SHARING COMMUNITY-BASED HEALTH PROGRAM EXPERIENCES: NEPAL AND MADAGASCAR

Final Report of Study Tour to Observe the Female Community Health Volunteer Program in Nepal

Dates: March 13 – 23, 2012
Prepared by: Penny Dawson, MD
Chief of Party, JSI R&T/MAHEFA

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Front Cover Photo: Female Community Health Volunteers wearing matching saris with program logo. Saris and supplies provided by the Ministry of Health and Population/Nepal. Photo taken by Penny Dawson, JSI R&T/MAHEFA.

Left Back Cover Photo: Nepali mother and child. Photo taken by Penny Dawson, JSI R&T/MAHEFA.

Right Back Cover Photo: Malagasy mother and child. Photo taken by Brianna Engelson, intern JSI R&T/MAHEFA.

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Abbreviations

AHW	Auxiliary Health Worker
ALRI	Acute Lower Respiratory Infection
AMSTL	Active Management of Third Stage of Labor
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BPP	Birth Preparedness Package
CB-IMCI	Community-Based Integrated Management of Childhood Illness
CB-NCP	Community-Based Newborn Care Program
CHW	Community Health Worker
DHS	Demographic and Health Survey
DOTS/TB	Directly Observed Treatment Short Course/Tuberculosis
EDP	External Development Partners
EPI	Expanded Program for Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
GDP	Gross Domestic Product
GON	Government of Nepal
HDI	Human Development Index
HF	Health Facility
HFOMC	Health Facility Management Committee
IUD	Intrauterine Device

Abbreviations

LAM	Lactational Amenorrhea
MCHIP	Maternal and Child Health Integrated Program
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MOHP	Ministry of Health and Population
NFHP	Nepal Family Health Program
NNIPS	Nepal Nutrition Intervention Project –Sarlahi
OPD	Out Patient Department
PNC	Post Natal Care
PNSC	National Community Health Policy
PPH	Postpartum Hemorrhage
SBA	Skilled Birth Attendant
SHP	Sub Health Post
TFR	Total Fertility Rate
VDC	Village Development Committee
WHO	World Health Organization
VHW	Village Health Worker
VHW	Village Health Worker

1. **Background:** The MAHEFA Community-based Integrated Health Program in Madagascar, which is funded by USAID and implemented by JSI R&T with partner organizations, The Manoff Group and Transaid, works with NGOs to train and improve the quality of services provided by community health workers (CHWs). As part of the workplan for 2011/2012 activities for MAHEFA, a study tour was approved to expose public health professionals from Madagascar to the successful community health volunteer program in Nepal.

2. **Context and Justification**: The Ministry of Health (MOH)/Madagascar, in collaboration with development partners, finalized a strong National Community Health Policy (PNSC) in 2009 and has renewed its commitment to implement this policy through training and supervision of a large cadre of volunteer CHWs, who are selected and supported by their communities. External development partners are providing support in different regions of the country to bring quality services to the remote and rural populations of the country, despite numerous challenges including shortages of trained staff and commodities as well as seasonal and geographic accessibility issues.

   A workshop was held in Antsirabe in November 2011 to establish a common vision for all partners for the implementation of the PNSC for Madagascar. However, there are continuing problems with the standardized recruitment of the CHWs and a lack of coordination between the NGO partners and the MOH/Madagascar. The various partners do not all agree upon what constitutes appropriate CHW incentives. At present, these are critical issues that the MOH and the partners are trying to address as they move forward with the expansion of the program and growing recognition of the need for sustainable and community-led support for CHWs.

   This study tour offered the Malagasy public health professionals an opportunity to learn from the experiences of another country, Nepal, with a large cadre of volunteer CHWs (approximately 50,000) who have been trained and supported to provide many essential services as an extension of the formal health sector. The community health workers in Nepal are referred to as Female Community Health Volunteers (FCHVs) and the program has expanded, flourished and experienced modifications since its inception in 1988. The FCHV program is an official program of the Ministry of Health and Population (MOHP)/Nepal with an approved strategy (ref. 10). The FCHVs are located in all 75 districts of the country and are based at the ward level, which is the smallest civil administrative unit, similar to a *fokontany* in Madagascar. They are trained and supported to provide counseling, treatment and referral services for a wide range of conditions and illnesses and their work has contributed to the steady improvement of Nepal's health indicators, putting this country well on the road to attaining MDG 4 and 5. Several papers have been published which document the role of the FCHVs in providing potentially life-saving treatments and interventions at the community level (ref. 2,3,6,7,11).

The MOHP and external development partners (EDPs) involved in providing FCHV program support in Nepal have explored different methods of providing incentives and support to FCHVs, some of which are summarized in reference 4. This study tour provided the opportunity for the team from Madagascar to discuss with the MOHP/Government of Nepal, health facility and EDP staff, about the programs that have been successful – including a community-based fund, referred to originally as the "endowment fund" and now "FCHV fund", stipends for trainings and specific campaign days, the establishment of a National FCHV day, the preparation of a documentary about FCHVs and the mobilization of communities to recognize and support their volunteers (ref. 14).

The Human Development Index (HDI) for 2011, which takes into account health, education, and living standards, ranks Nepal and Madagascar 157 and 151 of 187 countries respectively.* The 2011 GDP ranking for the two countries is also similar. Nepal is ranked 107 out of 191 countries, while Madagascar is ranked 131.** Despite these similarities, Nepal has better health indicators (as is illustrated in the chart below), which may be due in part to their strong community-based public health program.

*Data taken from http://hdr.undp.org/en/statistics/hdi/

**Data taken from https://www.cia.gov/library/publications/the-world-factbook/rankorder/2004rank.html

Comparison of Key Indicators Between Nepal and Madagascar

	Nepal	Madagascar
Fertility		
Total Fertility Rate (TFR)[1]	2.6	4.8
Infant and Child Mortality[2]		
Neonatal Mortality (NN)	33	24
Infant Mortality ($_1q_0$)	46	48
Under 5 Mortality ($_5q_0$)	54	72
Maternal Health		
Maternal Mortality Ratio (MMR)[3]	281*	498
Family Planning		
Contraceptive Use (any modern method)[4]	43.2	29.2
Child Vaccination Coverage[5]		
DPT3[6]	91.7	72.8
Measles	88.0	69.6
All Basic Vaccinations[7]	87.0	61.6
Housing Characteristics		
Percent total population using any improved source of drinking water	88.6	40.0
Sociodemographic Characteristics		
% Literacy: Men (age 15-49)	87.0	78.3
% Literacy: Women (age 15-49)	66.7	74.7
Economy		
GDP Per Capita[8**]	$1,300	$900

[1] Expressed per woman (ages 15-49) for period of three years preceding surveys

[2] Deaths per 1,000 live birth for the period 0-4 years preceding the surveys

[3] Expressed per 100,000 live births; calculated as the maternal mortality rate divided by the general fertility rate. Estimates for the period 0-6 years prior to the surveys

[4] Percent distribution of currently married women age 15-49

[5] Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report)

[6] DPT vaccinations include DPT/HepB as well as DPT/HepB/Hib.

[7] BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)

[8] 2011 est.

Data taken from Nepal Demographic and Health Survey 2011, and Madagascar Demographic and Health Survey 2008-2009

*Data taken from Nepal Demographic and Health Survey 2006

**Data taken from https://www.cia.gov/library/publications/the-world-factbook/rankorder/2004rank.html

3. General and Specific Objectives of the Study Tour:

General Objectives:

a. To provide an opportunity for a diverse group of public health professionals, currently working in Madagascar, to observe on the ground the totality of the FCHV program, from meetings with senior officials in the MOHP/Nepal, to EDPs and partner organizations and health facility staff, FCHVs
b. To discuss approaches with community members and leaders who have facilitated local support for this cadre of volunteers in their villages
c. To share the multiple experiences of the implementation of Community Health Worker programs in Madagascar

Nepal was selected as the best possible destination to fulfill the trip objectives as:

- Nepal has a long history of successful community-based program implementation
- Programs have succeeded at a national scale despite significant economic and geographic challenges

Specific Objectives:

a. To learn how Nepal has addressed the issue of incentives for volunteers, and the lessons learned to date
b. To observe the function and advantages of a "unified" cadre of volunteer workers, rather than a disparate and poorly coordinated ensemble as currently exists in Madagascar
c. To consider the additional programmatic components that might be included in the CHW package in Madagascar to further extend essential maternal, newborn and child health (MNCH) services
d. To consider what factors have contributed to the sustainability of Nepal's FCHV program which has a very low "turnover rate" among the volunteers
e. To learn about approaches for program implementation in the most remote and hard to reach villages and districts and seek lessons applicable to Madagascar
f. To utilize this unique opportunity to develop a plan to:
    - *inform and harmonize approaches related to the implementation of the Community Health Program in Madagascar*
    - *fine-tune technical approaches that will foster sustainability*
    - *strengthen coordination among key decision makers*

4. Participants and Organizers: The participants from Madagascar were public health professionals looking for innovative approaches and new ideas to support the technical implementation of CHW programs. MAHEFA is a new USAID-funded program, with a mandate to work at the community-level in remote and difficult to reach areas through

May 2016. It is expected that developing a cadre of MAHEFA and partner staff who are ready and willing to explore new approaches to implementing community-based health programs will facilitate more creative planning and support for programs in Madagascar. This study tour was not seen as an end in itself, but an opportunity to further strengthen alliances and support for the Madagascar CHW programs. The participants were:

1. Dr. Jocelyne ANDRIAMIADANA, AOR/MAHEFA, USAID Health Office

2. Dr. Penny Dawson, COP, MAHEFA

3. Dr. Robertine RAHELIMALALA : Senior Community Health Advisor, MAHEFA

4. Dr. Rene RANDRIAMANGA, MNCH Advisor, MAHEFA

5. Mr. Jean Pierre RATSIMBAZAFY, NGO -SAF, Melaky

6. Mr. Haingolalao Jerison RASOLONIRINARIMANANA , NGO SAGE, Diana

7. Dr. Jean Pierre RAKOTOVAO, COP, MCHIP

Dr. Sahondra Harisoa Lalao JOSEE, SSD/MOH was also able to join the group utilizing non-USAID funds for her support.

The program in Nepal was organized by the JSI R&T Nepal Family Health Program (NFHP) II in coordination with USAID and Ministry of Health. Mr. Sushil Karki, Field Coordinator for NFHP II played a key role in coordinating and communicating with the Malagasy team. In Madagascar, the MAHEFA program (JSI R&T led bilateral) took the lead to organize the logistics for the team.

An orientation was held at the MAHEFA office in Antananarivo and the participants were briefed on the objectives, context, and logistics for the trip. The participants were then asked to share their personal and professional objectives for the tour before leaving Madagascar. These objectives are summarized below:

- To observe and understand the organization of the Ministry of Health/Nepal, the health care system and the approaches being used to implement the community health strategy, particularly the support needed to ensure a sustainable community health outreach program using volunteer health workers (CHWs)
- To understand how the contribution of these CHWs has enabled Nepal to meet MDG 4 and 5
- To understand the mechanisms used as incentives (direct and indirect) for the CHWs

- To see the actual tools and materials used in the training, follow-up and motivation of the CHWs and to bring some of the tools and materials back to Madagascar, if appropriate
- To observe some of the innovative programs on the ground – use of misoprostol at the community level to prevent postpartum hemorrhage, use of chlorhexidine at the community and facility level for umbilical cord care in the newborn as a means to prevent neonatal infections and sepsis
- To understand the MOH resolutions and mechanisms that allowed them to move forward with these innovations despite international WHO recommendations and reservations
- To prepare recommendations to help improve the implementation of the PNSC in Madagascar, particularly in relationship to motivating the CHWs and supporting the activities implemented by them

5. Agenda for Study Tour and Field Site Visits

General Schedule: The team left Madagascar on March 12 and arrived in Kathmandu, the capital of Nepal, on March 13. March 14 was reserved as a day for general programmatic orientation from the team of NFHP II. From March 15 – 19, the teams were in the field. March 20 – 22 were days for sharing of impressions and consolidation of reports as well as a debriefing with MOHP/Nepal and NFHP II officials and staff.

Before the team left Madagascar, they decided to split into two groups for the field visits in Nepal to maximize the opportunities to see and learn different aspects of the program implementation. The schedule was planned to allow adequate time after the field visits for sharing between the two groups. As Nepal is quite geographically diverse, it was decided that one group would visit a flatland district, Mahottari, with the opportunity for a side visit to observe Johns Hopkins University's research programs (NNIPS) in Sarlahi. The other group would visit a mid-hill district, Salyan, with the opportunity to visit an NFHP II field office in Banke district and observe innovative programs for misoprostol and chlorhexidine. The map below shows the areas visited and the following chart shows the primary differences between the two field sites.

Nepal

Field Visits

Salyan District	Mahottari District
• District Health Office, Health Post, Sub HP, FCHV level for CB-NCP, IMCI, FP, including outreach for EPI/FP • Meet Health Facility and FCHV fund management committees • PLUS –Community-based misoprostol distribution for prevention of postpartum hemorrhage • PLUS –Discussion and observation (Dr. JP) of community-based use of chlorhexidine for prevention of umbilical cord infections	• District Health Office, Health Post, Sub HP, FCHV level for CB-NCP, IMCI, FP, including outreach for EPI/FP • Meet Health Facility and FCHV fund management committees • PLUS –Opportunity for more indepth discussion on management of FCHV fund as this district had special orientation to strengthen FCHV fund management. • PLUS –Visit to Johns Hopkins University's research site in Sarlahi district (site of original vitamin A and chlorhexidine research and current indoor air pollution, newborn massage and maternal influenza vaccine study, plus more)

The NFHP II/JSI R&T team in Nepal prepared a detailed plan to allow the visitors to have broad and varied experiences in the field. After the day of program specific orientations in the NFHP II office in Kathmandu, the team was split into two groups. The group members are listed below.

SALYAN TEAM
Salyan Team from Madagascar: 1. Dr. Jocelyne ANDRIAMIADANA - USAID/Madagascar 2. Dr. Rene RANDRIAMANGA - MNCH Coordinator, MAHEFA/JSI R&T 3. Mr. Jean Pierre RATSIMBAZAFY, Regional Coordinator, SAF-FJKM (NGO) NFHP Staff to join Salyan team: 1. Dr. Robin Houston 2. Santosh Neupane, Field Officer, Salyan District 3. Pam Poon, French Translator
Banke visit from MCHIP Madagascar Team: (also joined by Salyan Team after returning from the hills to the flatlands). 1. Dr. Jean Pierre RAKOTOVAO, Country Representative, MCHIP Staff from Nepalgunj Field Office: 2. Hem R. Poudel, Child Health Program Officer, Nepalgunj Field Office 3. Hari Krishna Shah, CB-NCP Program Officer, Nepalgunj Field Office
MAHOTTARI TEAM Mahottari Team from Madagascar: 1. Dr. Harisoa Lalao Josee SAHONDRA, Director of District Health, MOH/Madagascar 2. Dr. Robertine RAHELIMALALA, Senior Community Health Advisor, MAHEFA/JSI R&T 3. Dr. Penny DAWSON, COP, MAHEFA/JSI R&T 4. Mr. Haingolalao Jerison RASOLONIRINARIMANANA , Regional Coordinator, SAGE (NGO) NFHP Staff to join Mahottari Team: 1. Dilip Poudel, Team Leader, Child Health 2. Arbinda Yadav, Field Officer, Mahottari 3. Sajjan Yogesh, CB-NCP Field Officer, Mahottari 4. Shriya Pant – French Translator

Detailed trip reports from each group are included in Appendix 10.B of this report.

Salyan Team

Mahottari Team

6. Lessons Learned: Specific Programmatic points for consideration for the Madagascar CHW program

Overall Health Situation – Nepal has already met MDG 4 (DHS, 2011) and is likely to meet its MDG 5 goal. Although strong health facility and community-based programs have contributed to the reduction in under-five mortality, newborn mortality is still very high (33/1000 live births), and the government of Nepal (GON)/MOHP and partners are making substantial efforts to address this problem. Many individuals who met the team attributed Nepal's success in reducing the maternal mortality rate (halving of the MMR in 10 years) to several factors: legalization of abortion in 2002, better access to uterotonics to prevent post- partum hemorrhage (active management of the third stage of labor, including use of oxytocin in health facilities (HF) and skilled birth attendant (SBA) deliveries, and misoprostol for home deliveries), increased training and support for SBAs, maternity incentive schemes by which women receive Rs 400 if they complete four antenatal care (ANC) visits per the MOHP recommended schedule (four, six, eight, and nine months) plus a financial incentive to cover transportation costs to have a delivery in a facility (Rs 500 in the flatlands, Rs 1000 in the hills, and Rs 1500 in the mountains). There has also been a reduction in TFR, which is now 2.6. The government commits seven percent of its overall budget to health programs and the MOHP makes a large commitment to community-based services. The Ministry of Local Development also has a large local budget, of which a considerable proportion is spent on health-related services (eg. providing additional staff for facilities where needed, refills for drugs if shortages occur) and infrastructure (including funds for new buildings, birthing centers, etc.). The government is actively pursuing a policy to decentralize budgeting and planning for health activities and budgets are sent to the District and Health Facility level to allow more local management of funds.

Health Facility Level – Communities are informed about essential drugs, available services, staffing, and CHW names, locations, and phone numbers (if available). There is excellent stock management, orderly reporting, and wall charts are used to show targets and achievements. A fixed schedule is in place for an expanded program for immunization (EPI) as well as outreach clinics. CHWs are responsible for informing the community of these programs in advance, accompanying program attendees, and following up with defaulters. A fixed schedule is also in place for FCHV/CHW monthly meetings at the health facility. The community and facility levels are well integrated and there is local support for additional health staff to assist with the work at the SHP level. The role of the CoSan (like the HFOMC) has also been strengthened to aid the facilities, including fund raising and supporting staff.

Community Health Workers – Integrated services are available at the community level through a large cadre of volunteers (48,000 in rural areas and an additional 4,000 in municipalities). Regular, fixed dates are set for meetings at the Health Facility to give reports, receive supplies, share problems and get on the spot training. There is strong basic training with standardized curricula and experienced trainers, and review meetings

are held twice annually. In addition to refresher trainings, supplementary trainings for program additions are also given. There is a good supply of tools, registers and products as well as strong support and linkage with the Health Facility staff who work with the CHWs to promote health services.

7 key commodities – The following commodities are provided and always available to FCHVs: iron/folate, ORS, zinc, cotrimoxazole-P, pills, condoms, and vitamin A. Additional supplies may be given for campaigns (albendazole, polio). For training days (and campaign days), the FCHVs receive a transportation allowance of Rs 200 (about USD $2.50) per day.

Non-financial incentives – The MOHP has declared December 5th (which is International Day of Volunteers) as the FCHV day in Nepal. Celebrations are conducted at local, district, regional, and national levels. This year, a TV drama (with famous local actors) was prepared and aired to mark the day. FCHVs also receive two saris with the logo of the program (to be given annually), ID cards/badges, bags to carry and store supplies, torches/flashlights, and umbrellas. In some areas the VDC/community funds have been used to provide bicycles for the volunteers.

Performance-based Incentives – One MOHP program, the Community-based Newborn Care Program (CB-NCP), provides a financial reward if the FCHVs meet certain specific criteria in the care of the pregnant woman and her newborn (summarized in the Salyan section of this report). This is a relatively new approach, which is still being evaluated to determine if performance based incentives are having a negative impact on other FCHV program components for which FCHVs do not receive any financial reward.

FCHV/CHW fund – This is a government initiated fund (Rs 50,000 per VDC, about USD $600) with annual increments (Rs 10,000, about USD $120) for utilization by FCHVs in their communities. The chairperson and secretary of the fund management committee (a total of five persons) must be CHWs. Of the five members, four are FCHVs and one is a member of the health facility staff. FCHVs feel empowered with this money and often use it as a kind of microcredit system with interest bearing loans (1% per month, 12% per annum). The performance-based incentive from the CB-NCP program is also deposited into the FCHV fund and then provided to the individual FCHVs, according to their performance. NGOs and other partners can also donate to the fund for the common good of the FCHVs. The FCHVs are free to use innovative mechanisms to increase their fund, e.g. raffles, lotteries, and contests. Twenty five percent of the fund is kept for emergencies. The remainder can be available for loans. The first priority is for FCHVs, the second for members of the mothers' group and the third is for general community members.

Innovations – The community-based programs for the use of misoprostol to prevent postpartum hemorrhage (PPH) and chlorhexidine to prevent umbilical cord/general infections in neonates are promising options for implementation by CHWs in

Madagascar. In addition to these programs, FCHVs in Nepal are involved in a pilot for the use of calcium to prevent preeclampsia. The volunteers also treat neonatal sepsis with oral antibiotics and make referrals to health facility staff for injectables. They have been trained in neonatal resuscitation (vigorous massage/stimulation, use of DeLee suction tube, bag and mask) as well. In many communities, they provide clean delivery kits to women who may deliver at home.

7. Sharing of Lessons Learned

The NFHP II team provided the opportunity for a debriefing session with members of their internal team and also with two members of the MOHP – the Director of the Family Health Division, Dr. Naresh KC and the Chief of the Female Community Health Volunteer Program, Ms. Mangala Manandhar. During the meeting with the NFHP II team, Dr. Josee presented the key positive findings from the study tour; these are summarized below.

7.1 Government

- Government commitment at all levels (Central, Regional, District, Towns, Villages, Hamlets)
- Directorate of Community Activities in the Ministry of Health is effective and autonomous
- Effective decentralization at all levels (decision making, personnel management, financial inputs ..)
- Institutionalization of 52,000 female health volunteers

7.2 Training of CHWs

- Tools prepared for use of FCHVs are pictorial
- Health activities are integrated at the community level – not multiple types of FCHVs, but single cadre trained and supported to do many tasks
- Initial training for FCHVs of 18 days in two sessions of 9 days
- Refresher training of 2 days twice a year
- Training as each new program component is added, with reinforcement of previous components
- FCHVs treat 70 % of pneumonia cases (the remaining 30% of cases are treated at static health facilities)
- FCHVs are involved in the integrated management of childhood illnesses at the community level (CB-IMCI) and linked with and supported by the health facility to treat diarrhea, pneumonia, and newborn sepsis and birth asphyxia in a new expanding program (CB-newborn care package) –they also use chlorhexidine and misoprostol

7.3 Organization

- HMIS and LMIS are well organized and coordinated

- Records are coded by the program and data is consolidated once a month at the monthly meetings at health facilities with the FCHVs (CHWS)
- The health facilities display lists of FCHVs with their photos
- A list of the members of the FCHV fund management committee is also displayed
- A list of the health facility management committee members and positions is shown

7.4 Motivation and Community Support

- Local governance (involvement, volunteering)
- Multiple motivating factors exist for the FCHVs (Social, financial, equipment, spousal support, national day of FCHVs)
- Moral satisfaction FCHVs who provide services in their communities
- Possibility of receiving local loans with reasonable interest at 1% per month, with a ceiling of 4000 RPs for a period of six months
- Community leaders support and provide solutions if necessary on all health activities in their villages
- National day is held every year for Female Community Health Volunteers
- Interaction between FCHVs and the Mother's Groups with a meeting every month (on average 30 members)

8. Next Steps

Since returning to Antananarivo, plans are underway to move to the next level with the operationalization of the National Community Health Policy (PNSC). The first workshop to bring together all the key players for developing the implementation plan was held in Antananarivo on April 3-4 and Dr. Josee shared these lessons learned and observations from the study tour to Nepal. There was a lot of interest and a followup meeting is planned for early July, when the partners will hear more details about the study tour and also have an opportunity to see many of the materials and job aids which were shared by the team in Nepal. A list of these materials is included with this report as Appendix 10.D. A second workshop to review the progress towards the development of a detailed implementation plan to operationalize the PNSC is also planned, but the date has not yet been established at the time of the writing of this report.

9. Conclusions

Nepal has made significant efforts to strengthen community-based health services and the FCHVs are the pillars of this approach. Strengthening of the peripheral health facilities, the Sub Health Posts and the Health Posts and the availability of increased local funds to support these institutions has also greatly contributed to the development of a strong community base. The coordination and respect between the volunteers, the Health Facility staff and the local leaders (VDC, Health Facility

Management committee, teachers, etc) is helping to make health a priority in the villages.

Many of the lessons learned on this study tour are applicable to the CHW program in Madagascar and this group will disseminate their findings and recommendations to strengthen the Malagasy program. Particular lessons learned that are applicable to the CHW program in Madagascar include government leadership and coordination of all partners as well as motivation and support of CHWs through nonfinancial incentives. Specific non-financial incentives that could be used to motivate CHWs in Madagascar include: a national day to recognize CHWs, badges, bags to carry supplies, and a uniform with the program logo. Additionally, the use of misoprostol to prevent PPH as well as chlorhexidine to prevent umbilical cord/general infections in neonates is worth exploring in Madagascar.

Group members at airport in Kathmandu, Nepal.

Appendices

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B. Trip Reports – Salyan and Mahottari

B.1. Summary of Field Visit to Salyan – March 14 – 19, 2012.

Travellers from Kathmandu: Dr. Jocelyne Andriamiadana, Dr Rene, Mr. Jean Pierre, Dr.Robin Houston, DCOP, NFHP II, Ms. Pam Poon (Translator). Later Dr. Jean Pierre Rakatovao joined the group in Nepalgunj, Banke.

Field Trip Report Prepared by Dr. Jean Pierre Rakotavao- MCHIP

Specific Objectives:

1. To learn how Nepal was able to implement innovative community- level programs using both chlorhexidine and misoprostol, in spite of current WHO guidance, which recommends against similar community based programs involving CHW distribution of misoprostol for women to take on their own.

2. To understand how Nepal implements and scales up PPH prevention activities.

3. To understand how Nepal implements and scales up neonatal cord infection prevention interventions.

Trip Summary

Dr. Rakotovao took advantage of programmatic opportunities to learn about what Community Health Workers (CHW) are doing in counseling on birth preparedness, the use of misoprostol to prevent postpartum hemorrhage, chlorexidine for cord care, and Active Management of Third Stage of Labor (AMSTL). He learned other approaches for the design and management of operations research and the development of programs for chlorhexidine and misoprostol in particular. Finally, he was able to meet with relevant stakeholders to discuss and share experiences and challenges to implementing community-based activities so that upon his return to Madagascar he would have new ideas and insights on how to further strengthen the community-health programs in Madagascar, thus enabling him to also inform current MCHIP community-level activities.

Importantly, this trip to Nepal provided a strategic opportunity to gather information on how to implement interventions that can be quickly scaled up to reduce the rates of maternal and neonatal mortality. Dr. Rakotovao conducted a field visit in Bhawaniyapur, a town in Banke District in the Bheri Zone of south-western Nepal, in order to familiarize himself with the community health system used in Nepal, in particular the benefits of their integrated community-level approach. Lessons learned about the benefits of an integrated community- level program with a focus on innovative interventions at the community level will inform current planned MCHIP activities, in particular the proposed introductory programs for both PPH prevention and the use of chlorhexidine for umbilical cord care. Given Dr. Rakotovao's stature and role as MCHIP Chief of Party, JSI's MAHEFA senior project

staff considered his participation essential for advocating with relevant stakeholders for a similar CHW program here in Madagascar.

Objective 1:
To learn how Nepal was able to implement innovative community- level programs using chlorhexidine and misoprostol (in spite of current WHO guidance which recommends against similar community-based programs where CHW distribute misoprostol for women to take themselves) ;

Findings:

- In spite of opposition from the WHO, the government took into account the findings from pilot projects to make policy decisions , namely to adopt pilot program recommendations to have CHWs distribute misoprostol and chlorhexidine for women to use in order to combat high rates of maternal and neonatal mortality, respectively. It is important to note that the WHO does recommend the use of an antiseptic such as chlorhexidine in a setting where the prevention of infection is not possible or there is a high risk of infection.

Objective 2 and 3:
Learn how Nepal implements and scales up PPH intervention/ neonatal cord infection prevention, including challenges encountered and solutions implemented.

Findings:

- Implementation has to be done step by step, starting with a pilot phase, then an introductory program; next limited scale up, and finally national scale up.
- To avoid the misuse of misoprostol (one of the key concerns), misoprostol is not available outside the government supply system, such as in private pharmacies.
- In Nepal there is a local manufacturer of chlorhexidine, whereas Madagascar would need to import from Nepal.
- The MoH successfully integrated new innovations and approaches into existing interventions for a more holistic approach, such as by incorporating best practices in nutrition, child survival, family planning and other sectors into existing CHW activities.
- The MoH takes a leading role in health interventions throughout the country, regardless of recommendations put forward by other organizations, including the WHO.
- Practical tips were shared about how to package and distribute misoprostol for a community based program.

Next steps:

- Closely liaise with collaborating partners- such as JSI, MSM, and PSI, along with the MoH representative who participated in the study tour, Dr. Josee, the Director of District Health Care, in order to share lessons learned in Nepal with key decision-makers here in Madagascar. One key goal is to strengthen community-based health care service delivery based on the Nepal experience.
- Additionally, Dr. Rakotovao will work to convince key stakeholders of the strategic importance of moving forward with MCHIP's proposed PPH Prevention Program, especially in light of current MOH/DAM (Drug Regulatory Agency) concerns about the use of misoprostol for PPH prevention.

Field Trip Report Prepared by Dr. Rene Randriamanga, MNCH Coordinator, MAHEFA

Objectives of the Study Tour and Field Visit

- Learn how Nepal was able to resolve the issue of motivating volunteer CHWs
- Observe the uniformity of the working volunteer operation.
- Consider additional programs to be included in the package of CHW activities in Madagascar to further expand essential services for neonatal care.
- Consider what factors contributed to making the CHW program (which has a very low dropout rate of volunteers) permanent in Nepal.
- Learn approaches for the implementation of health programs in districts and villages that are remote and difficult to access and draw lessons applicable to Madagascar.

Trip Summary

March 15, 2012: Visit to the District Hospital (DPHO): we met with officials (Dr. Bikash Devkota-DHO, Mr Khimendra Shakya-FP Officer/Supervisor FCHV, and Mr Nagendra Maharjan-CB-NCP/CB-IMCI Supervisor). They explained the organizational structure and activities of Female Community Health Volunteers (FCHV) and the Sub Health Post (SHP).

March 16, 2012: Visit to the Marke SHP: At the health facility, we met Mr. Gorakh Thapa, Ms. Nirmala BK (ANM) and Ms. Shanti Thapa (ANM) who supervise the FCHVs by managing the availability of commodities for prevention and treatment, filing records, checking the reference sheet, and ensuring capacity of the FCHV building. What impressed us was that the list of essential drugs (22 types) and all services (14) were displayed on the wall by the SHP. We also met Tara BK-MCHW and Dr. Prakash Badal-VHW, according to them, the Maternal and Child Health Workers (MCHW) select and designate the FCHV.

In the afternoon, we met with the Health Facility Operationnal Management Community (HFOMC): This committee is composed of 9 members including the FCHV. Their roles are:

managing the program while defining the objectives or expected results, identifying problems, logistics, seeking funding, and developing management guidelines.

March 17, 2012: FCHVs Marke visit: We were impressed that there is a FCHV logo that is consistently used on the FCHV builiding, saris, bag, etc. The FCHV kit consisted of: thermometer, registers, color-coded salter scale, oral rehydration salt, communication materials, bag and mask for neonatal resuscitation, oral contraceptives, condoms, medicine, zinc, cotrimoxazole…

The FCHV explained how they use pictorial job aids and management registers. We met two women with their children who had benefitted from the FCHV program.
In the afternoon, we met with community representatives who work with the SHP. This committee was created 6 months ago, with the staff of the SHP action plan (monitoring, evaluating and supervising). They organize events for the background research to support AHW/ANM, and provide supervision of the FCHV.

March 18, 2012: SHP Damachaur visit: we met the head SHP, Mr Oli (Health Facility), the two midwives, Ms. Karuna Oli and Gautam Janaki. They explained how they do their work and that a bloodtyping program is in place. We also met nine FCHVs and learned that the lactational amenorrhea method (LAM) of family planning is not feasible because the women often work away from their chldren. PSI distributes IUDs and implants.

March 19, 2012: Back to Kathmandu.bIn the afternoon, we visited the NFHP Office/ Nepalgunj, where we met Dr Jean Pierre RAKOTOVAO, who visited the district for the program Banke chlorhexidine (CHX) and mesoprostol.

March 20, 2012: Meeting in the NFHP office/ KATHMANDU NEPAL. Briefing on the missionaries' experiences. In the afternoon, we met the head of the FCHV program of the Ministry of Health in NEPAL, Ms. Mangala, and also participated in the presentation of Mr Luke Mullany research "CHLORHEXIDINE CORD CLEANSING" who is a student at Johns Hopkins University Bloomberg / School Public Health.

March 21, 2012: Presentation of our results on the "STUDY TOUR" by Dr. Josée SAHONDFRA.

Possible activities to be implemented by MAHEFA are utilizing simple training and management tools with pictures; support of a national day for CHWs; CHW motivations including microcredit schemes and use of chlorhexidine if the product is included in the list of essential drugs.

B.2. Summary of Field Visit to Mahottari - March 15 – 19, 2012*

Travellers from Kathmandu: Dr Sahondra, Dr. Robertine, Haingo, Dilip Poudel (Child Health Team Leader) , Shriya Pant (Translator), Penny Dawson

Summary prepared by: Penny Dawson, MAHEFA

Thursday, March 15 – The team took a flight from Kathmandu to Janakpur, a large town in the Central (eastern) Terai or flatlands. On arrival, we were met by NFHP/JSI staff from the Hetauda Regional Office (Madhan Thapa) and the Dhanusha district-level office (Shambu Jha). The group then travelled to Jaleswor, the district headquarters of Mahottari where they were warmly welcomed on arrival at the District Health Office by Mr. Vijay Kumar Jha, the District Public Health Administrator for Mahottari and his staff. They were presented with flower garlands on arrival at Mr. Jha's office and then invited up to a meeting hall where all of his team assembled for introductions and presentation of the program. The team was joined here by 2 NFHP/JSI staff – Arvind Yadav and Sujjan Yogesh. Vijay Jha gave a very detailed overview of the public health system and programs in Mahottari , but then he sat and just chatted with the visitors for an extended period of time. He answered many questions from the team.

Particular topics of interest were: free drug supply, supervision and support for the FCHVs – including the FCHV fund, relative autonomy of district budgets, integration of program activities, particularly at the community level.

Friday, March 16 –The Mahottari team was divided into 2 groups. Team A (Dr. Sahondra, Penny, Shriya and Sujjan) visited Bijalpura Sub Health Post, which was about 20 kms from Janakpur. A sub health post is the smallest peripheral health facility and has 3 staff paid by the government/MOHP . The in-charge, Mr. Ashoke Mahato, is a Senior Auxilliary Health Worker, and he has one Village Health Worker (Pradeep) and one Maternal Child Health Worker (Indu) to work with him. The latter two have a rigorous field schedule and are in the field about 19-20 days per month. Today was the 3rd day of the Nepali month, the fixed date for the provision of immunization services from the SHP, so the team was also able to observe EPI services.

The Sub Health Post is housed in a building constructed with funding from the Village Development Committee and has three rooms – the examination room (which is divided into sections to allow privacy for FP and ANC/PNC exams), a drug and supplies storeroom and a larger hall which was being used today for the EPI clinic, but can be used as a training or meeting hall.

* The group that visited Mhottari was split into two: Group A and Group B. Both groups had similar findings. The summary included in this report was written by a Group A participant.

Painted signs on the outside walls of the SHP showed the list of essential drugs that should be available free of charge and the list of services that should be provided from the facility. On an interior wall the list of staff names and all the names of the FCHVs were clearly displayed.

Ashoke (the in-charge) gave the team a thorough overview of the outpatient services provided at the facility and in the community, including CB-IMCI, CB-NCP, the birth preparedness counseling, family planning and other campaign services like semi-annual vitamin A distribution for children 6- 59 months and deworming, and the polio campaigns where FCHVs are included. He showed us all the reporting forms, registers, etc used both at the facility and community level. A discussion about the FCHV fund management was interesting and the team saw the wall poster with the names of the members. Indu showed the FP information and the BPP, plus her small examining area for ANC/PNC. She has not been trained to provide IUDs and Norplant, but does provide pills, condoms and Depo injections. The FCHVs coordinate with her to refer clients and also follow-up on defaulters. The team saw the Clean Delivery Kit (which sells for Rs 25) which contains soap, plastic, string, clean blade and "plastic coin" for cutting the cord.

The EPI clinic was efficiently run with the FCHVs from the wards attending as well to ensure the babies from their villages were being immunized. This particular clinic, at the SubHP is held on the 3rd of each Nepali month. So, on the 2nd day of the month the FCHVs go around, door to door, to the homes with eligible children and remind them to come for the clinic on the 3rd. If families do not come, she will follow-up immediately and remind them for the following month.

The team had an opportunity to sit and talk with the 3 FCHVs about their experiences and changes over the 23 plus years of the program. One FCHV had worked since the beginning, one for 15 years and one for less than 1 year. They have seen a decline in child deaths in their villages and changed attitudes about EPI.

Highlights of the day: Introduction to the FCHV fund and how it works; information on incentives given to FCHVs through the CB-NCP program, and their new saris; essential drug list and services painted on the SHP walls for the whole community to see; integration and extent of the services available at a SHP and in the community and the coordination and respect between the two levels; EPI clinic – professional and efficient and linked with FCHVs for identifying and following children.

Saturday, March 17 – The team left Janakapur and arrived in Hariaun, in the adjacent district of Sarlahi, to a warm welcome with flowers and tika powder from the Johns Hopkins University research team (NNIPS – Nepal Nutrition Intervention Project – Sarlahi). The Field Director/JHU Representative, Steve LeClerq, gave the team an overview of the many research projects that have been conducted in this field site since 1989. In summary, there have been several generations of NNIPS projects. NNIPS – 1 was vitamin A supplementation for children under 5 years of age and the results showed a 30% reduction in mortality for

children between 6 and 59 months of age. This study led to the implementation of not only the national program in Nepal but influenced policy for such programs internationally. A mega-analysis of many similar studies led most of the world health community to conclude that this program is essential in reducing child mortality. NNIPS – 2 supplemented pregnant women with low dose vitamin A and beta-carotene (and a placebo) and showed a reduction in maternal mortality reduction with either vitamin A or beta-carotene but no impact on neonatal mortality. NNIPS – 3 was a study with multiple micronutrients given to women in pregnancy, which showed the best association between newborn survival and maternal supplementation with iron and folic acid in the prenatal period. NNIPS- 4 was a study with zinc and iron supplements to children and showed modest evidence that zinc supplementation in combination with iron-folic acid reduced the incidence of diarrhea, dysentery & ALRI. Among children 12 months or older there was a 20% reduction in mortality with zinc supplementation but the level of evidence for this difference was modest. No effect on the incidence of diarrhea or respiratory infections was found.

During this time period, the chlorhexidine trial with application of 4% chlorhexidine to the umbilical cord and stump showed significant results, with an overall 24% reduction in neonatal mortality, but a 34% reduction if the application of 4% chlorhexidine to the cord was given within 24 hours of birth. No impact of soap & water on mortality.

A large cohort study was also conducted to follow-up on the children first dosed with vitamin A in NNIPS 1 to look at the impact on their health as they became young adults and started to have their own families. The current studies are:

1. Use of improved cook stoves to determine the impact on indoor air quality and the incidence of respiratory illness in women and children particularly

2. Use of two different massage oils (sunflower and mustard) to determine if there is a difference in neonatal mortality between the groups.

3. Maternal influenza vaccine.

The team then visited the field and observed the use of the improved cookstoves in 2 households, the use of massage oil for a baby just 7 days old and saw the birth assessment of a baby born just 11 hours before the visit. The baby, a health boy, had been born at the Primary Health Care Centre and the team took the opportunity to make a brief visit. As it was Saturday, the general OPD was closed, but the team of ANMs who provide 24 hour delivery service were working and there was a delivery underway.

Highlights: The visit to NNIPS reinforced the importance of a strong evidence-base for public health programs. Vitamin A supplementation for children and use of chlorhexidine for cord care are two studies with major impact on mortality and suitable for wide-scale community-based programming.

Sunday, March 18 – Again there were two groups formed and Team A headed off to Meghnath Gorhanna Sub Health Post in the mid-central part of the district. Met the Sr. AHW, Village Health Worker and MCHW, plus the two additional staff supported by the VDC (one is an assistant level and the other works for the DOTS/TB program). In this SubHP the names of the FCHVs and their telephone numbers are pasted on an interior wall, along with a chart that shows the services that should be available. As the building does not belong to the SHP, they did not paint on the exterior walls. There was also a large, plasticized wall chart with targets and achievements for the major program areas, by month. This is provided by the MOHP/Nepal for each health facility. After a review of the general services provided by the SHP and the reporting systems, there was a lot of discussion centered on the formation and function of the Health Facility Operations Management Committee (HFoMC). It was explained that they are like a quality assurance committee to make sure that the services provided by the SHP are good. They check on performance, targets and achievements, availability of stocks, regularity of programs, like EPI/PHC ORC.

The HFoMC has a minimum of 7 members and in this Health facility they are as follows:

1. Chairman – VDC Secretary
2. Secretary – SHP in Charge
3. Member – Teacher from the local school
4. Member of a Marginalized Community – here a female of the Paswan caste
5. Community Member – influential
6. Other female community member
7. FCHV of the ward where the SHP is located.

The team met 3, 4 and 7 from the list above. They explained their role as one for primarily solving problems that may arise in the SHP management. They meet once per month on the 25th day and review the health post data and achievements. They have a budget from the money that the government pays to the Facility annually based on the number of clients they see. The rate is Rs 5 per client, so for this facility they said that would mean Rs 20,000 to 25,000 per year (as they see 4000 – 5000 patients). They use the funds to buy emergency medicines, if there is a stock out and for stationery needs of the SHP. They do advocacy and sensitization and mobilization in the villages for SHP services. They helped to influence a local person to donate land for the birthing centre which will be built soon in their VDC. In this VDC a local person has also donated land for the construction of a new SHP and the VDC is providing the funds. It is now partially completed – adjacent to the current SHP, which is housed in the VDC building. The HFoMC members were asked what are the three most important things to consider when starting up a HFoMC. They responded:

1. Selection of the right people – to represent all parts of the VDC both ethnically, geographically and with a good gender mix.
2. Clear definition of the responsibilities of the members of the committee
3. Active leadership

Following the discussion with the HFoMC members, Team A moved to the home of one FCHV where they met with a total of 4 FCHVs and the MCHW/ANM from the SHP. The FCHVs described how they manage their time, as volunteers, between family and their FCHV responsibilities. Then they showed their supplies and the job aids, tools and recording/reporting forms that they have to maintain. They described also the FCHV fund and were very positive and engaged. The FCHV fund training was conducted in May 2011 and at that time they had the base of 50,000 Rs in the fund, plus the annual increment of 10,000 for 2 years – making a total of 70,000. They have been lending out money (maximum loan is 14,000 rupees, for 6 months, at an interest rate of 1% per month) and have already earned about Rs 30,000 in interest. They have not had any defaulters yet. The money for the incentive paid to them for the CB-NCP program comes to that fund too, but then is paid to the individual FCHVs who earned this from their work with CB-NCP. There has only been one payment so far for the CB-NCP but they say it went smoothly as the SHP had calculated the amount per FCHV and they had been paid according to that amount. They seemed excited about the control of the money and the potential. When asked what they might do with the interest money – which is available for the discretionary use of the FCHVs (if they agree on how to use it) – they said they didn't know but were considering purchasing an ambulance. Not only FCHVs can borrow from the fund – but members of their mother's group and it seemed that other community members could borrow too. One FCHV had used the loan to open a small shop. The FCHV secretary of the FUND keeps Rs 5,000 in cash for real emergency use by a woman in labor and if two FCHVs agree these funds can be released on an emergency basis.

Highlights of the day: (and some from previous days) included: Opportunity to see all the tools that FCHVs use – and especially the pictorial nature of some of the reporting forms and the ward register; the regular meeting of FCHVs at the SHP for reporting, getting supplies etc.; mothers' group meetings and the idea that they also include men and other community members; Understanding the functioning of the FCHV fund and the HFoMC (7 members, 5 year mandate, assist with emergency drug supply, have formal guidelines for functioning of the committee; volunteer their time for this service to their community). Other high points mentioned included: FCHV motivation to try to save money to buy an ambulance; general time management of the FCHVs; ward register; metal sharp box (cardboard only in Madagascar).

Evening discussion and sharing between the two groups and initiation of planning for the debriefing in Kathmandu – with the other team on March 20 and with NFHP on March 21.

Monday, March 19, 2012 – Team A left Janakpur for Khairamaya VDC and went straight to the home of the Village Health Worker, Dinesh Devkota, who had kindly provided the venue for a meeting with the FCHVs. Four FCHVs were present, along with the SHP in charge, Manoj Kumar Singh and Dinesh. Later the MCHW also arrived along with other members of the community. The team discussed about the CB-NCP program. The FCHVs here have not had to resuscitate any babies using the bag and mask but have attended deliveries. The MCHW conducts some home deliveries for women who do not go to the health center. The

closest facility for deliveries is in Bardibas which is about 15 kms away. It is possible to call for a vehicle or an ambulance in emergencies. They receive Rs 500 for a HF delivery. The discussion about the FCHV fund revealed that they currently have about Rs 80,000 in the fund but are not actively using it, just letting the interest grow. They have not received the money for the CB-NCP performance based incentives, but have been informed that the money has been received in their account. The bank account is currently in Jaleswor, which is far away, but they plan to open an account closer to their village and transfer the money there.

The FCHVs said that the VDC has not been very active in supporting them but does give them Rs 200 per month as a stipend for their volunteer services. VDC members present later said that they plan to give Rs 500 per month starting this year (but the FCHVs were a bit skeptical about whether or not this would materialize). The VDC members have also provided support during campaign programs like polio and vitamin A. They were not given any individual recognition during the National FCHV day on December 5th, but two of the FCHVs from this VDC were invited to the district centre for the celebrations. As an example of the activities there, they described a health quiz and the winners were given prizes.

Influential community members, including teachers, described the FCHV program and said it was the pillar of health programs in their VDC. They described the changes they have seen over the 22 years of implementation of the FCHV program. In the past children commonly died of diarrhea and pneumonia, but this is not occurring now. They also said that people were taking family planning advice and family size was dropping – now only 2-3 children per family, compared to the previous 7- 9. School Health programs promote child-to-parent information sharing – for example for EPI programs, handwashing, etc.

Then the team visited the home of the FCHV from Ward #8 (Renuka Ray) and met two mothers whom she had counseled during pregnancy. They both had attended 4 ANC check ups at the SHP, taken 2 TT shots and taken iron/folate. Due to a shortage of iron they had to buy part of their supply but had complied with her advice. They had both delivered in facilities – one in Bardibas Hospital and one in Jaleswor. The one baby had been low weight and the FCHV had counseled about skin-to-skin care and frequent breastfeeding. They also recalled her advice about delayed bathing, keeping the baby warm. Both have now received their BCG and they know when they need to go again to start the combo vaccine (DPT/HepB/HiB) at the EPI clinic. They are satisfied with the advice and care given by the FCHV and are aware of the danger signs for which they need to seek her advice or go to the Sub Health Post. The FCHV showed her kit bag, supplies and registers/materials as supplied by the program.

The group returned to Janakpur in time to catch the flight to Kathmandu in the late afternoon. A road blockage near Bardibas meant that they had to travel through back roads, jungle and cross a couple of rivers to get to Janakpur on time. Hazy weather again precluded good mountain views, although there was a brief glimpse.

C. Selected Photos

An Auxiliary Nurse Midwife distributes polio drops at an immunization clinic.

A Female Community Health Volunteer demonstrates neonatal resuscitation using a bag and mask.

A Village Health Worker gives an injection at an immunization clinic.

Female Community Health Volunteers wearing matching saris provided by the Ministry of Health and Population/Nepal.

Health education materials including family planning choices.

A signboard displaying the Female Community Health Volunteer program logo identifies the home of a volunteer.

Traditional newborn massage.

Visitors reviewing health facility registers.

D. Materials Brought to Madagascar from NFHP II, Nepal

MATERIALS FROM NEPAL

Dolls for Chlorhexidine demonstration during CHW training
FP demonstration box
FP counseling Flipchart
Female Community Health Volunteer Fund -operational guidelines
National Female Community Health Volunteer Program Strategy
Jobaid to Rule out Pregnancy
National Medical Standard Vol 1 - Contraception
Condom Model
Timer
Materials for FP (CD)
Materials in Nepali for FP (CD)
Technical Briefs – Summaries of Program Achievements (by Subject)
FCHV training manual and pictorial booklet

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