and Supply Chain Management in Reproductive Health
CONTACT PERSON (responsible for updates to this matrix)	Minister of Health, Director General of quality extension
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	NO
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO
15. How frequently do stock-outs of oxytocin occur?	Not once in the last two years at the national level.
M&E	
16. Is AMTSL included in the national HMIS?	It's not integrated at the national level. Microsoft Excel is used and it's sent by e-mail. This collects the basic indicators of maternal health.
17. Where is AMTSL recorded?	Ministry of Health's standards and indicators of quality.

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Standards promotion and monitoring: labor, partograph, AMTSL. Surveillance in the immediate postpartum period. Training in prevention of obstetric complications to multidisciplinary teams. Training of community level health workers in recognition of danger signs and symptoms.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	DELIVER: Technical support in logistics and availability of supplies en SR HCI: Strengthening quality improvement standards of the health services.
20. Activities in PPH prevention/management undertaken by other partners?	Ministry of Health: Maternal Infant Care Program UNFPA: Global Maternal Health Program PAHO: Maternal Health Program UNICEF: Domestic Violence Component HCI/USAID: Quality of Service Standards DELIVER: Logistic and Supply Chain Management in Reproductive Health
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	By law, 100% of the sites should be in compliance with the standards nevertheless there's not a good way to supervise this.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Update, reproduce, train and disseminate the standards. Strengthen the community level coordination; train the brigades and health technicians. Monitoring and evaluation program: technical and financial support.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Update, reproduce, train and disseminate the standards. Strengthen the community level coordination; train the brigades and health technicians. Monitoring and evaluation program: technical and financial support.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MagSO4 *YES* Diazepam *NO* Phenytoin (Dilantin) *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *NO, it's the third-line option* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *(ES* Nifedipine *YES* Methyldopa *NO*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, it's directed at physician and nurse professionals through the university track.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	NO
10. Frequency of MgSO4 stock-outs?	Not once in the last two years at the national level.

M&E	
11. Indicator of severe PE/E management in HMIS?	YES
12. What is indicator and where is it recorded?	Quality standards and indicators of the MOH indicator: Total users who receive treatment following the protocol for severe gestational hypertension syndrome and eclampsia.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Standards promotion and monitoring: labor, partograph, AMTSL. Surveillance in the immediate postpartum period. Training in prevention of obstetric complications to multidisciplinary teams training of community level health workers in recognition of danger signs and symptoms.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	HCI: strengthen quality standards PAHO: training on care standards UNFPA: provision of supplies and training
15. Activities in PE/E prevention and management undertaken by other partners?	AECI (Spanish Cooperating Agency): Monitoring and evaluation in quality standards in Jinotega and RAAN.
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	100% by law
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Supplies: urinalysis paper to detect proteinuria, scales, BP cuffs, etc. Monitoring and evaluation. Training internships for department teams of national referral hospitals. Provide calcium and aspirin in antenatal care.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Competency strengthening of health workers in the diagnosis and timely approach.

NIGERIA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Olumuyiwa Manuel Oyinbo, omooyinbo@yahoo.com +234-805-274-4415
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, except where there are obstetricians e.g., in teaching hospitals.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, physicians, nurses, midwives, trained CHEWs
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	Sometimes
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	VARIABLE (GUESTIMATE WILL BE ABOUT 25%)
M&E	
16. Is AMTSL included in the national HMIS?	NO, except in special programs like MCHIP, TSHIP etc.
17. Where is AMTSL recorded?	Maternity chart
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	AMTSL and Treatment of PPH are included in pre-service education and in-service training curricula. FMOH has registered Misoprostol for use in the country. The national Primary Health Care Development Agency (NPHCDA) has also included AMTSL in its training programs for recently recruited midwives assigned to PHCs. Nigeria Govt. also procured and distributed anti-shock garments to some health facilities.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	USAID-funded ACCESS, MCHIP and TSHIP programs address PPH prevention and treatment. The topic is included in all LSS and/or Emergency Obstetric and Newborn Care trainings. It is also included in the Nationally approved performance standards for emergency obstetric and newborn care.
20. Activities in PPH prevention/management undertaken by other partners?	• Society for Family Health (SFH) is involved in social marketing of the misoprostol. • PPRHI conducted the operational research on the community use of misoprostol in Zaria. • VSI supports/funds misoprostol procurement, supports the MOH to produce policy documents. • MacArthur Foundation is promoting the community use of misoprostol. • IPAS project promotes the use of the drug in post-abortion care (PAC). • CEDPA supported the development of advocacy kits for misoprostol. • PATHS and WHO also involved in roll out of interventions for prevention and treatment of PPH.
21. % districts covered by national PPH programs?	Approximately 50% of LGAs. Also only 39% of deliveries are conducted by skilled birth attendants.
22. % SBAs reached by national PPH programs?	NO data to determine this.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	The MOH has policies and programs in place for the prevention and management of PPH but needs support for program roll-out. The President's commitment at the UNSG Global Strategy on Women and Children's Health held in 2010 includes the following quote: • "… plan to mobilize additional financial resources through innovative approaches to realize the US$32 per capita investment required to fully fund the National Health Plan (2010–2015). Furthermore, we intend to uphold the Nigeria IHP+ country compact with our development partners, to make huge resources available to deliver on the health MDGs and other national health objectives and targets." • Pre-service and in-service training curricula have been updated with appropriate content for the prevention and management of PPH (e.g., LSS/MLSS/ELSS training courses). • Effective social marketing of misoprostol at subsidized prices. • Effective and extensive policy dissemination. • Advocacy for inclusion of misoprostol in the DRF in the states. • Partnership with pharmaceutical companies for local manufacture of misoprostol. Most PHCs are currently manned by Community Health Extension Workers. This cadre of health care workers needs to be trained and resourced to provide AMTSL. The current MSS program being run by the National Primary Health Care Development Agency (NPHCDA) can champion the training and use of CHEWs to scale up AMTSL at facility or home deliveries.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Shortage and maldistribution of skilled birth attendants (Increasing admission quota for midwifery training, introduction of community midwifery program, midwives' service scheme, NYSC, FMOH/WHO project on rural posting of doctors). 2. Shortage of uterotonics plus challenges of maintaining a cold chain for oxytocin (inclusion of oxytocin and misoprostol in EDL, social marketing of misoprostol). 3. Preference for home deliveries (community mobilization for better health seeking behavior).
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*

2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *NO* Methyldopa *NO*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *NO* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, physicians, midwives, nurses
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgSO4 occur?	YES
10. Frequency of MgSO4 stock-outs?	Estimate is 50%
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	N/A
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	• FMOH, with support from MacArthur Foundation, procured magnesium sulfate and built the capacity of between 20 and 40 providers from 10–15 local governments in each of the 36 states in the country and the Federal Capital Territory. These trainings were done using the national training manual. • Inclusion of MgSO4 in the EDL.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	ACCESS, MCHIP, TSHIP: 1. Early detection of pre-eclampsia. 2. Treatment of severe pre-eclampsia and eclampsia with MgSO4 or diazepam. 3. Treatment of high blood pressure with hydralazine or labetolol.
4. Activities in PE/E prevention and management undertaken by other partners?	Population Council, MacArthur Foundation, UNFPA, CEDPA on advocacy kit: 1. Early detection of pre-eclampsia. 2. Treatment of severe pre-eclampsia and eclampsia with magnesium sulfate or diazepam. 3. Treatment of high blood pressure with hydralazine or labetolol.
4. % of districts covered by PE/E programs?	Approximately 50%.
5. % of SBAs reached by national PE/E programs?	No data to decide this.

OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
6. Opportunities for program introduction, expansion, or scale-up.	Most PHCS are currently manned by community health extension workers. This cadre of health care workers needs to be trained and resourced to identify and refer cases of pre-eclampsia before they progress to eclampsia and to administer start dose of MgSO4. The current MSS program being run by the national primary health care development agency (NPHCDA) can champion the training and use of chews to scale-up management of eclampsia with mgso4 at facilities; passage of the national health bill will increase available funding to PHCs to be used partly for health insurance and drug purchase.
7. Significant bottlenecks to scaling up PE/E management programs in your country?	1. Shortage of SBAs 2. Shortage of MgSO4 (including high cost) 3. Preference for home deliveries and delay in recognizing danger signs for pet and eclampsia

PARAGUAY

Is there an MCHIP presence in this country? ***(YES/NO)***	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Vicente Bataglia Araújo. vbataglia@mchip.net, vbataglia@hotmail.com, 595-981-442819
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	No, observation: at this time, this drug is not legally distributed in this country.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO
15. How frequently do stock-outs of oxytocin occur?	N/A
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	Simplified intrapartum clinical history (form)—sip-clap.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	NO

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	YES, MCHIP is currently working on: updating the national standards, clinical training in delivery care and emergency obstetrics, training of trainers (ToTs) in clinical and community education to recognize danger signs among other things. All of this is being done in two health regions of the country, selected by the MOH, which have the highest maternal mortality rate.
20. Activities in PPH prevention/management undertaken by other partners?	YES, workshops in emergency obstetrics in other regions with the support of PAHO.
21. % districts covered by national PPH programs?	Data not known.
22. % SBAs reached by national PPH programs?	Data not known.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Adding to the initiative the major schools recognized for human resources in obstetrics: faculty of medicine, clinical hospital of the National University of Asunción (UNA) and the college of obstetrics "Andre Barbero" also of UNA.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Raise funds for this initiative. The MOH receives support from PAHO for this task.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	NO
7. Global management principles for PE/E in in-service training courses for SBAs?	NO
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Not often
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	N/A
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Not alone. YES, in collaboration with the MCHIP Paraguay project in two health regions of the country and with PAHO in other regions.

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	MCHIP Paraguay—training in the provision of high-quality care and updates in delivery care, and emergency obstetric and neonatal care to health care workers of the public health system in two health regions of Paraguay. MCHIP works to update national standards, clinical training in obstetric and emergency obstetric care, ToTs and community education to recognize danger signs and other things. All of this is done in the two health regions of the country selected by the MOH with the worse maternal mortality rates.
15. Activities in PE/E prevention and management undertaken by other partners?	Emergency obstetric workshops in other regions supported by PAHO.
16. % of districts covered by PE/E programs?	Data not known.
17. % of SBAs reached by national PE/E programs?	Data not known.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Adding to the initiative, the major schools recognized for human resources in obstetrics: faculty of medicine, clinical hospital of the national university of Asuncion (UNA) and the college of obstetrics "Andre Barbero" also of UNA.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Raise funds for this initiative. The MOH receives support from PAHO for this task.

RWANDA

Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Dr. Beata Mukarugwiro, bgrugwiro@yahoo.fr, +250788434986
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, nursing schools that include midwifery.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES, we are at beginning working in 4 districts with MOH that has VSI/MCHIP support. Misoprostol is already approved with CHW PPH prevention and in clinic for PAC.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	Scaling up in one year the program of CHW giving misoprostol to pregnant women. In two years, plan to be in all 30 districts. CHW program is quite well-organized in all districts.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	NO, it is available during supervision visits. Also probably due to the supply process to get meds to the district level.
15. How frequently do stock-outs of oxytocin occur?	
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	On the partograph but not standardized (providers initiative). Plan to include in upcoming revision of HMIS. Only on the partograph if the midwife takes the initiative to write it in.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	EmONC training with AMTSL, avail oxytocin at health facilities, use of misoprostol approved at community level and the country is in the process of starting its provision.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	EmONC training with AMTSL, introduction of misoprostol at community level, supporting the participation in PPH conference.
20. Activities in PPH prevention/management undertaken by other partners?	Global fund: equipment, drug, infrastructure (rehabilitating facilities), oxytocin provision UNFPA, WHO, UNICEF, GTZ: training in EmONC, oxytocin provision UNICEF; also working in infrastructure.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	20%
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Training organized by MOH; MCH conference every year could be a place to discuss achievements; misoprostol approved to be used at community level; integration in curriculum of nursing schools.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Community prevention of PPH just at the beginning, need to be reinforced. 2. PAC: approved in policy and training done but NO MVA equipment in health facilities. 3. Staff turn over.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *NO (can be used as second-line)*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES, second-line* Hydralazine *YES, first-line* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, they teaching using MOH protocols, medical doctors, nurses, midwives.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	At DH level
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	NO, often at DH, frequently at HC.
M&E	
11. Indicator of severe PE/E management in HMIS?	YES, in maternity indication of cesarean section PE/E and in revision to be added if the woman has a vaginal birth.
12. What is indicator and where is it recorded?	Maternity chart, cesarean section log book
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Training in FANC (focused ANC which includes nutrition, IPT, iron/folate, BP check) and assessing all women for HBP, assure availability of MgSO4, assure availability of IV HBP drugs.

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Review of the training materials to include management of eclampsia. Training of providers in management of eclampsia, training of providers in prevention of PE/E.
15. Activities in PE/E prevention and management undertaken by other partners?	Buying drugs, training
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	20% with EmONC training.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	MCH conference every year could be a place to discuss achievements, integration in curriculum of nursing schools.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Availability MgSO4 and HBP IV drugs. Management postpartum. Little proportion of women having four recommended ANC.

SENEGAL

Is there an MCHIP presence in this country? ***(YES/NO)***	NO MNCH/FP/MALARIA bilateral INTRAHEALTH International
CONTACT PERSON (responsible for updates to this matrix)	Dr. Fatou Ndiaye, fndiaye@intrahealth.org, 00221775208669
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	NO
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, ob/gyn, midwives nurses
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO, misoprostol for PPH prevention is being piloted at health hut level by Abt in collaboration with CEFOREP and MOH.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Depend on facilities stock-outs occur less frequently at hospital level and more frequently at health post level.
M&E	
16. Is AMTSL included in the national HMIS?	YES
17. Where is AMTSL recorded?	Delivery register, partograph
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Advocacy with USAID and others partners to support PPH program. Introduced oxytocin on EDL.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Strengthening providers competency through: • Training • Supportive supervision • Logistics • Advocacy in community to prevent PPH
20. Activities in PPH prevention/management undertaken by other partners?	UNFPA is training nurse and midwives to strengthen their competencies in non-USAID regions.
21. % districts covered by national PPH programs?	70%
22. % SBAs reached by national PPH programs?	
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	MOH has policy in place and needs support for program generalization in all regions. Particularly, regions not covered by any maternal health program. Train all SBA on AMTSL.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Stock-out of oxytocin Inadequate cold chain has a negative effect on quality Lack of trained providers
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, included in obstetric program, midwives, ob/gyn, nurses.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Available only in hospitals and level 2 clinics.
M&E	
11. Indicator of severe PE/E management in HMIS?	NO, PE/E only recorded at service delivery level.
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Make available essential drugs.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	none
15. Activities in PE/E prevention and management undertaken by other partners?	none

16. % of districts covered by PE/E programs?	Only in hospital and level 2 health centers.
17. % of SBAs reached by national PE/E programs?	Only ob/gyns
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Integrate PE/E with new bilateral.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	NO, donors to support PE/E programs. The lack of competence for facility-based midwives to use MgSO4 correctly. The lack of training in facilities.

SOUTH SUDAN

Is there an MCHIP presence in this country? ***(YES/NO)***	NO MCHIP presence in country. There are a number of maternal health programs: 1. The government outsourced BPHS, part of which involves providing the whole package of PHC activities at the PHCC and PHCU. 2. Sudan Health Transformation Project II implemented by Management Sciences for Health (MSH) in collaboration with the 14 MOH-focus counties: MNH, FP are some of the high-impact activities. 3. UNFPA supporting EmONC, MISP, PAC training for all states: so far trained 326 mixed providers, doctors and MLPs from all the 10 states. 4. American Refugee Council (ARC) providing integrated comprehensive RH services in Upper Nile State, Malakal County. 5. UNICEF trained providers in LSS in EmONC, in neonatal care. 6. IMPAC (integrated management of pregnancy childhood illnesses) conducted by MOH and WHO.
CONTACT PERSON (responsible for updates to this matrix)	Dr. Mergani Abdalla Mohammed, consultant obstetrician and gynecologist, Juba Teaching Hospital +249 9126 779 46. E-mail: amergani@ymail.com.OR merganiabdalla@gmail.com Alternate: Dr. Edward Eremugo Luka, PHC advisor, MSH/SHTP II, JUBA, South Sudan E-mail: eluka@msh.org Tel: +249 912 925 346
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	NO, AMTSL is not specifically singled out as a national policy, but in: • South Sudan Interim Health Policy • MRH Policy in January 2007 • MRH Situational Analysis in April 2007 • Reproductive Health Commodity Security Situational Analysis • Maternal, Neonatal and Reproductive Health Strategy • Prevention and Treatment Guidelines for PHCC and hospitals—All these documents, especially the guidelines, are very specific on the need for and how to manage PPH and PE/E. • Family Planning Technical Guidelines
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, in the Prevention and Treatment Guidelines for PHCC and hospitals; these guidelines are very specific.
3. Is misoprostol approved for prevention and/or treatment of PPH?	Misoprostol currently is not registered in South Sudan. There are recommendations to have it on the EDL and hence in the various kits—RH kits supplied and supported by UNFPA, governments drug kits to the PHCC. NO, but is used by some obstetricians if available. The cost of one 200 microgram tablet in the private pharmacies is 25 SDG.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	As of now, the regulations and standards are being developed. However, in most facilities, midwives are the ones who conduct the deliveries including attempts to remove retained placenta manually. This is one of the skills that the people who undergo the accelerated training in EmONC acquire and they are practicing the same.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, particularly in the hospital settings. The challenge over the last five years has been the availability of oxytocin consistently, especially at the PHCC and more so at the PHCU.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, especially the new diploma midwifery training in Juba Teaching Hospital. The various training institutions are in the process of upgrading their curriculum to include LSS in EmONC. The same is being done in the school of Midwifery, Juba. It was included in the community midwifery curriculum; we believe it will be included in the medical school curriculum.

7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, in the Community Midwifery Program and the Diploma in Midwifery Program being finalized. It will be more emphasized with the new curriculum.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO, misoprostol is not available in the country. It is available in the black market but very expensive. It retails at 25 SDP for the 200 microgram.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO, it is not available.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	NO
13. Is oxytocin regularly available at facilities with maternity services?	NO, it is available at the hospitals throughout but not at the primary health care facilities. These facilities experience stock-outs on and off for various reasons.
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Sometimes stock-outs can be for a very long period of time. At the PHCU, sometimes it is not in the drug kits and if it misses in the drug kit, then it means it can stock-out for up to four to six months, depending on the season.
M&E	
16. Is AMTSL included in the national HMIS?	NO, it has not been included it is hoped with the current ongoing revisions it will be included. What is included in the delivery register is whether oxytocin has been given or not but not the whole package of AMTSL.
17. Where is AMTSL recorded?	Oxytocin is recorded in the delivery register. Sometimes the whole process of AMTL is recorded in the clients' clinical notes. The whole record system is very poor at the moment in most facilities. The record that is consistently had is the delivery records but the record book does not have provision for its recording. The maternity charts are not available at the PHC facilities.
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	The MOH together with various partners working at the PHC levels is being trained on comprehensive life-saving skills in maternal and neonatal heath care with emphasis on: • Education of women and the community on danger signs in pregnancy especially bleeding and education. • Sensitization and mobilization for health facility delivery. • Introduction of AMTSL in the basic training in midwifery. • Dissemination of the various policies and guidelines on MNH. • The Ministry is targeting the issues of maternal health and especially PPH, which is the leading killer of women. • Educating women and the communities to attend ANC and health facility delivery with a SBA. • Skills training in EMOC by UNFPA in collaboration with the MOH. • Skills training in MNH by SHTP II managed by MSH in collaboration with MOH and subcontracting partners. • IMPAC skills training by WHO/UNICEF in collaboration with MOH.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Supporting training in MNH to all levels of health providers, these training programs focus on: • Management, roles and responsibilities of all health providers. • Importance in being proactive in communities education, sensitization and mobilization for ANC, facility delivery and PNC. • Family planning/birth spacing. • Reprinting, dissemination and distribution of the relevant guidelines in MNH. • Collaboration with SCP to assist with transport logistics for referrals of mothers where there are no ambulances. • Through the SCP helping distribute the drugs, RH kits. supplied by UNFPA included in this are the oxytocic drugs. • Facilitative support supervision to the staff and facilities in SHTPII focus areas. • Improving infrastructure to make facility delivery attractive. • Supporting infection prevention activities (waste and sharps disposal).
20. Activities in PPH prevention/management undertaken by other partners?	Training in LSS in EmONC. Training in infection prevention practices, health education on danger signs in pregnancy, labor and childbirth. Currently, ARC is working on management of PE/E and PPH in two sites in Malakal, Upper Nile State; BAM PHCC and Malakal Teaching Hospital. ARC's work in these sites has been part of a larger multi-year comprehensive RN program that focuses on upgrading these facilities to include basic EmONC and comprehensive EmONC services. Over the past five years, ARC has sent medical doctors, nurses, clinical officers and registered nurses to competency-based clinical training on emergency obstetrics, including management of obstetrical complications (i.e., PE/P and PPH) at the Marie Stopes International/Eastleigh Training Institute in Nairobi, Kenya. In addition, ARC has worked closely with UNFPA and the MOH to ensure that there is a constant supply of uterotonics and anti-convulsions drugs in each facility.
21. % districts covered by national PPH programs?	There is NO exact mapping available as yet. There is NO national PPH program.
22. % SBAs reached by national PPH programs?	There is NO exact mapping available as yet. There is NO PPH program.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	There are opportunities for starting the program as a national program integrated with all the ongoing initiatives: Political Level: 1. The Minister for Health is very passionate about MNH. He is proactive and from a RH programmatic background. 2. At policy level, the Undersecretary and all the relevant DGs area ll is very concerned about the high levels of MMR and the NNMR and the fast approaching MDG target year. 3. The resurrection of the RH working group is a forum that can be effectively used. 4. There are curriculums being finalized for midwifery, medical school and community midwifery curriculum being reviewed all these are opportunities. 5. Champions are available among several DGs. 6. Use the experiences of ARC at Bam and Malakal as a model and roll in components of community education activities that have been very successful in other locations in Southern Sudan (radio, video, drama, peer to peer education, etc.).

24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Health Systems—the country is just recovering from a long civil strife. The health services have been provided on an emergency state with NO development and sustainability component. The MOH GOSS is in the process of: o Rolling out various policies, protocols, standards and guidelines, sorting out the M&E, the mapping of health facilities, current personnel and services is just being concluded. Scaling will depend on the specific unit programs done by different organizations. These can be started as national programs and compared in different states. 2. Accelerating the refresher causes on the skills to already serving service providers: o On AMTSL program and protocols o Lobby for the registration of misoprostol and add it to EDL
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine*YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	The Prevention and Treatment Guidelines for PHCC and hospitals very clearly spells out what they need to do before referral. The same guidelines also spells out very clearly what they can do to eclamptic patients using MgSO4.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, pre-service curriculum for midwives is currently being updated to include this. The community midwifery curriculum will too be updated. It is hoped.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	It is not regularly available.
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Sometimes very frequently especially at the PHCC facilities.
M&E	
11. Indicator of severe PE/E management in HMIS?	Not at the moment.
12. What is indicator and where is it recorded?	It is lumped under complications of pregnancy.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	There are NO specific programs for PE/E but it is being covered under essential obstetrics and neonatal care and comprehensive obstetrics and neonatal care. The various guidelines for PHCU, PHCC and hospitals spell out what can be done at what.

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Supporting training in MNH to all levels of health providers; the training programs focus on: • Management, roles and responsibilities of all health providers • Importance in being proactive in communities education, sensitization and mobilization for ANC, facility delivery and PNC • Family planning/birth spacing • Reprinting, dissemination and distribution of the relevant guidelines in MNH • Collaboration with SCP to assist with transport logistics for referrals of mothers where there are NO ambulances • Through the SCP helping distribute the drugs, RH kits supplied by UNFPA included in this is the oxytocics drugs • Facilitative support supervision to the staff and facilities in SHTPII focus areas • Improving infrastructure to make facility delivery attractive • Supporting infection prevention activities (waste and sharps disposal)
15. Activities in PE/E prevention and management undertaken by other partners?	Trainings in infection prevention practices, health education on danger signs in pregnancy, labor and childbirth. Currently, ARC is working on management of PE/E and PPH in two sites in Malakal, Upper Nile State; BAM PHCC and Malakal Teaching Hospital. ARC's work in these sites has been part of a larger multi-year comprehensive RH program that focuses on upgrading these facilities to include basic EmONC and comprehensive EmONC services. Over the past five years, ARC has sent medical doctors, nurses, clinical officers and registered nurses to competency-based clinical trainings on emergency obstetrics, including management of obstetrical complications (i.e., PE/P and PPH) at the Marie Stopes International/Eastleigh Training Institute in Nairobi, Kenya. In addition, ARC has worked closely with UNFPA and the MOH to ensure that there is a constant supply of uterotonics and anti-convulsions drugs in each facility.
16. % of districts covered by PE/E programs?	Between 2007 and now, staff from all counties have been reached by LSS trainings in EmONC and MNH trainings.
17. % of SBAs reached by national PE/E programs?	NA
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	There are opportunities for starting the program as a national program integrated with all the ongoing initiatives: Political Level: 1. The Minister for Health is very passionate about MNH. He is proactive and from a RH programmatic background. 2. At policy level, the Undersecretary and all the relevant DGs area ll very concerned about the high levels of MMR and the NNMR and the fast approaching MDG target year. 3. The resurrection of the RH working group Is a forum that can be effectively used. 4. There are curriculums being finalized for midwifery, medical school and community midwifery curriculum being reviewed all these are opportunities. 5. Champions are available among several DGs. 6. Use the experiences of ARC at Bam and Malakal as a model and roll in components of community education activities that have been very successful in other locations in Southern Sudan (radio, video, drama, peer to peer education, etc.). 7. The guidelines will need: disseminations and roll out to all facilities. 8. Use the Reproductive Health Council of Ministers for advocacy especially institutionalizing trainings of health providers locally. 9. Support to the HR Directorate to lobby to resuscitate all institutions that were training any form of health providers to be upgraded to train MLPs especially nurse-midwives who can be used to scale up the programs especially if the programs are inbuilt in the basic training.

19. Significant bottlenecks to scaling up PE/E management programs in your country?	1. Health Systems—the country is just recovering from a long civil strife. The health services have been provided on an emergency state with NO development and sustainability component. The MOH GOSS is in the process of: o Rolling out various policies, standards and guidelines, sorting out the M&E, the mapping of health facilities, current personnel and services is just being concluded. Scaling will depend on the specific unit programs done by different organizations. These can be started as national programs and compared in different states. 2. Accelerating the refresher causes on the skills to already serving service providers.

TANZANIA

Is there an MCHIP presence in this country? ***(YES/NO)***	YES, for male circumcision. USAID MNH support is channeled primarily through the MAISHA Program (associate award under ACCESS), led by Jhpiego, partnering with Save the Children, Futures Group/White Ribbon Alliance, IMA World Health and T-MARC.
CONTACT PERSON (responsible for updates to this matrix)	MAISHA/Tanzania
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, for PPH by both Tanzania Food and Drug Authority (TFDA) and MOHSW, but only approved by TFDA so far for use in PAC.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, ongoing, midwives, nurses with midwifery skills, non-physician clinicians with obstetrical skills, general doctors with obstetrical skills or obstetric specialists.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, ongoing
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	NO
14. Do stock-outs of oxytocin occur?	YES, there are also frequent stock-outs of misoprostol.
15. How frequently do stock-outs of oxytocin occur?	Frequently, at some facilities throughout a quarter, per MAISHA sentinel site database.
M&E	
16. Is AMTSL included in the national HMIS?	YES, but in draft form.
17. Where is AMTSL recorded?	Proposed to be included in delivery register, partograph notes in HMIS tools, which are in draft.

PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Training of service providers on EmONC. Include in guidelines. Supportive supervision. Conducting study change project in AMTSL at Tumbi Regional Hospital and Kigamboni Health Center (Dr. Winani 2009).
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Support BEmONC training of service providers at facilities. Supportive supervision and quality improvement.
20. Activities in PPH prevention/management undertaken by other partners?	Training of service providers, supply posters and follow-up supervision. Training on BEmONC.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	Unclear, all are targeted, but not all have yet been reached.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Policy environment is conducive, White Ribbon allies creating opportunities and opening up for developing champions through it structured support would lead to dissemination of messages; national conference scheduled for next year needing support include; RMOS and DMOS meetings, nursing and midwives association annual meetings. MOH has policy in place and needs avenues to disseminate it; MOH has an annual RCH coordinators meeting where PPH work can be discussed and disseminated.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Effective training, supervision, coaching and mentoring of service providers on AMTSL on site. Constant supply of uterotonics. Inadequate supply of skilled service providers. Poor attitude of some health care providers.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine *YES* Nifedipine *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, ongoing, midwives, nurses with midwifery skills, non-physician clinicians with obstetrical skills, general doctors with obstetrical skills or obstetric specialists.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Sometimes whole quarter

M&E	
11. Indicator of severe PE/E management in HMIS?	YES, in the proposed draft document.
12. What is indicator and where is it recorded?	Proportion of women who delivered and had eclampsia. Delivery register, HMIS quarterly tool.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Coordinate curricular review coordinate curricular implementation; training on AMTSL.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Technical assistance from advocacy to program design, implementation, monitoring and evaluation as well as provision of funds, equipment and instruments.
15. Activities in PE/E prevention and management undertaken by other partners?	Health facility strengthening, training, supervision, mentoring, equipping facilities.
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Policy environment is conducive, White Ribbon allies creating opportunities and opening up for developing champions through it structured support would lead to dissemination of messages; national conference scheduled for next year needing support include; RMOS and DMOS meetings, nursing and midwives association annual meetings. MOH has policy in place and needs avenues to disseminate it.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Supervision, coaching and mentoring of service providers on detection and management of PE/E on site. Effective training focusing on necessary competencies. Non-availability of constant supply of magnesium sulfate, hydralazine, nifedipine, methyldopa, hydralazine.

UGANDA

Is there an MCHIP presence in this country? ***(YES/NO)***	NO 1. STRIDES for Family Health Project by Management Sciences for Health (MSH) implementing in 15 districts (total 112 districts in Uganda) as part of the Life-Saving Skills training for Emergency Obstetric and Newborn Care Package 2. Health Care Initiatives by URC—implementing in two districts 3. Association of Obstetricians and Gynecologists of Uganda implementing in two districts 4. HSSPP II by the African Development bank in 10 districts 5. PREFA in four districts 6. EngenderHealth support the prevention of Obstetric Fistula 7. Pathfinder International supports training in EmONC 8. Marie Stopes Uganda supports EmONC through using the voucher system "OBA" 9. UNICEF supporting ANC within in eight districts 10. UNFPA strengthening midwifery in six districts
CONTACT PERSON (responsible for updates to this matrix)	Dr. Miriam Sentongo, Senior Medical Officer, Reproductive Health Division Ministry of Health, Uganda, mirnastogo@gmail.com Tel: 256-772-413433
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, as part of the In-service Training Guidelines.
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, as a second-line drug.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES, as part of the basic emergency obstetric care services.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES, all midwives are authorized to use oxytocin for prevention of PPH. However, some facilities still have ergometrine stocks, and many midwives have not been trained in the skill.
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, for medical officers, medical clinical officers and midwifery training institutions in the private sector. For the midwifery training schools in the public sector under the Ministry of Education, only a quarter of the tutors have so far been oriented in the provision of AMTSL by the MOH. The curriculum is difficult to change outside of the scheduled reviews.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	Not clear as yet.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, as part of Life-Saving Skills curriculum.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO, it is not the policy to distribute misoprostol at the community level.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES

14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	Infrequently because of the PUSH system of medicines delivery to the lower-level health facilities.
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery logs (maternal register), maternity chart (partographs)
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	AMTSL, intravenous oxytocics for all SBAs at all levels of service delivery.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	AMTSL in only two districts by URC.
20. Activities in PPH prevention/management undertaken by other partners?	AMTSL—Health Care Initiatives URC. Association of Obstetricians and Gynecologists of Uganda.
21. % districts covered by national PPH programs?	Cannot tell because new districts created; however, all regional referral hospitals were covered. Under the current policy it should be all health facilities in the public sector and private sector that collaborate with the district local authorities.
22. % SBAs reached by national PPH programs?	Not known
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	MOH has the policy in place and needs to be supported to roll out the in-service training and support the service provision with coaching and mentoring of service providers.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	1. Funding for the training of service providers. 2. Solutions: Well-coordinated implementing partners to cover the whole country. 3. Availability of skilled human resource for health. 4. Solutions: Recruitment of new staff to fill the existing gaps; incentives to retain staff in some difficult to stay areas. 5. Stock-outs of medicines and supplies including the oxytocin and MgSO4. 6. Solutions: An essential medicines kit for MCH services is delivered to the lower-level health facilities by the PUSH system, to reduce on stock-outs, although this may not suffice for facilities with a high volume of patients. 7. Low numbers of mothers delivering at the health facility. 8. Solutions: BCC campaigns to encourage mothers deliver under the care of a skilled attendant at a health facility.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES

TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES for medical doctors, for private nursing/midwifery schools. The public schools are under the jurisdiction of the Ministry of Education and only some of the tutors have been oriented in the practice. NO materials have been updated yet by MOH for the pre-service training.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES, because of the PUSH system of delivery of medicines and supplies.
9. Do stock-outs of MgS04 occur?	YES, even due to expiry as a result of: 1. Lack of skills, amongst the service providers in administering of MgSO4. 2. Infrequent diagnosis or admission of PE/E cases at the lower level facilities. 3. It seems to have a short shelf-life.
10. Frequency of MgSO4 stock-outs?	
M&E	
11. Indicator of severe PE/E management in HMIS?	NO
12. What is indicator and where is it recorded?	
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	In-service training under the Basic EmONC package: diagnosis and provision of magnesium sulfate to public and some private sector health facilities within the essential MCH medicines package.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Training and mentoring of service providers under the EmONC package.
15. Activities in PE/E prevention and management undertaken by other partners?	Training and mentoring of service providers under the EmONC package.
16. % of districts covered by PE/E programs?	Unknown, awaiting Service Provision Assessment Survey.
17. % of SBAs reached by national PE/E programs?	Unknown, there is NO central inventory.
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	There is a policy in place that needs financial support to roll out.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	1. Service providers without the required skills at the lower health facilities to diagnose and treat the condition. 2. **Solution:** In-service training. 3. Service providers without the supplies and medicines to manage a case. 4. **Solutions:** PUSH system to reduce the stock-outs. 5. Inadequate numbers of service providers to train. 6. **Solutions**: Recruitment of more providers or task-shifting.

ZAMBIA

Is there an MCHIP presence in this country? ***(YES/NO)***	NO • Zambia Integrated Services and Systems Program (ZISSP), USAID bilateral, Abt. Associates prime • Mobilizing Access to Maternal Health Services in Zambia (MAMaz), DfID community EmONC project, Health Partners International • DfID Human Resources for Health, Crown Agents International • GRZ/UNFPA Joint Country Program (for IRH and SM)
CONTACT PERSON (responsible for updates to this matrix)	Dr. Reuben Mbewe, Deputy Director, Public Health and Research Reproductive Health, rmkamoto@hotmail.com, +260 977 823 380
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES, AMTSL is included in both the national Safe Motherhood Guidelines and the national Integrated Technical Guidelines for Frontline Health Workers.
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES, it is approved for prevention and treatment of PPH; however, it is not yet incorporated with the Safe Motherhood or Integrated Technical Guidelines or the midwifery pre-service curriculum. It is included in the draft national in-service EmONC training curriculum, which is in the process of revision.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, medical doctor, clinical officer, registered and enrolled midwife, registered and enrolled nurse
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES for doctors, midwives, clinical officers and medical licentiates
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, it is included in the national EmONC in-service training curriculum, which trains all SBA cadres.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	YES, it was piloted in 15 districts in 2010 (10 districts PSI, five districts VSI). Pilot was completed and results disseminated in 2010.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	YES, scale-up planned to at least 10 districts in 2011.
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES, but for treatment of ulcers, not PPH prevention.
13. Is oxytocin regularly available at facilities with maternity services?	Irregular stocks in rural areas due to delays in facility ordering, stock delivery delays, and central-level stock-outs.
14. Do stock-outs of oxytocin occur?	YES
15. How frequently do stock-outs of oxytocin occur?	PSI reports that in January–December 2010, 84% of 209 facilities visited in 10 rural districts had NO oxytocin due to stock-outs at Central Medical Stores. This was an increase from March–December 2009 when 54% of 205 health facilities had stock-outs.

M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery log, maternity charts
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Pre-service Education: • Manual removal of the placenta • AMTSL EmONC In-service Training Program – 53/73 districts reached: • Manual removal of the placenta • AMTSL Community Interventions: • Training of community Safe Motherhood Action Groups (SMAGs) to sensitize on SM and assist with transport for facility delivery.
19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	**ZISSP Bilateral** (follow-on from HSSP Bilateral)—Plans for: EmONC ToTs, establish two new EmONC training sites (for total of four), finalize revised EmONC curriculum, community training in home-based Life-Saving Skills. Communications Support for Health Bilateral (CSH): RH health promotion programs, including EmONC job aids. **PSI**—Potential USAID funding for scale-up in an additional five to 10 districts. **USAID DELIVER**—Established new LMIS, which includes oxytocin.
20. Activities in PPH prevention/management undertaken by other partners?	**Africare**—Supporting community Safe Motherhood Action Groups to encourage and facilitate facility deliveries. **CHAZ**—Supporting SMAGs, maternity waiting homes; administer midwifery schools. **DFID HRH Project**—Procuring and distributing EmONC equipment to MOH facilities in 18 rural districts. **MaMaz** (DfID) —Refresher training for SMAGs on danger signs; support to communities to identify danger signs and act; incentives for ANC and institutional deliveries, and emergency transport between homes and BEmONC centers; documentation of demand-side best practices to increase utilization of MNH services. **Riders for Health**—Coordinate community transport to increase facility deliveries in one district (soon to be two districts). **WHO**—Funding EmONC in-service training, supervision. **UNICEF**—Funding EmONC in-service training, supervision; procuring equipment; training and material support to SMAGs. **UNFPA**—Funding EmONC in-service training, supervision; procuring equipment; training and material support to SMAGs. **VSI**—In 2010, completed a pilot on facility-based distribution of Misoprostol for prevention of PPH in 5 districts – clinical training for service providers and IEC training for Safe Motherhood Action Groups. Seconding National Misoprostol Program Coordinator to MOH through March 2011. **World Bank RBF**—EmONC equipment, maternity ward refurbishments, building of maternity waiting shelters in 18 districts. ***NB:*** *MOH and partners co-funding EmONC trainings and supervision via EmONC TWG; Zambia Cabinet Office contributing funds for procurement of EmONC equipment to reach 39 districts total.*
21. % districts covered by national PPH programs?	100%, all delivery centers (taking into account pre-service and the variety of programs listed above); 83% reached by EmONC in-service program.
22. % SBAs reached by national PPH programs?	100% (taking into account pre-service and the variety of programs listed above).

OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Revised EmONC In-Service training curriculum, with inclusion of misoprostol for PPH prevention; revision completed but finalization currently stalled. Inclusion of misoprostol in the EDL for PPH prevention—efforts currently under way. Inclusion of misoprostol for PPH prevention in the clinical guidelines and pre-service and midwifery in-service curriculums. Roll-out of anti-shock garment to all delivery centers—pilot under way by UCSF Bixby Center.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Human Resource Shortage (inadequate service providers and weak supervision) • Introduction of the Direct-Entry Midwifery Program (with mentorship curriculum). Second group to graduate this year, but they can only provide midwifery services and therefore cannot work alone at a health facility. • EmONC in-service training includes registered and enrolled nurses and clinical officers. • Rural retention schemes. • Roll out of IRH Supervisory Tool in some provinces. • Training for current nursing/midwifery managers. • Development of EmONC mentorship tool; training of mentorship teams. • Strengthening of Performance Management Appraisal System – cabinet to fund training of all health workers. Low Rate of Facility Delivery (43.2%): • Training and support to Safe Motherhood Action Groups (training curriculum awaiting MOH approval) to conduct integrated group education on SM and to assist with transport for facility delivery. Shortage of Equipment and Supplies: • Equipment being purchased and distributed through DfID HRH project and World Bank SDIF. • MOH trying to bring in public-private partnerships to support equipment and infrastructure improvements.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES* Diazepam *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *YES, but not available due to high cost* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *YES, but not available* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, doctors, clinical officers, enrolled and registered midwives and nurses.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	YES

9. Do stock-outs of MgS04 occur?	YES, but not at central level; often due to bottlenecks in ordering and delivery.
10. Frequency of MgSO4 stock-outs?	Rarely
M&E	
11. Indicator of severe PE/E management in HMIS?	NO, there is only a general indicator for "pregnancy complications."
12. What is indicator and where is it recorded?	Maternity charts, delivery log, district level database
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Pre-service Education: • FANC • Management with MgSO4 FANC In-service Training: EmONC In-service Training Program – 53/73 districts reached Community Interventions: • Training of community Safe Motherhood Action Groups (SMAGs) to sensitize on ANC attendance and danger signs in pregnancy.
14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	**ZISSP Bilateral** (follow-on from HSSP Bilateral)—Plans for EmONC ToTs, establish two new EmONC training sites (for total of 4), finalize revised EmONC curriculum, community training in home-based life-saving skills. **Communications Support for Health Bilateral (CSH)—**RH health promotion programs, including EmONC job aids. **USAID DELIVER**—Established new LMIS, which includes MgSO4.
15. Activities in PE/E prevention and management undertaken by other partners?	**Africare**—Supporting community Safe Motherhood Action Groups to encourage ANC attendance and sensitize on danger signs in pregnancy within integrated SM education. **CHAZ**—Supporting SMAGs, maternity waiting homes; train enrolled midwives. **DFID HRH Project**—Procuring and distributing EmONC equipment to MOH facilities in 18 rural districts. **MaMaz** (DfID) —Refresher training for SMAGs on danger signs; support to communities to identify danger signs and act; incentives for ANC and institutional deliveries, and emergency transport between homes and BEmONC centers; documentation of demand-side best practices to increase utilization of MNH services. **Riders for Health**—Coordinate community transport and assist districts to maintain vehicles, to increase facility deliveries in one district (soon to be two districts). **WHO**—Funding EmONC in-service training, supervision; funding FANC training. **UNICEF**—Funding EmONC in-service training, supervision; procuring equipment; training and material support to SMAGs; funding FANC training. **UNFPA**—Funding EmONC in-service training, supervision; procuring equipment; training and material support to SMAGs; funding FANC training. **World Bank RBF**—EmONC equipment, maternity ward refurbishments, building of maternity waiting shelters in 18 districts. ***NB:*** *MOH and partners co-funding EmONC training and supervision via EmONC TWG; Zambia Cabinet Office contributing funds for procurement of EmONC equipment to reach 39 districts total.*
16. % of districts covered by PE/E programs?	100% , all delivery and ANC centers (taking into account pre-service and the variety of programs listed above); 83% reached by EmONC in-service program.
17. % of SBAs reached by national PE/E programs?	100%, taking into account pre-service and the variety of programs listed above.

OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Scale-up of EmONC in-service training to all 73 districts. Roll out of PPP for infrastructure and equipment support. Scale-up of SMAG programs to increase early ANC attendance and facility delivery. MOH and Zambia Forum for Health Research to conduct research on eight priority areas in RH, including EmONC.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Human Resource Shortage (inadequate service providers and weak supervision): • Introduction of the Direct-Entry Midwifery Program (with mentorship curriculum). Second group to graduate this year, but because they do not have the full set of nursing skills, they cannot be placed in the most rural, high-need facilities. • EmONC in-service training includes registered and enrolled nurses and clinical officers. • Rural retention schemes. • Roll out of IRH Supervisory Tool in some provinces. • Management training for current facility in-charges. • Development of EmONC mentorship tool; training of mentorship teams. • Strengthening of Performance Management Appraisal System—cabinet to fund training of all health workers. Late attendance at ANC (19% attendance in first trimester): • Sensitization by SMAGs on early ANC attendance, danger signs in pregnancy, and male involvement. Low Rate of Facility Delivery (43.2%): • Training and support to Safe Motherhood Action Groups (training curriculum awaiting MOH approval) to conduct group education on SM and to assist with transport for facility delivery.

ZANZIBAR

Is there an MCHIP presence in this country? ***(YES/NO)***	NO USAID MNH support is channeled primarily through the MAISHA Program (associate award under ACCESS), led by Jhpiego, partnering with Save the Children, Futures Group/White Ribbon Alliance, IMA World Health and T-MARC.
CONTACT PERSON (responsible for updates to this matrix)	MAISHA/Tanzania
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	YES
3. Is misoprostol approved for prevention and/or treatment of PPH?	YES
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	YES
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, it was included during the update of curriculum of collage of health science for nurses and clinical officers.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES, assessments are done during their practical session/skills.
8. Is AMTSL included in in-service training curricula for all SBA cadres?	YES, ongoing
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NOT YET, under discussion.
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	NO
14. Do stock-outs of oxytocin occur?	YES, there are also frequent stock-outs of misoprostol.
15. How frequently do stock-outs of oxytocin occur?	Frequently, at some facilities throughout a quarter, per MAISHA sentinel site database.
M&E	
16. Is AMTSL included in the national HMIS?	Not all components of AMTSL are captured in HIMS form. Only oxytocin is recorded.
17. Where is AMTSL recorded?	Maternity registers book, HIMS forms
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Training of service provider on EMONC Include in guidelines Supportive supervision

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Support BEmONC training of service providers at facilities. Supportive supervision and quality improvement.
20. Activities in PPH prevention/management undertaken by other partners?	Training of service providers in BEMONC, supply posters and follow-up supervision.
21. % districts covered by national PPH programs?	100%
22. % SBAs reached by national PPH programs?	Unclear—all are targeted, but not all have yet been reached.
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	Policy environment is conducive, White Ribbon allies creating opportunities and opening up for developing champions through it structured support would lead to dissemination of messages; MOH has policy in place and needs avenues to disseminate it; good champions in place but more are needed at operational level.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	Effective training, supervision, coaching and mentoring of service providers on AMTSL onsite. Constant supply of uterotonics Inadequate supply of skilled service providers Poor attitude of some health care providers
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
1. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES*
2. Is MgSO4 on the EDL for severe PE/E?	YES
3. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
4. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
5. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	YES, midwives are trained to diagnose and administer initial dose of MgSO4. It is ongoing program.
TRAINING	
6. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, it was included for nurses and clinical officers.
7. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
8. MgSO4 regularly available at facilities?	NO
9. Do stock-outs of MgS04 occur?	YES
10. Frequency of MgSO4 stock-outs?	Sometimes whole quarter
M&E	
11. Indicator of severe PE/E management in HMIS?	YES
12. What is indicator and where is it recorded?	HIMS form captured availability of MgSO4.
PROGRAMMING	
13. Activities in PE/E prevention and management undertaken by the MOH?	Coordinate curricular review. Coordinate curricula implementation; training on AMTSL.

14. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Technical assistance from advocacy to program design, implementation, monitoring and evaluation as well as provision of funds, equipment and instruments.
15. Activities in PE/E prevention and management undertaken by other partners?	Health facility strengthening, training, supervision, mentoring, equipping facilities.
16. % of districts covered by PE/E programs?	100%
17. % of SBAs reached by national PE/E programs?	
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
18. Opportunities for program introduction, expansion, or scale-up.	Policy environment is conducive, White Ribbon allies creating opportunities and opening up for developing champions through it structured support would lead to dissemination of messages; MOH has policy in place and needs avenues to disseminate it; good champions in place but more are needed at operational level.
19. Significant bottlenecks to scaling up PE/E management programs in your country?	Supervision, coaching and mentoring of service providers on detection and management of PE/E on site. Effective training focusing on necessary competencies un availability of constant supply of MgSO4, hydralazine, nifedipine, methyldopa, hydralazine.

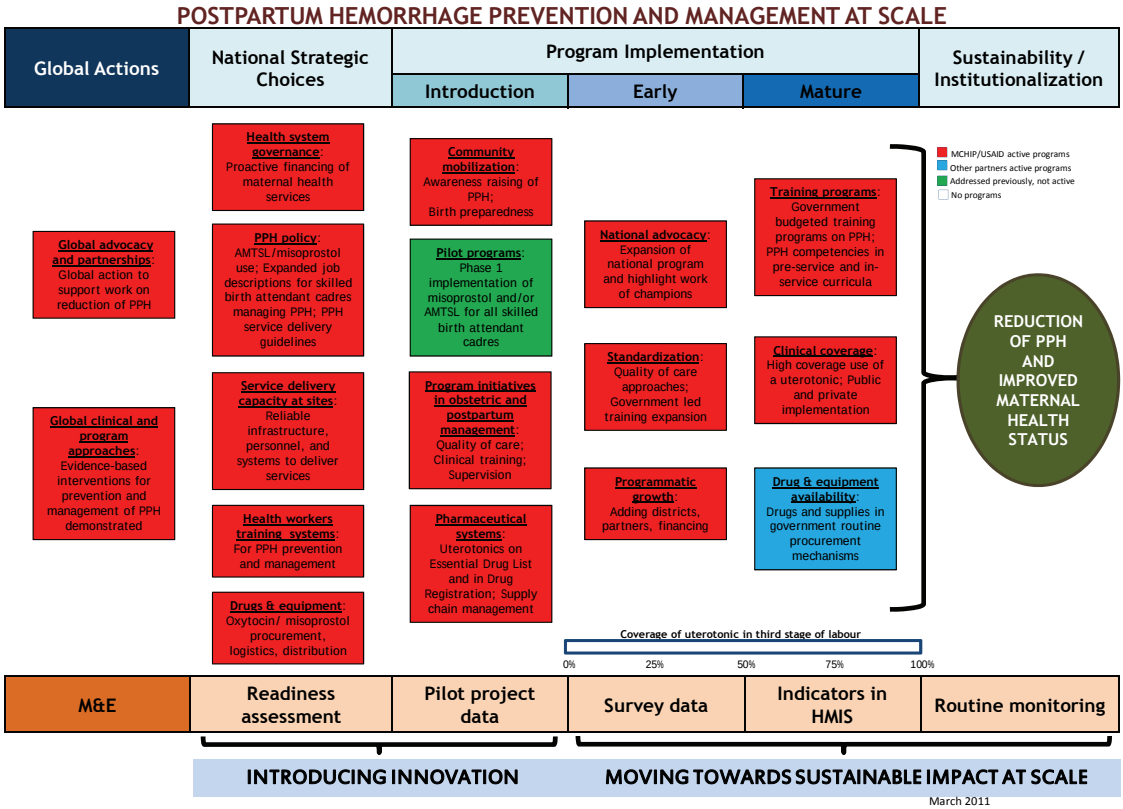
ZIMBABWE

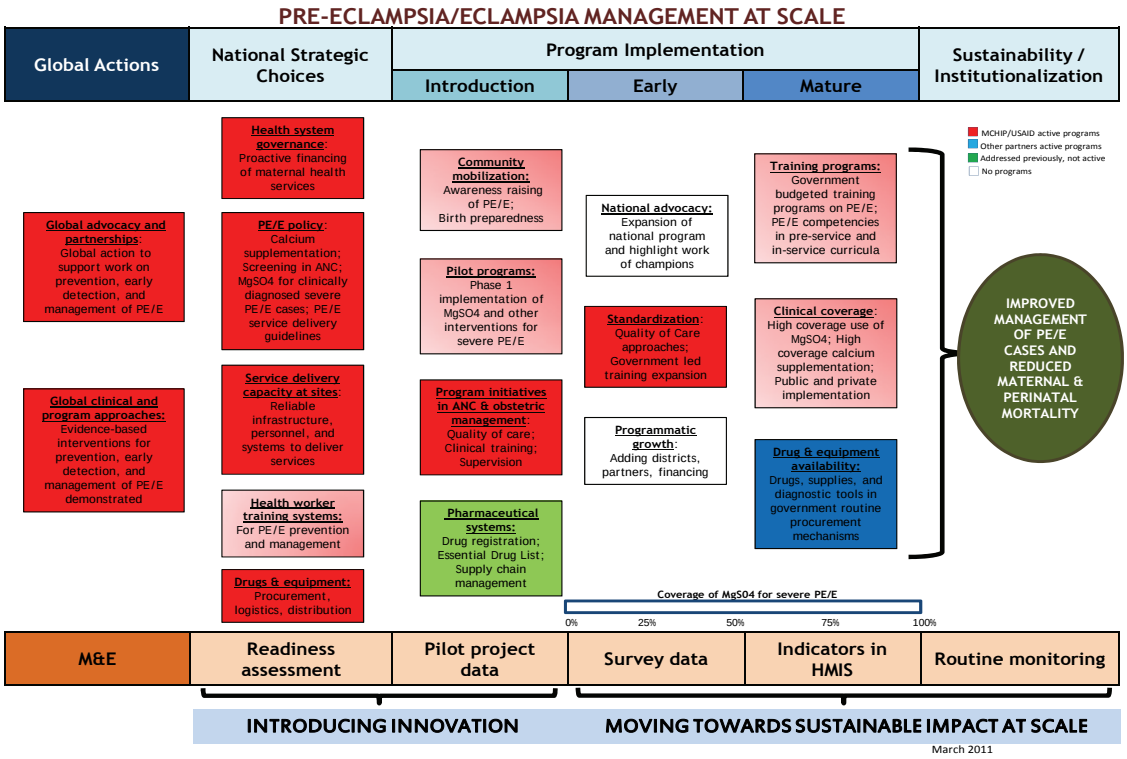
Is there an MCHIP presence in this country? *(YES/NO)*	YES
CONTACT PERSON (responsible for updates to this matrix)	Hillary Chiguvare, 00263772816636, Hillary@mchipzim.org
SECTION 1: POSTPARUM HEMORRHAGE (PPH)	
POLICY	
1. Is AMTSL at every birth approved as national policy?	YES
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	NO, guidelines still being developed.
3. Is misoprostol approved for prevention and/or treatment of PPH?	Partly, still reserved for use by specialists (ob/gyn) and only in central hospitals.
4. Are midwives authorized to perform manual removal of placenta at all levels of the health system?	NO, midwives at BEmOC facilities not performing MRP despite the policy statement from MOHCW (MOH and child welfare) allowing them to do so.
5. Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	YES
TRAINING	
6. Is PSE curricula updated to include AMTSL for all SBA cadres? If so, which cadres?	YES, midwives, doctors.
7. Are students assessed for competency of AMTSL as a clinical skill prior to graduation?	YES
8. Is AMTSL included in in-service training curricula for all SBA cadres?	NO, curricula for RGNs (regional general nurses) and PCNs (Primary Care Nurses, minimal training in midwifery) does not adequately cover AMTSL, yet these cadres assist in the majority of deliveries.
DISTRIBUTION OF MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH	
9. Is distribution of misoprostol for PPH prevention during home births being piloted?	NO
10. Is distribution of misoprostol for PPH prevention at home births being scaled up?	NO
LOGISTICS	
11. Is oxytocin on the EDL?	YES
12. Is misoprostol on the EDL?	YES
13. Is oxytocin regularly available at facilities with maternity services?	YES
14. Do stock-outs of oxytocin occur?	Sometimes. The PUSH system: checks on inventory and supply at all levels of health care system. Funded by UNICEF since late 2008.
15. How frequently do stock-outs of oxytocin occur?	Rarely
M&E	
16. Is AMTSL included in the national HMIS?	NO
17. Where is AMTSL recorded?	Delivery record, maternity register
PROGRAMMING	
18. What activities in PPH prevention and management are being undertaken by MOH?	Pre-service education for SBA covering PPH. Reviewing use of misoprostol at lower levels of the health system. Revising service delivery guidelines to cover AMTSL and management of PPH. Supporting procurement and distribution of oxytocin. Tracking and monitoring PPH contribution to maternal deaths.

19. Activities in PPH prevention/management undertaken by USG-sponsored programs?	Introducing and scaling up MNH SBM-R, which includes performance standards on prevention and management of PPH. In-service training on managing normal and complicated labor and delivery; including prevention and management of PPH. Supporting "up-skilling" of Primary Care Nurses with midwifery skills through a 6 month post-qualification training. Evaluating quality status of MNH care through supporting the MNH Quality of Care Study, which covers PPH. Supporting review of EDL and related policy advocacy for down grading misoprostol to "C" class in the EDL for use at lower levels of the health system. Supporting development of a comprehensive pre-service education strategy that includes incorporating PPH and other MNCH issues with pre-service education.
20. Activities in PPH prevention/management undertaken by other partners?	In-service training of LSS, which includes PPH Procurement and distribution of oxytocin Advocacy for SBAs to be allowed to do AMTSL Advocacy for down-grading of misoprostol to "C" level
21. % districts covered by national PPH programs?	100
22. % SBAs reached by national PPH programs?	More than 80%
OPPORTUNITIES FOR EXPANSION AND SCALE-UP	
23. Opportunities for program expansion/scale-up.	CARMMA ambassador (Deputy Prime Minister) has demonstrated her capacity to advocate for MNCH issues so she is an important person for advocacy. Pre-service education strategy and curricula review being planned for this year will provide an opportunity for incorporating PPH issues. Increasing number of partners supporting MNCH activities at the national level provides a platform for leveraging resources for PPH. MNH Road Map identifies PPH as a major cause of maternal mortality and specifies interventions that need scaling up.
24. Significant bottlenecks to scaling up PPH reduction programs in your country?	High attrition rate of SBAs— a retention scheme for health professionals is being implemented. Resistance by professional associations for lower level cadres to perform all components of preventing and managing PPH—more advocacy work is on but a clearer advocacy and communication strategy for MNH is required. Financing trainings for in service education—a joint national implementation plan for MNH has been developed and a resource mobilization strategy is being developed.
SECTION 2: PRE-ECLAMPSIA/ECLAMPSIA (PE/E)	
POLICY	
20. Drugs approved by national policy/SDGs as 1st line anticonvulsants for severe PE/E?	MgSO4 *YES, It is currently the second-line treatment with current policy but the policy is being revised and MgSO4 will then be first-line and Diazepam second-line.* Diazepam *YES*
21. Is MgSO4 on the EDL for severe PE/E?	YES
22. Drugs approved by national policy/SDGs as 1st line anti-hypertensive in severe PE/E?	Labetolol *NO* Hydralazine *YES, second-line* Nifedipine *YES, first-line* Methyldopa *YES, first-line for maintenance*
23. Drugs listed on EDL, as anti-hypertensive in management of severe PE/E?	Labetolol *NO* Hydralazine *YES* Nifedipine *YES* Methyldopa *YES*
24. Midwives authorized to diagnose severe PE/E and give 1st dose of MgSO4?	NO, MgSO4 is only administered at hospital level.

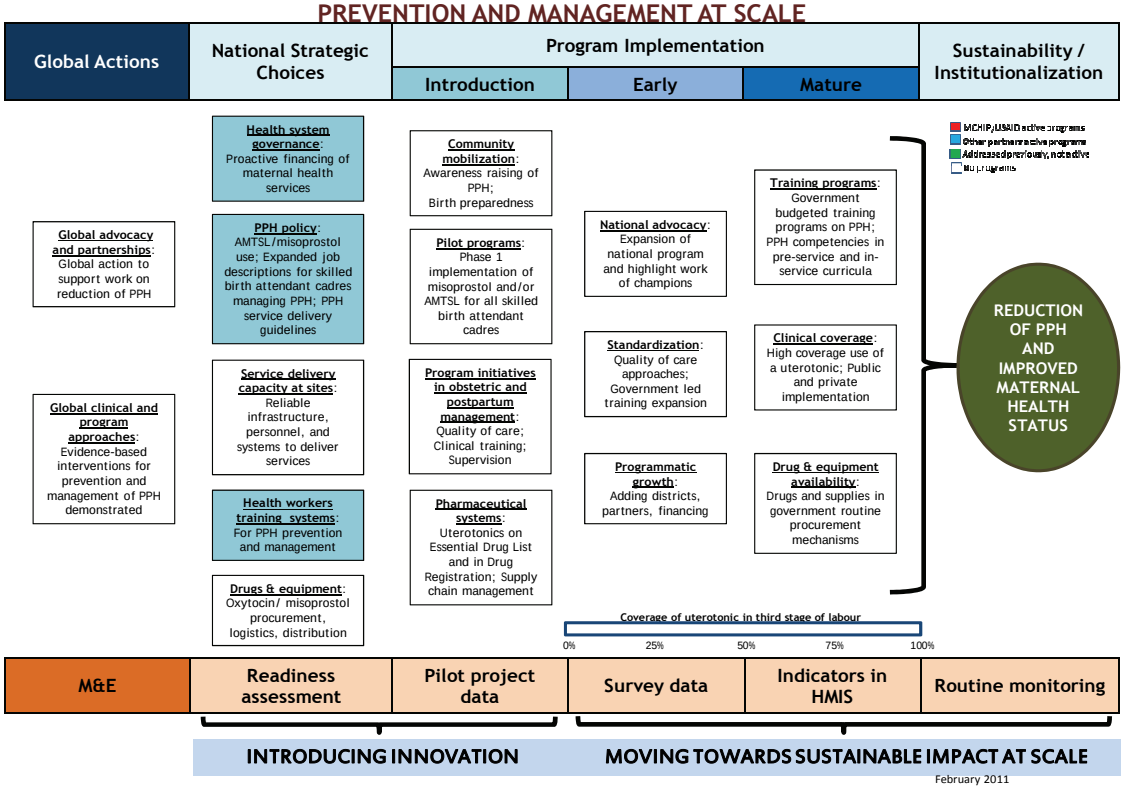
TRAINING	
25. PSE curricula include global management principles for PE/E for all SBA cadres?	YES, doctors and midwives
26. Global management principles for PE/E in in-service training courses for SBAs?	YES
LOGISTICS	
27. MgSO4 regularly available at facilities?	NO because currently not first-line anticonvulsant
28. Do stock-outs of MgS04 occur?	YES
29. Frequency of MgSO4 stock-outs?	Often
M&E	
30. Indicator of severe PE/E management in HMIS?	NO
31. What is indicator and where is it recorded?	N/A
PROGRAMMING	
32. Activities in PE/E prevention and management undertaken by the MOH?	Pre-service and in-service training on PE/E for midwives and doctors.
33. Activities in PE/E prevention and management undertaken by USG-sponsored partners?	Advocating for down-grading MgSO4 to lower level facilities. Supporting review of EDL to ensure down-grading of MgSO4. Supporting pre-service and in-service training on PE/E for midwives and doctors. Introducing and scaling up SBM-R covering PE/E. Monitoring contribution of PE/E to maternal mortality. On-job training and mentoring staff on PE/E.
34. Activities in PE/E prevention and management undertaken by other partners?	Procurement and distribution of MgSO4 Pre-service and in service training on PE/E for midwives and doctors
35. % of districts covered by PE/E programs?	100%
36. % of SBAs reached by national PE/E programs?	More than 80%
OPPORTUNITIES FOR INTRODUCTION, EXPANSION AND SCALE-UP	
37. Opportunities for program introduction, expansion, or scale-up.	CARMMA ambassador (Deputy Prime Minister) has demonstrated her capacity to advocate for MNCH issues so she is an important person for advocacy. Pre-service education strategy and curricula review being planned for this year will provide an opportunity for incorporating PE/E issues. Increasing number of partners supporting MNCH activities at the national level provides a platform for leveraging resources for PE/E MNH Road Map identifies PE/E as a major cause of maternal mortality and specifies interventions that need scaling up.
38. High attrition rate of SBAs— a retention scheme for health professionals is being implemented.	Resistance by professional associations for lower level cadres to perform all components of preventing and managing PE/E—more advocacy work is on but a clearer advocacy and communication strategy for MNH is required. Financing training for in-service education—a joint national implementation plan for MNH has been developed and a resource mobilization strategy is being developed.

Appendix C: Country Scale-up Maps of PPH and PE/E

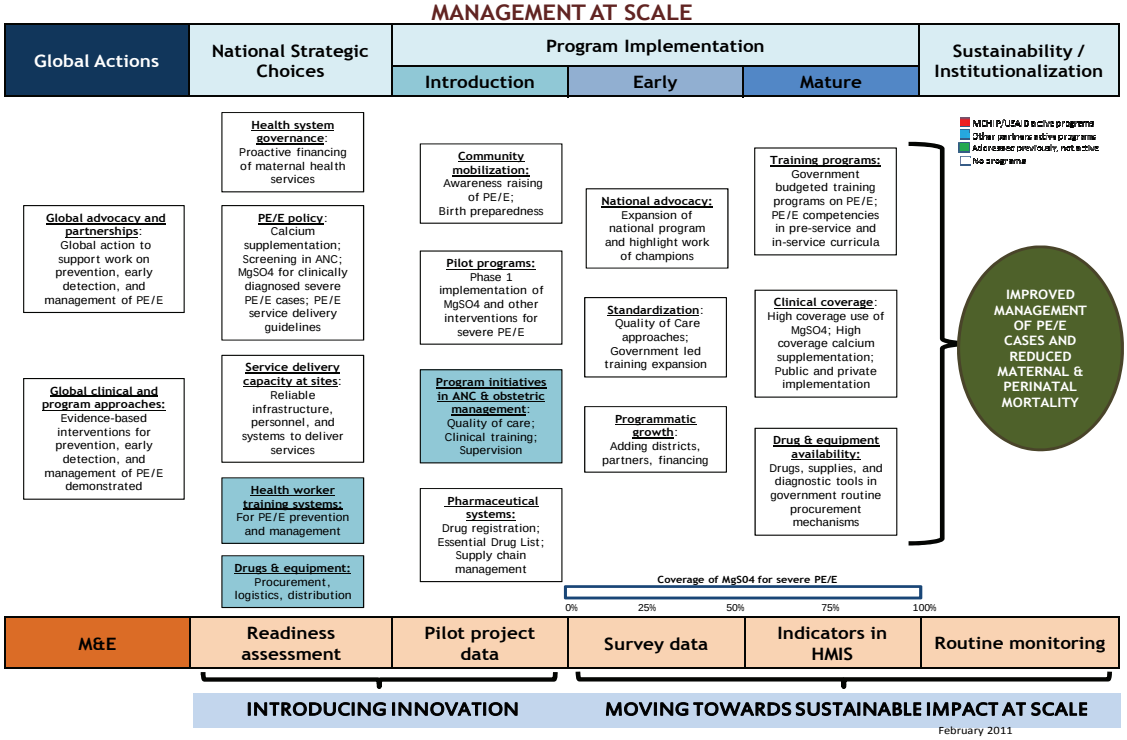




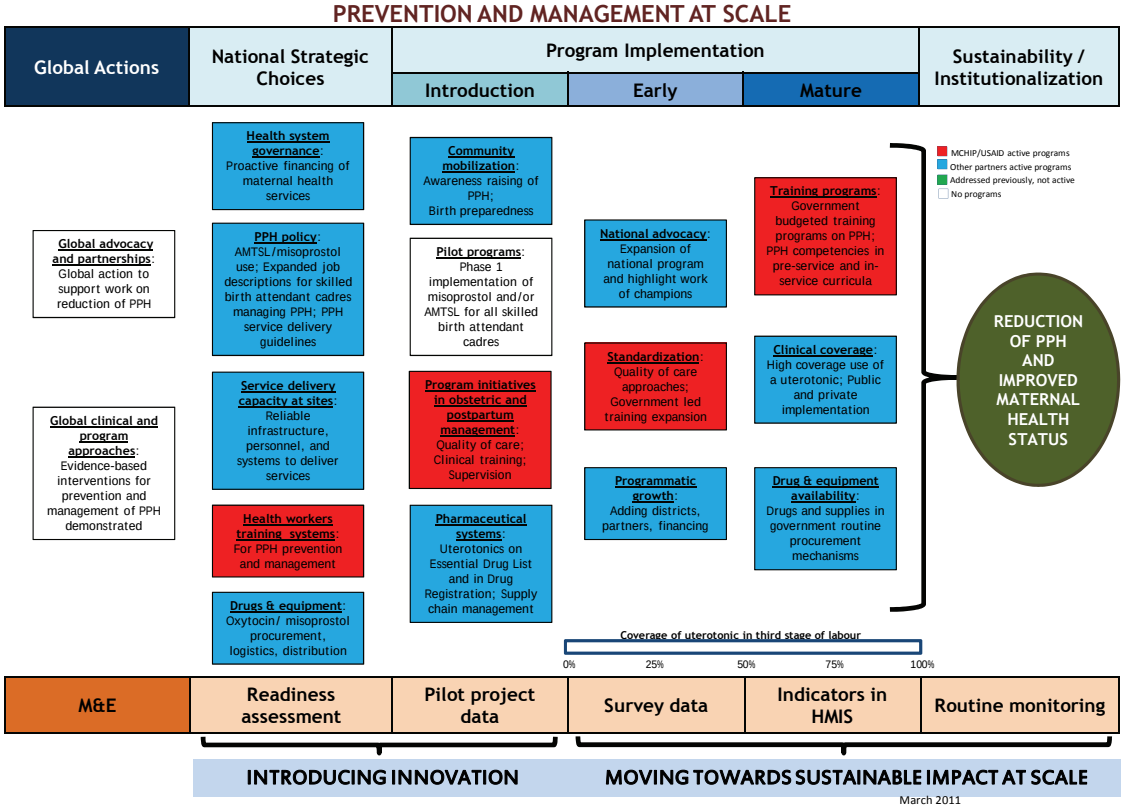
ANGOLA: PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



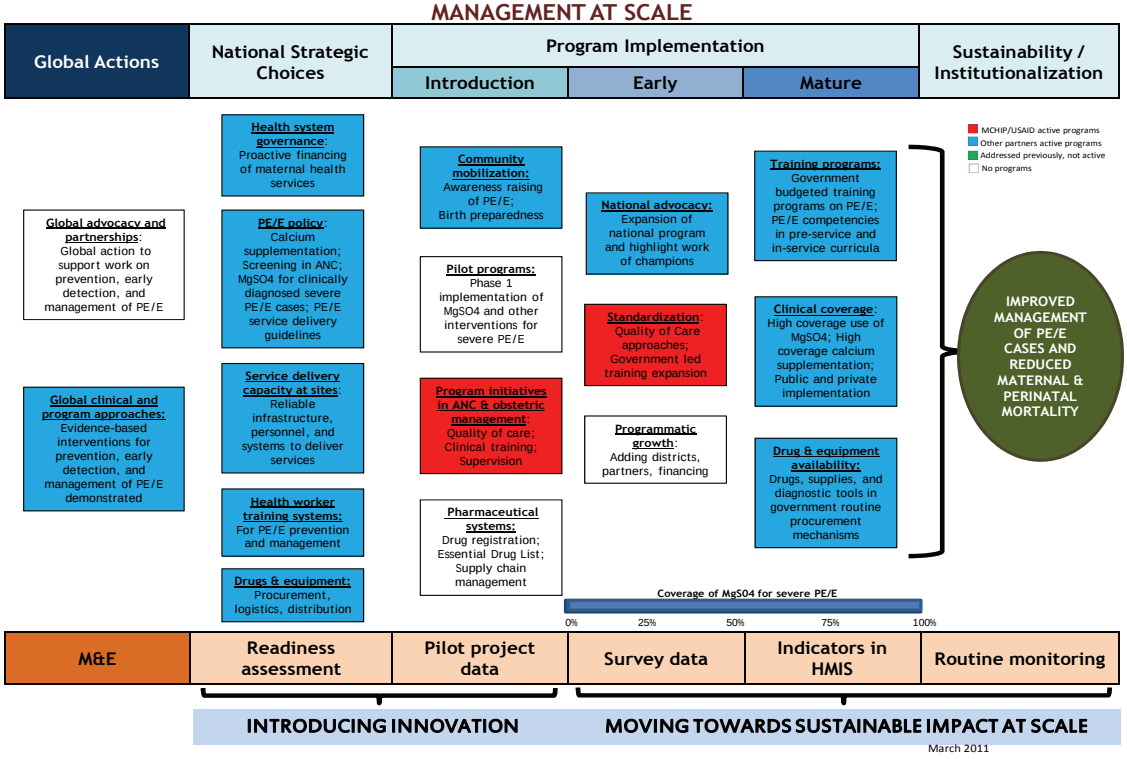
ANGOLA: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



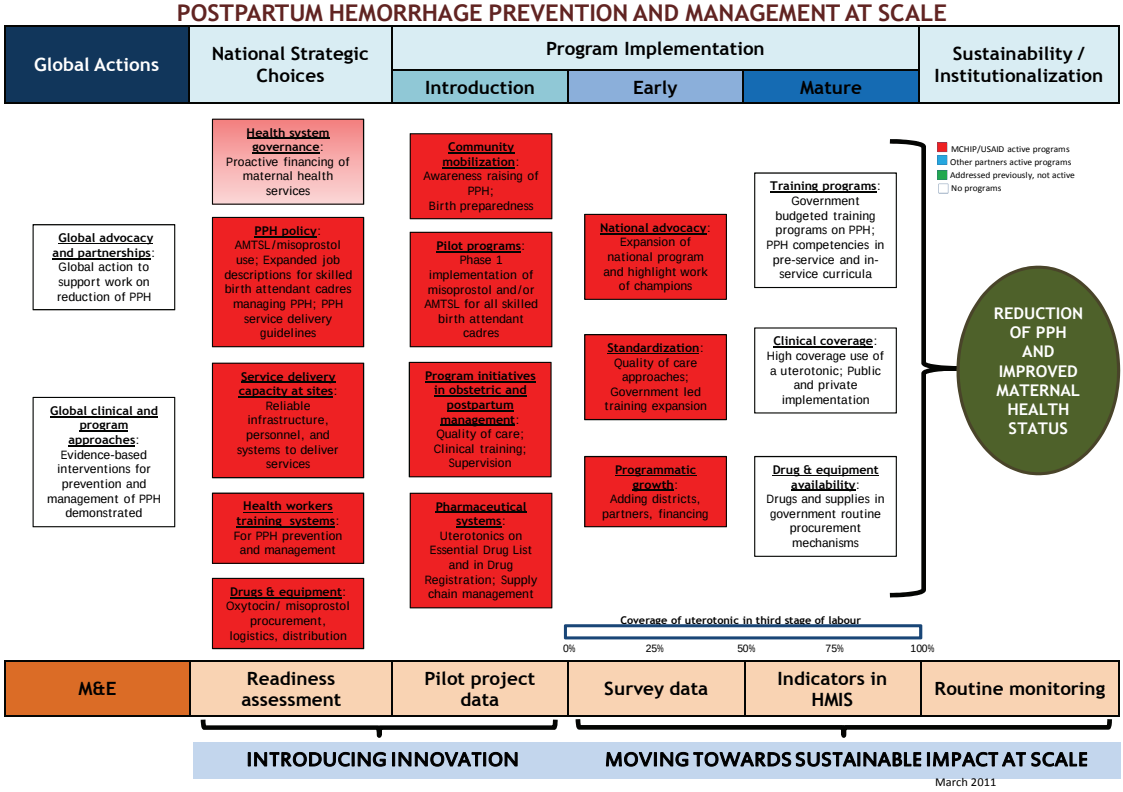
BOLIVIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



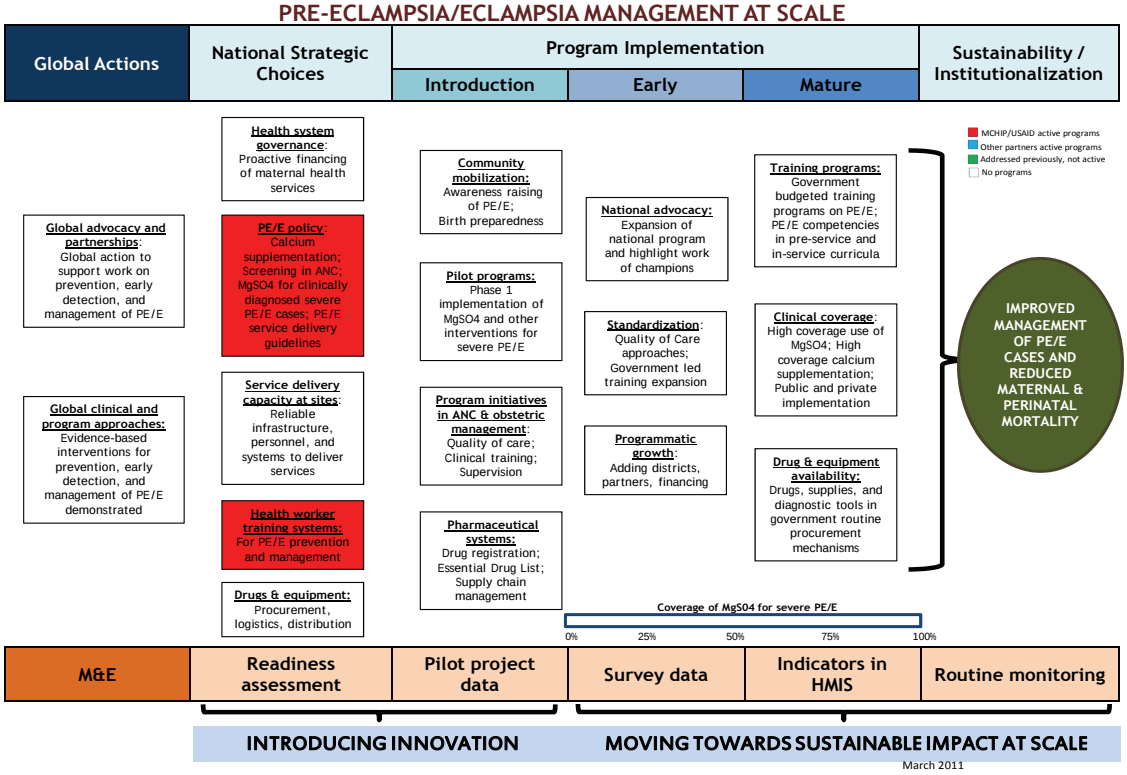
BOLIVIA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



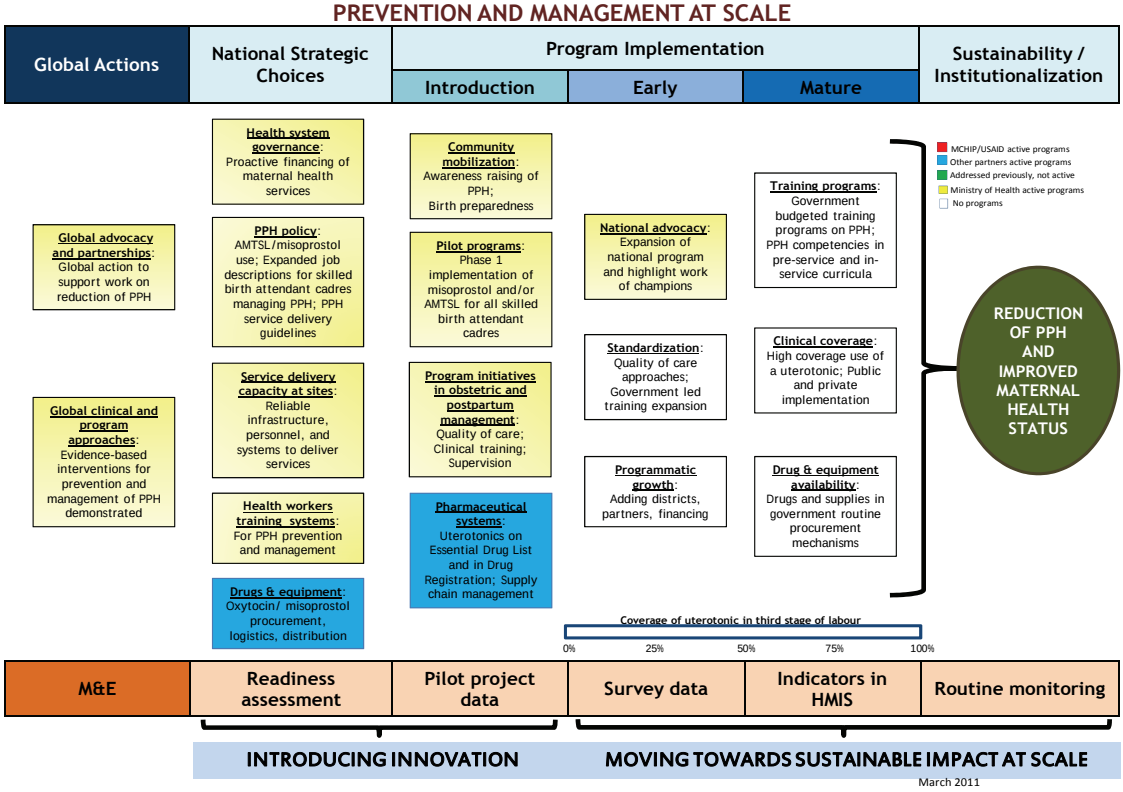
DEMOCRATIC REPUBLIC OF THE CONGO - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



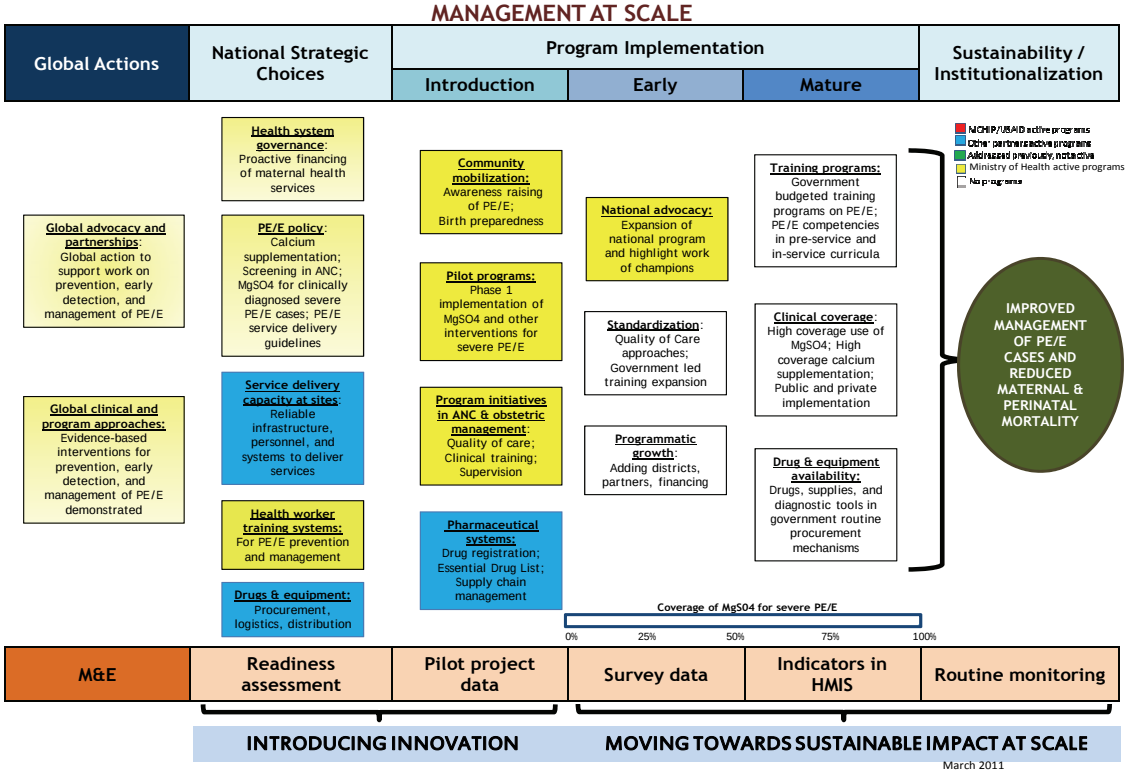
DEMOCRATIC REPUBLIC OF THE CONGO - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



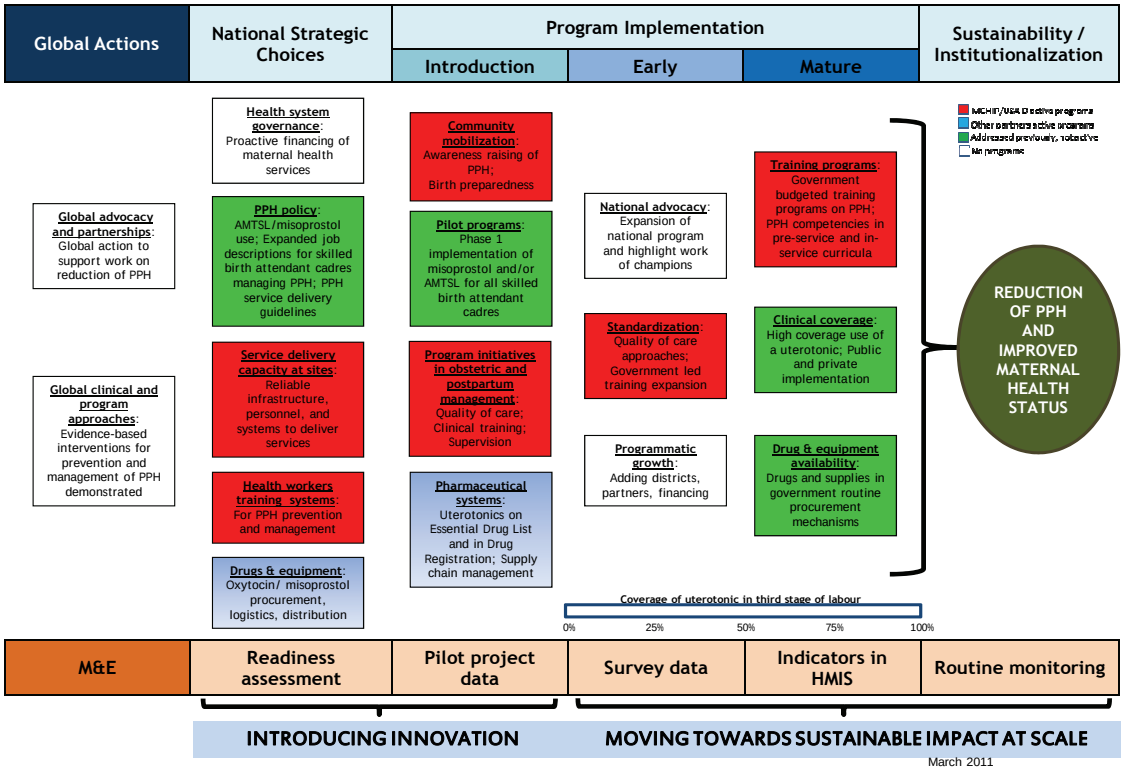
EQUATORIAL GUINEA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



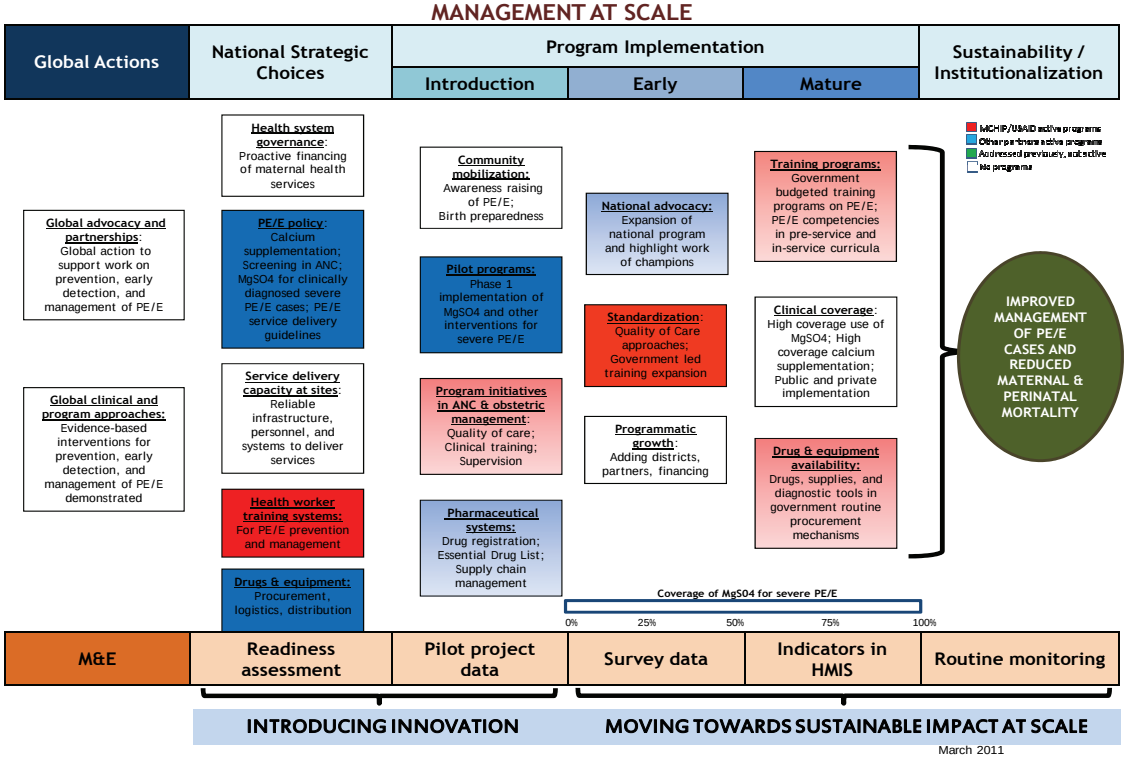
EQUATORIAL GUINEA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



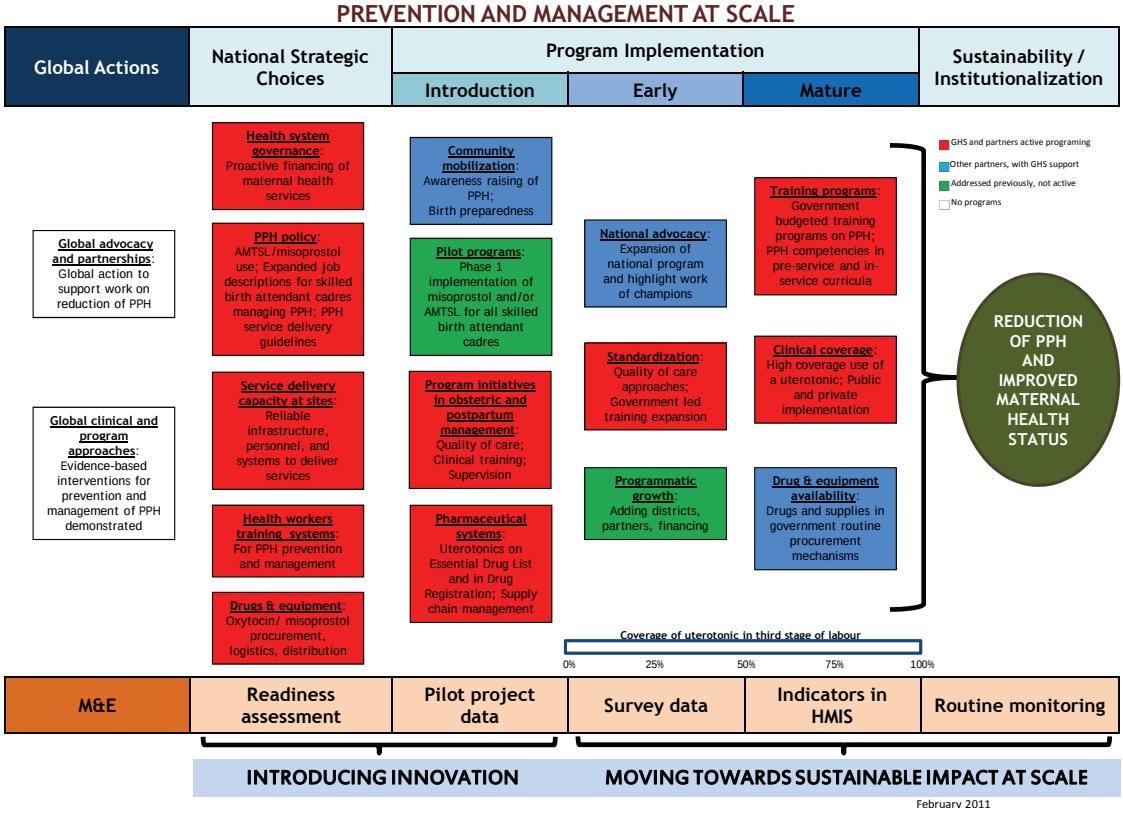
ETHIOPIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



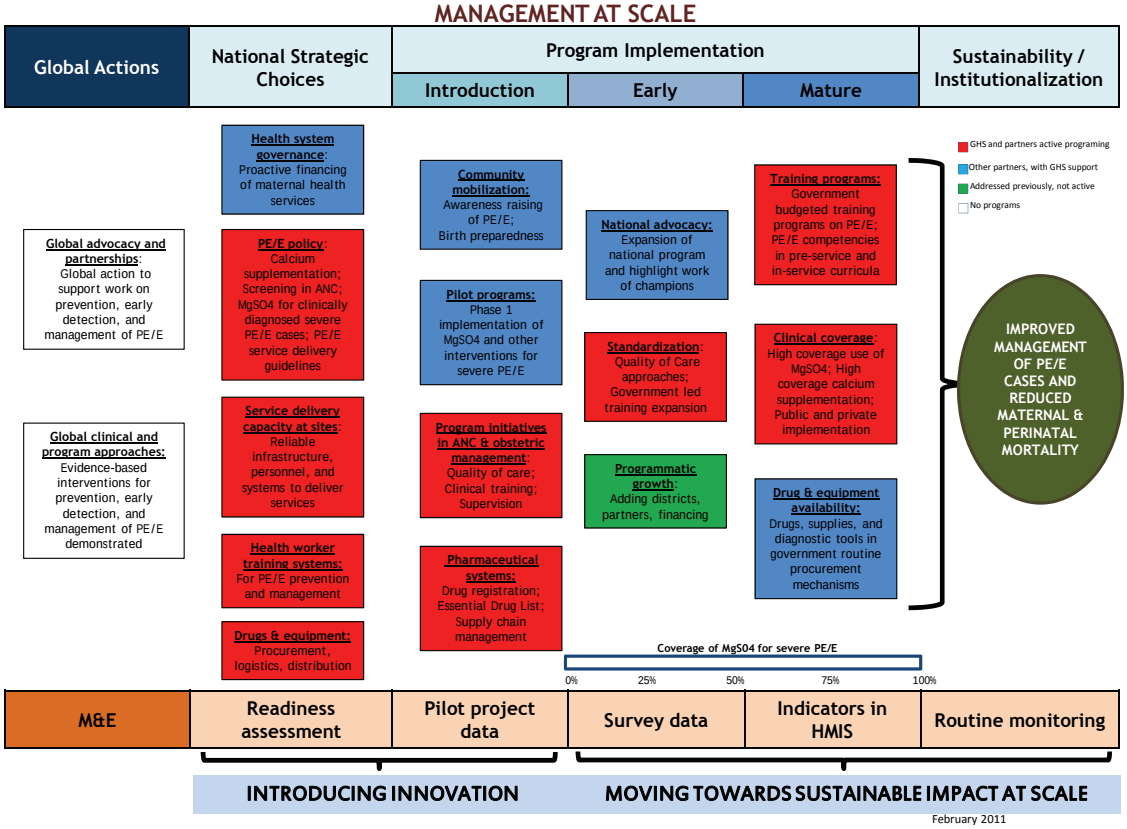
ETHIOPIA: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



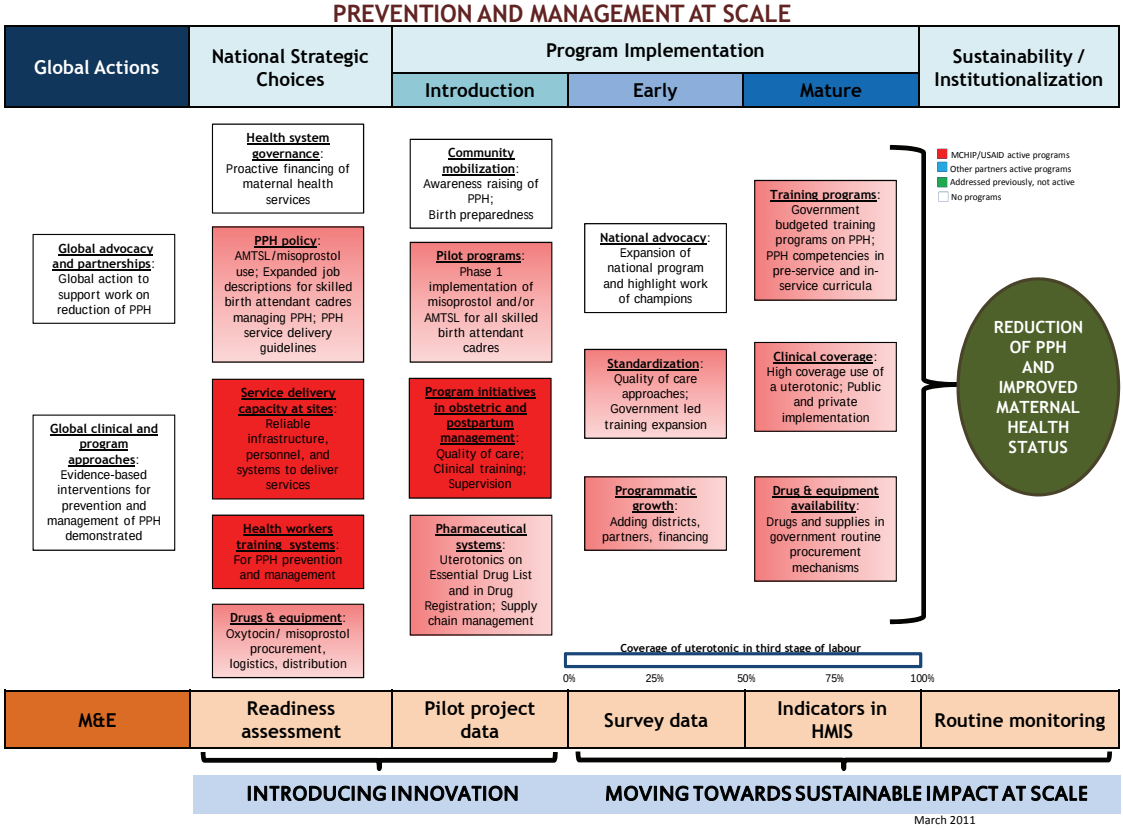
GHANA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



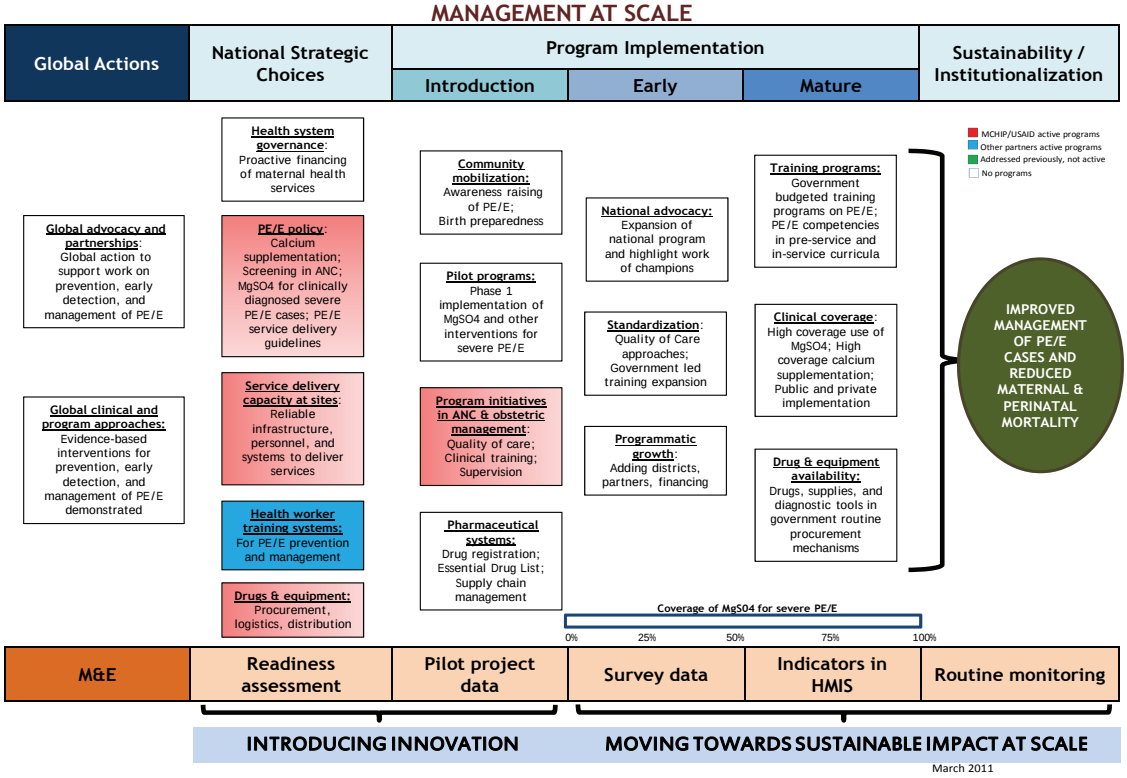
GHANA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



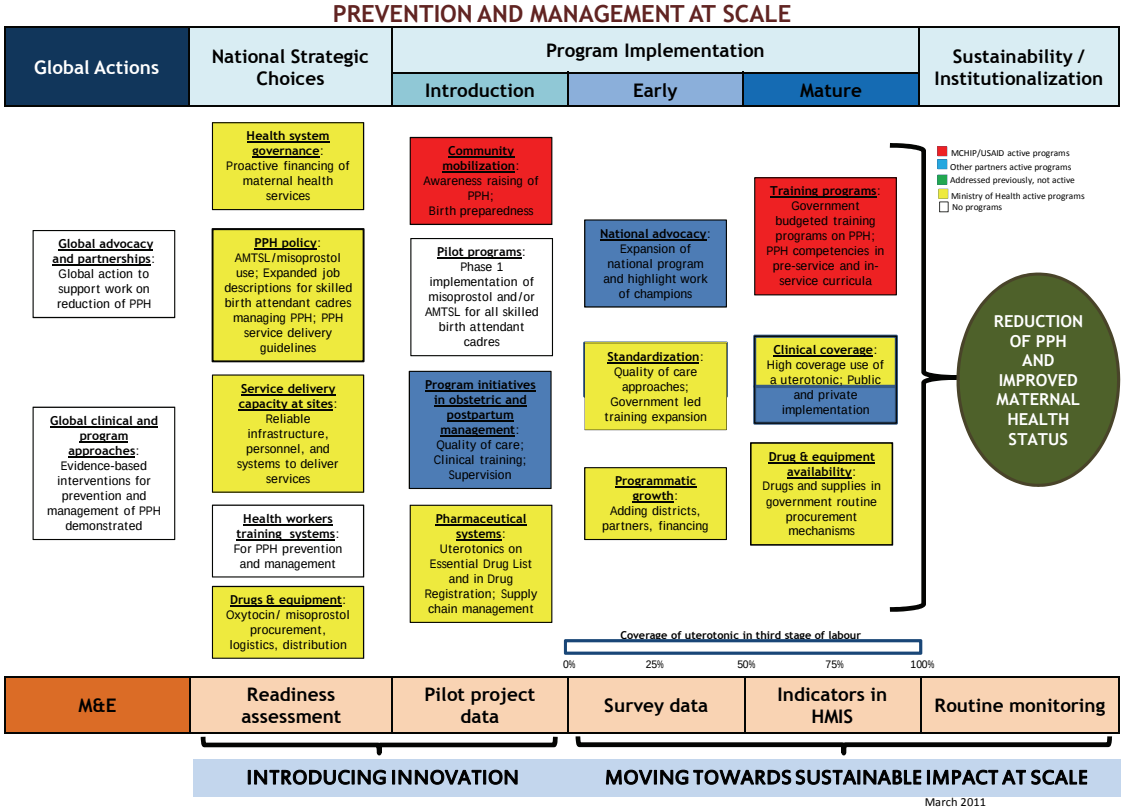
GUINEA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



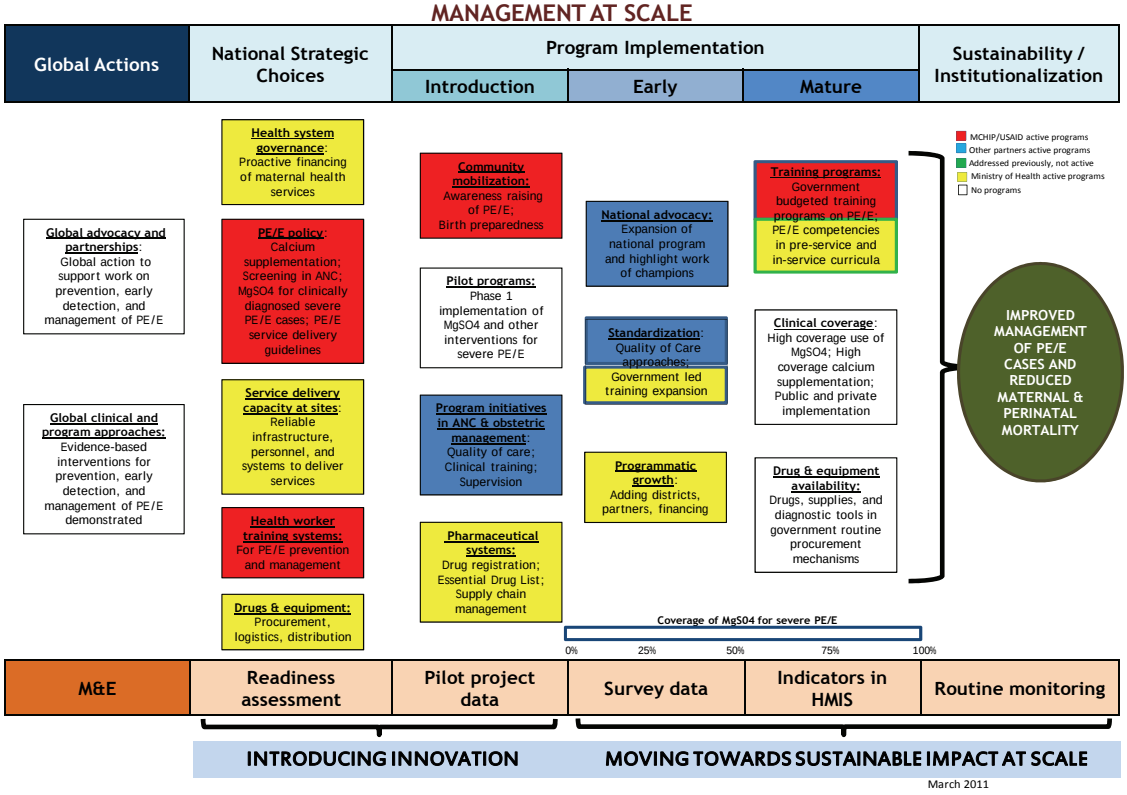
GUINEA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



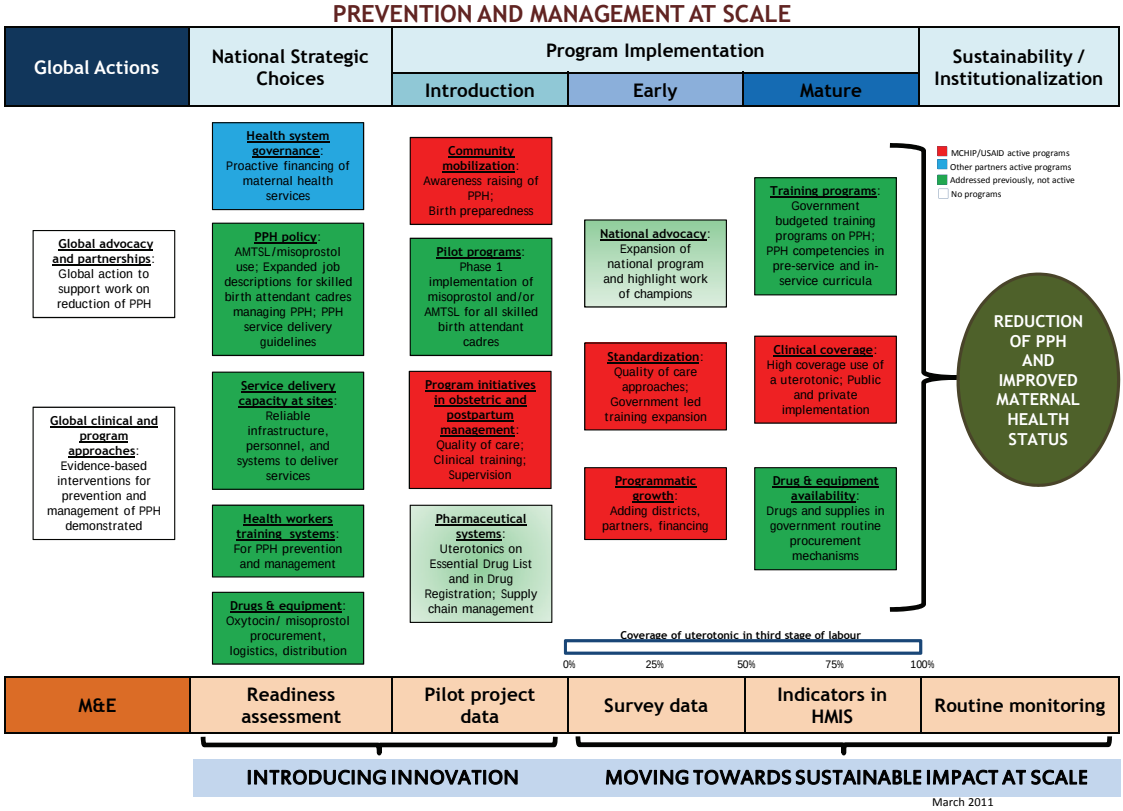
INDIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



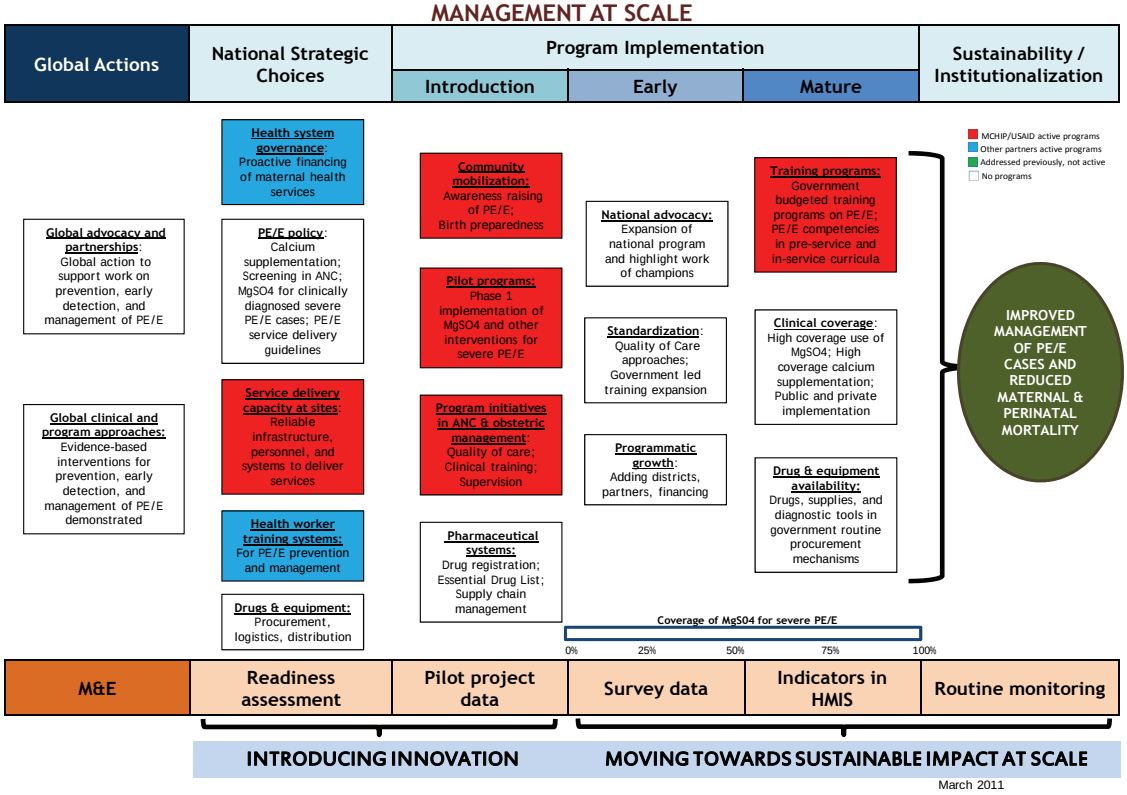
INDIA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



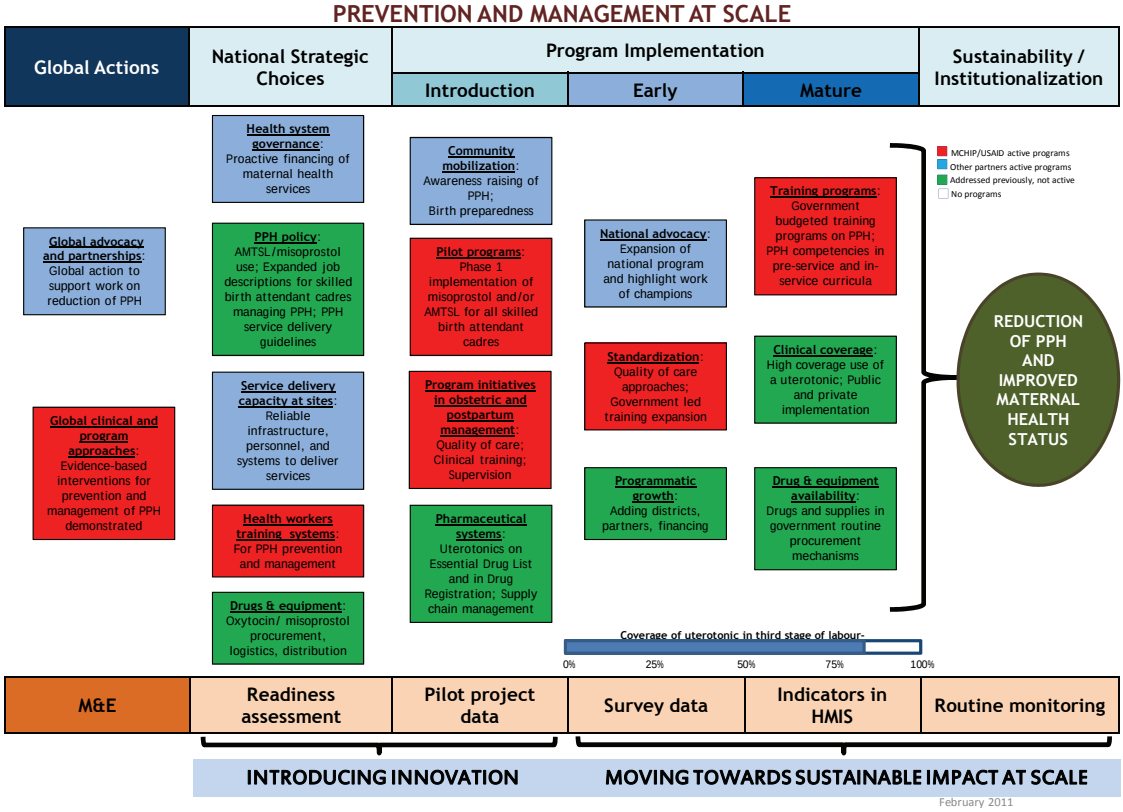
INDONESIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



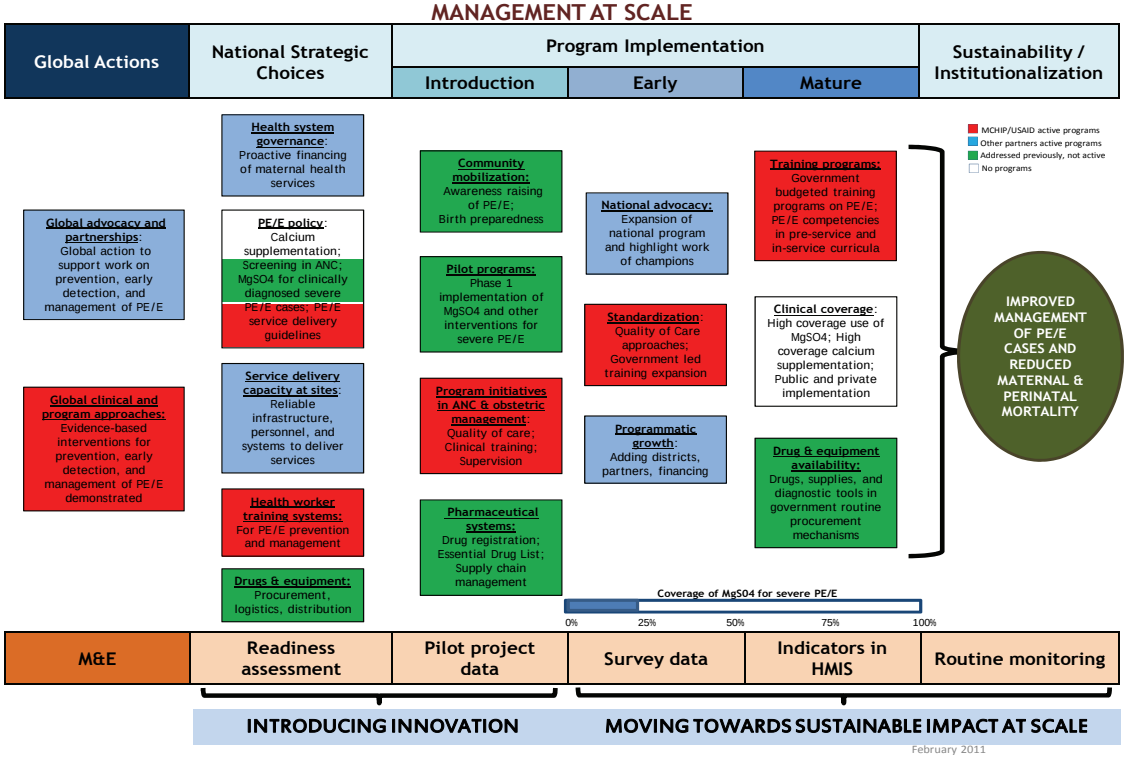
INDONESIA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



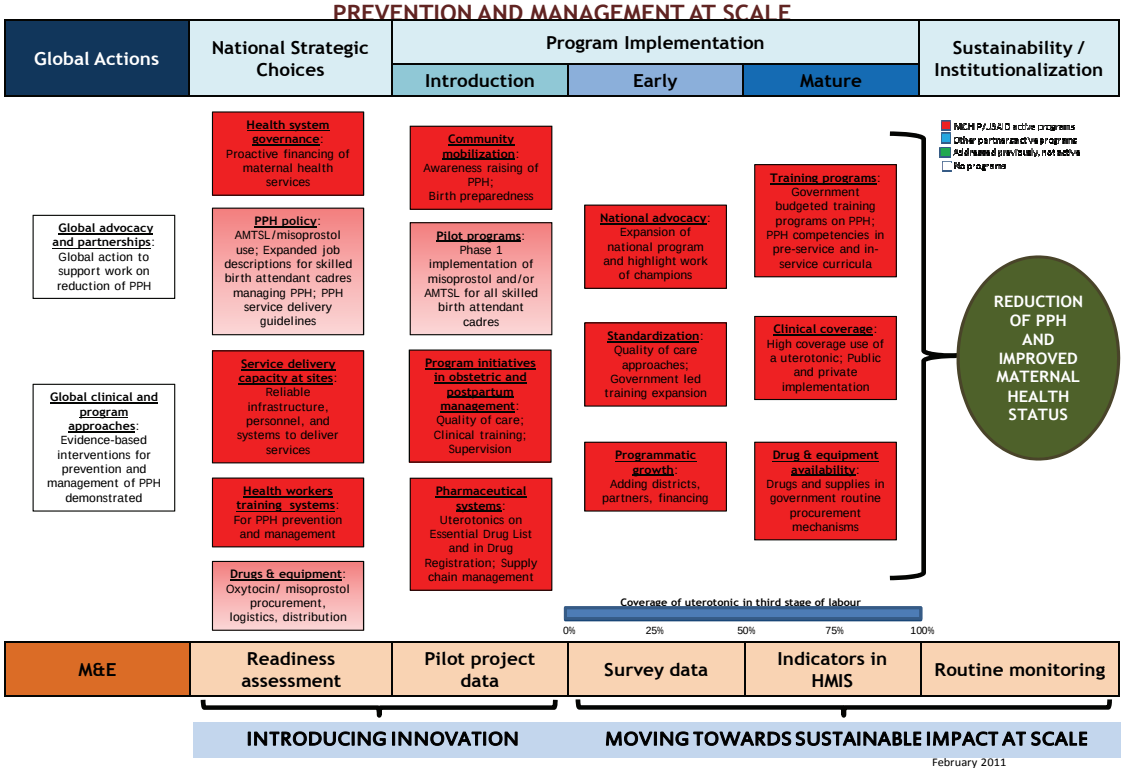
KENYA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



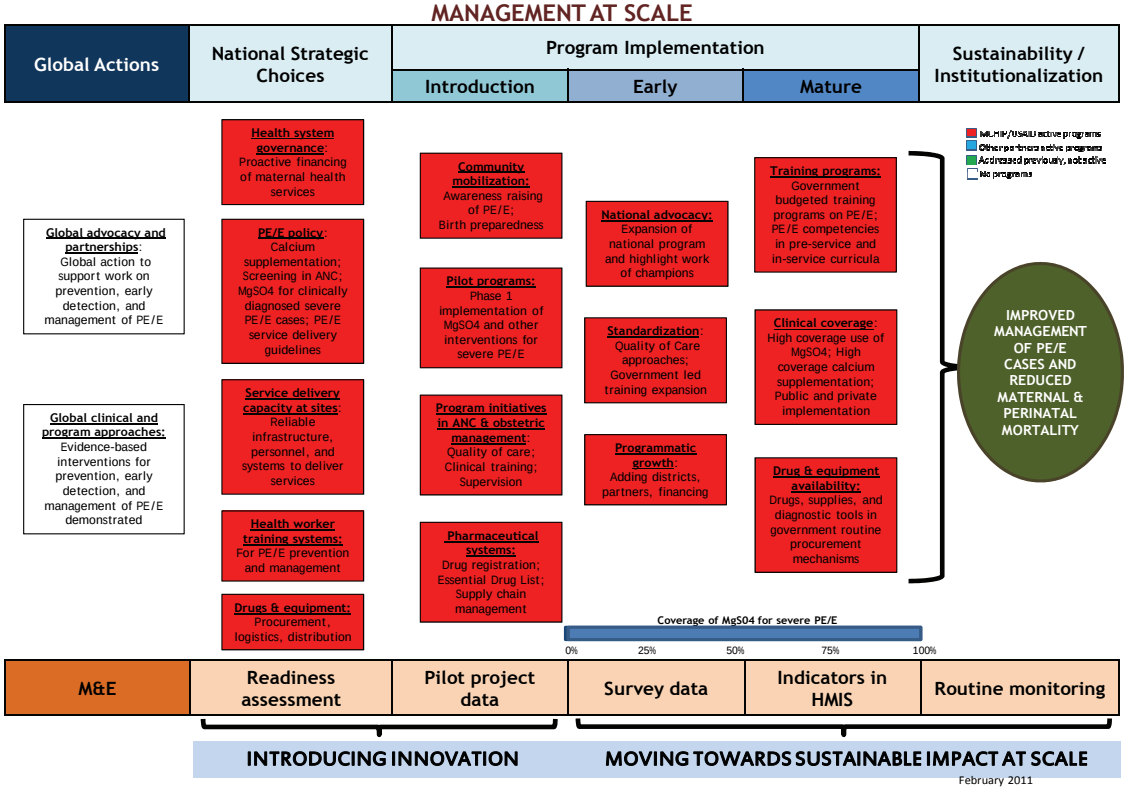
KENYA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



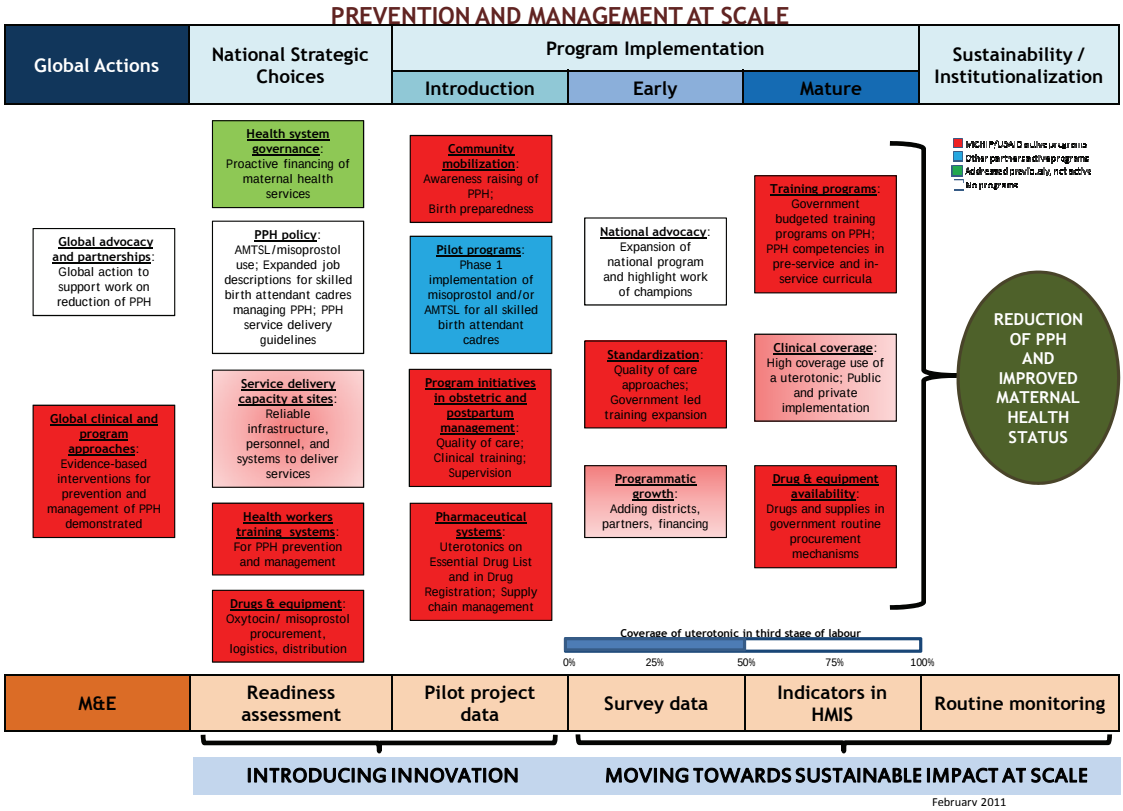
LIBERIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



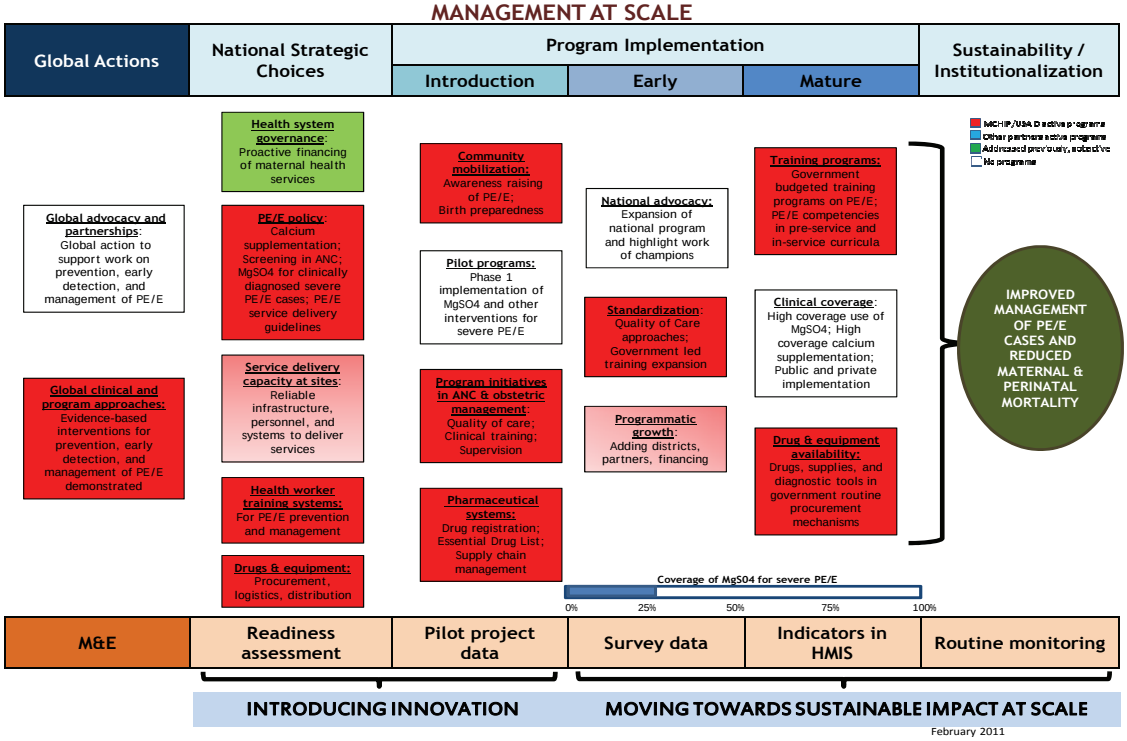
LIBERIA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



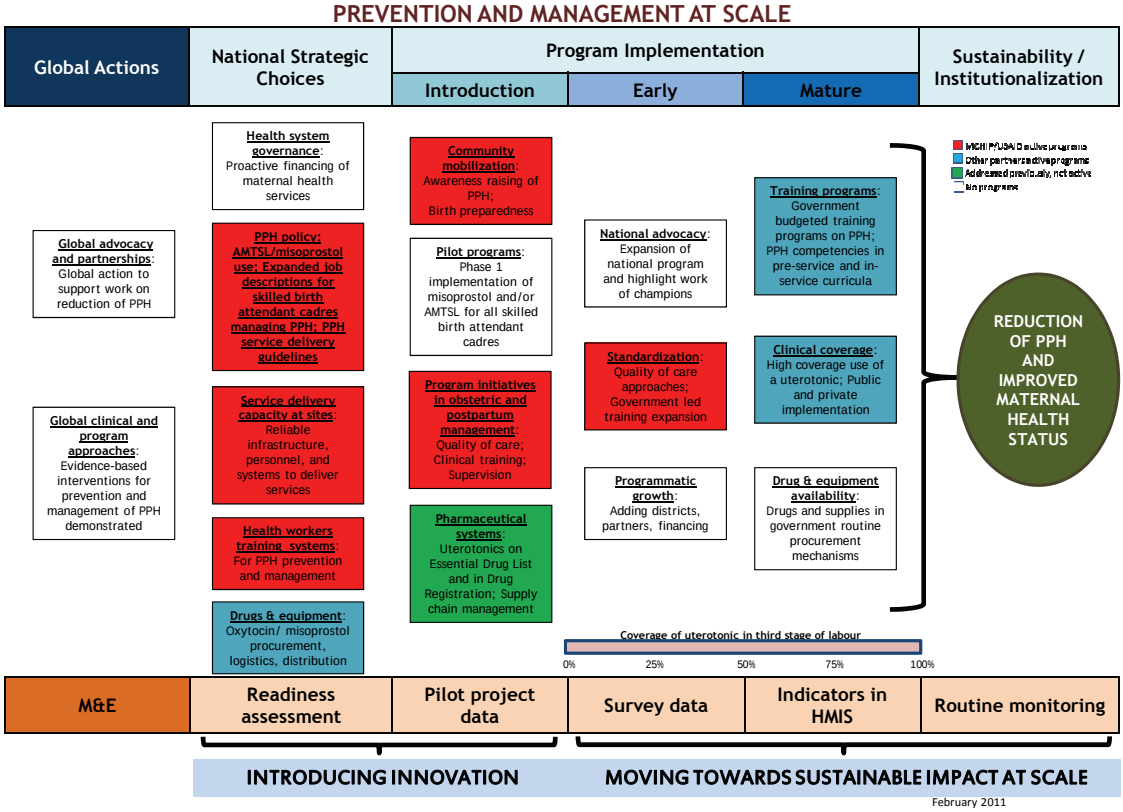
MADAGASCAR- PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



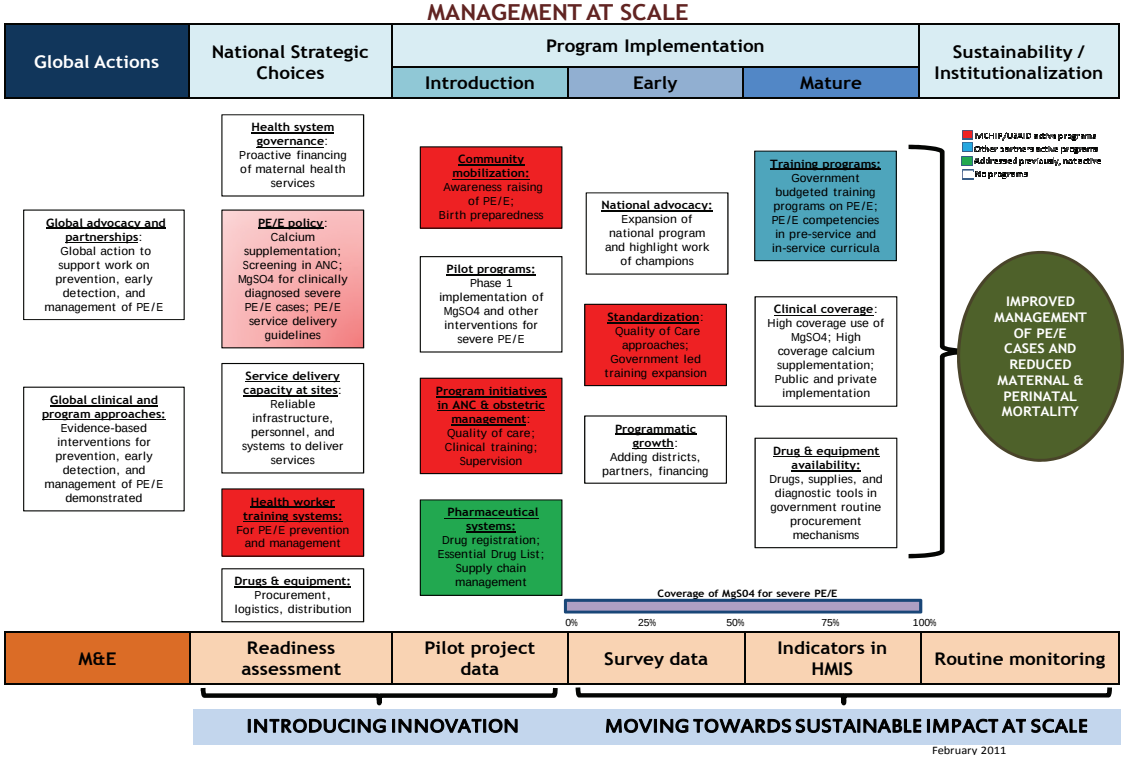
MADAGASCAR: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



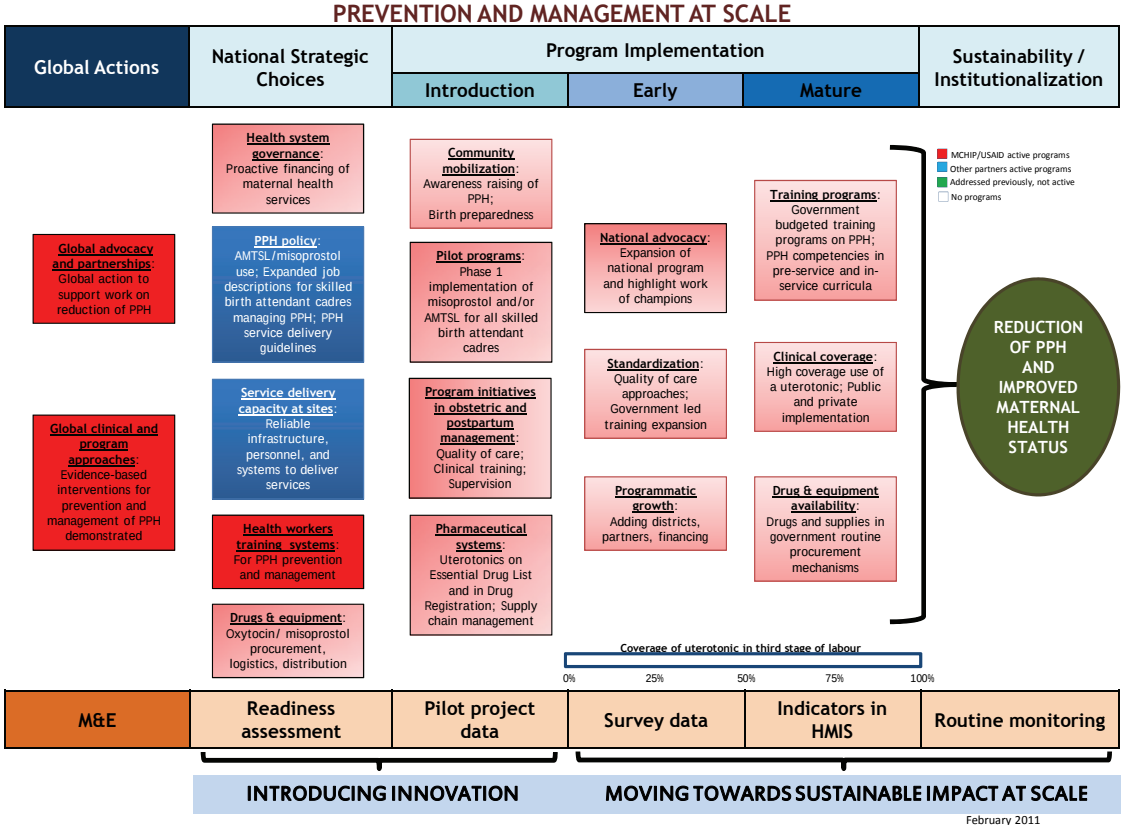
MALAWI - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



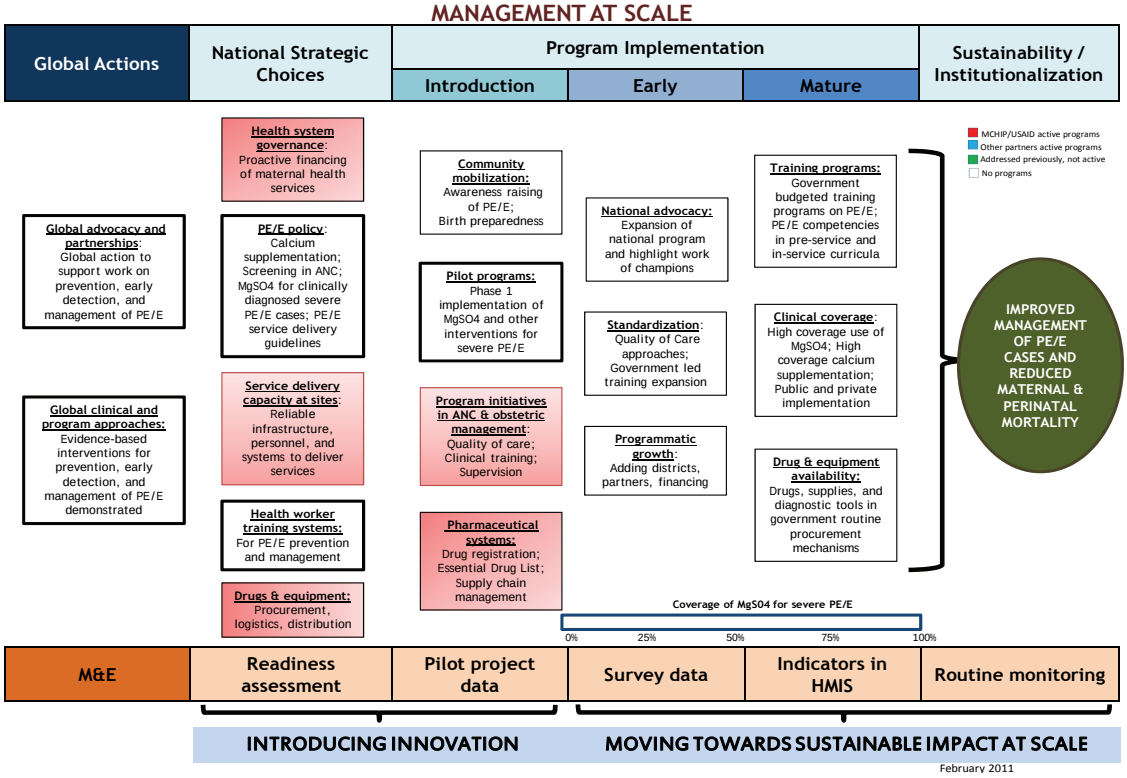
MALAWI - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



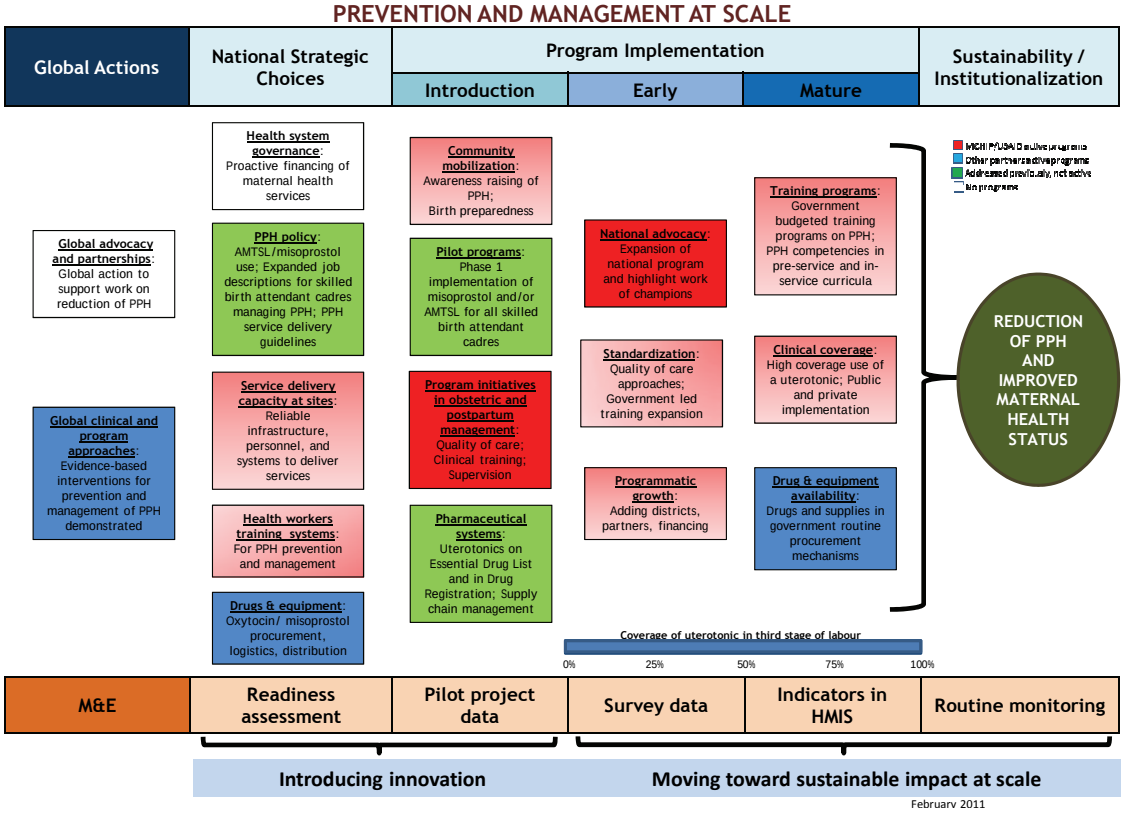
MALI - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



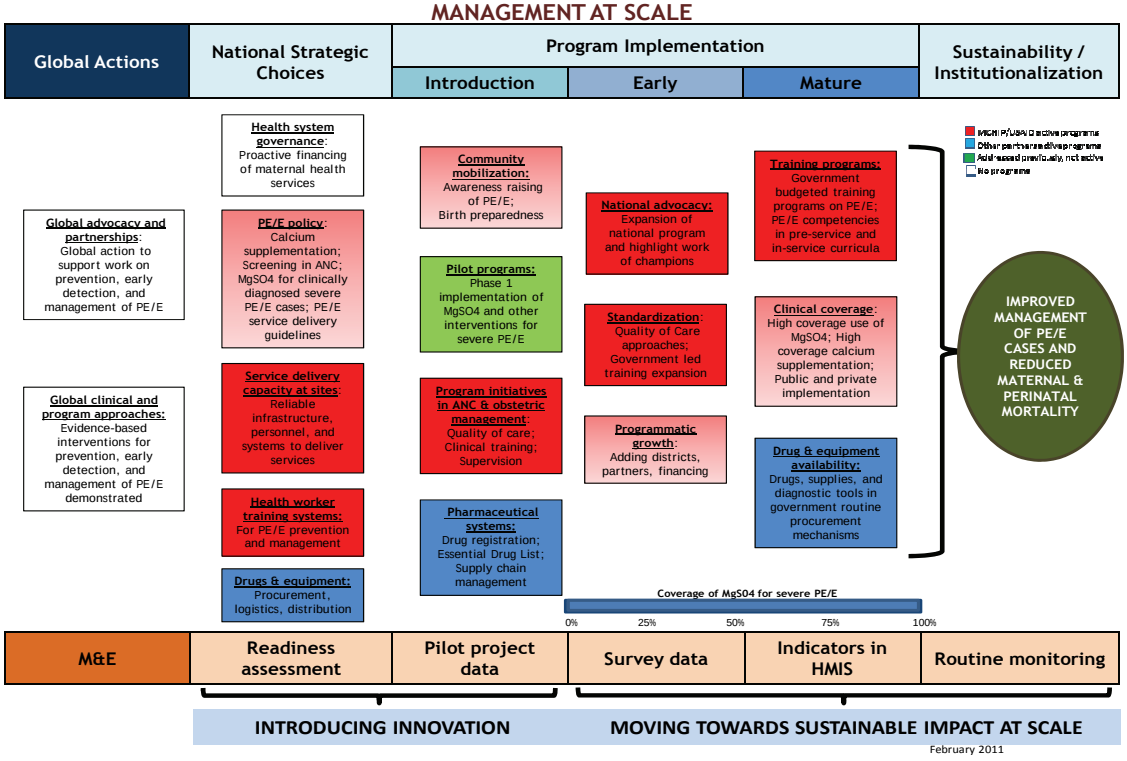
MALI - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



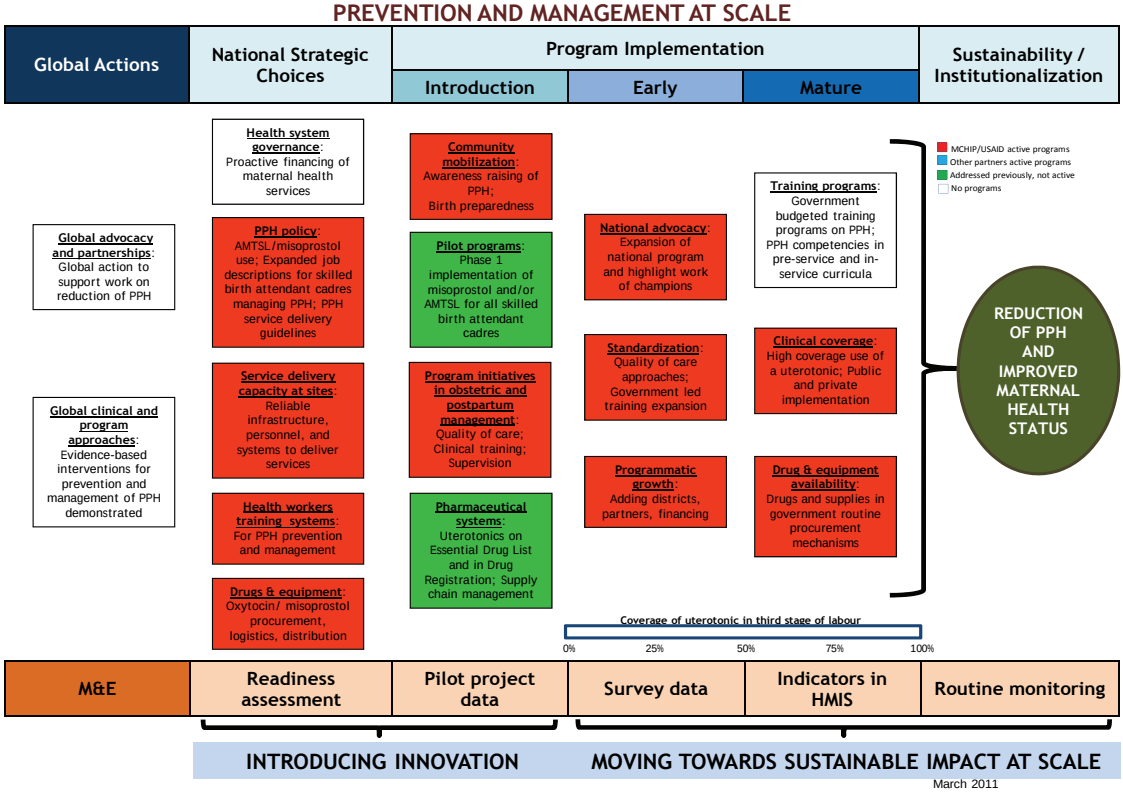
MOZAMBIQUE - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



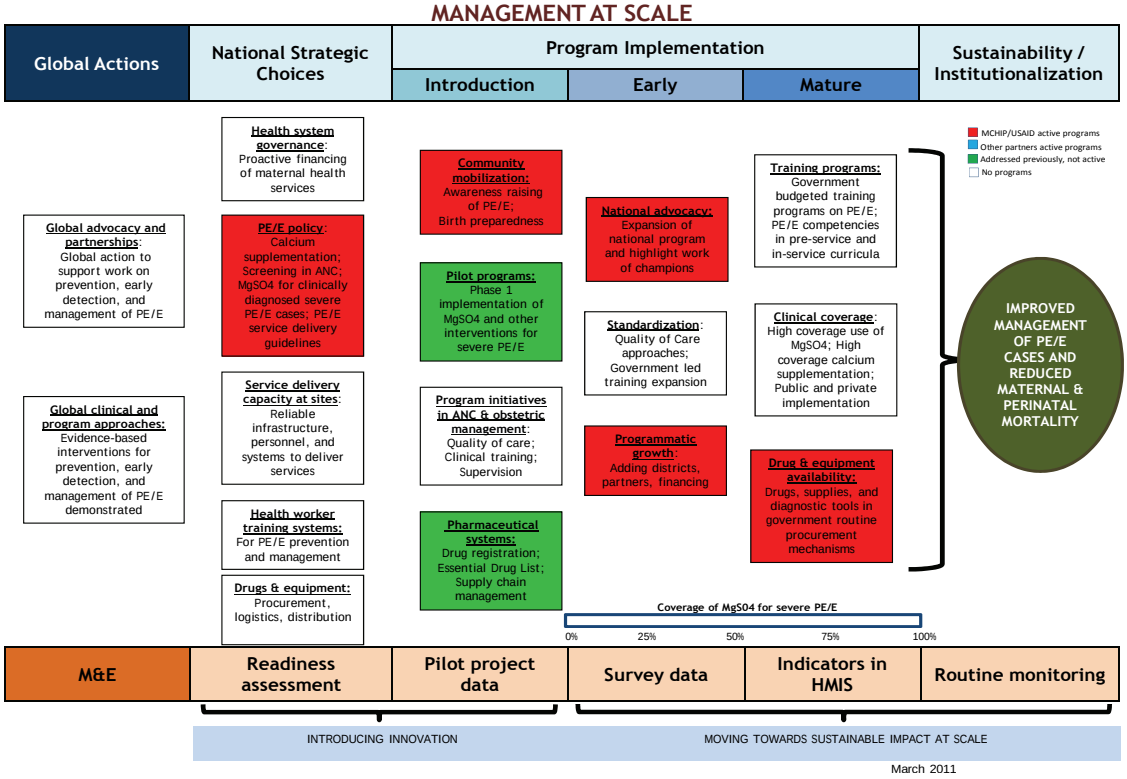
MOZAMBIQUE - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



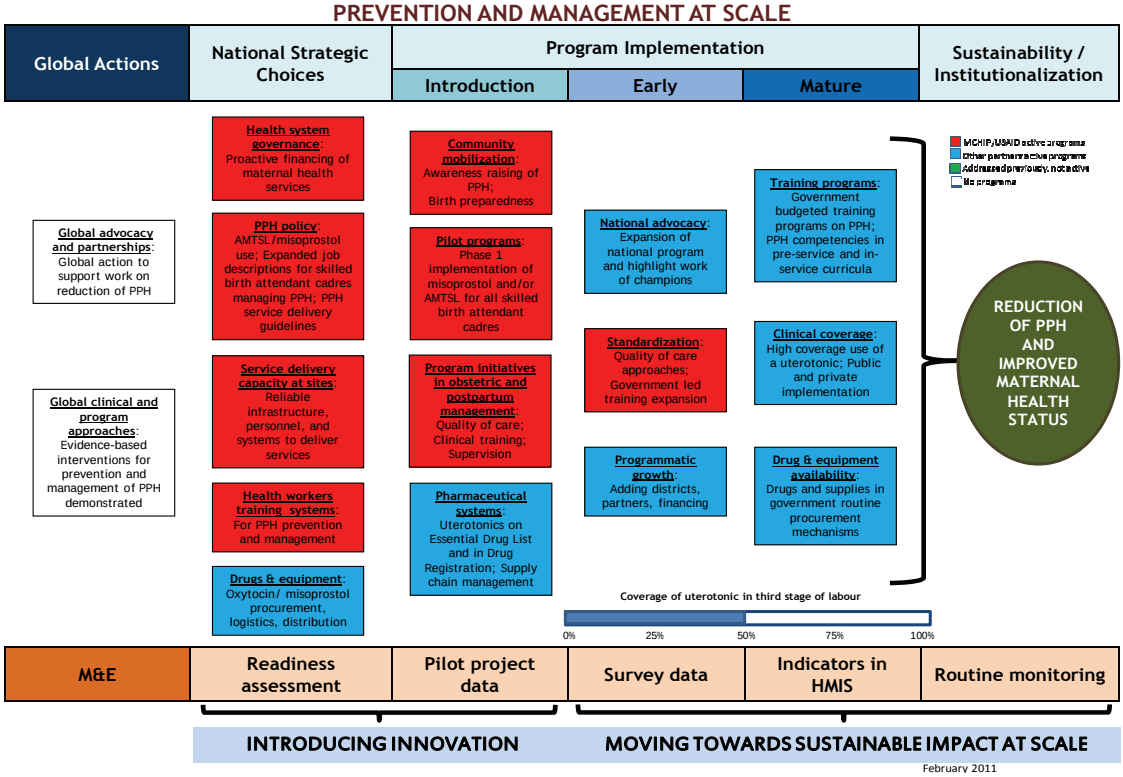
NEPAL - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



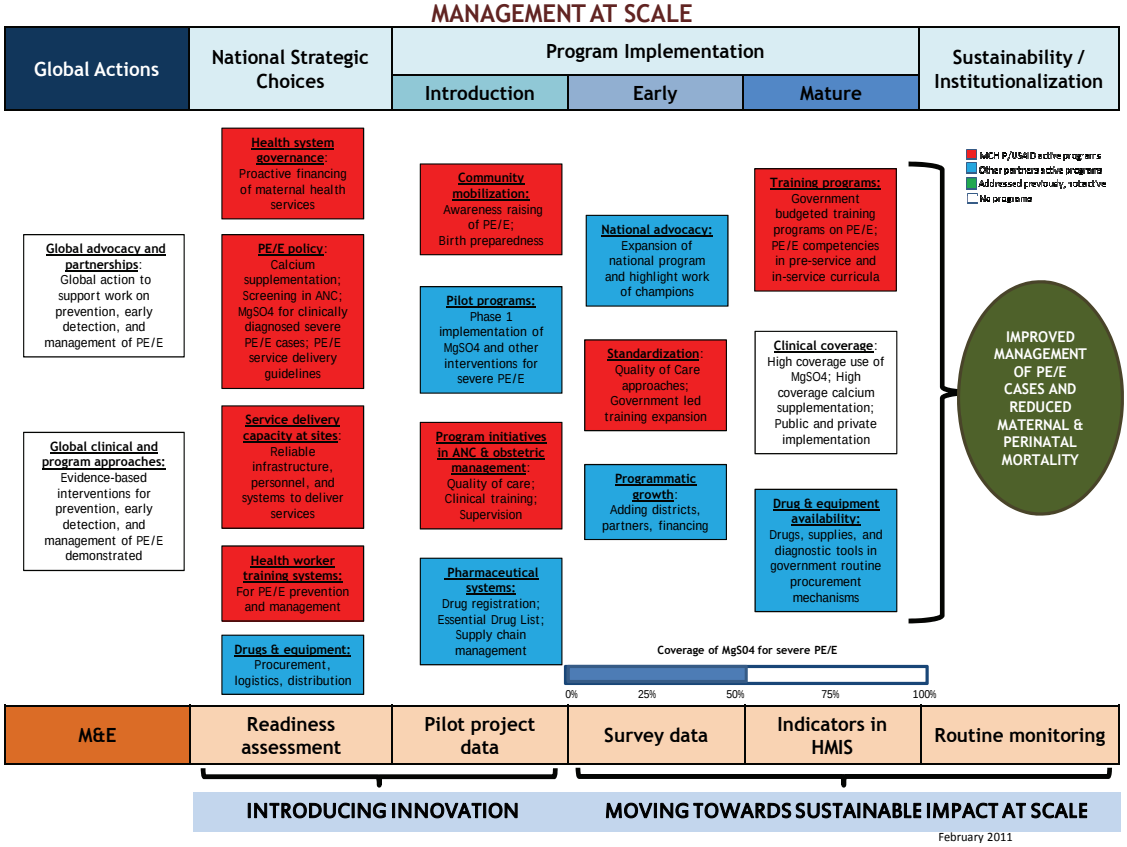
NEPAL - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



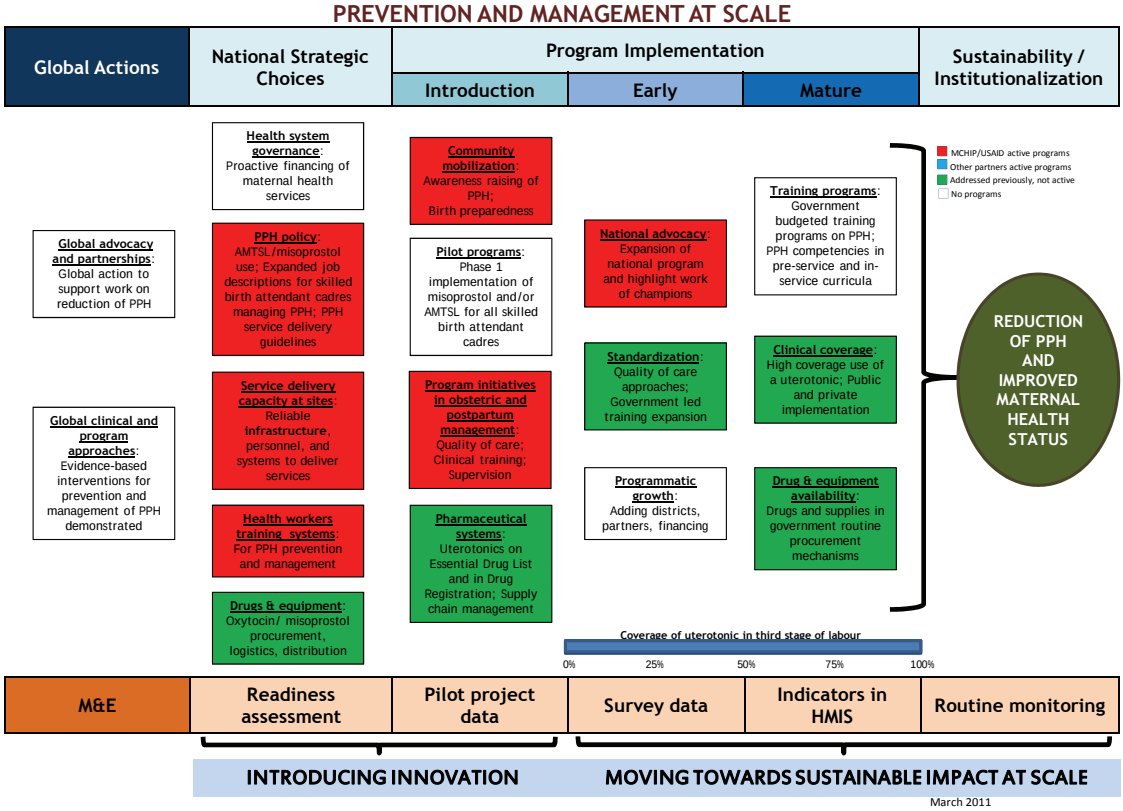
NIGERIA: PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



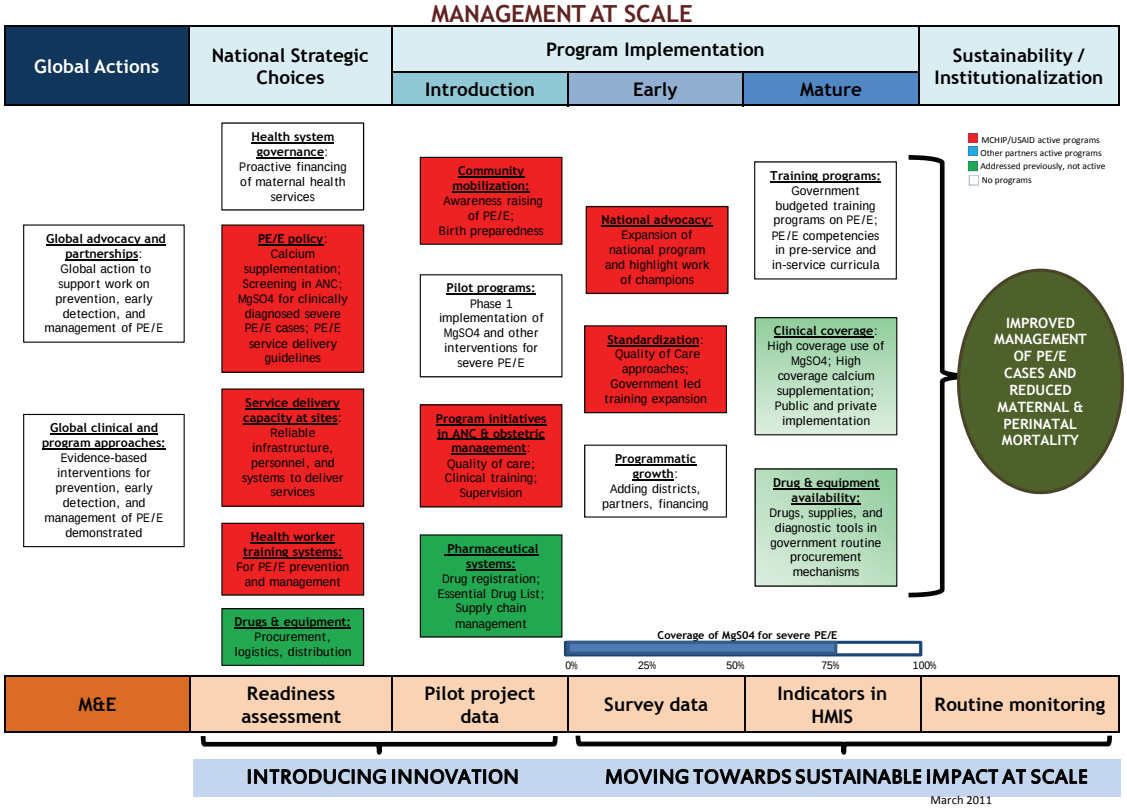
NIGERIA: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



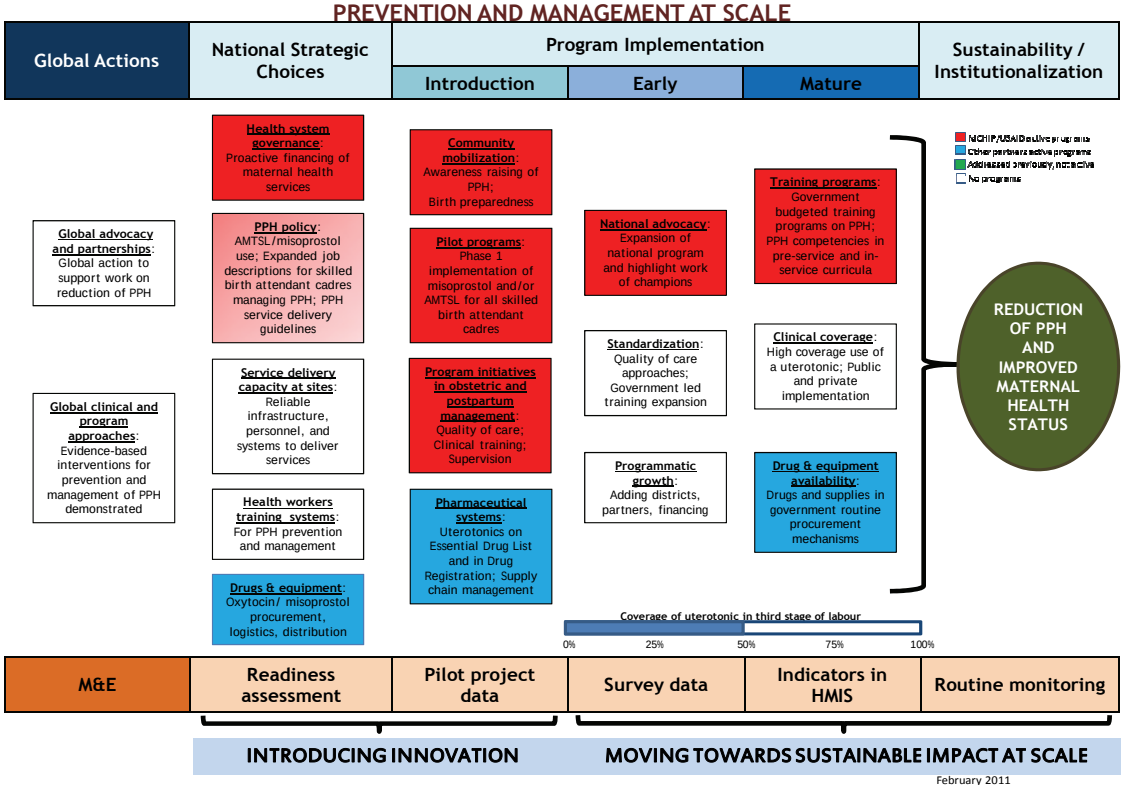
PARAGUAY - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



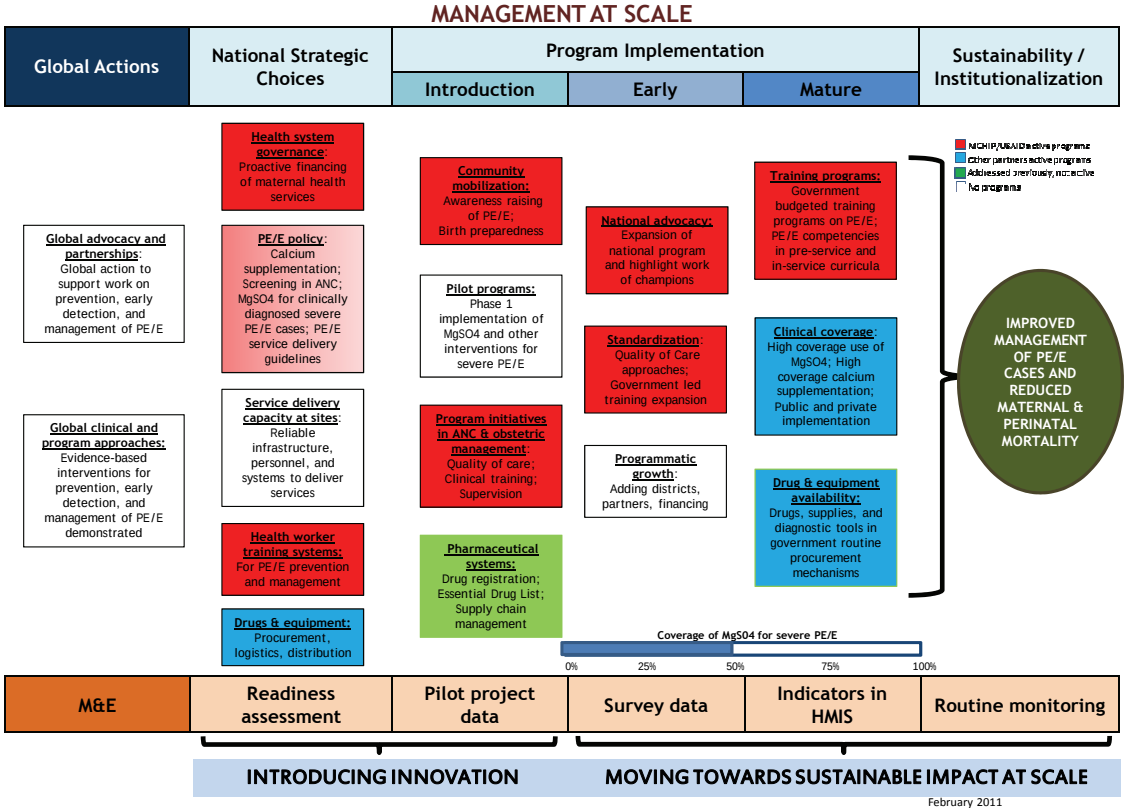
PARAGUAY - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



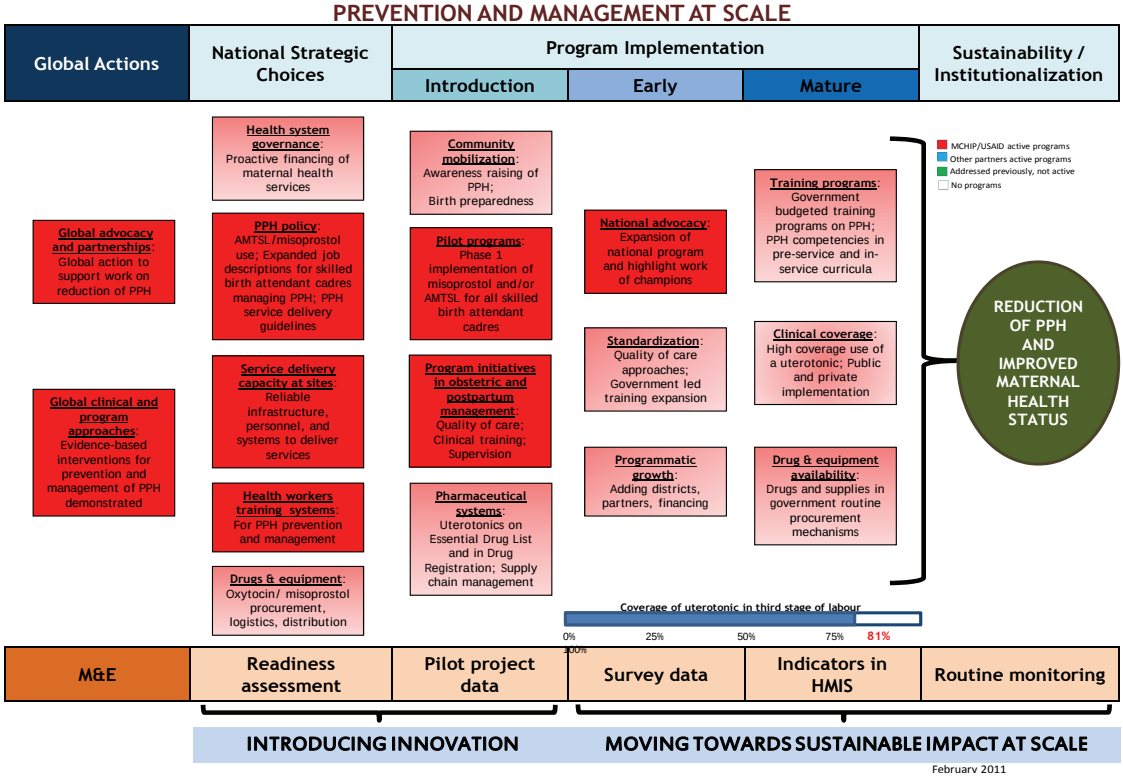
RWANDA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



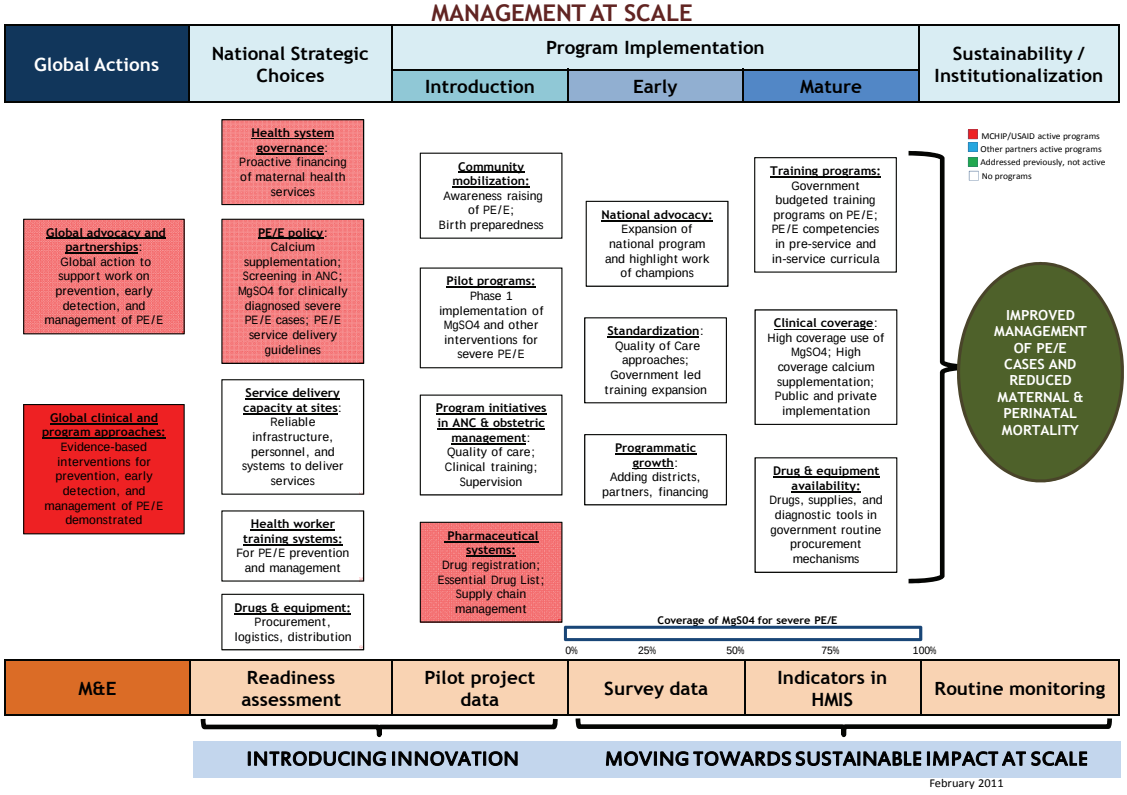
RWANDA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



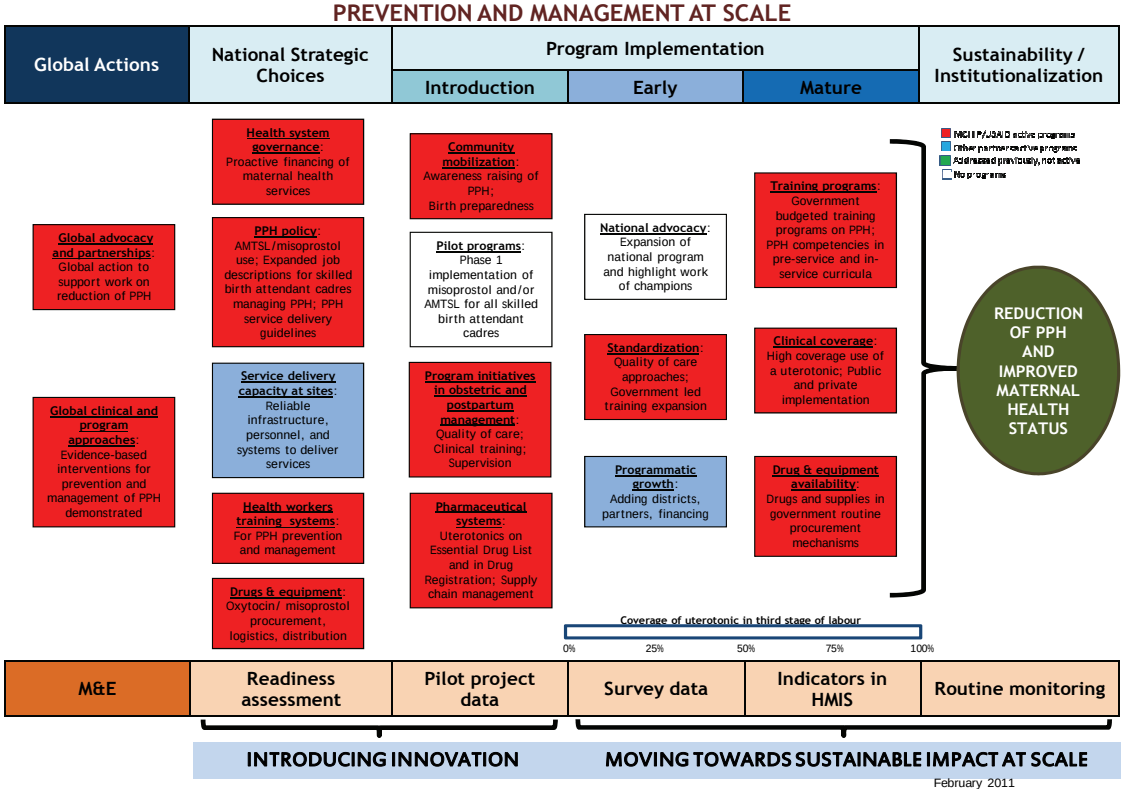
SENEGAL - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



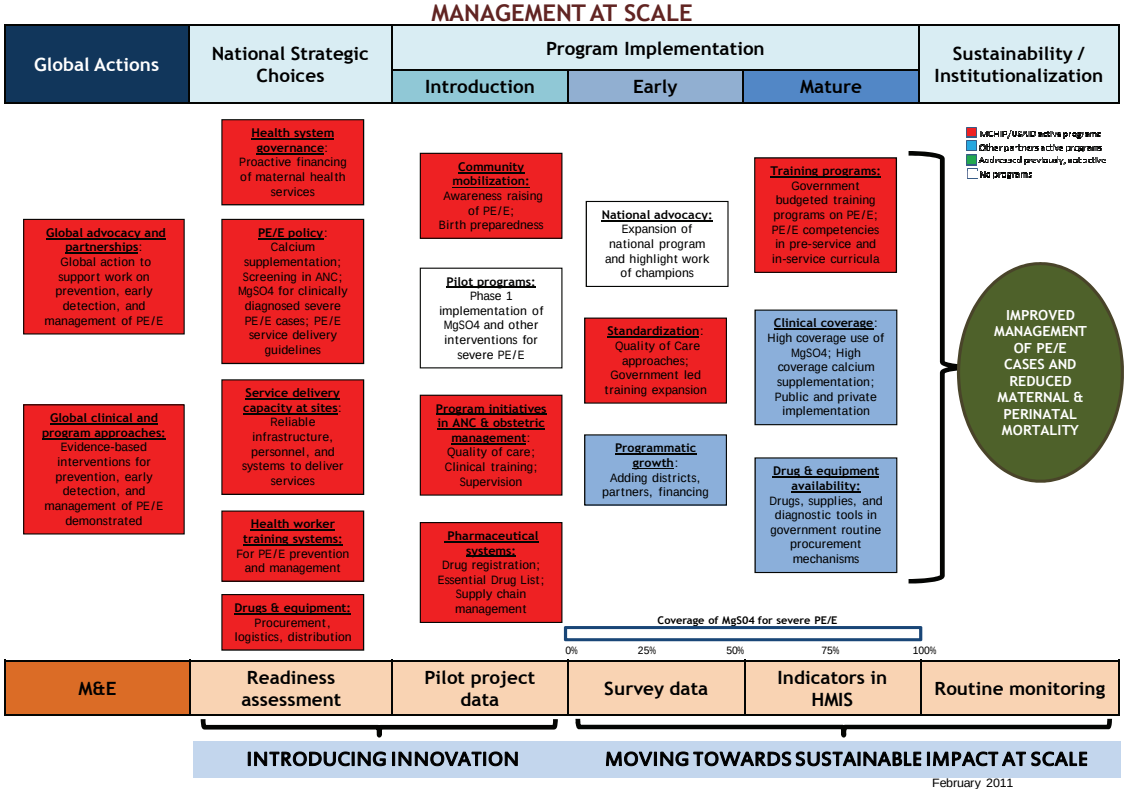
SENEGAL - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



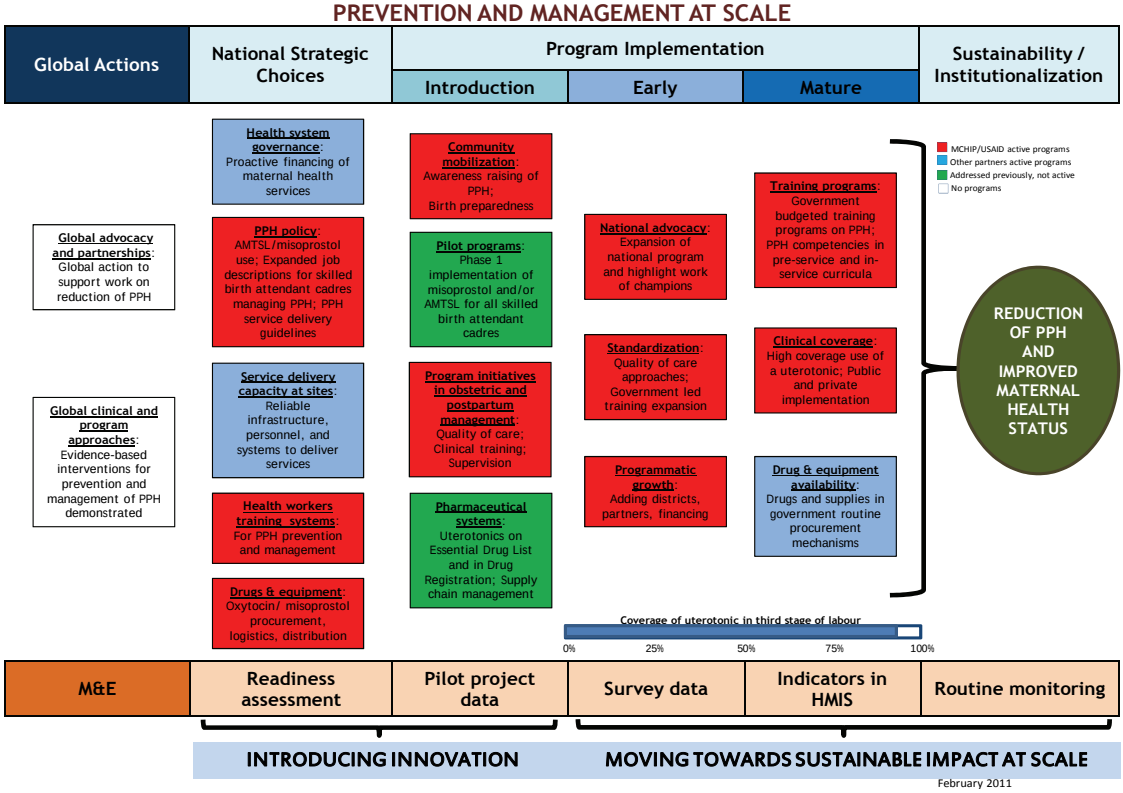
SOUTH SUDAN- PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



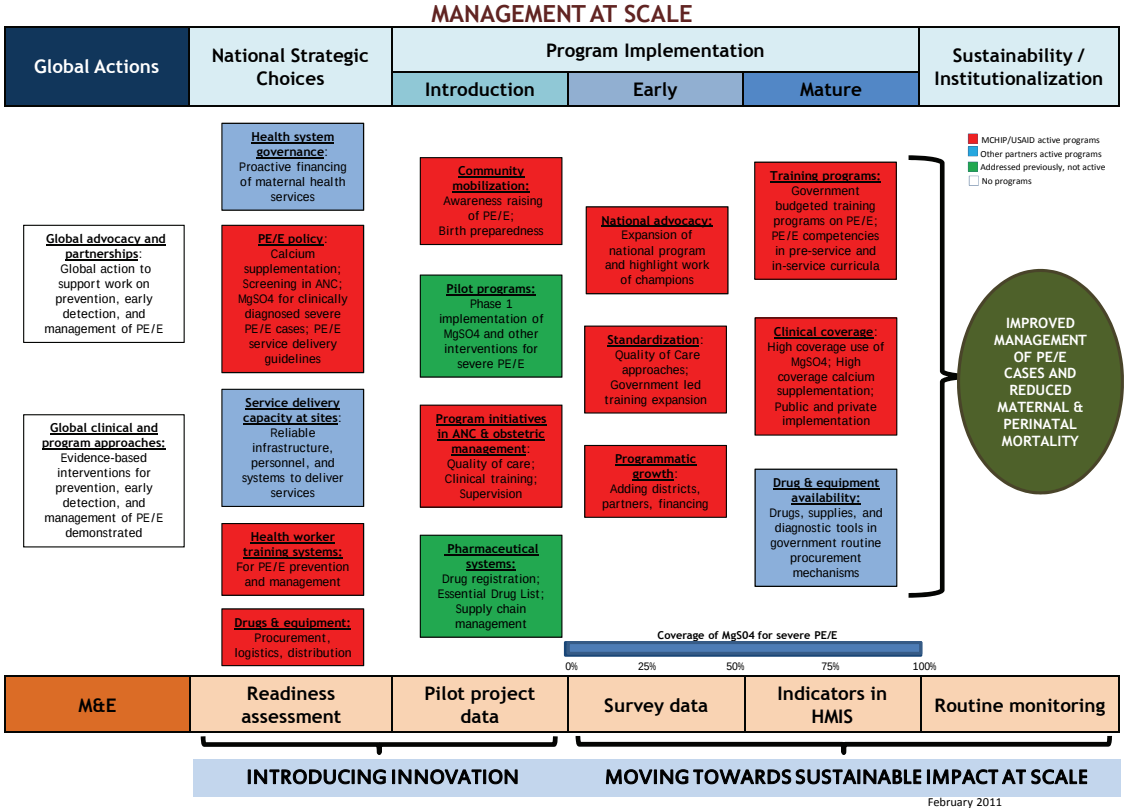
SOUTH SUDAN- PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



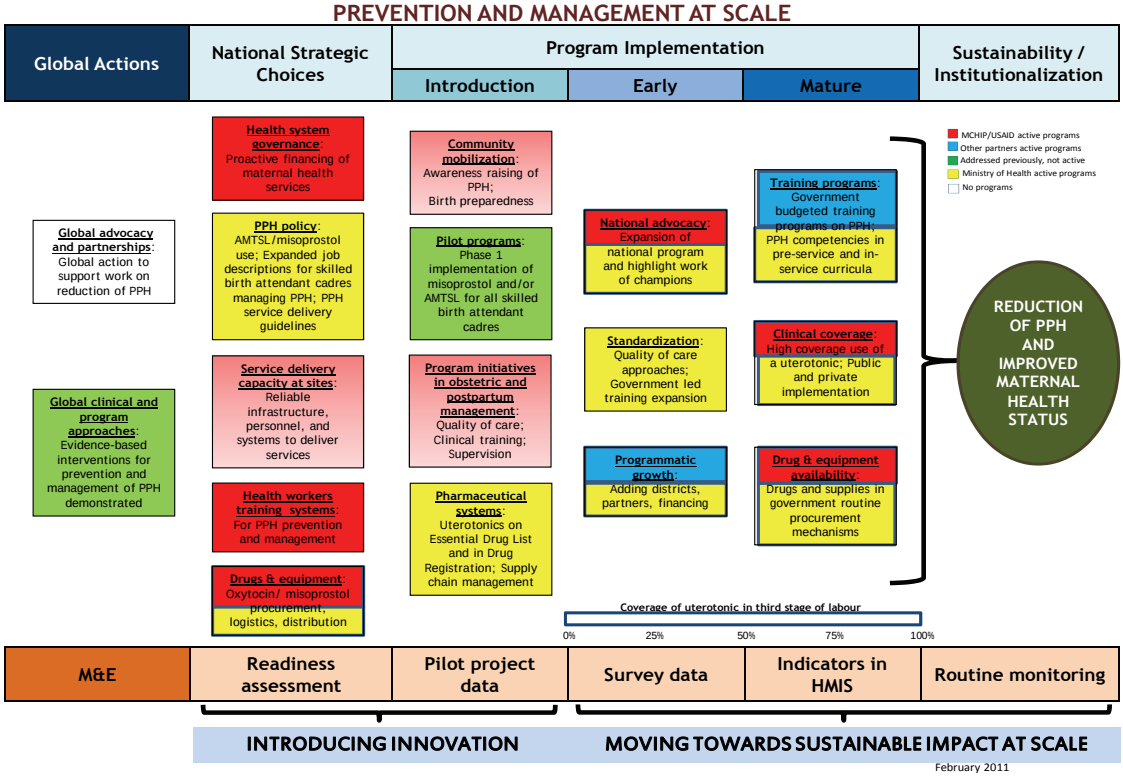
TANZANIA - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



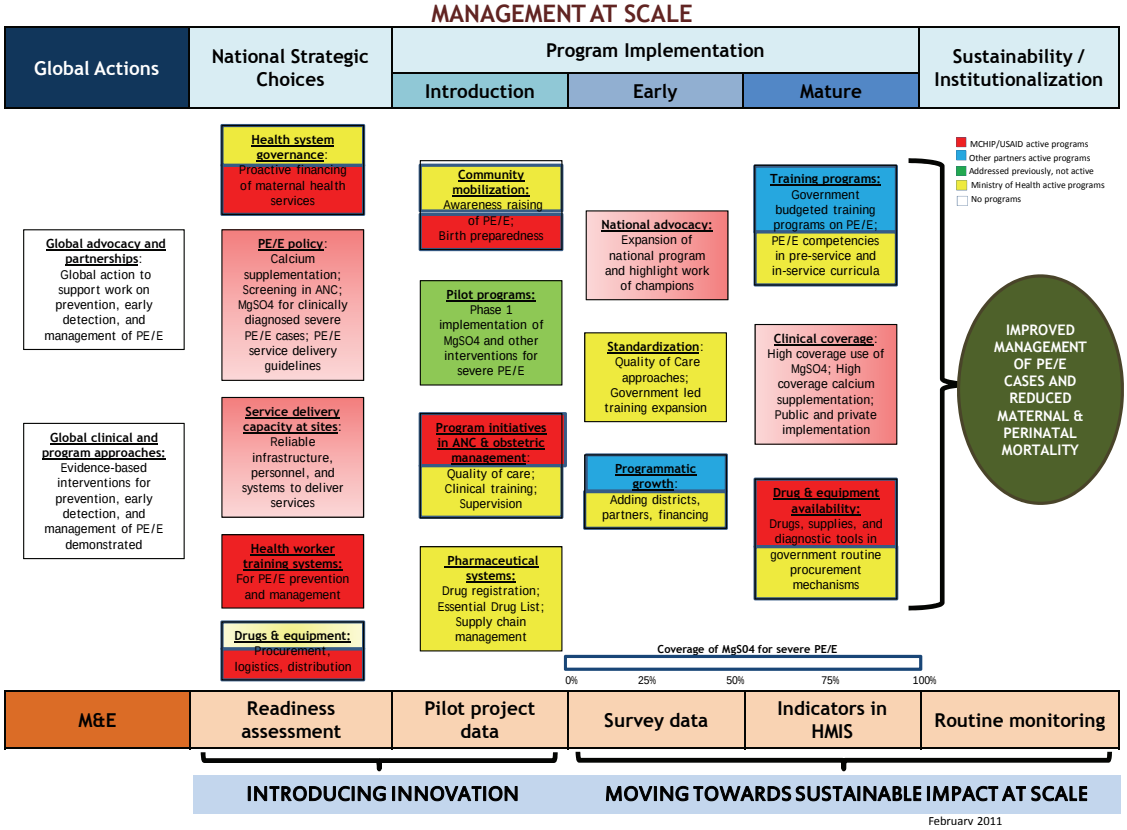
TANZANIA - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



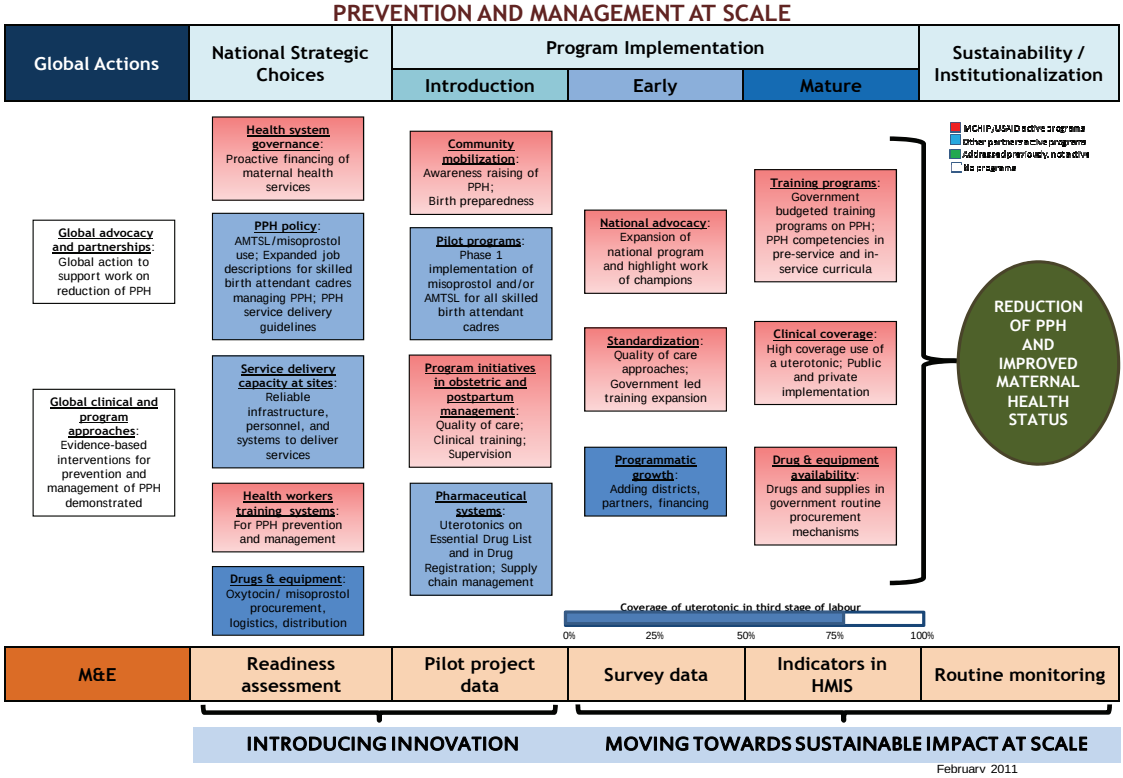
UGANDA: PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



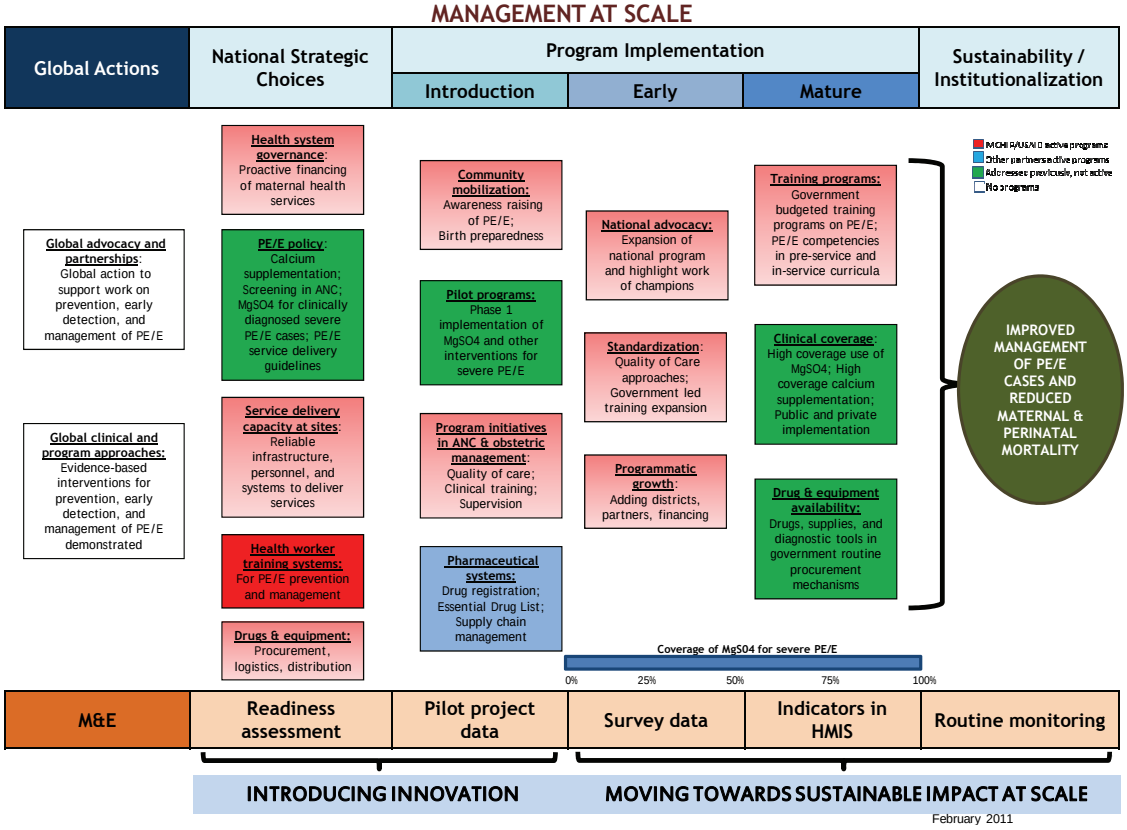
UGANDA: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



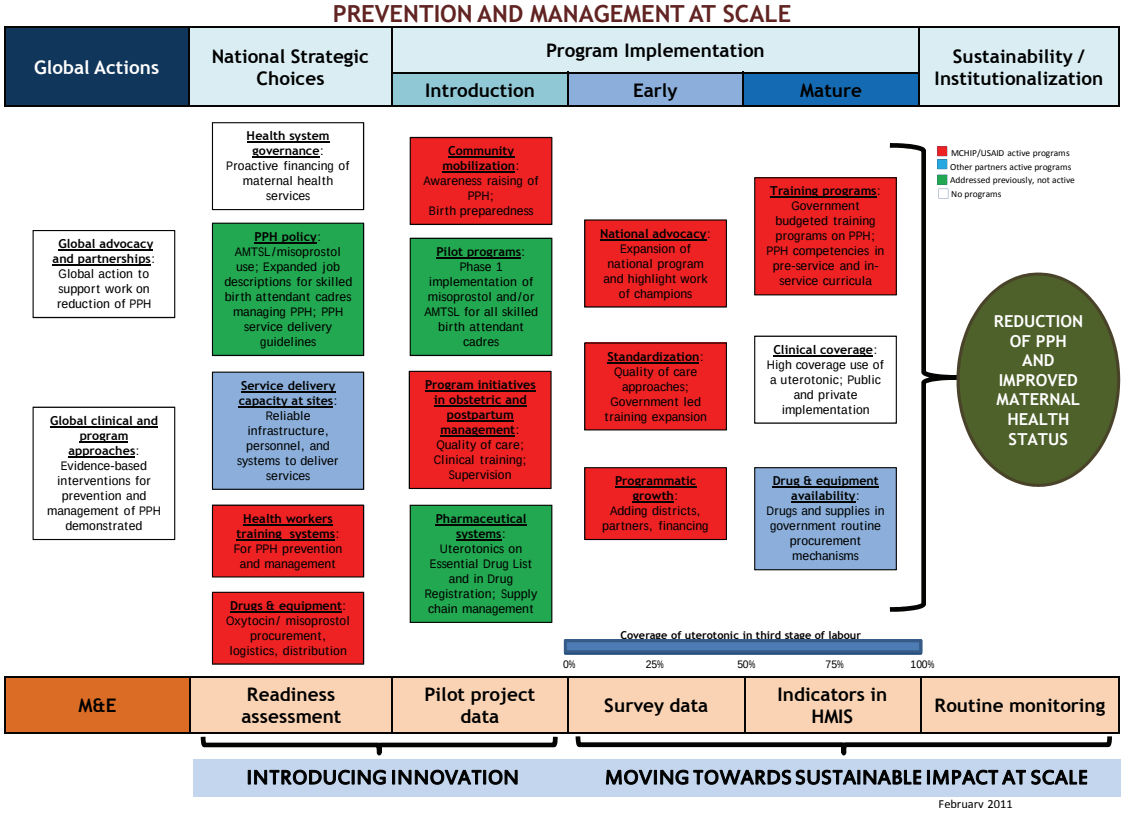
ZAMBIA: PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



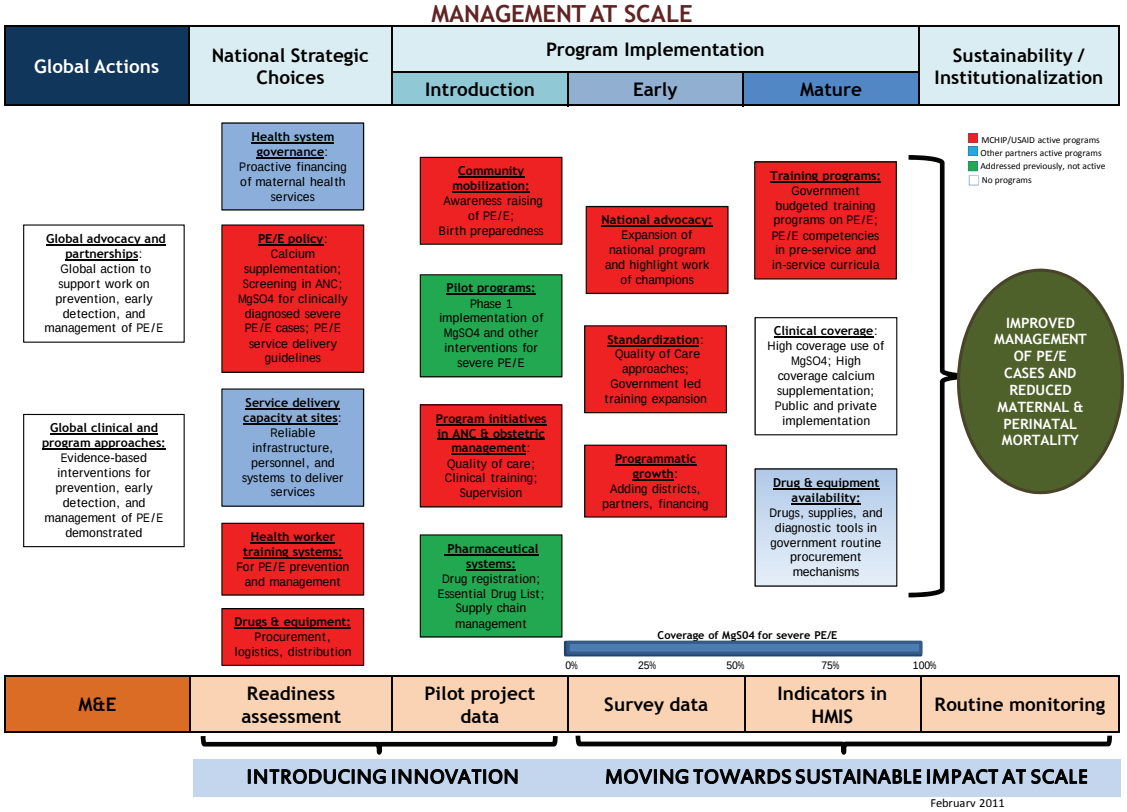
ZAMBIA: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



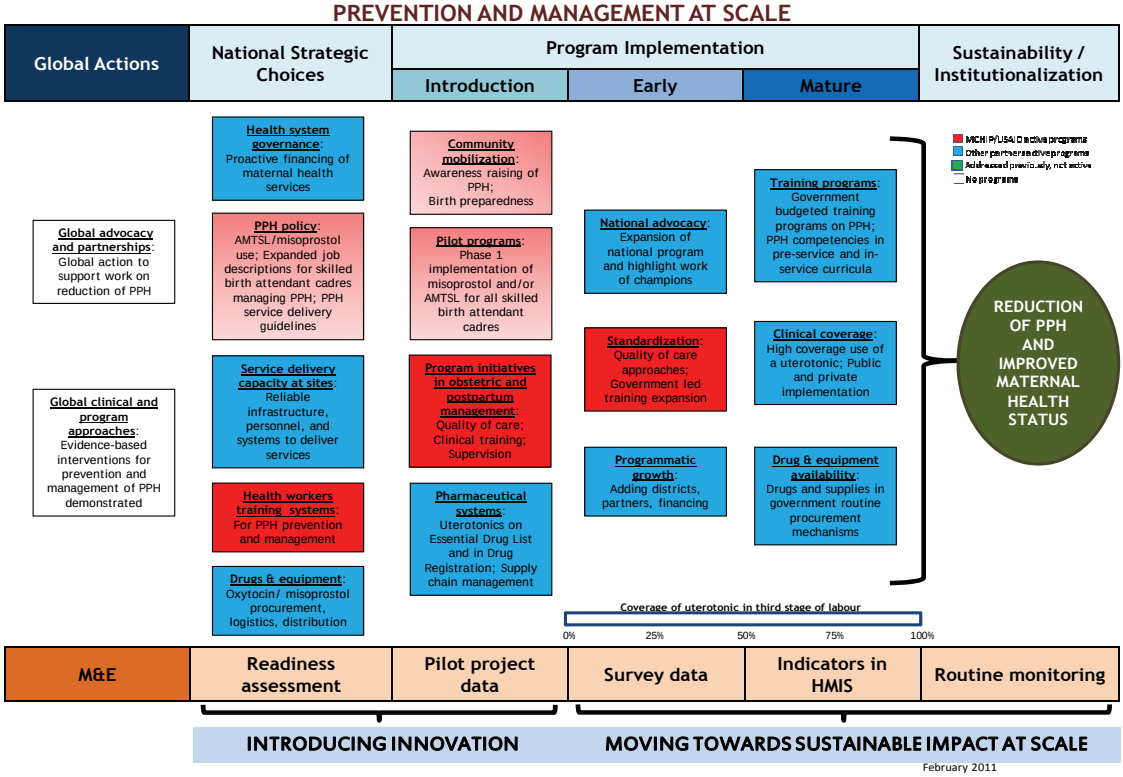
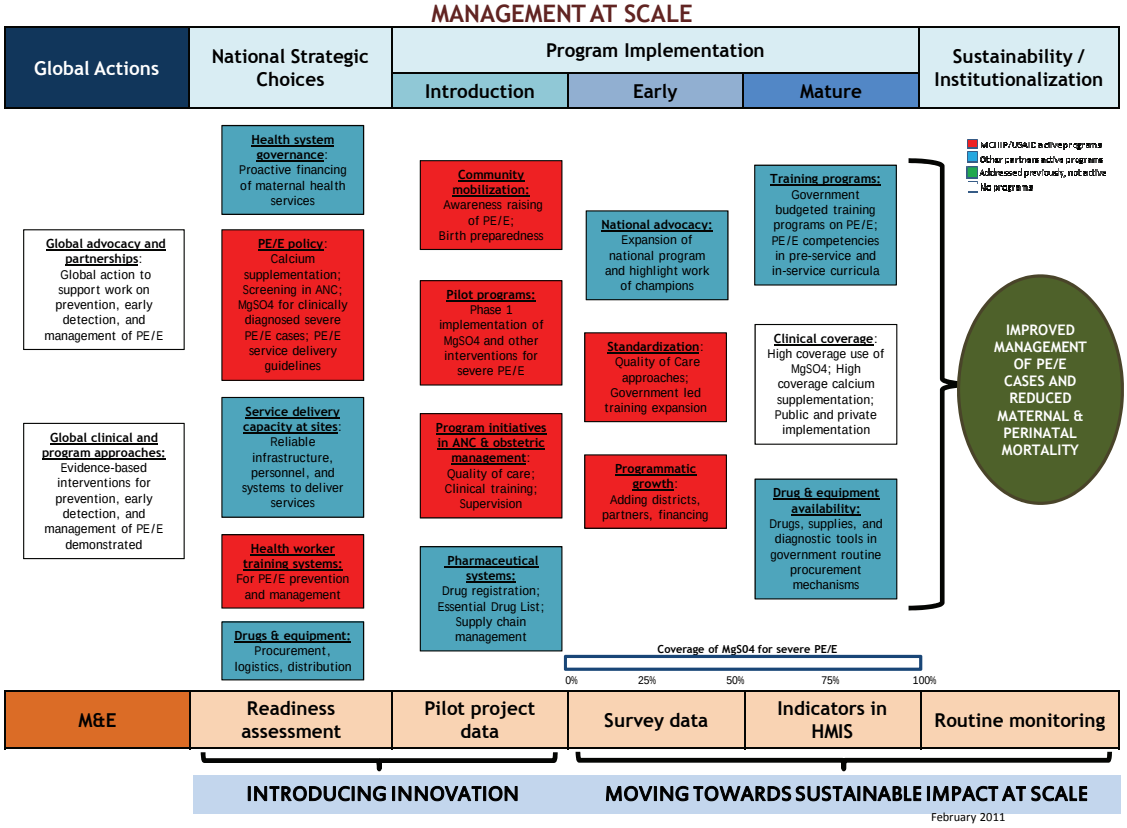
ZANZIBAR - PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



ZANZIBAR - PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



ZIMBABWE: PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE



ZIMBABWE: PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE