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MCHIP
Maternal and Child Health
Integrated Program

National Programs for the Prevention and Management of Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia

A Global Survey, 2012

photo by Kate Holt/Jhpiego

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ABBREVIATIONS AND ACRONYMS

AMTSL	Active management of third stage of labor
BEmONC	Basic emergency obstetric and newborn care
CCT	Controlled cord traction
DRC	Democratic Republic of Congo
EML	Essential medicines list
HCI	Health Care Improvement Project
HMIS	Health management information system
ICM	International Confederation of Midwives
IM	Intramuscular
IV	Intravenous
LAC	Latin America and the Caribbean
M&E	Monitoring and evaluation
MCHIP	Maternal and Child Health Integrated Program
MCPC	Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors
MgSO4	Magnesium sulfate
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
PE/E	Pre-eclampsia/eclampsia
PHC	Primary health center
PPH	Postpartum hemorrhage
SBA	Skilled birth attendant
SDG	Service delivery guideline
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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We would like to give a special thanks to the national Ministries of Health, and related departments, committees and working groups of maternal and reproductive health in the countries that completed the surveys. These groups met and answered the survey questions as a collective exercise to provide the requested data for this global survey and to analyze and further understand their national programs and efforts.

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- Africa: Angola, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Zanzibar and Zimbabwe.
- Asia: Afghanistan, Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Timor Leste and Yemen.
- Latin America: Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua and Paraguay.

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

INTRODUCTION

Programs to reduce mortality from postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E) are in place in many countries worldwide. The United States Agency for International Development (USAID), with the support of the Maternal and Child Health Integrated Program (MCHIP) and through its multiple partners, tracks the implementation and progress of these country programs. In support of this effort to understand global progress in reduction of maternal mortality, in 2010 MCHIP developed and continues to maintain a database of PPH and PE/E country-level information worldwide. A further update and analysis of this database are presented here for 37 countries worldwide. This exercise is a continuation of the MCHIP mandate to support the scale-up and expansion of proven public health program activities in the USAID priority countries. The database will continue to track ongoing progress of programs that target PPH and PE/E in multiple countries worldwide and provide that information for a global audience. More complete understanding of these data 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.

Maternal mortality ratios (MMRs) still remain unacceptably high worldwide, but there has been progress in recent years. According to *Trends in Maternal Mortality: 1990 to 2010*,[1] the number of global maternal deaths has been cut in half over this 20-year period. Approximately 287,000 women died of pregnancy-related causes in 2010, a decline of 47% since 1990.

Although the global estimate of MMR in 2010 was 210 maternal deaths per 100,000 live births, wide variations still exist among countries. The MMR in sub-Saharan Africa is well above this level and is the highest of any region, with 500 maternal deaths per 100,000 live births. Though South Asia is just above the global median, at 220 maternal deaths per 100,000 live births, it still represents 29% of the global burden of maternal mortality.

Even as most countries are experiencing a decline in MMR, the pattern, pace and reasons for that decline vary. Furthermore, to maintain momentum in the reduction of maternal mortality, national programs will need to ensure both adequate coverage and sustainability.

To this end, MCHIP undertook its second annual survey of national programs for the prevention and management of PPH and PE/E from January to March 2012. This country-level program analysis included countries from Africa, Asia and Latin America, focusing on those USAID priority countries that face the highest burden of maternal morbidity. The purpose of this review was to understand the status of national programs and to monitor their progress. Previously, the same survey was conducted from January to March 2011, allowing for comparison between the reported situation in 2011 and that in 2012.

This survey offers opportunities to review and understand national programs for addressing PPH and PE/E. First, it provides a global snapshot of policy, practice, supplies and activities, and guides national and global program managers and policymakers in setting priorities. Second, it allows an understanding of where progress has been made from 2011 to 2012. Finally, for the 30 countries for which there are quantitative and scale-up map data from both years, the analysis allows for the tracking of specific, national progress on priority issues and more general tracking of evolution of national programs through the use of the scale-up maps.

[1] WHO, UNICEF, UNFPA and The World Bank. 2012. *Trends in Maternal Mortality: 1990 to 2010,* http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/index.htm

METHODS

The survey incorporates non-experimental methods, using available national data and collective discussion and information from key informants. It captures a cross-section of countries that are either priority countries within USAID's global health strategy, or engaged in relevant maternal mortality reduction efforts. The questionnaire includes both quantitative and qualitative questions. The respondent teams in the countries aimed to answer the quantitative questions objectively, based on national policy and existent data and the current situation in-country, rather than based predominantly on opinion. The qualitative questions called for some subjective responses in order to triangulate and add depth to the quantitative responses. In addition, countries filled out conceptual "scale-up maps," which are visual representations of national policy, rollout and scale-up of PPH and PE/E programs. Finally, the research team conducted a smaller analysis of 20 countries' service delivery guidelines (SDGs) to delve into national-level policies with more specificity and to cross-check perceptions of policy with the actual policies. The maps and service delivery guidelines were used to gain a more comprehensive view of "policy to practice" in maternal health in 2012 in the 37 participating countries. It is anticipated that this survey will be conducted on an annual basis for the life of MCHIP.

Once received by the research team in Washington, all surveys and maps were checked for completeness and clarity. When questions arose, the MCHIP maternal health team worked with country respondents to clarify responses. The MCHIP maternal health team conducted an analysis of quantitative responses, aggregating answers and comparing them to the 2011 responses. In addition, qualitative responses were coded, aggregated, analyzed, mined for illustrative quotes and compared to quantitative responses where appropriate.

Survey Instruments

The questionnaire that had been used for the 2011 survey was reviewed before the 2012 data collection began, and modifications were considered. In instances where the questions appeared confusing or elicited a wide variety of responses in 2011, they were made more specific. Changes were made to questions in cases where it was necessary to facilitate comparability between years. Ultimately, three questions were added, two questions were changed, 10 questions were modified slightly, eight response choices were modified and one question was removed. All survey instruments were translated from English into French and Spanish using professional translators.

The 46-item questionnaire included six core components: policy, training, drug distribution and logistics, national reporting of key maternal health indicators, programming, and challenges to and opportunities for scale-up. The full survey questionnaire for 2012 is included in Appendix 2 in the full report.

Six Core Components

- Policy
- Training
- Drug distribution and logistics
- National reporting of key maternal health indicators
- Programming
- Challenges to and opportunities for scale-up

Perceptions of expansion and scale-up of national efforts are also visually represented in color-coded conceptual maps (see Appendix 3 in the full report) to indicate current national program progress in scaling up PPH and PE/E prevention and management interventions. Different colors were used by national teams to represent effort related to a specific program component, including components active under USAID support (red), components active under other partner support (blue) and components previously addressed and no longer active (green). Although this exercise operates under a fundamental supposition that all program components are guided and promoted by local government efforts, some respondent teams felt it necessary to demonstrate that through

shading with a different color (yellow). 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: national strategic choices, phased program implementation, and sustainability and institutionalization.

Data Collection Procedures

Data collection was coordinated by the MCHIP maternal health team in Washington, D.C., during the months of January, February and March 2012.

Contact information was compiled for an identified focal person in each of the 43 targeted countries. His or her name and contact information can be found at the top of each country's survey in Appendix 2 in the full report. The contact list from 2011 was used and the individual's continuing engagement with national activities was confirmed. Additional sources were contacted in an effort to ensure that there was an appropriate coordinator for the data-gathering activities in each country.

The coordinator for each country was sent an e-mail with anticipated dates and activities six weeks in advance of receiving the survey. He or she was instructed to contact national counterparts in the government as well as leading implementing partners. The country coordinator was given a timeline of pending requests and asked to arrange meetings with national consultative groups to ensure a national participatory process for the completion of the survey instruments. In most cases this was possible.

Key stakeholders from government, ministries, MCHIP programs, other USAID bilateral programs, UN partners and other implementing agencies met to collect data and respond to the 46-item questionnaire and the scale-up map. In most cases, these consultative groups found it necessary to meet twice to ensure accuracy and completeness of responses.

The questionnaire and scale-up maps were revised from the 2011 versions, based on responses, questions and feedback from the 2011 survey administration. Surveys were sent out via e-mail in English French and Spanish, and countries received copies of their 2011 surveys, which served as a starting point. Stakeholders met in-country to collect data and respond to the survey, and contacted the MCHIP maternal health team with questions. Responses were shared via e-mail in English, French and Spanish. Professional translators translated French and Spanish survey responses into English.

Data Analysis

All survey responses were entered into a Microsoft Access Database to facilitate ease of data entry and analysis. Reports aggregating quantitative survey responses and graphs by region were created in Microsoft Excel. Qualitative responses were first collected in Access and then transferred by theme into Microsoft Excel. Responses were coded, aggregated, analyzed and compared to quantitative responses where appropriate.

Country respondent teams were also asked to submit national SDGs and copies of essential medicine lists (EML). Twenty countries' SDGs were reviewed, and the findings are presented under the corresponding themes in the Findings section. SDG documents that were submitted in English were reviewed for accuracy and completeness of the following necessary components: 1) active management of the third stage of labor (AMTSL), 2) the use of misoprostol for the prevention of PPH, 3) the diagnosis and management of PE/E, and 4) the use of

antihypertensives for severe hypertension[2] in pregnancy. Non-English national SDG documents were reviewed through discussion with country respondents to ensure that the data were accurately presented. The research team used a standardized checklist adapted from the World Health Organization (WHO) publication *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (MCPC) [3] to review each SDG.

FINDINGS

Overview

The findings presented in this section are a compilation of data collected from 37 countries in Africa, Asia and Latin America (see box at right for list of countries surveyed).

These findings build upon those in last year's report and explore additional themes relevant to the prevention and management of PPH and PE/E. Such in-depth analyses each year provide countries the opportunity to recognize progress in particular areas and identify other areas for development. In addition, the comparison of national programs will guide global prevention and management efforts moving forward.

Despite initial correspondence and follow-up with in-country representatives, five countries were not able to complete the survey: Burkina Faso, Dominican Republic, Laos, Myanmar and Peru. Zambia completed the survey in 2011, but was unable to do so in 2012. The MCHIP maternal health team will continue to work with these countries and other countries not previously represented in the report to disseminate best practices in maternal health and to assist them should they be able to participate in the survey in the future.

The figures and analyses presented in this section compare country responses to three or four questions, grouped by themes across the 37 countries. When data for a given question are present from both years, responses from 2012 are compared to those from 2011.

Countries Surveyed, by Region

Region	2011	2012
Africa	Angola Democratic Republic of Congo Equatorial Guinea Ethiopia Ghana Guinea Kenya Liberia Madagascar Malawi Mali Mozambique Nigeria Rwanda Senegal South Sudan Tanzania Zambia Zanzibar Zimbabwe	Angola Democratic Republic of Congo Equatorial Guinea Ethiopia Ghana Guinea Kenya Liberia Madagascar Malawi Mali Mozambique Nigeria Rwanda Senegal South Sudan Tanzania Uganda Zanzibar Zimbabwe
Asia	Afghanistan Bangladesh India Indonesia Nepal	Afghanistan Bangladesh Cambodia India Indonesia Nepal Pakistan Philippines Timor Leste Yemen
Latin America	Bolivia Guatemala Honduras Nicaragua Paraguay	Bolivia Ecuador El Salvador Guatemala Honduras Nicaragua Paraguay

[2] Diastolic blood pressure 110 mmHg or more after 20 weeks gestation and proteinuria 3+ or more are the cardinal signs of severe PE. If diastolic blood pressure remains above 110 mmHg, antihypertensive drugs should be given.
[3] http://www.iawg.net/resources/RH%20Kit%2011%20-%20Complications%20of%20pregnancy%20and%20childbirth_midwives%20and%20doctors.pdf

The findings are presented across the eight themes presented in the box at right. Please see Appendix 2 in the full report for each country's full questionnaire and complete responses.

Findings Grouped by Themes

1. 1a. Availability of uterotonic medications
   1b. Availability of magnesium sulfate (MgSO4) for the management of severe PE/E
2. Lifesaving medicines approved at the national level
3. National policies regarding AMTSL
4. Expansion and scale-up of misoprostol availability and PPH-reduction programs
5. Midwife and skilled birth attendant (SBA) scope of practice
6. Education and training in AMTSL and PE/E management principles
7. National reporting on selected maternal health indicators
8. Potential for scale-up and bottlenecks

An analysis of national SDGs from 20 countries and an extensive qualitative analysis of all surveys on reported bottlenecks and challenges were conducted. These analyses provide a greater understanding of the quantitative answers given on the surveys and triangulate responses from country teams. Specific findings from the national SDGs and qualitative data analyses are presented throughout the report.

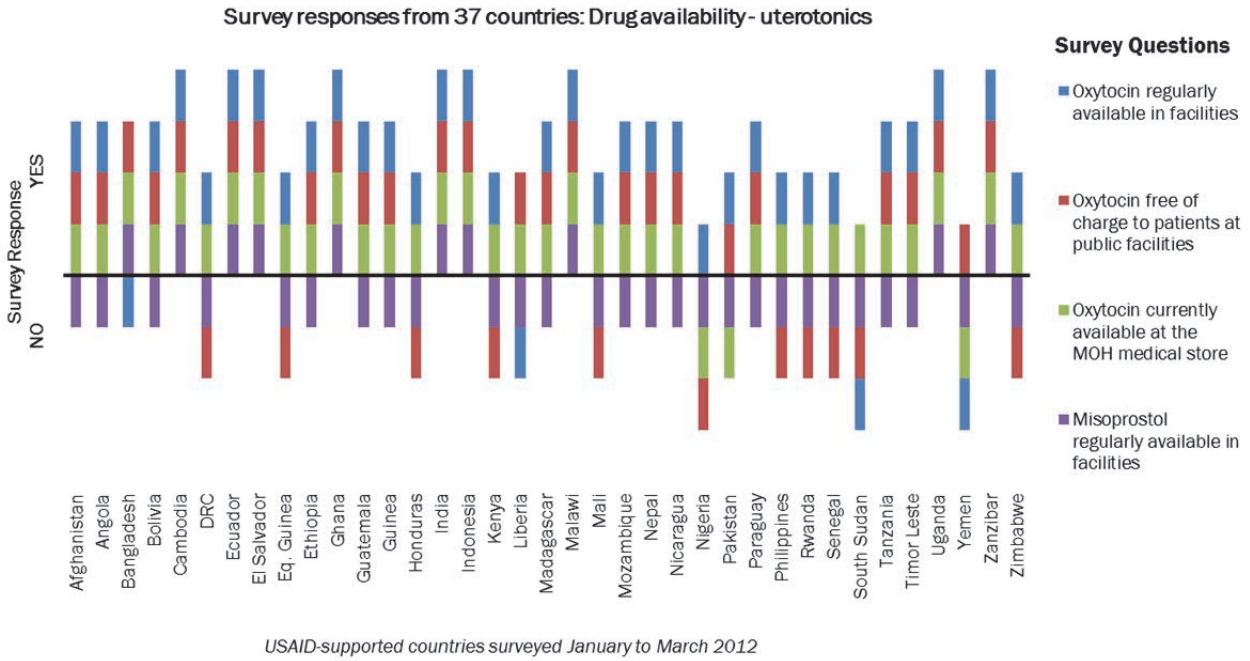
The purpose of the review of national SDGs was to determine the accuracy and completeness of guidelines for AMTSL and the management of severe PE/E. The following 20 reviews were conducted:

- Independent review of English SDGs: Afghanistan, Cambodia, Ethiopia, Ghana, India, Kenya, Liberia, Malawi, Nigeria, Timor Leste, Yemen and Zimbabwe.
- Joint review (with Jhpiego country representative) of non-English SDGs: Angola, Bolivia, Equatorial Guinea, Guinea, Indonesia, Madagascar, Paraguay and Rwanda.

Each respondent team from participating countries also completed a scale-up map, coded to represent the current state of progress in the national scale-up of PPH and PE/E reduction and management programs. All 37 countries participating in the survey filled out these conceptual maps for their country, and the maps are presented in Appendix 3 of the full report. The scale-up maps are useful for global tracking, and completing them was a beneficial exercise for the national program management teams. The country respondents who met to fill out the surveys and maps were able to conceptualize where national progress and gaps are, and in which technical area. Qualitatively, it can be observed that the country teams were more familiar with the format of the maps this year, and potentially were able to complete them more accurately. It is notable that the scale-up maps for 2012 reveal that the majority of countries have PPH and PE/E programs that are based on broad partnerships, most notably collaboration among USAID programs and projects and other partners, or collaboration between the local Ministry of Health (MOH) and other partners.

Theme 1A: Drug Availability: Uterotonics

Figure 1: Global Summary of Uterotonics, Selected Countries, 2012



USAID-supported countries surveyed January to March 2012

The 2012 survey results show that access and availability of oxytocin has improved globally—increasing from regular availability in 74% of countries (23 of 31) in 2011 to 89% of countries (33 of 37) responding in 2012. Eighty-nine percent of countries surveyed report regular availability of oxytocin and 92% report oxytocin availability in the MOH medical store. Seventy percent of countries report that oxytocin is free of charge, and only four countries report that oxytocin is not available more than half the time.

Qualitative data reveal that regular supply of oxytocin is still an issue. Nine countries cite that patients have to pay for oxytocin out of pocket at least some of the time. Of those nine countries, 50% exhibit a gap between national policy and practice. Their responses show that clients are paying for oxytocin out of pocket even though national policy states that it should be provided at no cost to the patient.

Smaller gains, however, have been made regarding the availability of misoprostol. Respondents state that misoprostol is regularly available (more than half the time) in only 10 countries, while 73%, or 27 countries, state that misoprostol is available less than half the time or never in public health facilities with maternity services.

Qualitative data show a correlation between national policy and availability: countries that do not support the provision of misoprostol at the national level do not have misoprostol at public health facilities. Sixteen countries provide additional qualitative comments to their answers. Three of these countries said that although misoprostol is available more than half the time, it is available at only certain types of health facilities, but not all.

The majority of countries that provide additional qualitative comments state that they do not have misoprostol available in public health facilities. Four countries cite that patients can obtain the drug with an out-of-pocket cost, and two of those countries state that misoprostol can be purchased only in the private sector.

Oxytocin availability was a survey question in both 2011 and 2012. Regionally, mixed progress has been made regarding the availability of oxytocin in Asia. While India and Nepal now report that oxytocin is regularly available, Bangladesh considers it to be less available in 2012 than in 2011.

Progress has been made in Latin America in the availability of oxytocin. In 2011, four of five countries reported regular availability of oxytocin, while Guatemala reported irregular availability of the medicine. In 2012, all countries surveyed from LAC, including Guatemala, report that it is now regularly available.

Several African countries report improvements in oxytocin availability. Of the five countries that reported oxytocin as not regularly available in 2011, only South Sudan still reports oxytocin as not regularly available.

Figure 2: Availability of Oxytocin in Health Facilities, 2011 and 2012

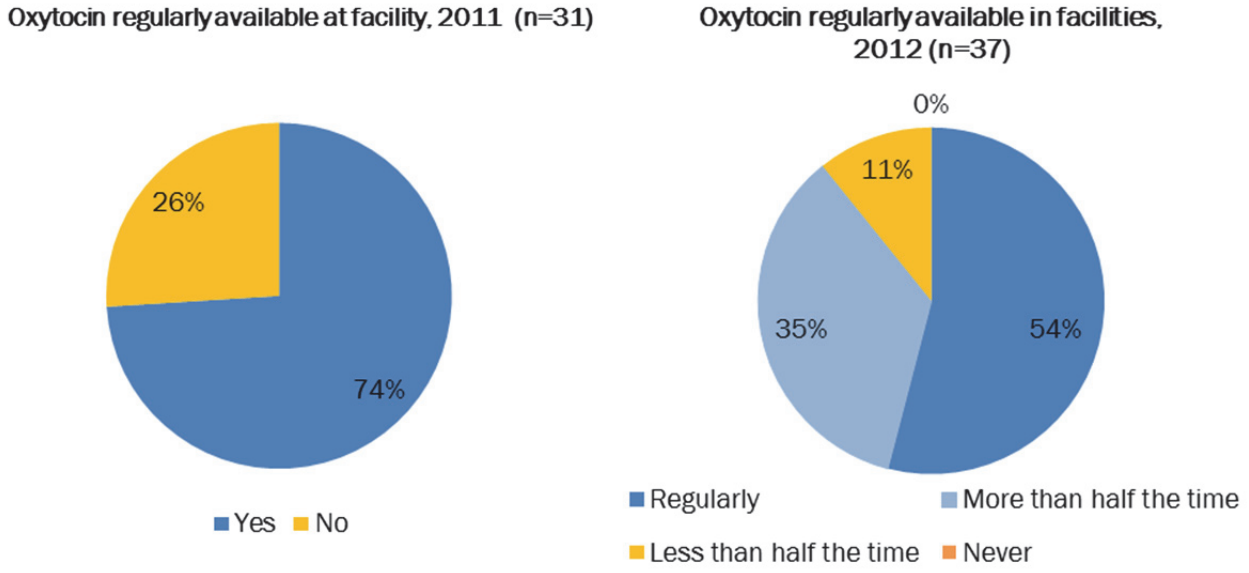
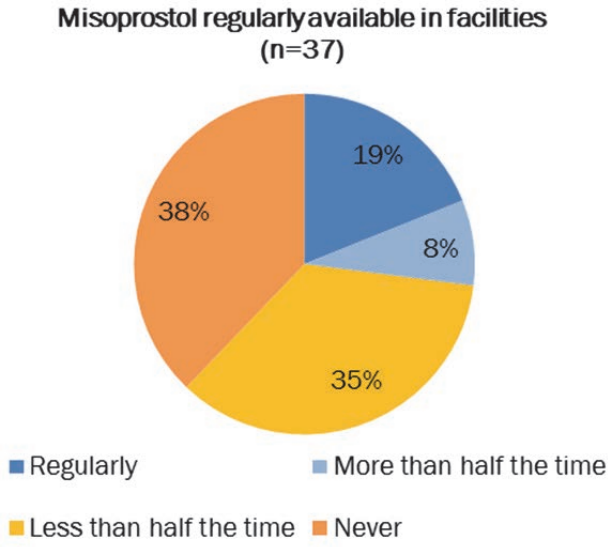


Figure 3: Availability of Misoprostol in Maternity Centers, 2012

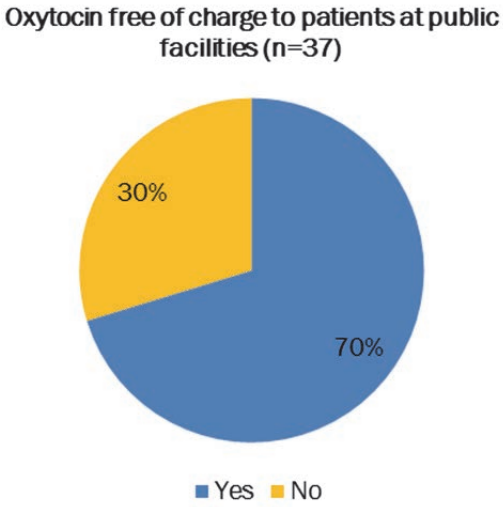


Illustrative Qualitative Responses

Several countries' qualitative answers add important, complementary information to their quantitative responses. The first and second countries below state that misoprostol is never available in public maternity centers, while the third country says that it is available more than half the time. They qualified their answers with the following:

- "Misoprostol is not on National EML of [our country], so whenever it is required, it is purchased."
- "The doctors prescribe it for the family of the patient, and the family buys it from the private pharmacy."
- "Depends on the workload at that facility and whether there is sharing of supplies between higher- and lower-level facilities in the same area."

Figure 4: Oxytocin Cost to Patients in 37 Countries, 2012



Illustrative Qualitative Responses

Two of the countries stating that oxytocin is free of charge to patients in public health facilities qualify their answers with the following:

- "It is free of cost, whenever available. Most of the time it is not available and patients have to buy it or it is provided through charity/ donation, but not refrigerated."
- "If the Medical Supply at the Ministry distributes it, it will be free. But most of the time, it may not be there, as the amount distributed to health facilities is not sufficient. If it is not available, the family may buy it from the private pharmacy."

Figure 5: Frequency of Oxytocin Stock-Outs, 2012

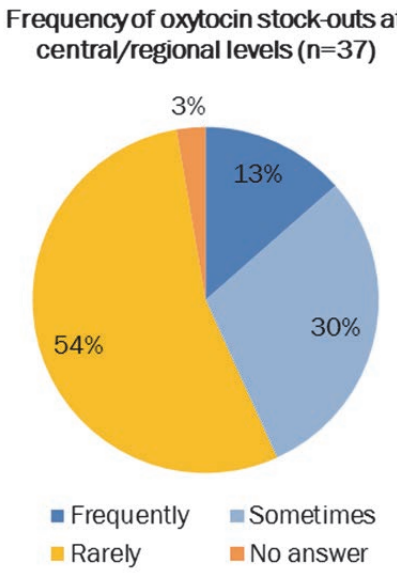
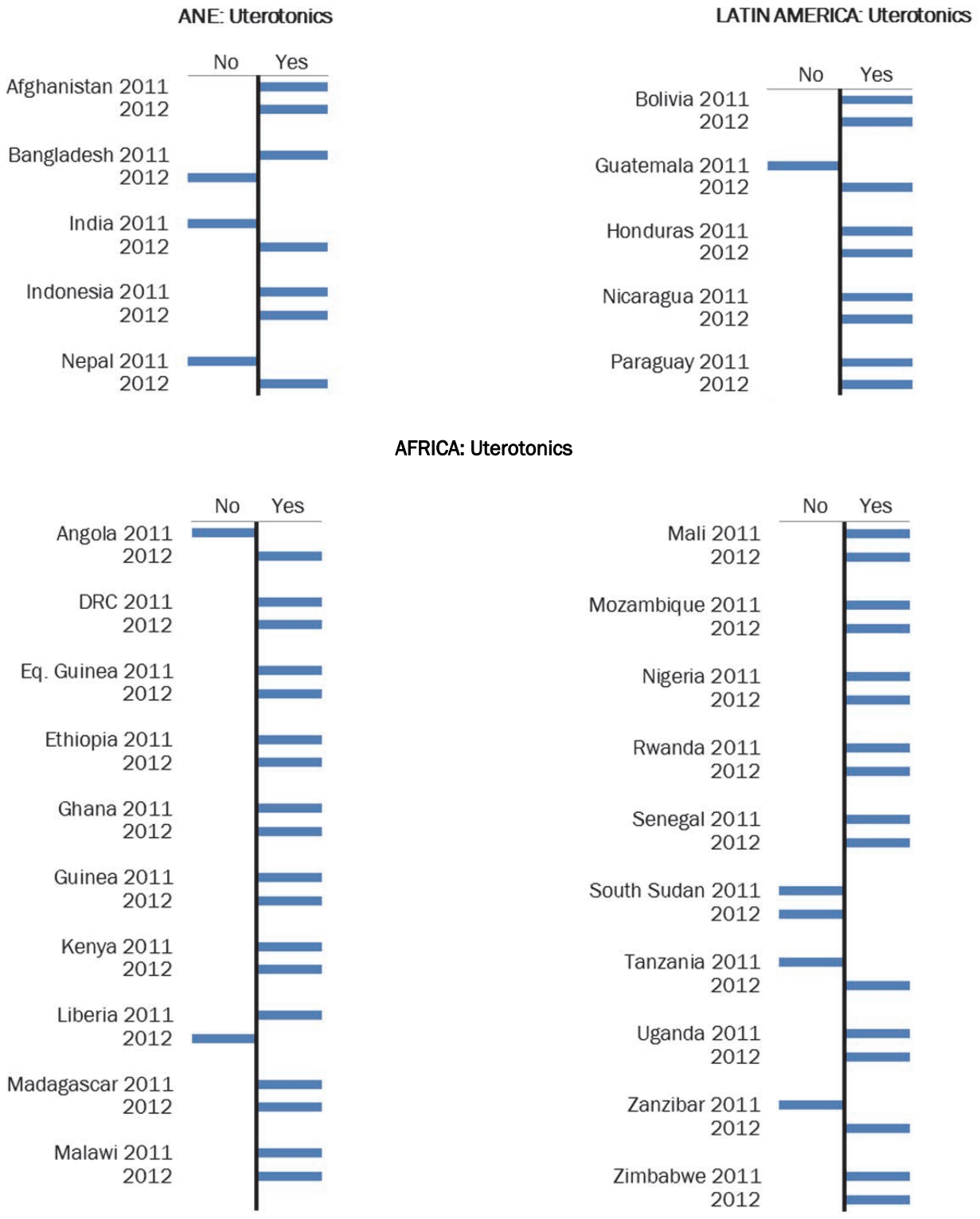


Figure 6: Oxytocin Availability in 2011 and in 2012, by Region

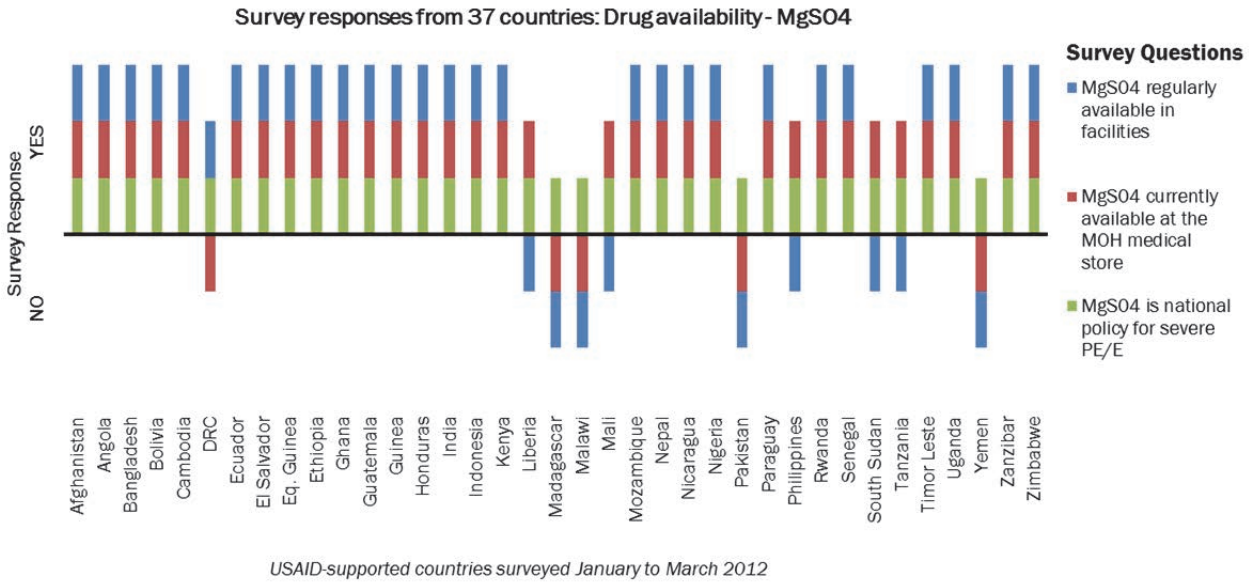


Survey Question

- Oxytocin regularly available in facilities

Theme 1B: Drug Availability: Magnesium Sulfate

Figure 7: Global Summary of Magnesium Sulfate, Selected Countries, 2012



USAID-supported countries surveyed January to March 2012

Globally, countries report that progress has been made in the availability of magnesium sulfate (MgSO4); the percentage of countries that report that it is regularly available has increased substantially from 48% (15 of 31 countries) in 2011 to 76% (28 of 37 countries) in 2012. Notably, 12 countries that did not report regular availability in 2011 now report regular availability in 2012. Despite this progress, in 2012, seven countries in Africa and two in Asia report that MgSO4 is still not regularly available at least half the time.

More countries report that MgSO4 is available in the MOH medical store (86%) than regularly available in the facility (76%), revealing a supply chain and distribution problem. Of the 37 countries surveyed, 46% report that stock-outs of MgSO4 are rare, 30% that they occur sometimes and 16% that they are frequent (see Figure 9).

Regionally, there has been progress in availability from 2011 to 2012. In Latin America, all five countries surveyed report regular availability both in 2011 and in 2012. In Asia, of the five countries with data from both years, three note progress in regular availability of MgSO4, with all five now responding positively regarding availability and inclusion in the national policy. In Africa, overall progress has been made between 2011 and 2012. Nine African countries that did not report regular availability of MgSO4 in 2011 now report regular availability. Four still do not have regular availability, and Liberia and Mali reported regular availability in 2011, but not in 2012.

Figure 8: Availability of Magnesium Sulfate in Health Facilities, 2011 and 2012

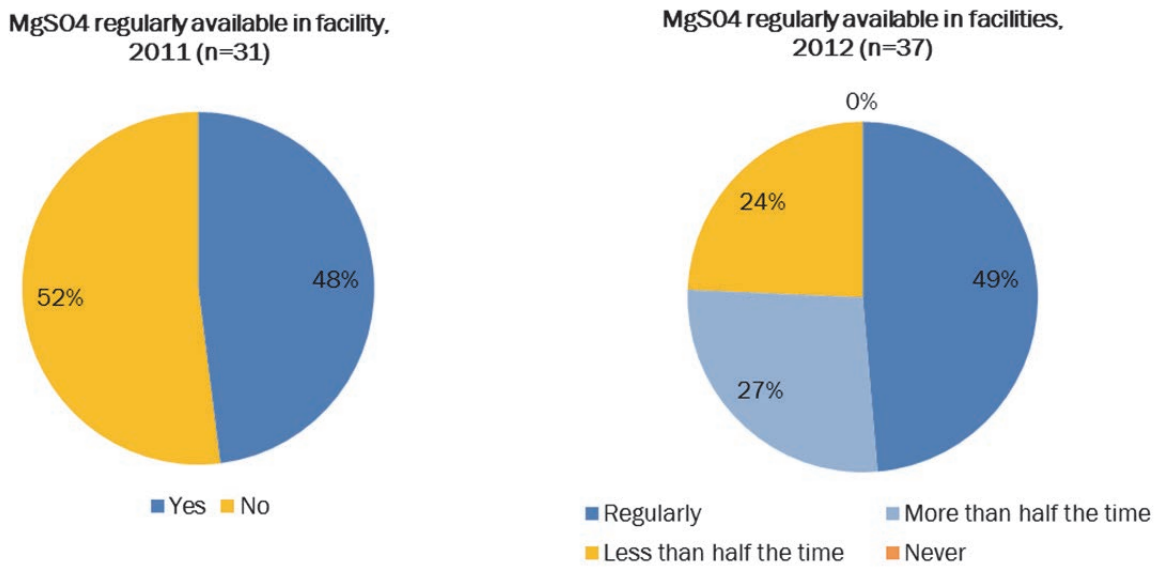


Figure 9: Magnesium Sulfate Stock-Out Frequency, 2012

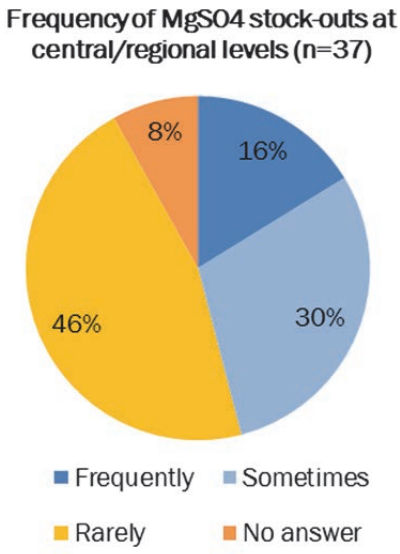


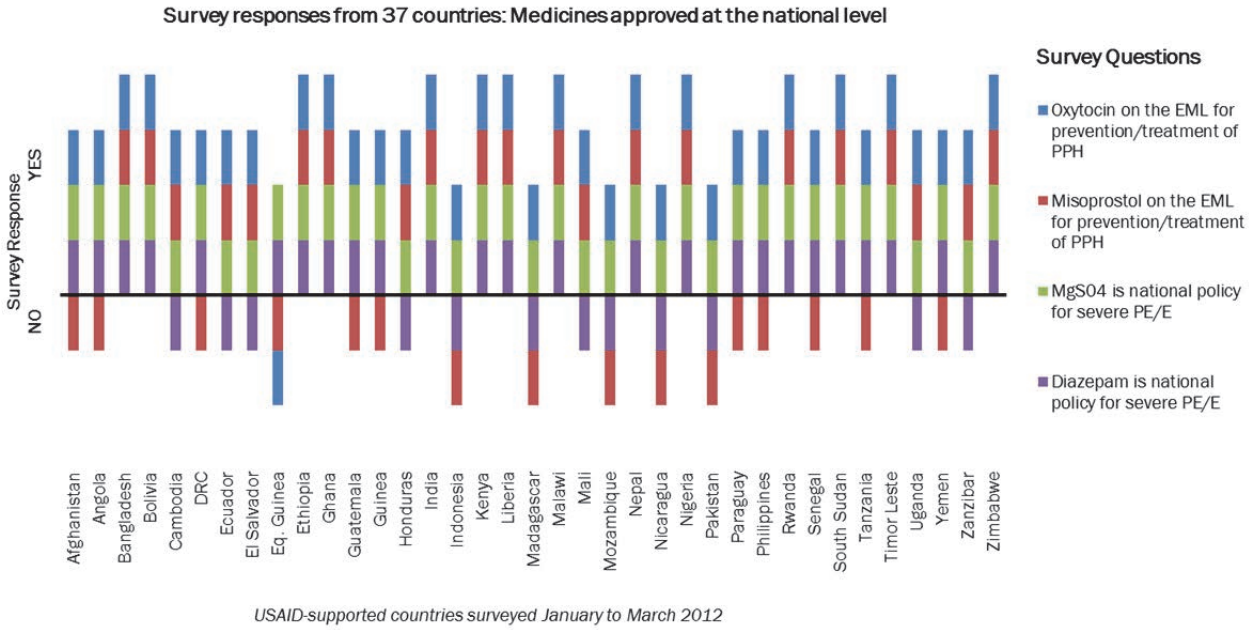
Figure 10: Magnesium Sulfate Availability in 30 Countries in 2011 and in 2012, by Region

Survey Questions

- MgSO4 regularly available in facilities
- MgSO4 is national policy for severe PE/E

Theme 2: Medicines Approved at the National Level

Figure 11: Global Summary of Medicines Approved at the National Level, Selected Countries, 2012



There is global approval of oxytocin to prevent and manage PPH; all of the 31 countries surveyed in 2011 responded that oxytocin was approved on the EML, and in 2012 every country except for Equatorial Guinea reports that oxytocin is approved on the EML, although Equatorial Guinea reports that AMTSL is approved and that use of oxytocin is part of SDGs. All 20 SDGs recommended the provision of oxytocin, and 18 of the 20 SDGs reviewed included the correct dose of oxytocin within their recommendation for AMTSL.

There was no progress in the inclusion of misoprostol on national EMLs for preventing/ managing PPH. Only 57% of the 37 countries surveyed in 2012 report that misoprostol is on the EML for PPH, while 61% of 31 countries responded positively in 2011.

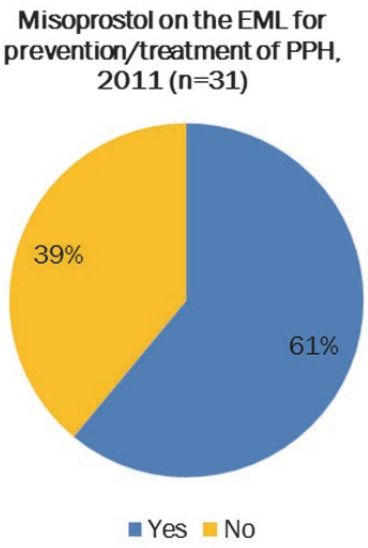
Few countries have clear national guidelines for the use of misoprostol to prevent PPH. Guidelines in India, Liberia and Nigeria indicate the use of 600 mcg of misoprostol to prevent PPH, while in Ethiopia the dose is 400–600 mcg and in Equatorial Guinea it is 400 mcg. Cambodia, Ghana, Kenya, Malawi and Rwanda state that misoprostol is on the EML for prevention and/or treatment of PPH, yet none contain guidance in their SDGs.

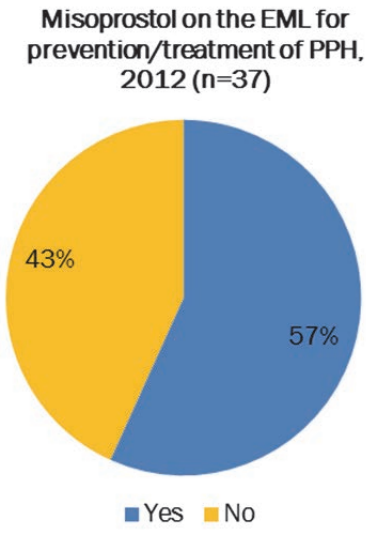
All regions of the world show a similar lack of progress regarding the inclusion of misoprostol on the EML. In Latin America, Guatemala and Nicaragua continue to report the absence of misoprostol from the EML, and Paraguay clarified its response from 2011 to 2012 and now indicates that misoprostol is not on the EML. In Asia, the survey shows that misoprostol is not on the EML in Afghanistan and Indonesia.

In Africa, the three countries that responded negatively in 2011, Liberia, Rwanda and South Sudan, now report that misoprostol is on the national EML in 2012. That progress is counterbalanced by three other countries, Democratic Republic of Congo (DRC), Equatorial

Guinea and Tanzania, which reported misoprostol was on the EML in 2011, but in 2012 report that it is not.

Figure 12: Misoprostol Inclusion on EML, 2011 and 2012





The 2012 survey results show that all 37 countries surveyed report that MgSO4 is approved in national policy as the first-line treatment for severe PE/E, representing a global commitment to its use. This was also the case in 2011, when all 31 countries surveyed reported MgSO4 as approved in the national policy guidelines. However, the 2012 survey shows that a majority of countries also include diazepam as a first-line anticonvulsant for severe PE/E, increasing from 19 countries in 2011 to 25 countries in 2012.

Despite wide approval of MgSO4 for first-line treatment of PE/E, implementation guidance can be inconsistent. WHO documents such as the MCPC set forth a standard protocol for the use of MgSO4, including an initial loading dose by both intravenous (IV) and intramuscular (IM) routes, followed by IM maintenance doses. In the SDGs reviewed, however, some parts of the standard protocol lacked clarity or specificity. For example, SDGs from Zimbabwe and Angola did not contain guidelines for the use of MgS04 to prevent eclampsia and manage severe PE/E, and India's SDG did not provide guidelines for the IV loading dose or maintenance doses. Documents from Yemen and Indonesia did not provide guidelines for the IM loading dose, and the document from Cambodia lacked guidance for the maintenance dose. Although it is encouraging that universal approval has been achieved, additional clarity in national clinical recommendations is needed.

The majority of countries include administration of a recommended antihypertensive for diastolic BP $\geq$ 110 in severe PE/E. Most guidelines recommend the use of hydralazine (92%) or nifedipine (89%), although there is great variation in the specificity of treatment regimens.

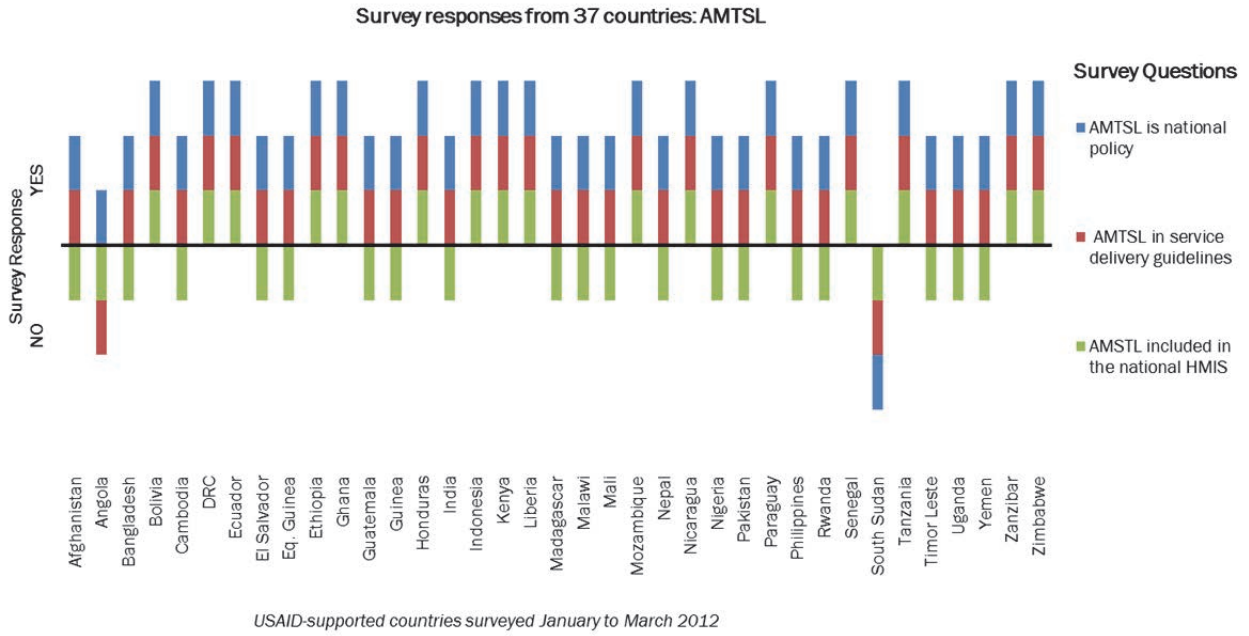
Figure 13: Approval of Maternal Health Medicines at the National Level in 2011 and in 2012, by Region

Survey Questions

- Oxytocin on the EML for prevention/treatment of PPH
- Misoprostol on the EML for prevention/treatment of PPH
- MgSO4 is national policy for severe PE/E
- Diazepam is national policy for severe PE/E

Theme 3: AMTSL

Figure 14: Global Summary of AMTSL, Selected Countries, 2012



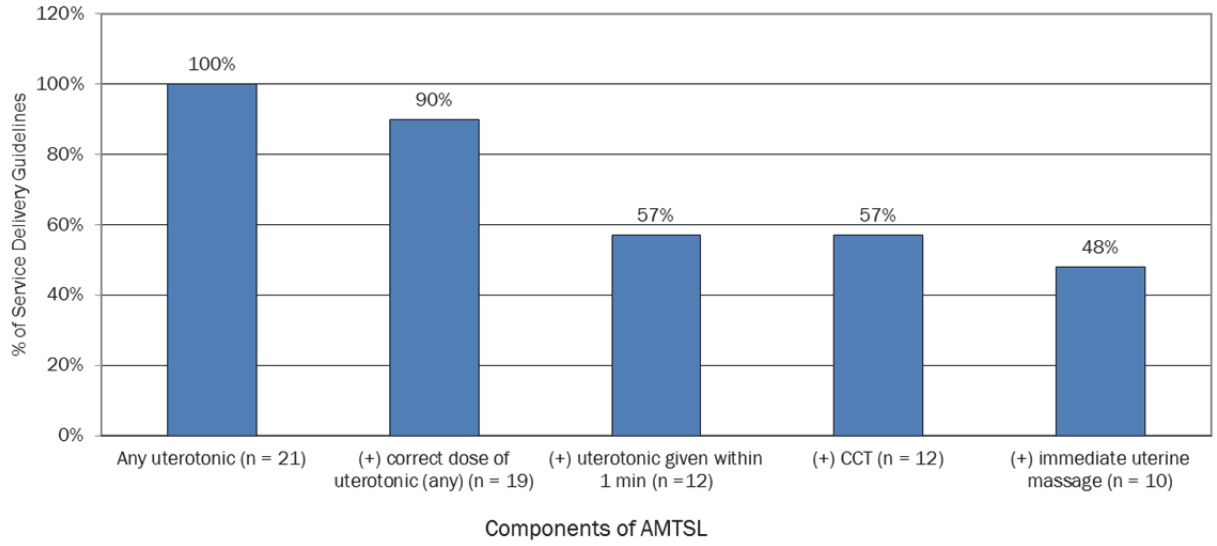
Acceptance of the use of AMTSL for the prevention of PPH is nearly universal, with 36 of 37 countries approving it as national policy, and 35 of 37 countries including it in national SDGs. The review of the 20 national SDGs, however, reveals a lack of clarity and specificity.

The analysis of SDGs found that guidelines were sometimes incomplete or outdated. While all of the countries responded in the survey that AMTSL is included in their SDGs, the review of the SDGs showed that 48% of documents reviewed[4] contained complete descriptions of all three components of AMTSL. Common omissions included failure to instruct administration of a uterotonic within one minute of birth (included in 48% of SDGs) and failure to instruct immediate uterine massage after delivery of the placenta (included in 24% of SDGs). Additionally, while prudent, immediate postpartum management includes ongoing assessment for uterine tone and appropriate action such as massage in the event that the uterus is found to be relaxed (soft), only 43% (six of 14 SDGs reviewed) provided this guidance. The accuracy and completeness of guidelines for AMTSL diminished with the inclusion of each additional component (Figure 14). Only the SDGs from Afghanistan, Ethiopia and Ghana correctly contained all components of AMTSL as defined by WHO.

While the precision of the steps necessary to perform AMTSL remains a concern, the lack of data on the coverage of AMTSL is an additional lingering concern. Only 43% of the 37 countries track AMTSL in their national health management information systems (HMIS). Figure 15: Percentage of Service Delivery Guidelines Correctly Containing Components of AMTSL.

[4] In Equatorial Guinea, Guinea, Indonesia, Paraguay and Rwanda, the first three components of AMTSL, as listed above, were reviewed. In Nigeria, Malawi and Kenya, the first four components were reviewed, and only the first three were written correctly. Palpation of the uterus is the fourth component.

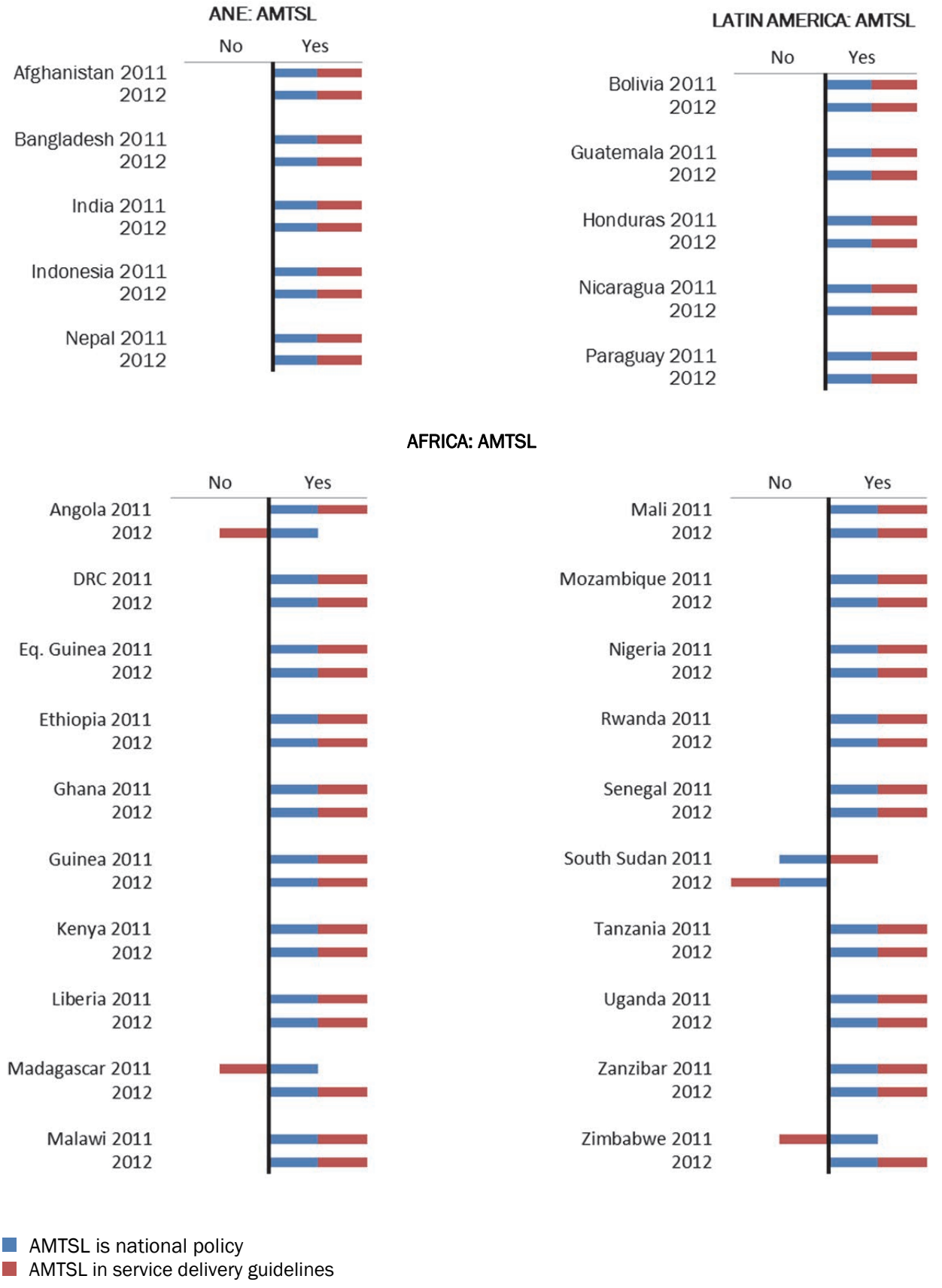
Figure 15: Percentage of SDGs Correctly Containing Components of AMTSL (n=21*)



*20 countries' SDGs were assessed. However, there are 21 documents in this chart because Malawi and Nigeria submitted two AMTSL documents each, while Angola did not submit any documents related to AMTSL.

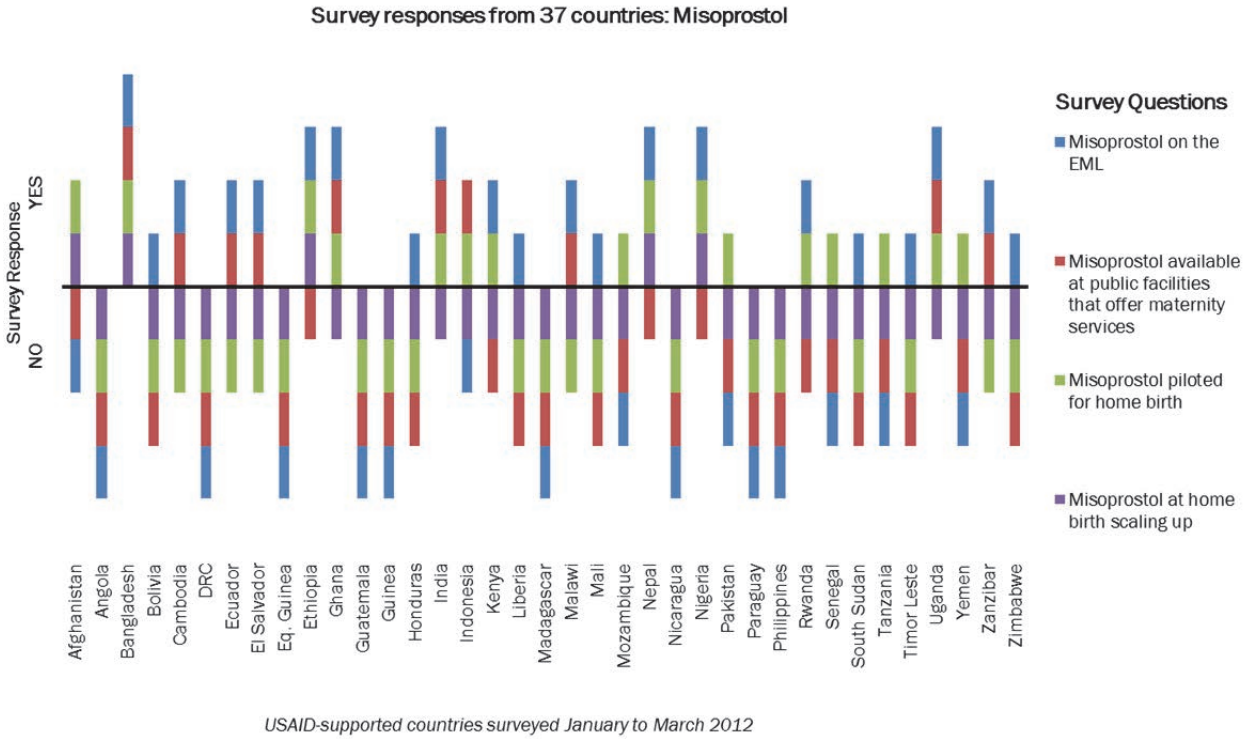
In both the 2011 and 2012 surveys, countries were asked if AMTSL was the national policy and if it was included in the SDGs. The 10 countries with data from both years in Asia (five) and Latin America (five) responded positively for both years. Regionally, Africa made progress since 2011, with three of the four countries that responded negatively about SDGs in 2011 responding positively in 2012.

Figure 16: AMTSL Policy and Guidelines in 2011 and in 2012, by Region



Theme 4: Misoprostol

Figure 19: Global Summary of Misoprostol, Selected Countries, 2012



USAID-supported countries surveyed January to March 2012

Lack of Progress

Globally, progress with misoprostol has been slow, with only 57% of countries surveyed in 2012 reporting that it is on the EML, and 27% reporting that it is available in facilities regularly or more than half the time. Forty-three percent of countries report they are piloting or have piloted the use of misoprostol for prevention of PPH at home birth, yet only 14% report they are scaling up this program.

Qualitative data reveal a recurrent theme—that there is a lack of government support for misoprostol use for the prevention of PPH in home births, both in piloting and in scale-up. Seven countries, of the 28 that responded with qualitative data, report that their governments do not support misoprostol for use at home births. The textbox below gives examples of written responses to the question of misoprostol for PPH piloting and scale-up.

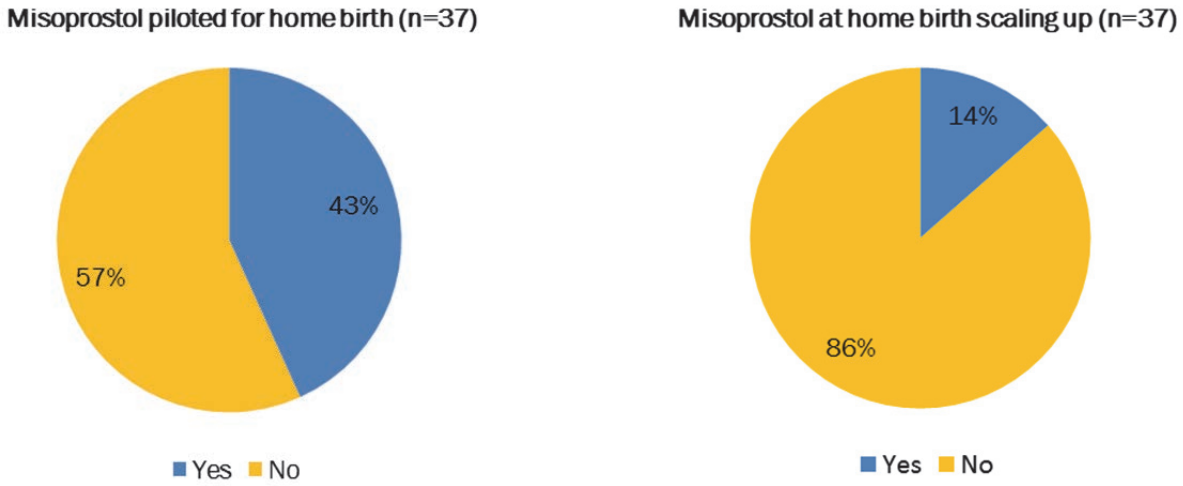
Illustrative Quotes from Countries on Misoprostol Policies:

- "MOH supports primarily institutional births. In 2007, [a donor] proposed several efforts to MOH. No progress has been seen due to the fear among MOH officials that the use of misoprostol will encourage illegal abortion."
- "Pilot is ongoing, led by the University Department of Obstetrics and Gynecology. However, current policy does not support home births; mothers are supposed to deliver at health facilities."
- "It is implemented in some places, but not scaled up, as the misoprostol is not in the National Drug List. We are waiting for the result of the study (effect of misoprostol in preventing PPH) to convince the Supreme Board of Drugs at the Ministry to include misoprostol on the National Drug List. If we succeed, then it will be available for all midwives."

There are inconsistencies between approval and availability of such programs. The situation in Ghana presents an example of this inconsistency. While misoprostol has been piloted for prevention of PPH at home births, it is on the national EML for this indication and respondents say that it is available more than half the time at public health facilities with maternity services, there are no guidelines on its use in the SDGs.

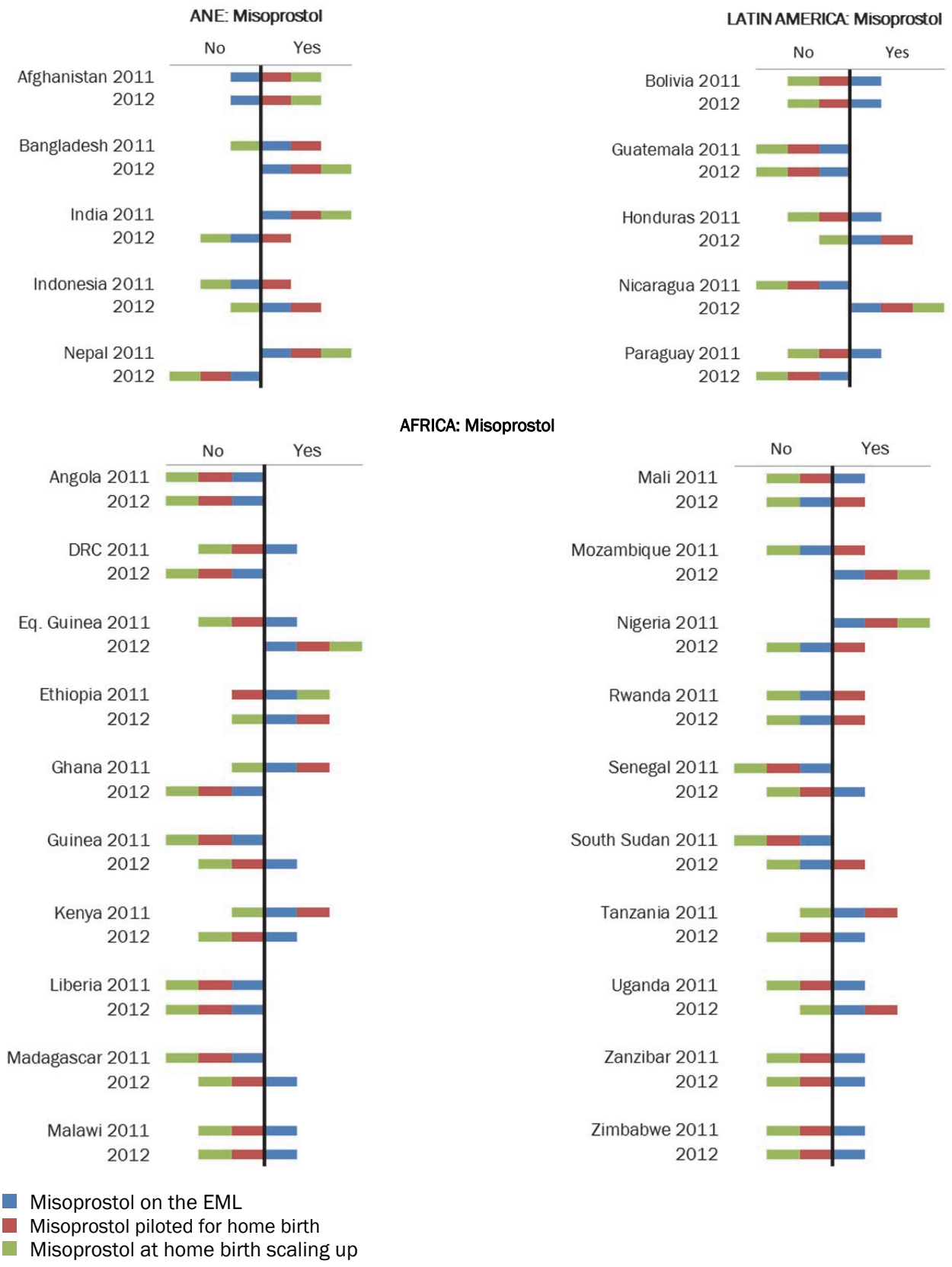
Cambodia, Ghana, Kenya, Malawi and Rwanda all state that misoprostol is on the EML for prevention and/or treatment of PPH, yet none contain guidelines in their SDGs.

Figure 20: Misoprostol Programs, 2012



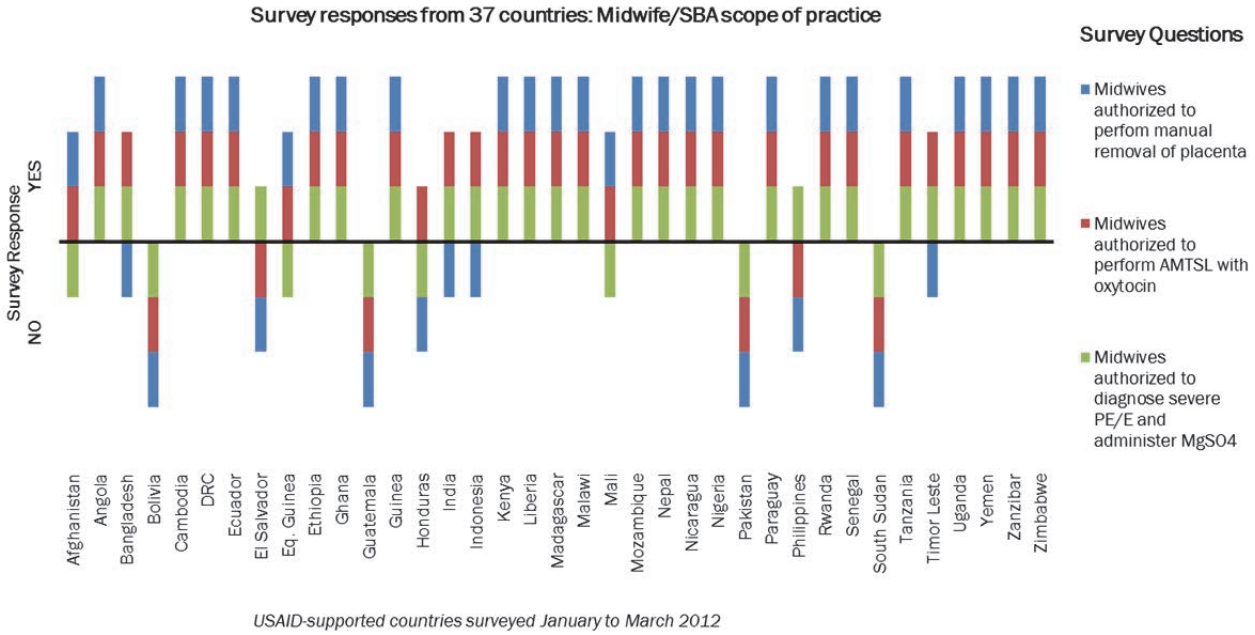
Regionally, the most progress has been made in Africa. Of the 30 countries asked these questions in 2011 and 2012, three countries that had not piloted misoprostol in 2011 (Ethiopia, Senegal, Uganda) reported piloting it in 2012, and Ethiopia now reports scale-up of misoprostol for home births. In Asia, Bangladesh now reports scaling-up of misoprostol for home birth in 2012.

Figure 21: Misoprostol Programs in 30 Countries in 2011 and in 2012, by Region



Theme 5: Midwife/Skilled Birth Attendant Scope of Practice

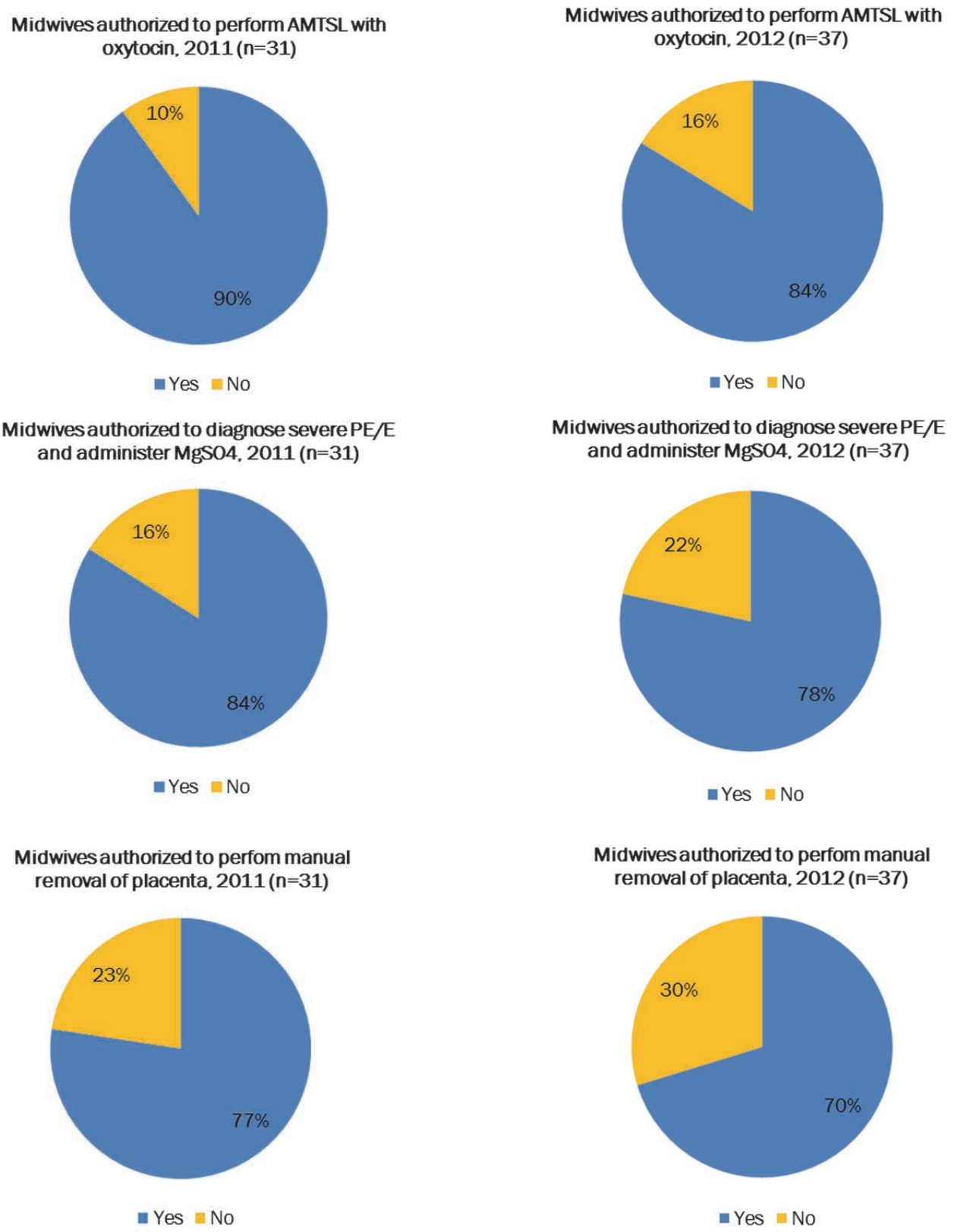
Figure 22: Global Summary of Midwifery Scope of Practice, Selected Countries, 2012



Generally, there is strong support for a scope of practice for midwives that will allow them to provide the services needed to reduce the main causes of maternal mortality, as outlined in the essential competencies for midwifery practice by the International Confederation of Midwives (ICM).[5] In 2012, there is more support for AMTSL (84%) and management of PE/E (78%) than there is for manual removal of the placenta (70%). Globally, there has not been much change in the percentage of midwives authorized to perform manual removal of the placenta. In 2011 (n=31), 77% of countries authorized it, while in 2012 (n=37), 70% of countries authorize it.

[5] ICM. 2010, http://www.internationalmidwives.org/

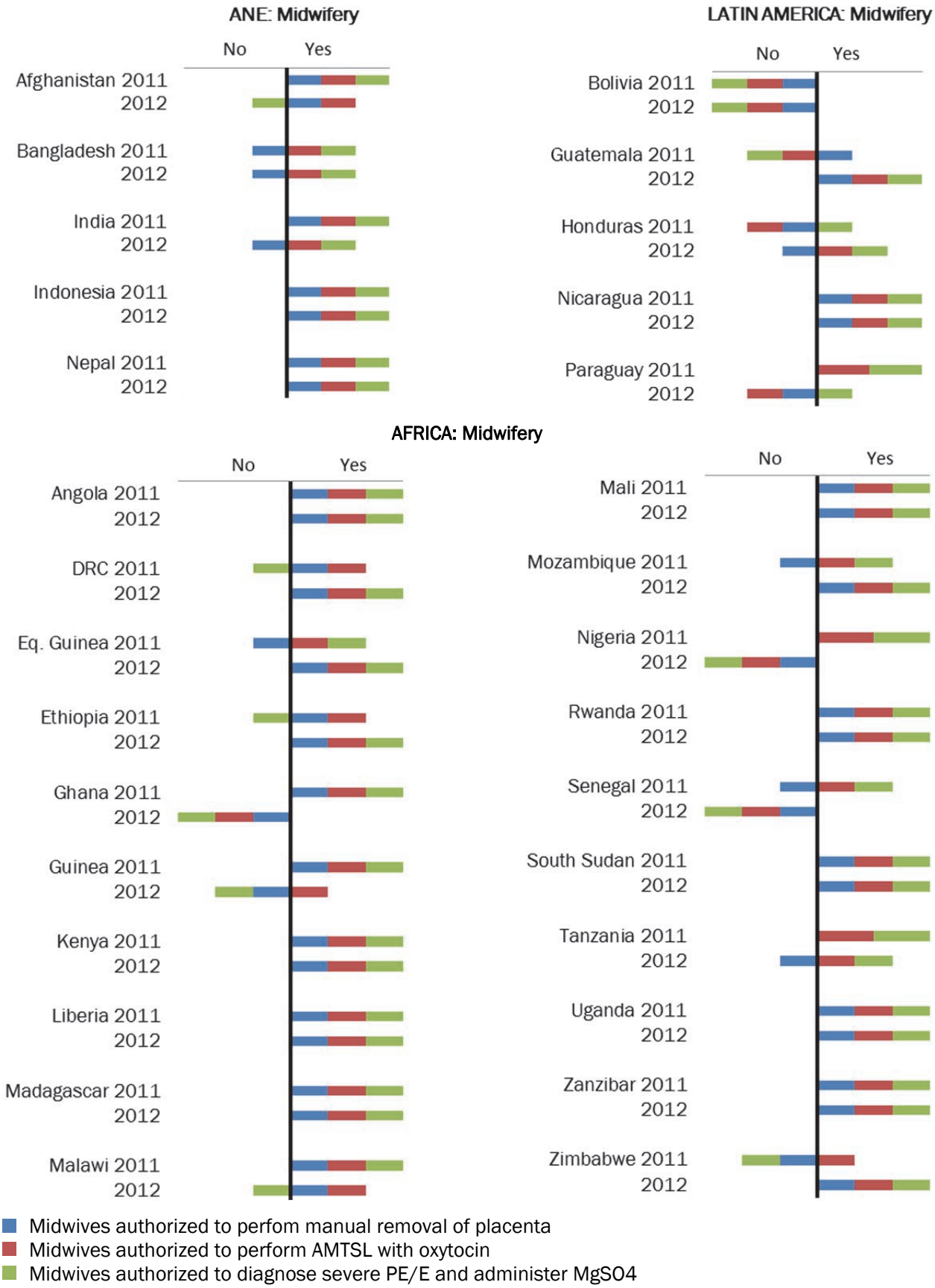
Figure 23: Percentage of Countries Reporting Midwives Authorized to Perform Key Skills, 2011 and 2012



The scope of practice for midwives follows a regional pattern more closely than for other themes, with Africa generally less restrictive than other regions. Midwives have a larger scope of practice in Asia and Africa compared to their scope in Latin America, where three LAC countries do not allow midwives to perform AMTSL. Only Nicaragua and Paraguay report allowing midwives to perform the three skills (AMTSL, manual removal of placenta and administration of MgSO4). Bolivia reports that it will graduate its first group of professional midwives in 2012.

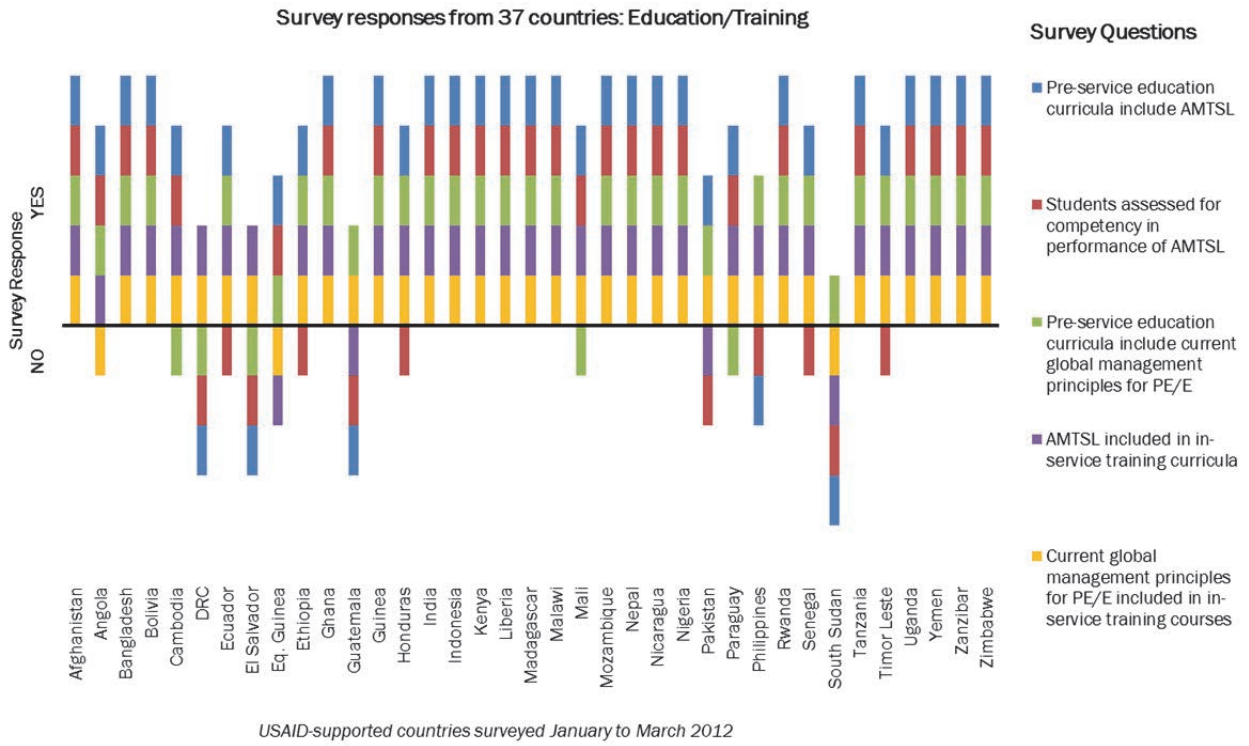
Of the 30 countries surveyed both years, in 2012 only South Sudan does not report that midwives are authorized to perform manual removal of the placenta. Ethiopia and Zimbabwe report more inclusive scope of practice in 2012 than in 2011. In Equatorial Guinea, Mali and South Sudan, in 2011, midwives were reported to be authorized to diagnose PE/E and provide MgS04, but, in 2012, they report that they are not authorized to perform that skill. It is possible that these changes are simply the result of clarification of the responses to the questionnaire, rather than policy changes.

Figure 24: Midwifery Scope of Practice in 2011 and in 2012, by Region



Theme 6: Education/Training

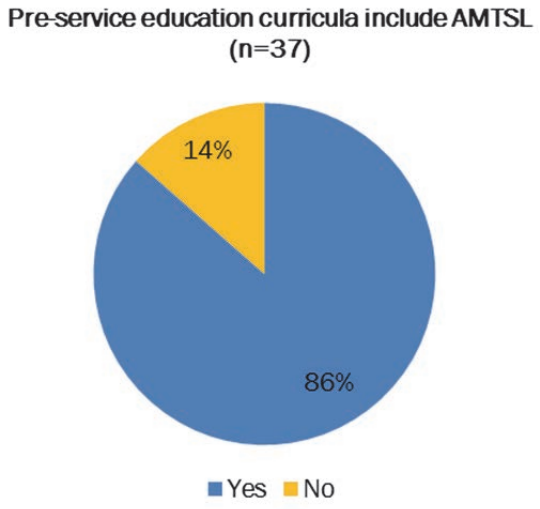
Figure 25: Global Summary of Education and Training, Selected Countries, 2012

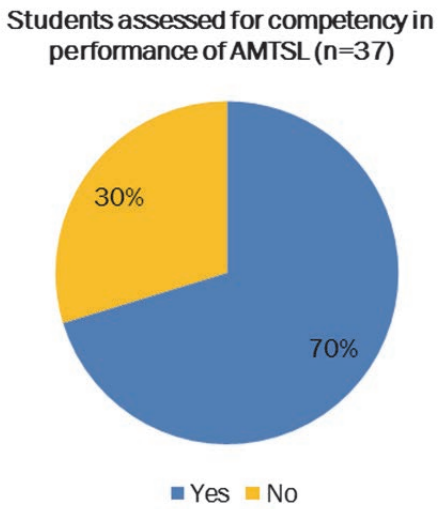


USAID-supported countries surveyed January to March 2012

Globally, most countries' education and training programs for SBA cadres address prevention and management of PPH and PE/E. The majority of countries, 86%, report that AMTSL and current PE/E management are included in pre-service education curricula; however, only 70% report assessing student competency in performance of AMTSL. In addition, 92% of countries report including current global management principles of PE/E and 89% report including AMTSL as part of in-service training programs.

Figure 26. Curriculum and Assessment of AMTSL, 2012





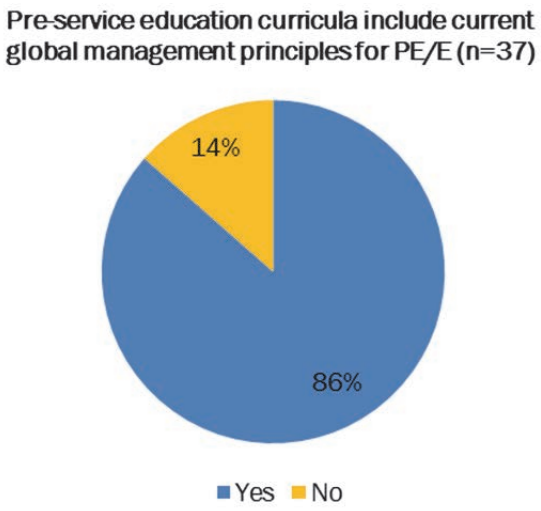
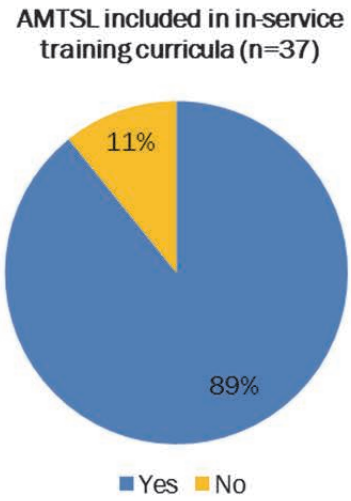
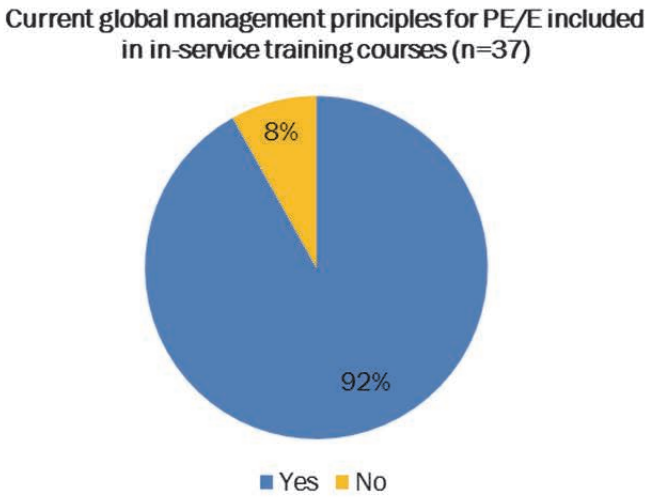


Figure 27. Summary of Content Covered in In-Service Training Courses, 2012

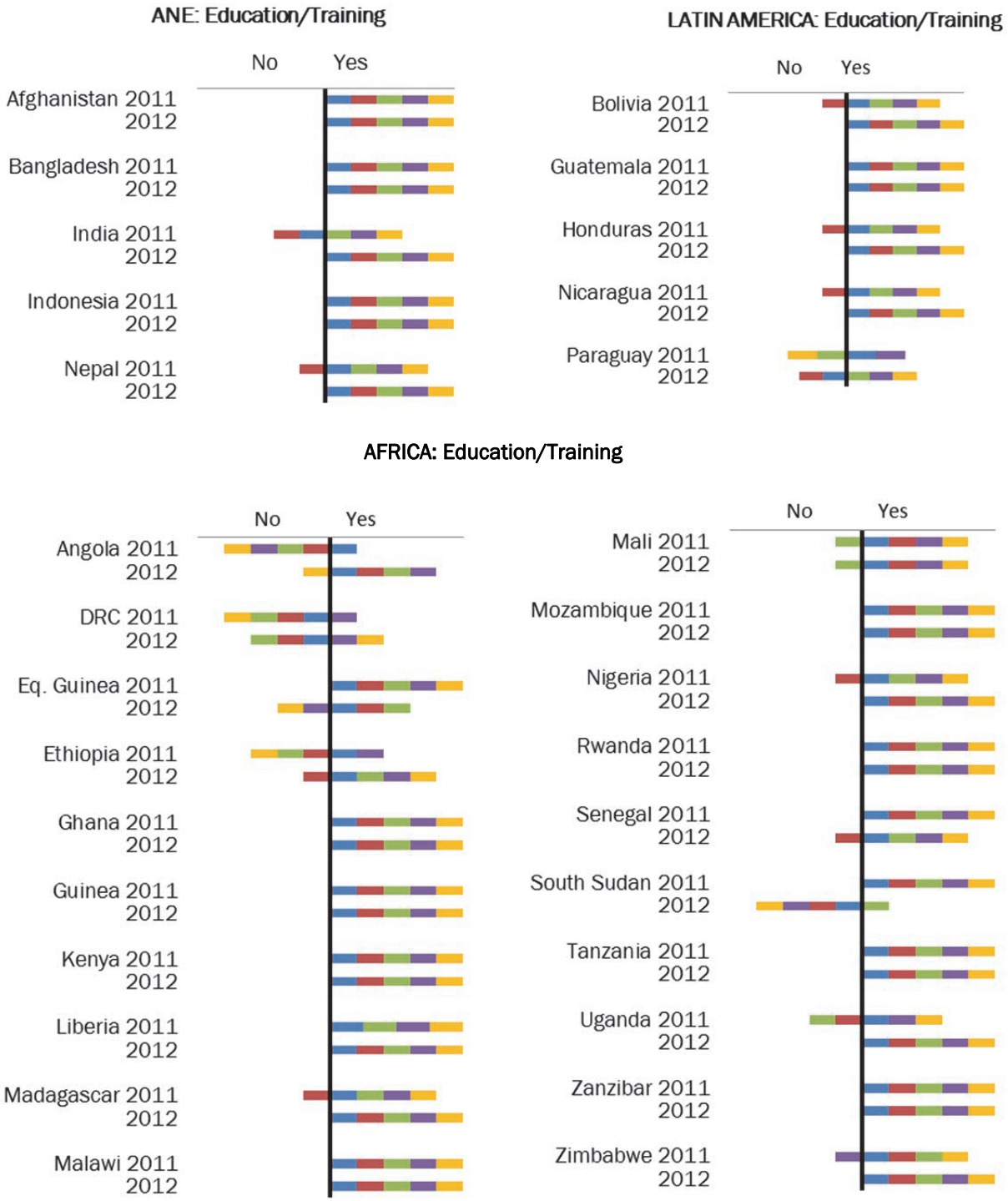




Overall, global trends are moving in a positive direction, with progress in the inclusion of PPH and PE/E in education and in-service training programs. In Asia, India and Nepal report assessing students in AMTSL in 2012, although they had not done so in 2011. Similarly, in Latin America, Bolivia and Nicaragua report assessing students in AMTSL in 2012, though they had not in the previous year. Guatemala, however, responded positively to including AMTSL in pre-service education and in-service training, and assessing students in AMTSL in 2011, but not in 2012.

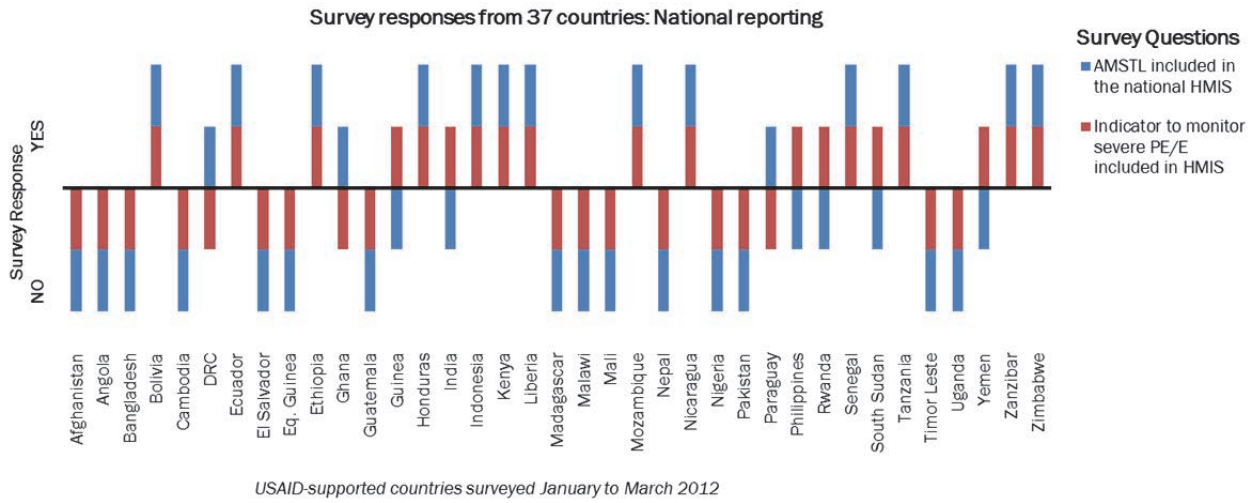
Overall, African countries have integrated important topics into pre-service education and in-service training. Angola and Ethiopia, for example, have both made significant progress in education and training. Angola did not report positively regarding pre-service education in 2011, but, in 2012, reports including and assessing AMTSL and PE/E. However, South Sudan reported positively on all components in 2011, but in 2012, responds positively only about addressing PE/E in pre-service education.

Figure 28. Education and Training in 2011 and in 2012, by Region



Theme 7: National Reporting on Selected Maternal Health Indicators

Figure 29: Global Summary of National Reporting, Selected Countries, 2012



Globally, improvements are needed in national monitoring of key maternal health indicators. Forty-three percent of countries report that they track AMTSL, and 51% report that they track an indicator in their HMIS (either through delivery logs, maternity charts or other HMIS forms) to monitor severe PE/E. This information was not captured in 2011 so no assessment of progress can be discussed.

In countries' qualitative responses regarding bottlenecks to care, numerous respondents mention monitoring and evaluation (M&E) and supervision. Eight countries list poor supervision, limited clinical mentoring and inadequate M&E and supervision activities as bottlenecks. Illustrative examples of these issues from two countries include: "Enough resources to cover supervision once training has been done for AMTSL [are needed]." and "[There is] Weakness in tracking progress."

Theme 8: Potential for Scale-Up and Bottlenecks

In an effort to provide a more comprehensive and substantive understanding of national work in PPH and PE/E, countries were asked to respond qualitatively to questions on opportunities for program scale-up and bottlenecks to scale-up. Recurring themes in relation to these two topics emerged across all countries that provided survey answers, with national policies and training and education mentioned most frequently.

National Policy

A supportive national policy is cited as a necessary component for scale-up by the majority of countries for both interventions (PPH=22, PE/E=19), the lack of which is also identified as one of the three most significant bottlenecks for many countries (PPH=14, PE/E=10). Countries trying to scale up PE/E programs cite a gap between policy and practice as a bottleneck (n=12); countries often included anecdotes illustrating the inconsistent implementation of policies and service protocols, as well as the inability to apply such protocols because of inadequate supplies and medicines (see textbox below). Some countries report that while the national policy atmosphere supports PE/E programming, providers lack confidence and/or competence in the administration of MgS04.

Illustrative Examples of Policy Challenges

PPH:

- "Two national, separate guidelines are published; and they are not fully consistent."
- "Lack of political will to scale up [is a challenge]."
- "By law, the public health system and private health sub-system must apply the health care guidelines established by the MOH. The approved activities in PPH prevention and management have been communicated to the [health service institutions] and the [medical provider clinics]; these are two types of health care providers outsourced by the national social security system. Only a few…monitor compliance with the MOH guidelines by [the institutions]."

PE/E:

- "The MOH has developed a policy, but needs support to implement it."
- "Policies, guidelines and protocols are being developed."
- "The development of a national PE/E monitoring system is under way, but it needs strong political commitment."
- "No formal program exists. Inconsistencies in supplies of magnesium sulfate."

Training, Education and Human Resources

Training, education and human resources are mentioned almost as often as supportive national policy in relation to program expansion and scale-up for both PPH and PE/E. Training, education and human resource themes raised in relation to PPH and PE/E are similar and focus on pre-service and in-service training, subject-specific training in curricula used at medical colleges and midwifery/nursing schools, and the need for increased numbers of SBAs. As mentioned above, a lack of provider confidence or competence with administration of MgSO4 is prevalent specific to PE/E (see third textbox on the next page), along with human resources issues related to brain drain and motivation. Other challenges are retaining trained providers and addressing low morale; multiple countries mention these challenges, as illustrated by the following descriptions of bottlenecks: "Staff negative attitude. High staff turnover ratios" and "Trained staff turnover."

Illustrative Examples of Training, Education and Human Resources Challenges and Opportunities

- "Onsite training approved by the MOH can also serve to train more providers and update the national pool of trainers."
- "Although PPH management is part of pre-service and in-service training, there is still a need for enhancing health worker knowledge and skills for better outcomes."
- "Lack of human resources [is a bottleneck]."

Solutions to address the lack of adequately trained health personnel are mentioned for already existing cadres of health personnel by a number of countries. Eight countries report task-shifting as a strategy for scale-up of PPH, primarily focused on ensuring an expanded scope of practice for midwives. Examples of the ways in which countries are task-shifting are shown in the illustrative quotes in the box below.

Illustrative Examples of Task-Shifting Opportunities

- "Policy change allowing matrons to use AMTSL."
- "Currently, the MOH is in the process of updating the midwifery job description and curriculum."
- "Propose that the MOH allows the use of misoprostol by associate technical nursing staff attending home deliveries under the supervision of [the NGO sector]."

Illustrative Examples of Issues with Provider Competence and Confidence in Administering MgSO4

- "Lack of knowledge and skills to use MgSO4; its use depends on the ob/gyn's acceptance of it."
- "Directors lack skills to manage PE/E cases."
- "Reluctance to change to the use of magnesium sulfate."
- "Lack of competence in using MgSO4."
- "Resistance by few providers in using MgSO4 for PE/E."
- "Although PE/E management is part of pre-service and in-service training, most health providers are unable to detail the features of severe PE/E and are also reluctant to use MgSO4, as they fear the potential side effects. There is still a need for enhancing health worker knowledge and skills for better utilization."

Community versus Facility

Other themes revealed in 10 countries' qualitative responses include a focus on scale-up and program expansion of PPH, either at the facility or the community level. The majority of these countries are planning to focus on implementation in facilities, while only a few will focus on interventions at the community level. Misoprostol and AMTSL are cited as foci of facility-based interventions in two of the countries.

Illustrative Examples of Countries Focusing on Either the Community or Facility

- "Decide if/how to promote misoprostol as a supplement to treat PPH at the hospital level."
- "Government has been talking of increasing the number of SBAs at primary health centers (PHCs) through the Midwives Service Scheme (MSS)."
- "PPH prevention with misoprostol at community level begins this quarter."
- "The Model Maternities Initiative is the vehicle for integrated scale-up of essential obstetric and newborn interventions as well as BEmONC [basic emergency obstetric and newborn care] interventions. It is currently in facilities covering about one-third of institutional births and will cover more than half by 2014. The MOH needs help directed through this mechanism."

DISCUSSION

The data across the eight themes highlight important successes and significant gaps in expanding programs for the prevention and management of PPH and PE/E.

Globally, national approval of and access to oxytocin and MgSO4 are robust and have progressed, but approval and availability of misoprostol have not. It is of concern that nine countries respond that clients are paying for oxytocin at least some of the time, so free distribution and regular supply are ongoing challenges, despite nationally reported progress in availability across the globe. It is not surprising that misoprostol is rarely available, given that there are lower levels of national approval of misoprostol as an essential drug and poor or complete lack of service delivery guidance on its use. Discrepancies between reported accuracy and completeness of guidelines and findings from this review suggest that some program directors may be unaware of the state of national SDGs or internationally recommended best practices.

Inconsistent availability of essential medications limits policy implementation and can lead to unclear treatment guidelines in the absence of alternative therapies. Qualitative data reveal that for PE/E in particular, regular MgSO4 availability is one of the most critical bottlenecks to scaling up the intervention.

In addition to working toward inclusion of lifesaving medicines in national EMLs and SDGs, making certain that the specific instructions and dosages of these medicines are correct, and scaling up provider training in administration, ensuring the regular supply of these essential medicines is critical. Health personnel and programs can work with the central or regional medical store and supply chain programs to help resolve supply chain bottlenecks. Another complementary intervention is ensuring the cold chain for oxytocin.

The lack of progress in approval of misoprostol for prevention of PPH and its limited usage are notable. As seven of 28 countries explain, their governments do not support misoprostol for use at home births. This finding presents an opportunity for global action and advocacy, especially given that in 2011 WHO included misoprostol on the EML for the indication of PPH, and because of the growing support for programs to address PPH prevention using misoprostol.

While the scope of use of misoprostol has evolved with the growing evidence base, it is not apparent that national policies and programs have evolved apace. Two indicators of program progress might be inclusion of misoprostol on national EMLs and the piloting or scale-up of misoprostol for prevention of PPH. For these indicators, there has been essentially no progress from 2011 to 2012. Even in those countries where there have been pilots, there is limited movement regarding scale-up. This finding is of concern because it shows that countries may be reluctant to move forward, even after they have the results of pilot programs.

Until now, this reluctance for robust program expansion could be understood as a result of conflicting global guidance. Global experience and enthusiasm have not completely matched the recommendations and guidelines issued by global agencies. In 2011, however, WHO revised its EML, including, for the first time, misoprostol with the specific indication of use for the prevention of PPH. It is hoped that this inclusion will trigger revisions to national EMLs in the coming year. In addition, WHO is currently working on revised PPH guidelines, which expand the recommendations for use of misoprostol for PPH prevention.

The results suggest that although 2012 has shown expanded policy for and increased access to MgSO4, more support is needed regarding provider competence and confidence for its use. Providers' reluctance to administer MgSO4 may be due to persistent, concurrent approval of

diazepam as a first-line anticonvulsant for severe PE/E, found in 19 countries in 2011 but 25 countries in 2012. This finding presents a potentially confusing scenario for health care providers and managers. If both drugs are noted as "first-line anticonvulsants," does this mean that the provider can choose between them? If they are given equal weight in national policy and program documents, what impact does this have on actual patient care? These questions should be explored further when the survey is repeated in 2013.

Furthermore, qualitative responses reveal that providers still use diazepam, partly because of a lack of understanding of administration and usage of MgSO4, or fear of the medication's perceived side effects. This concern persists, despite ongoing training and full inclusion in both education and training programs. The situation is perhaps exacerbated by incomplete, confusing and potentially conflicting EMLs, SDGs, training manuals and job aids from various sources. For example, India's SDG did not provide guidelines for the IV loading dose or maintenance doses. This omission may be because the document reviewed for India described provision of MgSO4 before referral to a higher-level facility, and other documents unavailable to the reviewers may provide broader guidance. Additionally, some countries have approved health care providers to administer only the IM component of the loading dose.

Innovative and accurate support materials and approaches are needed to help providers attain and maintain the confidence they need to administer and continue MgSO4 therapy and manage women with severe PE/E. The large majority of countries respond that education and training programs include AMTSL and management of PPH and PE/E. However, qualitative data indicate that the need for training, education and sufficient human resources for supervision is one of the top two themes identified as critical for scale-up, and one of the major bottlenecks. The lack of clinical exposure to complicated cases during training and inadequate clinical practice in pre-service education have been documented as problems.[6] Furthermore, many in-service training programs still rely almost exclusively on ineffective teaching/learning techniques, such as lecture or reading,[7] although simulations and in-hospital clinical practice are preferred educational techniques for critical lifesaving skills.[8] Sufficient training and practice are needed for mastery of complicated skills.[9] There is an urgent need for pre-service education programs to address both interventions sufficiently in clinical practice with clients, through realistic simulations and in the final clinical assessment. This issue with performance is further complicated by inaccuracies in SDGs regarding AMTSL and PE/E management, thereby creating confusion for students and providers.

It is also noteworthy that in 2012, the midwifery scope of practice is not as comprehensive as is necessary to reduce maternal mortality. To save a mother's life during childbirth when there are complications, a midwife or skilled birth attendant needs to be both empowered and competent to perform all aspects of BEmONC.[10] Although there has been some progress in advancing the midwifery scope of practice related to AMTSL, manual removal of the placenta

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[6] Fullerton JT, Johnson PG, Thompson JB, Vivio D. 2011. Quality considerations in midwifery pre-service education: Exemplars from Africa. *Midwifery* 27(3): 308–315.

[7] Bloom BS. 2005. Effects of continuing medical education on improving physician clinical care and patient health: A review of systematic reviews. *Int J Technol Assess Health Care* 21(3): 380–385.

[8] Issenberg SB, McGaghie WC, Petrusa ER, Gordon D, Scalese RJ. 2005. Features and uses of high-fidelity medical simulations that lead to effective learning: A BEME systematic review. *Med Teach* 27(1): 10–28; Daniels K, Arafeh J, Clark A, Waller S, Druzin M, Chueh J. 2010. Prospective randomized trial of simulation versus didactic teaching for obstetrical emergencies. *Simul Healthc* 5(1): 40–45.

[9] McGaghie WC, Siddall VJ, Mazmanian PE, Myers J, American College of Chest Physicians Health and Science Policy Committee. 2009. Lessons for continuing medical education from simulation research in undergraduate and graduate medical education: Effectiveness of continuing medical education: American College of Chest Physicians Evidence-Based Educational Guidelines. *Chest* 135(3 Suppl): 62S–68S.

[10] UNFPA. 2011. *The State of the World Midwifery Report 2011: Delivering Health, Saving Lives*, http://www.unfpa.org/sowmy/report/home.html

and management of PE/E, there are still notable gaps. Not all countries consider these skills to be part of a midwife's responsibilities. For example, only 70% of the countries in this survey allow a midwife to perform manual removal of the placenta although it has long been part of BEmONC. Furthermore, all of these skills are included in the 2011 ICM Essential Competencies for Basic Midwifery Practice and are listed as essential interventions by WHO.[11] Task-shifting and supportive policies are reinforced in qualitative responses as essential for program scale-up.

The variations in the scope of practice for midwives are detailed in Theme 5. The midwife's scope of practice is most limited in Latin America, where three of the countries surveyed do not allow midwives to perform AMTSL. This may be due to definitional and linguistic differences, as some countries in Latin America appear to have different clinical cadres that address specific elements of midwifery, while other countries have midwives who meet a global definition. In addition, while it may be assumed that a physician is allowed to perform all BEmONC signal functions, it cannot be assumed that a midwife is allowed to do the same. Overall, although the role of the midwife varies by country, it is vital to define cadres clearly, to expand the role of the midwife to include all BEmONC skills (as endorsed by WHO, the United Nations Population Fund [UNFPA], ICM and the United Nations Children's Fund [UNICEF]) and, further, to train midwives to competency to ensure that women who experience complications have improved access to skilled care.

Finally, another issue identified as essential is the lack of national reporting on key indicators related to maternal health outcomes. Less than half of the countries respond that AMTSL and indicators related to severe PE/E are a part of the HMIS. This finding is reinforced by qualitative data reporting that poor supervision, limited clinical mentoring and inadequate M&E are barriers to scale-up of these services. Gathering sufficient data is important to ensure that these interventions are prioritized, recognizing that "what matters gets measured and what gets measured matters." There is an urgent need to strengthen maternal health monitoring and reporting systems.

Finally, the subset review of available SDGs was an important and positive exercise in the face of evolving global guidelines. National SDGs give vital clinical guidance and are widely used in all countries to establish and perpetuate clinical norms. Such a review was done with the knowledge that national SDGs also evolve with time and advancing global evidence.

This analysis puts a priority on the accuracy of information in the SDGs related to the use of AMTSL. AMTSL is the intervention that has proven most successful in prevention of PPH.[12] AMTSL includes the administration of a uterotonic medication immediately after birth, with oxytocin being the drug of choice. AMTSL (according to the WHO definition) has three components:

1. Oxytocin, 10 IU IM immediately after birth
2. Controlled cord traction
3. Uterine massage to ensure uterine tone

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[11] The Partnership for Maternal, Newborn and Child Health, WHO and Aga Khan University. 2011. *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health,* http://www.who.int/pmnch/topics/part_publications/201112_essential_interventions/en/index.html

[12] The Partnership for Maternal, Newborn and Child Health, WHO, and Aga Khan University.2011. *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health*, http://www.who.int/pmnch/topics/part_publications/201112_essential_interventions/en/index.html

The analysis of the SDGs found that although the majority of the critical information regarding AMTSL was present, there were certain gaps in guidance when compared to the WHO definition.[13]

The SDG review shows that there were instances of recommendations regarding dosing or timing of uterotonic that differed from internationally approved recommendations. These findings at times contradicted the answers to the survey, suggesting that some respondents may perceive their country guidelines to be more accurate than they in fact are.

Several important findings emerge from the qualitative analysis, including the need for supportive national policies, gaps in training and education, challenges regarding the availability of essential medicines, issues with motivation and human resources, and gaps between policy and practice. In prevention of PPH, there is uncertainty about the correct and appropriate use of misoprostol, and in management of severe PE/E, there are significant issues with provider competence and confidence in the correct use of MgSO4. MgSO4 is the first-line drug of choice for prevention of and managing PE/E.[14]

Limitations

Efforts were made to ensure that this global survey is as objective as possible, within the constraints of existing human resources and funding. Despite efforts to design an objective questionnaire and to provide clear instructions to national partners in the formation of responses, the data from this survey should be viewed in the context of certain limitations.

Although the 2012 survey asks for objective, quantitative responses to a majority of questions, country respondents may not have had complete information or full access to such information to allow for thorough responses. For example, in certain countries, some key maternal health stakeholders may not have been involved in filling out the survey, and respondents had different levels of access to data and national documents. Therefore, not all of the country responses may reflect the exact situation in the country, or some current or planned activities may have been overlooked. In addition, although efforts were made for the same focal person and country respondents to complete the survey in both years, in some cases new MOH colleagues or other respondents participated in the survey. Necessarily, this can result in different responses. By the time the data are published, they are likely to be at least somewhat out of date, because responses were collected from January through March, 2012. What is more, there are multiple SDG documents in many of the countries surveyed, and in some countries, updated SDGs are awaiting approval. Finally, qualitative responses are opinion-based, and although they provide valuable information regarding opportunities and challenges and triangulate the quantitative responses, they may not represent the majority opinion of health professionals in a particular country.

In some cases there may be a tendency for individuals to present overly encouraging or positive responses to certain questions or for the scale-up maps. As the MCHIP maternal health team tracks, compares and discusses the results objectively each year, this in turn encourages objective responses from the country teams completing the surveys. It appears that some respondents were too optimistic in 2011, and, given the more thorough review in 2012 and respondents' greater comfort with the survey process, some results may appear to be more

[13] WHO. 2000. *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, https://www.google.com/search?aq=f&sugexp=chrome,mod=4&sourceid=chrome&ie=UTF-8&q=WHO+(2000)+Managing+Complications+in+Pregnancy+and+Childbirth

[14] WHO. 2011. *Recommendations for Prevention and Treatment of Pre-Eclampsia and Eclampsia*, http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/9789241548335/en/index.html

negative in 2012 than 2011. These results, which appear to show the opposite of progress, may in fact just indicate that the 2012 responses are simply more accurate. As the survey continues into the next year, we will continue to see true tracking of progress.

With regard to nomenclature, different countries use different terms for similar cadres. For example, in Latin America, there are several names for midwives, and distinctions to be made among skilled birth attendants, midwives and traditional midwives. The MCHIP maternal health research team attempted to clarify questions containing the term "midwife" with each Latin American country. In addition, some questions will not necessarily pertain to all countries and, therefore, responses cannot always be answered yes or no or aggregated easily. For example, some countries may have regional medical stores but the survey asked questions about national medical stores. In addition, different countries and programs have varied definitions of "scale-up." Some might believe moving into several regions can be termed scale-up, while others might use the phrase only when talking about national-level rollout.

During data entry, grammatical and spelling changes were made to qualitative responses to facilitate ease of understanding and allow computer-aided analysis, without losing meaning or intent. It is possible some nuances were lost in translation from French or Spanish or were not always conveyed completely accurately in French or Spanish, although the questions and answers were translated by professionals well-versed in medical and public health terms. The scale-up maps show a broad range of responses and styles, given that related questions are open-ended and require creativity and subjective use of colors to represent programming. Accordingly, styles and colors are not uniform, and aggregation is difficult. In addition, the process to fill out the maps in 2011 was perhaps not as well understood as we had hoped, although countries often worked directly with the research team to fill out the maps to represent the situation as accurately as possible. In 2012, the instructions accompanying the maps were clearer and more detailed, and improvements can likely be made to further improve clarity in future surveys. Finally, while the maps do indicate that the majority of countries have PPH and PE/E programs, and represent which partners are implementing these programs, there are limitations to the comparison between the 2011 and 2012 maps. The quantitative data in this report provide a better basis for analysis of PPH and PE/E programming.

Although more than 20 countries submitted documents to serve as SDGs, only the nationally approved SDGs could be used in the analysis. The 12 approved guidelines in English were independently reviewed by the research team, and the eight nationally approved, non-English SDGs were reviewed in conjunction with an MCHIP country representative using a shorter checklist. Therefore, the questions reviewed are not exactly the same, although only questions asked of all countries are included in the analysis.

In several cases, especially with regard to the approved medicines questions for PE/E, there were gaps in answers. Where possible, the MCHIP research team worked with countries to fill in gaps and at times was able to verify the "Yes/No" response from the documentation sent by the countries.

CONCLUSION, RECOMMENDATIONS AND OPPORTUNITIES FOR EXPANSION

This 2012 multi-country analysis of national programs for prevention and management of PPH and PE/E provides a large amount of useful data upon which actions can be based. The varied ways in which the data are presented allow for global and national understanding of important themes, as well as identification of progress on certain topics.

While AMTSL and management of PE/E are strongly represented in the policy and education/ training initiatives of national programs throughout the 37 countries surveyed, many issues remain. It is encouraging to see widespread acceptance of AMTSL for prevention of PPH in facility births; however, there is substantially less support for use of misoprostol for prevention of PPH at home births. This finding could potentially represent a strategic choice for promotion of facility-based births, but overlooks a proven intervention that allows for a greater public health impact. This is especially important in areas with high maternal mortality, high home birth rates and low numbers of births attended by a SBA.

Although approval of the use of MgSO4 is universal, its actual use is far from universal. Where availability of MgSO4 has expanded, those gains may not persist without regular use of the drug and, thus, awareness among clinicians and managers of the need to reorder, resupply and restock it regularly. Efforts must be made for appropriate and comprehensive management of women with PE/E, which includes the correct use of MgSO4, appropriate use of an antihypertensive, expedited termination of pregnancy and overall vigilance in patient care.

Worldwide, midwives must deal with an identity crisis unknown to doctors. Throughout the world, when someone identifies himself or herself as a doctor, a clear picture of professional responsibilities is formed. This is not the case for a midwife. In virtually every health system in the developing world, the definition, role and scope of practice of a midwife differ. Introduction of the term must be followed by clarifying questions such as, what kind of midwife do you mean, what can she or he do, what are his or her competencies? The data from this survey yield similar responses, showing approval for varied scopes of practice and an incomplete set of skills. To improve access to and quality of maternal and newborn health care, in every country of the world, the midwifery scope of practice should be clearly defined and comprehensively and uniformly applied, consistent with the ICM's recognized essential competencies[15] and the international definition of a midwife.[16]

The publication of WHO's *Recommendations for the Prevention and Treatment of Pre-Eclampsia and Eclampsia* in 2011 and the anticipated publication by WHO of new recommendations for preventing and managing PPH provide an excellent opportunity for the international community to work with Ministry of Health staff to update guidelines and expand programs.

Robust national programs exist, solving problems with creative solutions and clear determination. We must continue to be engaged with such programs, to foster communication and information-sharing and to track progress of national programs as we support greater efforts to reduce maternal morbidity and mortality.

[15] ICM.2011. *Essential Competencies for Basic Midwifery Practice 2010*, http://www.unfpa.org/sowmy/resources/docs/standards/en/R430_ICM_2011_Essential_Competencies_2010_ENG.pdf
[16] http://www.internationalmidwives.org/Portals/5/2011/Definition%20of%20the%20Midwife%20-%202011.pdf

Appendix 1: Global Surveys of Scale-Up of National PPH and PE/E Programs in English, French and Spanish

QUESTION	RESPONSE AND FURTHER INFORMATION
Country	
Is there an MCHIP presence in this country?	☐ Yes ☐ No If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).

NOTE: Throughout this questionnaire, the term skilled birth attendant (SBA) is used to describe midwives, nurses with midwifery skills, non-physician clinicians with obstetric skills, general doctors with obstetric skills or obstetric specialists.

Section 1: Postpartum Hemorrhage (PPH)	
Policy	
1. Is AMTSL[17] at every birth approved as national policy?	☐ Yes ☐ No
2. Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	☐ Yes (Please attach a scanned/soft copy of the service delivery guidelines for PPH prevention.)[18] ☐ No
3. Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?[19]	☐ Yes If Yes, at which level(s) of the health system can the drug be administered? ☐ 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

[17] Active management of the third stage of labor
[18] In 2011, countries were not asked to provide Service Delivery Guidelines or Essential Medicines Lists.
[19] This question was changed in 2012.

6.	**Is oxytocin on the National EML for prevention and/or treatment of PPH?**[20]	☐ **Yes** If Yes, at which level(s) of the health system can the drug be administered? ☐ **No** **Please include a scanned/soft copy of the section in the EML relating to oxytocin and misoprostol.**
Training		
7.	**Do pre-service education curricula include AMTSL for all SBA**[21] **cadres?**[22]	☐ **Yes** If Yes, which cadres? ☐ **No**
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**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	**Has the use of misoprostol for the prevention of PPH at home births been piloted?**[23]	☐ **Yes** If Yes, please provide some brief details. ☐ **No**
11.	**Is the use of misoprostol for PPH prevention during home births being scaled up?**[24]	☐ **Yes** If Yes, please provide some brief details. ☐ **No**
Logistics		
12.	**Is oxytocin available at public facilities that offer maternity services?**[25]	☐ Regularly ☐ More than half the time ☐ Less than half the time ☐ Never
13.	**Is oxytocin free of charge to patients at public health facilities?**[26]	☐ **Yes** ☐ **No**

[20] This question was changed in 2012.
[21] Skilled Birth Attendant
[22] The wording on this question changed slightly from 2011 to 2012.
[23] The wording on this question changed slightly from 2011 to 2012.
[24] The wording on this question changed slightly from 2011 to 2012.
[25] The wording of this question and the response choices were changed in 2012.

14.	**How frequently do stock-outs of oxytocin occur at the central/regional levels?**[27]	☐ Frequently (once in every 2 months or less) ☐ Sometimes (every 3 to 6 months) ☐ Rarely (once a year)
15.	**Is oxytocin currently available at the MOH**[28] **medical store?**	☐ **Yes** ☐ **No**
16.	**Is misoprostol available at public facilities that offer maternity services?**[29]	☐ Regularly ☐ More than half the time ☐ Less than half the time ☐ Never
M&E		
17.	**Is AMTSL included in the national HMIS?**[30,31]	☐ **Yes** If Yes, where are AMTSL data recorded? (e.g., delivery logs, maternity chart, other registers) ☐ **No** If No, are any organizations collecting data on AMTSL? What are their names?
Programming		
18.	**Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.**	
19.	**Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.**[32]	
20.	**Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.**	
21.	**What % of districts are covered by current national PPH programs?**	%
22.	**What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?**	(Provide your best possible estimate and any details you think would be helpful.)[33]

[26] This question was added in 2012.
[27] The wording of this question changed slightly and the response choices were changed in 2012.
[28] Ministry of Health
[29] This question was added in 2012.
[30] Health Management Information System
[31] The response choices were changed in 2012.
[32] The wording on this question changed slightly from 2011 to 2012.
[33] This wording was added in 2012.

Opportunities for Expansion and Scale-Up	
23. Please describe any potential opportunities that you see for program expansion or scale-up.	(e.g., Champion exists who need support to disseminate messages; National conference scheduled for next year and curriculum revision planned; MOH has policy in place and needs support for program rollout.)
24. What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	
Contact Person	
25. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	

Section 2: Pre-Eclampsia/Eclampsia (PE/E)	
Policy	
1. What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol ☐ Yes ☐ No Hydralazine ☐ Yes ☐ No Nifedipine ☐ Yes ☐ No Methyldopa ☐ Yes ☐ No Other (Please describe)
2. What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol ☐ Yes ☐ No Hydralazine ☐ Yes ☐ No Nifedipine ☐ Yes ☐ No Methyldopa ☐ Yes ☐ No Other (Please describe)
3. What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	MgSO4 ☐ Yes ☐ No Diazepam ☐ Yes ☐ No Other (Please describe)
4. Is MgSO4[34] on the National EML for: severe pre-eclampsia?; eclampsia?[35]	Pre-eclampsia ☐ Yes ☐ No Eclampsia ☐ Yes ☐ No **Please attach a scanned/soft copy of the service delivery guidelines for the management of severe pre-eclampsia/eclampsia (PE/E), including the protocol for antihypertensives and administration of MgSO4.**
5. Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest level facility that they work at within the health system?[36]	☐ Yes ☐ No

[34] Magnesium Sulfate
[35] The response choices were added in 2012.
[36] The wording on this question changed slightly from 2011 to 2012.

Training		
6.	**Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?**[37]	☐ **Yes** If Yes, which cadres? ☐ **No**
7.	**Are current global management principles for PE/E included in in-service training courses for SBAs?**	☐ **Yes** ☐ **No**
Logistics		
8.	**Is MgSO4 available at public facilities that offer maternity services?**[38]	☐ Regularly ☐ More than half the time ☐ Less than half the time ☐ Never
9.	**How frequently do stock-outs of MgSO4 occur at the central/regional levels?**[39]	☐ Frequently (once in every 2 months or less) ☐ Sometimes (every 3 to 6 months) ☐ Rarely (once a year)
10.	**Is MgSO4 currently available at the MOH medical store?**[40]	☐ **Yes** ☐ **No**
M&E		
11.	**Is an indicator to monitor severe PE/E included in the national HMIS?**	☐ **Yes** If Yes, what is this indicator and where is it recorded? (e.g., delivery logs, maternity chart, other registers) ☐ **No**
PROGRAMMING		
12.	**Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.**	
13.	**Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.**[41]	
14.	**Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.**	

[37] The wording on this question changed slightly from 2011 to 2012.
[38] The response choices were changed in 2012.
[39] The wording of this question changed slightly and the response choices were changed in 2012.
[40] This question was added in 2012.
[41] The wording on this question changed slightly from 2011 to 2012.

15.	**What % of districts are covered by current PE/E programs?**	
16.	**What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?**	(Provide your best possible estimate and any details you think would be helpful.)[42]
Opportunities for Introduction, Expansion and Scale-Up		
17.	**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 rollout.)
18.	**What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.**	
Contact Person		
19.	**Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.**	

[42] This wording was added in 2012.

Enquête globale pour les passage à l'échelle national des programmes d'HPP et de PE/E

QUESTION	REPONSE ET INFORMATION SUPPLEMENTAIRE
Pays	
Y a-t-il une présence MCHIP dans ce pays?	☐ Oui ☐ Non Si Non, quel est le principal projet bilatéral de santé maternelle et infantile et qui l'exécute ?

NOTE: Dans ce questionnaire, le terme prestataire qualifié est utilisé pour décrire les sages-femmes, les infirmiers/es ayant des compétences obstétricales, les cliniciens autres que les médecins avec des compétences obstétricales, les médecins généralistes avec des compétences obstétricales ou des spécialistes en obtétriques.

Section 1: Hémorragie du postpartum (HPP)		
Politique		
1.	Est-ce que la GATPA[43] est approuvée pour chaque accouchement comme politique nationale?	☐ Oui ☐ Non
2.	Est-ce que les étapes pour l'exécution correcte de la GATPA sont incorporées dans les directives de prestation de services?	☐ Oui (Veuillez joindre une copie scannée/téléchargée des directives de prestation de services pour la prévention de l'HPP.) ☐ Non
3.	Est-ce que le misoprostol est sur la Liste nationale de médicaments essentiels (LME), en particulier pour la prévention et/ou le traitement de l'HPP à tout niveau du système de santé?	☐ **Oui** Si oui, à quel niveau du système de santé est administré le médicament? ☐ **Non**
4.	Est-ce que les sages-femmes sont autorisées à faire la délivrance artificielle du placenta à tous les niveaux du système de santé?	☐ **Oui** ☐ **Non**
5.	Est-ce que les sages-femmes sont autorisées à effectuer la GATPA en administrant l'ocytocine à tous les niveaux du système de santé?	☐ **Oui** ☐ **Non**
6.	Est-ce que l'ocytocine est sur la LME nationale pour la prévention et/ou le traitement de l'HPP?	☐ **Oui** Si oui, à quel(s) niveau(x) du système de santé est administré le médicament? ☐ **Non** Veuillez inclure une copy scannée/téléchargée de la section dans la LME, liée à l'ocytocine et au misoprostol.

[43] Gestion active de la troisième période du travail

Formation		
7.	Est-ce que le programme d'études de base inclut la GATPA pour tous les cadres de prestataires[44]?	☐ **Oui** Si oui, quels cadres? ☐ **Non**
8.	Les étudiants sont-ils évalués en compétences dans la performance de la GATPA comme une compétence clinique avant d'obtenir leur diplôme?	☐ **Oui** ☐ **Non**
9.	Est-ce que la GATPA est inclue dans le programme de formation continue pour tous les cadres de prestataires qualifiés?	☐ **Oui** ☐ **Non**
Distribution du misoprostol pour la prévention de l'HPP lors des accouchements à domicile		
10.	Est-ce que le misoprostol pour la prévention de l'HPP lors des accouchements à domicile en train d'être piloté?	☐ **Oui** Si Oui, veuillez donner des brefs détails. ☐ **Non**
11.	Est-ce que l'utilisation du misoprostol pour la prévention de l'HPP lors des accouchements à domicile est passée à l'échelle?	☐ **Oui** Si Oui, veuillez donner des brefs détails. ☐ **Non**
Logistique		
12.	Est-ce que l'ocytocine est disponible dans les structures de santé publique qui offrent des services de maternité:	☐ Régulièrement ☐ Plus de la moitié du temps ☐ Moins de la moitié du temps. ☐ Jamais
13.	Est-ce que l'ocytocine est gratuit pour les clientes des structures de santé publique?	☐ **Oui** ☐ **Non**
14.	Quelle est la fréquence des ruptures de stock en ocytocine au niveau central/régional?	☐ Souvent (une fois tous les 2 mois ou moins) ☐ Quelquefois (tous les 3 à 6 mois) ☐ Rarement (une fois par an)
15.	Est-ce que l'ocytocine est disponible actuellement au dépôt médical du MSP[45]?	☐ **Oui** ☐ **Non**
16.	Est-ce que le misoprostol est disponible dans les structures de santé publique qui offrent des services de maternité:	☐ Régulièrement ☐ Plus de la moitié du temps ☐ Moins de la moitié du temps. ☐ Jamais

[44] SBA : prestataire qualifié
[45] Ministère de la santé publique

S&E		
17.	Est-ce que la GATPA est incluse dans le Système national de Gestion de l'information sanitaire (SGIS)[46]?	☐ **Oui** Si Oui, où sont enregistrées les données de la GATPA? (par ex: dossiers d'accouchement, registre de maternité, autres registres) ☐ **Non** Si Non, est ce que d'autres organisations font la collecte des données de la GATPA? Lesquelles?
Programmation		
18.	Quelles activités de prévention et de prise en charge de l'HPP sont réalisées par le MSP? Décrivez brièvement ce qui est fait.	
19.	Quelles activités de prévention et de prise en charge de l'HPP sont entreprises par les programmes parrainés par les Etats-Unis ? Décrivez brièvement ce qui est fait.	
20.	Quelles activités de prévention et de prise en charge de l'HPP sont entreprises par d'autres bailleurs ou partenaires? Décrivez brièvement ce qui est fait.	
21.	Quel est le pourcentage de districts couvert par les programmes nationaux actuels d'HPP?	%
22.	Quel pourcentage de prestataires qualifiés actuels est atteint par les efforts programmatiques des programmes nationaux actuels sur l'HPP?	(Donnez votre meilleure estimation et tout détail que vous trouvez utile.)
Possibilités d'expansion et de passage à l'échelle		
23.	Veuillez décrire les possibilités que vous envisagez pour l'expansion ou le passage à l'échelle du programme.	(par ex: Champion en place qui a besoin de soutien pour disséminer des messages; conférence nationale prévue pour l'année prochaine et révision prévue des programmes; MSP a une politique en place et a besoin de soutien pour le déploiement du programme)
24.	Quels sont les trois goulots d'étranglement les plus importants empêchant l'expansion des programmes de réduction de l'HPP dans votre pays? Décrivez brièvement ce qui est fait pour répondre à ces problèmes, le cas échéant.	
Personne contact		
25.	Contact qui sera responsable de la mise à jour de cette matrice. Veuillez inclure le nom, numéro de téléphone et l'adresse e-mail.	

[46] Système de gestion de l'information sanitaire (SGIS)

Section 2: Pré-éclampsie/Eclampsie (PE/E)		
POLITIQUE		
1.	Quels sont les médicaments approuvés dans le cadre des directives nationales/directives de prestation de services pour l'administration des antihypertenseurs de première ligne pour la pré-éclampsie/éclampsie sévère (PE/E)?	Labétolol ☐ **Oui** ☐ **Non** Hydralazine ☐ **Oui** ☐ **Non** Nifédipine ☐ **Oui** ☐ **Non** Méthyldopa ☐ **Oui** ☐ **Non** Autre (Veuillez décrire)
2.	Quels sont les médicaments figurant sur la Liste nationale des médicaments essentiels (LME), comme antihypertenseurs pour le traitement de la PE/E sévère ?	Labétolol ☐ **Oui** ☐ **Non** Hydralazine ☐ **Oui** ☐ **Non** Nifédipine ☐ **Oui** ☐ **Non** Méthyldopa ☐ **Oui** ☐ **Non** Autre (Veuillez décrire)
3.	Quels sont les médicaments approuvés dans le cadre des directives nationales/directives de prestation de services en matière d'anticonvulsivants de première ligne pour la PE/E sévère?	MgSO4 ☐ **Oui** ☐ **Non** Diazépam ☐ **Oui** ☐ **Non** Autre (Veuillez décrire)
4.	Est-ce que le MgSO4[47] est sur la Liste nationale des médicaments essentiels (LME) pour la pré-éclampsie? Pour l'éclampsie?	Pré-éclampsie ☐ **Oui** ☐ **Non** Eclampsie ☐ **Oui** ☐ **Non** **Veuillez joindre une copie scannée/téléchargée des directives de prestation de services pour le traitement de la PE/E sévère, y compris les protocoles pour les antihypertenseurs et l'administration du MgSO4.**
5.	Est-ce que les sages-femmes sont autorisées à diagnostiquer la PE/E sévère et administrer la dose de charge initiale de MgSO4 au premier niveau de site sanitaire dans lequel elles travaillent au sein du système de santé?	☐ **Oui** ☐ **Non**
FORMATION		
6.	Est-ce que les programmes d'enseignement de base incluent les principes actuels de gestion globale pour la PE/E pour tous les cadres de prestataires?	☐ **Oui** Si Oui, quels cadres? ☐ **Non**
7.	Est-ce que les principes actuels de gestion globale pour la PE/E sont inclus dans les stages de formation sur le tas pour les prestataires qualifiés?	☐ **Oui** ☐ **Non**
LOGISTIQUE		
8.	Est-ce que le MgSO4 est disponible dans les structures de santé publiques qui offrent des services de maternité?	☐ Régulièrement ☐ Plus de la moitié du temps ☐ Moins de la moitié du temps. ☐ Jamais

[47] Magnesium Sulfate

9.	Quelle est la fréquence des ruptures de stock de MgSO4 au niveau central/régional?	☐ Souvent (une fois tous les 2 mois ou moins) ☐ Quelquefois (tous les 3 à 6 mois) ☐ Rarement (une fois par an)
10.	Est-ce que le MgSO4 est disponible actuellement au dépôt médical du MSP?	☐ **Oui** ☐ **Non**
S&E		
11.	Y a-t-il un indicateur pour le monitorage de la PE/E sévère dans le Système national de gestion de l'information sanitaire (SGIS) ?	☐ **Oui** Si Oui, quel est l'indicateur et où est-il enregistré? (par ex: dossiers d'accouchement, registre de maternité, autres registres) ☐ **Non**
PROGRAMATION		
12.	Quelles activités de prévention et de prise en charge de la PE/E sont réalisées par le MSP? Décrivez brièvement ce qui est fait.	
13.	Quelles activités de prévention et de prise en charge de la PE/E sont entreprises par les programmes parrainés par les Etats-Unis ? Décrivez brièvement ce qui est fait.	
14.	Quelles activités de prévention et de prise en charge de l'HPP sont entreprises par d'autres bailleurs ou partenaires? Décrivez brièvement ce qui est fait.	
15.	Quel est le pourcentage de districts couvert par les programmes nationaux actuels de PE/E?	
16.	Quel pourcentage de prestataires qualifiés actuels est atteint par les efforts programmatiques des programmes nationaux actuels sur la PE/E?	(Donnez votre meilleure estimation et tout détail que vous trouvez utile.)
Possibilités d'expansion et de passage à l'échelle		
17.	Veuillez décrire les possibilités que vous envisagez pour l'expansion ou le passage à l'échelle du programme.	(par ex: Champion en place qui a besoin de soutien pour disséminer des messages; conférence nationale prévue pour l'année prochaine et révision prévue des programmes; MSP a une politique en place et a besoin de soutien pour le déploiement du programme)
18.	Quels sont les trois goulots d'étranglement les plus importants empêchant le passage à l'échelle des programmes de traitement de la PE/E dans votre pays? Décrivez brièvement ce qui est fait pour aborder ces problèmes, le cas échéant.	
Personne contact		
19.	Contact qui sera responsable de la mise à jour de cette matrice. Veuillez inclure le nom, numéro de téléphone et l'adresse e-mail.	

Encuesta mundial sobre los programas de pre-eclampsia/eclampsia y hemorragia posparto a nivel nacional

PREGUNTA	RESPUESTA Y OTRA INFORMACIÓN
País	
¿Existe el programa de MCHIP en este país?	☐ Sí ☐ No Si respondió No, dé el nombre de los principales proyectos en salud materna y quién los está implementando.

NOTA: En este cuestionario, el término "asistente de parto capacitado" está siendo usado para describir obstetrices, enfermeras con habilidades obstétricas, proveedores con habilidades obstétricas que no son médicos, médicos generales con habilidades obstétricas, o especialistas en obstetricia.

Sección 1: Hemorragia posparto (HPP)		
Política		
1.	¿El AMTSL[48] está aprobado para cada parto en la política nacional?	☐ Sí ☐ No
2.	¿Las etapas para demonstrar correctamente el AMTSL están integradas en las directrices de la prestación de servicios?	☐ Sí (Por favor, adjunte copia digital de las directrices de la prestación de servicios para la prevención de la HPP) ☐ No
3.	¿El misoprostol aparece en la Lista Nacional de Medicamentos Esenciales, específicamente con una indicación para la prevención y/o tratamiento de la HPP en cualquier nivel del sistema de salud?	☐ **Sí** Si respondió Sí ¿en qué nivel(es) del sistema de salud se puede administrar el medicamento? ☐ **No**
4.	¿Las obstetrices[49] están autorizadas para hacer remoción manual de la placenta en todos los niveles del sistema de salud?	☐ **Sí** ☐ **No**
5.	¿Las obstetrices están autorizadas para hacer AMTSL con oxitocina en todos los niveles del sistema de salud?	☐ **Sí** ☐ **No**

[48] Manejo activo de la tercera etapa del trabajo de parto

[49] El equipo MCHIP aclaró cada instancia de la palabra "obstetrices" con los equipos en los países donde se habla español, para confirmar que entendieron que las preguntas se refieren a una persona que se ajuste a la definición internacional de obstetra y es una "persona cualificada para atender los partos.

6.	¿La oxitocina aparece en la Lista Nacional de Medicamentos Esenciales para la prevención y/o tratamiento de la HPP?	☐ **Sí** Si respondió Sí, ¿en qué nivel(es) del sistema de salud se puede administrar? ☐ **No** Por favor, adjunte copia digital de la sección de la Lista de Medicamentos Esenciales correspondiente a la oxitocina y misoprostol.
Capacitación		
7.	¿El plan de estudios pre-servicio está actualizado con temas sobre el AMTSL para todos los niveles de asistentes de parto capacitados[50]?	☐ **Sí** Si respondió Sí ¿qué niveles? ☐ **No**
8.	¿Los estudiantes son evaluados en sus habilidades para ejecutar AMTSL como calificación clínica antes de graduarse?	☐ **Sí** ☐ **No**
9.	¿El AMTSL se incluye en los planes de estudios de capacitación continua para todos los asistentes de parto capacitados?	☐ **Sí** ☐ **No**
Distribución de misoprostol para la prevención de la HPP en partos domiciliarios		
10.	¿Hay programas piloto sobre el uso de misoprostol para la prevención de la HPP en partos domiciliarios?	☐ **Sí** Si respondió Sí, por favor dé algunos detalles. ☐ **No**
11.	¿El uso de misoprostol para prevenir la HPP durante los partos domiciliarios se ha expandido en escala?	☐ **Sí** Si respondió Sí, por favor dé algunos detalles. ☐ **No**
Logística		
12.	Hay disponibilidad de oxitocina en los establecimientos públicos con servicios de maternidad:	☐ De manera regular ☐ Más de la mitad de las veces ☐ Menos de la mitad de las veces ☐ Nunca
13.	¿Los establecimientos públicos ofrecen oxitocina al público sin cobrar a las pacientes?	☐ **Sí** ☐ **No**

[50] "Asistentes de parto capacitado" o SBA por sus siglas en inglés.

14.	¿Con que frecuencia se agota la oxitocina en los niveles central/regional?	☐ Con frecuencia (una vez cada dos 2 meses o menos) ☐ Algunas veces (cada 3 a 6 meses) ☐ Muy pocas veces (una vez al año)
15.	¿Hay oxitocina disponible actualmente en la farmacia del MINSA[51]?	☐ **Sí** ☐ **No**
16.	Hay disponibilidad de misoprostol en los establecimientos públicos con servicios de maternidad:	☐ De manera regular ☐ Más de la mitad de las veces ☐ Menos de la mitad de las veces ☐ Nunca
Monitoreo y Evaluación		
17.	¿El AMTSL está incluido en el SIGS[52] nacional?	☐ **Sí** Si respondió Sí ¿dónde está documentado? (Ej. Registro de partos, Cuadro de maternidad, otros registros) ☐ **No** Si respondió No ¿existe alguna organización que documenta el AMTSL? ¿Cuál?
Programación		
18.	¿Qué actividades está ejecutando el MINSA para la prevención y manejo de la HPP? Explique brevemente qué se está haciendo.	
19.	¿Qué actividades están ejecutando los programas auspiciados por USAID para la prevención y manejo de la HPP? Explique brevemente qué se está haciendo.	
20.	¿Qué actividades están ejecutando otros donantes y socios para la prevención y manejo de la HPP? Explique brevemente qué se está haciendo.	
21.	¿Qué porcentaje de distritos están cubiertos por los programas nacionales de HPP en la actualidad?	%
22.	¿A qué porcentaje de asistentes de parto capacitados se puede llegar a través de los esfuerzos programáticos de los programas nacionales de HPP en la actualidad?	(Proporcione su mejor estimado posible y algunos detalles que en su opinión sean útiles)

[51] Ministerio de Salud
[52] Sistema Informático de Gestión de la Salud

Oportunidades para la expansión y escala	
23. Por favor, describa toda posible oportunidad que usted vea de expandir o llevar a escala el programa.	(Ej. Hay gestores expertos que necesitan apoyo para diseminar mensajes; conferencia nacional programada para el próximo año y actualización de los planes de estudio; el MINSA cuenta con una política pero necesita apoyo para lanzar el programa)
24. ¿Cuáles son los tres obstáculos más significativos para escalar los programas de reducción de la HPP en su país? Explique brevemente qué se está haciendo para resolverlos, si fuera el caso.	
Persona de contacto	
25. Persona que será responsable de las actualizaciones de este documento. Incluya nombre, número de teléfono y correo electrónico.	

Sección 2: Pre-eclampsia/Eclampsia (PE/E)	
POLÍTICA	
1. ¿Cuáles son los medicamentos de la primera línea de tratamiento que están aprobados a través de la política nacional/directrices de prestación de servicios como antihipertensivos para tratar la pre-eclampsia grave/eclampsia?	Labetalol ☐ Sí ☐ No Hidralazina ☐ Sí ☐ No Nifedipina ☐ Sí ☐ No Metildopa ☐ Sí ☐ No Otro (Por favor, describa)
2. ¿Cuáles son los medicamentos que aparecen como antihipertensivos en la Lista de Medicamentos Esenciales para el manejo de pre-eclampsia grave/eclampsia?	Labetalol ☐ Sí ☐ No Hidralazina ☐ Sí ☐ No Nifedipina ☐ Sí ☐ No Metildopa ☐ Sí ☐ No Otro (Por favor, describa)
3. ¿Cuáles son los medicamentos de la primera línea de tratamiento que están aprobados a través de la política nacional/directrices de prestación de servicios como anticonvulsivos para tratar la pre-eclampsia grave/eclampsia?	Sulfato de magnesio ☐ Sí ☐ No Diazepan ☐ Sí ☐ No Otro (Por favor, describa)
4. ¿El MgSO4[53] aparece en la Lista de Medicamentos Esenciales para pre-eclampsia grave/eclampsia?	Pre-eclampsia ☐ Sí ☐ No Eclampsia ☐ Sí ☐ No **Por favor, adjunte copia digital de las directrices de la prestación de servicios para el manejo de pre-eclampsia grave/eclampsia (PE/E), incluyendo el protocolo para antihipertensivos y administración de sulfato de magnesio.**
5. ¿Las obstetrices están autorizadas a diagnosticar casos de pre-eclampsia grave/ eclampsia y administrar la dosis inicial de sulfato de magnesio en el establecimiento de más bajo nivel donde trabajen dentro del sistema de salud?	☐ Sí ☐ No

[53] Sulfato de magnesio

CAPACITACIÓN		
6.	¿El plan de estudios pre-servicio incluye los principios en uso actualmente a nivel mundial para el manejo de la PE/E para todos los asistentes de parto capacitados?	☐ **Sí** Si respondió Sí ¿qué niveles? ☐ **No**
7.	¿Los principios en uso actualmente a nivel mundial para el manejo de la PE/E están incluidos en los cursos de capacitación continua para los asistentes de parto capacitados?	☐ **Sí** ☐ **No**
LOGÍSTICA		
8.	Hay disponibilidad de sulfato de magnesio en los establecimientos públicos con servicios de maternidad:	☐ De manera regular ☐ Más de la mitad de las veces ☐ Menos de la mitad de las veces ☐ Nunca
9.	¿Con que frecuencia se agota el sulfato de magnesio en los niveles central/regional?	☐ Con frecuencia (una vez cada dos 2 meses o menos) ☐ Algunas veces (cada 3 a 6 meses) ☐ Muy pocas veces (una vez al año)
10.	¿Hay sulfato de magnesio disponible actualmente en la farmacia del MINSA?	☐ **Sí** ☐ **No**
MONITOREO Y EVALUACIÓN		
11.	¿Existe un indicador en el SIGS nacional para monitorear la calidad del manejo de la PE/E?	☐ **Sí** Si respondió Sí ¿cuál es este indicador y dónde está documentado? (Ej. Registro de partos, Cuadro de maternidad, otros registros) ☐ **No**
PROGRAMACIÓN		
12.	¿Qué actividades está ejecutando el MINSA para la prevención y manejo de la PE/E? Explique brevemente qué se está haciendo.	
13.	¿Qué actividades están ejecutando los socios implementadores apoyados por USAID para la prevención y manejo de la PE/E? Explique brevemente qué se está haciendo.	
14.	¿Qué actividades están ejecutando otros donantes y socios para la prevención y manejo de la PE/E? Explique brevemente qué se está haciendo.	
15.	¿Qué porcentaje de distritos están cubiertos por los programas nacionales de PE/E en la actualidad?	

16.	¿A qué porcentaje de asistentes de parto capacitados se puede llegar a través de los esfuerzos programáticos de los programas nacionales de PE/E en la actualidad?	(Proporcione su mejor estimado posible y algunos detalles que en su opinión sean útiles)
OPORTUNIDADES PARA LA INTRODUCCIÓN, EXPANSIÓN Y ESCALA		
17.	Por favor, describa toda posible oportunidad que usted vea de introducir, expandir o llevar a escala el programa.	(Ej. Hay gestores expertos que necesitan apoyo para diseminar mensajes; conferencia nacional programada para el próximo año y actualización de los planes de estudio; el MINSA cuenta con una política pero necesita apoyo para lanzar el programa)
18.	¿Cuáles son los tres obstáculos más significativos para escalar los programas de manejo de la PE/E en su país? Explique brevemente qué se está haciendo para resolverlos, si fuera el caso.	
PERSONA DE CONTACTO		
19.	Persona que será responsable de las actualizaciones de este documento. Incluya nombre, número de teléfono y correo electrónico.	

Appendix 2: Completed Global Surveys of Scale-Up of National PPH and PE/E Programs

AFGHANISTAN

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **Bilateral: USAID-HSSP, JICA** **Multilateral: UNICEF, UNPA, WHO, World Bank, EC** **Implementers: Ministry of Public Health (MoPH), NGOs**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[54] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**No** **Misoprostol is still on the national special medicines list. Advocacy to include the medicines in National Essential Medicines List (EML) is started.**
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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels of health facilities.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[55] cadres?	**Yes** **Medical doctors, Ob/Gyn, midwives.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Initial efficacy study was conducted in 2006. Currently, operations research is being conducted to test implementation of prevention of PPH using misoprostol in real conditions.**

[54] Active management of the third stage of labor
[55] Skilled Birth Attendant

11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**Yes** **It is scaled up as a part of operations research.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[56] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[57]?	**No**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Provision of SBA-assisted delivery services through Basic Package of Health Services (BPHS) in 96% of districts.** **Provision of stewardship for public and professional awareness on prevention of PPH modalities through reproductive health directorate and NGOs.** **Maintenance of up-to-date knowledge and skills among SBAs by provision of BEmONC and CEmONC in-service trainings (directly or through training specialist NGOs).** **Monitoring and evaluation of provision of prevention of PPH activities are being conducted.** **Authorized Health Services Support Project (HSSP) to conduct operational study on effectiveness of misoprostol distribution at community level.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**A pilot project to see feasibility of PPH implementation conducted at community level.** **An expansion project is being conducted to collect further evidence for planning to increase the coverage.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	
21.	What % of districts are covered by current national PPH programs?	**96%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**100%**

[56] Ministry of Health
[57] Health Management Information System

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**96% of the country is covered by BPHS.** **One study was conducted, and the second study is ongoing.** **Included in reproductive health policy and strategy.** **NGOs' interest in implementation of prevention of PPH activities.** **USAID support to implemented activities for prevention of PPH.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Misoprostol is not approved for prevention of PPH at community level by WHO and MoPH; therefore, not included in the EML for this purpose.** **Underutilization of the institutional deliveries and unavailability.** **Security and geographical barriers.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Partamin** **E-mail: partamin@jhpiego.net** **Tel.: 93.799.235.085**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4.	Is MgSO4[58] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**	
Training			
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors, midwives**	

[58] Magnesium Sulfate

7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**No data available.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Provision of SBA-assisted delivery services through BPHS is 96%.** **Provision of MgSO4 in all levels of BPHS.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Supporting BPHS in 13 provinces of Afghanistan.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**WB, EC and other donors support other BPHS projects.**
15.	What % of districts are covered by current PE/E programs?	**N/A**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**N/A**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**HSSP is advocating for conducting (and ready and able to conduct) an operations study on prevention of PE/E using supplementary calcium.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Security barriers, geographical barriers, culture barriers.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Partamin** **E-mail: partamin@jhpiego.net** **Tel.: 93.799.235.085**

ANGOLA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **Strengthening Angolan Systems for Health (SASH) implemented by Jhpiego** **Family planning implemented by Pathfinder** **Cuidados Obstétricos implemented by CUAMM**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[59] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**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** **It is necessary to include it in national guidelines.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[60] cadres?	**Yes** **Yes, only for Midwifery School (Obstetricians); not for other technical cadres.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **Yes, only for Obstetrician School; not for other technical cadres.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Discussions within the National Committee of Public Health for an AVS project to introduce misoprostol at the community level. Approval is pending.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**

[59] Active management of the third stage of labor
[60] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).** **However, it is to be noted that data collection is difficult because the availability of oxytocin is not integrated with the reports of the Maternal Health Program Service Units.**
15.	Is oxytocin currently available at the MOH[61] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.** **The problem derives from the fact that misoprostol is not included in the National Standards. The use of the medication at Service Units, mainly hospitals, depends on staff initiative to use it.**
M&E		
17.	Is AMTSL included in the national HMIS[62]?	**No** **No organization is documenting AMTSL. In 2010, SES advanced a proposal to include an AMTSL indicator, but no data have been collected yet.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Developing standards for emergency obstetric care management.** **Elaborating on a learning package to train technical cadres.** **Creating awareness for staff from service units to comply with the standards to use oxytocin postpartum.** **Developing a pilot to use misoprostol at the community level.** **Elaborating on a proposed standard for use of misoprostol within service units.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**SASH, Pathfinder ASH and Pathfinder are focusing primarily on reproductive health initiatives (family planning). No directive has been issued for maternal health. USAID is committed to securing additional funds to expand SASH work into maternal health services. MCHIP has proposed a centralized fund to encourage an investment in the area of maternal health by the USAID Mission in Angola.** **Other partners of USAID are working mainly in the areas of HIV and malaria.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**CUAMM** **WHO technical assistance for standards development.**

[61] Ministry of Health
[62] Health Management Information System

21.	What % of districts are covered by current national PPH programs?	**There is no national PPH program. The National Maternal Health Program has implemented training activities addressing technical cadres; it is doing its best to secure the provision of oxytocin.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Up to 50% could be reached. The National Program is making its best effort to upgrade the skills of staff in 400 delivery wards nationwide, to train them on the use of PPH management best practices.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**RH/FP Program meeting in September 2012.** **Meeting between PNSR/PF and the Congressional Public Health Committee to discuss the situation of maternal mortality in Angola.** **Provincial and municipal meetings to appoint committees to address maternal mortality prevention efforts, 2012.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**A decision is needed from MOH policymakers.** **The curricula used at nursing schools need to be updated to include PPH management and other obstetric emergency care practices.** **More in-service training programs on PPH management are needed to address the needs of birth attendants.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Ines Leopoldo** **Directora del Programa Nacional de SR/PF** **Tel.: +244 935768623** **E-mail: ines_54@yahoo.com.br**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[63] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **Yes, they are authorized, but this is limited to referral facilities and hospitals.**

[63] Magnesium Sulfate

Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Universities**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**No** **The curricula used in technical schools are not updated.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly** **Available on a regular basis. The difficulty derives from the fact that technical staff lack self-confidence to use MgSO4 and prefer to refer the patient, many times without starting treatment. This increases the risk for the mother due to difficult conditions to access the facilities and lack of sufficient ambulance vehicles.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Updating the national standards.** **Elaborating on new learning packages to train cadres.** **Developing trainings to address the needs of birth attendants.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**No USAID-supported implementing partner is working in this area at this time. SASH and Pathfinder are focusing primarily on reproductive health initiatives (family planning). No directive has been issued for Maternal Health. USAID is committed to securing additional funds to expand SASH work into maternal health services. MCHIP has proposed a centralized fund to encourage an investment in the area of maternal health by the USAID Mission in Angola.** **Other partners of USAID are working mainly in the areas of HIV and malaria.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**None**
15.	What % of districts are covered by current PE/E programs?	**There is no national PE/E program. The National Maternal Health Program has implemented training activities addressing technical cadres, and it is doing its best to secure the provision of MgSO4.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**Up to 40% could be reached. The National Program is making its best effort to upgrade the skills of staff in 400 delivery wards nationwide, to train them on the use of PE/E management best practices.**

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**RH/FP Program meeting in September 2012.** **Meeting between PNSR/PF and the Congressional Public Health Committee to discuss the situation of maternal mortality in Angola, March 2012.** **Province and municipal meetings to appoint committees to address maternal mortality prevention efforts, 2012.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**A decision is needed from MoH policymakers.** **The curricula used at Nursing Schools need to be updated to include PE/E management and other obstetric emergency care practices.** **More in-service training programs on PE/E management are needed to address the needs of birth attendants.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Ines Leopoldo** **Directora del Programa Nacional de SR/PF** **Tel.: +244 935768623** **E-mail: ines_54@yahoo.com.br**

BANGLADESH

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

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Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[64] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **At home deliveries.**
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**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[65] cadres?	**Yes** **Doctors, nurses, Family Welfare Visitors (FWVs), Community Skilled Birth Attendants (CSBAs).**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**Yes**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Less than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**

[64]Active management of the third stage of labor
[65] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Frequently (once in every 2 months or less).**
15.	Is oxytocin currently available at the MOH[66]medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly** **Six districts covered by Mayerhashi and MaMoni.**
M&E		
17.	Is AMTSL included in the national HMIS[67]?	**No** **Mayerhashi**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Policy: AMTSL, oxytocin, misoprostol.** **Training: AMTSL.** **Services: AMTSL at all levels.** **Supply: Oxytocin in all institutions.** **Curriculum: All curricula now include AMTSL.** **Field Implementation: USAID assisted in Mayerhashi and MaMoni areas.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Assistance to MOH for AMTSL and misoprostol introduction for PPH prevention.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**AMTSL, maternal and newborn health (MNH), maternal, newborn and child health (MNCH), MNCS.**
21.	What % of districts are covered by current national PPH programs?	**21 districts for AMTSL, six districts for misoprostol.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**AMTSL in 21 districts, misoprostol six districts, all districts SBA.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**MOH has policy and activities.** **Local-level facilitation by partners.** **FWV recruitment for vacant posts.** **FWC upgrading.** **Champion exists: professional body, active role.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Fewer facility deliveries, lack of skilled manpower, lack of awareness.**

[66] Ministry of Health
[67] Health Management Information System

Contact Person	
25. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Sabbir Ahmed** **E-mail: sabbir.ahamed@savechildren.org** **Tel.: 0088 01730020276** **Dr. Jebun Rahman** **Tel.: 0088 01819248721**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1. What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
2. What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Nifedipine** **Methyldopa**	**Yes** **Yes**
3. What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4. Is MgSO468 on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5. Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**	
Training		
6. Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors, nurses, midwives, FWVs, CSBAs.**	
7. Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**	
Logistics		
8. Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**	
9. How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Frequently (once in every 2 months or less).**	
10. Is MgSO4 currently available at the MOH medical store?	**Yes**	

[68] Magnesium Sulfate

M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Facility-based management of PE/E management in the system.** **Guidelines for management of PE/E available for all SBAs.** **MgSO4 on Essential Medicine List for PE/E management and prevention.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Community-based prevention and management using MgSO4.** **National guidelines development and implementation in one district.** **Assistance for research.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Research by ICDDR,B for community-based PE/E prevention and management by CSBAs using MgSO4.**
15.	What % of districts are covered by current PE/E programs?	**All secondary and tertiary facilities.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**All secondary and tertiary facilities.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Policy and training.** **Services at all facilities.** **Champion exits: professional body.** **OP indicator in HPNSDP.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Regular, uninterrupted logistics and medicine supply.** **Community-based diagnosis of cases and referral to appropriate facility.** **Lack of skilled manpower.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Sabbir Ahmed** **E-mail: sabbir.ahamed@savechildren.org** **Tel.: 0088 01730020276** **Dr. Jebun Rahman** **Tel.: 0088 01819248721**

BOLIVIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[69] at every birth approved as national policy?	Yes National Policy on Maternal and Newborn Health Practices and Technologies, Resolution No. 0496, 2001 (MOH).
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	Yes In December 2011, the MOH issued Resolution No. 240, regulating the provision of comprehensive services across the continuum of health: adolescent pregnancy, childbirth, postpartum, newborn and children under the age of five. Pages 37 and 63 provide a description of the steps for performing AMTSL.
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Misoprostol can be used at all three levels of care, in conformity with Resolution No. 142, MOH (p. 16): Uses of Misoprostol in Obstetric Care, 2009.
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	No As of 2012, nine students are participating in a rotatory internship training program (First Graduating Class–Obstetrics Training Program) with participation of three state universities (Chuquisaca, Tarija and Potosi) and the support of UNFPA. Coordinators: nancymanjon@hotmail.com, Chuquisaca mvargasv@uajms.edu.bo, Tarija Flora Poma Jurado, flora_poma@hotmail.es, Potosi
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	No Bolivia will have its first graduating class by the end of 2012.
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes If Yes, which cadres? All three levels of care.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[70] cadres?	Yes Primary, secondary and tertiary medicine education programs (ob/gyn and pediatrics interns, graduate residents), RN and associates from state universities and technical schools. Discussions with private universities are underway.

[69] Active management of the third stage of labor
[70] Skilled Birth Attendant

8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **It is a requirement for undergraduate students.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **No pilots have been conducted. The doctors and nursing associates attending home deliveries carry the "RED BOX" containing the medicine.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.** **A national study to be published by MOH/USAID found 40% stock-out at visited facilities. Another difficulty results from the medicine cold chain requirement.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **Covered by SUMI (national mother/child insurance plan).**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[71] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.** **Even though it is on the EML and its use is approved for all levels of health care, for municipalities to obtain funds to buy misoprostol for public facilities, first the SUMI system has to elaborate the protocol for use of the medicine at the beneficiary facilities. It is currently available within the private system.**
M&E		
17.	Is AMTSL included in the national HMIS[72]?	**Yes** **AMTSL data are collected through perinatal medical records, and then these can be entered into the National HMIS. The process is regulated by a Resolution of MOH, though not widely used yet.** **MCHIP and UNICEF document through monitoring of standards at the facilities selected by MOH/USSC (Unidad de Servicios de Salud y Calidad).**

[71] Ministry of Health
[72] Health Management Information System

Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**MOH has implemented specific policies to reduce maternal, perinatal and neonatal mortality in Bolivia. The government has established a Strategic Maternal, Perinatal and Newborn Health Plan for 2011–2015. Other social strategies have been launched to increase access to prenatal, birth, postpartum and newborn care, through a social incentive program (Juana Azurduy) that provides financial help to women and their children at different stages. On the other hand, the government is providing national coverage through a national insurance plan (Seguro Universal Materno Infantil or SUMI) offering free access to an array of services to children under the age of five and their mothers, including prenatal care, birth and postpartum care, family planning and assistance to prevent and manage malnutrition (AIEPI-NUT Program). MCHIP and UNICEF support the MOH through the monitoring of standards.** **In 2012, the institution Mesa de Maternidad y Nacimiento Seguros will launch a new strategy to reduce maternal mortality, focusing on four aspects: 1. PPH prevention; 2. Management of complications; 3. PPH monitoring based on national surveillance; 4. Regulations to integrate health education materials with high school programs.** **State-operated TV channels will reach 1,500,000 students every week. Maternal and newborn mortality will become the main focus.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**All 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; the updating of providers according to the national protocols, standards and scientific evidence; and provision of basic equipment for PPH. This activity takes place basically in geographical areas of the new strategy by the FORTALESSA Program.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**UNICEF: Implementation of a strategy to provide short-cycle secondary and tertiary health care services. JICA, GAVI, UNFPA follow MOH standards for the implementation; they are interested in implementing AMTSL standards.**
21.	What % of districts are covered by current national PPH programs?	**100%** **SUMI offers national coverage at all levels of the health care system.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**80%**

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**1. Developing collaboration alliances with the universities.** **2. Supporting MOH education program.** **3. Proposing MOH to allow the use of misoprostol by associate technical nursing staff attending home deliveries under the supervision of FORTALLESA.** **4. Supporting MOH in its efforts to implement blood products management at secondary facilities in rural areas.** **5. Improving management of the cold chain for oxytocin.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Local resources do not have timely access to evidence-based medicine data.** **2. Jurisdiction and administrative barriers to municipalities hinder their efforts to maintain ongoing supply of oxytocin at the public facilities, especially in rural areas.** **3. Community unawareness on PPH warning signs.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Jackeline Reyes Maldonado** **Responsable de Salud Materna, MCHIP Bolivia** **E-mail: jreyes@jhpiego.net** **Tel.: 591-77210980, 591-2-2971458**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **MOH/USS has approached UNIMED (Unidad de Medicamentos) for inclusion of Labetolol on the EML.**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (Please describe)** **The national maternal and newborn service delivery guidelines now include diazepam.**
4.	Is MgSO4[73] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**

[73] Magnesium Sulfate

5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No** **Bolivia will see its first graduating class by the end of 2012, but the curriculum includes this diagnosis and the administration of MgSO4.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **It is part of the curriculum for all training levels.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **MOH is working with UNICEF, SBGO and MCHIP to develop PE/E standards at all levels of health care; also, training efforts have been made since 2011 to train staff.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).** **Sometimes the municipalities face jurisdiction barriers that make it dificult to maintian stocks of MgSO4; the beneficiary public facilities cannot receive resources from SUMI.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes** **In-country manufacturing capacity.**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **The National HMIS includes an epidemiological monitoring component that issues weekly reports about PE/E cases; the perinatal clinic history includes the same indicator.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Implementing standards at all three levels of health care. MOH/PAHO have recently issued Regulation N0. 240, regulating the provision of comprehensive services across the continuum of health: adolescent pregnancy, childbirth, postpartum, newborn and children under the age of five. Page 68 provides a description of PE/E standards. Coordinations are being advanced for inclusion of labetolol on the EML.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**In 2011, MCHIP/UNICEF supported the MOH to develop PE/E standards for primary, secondary and tertiary health care. The new health strategy launched through USAID/FORTALESSA will reinforce the implementation of these standards within new areas.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**All the programs executed by other agencies and NGOs follow the policies of the MOH and help implement and disseminate them according to their respective agreements and areas of intervention.**

15.	What % of districts are covered by current PE/E programs?	**Departmental Health Services (known as SEDES) and health care networks receive 100% support at the national level. However, at the primary care level, there is poor availability/management of antihypertensive medicine.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**As a collaborative effort among all implementing partners: 60%.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Supporting the implementation and rollout of MOH's strategic plan to reduce maternal and neonatal mortality.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Labetolol is not available for tertiary health care.** **2. Hydralazine is not provided, even though it is listed on the EML.** **3. The development of a national PE/E monitoring system is under way, but it needs strong political commitment.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Jackeline Reyes Maldonado** **Responsable de Salud Materna, MCHIP Bolivia** **E-mail: jreyes@jhpiego.net** **Tel.: 591-77210980, 591-2-2971458**

CAMBODIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**No** **USAID: URC, RHAC (Reproductive Health Association of Cambodia), RACHA (Reproductive and Child Health Alliance)**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[74] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **Level CPA2 and CPA3 hospitals.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**Yes** **If trained; normally secondary midwives (MWs).**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**Yes**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Health centers and hospitals.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[75] cadres?	**Yes** **Secondary MWs, which is the only MW category being educated today; also, previously educated primary MWs can do AMTSL.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **It has been decided to not promote or test this, since we have a rapidly rising rate of facility births.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**

[74] Active management of the third stage of labor
[75] Skilled Birth Attendant

CAMBODIA

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[76] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly** **At hospitals, not at health centers.**
M&E		
17.	Is AMTSL included in the national HMIS[77]?	**No** **URC**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**New Safe Motherhood Protocols (SMPs) for health centers (2010) and hospitals (in press, 2012). Separate guidelines on PPH, not fully consistent with new SMPs, recently published. Mentions neither HC, MW nor simple algorithm, unfortunately. Held six "key intervention workshops" with URC, RHAC, RACHA and UNICEF in 2010. PPH topic often part of regional CME.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**As above. URC is now also planning pilot of NASG, in collaboration with national program.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**AMTSL being promoted by all partners.** **Trauma Care has been training on balloon tamponade.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**80–90%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Print and disseminate SMPs for hospitals, see above. This would make it possible to move on, provide job aids, based on the SMPs. Decide if/how to promote misoprostol as a supplement to treat PPH at the hospital level. Adopt either NASG or balloon tamponade, or both as second-line treatment of severe PPH. Consider making metilergometrine available routinely, to supplement oxytocin.**

[76] Ministry of Health
[77] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Uncertainty about use of misoprostol. Two national, separate guidelines are published; and they are not fully consistent. Rejection of balloon tamponade quoting lack of evidence.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jerker Liljestrand** **Tel.: 0855 16 242135** **E-mail: jliljestrand@urc-chs.com**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** Nifedipine No **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[78] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**No**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**

[78] Magnesium Sulfate

9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).** **Since the rollout is recent, it is difficult to say. Rapid uptake of the new regimen caused national-level stock-out, which was resolved after two months.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Training of trainers (TOT) for provincial trainers in 2011. Continued, multipronged efforts to roll out MgSO4.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Strengthen providers' knowledge through midwife quarterly meeting.** **Provide one-on-one coaching for providers, to ensure that pregnant women receive proper care.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**National workshop, training, PE/E posters, job aids, eclampsia kit.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**(Provide your best possible estimate and any details you think would be helpful.)** **90%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**New EmONC training by National Institute being accelerated.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Has not provided training for all health center midwives in the country yet.** **Referral system does not function well yet.** **Awareness of PE/E prevention for women is still limited.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jerker Liljestrand** **Tel.: 0855 16 242135** **E-mail: jliljestrand@urc-chs.com**

DEMOCRATIC REPUBLIC OF CONGO

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**No**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[79] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[80] cadres?	**No**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **74% of assisted deliveries.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Home births are not recommended in the national norms.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**

[79] Active management of the third stage of labor
[80] Skilled Birth Attendant

13.	Is oxytocin free of charge to patients at public health facilities?	**No**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Frequently (once in every 2 months or less).**
15.	Is oxytocin currently available at the MOH[81] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **Available in private pharmacies.**
M&E		
17.	Is AMTSL included in the national HMIS[82]?	**Yes** **Need to standardize the reporting format.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Prevention: this is not really clear, iron folate supplementation, malaria prevention, presumptive treatment of hookworm infection during pregnancy, no systematic episiotomy, AMTSL.** **Treatment: management depending on the cause, uterotonics, uterine massage to treat atony, soft tissue repair in case of tears, manual removal of placenta, placental fragments, transfusion, etc.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**As above**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**As above**
21.	What % of districts are covered by current national PPH programs?	**Data not available. AMTSL training has been done in almost all the health zones (88 health zones covered by the project).**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Data not available.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**MNHI national norms and protocols developed; need support for implementing interventions in various health centers in the country.**

[81] Ministry of Health
[82] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Insufficient resource for scale up.** **Lack of cold chain storage for oxytocin; negotiations with other partners (PARS, FED and others).**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Kalume Tutu** **Tel.: 0999913011** **E-mail: tutukalume@yahoo.fr** **Dr. Marie Louise Mbo** **Tel.: 0815093945** **E-mail: marielouisembo@yahoo.fr** **Dr. Marie Claude Mbuyi** **Tel.: 0817006411** **E-mail: mbuyim@cd.afro.who.int** **Mme. Lucie Zikudieka** **Tel.: 0970007780** **E-mail: lzikudieka@msh.org**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** Nifedipine No **Methyldopa Yes** **Other (Please describe)** **Clonidine**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** Nifedipine No **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (Please describe)** **If lack of MgSO4, diazepam is used.**

4.	Is MgSO4[83] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**No**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Frequently (once in every 2 months or less).** **Sometimes available in private pharmacies.**
10.	Is MgSO4 currently available at the MOH medical store?	**No**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Prevention: BP control, control of proteinuria, check for lower limb swelling, information/recognition of danger signs during pregnancy.** **Treatment: Rapid assessment, administration of antihypertensives/anticonvulsant, obstetric management.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**As above**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**As above**
15.	What % of districts are covered by current PE/E programs?	**Not available**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**(Provide your best possible estimate and any details you think would be helpful.)** **Not available**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**MNHI national norms and protocols developed; need support for implementing interventions in various health centers in the country.**

[83] Magnesium Sulfate

18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**No formal program exists.** **Inconsistencies in supplies of magnesium sulfate. Lack of financial resources to scale up.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Kalume Tutu** **Tel.: 0999913011** **E-mail: tutukalume@yahoo.fr** **Dr. Marie Louise Mbo** **Tel.: 0815093945** **E-mail: marielouisembo@yahoo.fr** **Dr. Marie Claude Mbuyi** **Tel.: 0817006411** **E-mail: mbuyim@cd.afro.who.int** **Mme. Lucie Zikudieka** **Tel.: 0970007780** **E-mail: lzikudieka@msh.org**

ECUADOR

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[84] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **At all levels, from outpatient care to hospital-based care.**
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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **At all levels.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[85] cadres?	**Yes**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**

[84] Active management of the third stage of labor
[85] Skilled Birth Attendant

13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Unknown**
15.	Is oxytocin currently available at the MOH[86] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly**
M&E		
17.	Is AMTSL included in the national HMIS[87]?	**Yes** **National service quality indicators and standards in the monitoring system.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Monitoring the use of oxytocin.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Technical support to the MOH.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Unknown**
21.	What % of districts are covered by current national PPH programs?	**95%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**70%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Developing career profiles of undergraduate and postgraduate students.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Difficulty to monitor the application of standard implementation of protocols.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Patricio Ayabaca** **Tel.: 095029473** **E-mail: payabaca@urc-chs.com**

[86] Ministry of Health
[87] Health Management Information System

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[88] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **All three levels of the health care system.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **PE/E service quality indicators in the monitoring system.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Monitoring the application and implementation of standards.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Technical support**

[88] Magnesium Sulfate

14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	
15.	What % of districts are covered by current PE/E programs?	95%
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	(Provide your best possible estimate and any details you think would be helpful.) 80%
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	Scientific forums with the participation of professional schools and scientific associations; skills update trainings.
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	Non-application or poor application of the standard. Insufficient supervision to monitor the application of the standard. Resistance to use sulfate without an infusion pump.
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	Patricio Ayabaca Tel.: 095029473 E-mail: payabaca@urc-chs.com

EQUATORIAL GUINEA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**No** **1. "Support to reduce maternal and neonatal mortality in the Province of Litoral" – Jhpiego** **2. "Prosalud" Project in the Province of Centro-Sur – Montrose** **3. Strengthening the health care system through primary care - FRS (religious NGO): this initiative reaches almost the entire country through antenatal care (ANC) clinics/medical centers; some of these also provide birth services.**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[89] at every birth approved as national policy?	**Yes**
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	**Yes** **Note: The program is using checklists introduced by Jhpiego in the target Province of Litoral; these are also being used in the Province of Centro-Sur as a result of a healthy relationship established with Prosalud. Jhpiego's work plan for 2012 includes the development of a national guideline to extend the use of AMTSL checklists to all regions in the country (plus other checklists).**
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**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 oxytocin on the National EML for prevention and/or treatment of PPH?	**No** **Not on the National EML (we will have to double-check with the National Direction whether this statement is incorrect); however, it has been integrated with the national guidelines for complications management; it is often available at hospital pharmacies and included in health care protocols.**

[89] Active management of the third stage of labor

Training		
7.	Do pre-service education curricula include AMTSL for all SBA[90] cadres?	**Yes** **Doctors, nurses and assistants.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**No** **There is no in-service training in EG.**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**No** **Although a "public service," patients have to pay for everything.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[91] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[92]?	**No** **Jhpiego**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**The MOH is working in collaboration with Jhpiego to train maternity health care providers in the hospitals in Bata, Mbini and Kogo for PPH management. An additional register has been integrated with these services to monitor the administration of oxytocin within 1–3 minutes of birth (see #20 below).**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**There are no USAID-sponsored programs in EG.**

[90] Skilled Birth Attendant
[91] Ministry of Health
[92] Health Management Information System

20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Jhpiego: Our work in one province includes BEmONC trainings, implementation of checklists, monitoring of quality service delivery and health provider practices, and recollection of data on complications. At a national level, we have proposed national guidelines and norms that have been validated, reviewed and disseminated nationwide.** **Montrose: Introduction of AMTSL checklists (with the support of Jhpiego).**
21.	What % of districts are covered by current national PPH programs?	**16%** **Current health policies should be applied in the entire country; however, we cannot ensure that they are applied in other regions besides Jhpiego's target areas. I can ensure their application only in the three districts targeted by our initiative (out of a total of 18).**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Through the Jhpiego program, 26 health care providers were trained in 2011. (No national data are available for a total number of providers working in the country; we estimate about 180 are working in the hospitals.)**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**The MOH has developed a policy, but needs support for expansion, implementation and monitoring.** **As per its work plan for 2012, Jhpiego will develop a national campaign and one of the activities will be the delivery of trainings on the use of checklists, and their dissemination (including the AMTSL checklist).**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Stock-outs of oxytocin (still a problem).** **Poor training and commitment of human resources.** **Poor supervision.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Almudena González-Vigil** **Tel.: +240 222 275335** **E-mail: agonzalez@jhpiego.net** **Pastora Ndong Micué** **Coordinadora Regional SR** **Tel.: +240 222 278194**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa No**

3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO493 on the National EML for: severe pre-eclampsia?; eclampsia?	Pre-eclampsia No Eclampsia No **Not on National EML (updated by MOH as of June 2010); integrated with emergency care protocols developed last year by Jhpiego, then validated and now undergoing final review for dissemination.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No** **They do diagnose, but they do not administer treatment as this step is a doctor's responsibility. If a doctor is not available, then they administer treatment.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors and midwives.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**No** **UNFPA, Jhpiego and some other supporting organizations developed updates; this is not the case for MINSABS or the National University specifically (there are NO in-service training courses at all).**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No** **The Jhpiego program is making an effort for these data to be collected.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Same as #18 in Section 1 above.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**There are no USAID-sponsored programs in EG.**

[93] Magnesium Sulfate

14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Jhpiego: trainings, supervision, registers.** **Prosalud/Montrose: ANC screening, in the province of Centro-Sur.**
15.	What % of districts are covered by current PE/E programs?	**We can only provide data for our area of intervention: 16%.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**(Provide your best possible estimate and any details you think would be helpful.)** **I wouldn't be able to provide sound data--it has to be very low.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**The MOH has developed a policy but needs support to implement it.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Stock-outs of the necessary medications.** **Poor training and commitment of human resources.** **Poor supervision.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Almudena González-Vigil** **Tel.: +240 222 275335** **E-mail: agonzalez@jhpiego.net** **Pastora Ndong Micué** **Coordinadora Regional SR** **Tel.: +240 222 278194**

EL SALVADOR

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[94] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **Levels 1 and 2.**
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** **If level 1: only if delivery is imminent.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **At all levels.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[95] cadres?	**No**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Misoprostol can be used exclusively at hospitals.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Misoprostol can be used exclusively at hospitals.**

[94] Active management of the third stage of labor
[95] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[96] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly**
M&E		
17.	Is AMTSL included in the national HMIS[97]?	**No** **A database measures this indicator against quality standards; also included in the perinatal information system.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Disseminating the updated standard on PPH management.** **Developing trainings to update skills to manage obstetric complications.** **Monitoring and supervising regional facilitators on the appropriate application of the protocol.** **Assessing medical audit reports on obstetric morbidity and maternal mortality as a result of PPH.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Disseminating the updated standard on PPH management.** **Developing trainings to update skills to manage obstetric complications.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Disseminating the updated standard on PPH management.** **Developing trainings to update skills to manage obstetric complications.** **Establishing alliances in the health sector to address PPH cases.** **Disseminating updated information on PPH management.** **Implementing the IMFC and birth planning and complication readiness strategies to identify warning signs and symptoms of birth complications.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**100%**

[96] Ministry of Health
[97] Health Management Information System

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Developing trainings on obstetric skills to be delivered by regional facilitators at all levels of the health system.** **Disseminating updated information on management of obstetric morbidity at all levels of the health care system.** **Monitoring and assessing compliance with protocols.** **Strengthening the skills of directors to secure a steady supply of equipment and supplies to manage obstetric complications.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Directors lack skills to manage PPH cases: based on medical audit results, create awareness to secure a steady supply of equipment and supplies to address PPH cases.** **Insufficient human resources to implement programs: advocate with key stakeholders to secure human resources.** **Poor coordination between education authorities and the MOH with regard to pre-service curricula: advocate with the corresponding bodies to coordinate with the MOH on the design of the curricula on PPH management.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Sofia Villalta** **Coordinadora del SSR/MINSAL** **Tel.: 22057262** **E-mail: sofiavillaltadelgado@gmail.com**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** Diazepam	**Yes** No
4.	Is MgSO4[98] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No**	

[98] Magnesium Sulfate

EL SALVADOR

Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**No**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No** **A database measures this indicator against quality standards.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Disseminating the updated standard on PE/E management.** **Developing trainings to update skills to manage obstetric complications.** **Monitoring and supervising regional facilitators on the application of the protocol.** **Assessing medical audit reports on obstetric morbidity and maternal mortality.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Disseminating updated information on the PE/E standard.** **Training on updated skills to manage obstetric complications.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Disseminating the updated standard on PE/E management.** **Developing trainings to update skills to manage obstetric complications.** **Establishing alliances in the health sector to address PE/E.** **Disseminating updated information on PE/E management.** **Implementing IMFC and birth planning and complication readiness strategies to identify warning signs and symptoms of birth complications.**
15.	What % of districts are covered by current PE/E programs?	**100%**

16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**(Provide your best possible estimate and any details you think would be helpful.)** **100%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Developing trainings on obstetric skills to be delivered by regional facilitators at all levels in the health system.** **Disseminating updated information on management of obstetric morbidity at all levels of the health care system.** **Monitoring and assessing compliance with health care protocols.** **Strengthening management skills to secure a steady supply of equipment and supplies to manage obstetric complications.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Directors lack skills to manage PE/E cases: based on medical audit results, create awareness to secure a steady supply of equipment and supplies to address PE/E cases.** **Insufficient human resources to implement programs: advocate with key stakeholders to secure human resources.** **Poor coordination between education authorities and the MOH with regard to pre-service curricula: advocate with the corresponding bodies to coordinate with the MOH on the design of the curricula on PE/E management.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Sofia Villalta** **Coordinadora del SSR/MINSAL** **Tel.: 22057262** **E-mail: sofiavillaltadelgado@gmail.com**

ETHIOPIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[99] at every birth approved as national policy?	Yes
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	Yes Attached, pages 48–50 on "Management Protocol on Selected Obstetric Topics, FMOH Ethiopia, 2010."
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Can be administered at all levels (health post, health center, hospital), but oxytocin is the preferred drug at the health center and hospital levels.
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	Yes Included in the recently revised midwifery curricula and scope of work.
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	Yes
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes At health center and hospital. Included in the document "List of essential drugs for Ethiopia."
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[100] cadres?	Yes Clinical nurses, midwives, health officers, medical doctors.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	No Not being uniformly done.
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes Included in the basic and comprehensive EmONC trainings.
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes Piloted for the use of misoprostol at home and health post by Health Extension Workers (HEWs).
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	Yes Scale-up done for provision by HEWs in cases of deliveries at health post or home.

[99] Active management of the third stage of labor
[100] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **Delivery is one of the fee-exempted services at most public health facilities.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[101] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[102] ?	**Yes** **It is recorded in the maternity chart/client's card.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Training on Basic EmONC for mid-level health professionals.** **Training on Comprehensive EmONC for general medical practitioners and health officers.** **Training on clean and safe delivery for HEWs.** **Revision of curriculum to ensure inclusion of important interventions such as AMTSL.** **Guidelines and protocol development.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Training on Basic EmONC for mid-level health professionals.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Training on Basic EmONC for mid-level health professionals.** **Training on Comprehensive EmONC for general medical practitioners and health officers.** **Piloting and scale-up of misoprostol use at community level by HEWs.**
21.	What % of districts are covered by current national PPH programs?	**Approximately 40%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**About 30% of SBAs have been reached.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**The presence of HEWs and Health Development Army in the country is helpful in disseminating messages at the community level.** **The presence of support from partners and enabling national policy.**

[101] Ministry of Health
[102] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Incomplete recording and reporting by health facilities.** **Limited clinical mentoring activity.** **Low institutional delivery rate (10%).** **Knowledge update on the importance of recording, reporting and AMTSL.** **Supportive supervision to increase performance.** **Awareness creation at community level through HEWs and Health Development Army, so as to increase institutional delivery.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Nega Tesfaw** **E-mail: nwassie@jhpiego.et** **Tel.: 251911407203**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[103] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **Attached:** **1. Page 27 of "List of essential drugs for Ethiopia."** **2. Page 183-186 of "Management Protocol on Selected Obstetric Topics, FMOH Ethiopia, 2010."** **3. MgSO4 Protocol for Management of PE/E.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Included in the recently revised curricula.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **Included in EmONC training packages.**

[103] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.** **It is available in hospitals but not yet in health centers. Scale-up to health centers is a planned activity for 2012.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes** **It is available at store of PFSA (Pharmaceutical Fund and Supply Agency), which is under the Federal Ministry of Health (FMOH).**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **In the antenatal care (ANC) register: diastolic blood pressure 90 mm Hg or more at booking.** **In the delivery register and client card: eclampsia.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Advocacy.** **Creation of enabling policy and development of MgSO4 implementation manual.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**BEmONC trainings**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Provision of MgSO4.** **Mentoring.** **Development of implementation manual and protocol on use of MgSO4 for PE/E.**
15.	What % of districts are covered by current PE/E programs?	**About 80% of hospitals in the country have been covered during the MgSO4 program.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**About 20% of SBAs working at hospitals have been trained on use of MgSO4 for PE/E.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**The presence of HEWs and Health Development Army in the country is helpful in disseminating messages at the community level.** **The presence of support from partners and enabling national policy.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Trained staff turnover.** **Resistance by few providers in using MgSO4 for PE/E.** **Training of more SBAs and scale-up to health centers are upcoming planned activities.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Nega Tesfaw** **E-mail: nwassie@jhpiego.et** **Tel.: 251911407203**

GHANA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[104] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **For all levels by midwives and doctors, according to service protocols and guidelines. Community-level use being tested.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**Yes** **If trained.**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**Yes**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels by doctors, midwives and nurses.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[105] cadres?	**Yes** **Doctors, midwives, medical assistants.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **It is one of them.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Provided to pregnant women in cases of home births, with support from Ventures Strategies Innovation (VSI) and Millennium Villages Project in selected districts.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Not yet. Pilot has recently been completed.**

[104] Active management of the third stage of labor
[105] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **It is absorbed by National Health Insurance under the Free Maternal Health Policy.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[106] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly**
M&E		
17.	Is AMTSL included in the national HMIS[107]?	**Yes** **Assumed that all skilled deliveries use AMTSL in delivery logs.** Are any organizations collecting data on AMTSL? **Teaching hospitals involved in AMTSL project attempt to measure all components.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Healthy timing and spacing is practiced (family planning).** **Skilled attendance at delivery (AMTSL is compulsory at every birth).** **EmONC is available but with less coverage.** **Oxytocin is procured and stored at every facility that does delivery.** **All the above is included in the curriculum of medical and midwifery schools.** **Training, development of policies and guidelines, M&E, research.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**USAID sponsors all the above activities, but is not currently involved in the misoprostol pilot programs.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**They all support the national program in various ways, e.g., VSI has supported the misoprostol pilot, Millennium Villages Project.**
21.	What % of districts are covered by current national PPH programs?	**80%** **In principle, every facility and district is part of the national effort to prevent and reduce PPH according to National Service Protocols. However, coverage of skilled delivery is not universal in about 59% of births and can be used as proxy. A smaller proportion of districts are involved in the community pilot programs for oxytocin and misoprostol use.**

[106] Ministry of Health
[107] Health Management Information System

22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**50%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**MDG Accelerated Framework for MDG5 (MAF) work plan and implementation of recommendations of EmONC Assessment in improving skills, supplies, infrastructure, etc. Improved advocacy, resource mobilization and improvement of funding.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Inadequate skills training, monitoring and supervision.** **Staff shortages and inequitable distribution.** **Funding.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Gloria Quansah Asare** **E-mail: gloasare1@yahoo.com** **Tel.: 233 244281732**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[108] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **Scanned pages 16–21 of National Safe Motherhood Service Protocols (Dec. 2008).**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **Every level of health care has what it can do and drugs to use.**

[108] Magnesium Sulfate

Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Midwives and doctors.** **The curriculum includes PE/E, but as the policies and guidelines change, the outline for teaching is not regularly revised. Many midwifery schools do not have the requisite books and reference materials. Majority of tutors do not have the skills to teach.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **Majority of service providers have not had refresher courses.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**BEmONC in-service training and service delivery (antenatal care, skilled delivery, postnatal care, family planning).** **BEmONC is included in curricula of midwifery schools (pre-service training).** **Requisite drugs are procured and stored well for use.** **Monitoring, supervision and evaluation.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Sponsors and supports National Program including advocacy, IEC, BCC, reproductive health, and commodity security, including logistics management.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Revision of policy and guidelines.** **Training.** **Development and provision of job aids.**
15.	What % of districts are covered by current PE/E programs?	**70%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**50%**

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Implementation of MDG5 (MAF) work plan and recommendations of EmONC Assessment in improving skills, supplies, infrastructure, etc. Improved advocacy, resource mobilization and funding.** **Maintain high-quality implementation at all levels.** **Strengthen supportive supervision.** **Strengthen logistics and supply of MgSO4.** **Include indicators in District Health Information Management System.** **Operations research on quality of implementation and coverage.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Inadequate dissemination and use of service protocols/ job aids.** **Inadequate supply and use of MgSO4.** **Inadequate funding.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Gloria Quansah Asare** **E-mail: gloasare@yahoo.com** **Tel.: 233 244281732**

GUATEMALA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **URC/Health Care Improvement (HCI), Save the Children, UNDP, PAHO, Alerta Internacional, UNFPA, World Bank**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[109] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**No**
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?	**No** **There are no obstetricians in Guatemala. Only nurses.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[110] cadres?	**No** **Yes, for medical training programs/schools. No, for nurses.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**No**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**

[109] Active management of the third stage of labor
[110] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[111] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[112]?	**No** **URC/HCI, World Bank Health and Nutrition Program.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Integration with the national guidelines.** **The reproductive health program has trained 10/29 areas on reproductive health skills.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**With regard to PPH prevention, Save the Children is training community health workers and midwives to refer women to health care facilities for prenatal care; they are also being trained to refer postpartum emergencies. These activities are being performed only within one of the 22 geographical departments in Guatemala.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**HCI trained providers in 9/29 areas.** **HCI has piloted efforts at a hospital in San Marcos Código Rojo and Hora Dorada. The activities are being expanded to other facilities.**
21.	What % of districts are covered by current national PPH programs?	**66%** **National program and URC/HCI.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**100%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**The SR National Program and its team of facilitators could reach national scale. Financing and planning are needed.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Financing.** **Staff negative attitude.** **High staff turnover ratios.** **Most childbirths are still occurring in the community (home deliveries).**

[111] Ministry of Health
[112] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Carlos León** **E-mail: cleon@urc-chs.com** **Tel.: (502) 5550-6878**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Magnesium Sulfate**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa No** **Other (Please describe)** **Magnesium Sulfate**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[113] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No** **There are no obstetricians in Guatemala.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Medical staff**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **Very recently (2011).**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**

[113] Magnesium Sulfate

9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Integration with delivery guidelines, including PE/E management and training.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**URC/HCI monitors the quality of PE/E management, provides indicators and supports MOH to update guidelines.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	
15.	What % of districts are covered by current PE/E programs?	**66%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**(Provide your best possible estimate and any details you think would be helpful.)** **66%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**The SR National Program and its team of facilitators could reach national scale.** **Financing and planning are needed.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Financing.** **Staff negative attitude.** **High staff turnover ratios.** **Most childbirths are still occurring in the community (home deliveries).**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Carlos León** **E-mail: cleon@urc-chs.com** **Tel.: (502) 5550-6878** **Berta Taracena** **E-mail: btaracena@savechildren.org** **Tel.: (502) 2222-4444**

GUINEA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[114] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Hospitals (national, regional, prefecture), community medical centers and health centers (urban and rural).**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[115] cadres?	**Yes** **General practitioners, specialists, midwives, nurses.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Planned for 2012. The process of elaboration of the protocol is under way.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**

[114] Active management of the third stage of labor
[115] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.** **Available since the introduction of free delivery. Difficulty lies in restocking sites.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).** **Stock-outs are more frequent since the introduction of free delivery, as explained under question #12.**
15.	Is oxytocin currently available at the MOH[116] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **Misoprostol not yet available for the prevention of PPH.**
M&E		
17.	Is AMTSL included in the national HMIS[117]?	**No** **MCHIP Guinea: Data are collected in the patients' individual cards and logbooks. Indicators required by MCHIP are: Number and percentage of women giving birth who have benefited from AMTSL; number of sites with stock-out.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Development and dissemination of norms and protocols for diagnosis and management.** **Training of providers.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Technical support for the development of norms and protocols.** **Training of providers, post-training follow-up. Implementation of performance standards for PPH prevention and management.** **Data collection and analysis (number and percentage of women giving birth who have benefited from AMTSL).**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Technical support for the development of norms and protocols.** **Training of providers.** **Supplies in material and essential medicine. Implementation of performance standards for PPH prevention and management in collaboration with MCHIP (UNFPA, EngenderHealth, World Bank).**
21.	What % of districts are covered by current national PPH programs?	**70%** **About 70% of district hospitals. For health centers, the information is not available with precision.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**100% of qualified providers, in the districts where the program is implemented.**

[116] Ministry of Health
[117] Health Management Information System

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**In its road map, the MOH has planned to complete the dissemination of norms and protocols, expand the SBM-R coverage, provide in-service training for providers, and make essential medicine, consumables and material available. To roll out this program, the MOH needs to be supported financially and technically. The integration of reproductive health indicators with the HMIS is also one of the perspectives of the MOH.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Low availability of essential medicine. Inadequate financing for in-service training of providers.** **Inadequate follow-up and supervision.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Mamady Kourouma, Directeur National de la Santé Familiale et de la Nutrition, MSHP** **(National Director for Family Health and Nutrition, MOH)** **E-mail: mamadykourouma@yahoo.fr** **Tel.: 224 67 50 69 63/ 224 64 39 58 97** **Dr. Bokar Dem, CTSBM-R, MCHIP** **E-mail: bdem@jhpiego.net** **Tel.: 224 67 54 81 14**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Yes** **Hydralazine** **Yes** **Nifedipine** **Yes** Methyldopa No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine** **Yes** **Nifedipine** **Yes** Methyldopa No **Other (Please explain)** **Clonidine**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Yes** **Diazepam** **Yes**
4.	Is MgSO4[118] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Yes** **Eclampsia** **Yes** **Please attach a scanned copy of the service delivery guidelines for the treatment of severe PE/E, including protocols for antihypertensive drug and administration of MgSO4.**

[118] Magnesium Sulfate

5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	Yes
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	Yes If Yes, which cadres? General practitioners, specialists, midwives, nurses.
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	Yes
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	More than half the time.
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	Sometimes (every 3 to 6 months).
10.	Is MgSO4 currently available at the MOH medical store?	Yes
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	Yes Number of cases of eclampsia recorded in the logbooks and monthly reports under complications of pregnancy and childbirth.
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	Elaboration and dissemination of norms and protocols for diagnostic and management. Training of providers.
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	Training of providers. Follow-up post-training. Implementation of performance standards for management of PE/E. Data collection and analysis (percentage of cases of PE/E treated with MgSO4).
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	Training of providers through Safe Motherhood program (UNFPA, World Bank). Supply of material and essential medicine.
15.	What % of districts are covered by current PE/E programs?	About 50% of district hospitals and very few health centers (unknown percentage). Data not available at the central level.
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	(Provide your best possible estimate and any details you think would be helpful.) It is difficult to specify the percentage. However, the providers working in the health structures where SBM-R is practiced are trained.

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**In its road map, the MOH is planning to disseminate the norms and protocols, institutionalize SBM-R, ensure in-service training of providers, and make essential medicine and materials available. To roll out this program, the MOH needs technical and financial support.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Low availability of essential medicine.** **Inadequate financing for in-service training of providers.** **Inadequate follow-up and supervision.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Mamady Kourouma, Directeur National de la Santé Familiale et de la Nutrition, MSHP** **(National Director for Family Health and Nutrition, MOH)** **E-mail: mamadykourouma@yahoo.fr** **Tel.: 224 67 50 69 63/ 224 64 39 58 97** **Dr. Bokar Dem, CTSBM-R, MCHIP** **E-mail: bdem@jhpiego.net** **Tel.: 224 67 54 81 14**

HONDURAS

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **Social Security (SS) develops the strategy with support from agencies for no particular project.**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[119] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **Hospital and Maternal and Child Health Clinic (CMI).**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**No** **There are no obstetric cadres, per se, in Honduras. The procedure is performed by CMI skilled attendants.**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**Yes**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Hospital and CMI.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[120] cadres?	**Yes** **Pre-service and in-service.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**

[119] Active management of the third stage of labor
[120] Skilled Birth Attendant

13.	Is oxytocin free of charge to patients at public health facilities?	**No**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[121] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[122]?	**Yes** **Antenatal care (ANC) clinical records.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Training on Maternal and Newborn Care Service Guidelines.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Provided support to training program activities.** **Helped update guidelines with latest evidence-based practices.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Provided support to training program activities.** **Helped update guidelines with latest evidence-based practices.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**60%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**We need funding for in service training.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Lack of a reliable and ongoing blood source; this matter has not been resolved because the Red Cross is the designated provider appointed by the SS.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Ivo Flores Flores** **E-mail: floresfloresivo@yahoo.com** **Tel.: 504 22221257**

[121] Ministry of Health
[122] Health Management Information System

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Yes** **Hydralazine** **Yes** **Nifedipine** **Yes** Methyldopa No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol** **Yes** **Hydralazine** **Yes** **Nifedipine** **Yes** Methyldopa No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Yes** Diazepam No
4.	Is MgSO4[123] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Yes** **Eclampsia** **Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Referred patients must have the first doses of MgSO4.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Pre-service and in-service.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Balance score card for hospital reorganization.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**In-service training on updated guidelines.**

[123] Magnesium Sulfate

13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**In-service training on updated guidelines.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**In-service training on updated guidelines.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**60%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Funding is needed.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Early screening and treatment.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Ivo Flores Flores** **E-mail: floresfloresivo@yahoo.com** **Tel.: 504 22221257**

INDIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[124] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Injection oxytocin is the drug of choice for all the health facilities (including sub-centers) and for outreach. It is tablet misoprostol. Misoprostol can be used at any level of facility as a second-line treatment of PPH and also as a substitute when oxytocin is not available.
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 At all levels of health facilities.
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes Health sub-center and above.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[125] cadres?	Yes MBBS doctors, staff nurses, Auxiliary Nurse Midwives (ANMs), Lady Health Visitors.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes Inconsistent and variable assessments throughout the country in pre-service education of doctors and paramedics.
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No ANMs/SBAs can administer misoprostol while conducting home deliveries.

[124] Active management of the third stage of labor
[125] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly** **Facilities are authorized to do local purchase in cases of stock-outs.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[126] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly**
M&E		
17.	Is AMTSL included in the national HMIS[127]?	**No** **Use of uterotonics is noted in the delivery case sheets.** What are the organizations collecting data on AMTSL? **MCHIP, Jhpiego (other programs).**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Policy/guidelines/training materials are in place, present in EML.** **SBA trainings ongoing; job aids.** **Setting up blood banks at FRUs.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Training for AMTSL.** **Strengthening SBA training.** **Strengthening intrapartum care at targeted facilities.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Support for strengthening of SBA training being provided by agencies including UNICEF, WHO, DfID, UNFPA.**
21.	What % of districts are covered by current national PPH programs?	**100%** **There is no specific PPH prevention program. It is a part of SBA guidelines and SBA training, which is implemented throughout the country by the Government of India.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Data on coverage of SBA trainings not available. 76% of deliveries are being conducted by SBAs (CES 2009).**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Strengthening prevention and management of PPH component of SBA trainings.** **Post-training follow-up for ensuring TOL. Supportive supervision for intrapartum care. Strengthening SBA practices at medical colleges and nursing schools.**

[126] Ministry of Health
[127] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Inconsistent quality of in-service and pre-service training. Inadequate supportive supervision/post-training follow-up at clinical sites.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**skumar@jhpiego.net**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No **Other (Please describe)** **Hydralazine is the drug of choice (DOC). Nifedipine is to be given only if hydralazine is not available.**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Hydralazine is missing in some of the procurement lists due to procurement issues.**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (Please describe)** **MgSO4 is DOC; diazepam when MgSO4 not present/ convulsions not controlled.**
4.	Is MgSO4[128] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **Approved for severe PE/E.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **ANMs, staff nurses (pre-service education, SBA guidelines), doctors (BEmONC/CEmONC).**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**

[128] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly** **Facilities are empowered for local purchase in cases of stock-outs.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Number of PE/E cases managed" is a part of HMIS, noted in the delivery case sheets.** **Indicator no. 1.6.1 and 1.6.2 of NRHM HMIS; these are, however, not used consistently.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**No separate activity. It is a part of the national SBA and BEmONC, CEmONC training.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Support for SBA training: MCHIP, Vistaar (IH) in form of technical assistance.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Support for strengthening SBA training being provided by agencies such as UNICEF, WHO, DfID, UNFPA.**
15.	What % of districts are covered by current PE/E programs?	**There is no specific PE/E program. It is a part of SBA and BEmONC/CEmONC guidelines and training, which are implemented throughout the country.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**Data on coverage of SBA trainings not available. 76% of deliveries are being conducted by SBAs (CES 2009).**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Strengthening of PE/E component of SBA training. Refresher trainings for prevention and management of PE/E.** **Post-training follow-up for ensuring TOL. Supportive supervision for antenatal, intrapartum and postpartum care.** **Strengthening SBA practices at medical colleges and nursing schools.** **Review adequate availability of supply chain system for MgSO4.** **Introduction of job aids/tools to identify correct timing and dosage for administration of MgSO4.**

18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Inconsistent quality of in-service and pre-service training.** **Inadequate supportive supervision at clinical sites.** **Competencies of different cadres for prevention and management of PE/E to be reviewed, and strengthening supplies of MgSO4 to be ensured at all facilities providing delivery services.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**skumar@jhpiego.net**

INDONESIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[129] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	No Off label
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	No Midwives are permitted to do so when no medical doctors are present.
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	Yes Permenkes No. 1464 (2010).
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes All levels of health facility. Will include from DOEN list.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[130] cadres?	Yes Midwives, midwifery/medical students/faculty of nursing.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes On models
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes Normal delivery care training (APN).
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes A SAFE study was conducted in Bandung and Subang Districts (West Java) in 2002, but it was not considered to be a pilot test. Home-based distribution was continued by UNICEF in NTT Province and Papua through 2007. Discontinued after a failure to register misoprostol for obstetric indications.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No Discontinued after a failure to register misoprostol for obstetric indications.

[129] Active management of the third stage of labor
[130] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **Optional/included in the package.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).** **Always available**
15.	Is oxytocin currently available at the MOH[131] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**More than half the time.** **This is NOT official policy. It is used for labor induction by doctors and private midwives.**
M&E		
17.	Is AMTSL included in the national HMIS[132]?	**Yes** **Partograph and LAMAT.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Provide guidelines (normal delivery care/BEmONC/ CEmONC).**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Clinical training, inclusion in SBM-R standards.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Donors working in maternal and child health (MCH) are all doing something related to PPH.**
21.	What % of districts are covered by current national PPH programs?	**100%** **Based on the national policy.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Around 20%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**AMTSL has been scaled up nationally through in-service and pre-service education and by ensuring that all steps are conducted on a routine basis. Oxytocin use is nearly universal in Indonesia, but some providers are still waiting for signs of separation before doing CCT.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Geography, culture, education and transportation (accessibility).**

[131] Ministry of Health
[132] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Anne Hyre** **Country Director** **E-mail: ahyre@jhpiego.net**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No Hydralazine No **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Nicardipine**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No Hydralazine No **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[133] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **The guidelines/protocols from hospital.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **As initial loading for referral.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Medical students, midwifery education, faculty of nursing.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly** **Antidote calcium gluconate.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**

[133] Magnesium Sulfate

M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **In the local area monitoring and tracking.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**In the national policy (BPCR, mothers' classes, Partnership Midwife-TBA, focused ANC, BEmONC, CEmONC training).**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**BPCR, mothers' classes, Partnership midwife-TBA, focused ANC, BEmONC, CEmONC training.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Same as above.**
15.	What % of districts are covered by current PE/E programs?	**100%** **There is no specific program for PE/E but it is included in the BEmONC/CEmONC training.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**Perhaps 20%, but the drugs are not always available.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**PE/E has been scaled up nationally through the BEmONC/CEmONC and pre-service education. MgSO4 is already in the national policy and has been used in some districts in Indonesia.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Lack of skills for early detection.** **Lack of knowledge and skills to use MgSO4; its use depends on the OB/GYNs acceptance of it.** **Disparity of PE/E prevalence area.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Anne Hyre** **Country Director** **E-mail: ahyre@jhpiego.net** **Wita Sari** **Chief of Party, MCHIP Indonesia** **E-mail: wsari@jhpiego.net** **Mobile: 620811967225** **Dr. Wibowo Noroyono** **SpOG (K)/POGI**

KENYA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[134] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** If Yes, at which level(s) of the health system can the drug be administered? **Not defined.** **Not yet in the national policy for PPH prevention and management.**
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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[135] cadres?	**Yes** **Nurses, doctors, clinical officers.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Kenya Obstetrical and Gynecological Society has piloted this with support from Venture Strategies Innovation (VSI).**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Not yet in policy. Discussions ongoing.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**

[134] Active management of the third stage of labor
[135] Skilled Birth Attendant

13.	Is oxytocin free of charge to patients at public health facilities?	**No** **Oxytocin is part of the delivery package. Delivery is charged as a package in hospitals, but is free in health centers and dispensaries. It is, therefore, difficult to ascertain if oxytocin itself is charged for.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[136] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **However, in the sites where it was piloted, it was available from VSI. Misoprostol is not being procured within MOH systems.**
M&E		
17.	Is AMTSL included in the national HMIS[137]?	**Yes** **Maternity register, partograph, clinical notes.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Policy formulation.** **Guideline development and dissemination. Health worker training, both pre-service and in-service.** **Commodity procurement and distribution.** **Infrastructure expansion.** **Increasing access to skilled care through other funding mechanisms, e.g., OBA and NHIF. Community midwifery, supportive supervision and mentorship.** **Increasing community awareness on danger signs and importance of SBA.** **Operations research.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Policy formulation and development/review of guidelines.** **Training of health service providers. Implementing community MNH.** **Supportive supervision and mentorship. Expanding rollout of community midwifery. Monitoring and evaluation.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Policy formulation and guideline development and dissemination.** **Health worker training, both pre-service and in-service.** **Commodity procurement and distribution. Infrastructure expansion.** **Increasing access through other funding mechanisms, e.g., OBA.** **Strengthening referral systems.** **Community midwifery, supportive supervision and mentorship.** **Increasing community awareness on danger signs and importance of SBA.** **Operations research.**

[136] Ministry of Health
[137] Health Management Information System

21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**About 80%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Blood transfusion: a key element in management of PPH is currently centralized. There is need for decentralization of blood transfusion services to ensure availability of blood as and when needed.** **Although the road networks and transport systems are undergoing some renovation, there is need for improvement of referral system to reduce the second and third delay.** **Only 43% of women deliver under SBA; hence, the need to increase SBA rate.** **Basic infrastructure exists but needs strengthening, especially in hard-to-reach areas. Although PPH management is part of pre-service and in-service training, there is still a need for enhancing health worker knowledge and skills for better outcomes.** **There is also need for increased numbers, improved deployment and motivation of existing health workers.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Inadequate SBAs: numbers, distribution and skills.** **Low proportion of skilled deliveries.** **Deficient infrastructure and supplies.** **What is being done:** **More nurses being employed and deployed.** **PPH management is part of pre-service and in-service curricula.** **Some infrastructure development is ongoing through the government's Economic Stimulus Programme (ESP).**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Nancy A. Kidula** **E-mail: nkidula@jhpiego.net**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** Methyldopa	**Yes** **Yes** **Yes** No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol **Hydralazine** Nifedipine **Methyldopa**	No **Yes** No **Yes**

3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (Please describe)** **Use diazepam if MgSO4 is not available.**
4.	Is MgSO4[138] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **However, actual utilization is low due to low competencies and low confidence of health workers.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Nurses, clinical officers, doctors.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Maternity register, MOH summary tools.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Policy formulation and guideline development and dissemination.** **Health worker training, both pre-service and in-service.** **Commodity procurement and distribution. Infrastructure expansion.** **Increasing access to skilled care through alternative funding approaches, e.g., OBA. Promotion of early initiation of antenatal care (ANC) and adherence to schedule.** **Supportive supervision and mentorship. Initiation of maternal death audits at facility and community levels.** **Increasing community awareness of danger signs.** **Strengthening referral systems.**

[138] Magnesium Sulfate

13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Policy formulation and guideline development and dissemination.** **Health provider training.** **Supportive supervision** **Community MNH activities.** **Advocacy and community mobilization.** **Maternal death audits.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Policy formulation and guideline development and dissemination.** **Health worker training, both pre-service and in-service.** **Commodity procurement and distribution.** **Infrastructure expansion.** **Increasing access to skilled care through alternative funding approaches, e.g., OBA. Promotion of early initiation of ANC and adherence to schedule.** **Supportive supervision and mentorship. Initiation of maternal death audits at facility and community levels.** **Increasing community awareness of danger signs.** **Strengthening referral systems.** **Advocacy and resource mobilization for maternal and newborn health.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**About 50%, no accurate data available.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Although 92% of clients attend ANC once, only 56% attend four ANC visits. Support for community mobilization for early ANC attendance, as well as attending four ANC visits, is needed.** **Although the road networks and transport systems are undergoing some renovation, there is need for improvement of referral system to reduce the second and third delay.** **Only 43% of women deliver under SBA, hence the need to increase SBA rate. Basic infrastructure exists but needs strengthening, especially in hard-to-reach areas.** **Although PE/E management is part of pre-service and in-service training, most health providers are unable to detail the features of severe PE/E and are also reluctant to use MgSO4, as they fear the potential side effects. There is still a need for enhancing health worker knowledge and skills for better utilization.** **There is also need for increased numbers, improved deployment and motivation of existing health workers.** **Many health facilities lack basic equipment to support timely diagnosis and management of PE/E, e.g., blood pressure machines, urinalysis sticks, etc. Support is needed to avail these basic equipment and supplies to facilitate timely diagnosis and management.** **Danger signs of eclampsia are easily confused with other ailments, e.g., cerebral malaria, epilepsy, etc. There is a need for increased community awareness on danger signs of PE/E and skills in emergency preparedness.**

18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Low fourth ANC visit and SBA.** **Lack of knowledge and skills on diagnosis and management of PE/E.** **Inadequate supplies and equipment, e.g., blood pressure machines.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Nancy A. Kidula** **E-mail: nkidula@jhpiego.net**

LIBERIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[139] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **From community level.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**Yes** **Not traditional midwives.**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**Yes** **Not traditional midwives.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** If Yes, at which level(s) of the health system can the drug be administered? **The health facility level.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[140] cadres?	**Yes**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Will be started this quarter.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Less than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**

[139] Active management of the third stage of labor
[140] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[141] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[142]?	**Yes** **Delivery logs, maternity chart.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**1. AMTSL.** **2. BCC/IEC on dangers signs.** **3. Bimanual compression, BLSS.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**1. AMTSL** **2. BCC/IEC on dangers signs.** **3. Bimanual compression, BLSS.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**1. AMTSL.** **2. BCC/IEC on dangers signs.** **3. Bimanual compression, BLSS.**
21.	What % of districts are covered by current national PPH programs?	**100%** **Not 100% in each district.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**40%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**PPH prevention with misoprostol at community level begins this quarter.** **In the process of nominating maternal and newborn health (MNH) champions.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Inadequately qualified health workers.** **2. No dedicated budget line for MNH including PPH.** **3. Underdeveloped road network.** **Being done: MNH is highlighted in the Essential Package of Health Services; free education for SBAs; establishing maternity waiting homes and Service Delivery Points (SDPs).**

[141] Ministry of Health
[142] Health Management Information System

Contact Person	
25. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Saye Baawo** **Tel.: + (231) 886 512 984** **E-mail: sdbaawo@gmail.com** **Bentoe Z. Tehoungue** **Tel.: + (231) 886 552 987** **E-mail: mbentoecat@yahoo.com** **Marion Subah** **Tel.: +(231) 777 870 090** **E-mail: msubah@jhpiego.net**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1. What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa** **Other (Please describe)**	**Yes** **Yes** **Yes** **Yes** **Methyldopa is mostly used.**
2. What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
3. What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4. Is MgSO4[143] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5. Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**	
Training		
6. Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes**	
7. Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**	
Logistics		
8. Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.**	

[143] Magnesium Sulfate

9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Number of patients with severe PE/E is recorded in delivery logs, registers and maternity charts.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**1. BCC/IEC.** **2. Screening in antenatal care (ANC) and immediate postnatal care.** **3. In-service and pre-service education.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**1. BCC/IEC.** **2. Screening in ANC and immediate postnatal care.** **3. In-service and pre-service education.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**1. BCC/IEC.** **2. Screening in ANC and immediate postnatal care.** **3. In-service and pre-service education.**
15.	What % of districts are covered by current PE/E programs?	**100%, but not 100% of facilities in each district.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**40%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**PPH prevention with misoprostol at community level begins this quarter.** **In the process of nominating MNH champions.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Inadequately qualified health workers.** **2. No dedicated budget line for MNH including PPH.** **3. Underdeveloped road network.** **Being done: MNH is highlighted in the Essential Package of Health Services; free education for SBAs; establishing maternity waiting homes and Service Delivery Points (SDPs).**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Saye Baawo** **Tel.: + (231) 886 512 984** **E-mail: sdbaawo@gmail.com** **Bentoe Z. Tehoungue** **Tel.: + (231) 886 552 987** **E-mail: mbentoecat@yahoo.com** **Marion Subah** **Tel.: +(231) 777 870 090** **E-mail: msubah@jhpiego.net**

MADAGASCAR

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[144] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[145] cadres?	For future nurses and midwives.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes It is part of it, but there isn't a special grade for this.
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Available 50% of the time.
13.	Is oxytocin free of charge to patients at public health facilities?	Yes In six out of 22 regions, if there are no stock-outs.
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	Rarely (once a year).

[144] Active management of the third stage of labor
[145] Skilled Birth Attendant

15.	Is oxytocin currently available at the MOH[146] medical store?	Yes
16.	Is misoprostol available at public facilities that offer maternity services?	Never
M&E		
17.	Is AMTSL included in the national HMIS[147]?	No MCHIP
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	The MOH promotes: family planning, delivery at health facilities with trained providers, distribution of iron/folic acid, deworming of pregnant women, IPTp, use of long-lasting insecticide nets (LLINs), awareness of danger signs, training of providers in management of PPH, training of community health workers on the danger signs and setting up a reference system for emergency, making oxytocin available with the individual delivery kit, generalized use of AMTSL, tools/job aids for community awareness, availability of management protocol with algorithm, practice of death audit.
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	Distribution of iron/folic acid and LLIN at community level. Training of community health workers for danger signs and referral. Awareness (antenatal care and delivery at health center). Family planning. Training of providers and community health workers on PPH prevention and management.
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	Family planning. Training in PPH prevention and management. Pilot study of misoprostol at primary-level health centers for prevention and management of PPH.
21.	What % of districts are covered by current national PPH programs?	There is no specific program for PPH, but prevention and management is part of the program activities of Safe Motherhood (100% of districts, or 112).
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	30%
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	Maternal and neonatal operational plan, including safe motherhood and EmONC; but financing remains uncertain. Financial support for coordination and sharing of good practice meeting for the districts and the regions. Use of NTIC (New Technology for Information and Communication) for e-training. Support for national coverage of oxytocin.

[146] Ministry of Health
[147] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Financing for activities.** **Advocacy for the creation of a budget line-item or increase in financial support from partners.** **Political will to accept effective interventions.** **Presentation of the package of essential interventions at every opportunity.** **Influence of traditional practices and customs.** **Mass awareness campaign.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jean Pierre Rakotovao** **E-mail: jrakotovao@jhpiego.net** **Tel.: 261340263218**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (please explain)** **If not available, diazepam is used.**
4.	Is MgSO4[148] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **Please attach a scanned copy of the service delivery guidelines for the treatment of severe PE/E, including protocols for antihypertensive drug and administration of MgSO4.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**

[148] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than 50% of the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Often (once every 2 months or less).** **Product was supplied by UNFPA/UNICEF.**
10.	Is MgSO4 currently available at the MOH medical store?	**No**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Family planning, focused ANC with BP and proteinuria, awareness of danger signs.** **Training and implementation of protocols. Promotion of birth with a qualified provider at health center level.** **Availability of awareness tools/algorithm.** **Collaboration with community health workers for awareness and referral for complications.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Family planning.** **Performance improvement with algorithm and job aids.** **Awareness of danger signs.** **Set up community referral.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Family planning, ANC.** **Promotion of assisted delivery.** **Training.** **Supply with magnesium sulfate donated by UNICEF/ UNFPA.** **Implement national protocol.**
15.	What % of districts are covered by current PE/E programs?	**Within safe motherhood: 100%.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**30%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Maternal and neonatal operational plan, including safe motherhood and EmONC; but financing remains uncertain.** **Financial support for coordination and sharing of good practice meeting for the districts and the regions.** **Use of NTIC for e-training.** **Support for national coverage for magnesium sulfate.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Reluctance to change to the use of magnesium sulfate.** **Follow-up and supervision after training.** **Non-availability of drugs (magnesium sulfate)/include in the SALAMA system (national central purchasing).** **Inability to do the follow-up and supervision.** **Lack of financial support.**

Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jean Pierre Rakotovao** **E-mail: jrakotovao@jhpiego.net** **Tel.: 261340263218**

MALAWI

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **Support for Service Delivery-Excellence (SSD-E)**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[149] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **Hospital, health center.**
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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Hospital, health center.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[150] cadres?	**Yes** **State Registered Nurse Midwife, (SRNM), Nurse Midwife Technician (NMT), doctor (DR), CO.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Plan to pilot in four districts under SSD-E.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Pilot will inform scale-up.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**

[149] Active management of the third stage of labor
[150] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[151] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**More than half the time.** **Currently available at central hospitals only.**
M&E		
17.	Is AMTSL included in the national HMIS[152]?	**No** **MCHIP, SSD-E will do the same.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Provision of oxytocin to public health facilities. In-service training, quality improvement and supportive supervision.** **Endorsement of pilot of misoprostol.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Clinical mentoring, quality improvement, onsite coaching and provision of equipment.** **Pilot misoprostol in four districts.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Supportive supervision, in-service training, coaching.**
21.	What % of districts are covered by current national PPH programs?	**100%** **There is no stand-alone PPH program. PPH is a major component of integrated maternal and newborn care (IMNC) and SBM-R for reproductive health.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**80% of SBAs in district and central hospitals (public facilities) and 7% of public health centers. (MCHIP scaled up SBM-R and IMNC in 32 health centers in four districts.) There are 28 districts and 430 health centers countrywide.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Next year, SSD-E will scale up SBM-R to 88 health centers in 11 districts.** **Plan to print and disseminate PPH protocols.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Stock-outs of oxytocin = partners have pledged to support MOH in procuring EHP drugs for 18 months.** **2. Inadequate numbers of SBAs especially at health center level = advocate with MOH Human Resources department.** **3. Scaling up SBM-R and IMNC to cover all hospitals and health centers in order to reach 100% coverage = advocate for leveraging of resources among other partners.**

[151] Ministry of Health
[152] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Tambudzai Rashidi** **E-mail: trashidi@jhpiego.net** **Tel.: 265 888201838**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** Nifedipine No Methyldopa No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** Nifedipine No Methyldopa No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[153] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **All SBAs**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **Incorporated with pre-service and in-service training programs, such as basic emergency obstetric and newborn care (BEmONC).**

[153] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time. Available in over 50% in hospitals and over 20% in health centers.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**No**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No** **There is no indicator in HMIS. Quality of care of severe PE/E management is hardly recorded.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**No stand-alone PE/E prevention and management program. However, this is a component of IMNC and SBM-R.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**SSD-E will support clinical mentoring, quality improvement, onsite coaching in the prevention and management of PE/E.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Supervision, coaching and in-service training.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**80% of SBAs in district and central hospitals (public facilities) and 7% of public health centers. (MCHIP scaled up SBM-R and IMNC in 32 health centers in four districts.) There are 28 districts and 430 health centers countrywide.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Next year SSD-E will scale up SBM-R to 88 health centers in 11 districts.** **Plan to print and disseminate MgSO4 protocols.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Stock-outs of MgSO4 = partners procuring EHP drugs for public health facilities for 18 months.** **2. Lack of competence in using MgSO4 = clinical mentoring, coaching and intensifying supervision.** **3. Inadequate numbers of SBAs especially at health center level = advocate with MOH Human Resources department.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Tambudzai Rashidi** **E-mail: trashidi@jhpiego.net** **Tel.: 265 888201838**

MALI

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[154] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	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
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes Midwives, obstetric nurses.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[155] cadres?	Yes
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Regularly
13.	Is oxytocin free of charge to patients at public health facilities?	No

[154] Active management of the third stage of labor
[155] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[156] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[157]?	**No** **MCHIP, ATNPLUS, PKCII, IntraHealth, HCI collect data in their region. The MOH is planning to include AMTSL among others in the system.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Strengthen AMTSL skills of qualified providers and matrons.** **EmONC training.** **Increased access to oxytocin.** **Facilitative site supervision.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Strengthen AMTSL skills of qualified providers and matrons.** **Collaborative approach to improving AMTSL care.** **Facilitative site supervision.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Strengthen AMTSL skills of qualified providers and matrons.**
21.	What % of districts are covered by current national PPH programs?	**62%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**70%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Policy change allowing matrons to use AMTSL.** **Elaboration and implementation of an action plan for the scale-up of AMTSL.** **Existence of a technical group and technical partners who follow up the action plan.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Stock-outs and problems with conservation of oxytocin.** **Low percentage of deliveries in health structures.** **MOH is promoting deliveries with qualified providers.** **Cesarean section is free.** **Pilot projects with Uniject and misoprostol.**

[156] Ministry of Health
[157] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Cheick Oumar Touré** **ACI 2000 Hamdallaye, Villa#1** **Bamako, BP 2243** **E-mail: ctoure@intrahealth.org** **Tel.: +223 20 22 87 83**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Clonidine**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Other (Please describe)** **Clonidine or nifedipine**
4.	Is MgSO4[158] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**No**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**

[158] Magnesium Sulfate

M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Training of providers through dissemination of national policies in reproductive health.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Pilot project in PE/E prevention and management in two health districts.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Nothing to report.**
15.	What % of districts are covered by current PE/E programs?	**15%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**10%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**The extension of the pilot project in PE/E prevention and management to additional districts.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Midwives are neither trained nor allowed to use MgSO4.** **Lack of provider skills for prevention and management of PE/E and use of MgSO4.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Cheick Oumar Touré** **ACI 2000 Hamdallaye, Villa#1** **Bamako, BP 2243** **E-mail: ctoure@intrahealth.org** **Tel.: +223 20 22 87 83**

MOZAMBIQUE

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[159] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[160] cadres?	Doctors, nurses
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes Venture Strategies Innovations (VSI) did a feasibility and acceptability pilot in Nampula Province in 2011.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Regularly
13.	Is oxytocin free of charge to patients at public health facilities?	Yes

[159] Active management of the third stage of labor
[160] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[161] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[162]?	**Yes** **In new delivery logs, which were rolled out nationwide in January 2012.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Scale-up of Model Maternities Initiative, which covers AMTSL for PPH prevention and treatment of PPH.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Support for Model Maternities through MCHIP. Collaboration of MCHIP with other USG clinical partners, mainly focusing on HIV/AIDS (Abt/CHASS, FHI, EGPAF). Pathfinder, MCHIP and World Vision are doing community mobilization for maternity use. JSI works on commodities management.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Canadian CIDA contributes to MOH basket funds being used for Model Maternities scale-up. DfID will start.**
21.	What % of districts are covered by current national PPH programs?	**100%** **When Model Maternities trainings occur, usually all districts in a province are invited to send representatives to be trained. Follow-up only occurs in Model Maternities facilities.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**30%** **This figure indicates the extent of expansion of the Model Maternities Initiative.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**The Model Maternities Initiative is the vehicle for integrated scale-up of essential obstetric and newborn interventions as well as BEmONC interventions. It is currently in facilities covering about one-third of institutional births and will cover more than half by 2014. The MOH needs help directed through this mechanism.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Enough resources to cover supervision once training has been done for AMTSL.**

[161] Ministry of Health
[162] Health Management Information System

MOZAMBIQUE

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jim Ricca** **E-mail: jricca@jhpiego.net** **Tel.: +258 84 32 33 005**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[163] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors, nurses, midwives.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).** **Even though Mozambique has a severe logistics management problem affecting all health programs, both MgSO4 and oxytocin are considered to be in a small set of "vital drugs" that are in kits that are "pushed out" to facilities on a monthly basis.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**

[163] Magnesium Sulfate

M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Use of MgSO4 for cases of severe PE/E. In new delivery logs rolled out nationwide in January 2012.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Improvement in PE diagnosis in antenatal care (ANC) in Model Maternities. Treatment of severe PE/E with MgSO4 in Model Maternity delivery wards.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Support for Model Maternities through MCHIP. Collaboration of MCHIP with other USG clinical partners, mainly focusing on HIV/AIDS (Abt/CHASS, FHI, EGPAF). Pathfinder, MCHIP and World Vision are doing community mobilization for maternity use. JSI works on commodities management.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Canadian CIDA funding used for delivery ward activities. DfID plans on programming to increase demand for institutional maternity services.**
15.	What % of districts are covered by current PE/E programs?	**100%, same explanation as with PPH.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**30%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Again, the Model Maternities Initiative is the vehicle for scale-up. Donor efforts should be channeled through this mechanism.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Supervision once training has occurred.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Jim Ricca** **E-mail: jricca@jhpiego.net** **Tel.: +258 84 32 33 005**

NEPAL

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[164] at every birth approved as national policy?	Yes Cited in the following documents: SBA Training Package; National Medical Standards for Reproductive Health; Clinical Protocols for Medical Officers (MO), Staff Nurses (SN) and Auxiliary Nurse Midwives (ANM); Maternal and Newborn Health Update Package; Pre-service Curriculum.
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	Yes
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes In the community for the prevention of PPH (for home birth, not assisted by SBA).
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	Yes Only those who have taken the SBA training.
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	Yes
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes At all levels of health facilities.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[165] cadres?	Yes Doctors, SNs, ANMs.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes The training for ANMs in some institutes may not be structured to ensure competency in AMTSL.
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes It was piloted in Banke district (2005–2007), which covered 73% of total expected pregnancies in the district. Among them, 53% of women had taken misoprostol after delivery.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	Yes Approval for national-level phase expansion was received in April 2010.

[164] Active management of the third stage of labor
[165] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **Under the Free Delivery Scheme and Free Health Care Policy, it is free for all deliveries.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).** **The storage condition is not optimal.**
15.	Is oxytocin currently available at the MOH[166] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **Not recommended for use in health facilities.**
M&E		
17.	Is AMTSL included in the national HMIS[167]?	**No** **Currently collecting data on AMTSL: NFHPII (USAID) in 12 districts and UNICEF in eight districts.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Pre-service training.** **SBA training for AMTSL and for the management of PPH. Misoprostol training and distribution at community level.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**NFHPII: MNH update and misoprostol.** **Health Right International: MNH update and SBA training.** **UNICEF: MNH update, SBA training and misoprostol.** **Care Nepal: MNH update and SBA training.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**NHSSP/DfID, UNICEF, NSI, WHO (supporting Government of Nepal), Save the Children.**
21.	What % of districts are covered by current national PPH programs?	**AMTSL in all the districts and misoprostol in 25 districts.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**All SBAs are being trained for AMTSL; at present, there are about 3,000 SBAs in the country.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**This is a national program. The constraining factor has been the inability to procure misoprostol.**

[166] Ministry of Health
[167] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Limited SBAs: with support of partners, expansion of training sites and training.** **Stock-out and storage of oxytocin.** **Availability of misoprostol.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Kusum Thapa** **ANE Regional Technical Advisor, Jhpiego** **E-mail: kthapa@jhpiego.net** **Tel.: 9841555740** **Dr. Shilu Adhikari** **Senior Program Officer,** **Nepal Family Health Program**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol Hydralazine Nifedipine Methyldopa	No No No No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol Hydralazine Nifedipine Methyldopa	No No No No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4.	Is MgSO4[168] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**	
Training			
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **SBAs**	
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**	
Logistics			
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**	
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).** **7.7% experience stock-out at least one time.**	

[168] Magnesium Sulfate

10.	Is MgSO4 currently available at the MOH medical store?	Yes
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	No
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	SBA training program nationally. Calcium piloting for the prevention of PE/E.
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	Focused ANC and Screening for PE/E with BP and testing for proteinuria where service is available. Training of ANMs, nurses and doctors on diagnosis and management of PE/E (including use of MgSO4). Design, develop, print and distribute job aids; orient health workers on these job-aids. Calcium for prevention of PE/E. Under Access Program, worked with NeSOG to strengthen 22 health facilities, both public and private, on use of MgSo4 for PE/E using the SBM-R approach.
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	NHSSP/DfID, UNICEF, WHO, NSI, NESOG.
15.	What % of districts are covered by current PE/E programs?	All districts
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	All SBAs; around 3,000 provide MgSO4. Also ob/gyns.
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	Still scope of program expansion, as SBAs are not adequate as per the national target.
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	Inadequate HR and delivery by SBA. Training sites not adequate and not adequately addressed in pre-service training and private sector. Problems with the supply of MgSO4 and antihypertensives.
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	Dr. Kusum Thapa ANE Regional Technical Advisor, Jhpiego E-mail: kthapa@jhpiego.net Tel.: 9841555740 Dr. Shilu Adhikari Senior Program Officer Nepal Family Health Program

NICARAGUA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[169] at every birth approved as national policy?	Yes Approved for vaginal births and cesarean.
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	Yes See attached copy of AMTSL guidelines and quality standards and indicators.
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	No
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	Yes Obstetricians: in Nicaragua they are called Obstetric Nurses.
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	Yes
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes At all levels of the health system. See attached copy of the section in the EML relating to oxytocin.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[170] cadres?	Yes For all cadres. Pre-service education curricula for general medicine schools, ob/gyn residents at all four hospitals training professionals nationwide, nursing schools (general, maternal and child, obstetric nurses, nursing associates).
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes Included in the pre-service and in-service curricula developed by the USAID/HCI training program.
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No MOH supports primarily institutional births. In 2007, USAID/HCI proposed several efforts to MOH. No progress has been seen due to the fear among MOH officials that the use of misoprostol will encourage illegal abortion.

[169] Active management of the third stage of labor
[170] Skilled Birth Attendant

11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).** **Oxytocin is always available.**
15.	Is oxytocin currently available at the MOH[171] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.** **When used, misoprostol is purchased through the service unit or directly by the staff using it or the patient's family.**
M&E		
17.	Is AMTSL included in the national HMIS[172]?	**Yes** **Quality standards and indicators for family planning, maternal health, newborn and child health, HIV/AIDS and hand hygiene practices. MINSA, Nicaragua, October 2009, pages 8, 9, 43 and 44. See copy of sections attached.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**AMTSL for all births (vaginal and cesarean).** **Postpartum monitoring every 15 minutes for two hours before moving a patient to the maternity ward, and then with every new nurse shift.** **Training on lifesaving procedures: manual removal of placenta, bimanual uterine compression, compression of abdominal aorta, management of PPH hypovolemic shock, ligation of hypogastric artery.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**The activities mentioned in #18 above are supported by USAID/HCI through the monitoring of quality standards and indicators for PPH prevention and management, and trainings and workshops with simulated practice environments using anatomic models.** **We have helped update the national health care guidelines, and founded the Nicaraguan Association of Obstetricians and Gynecologists (SONIGOB).**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**USAID/HCI experts and SONIGOB are supporting the MOH to update national guidelines.** **UNFPA and/or OPS/OMS are funding the update, documentation and distribution of guidelines.** **DELIVER is providing support to MOH with supplies, and the monitoring of quality indicators.** **Technical support in the field comes from USAID/HCI by working on the empowerment of local officials and capacity building.**

[171] Ministry of Health
[172] Health Management Information System

21.	What % of districts are covered by current national PPH programs?	**100%** **17 out of 17 SILAIS (Comprehensive Health Service Systems) in Nicaragua with 22 hospitals providing maternal and child health services, health care centers with inpatient and/or outpatient services, clinics in 153 municipalities nationwide.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**100%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**By law, the public health system and private health sub-system must apply the health care guidelines established by the MOH. The approved activities in PPH prevention and management have been communicated to the Instituciones de Prestación de Servicios de Salud (IPSS) and Clínicas Médicas Previsionales (CMP); these are two types of health care providers outsourced by the national social security system. Only a few SILAIS monitor compliance with the MOH guidelines by IPSS and CMPs. USAID/HCI is working with local universities to update their curricula.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**There are no barriers in the case of institutional births. Bottlenecks occur at the community level to implement AMTSL, and this depends on the MOH political interest.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Luis Manuel Urbina Téllez** **Tel.: 505-22787112, 22780447, 22780002 Ext. 105** **E-mail: lurbina@urc-chs.com**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** Methyldopa	**Yes** **Yes** **Yes** No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** Diazepam	**Yes** No
4.	Is MgSO4[173] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**

[173] Magnesium Sulfate

5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **All cadres**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly** **MgSO4 is always available.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**No stock-outs of MgSO4. Always available.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Quality standards and indicators for family planning, maternal health, newborn and child health, HIV/AIDS and hand hygiene practices. MINSA, Nicaragua, October 2009, pages 7, 41, 51 and 52. See copy of sections attached.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Urinalysis test strips for urine protein at prenatal visits, high blood pressure testing at all visits.** **2 g calcium oral supplements as of 20 weeks when at risk for PE/E.** **81 mg aspirin daily intake after 20 weeks, when at risk for PE/E.** **Counseling on warning signs during pregnancy, labor and postpartum.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**All activities in #12 above are supported by USAID/HCI through monitoring of antenatal care (ANC) quality standards and indicators and compliance with PE/E guidelines, and training and workshops.** **We have helped update health care guidelines, and founded the Nicaraguan Associations of Obstetricians and Gynecologists (SONIGOB).**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**OPS/OMS and UNFPA have funded the update, documentation and distribution of health care guidelines.**
15.	What % of districts are covered by current PE/E programs?	**100%**

16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**100%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**By law, the public health system and private health sub-system must apply the health care guidelines established by the MOH. The approved activities in PPH prevention and management have been communicated to the Instituciones de Prestación de Servicios de Salud (IPSS) and Clínicas Médicas Previsionales (CMP); these are two types of health care providers outsourced by the national social security system. Only a few SILAIS monitor compliance with the MOH guidelines by IPSS and CMPs. USAID/HCI is working with local universities to update their curricula.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**None**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Luis Manuel Urbina Téllez** **Tel.: 505-22787112, 22780447, 22780002 Ext. 105** **E-mail: lurbina@urc-chs.com**

NIGERIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	**Yes**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[174] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **All levels**
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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels (primary, secondary, tertiary).**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[175] cadres?	**Yes**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **This is not a requirement for every student. Assessment of AMTSL skills depends on the examiner and the school.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**Yes** **The National Council of State has approved this in principle. It is up to health care providers and managers to implement. Therefore, the scale-up is not coordinated.**

[174] Active management of the third stage of labor
[175] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**No** **Few facilities offer free maternity services, which includes AMTSL. In general, patients pay for services in most facilities.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Frequently (once in every 2 months or less).**
15.	Is oxytocin currently available at the MOH[176] medical store?	**Nigeria operates a federal system of governance that includes one Federal MOH, 36 State MOH and 774 health counselors.**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[177]?	**No** **MCHIP**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Promotion of AMTSL using either oxytocin or misoprostol. Community distribution of misoprostol is approved in principle.** **Training of health care providers (HCPs) in basic EmONC.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**USAID-supported programs implement basic and comprehensive EmONC, which includes AMTSL. HCPs are trained to provide these services.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**As above.**
21.	What % of districts are covered by current national PPH programs?	**There is no stand-alone national PPH program. There are numerous small-scale, integrated programs. Nigeria is a big country with a population of 167 million people in 36 states and approximately 6–7 million deliveries per year.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Estimate: 50%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Government has promised that funds saved from removal of fuel subsidy will partially go toward improved maternal health, which will include AMTSL (supply of uterotonic drugs, training of HCPs, etc.). Government has been talking of increasing the number of SBAs at primary health centers (PHCs) through the Midwives Service Scheme (MSS).**

[176] Ministry of Health
[177] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Lack of a national, coordinated PPH program (Govt. prefers integration with the LSS).** **2. Low skilled birth attendance rate due to shortage of SBAs.** **3. Traditional preference for home deliveries in some parts of the country.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Prof. Emmanuel O. Otolorin** **E-mail: eotolorin@jhpiego.net** **Tel.: +234-8034783549.** **Dr. Olumuyiwa Oyinbo, FMOH** **E-mail: omooyinbo@yahoo.com**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** Methyldopa	**Yes** **Yes** **Yes** No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4.	Is MgSO4[178] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**	
Training			
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes**	
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**	
Logistics			
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**	
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Frequently (once in every 2 months or less).**	

[178] Magnesium Sulfate

10.	Is MgSO4 currently available at the MOH medical store?	Yes
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	No
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	Prevention and management of PE/E are included in basic EmONC training (also called LSS); also included in the MSS program being run by the National Primary Health Care Development Agency.
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	All USAID-supported maternal health programs (MCHIP, TSHIP, etc.) include implementation of basic EmONC, which includes prevention and treatment of PE/E.
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	As above
15.	What % of districts are covered by current PE/E programs?	Cannot be quantified because there is no national PE/E program.
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	Estimate: 50%
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	Increased funding for maternal health should allow for expansion of the MSS program, which puts SBAs in PHCs.
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	1. Shortage of SBAs skilled to manage PE/E. 2. Stock-outs of MgSO4. 3. Preference for home deliveries in some parts of the country.
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	Prof. Emmanuel O. Otolorin E-mail: eotolorin@jhpiego.net Tel.: +234-8034783549. Dr. Olumuyiwa Oyinbo, FMOH E-mail: omooyinbo@yahoo.com

PAKISTAN

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **MNCH Program at national level**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[179] at every birth approved as national policy?	**Yes** **It is included in National EmONC Manual used by the National MNCH Program.**
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	**Yes** **AMTSL protocol from National EmONC Manual, page 137.**
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**No** **Attempts are being made by individuals/organizations to add it to the EML. However, it has been registered in Pakistan for prevention and treatment of PPH.**
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?	**No** **Trained and partially practicing, but there are no regulations.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **All levels**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[180] cadres?	**Yes** **All cadres**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No** **Not usually, but at some places it is included.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**No** **There is no curriculum for in-service trainings at national levels. Periodic trainings are held where AMTSL is included in training.**

[179] Active management of the third stage of labor
[180] Skilled Birth Attendant

Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Administration of misoprostol by trained traditional birth attendants to prevent postpartum hemorrhage in home births in Pakistan: A randomized placebo-controlled trial.** **N Mobeen, J Durocher, NF Zuberi, N Jahan, J Blum, S Wasim, G Walraven, and J Hatchera.** **http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02807.x/full**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Individual efforts are there, but not at national level.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **It is free of cost, whenever available. Most of the time it is not available and patients have to buy it or it is provided through charity/donation; but not refrigerated.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[181] medical store?	**No** **After devolution of Central Ministry of Health, provincial governments procure their supplies/medicine at the beginning of financial year; they stock out within few months. Later, either they are available through support by national/international NGOs or patients have to buy these medicines from the market.**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **Misoprostol is not on National EML of Pakistan; so whenever it is required, it is purchased.**
M&E		
17.	Is AMTSL included in the national HMIS[182]?	**No** **Some hospitals/health facilities collect data.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**MOH established the National Committee for Maternal and Neonatal Health (NCMNH) in 1994, which does the following:** **a) Advocacy.** **b) Training.** **c) Preparation of IEC material.** **National MNCH Program was established.** **National EmONC Manual updated and trainings are being given.** **Awareness campaigns are occasionally done.**

[181] Ministry of Health
[182] Health Management Information System

19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**USAID sponsored the following activities:** **PAIMAN: workshops for EmONC.** **TACMIL: workshops for EmONC.** **POPPHI: prevention of PPH initiatives.** **PRIDE: Developed on-the-job training modules in which PPH prevention was added. Trained all female service providers in two earthquake-affected districts (Mansehra and Bagh). Also developed job aids/posters for management of PPH.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Several donors have supported activities including training (on small scale), mainly trainings that were not standardized.**
21.	What % of districts are covered by current national PPH programs?	**There is no known national PPH program.** **Training for PPH prevention and treatment is included in the EmONC Program.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**There is no known national PPH program. Percentage of SBAs reached is not known.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Champions for PPH need support to disseminate messages, organize national conferences, revise curriculum for SBAs, and carry out trainings.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Lack of political will to scale up.** **Activities are project-oriented and funded by donors. When the donor assistance is discontinued, the program discontinues as well.** **Inefficient health care delivery system.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Shabana Zaeem** **E-mail: szaeem@jhpiego.net** **Tel.: 03345133538**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Yes** **Hydralazine** **Yes** **Nifedipine** **Yes** Methyldopa No **Other (Please describe)** **No national guidelines are available; the above information is given with reference to National EmONC Manual for trainings. Reference page no. 111.**

2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** Nifedipine No **Methyldopa Yes** **Other (Please describe)** **Most of the facilities still use methyldopa, which is considered a safe drug by them.**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[183] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **National EmONC Manual, pages 107–111. It is included in EML of AJK Province by PRIDE Program efforts.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No** **There are no regulations (authorization) though some MW may use it.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors only**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **There is no curriculum for in-service trainings at national levels. EmONC trainings are held through various channels, where PE/E prevention and management is part of training.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.** **There are many facilities that do not have MgSO4 available 24/7.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Frequently (once in every 2 months or less).** **Most of the time, it is not available. Patients have to buy it or these medicines are bought by charity/donation money.**
10.	Is MgSO4 currently available at the MOH medical store?	**Provincial government procures their supplies/medicine at the beginning of financial year, which stock out within few months. Later on, either they are supported by national/international NGOs or patients have to buy these medicines themselves.**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**

[183] Magnesium Sulfate

Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**With the initiatives of national and international NGOs, PE/E prevention and management has been included in curricula of several training workshops, but at national level only. MNCH Program covers this topic briefly.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**The curriculum of the USAID-supported Community Midwifery Training Program includes these activities.** **PRIDE Project developed on-the-job training modules that include management of PE/E as well as standards and flow charts for managing PE/E.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Other partners are SOGP, AMAN.** **Provincial MNCH Program includes it in its trainings of EmONC for doctors and midwifes.** **PRIDE in its two working districts trained all female staff on management of PE/E during on-the-job trainings.**
15.	What % of districts are covered by current PE/E programs?	**There is no known national PE/E program.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**There is no known national PE/E program.** **Percentage is difficult to estimate.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Champions for PE/E need support to disseminate messages, organize national conferences, revise curriculum for SBAs, and carry out trainings.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Lack of political will.** **Lack of coordination of central and provincial authorities.** **Inefficient health care delivery system.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Shabana Zaeem** **E-mail: szaeem@jhpiego.net** **Tel.: 03345133538**

PARAGUAY

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[184] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[185] cadres?	Yes
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Regularly
13.	Is oxytocin free of charge to patients at public health facilities?	Yes
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	Rarely (once a year).

[184] Active management of the third stage of labor
[185] Skilled Birth Attendant

15.	Is oxytocin currently available at the MOH[186] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[187]?	**Yes** **Medical records**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**PPH prevention and management efforts through the MCHIP Paraguay program.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Developing training centers, and training clinical trainers.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**UNFPA is developing trainings on obstetric emergencies in some regional health areas in the country.**
21.	What % of districts are covered by current national PPH programs?	**No data**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**No data**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Support to expand the program.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Training.** **2. Unavailability of human resources to receive skills updates trainings.** **3. Lack of in-service education among health care providers; MCHIP is working in two regions, but it would be beneficial to add more regions.** **4. Integrated now with obstetric undergraduate programs and medical undergraduate and postgraduate programs.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Vicente Bataglia Araújo**

[186] Ministry of Health
[187] Health Management Information System

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Clonidine**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol Yes** Hydralazine No **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[188] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**No**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **However, not for all levels or in all courses.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Finalizing the updated national guidelines on PE/E management.** **Developing standardized and updated trainings for clinical trainers.** **Implementing the SBM-R approach as a tool to improve the quality of updated services (these activities receive**

[188] Magnesium Sulfate

	the support of MCHIP).
13. Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Same as above, these activities are undertaken under the MCHIP Paraguay program framework, to support the MOH in two regions.**
14. Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**UNFPA is developing trainings on obstetric emergencies in some regional health areas in Paraguay.**
15. What % of districts are covered by current PE/E programs?	**No data**
16. What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**No data**
Opportunities for Introduction, Expansion and Scale-Up	
17. Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**It would be great to expand the MCHIP intervention to other sanitary regions, adding to the two target regions. To do this, programmatic and financial support would be welcomed, as the work in these two regions will result in clinical trainers who are prepared to participate in the expansion.**
18. What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Updating standards: upon completion of a final review, the updated guidelines will be disseminated.** **2. Lack of in-service education among health care providers; the MCHIP Program is working in two regions, but it would be beneficial to add more regions.** **3. It is difficult to get health care providers to leave their workplaces to attend trainings.**
Contact Person	
19. Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Vicente Bataglia Araújo**

PHILIPPINES

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **1. HealthGov Project, RTI/Jhpiego/USAID** **2. PRISM 2, Chemonics/USAID** **3. Women's Health and Safe Motherhood Project, WB** **4. WHO, UNFPA, UNICEF Joint Program for Maternal and Newborn Health** **5. JICA**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[189] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**No** **There is a Department of Health (DOH) memo indicating that misoprostol is not BFAD-approved for this indication.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**No** **The practice of manual removal of the placenta is not allowed among midwives; hence it is not included in the training curriculum for midwives.**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**No** **Midwives are allowed to administer oxytocin only if trained and under the presence of a supervising physician. Besides, the midwives themselves are not confident in administering oxytocin after delivery of the baby, but are stuck with the practice of giving oxytocin only after placental expulsion.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Oxytocin is on the National EML at all levels of the health system, up to the Barangay Health Stations.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[190] cadres?	**No** **Only for physicians, not for nursing or midwives.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No** **Assessment for competency in AMTSL is only for Ob/Gyn Residency Program, not medical students.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes** **BEmONC training includes AMTSL in the curriculum for all SBA cadres, which is a team of doctors, nurses and midwives.**

[189] Active management of the third stage of labor
[190] Skilled Birth Attendant

Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**No** **Misoprostol is not BFAD-approved for its use as an uterotonic.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **Misoprostol is not being used and it has not been piloted.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**No** **It is not given free of charge since most birthing facilities charge for drugs and services, as authorized by the DOH (user's fee).**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).** **Not applicable: Central/regional levels neither procure nor distribute drugs. The local health offices are mandated to procure the essential drugs and supplies in its Commodities Self-Reliance Programs. Stock-outs of drugs (oxytocin) may occur every 3–6 months at the local level.**
15.	Is oxytocin currently available at the MOH[191] medical store?	**Yes** **Oxytocin is available at DOH hospital pharmacies.**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[192]?	**No** **At present, there is no identified organization/institution that is tasked to monitor/record/report the implementation of AMTSL.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Most of the activities are related to conducting training courses, namely: BEmONC training for doctors, nurses and midwives; Essential Intrapartum and Newborn Care Workshops; and Midwives Capacity Enhancement on Maternal and Newborn Care. These are mainly training courses offered by DOH. There is no direct post-training monitoring and evaluation of the program.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**USAID cooperating agencies are: supporting local government units in facilitating the BEmONC training of identified BEmONC teams in project sites; developing a tool for rapid assessment of AMTSL/ENC service capacities of LGU facilities; planning to conduct a rapid assessment from selected LGUs in 25 provinces once the tool is finalized; engaging in ongoing development of OR protocol on AMTSL and ENC in selected LGU facilities in project sites.**

[191] Ministry of Health
[192] Health Management Information System

20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**UNFPA, UNICEF, WHO and JICA provide funding for BEmONC training that includes PPH prevention and management in the curriculum.** **UINCEF provides commodities (oxytocin) at the local level.**
21.	What % of districts are covered by current national PPH programs?	**47%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**60–70%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Ongoing medical revision of pre-service training on AMTSL.** **DOH-MNCHN MOP (policies and program) roll-out/dissemination.** **Ongoing development of CEmONC training curriculum.** **There is a planned National BEmONC Functional Assessment by DOH.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Philippine Midwifery Law specifies that midwives can administer IM oxytocin only after delivery of the placenta.** **Unavailability of the commodities in some facilities.** **There is still existing resistance from some sectors (private practitioners, midwives themselves, etc.) due to lack of AMTSL information rollout/implementation.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Cesar S. Maglaya, MD** **E-mail: cesarmaglaya@yahoo.com** **Tel.: (632) 931-2185**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol** **Hydralazine** **Nifedipine** **Methyldopa**	**Yes** **Yes** **Yes** **Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4.	Is MgSO4[193] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**

[193] Magnesium Sulfate

5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **Midwives are trained to recognize PE/E and are authorized to diagnose this for the purpose of immediate referral to physicians. Midwives are not confident in the administration of MgSO4 due to a lack of programmatic support, even from the national midwives organization, or restrictions from the Professional Regulatory Commission.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Includes doctors and midwives only.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes** **Includes all the members of the BEmONC team (doctors, nurses and midwives), which is trained as a team.**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).** **Not applicable; Central/regional levels neither procure nor distribute drugs. The local health offices are mandated to procure the essential drugs and supplies in the Commodities Self-Reliance Programs. Stock-outs of drugs (MgSO4) may occur every 3–6 months at the local level.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes** **MgSO4 is available at DOH hospital pharmacies.**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Public and private birthing facilities report cases of PE/E using incidence of PE/E as indicator. Reporting and recording in public facilities is still lacking.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**USAID CAs support by providing technical assistance in policy development of MNCHN, which covers PE/E prevention and management. In Muslim Mindanao, a USAID-funded project SHIELD is studying a community service delivery model for adapting to the cultural needs of a Muslim community. The study includes prevention of PE/E.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**UNFPA, UNICEF, WHO and JICA focus on implementation of BEmONC that complies with the DOH MNCHN program.**
15.	What % of districts are covered by current PE/E programs?	**47%**

16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**60–70%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**DOH sets a program target of 100% of all birthing facilities providing BEmONC services.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Doctors and midwives trained to administer MgSO4 fail to practice in the facilities due to lack of confidence.** **2. MgSO4 is not always available in health facilities, especially in primary birthing homes where this is a more immediate need.** **3. Absence in the training curriculum; basic midwifery course does not include pharmacology (e.g., MgSO4).** **4. National government cannot provide assurance that there are always lifesaving drugs (MgSO4 at the primary level).**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Cesar S. Maglaya, MD** **E-mail: cesarmaglaya@yahoo.com** **Tel.: (632) 931-2185**

RWANDA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[194] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Hospitals, health centers and community. Misoprostol is on the EML for use at reference hospitals and district hospitals. There is a ministerial decree allowing its use for prevention and treatment of PPH at the community level.
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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes On the EML, the use of oxytocin at the hospital level is authorized; but, in the standards and guidelines for provision of services for maternal health, oxytocin can be used at the health center level.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[195] cadres?	Yes Doctors, midwives, nurses.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes

[194] Active management of the third stage of labor
[195] Skilled Birth Attendant

Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **The program is being piloted in four districts. In Rwanda, all women are encouraged to deliver in a health center (FOSA). In each village (50 to 100 households), there is a specialized health community agent (Agent de santé maternelle, or ASM). The ASM observes and follows the pregnant women in the village and accompanies them to the health center when they start labor. The ASMs administer misoprostol to the women who might give birth before they reach the health center. The program is now in its recycling phase for distributors, and distribution could start soon.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**No** **Oxytocin is not free of charge, but cost is not a barrier. Delivery is free for women who attend the four standard antenatal (ANC) visits (39% of women); and for the rest of them, mutual health care (mutuelle de santé) pays most of the cost, or 90% (the woman has a co-payment of 10%). The coverage rate of the mutuelle is 95%.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[196] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.** **Misoprostol is available at the hospital level; mostly for the induction of labor, not for PPH prevention, as oxytocin is used for AMTSL at the health center level.**
M&E		
17.	Is AMTSL included in the national HMIS[197]?	**No**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Training and monitoring.** **Provision of oxytocin to health centers.** **Focused ANC.** **Programs for ASMs.** **Pilot project for the use of misoprostol for the prevention of PPH.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Training, formative supervision, material.**

[196] Ministry of Health
[197] Health Management Information System

20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Training.** **Supervision for the purchase of medicine such as oxytocin and misoprostol.** **Equipment/ambulance/construction-rehabilitation.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**50%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**15,000 ASMs can be used to disseminate messages for delivery at health centers.** **Onsite training approved by the MOH can also serve to train more providers and update the national pool of trainers.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Loss of trained providers, a great need for training.** **Few candidates in the schools of nursing. Prevention of PPH at the community level during the early stages needs to be strengthened. Competition for funding priority.** **On-the-job training would allow programs to train more providers. Ensure sustainability of the program by mobilizing additional funding. Scale up PPH prevention program at the community level.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Beata Mukarugwiro, MCHIP** **Tel.: +250788434986** **E-mail: bmukarugwiro@jhpiego.net** **Dr. Felix Sayinzoga, MOH** **Tel. +250788517814** **E-mail: fsayinzoga@yahoo.fr**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **These medicines are authorized at the hospital level only.**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**

4.	Is MgSO4[198] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **For reference hospitals only, but in the norms and protocols for provision of service, even district hospitals are authorized to administer these medicines.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly** **In hospitals**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **If Yes, what is this indicator and where is it recorded?**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Training, monitoring.** **Supplying MgSO4 to health centers.** **Focused ANC.** **Programs for ASMs who are able to detect signs of danger in relation to PE/E and refer women quickly to health centers.** **Use of instant messaging technology by the ASMs.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Training, formative supervision, equipment.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Training and monitoring.** **Purchase of medicine such as MgSO4. Equipment, ambulance/construction-rehabilitation.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**50%**

[198] Magnesium Sulfate

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**15,000 ASMs who can be used to disseminate PE/E danger signs messages, and refer women to health centers (69% of women give birth at health centers).** **Delivery at health centers.** **Onsite training approved by the MOH that can be used to train more providers.** **Health care (mutuelles de santé).** **Ambulances in all hospitals.** **Program for instant messaging (SMS).**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Even though in the norms and guidelines for provision of services, health centers are authorized to use MgSO4, it is not on the EML. Loss of trained staff.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Beata Mukarugwiro, MCHIP** **Tel.: +250788434986** **E-mail: bmukarugwiro@jhpiego.net** **Dr. Felix Sayinzoga, MOH** **Tel. +250788517814** **E-mail: fsayinzoga@yahoo.fr**

SENEGAL

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **Strengthening health care provision is the responsibility of IntraHealth International.**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[199] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**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 oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **Health posts, health care centers, hospitals.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[200] cadres?	**Yes** **Doctors, midwives, nurses.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**No**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Abt Associates conducted a pilot study on misoprostol for the prevention of PPH at the community level.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**No**

[199] Active management of the third stage of labor
[200] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[201] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[202]?	**Yes** **Maternity logbooks**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**AMTSL, community awareness of the danger of PPH.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**AMTSL, community awareness of the danger of PPH, pilot study on misoprostol at the community level.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**AMTSL, community awareness of the danger of PPH.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**95%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**The MOH has a policy in place and needs support to strengthen equipment and providers' skills.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Stock-outs.** **2. Slow expansion of misoprostol at the community level.** **3. Misoprostol for PPH prevention not included in the in-service training curriculum.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Fatou Ndiaye, Gynecologue/Obstetricien** **Tel.: 00 221 77121 33 34** **E-mail: fndiaye@intrahealth.org** **Dr. Ousseynnou Faye, Gynecologue/Obstetricien (Division de la Santé et de Reproduction MSP)** **Tel.: 00 222 77639 42 80** **E-mail: eofaye@refer.sn**

[201] Ministry of Health
[202] Health Management Information System

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No Hydralazine No **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No Hydralazine No **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[203] on the National EML for: severe pre-eclampsia?; eclampsia?	Pre-eclampsia No **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors, midwives, nurses.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Birth logbooks**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Awareness of danger signs at the community levels, taking BP during pregnancy and postpartum.**

[203] Magnesium Sulfate

13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Awareness of danger signs at the community levels, taking BP during pregnancy and postpartum, training of qualified providers in EmONC.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Awareness of danger signs at the community levels, taking BP during pregnancy and postpartum, training of qualified providers in EmONC.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**90%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Strengthen providers' skills and equipment.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Stock-outs.** **2. In-service training due to the absence of partner (in 2012, RPS will train providers in the prevention and management of PE/E).**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Fatou Ndiaye, Gynecologue/Obstetricien** **Tel.: 00 221 77121 33 34** **E-mail: fndiaye@intrahealth.org** **Dr. Ousseynnou Faye, Gynecologue/Obstetricien (Division de la Santé et de Reproduction MSP)** **Tel.: 00 222 77639 42 80** **E-mail: eofaye@refer.sn**

SOUTH SUDAN

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[204] at every birth approved as national policy?	No The national protocols for AMTSL are yet to be developed.
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	No The national protocols for AMTSL are yet to be developed.
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes It is yet to be registered by the National Pharmaceuticals Directorate and available in the country.
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?	No
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[205] cadres?	No It is now, in the Diploma Midwifery Course that was introduced in May 2011 (only 20).
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	No
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	No It is hoped that the new midwifery class will be assessed.
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Less than half the time. Only at the hospitals. Note: there are 27 county hospitals, seven state hospitals and three teaching hospitals in the whole country. It is difficult to keep items cool due to power challenges.

[204] Active management of the third stage of labor
[205] Skilled Birth Attendant

13.	Is oxytocin free of charge to patients at public health facilities?	**No** **Women are charged SSP 25, despite official policy of free health care services. Therefore, many mothers who cannot afford this decide to deliver at home.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Frequently (once in every 2 months or less).**
15.	Is oxytocin currently available at the MOH[206] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[207]?	**No** **The national protocols for AMTSL are yet to be developed.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Currently in the newly opened midwifery schools, AMTSL is being taught, as well as the use of oxytocin. In all HFs, delivery was being conducted by TBAs or VMWs who can neither read nor write.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**In the SHTP II and ARC Program, trainings in EmONC encourage AMTSL, use of oxytocin, and education on danger signs of pregnancy.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**There are other partners/donors who have supported the in-service trainings on EmONC, especially UNFPA. Other partners UNFPA included have supported the recruitment of qualified midwives who practice AMTSL, use oxytocin, and provide IEC on danger signs of pregnancy.**
21.	What % of districts are covered by current national PPH programs?	**0%** **There is no PPH program.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**No program**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Opportunities for starting the PPH program: Curricula review and updates for midwives and nurses ongoing; policies being reviewed and developed; regulatory frameworks being put in place; and the development of national protocols.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**For starting before scale-up: Human Resource for Health; policies and strategies; development of guidelines and protocols and their implementation; RH commodities security implementation.**

[206] Ministry of Health
[207] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Solomon Orero** **Senior TA RH/FP** **E-mail: sorero@jhpiego.net** **Tel.: +211-956-180-684**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** Nifedipine No **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[208] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **There is no national protocol. The Teaching Hospital has its own protocol, which has not been disseminated countrywide! The protocol is being updated to take into account the different levels of SBAs available in South Sudan.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**No** **MgSO4 is not available at the lower levels of health care. In most of the lower levels of health care, there are no midwives.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Midwives at diploma levels. The certificate and enrolled curriculum were just completed, and the training schools are taking their first students. The medical school is still closed, and it is not known when it will re-open.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**No** **There is no structured in-service training. There have, however, been ad hoc trainings in EmONC.**

[208] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.** **Only in hospitals (27 county, seven states and three teaching hospitals), but not in PHCC or PHCU.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).** **That is at the teaching hospitals and some state hospitals. In the county hospitals, sometimes it is not there for several months.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**None at the moment.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Through trainings in EmONC in programs such as SHTP II and ARC.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Through trainings in EmONC in program supported by UNFPA.**
15.	What % of districts are covered by current PE/E programs?	**No structured program.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**No structured program.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Policies, guidelines and protocols are being developed.** **More qualified SBAs are being recruited. Curricula are being reviewed and updated.** **Champions have been identified for training.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Human Resources for Health; policies and guidelines; protocols and logistics for commodity supplies distribution.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Solomon Orero** **Senior TA RH/FP** **E-mail: sorero@jhpiego.net** **Tel.: +211-956-180-684**

TANZANIA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[209] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes Health facilities of all levels: national, regional/provincial, district, health center, dispensary.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[210] cadres?	Yes Nurse-Midwives, Medical Doctors, Assistant Medical Officers, Clinical Officers and Assistants.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	Yes Piloted by at least two different individuals/ organizations; findings shared. The Ministry of Health (MOH) has yet to make a decision in relation to misoprostol use at the household level.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No

[209] Active management of the third stage of labor
[210] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[211] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.**
M&E		
17.	Is AMTSL included in the national HMIS[212]?	**Yes** **In new HMIS tools still being piloted. On delivery register.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Coordinating policy, guidelines and standards development; adherence; advocating to donors and local government to support the move.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Supporting the MOH to coordinate policy, guidelines and standards development; adherence through training, supervision and service delivery; advocating to local government and institutions to support the move.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**USAID is the main donor. Just as USAID, other donors support the MOH to coordinate policy, guidelines and standards development; adherence through training, supervision and service delivery; advocating to local government and institutions to support the move.**
21.	What % of districts are covered by current national PPH programs?	**100%** **But, few providers in few facilities in a district.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Close to 50%.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**MOH has a policy in place needing vigorous players for the implementation.** **Donor community supporting policy implementation.** **National and international conferences allowing learning from each other.** **Provider curricula under revision to include prevention and management of PPH.**

[211] Ministry of Health
[212] Health Management Information System

24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Resources to update all SBAs: advocacy undertaken for district councils to budget for PPH prevention updates.** **Putting uterotonics in place: follow up with the councils to budget for uterotonics.** **Facilitate internal and external supervision, coaching and mentoring: national materials and program design in place with recognition back-up.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Gaudiosa Tibaijuka** **Tel.: +225 754 695621** **E-mail: gtibaijuka@jhpiego.net**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes**
4.	Is MgSO4[213] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **Adapted PCPNC; attached page B13 and B14.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Review of curricula ongoing.** **Nurse-Midwives, Medical Doctors, Assistant Medical Officers, Clinical Officers and Assistants.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.**

[213] Magnesium Sulfate

9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Hypertension, albuminuria on maternity chart; ANC, labor and delivery and PP Card.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Coordinating policy, guidelines and standards development; adherence; advocating to donors and local government to support the move.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Supporting the MOH to coordinate policy, guidelines and standards development; adherence through training, supervision and service delivery; advocating to local government and institutions to support the move.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**USAID is the main donor. Just as USAID, other donors support the MOH to coordinate policy, guidelines and standards development; adherence through training, supervision and service delivery; advocating to local government and institutions to support the move.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**Close to 50%.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**MOH has a policy in place needing vigorous implementation.** **Donor community supporting policy implementation.** **National and international conferences allowing learning from each other.** **Provider curricula under revision to include prevention and management of PE/E.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Resources to update all SBAs: advocacy undertaken for district councils to budget for PE/E prevention updates.** **Putting uterotonics in place: follow up with the councils to budget for uterotonics and facilitate internal and external supervision.** **Coaching and mentoring: national materials and program design in place with recognition back-up.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Hilda Nyerembe** **Tel.: +255 754759998** **E-mail: hnyerembe@jhpiego.net**

TIMOR LESTE

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[214] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Misoprostol has been mentioned in the National Essential Medicine List (EML); however, none of the standard treatment guidelines has mentioned its appropriate usage.
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	No Only hospitals and community health centers (CHCs) are allowed, as per Basic Service Package (BSP).
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	Yes
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	Yes At all levels of health facility, from health post to hospital, including CHCs.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[215] cadres?	Yes Midwives
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	No Timor-Leste has a heterogeneous group of doctors trained in several countries, such as Cuba, Indonesia, Fiji and Australia; it is not clear to the MOH whether AMTSL was included in its curricula or not.
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No Misoprostol has been mentioned in the EML; however, it is not mentioned in any standard treatment guidelines.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No

[214] Active management of the third stage of labor
[215] Skilled Birth Attendant

Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Regularly**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).**
15.	Is oxytocin currently available at the MOH[216] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never**
M&E		
17.	Is AMTSL included in the national HMIS[217]?	**No** **AMTSL is included in the Supportive Supervision Checklist. The EmOC Needs Assessment checked the status in 2008.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Developed training modules on EmOC, integrated management of pregnancy and childbirth, and standard midwifery practice.** **In-service and pre-service education for SBAs addressing management of PPH.** **Supporting procurement and distribution of oxytocin.** **Tracking and monitoring PPH contribution to maternal deaths through health facility-based maternal death audit.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Support the MOH in the aforementioned interventions (#18).** **Support District Health Services (DHS) to conduct supportive supervision visits.** **Participate in periodic health facility assessment.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Support the MOH to the aforementioned interventions (#18).** **Support DHS to conduct supportive supervision visits.** **Participate in periodic health facility assessment.**
21.	What % of districts are covered by current national PPH programs?	**100%**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**65%**

[216] Ministry of Health
[217] Health Management Information System

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Maternal and reproductive health policies need to be reviewed, revised and approved.** **In-service training on managing normal and complicated labor and delivery, including prevention and management of PPH for doctors. Evaluating quality status of MNH care through supporting the MNH Quality of Care Study, which covers PPH.** **Establish community-based maternal death audit system.** **Train traditional birth attendants (TBAs).** **Increasing number of partners supporting MNCH activities at the national level provides a platform for leveraging resources for PPH.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Lack of sufficient and qualified health personnel: recruit midwives from Indonesia, strengthen the training institutes, staff assessment.** **2. Poor financial allocation: coordinate with UN agencies and other donors and partners toward the initiative of "one plan, one budget."** **3. Poor access to SBA: strengthen community mobilization and awareness approach, establish more health facilities.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Misliza Vital** **E-mail: mis_vital29@yahoo.com** **Mobile: +670 7821546** **Dr. Ruhul Amin** **E-mail: ramin@jsi-timor.com** **Mobile: +670 7432590**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol **Hydralazine** **Nifedipine** **Methyldopa**	No **Yes** **Yes** **Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4** **Diazepam**	**Yes** **Yes**
4.	Is MgSO4[218] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia** **Eclampsia**	**Yes** **Yes**

[218] Magnesium Sulfate

5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Midwives**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Developed training modules on EmOC, integrated management of pregnancy and childbirth, and standard midwifery practice.** **In-service and pre-service education for SBAs addressing management of PPH.** **Supporting procurement and distribution of oxytocin.** **Tracking and monitoring PPH contribution to maternal deaths through health-facility-based maternal death audit.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Support the MOH to the aforementioned interventions.** **Support DHS to conduct supportive supervision visits. Participate in periodic health facility assessment.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Support the MOH to the aforementioned interventions.** **Support DHS to conduct supportive supervision visits. Participate in periodic health facility assessment.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**65%**

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**Maternal and reproductive health policies need to be reviewed, revised and approved.** **In-service training on managing normal and complicated labor and delivery, including prevention and management of PPH for doctors. Evaluating quality status of MNH care through supporting the MNH Quality of Care Study, which covers PPH.** **Establish community-based maternal death audit system.** **Train traditional birth attendants (TBAs).** **Increasing number of partners supporting MNCH activities at the national level provides a platform for leveraging resources for PPH.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Lack of sufficient and qualified health personnel: recruit midwives from Indonesia, strengthen the training institutes, staff assessment.** **2. Poor financial allocation: coordinate with UN agencies and other donors and partners toward the initiative of "one plan, one budget."** **3. Poor access to SBA: strengthen community mobilization and awareness approach, establish more health facilities.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Misliza Vital** **E-mail: mis_vital29@yahoo.com** **Mobile: +670 7821546** **Dr. Ruhul Amin** **E-mail: ramin@jsi-timor.com** **Mobile: +670 7432590**

UGANDA

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**No** **1. Strides for Family Health Project: USAID-funded, implemented by Management Sciences for Health in 15 districts; EmONC training, support supervision and some provision of equipment and supplies.** **2. Health Care Initiative: USAID-funded, implemented by URC; quality improvement for MNH services, using HCI model, in two districts.** **3. Association of OB/GYNs of Uganda: providing technical support to various projects/activities.** **4. Marie Stopes Uganda: a) World Bank-funded project in west of country—voucher system to give women low-cost access to antenatal care, delivery and postnatal care at private facilities, coupled with training and quality improvement for facilities; b) foundation-funded: social marketing of misoprostol.** **5. UNFPA: providing comprehensive support including training, equipment, quality improvement and systems strengthening support, focusing on eight districts.** **6. World Bank/MOH: Uganda Health Systems Strengthening Project/HRH support, physical infrastructure improvement, and strengthening management, leadership and accountability.** **7. Saving Mothers Giving Life: includes all USG-funded agencies and partners in four districts; comprehensive support including training, infrastructure support, support for recruiting staff, equipment/supplies, advocacy, community outreach.** **8. Joint Programme on Population: funded by UK/AID (DfID) and implemented through a partnership among all UN Agencies, the Uganda government and a number of civil society organizations, covering 15 districts; among other emphases, ensuring that all women and children have access to comprehensive maternal and newborn care.** **9. Jhpiego: comprehensive MNH support to selected facilities in two districts; training, mentoring, support supervision, support with supplies/equipment as necessary, and community outreach.**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[219] 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 in-service training guidelines.**

[219] Active management of the third stage of labor

3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**Yes** **As a second-line drug at HCIII and above.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**Yes** **As part of 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 been trained in the skill.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **HCIII and above.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[220] 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 one-fourth of tutors have so far been oriented to the provision of AMTSL by the MOH. The curriculum is difficult to change outside of the scheduled reviews, but new maneuvers can be incorporated if the trainer is updated.**
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **Through practica**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes** **As part of the lifesaving curriculum.**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Pilot is ongoing, led by the Makerere University Department of Obstetrics and Gynecology, with PACE. However, current policy does not support home births; mothers are supposed to deliver at health facilities.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**More than half the time.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Rarely (once a year).** **There are rarely stock-outs at the central level, but sometimes stock-outs at the facility level.**

[220] Skilled Birth Attendant

15.	Is oxytocin currently available at the MOH[221] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**More than half the time.** **Depends on the workload at that facility, and whether there is sharing of supplies between higher- and lower-level facilities in the same area.**
M&E		
17.	Is AMTSL included in the national HMIS[222]?	**No**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**1. Updating service standards and guidelines.** **2. Development of job aids.** **3. Management protocols.** **4. Sensitization with VHTs.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Please see list at beginning of document. In most cases, PPH prevention/management is a component of programs, but not the only focus.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Please see list at beginning of document. In most cases, PPH prevention/management is a component of programs, but not the only focus.**
21.	What % of districts are covered by current national PPH programs?	**100%** **But there is varying coverage within districts. Coverage within districts is probably between 5-50% on average.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**50%**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Rollout has begun, but acceleration is the challenge.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Challenge: slow implementation of new MOH policies through MOE in pre-service education (most of the implementation to date has been in in-service).** **Means of Addressing: some updates are being given to tutors, but resource limitations make it difficult to scale up this activity.** **2. Challenge: gap between pre-service training and clinical practice; limited funding for production and dissemination of job aids.** **Means of Addressing: well-recognized challenge; strategies are being developed to address it.** **3. Challenge: lack of human resources.** **Means of Addressing: The challenge is well-recognized and a number of groups are working to address it, including MOH, Ministry of Finance, the Health Services Commission and districts themselves.**

[221] Ministry of Health
[222] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Miriam Sentongo** **Senior Medical Officer** **RH Division, Ministry of Health, Uganda** **E-mail: mirnastogo@gmail.com** **Tel.: +256-772-413433**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **Labetolol: hospital and HCIV; Hydralazine: HCIV; Nifedipine: for facilities lower than level III only the slow-release version is allowed.**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	**Labetolol Yes** **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes** **Other (Please describe)** **All are on the EML; however, the EML only gives the drugs' names and does not mention what they are to be used for. One must refer to the clinical guidelines for that information.**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No **Other (Please describe)** **The policy guidelines are clear, but the health workers sometimes do something different when MgSO4 is not available.**
4.	Is MgSO4[223] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes** **HCIII and upward.**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**

[223] Magnesium Sulfate

Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).** **At the central level, they rarely occur; at the facility level, it is hard to estimate because the "push system" is used to get MgSO4 out, so feedback is not usually received.**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**No** **Notification of death forms can provide some information/statistics.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**1. Strengthening auditing.** **2. Development of job aids.** **3. Materials for VHTs on danger signs.** **4. Intend to fine-tune in-service curriculum.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Please see list at the beginning of the document. In many cases, PE/E prevention and management is included in programs in some way, but is not the sole focus.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Please see list at the beginning of the document. In many cases, PE/E prevention and management is included in programs in some way, but is not the sole focus.**
15.	What % of districts are covered by current PE/E programs?	**100% of districts; but within districts there is only about 30% coverage, on average.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**25%**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**An auditing exercise has been introduced, but effort is needed to scale it up. One possibility on the table is scaling up through a campaign.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Challenge: keeping momentum.** **Response: Possibilities are being discussed, but a campaign is one possibility.** **2. Challenge: people are busy, so maintaining engagement is difficult.** **Response: MOH top management is engaged.** **3. Challenge: Institutionalization is difficult, given limited human resources.** **Response: has handed the auditing exercise over to the data management unit.**

Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Miriam Sentongo, Senior Medical Officer** **RH Division, Ministry of Health, Uganda** **E-mail: mirnastogo@gmail.com** **Tel.: +256-772-413433**

REPUBLIC OF YEMEN

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country? If not, name the leading maternal health bilateral(s) or project(s), and who is implementing it (them).	**Yes** **Is not a program; there is a Reproductive Health Directorate within the Population Sector in the Ministry of Public Health and Population that is responsible for all reproductive health (RH) programs. The Child Health Program is run by the Child Health Directorate, which is within the Primary Health Sector in the Ministry.**

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[224] at every birth approved as national policy?	**Yes** **AMTSL is in all EmOC Guidelines for Doctors and Midwives, but the training is not scaled-up at governorate and district levels due to financial shortage. It was implemented in 83 health facilities in the country during 2010.**
2.	Are the steps for correctly performing AMTSL incorporated into service delivery guidelines?	**Yes** **It is in the EmOC Guidelines for Doctors and Midwives.**
3.	Is misoprostol on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	**No** **Misoprostol is not on the EML, but it is available in the private market; most of the comprehensive EmOC hospitals are using it in prevention and treatment of PPH.**
4.	Are midwives authorized to perform manual removal of placenta at all levels of the health system?	**Yes** **The midwives who were trained with the EmOC Guidelines for Midwives are able to do so; it is in the job description for midwives. Now, we are in the process of updating the curriculum for midwifery training in health institutes. Competencies are very important, and all graduated midwives will be competent for all interventions that are included in their job description, including AMTSL.**
5.	Are midwives authorized to perform AMTSL with oxytocin at all levels of the health system?	**Yes** **They are authorized to perform it at facility level or even at home. We have the National Community-Based Maternal and Neonatal Care Guidelines; the midwives are trained to perform it at home.**
6.	Is oxytocin on the National EML for prevention and/or treatment of PPH?	**Yes** **At all levels where a doctor or a midwife is available.**
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[225] cadres?	**Yes** **Doctors and midwives.**

[224] Active management of the third stage of labor
[225] Skilled Birth Attendant

8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	**Yes** **Yes, all graduated doctors are assessed in their internship in the OBS department.**
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	**Yes** **For midwives, nurses and doctors.**
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	**Yes** **Piloted research for studying the effect of misoprostol in preventing PPH is going now, at the facility level through doctors and at the community level through midwives.**
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	**No** **It is implemented in some places, but not scaled up, as the misoprostol is not in the National Drug List. We are waiting for the result of the study (effect of misoprostol in preventing PPH) to convince the Supreme Board of Drugs at the Ministry to include misoprostol on the National Drug List. If we succeed, then it will be available for all midwives.**
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	**Less than half the time.** **Many times, may not be available due to shortage of funds. But, as it is available at the private pharmacies and not expensive, it may be provided by health facility or family.**
13.	Is oxytocin free of charge to patients at public health facilities?	**Yes** **If the Medical Supply at the Ministry distributes it, it will be free. But most of the time, it may not be there, as the amount distributed to health facilities is not sufficient. If it is not available, the family may buy it from the private pharmacy.**
14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Frequently (once in every 2 months or less).** **Once we receive certain amount from the Medical Supply, we distribute it all to functioning health facilities.**
15.	Is oxytocin currently available at the MOH[226] medical store?	**No**
16.	Is misoprostol available at public facilities that offer maternity services?	**Never** **The doctors prescribe it for the family of the patient, and the family buys it from the private pharmacy.**
M&E		
17.	Is AMTSL included in the national HMIS[227]?	**No** **USAID IBPs 2008–2011 did it for the supported facilities.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Include it in the EmOC Guidelines and in the pre-service training of midwives and doctors.** **Conduct in-service training.**

[226] Ministry of Health
[227] Health Management Information System

19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**BHS-ESD Projects/Pathfinder Int. (USAID) had been the leading project of PPH prevention and management since 2007 (AMTSL): starting from advocacy, sending health policy people to attend BPs conferences, training and introducing the activities to one teaching hospital in 2007, and then expanding to about 83 health facilities and more health service providers.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**Manual vacuum aspiration (MVA) supported by Marie Stopes International for abortion cases.** **Misoprostol is provided to midwives who work with Marie Stopes International.**
21.	What % of districts are covered by current national PPH programs?	**Approximately less than 50%.** **Those supported by USAID-ESD Project.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**Less than 50% of midwives and less than 30% of doctors.**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**1. Currently, the MOH is in the process of updating the midwifery job description and curriculum.** **2. There is strong advocacy with the Medical Supply and Supreme Board of Drugs to include misoprostol on the National Drug List.** **3. The MOH considers the Best Practices Program as part of its RH strategy.** **4. In-service training materials are available (EmOC and Community-Based Guidelines) but the training needs to be scaled up.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Misoprostol is not on the National Drug List.** **2. Financial shortage limits the Ministry from scaling up training (EmOC or Best Practices).** **3. Oxytocin is not available in the health facilities most of the year.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Eman A. Al-Kubati** **General Director of RH/Ministry of Public Health and Population** **E-mail: emanalkobaty@gmail.com** **Tel.: +967-733282678** **Ahemd Assalahy** **Pathfinder International/Yemen** **E-mail: aalssalahy@pathfinder.org** **Tel.: +967-733201007**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)			
Policy			
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol	No
		Hydralazine	**Yes**
		Nifedipine	**Yes**
		Methyldopa	**Yes**

2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** **Diazepam Yes** **Other (Please describe)** **MgSO4 is used in most of the comprehensive hospitals, but some hospitals still use diazepam.**
4.	Is MgSO4[228] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes** **It is there in the curriculum, the EmOC Guidelines for Doctors and Midwives and the Community-Based Maternal and Neonatal Care Guidelines for Midwives.**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Doctors, midwives**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Less than half the time.** **That depends on the health facility fund and the amount distributed by the Medical Supply.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Frequently (once in every 2 months or less).**
10.	Is MgSO4 currently available at the MOH medical store?	**No**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Hospital delivery file, the health registry of antenatal and postnatal care, and the delivery and Emergency Obs. registry.**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Include the early diagnosis and management in the service guidelines.** **Include it in the health education messages on radio, TV, volunteers, mobile cinema and journals.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Supported preparation of service guidelines.**

[228] Magnesium Sulfate

14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Not many**
15.	What % of districts are covered by current PE/E programs?	**Very limited health facilities.**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**Around 25% of midwives are trained by the Community-Based Maternal and Neonatal Care Guidelines that include the diagnosis and management of PE/E.** **Few midwives are trained on the EmOC Guidelines that include the diagnosis and management.** **Around 40 doctors had it in the High Diploma Course for Obs.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**1. Finalize process of updating the midwifery curriculum.** **2. Advocate to the Medical Supply to raise the amount of antihypertensive and MgSO4 that is distributed to health facilities.** **3. Support the scale-up of the training, as training references.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. Financial shortage prevents us from scaling up the training (EmOC or Community-Based MNH Guidelines) to all health providers.** **2. Antihypertensives and MgSO4 are not available in the health facilities most of the year.** **3. Financial shortage prevents us from printing the poster for the management protocol for PE/E and distributing it to all health facilities.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Dr. Eman A. Al-Kubati** **General Director of RH/Ministry of Public Health and Population** **E-mail: emanalkobaty@gmail.com** **Tel.: +967-733282678** **Ahemd Assalahy** **Pathfinder International/Yemen** **E-mail: aalssalahy@pathfinder.org** **Tel.: +967-733201007**

ZANZIBAR

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[229] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes Hospitals, health centers and primary health care units.
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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes Hospitals, health centers and primary health care units.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[230] cadres?	Yes All cadres
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	Regularly
13.	Is oxytocin free of charge to patients at public health facilities?	Yes

[229] Active management of the third stage of labor
[230] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[231] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Regularly**
M&E		
17.	Is AMTSL included in the national HMIS[232]?	**Yes** **Delivery logs**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**Trainings for service providers on emergency obstetric care including PPH and PE/E.** **Ensure availability of oxytocin in health facilities providing the services.** **Ensure availability of IV infusion and blood transfusion.** **Develop job aid and posters for emergency obstetric care.**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**Training in BEmONC.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**VSI: training health care providers on PPH.** **DANIDA: providing drugs and supplies.** **UNFPA, WHO and UNICEF: trained health care workers on lifesaving skills.** **Copenhagen University: training pre-service and in-service health care providers.**
21.	What % of districts are covered by current national PPH programs?	**All districts: 100 %** **Districts covered, but not to all relative service providers.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**About 70% of all providers have been trained on PPH under MAISHA, VSI and other partners (UN).**
Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**Reduction of maternal mortality is the Ministry's priority.** **It is also development partners' interest.** **Existence of community health strategy and community health committees.** **Existence of the policy for task-shifting to midwives.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**On-and-off shortage of oxytocin and supplies.** **Shortage of skilled staff.** **What has been done:** **Increase intake of nurses in College of Health Sciences in Zanzibar.** **Inclusion of misoprostol on Essential Medicine List.**

[231] Ministry of Health
[232] Health Management Information System

Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Azzah Amin** **E-mail: azzahnofly@yahoo.co.uk**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** Methyldopa No
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**Pre-eclampsia Yes** **Eclampsia Yes**
4.	Is MgSO4[233] on the National EML for: severe pre-eclampsia?; eclampsia?	**Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the health system?	**Yes**
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Nurses/midwives and clinical officers.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**Regularly**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Delivery logs**

[233] Magnesium Sulfate

Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**Trainings in collaboration with other partners.**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**Training health providers on BEmONC.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**Trainings by VSI and UNFPA.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**At least every provider working at hospitals, health centers and primary health care units; and received two-day training on PE/E and AMTSL.**
Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	**The same as in PPH.**
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**Irregular supply of magnesium sulfate and other supplies.** **Inadequate skills of service providers.** **Inadequate infrastructure.** **What has been done:** **Provision of trainings to service providers.** **Development of the guidelines for EmONC.**
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Azzah Amin** **E-mail: azzahnofly@yahoo.co.uk**

ZIMBABWE

QUESTION	RESPONSE AND FURTHER INFORMATION
Is there an MCHIP presence in this country?	Yes

Section 1: Postpartum Hemorrhage (PPH)		
Policy		
1.	Is AMTSL[234] 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 on the National Essential Medicines List (EML), specifically with the indication for prevention and/or treatment of PPH at any level of the health system?	Yes First-line going upward. Not at the community.
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 oxytocin on the National EML for prevention and/or treatment of PPH?	Yes From first-line upward.
Training		
7.	Do pre-service education curricula include AMTSL for all SBA[235] cadres?	Yes Doctors, nurses, midwives.
8.	Are students assessed for competency in performance of AMTSL as a clinical skill prior to graduation?	Yes
9.	Is AMTSL included in in-service training curricula for all SBA cadres?	Yes
Distribution of Misoprostol for PPH Prevention at Home Birth		
10.	Has the use of misoprostol for the prevention of PPH at home births been piloted?	No Pilot still being considered with Venture Strategies Innovations (VSI), Medical School, MCHIP and other partners.
11.	Is the use of misoprostol for PPH prevention during home births being scaled up?	No Misoprostol not authorized for home births.
Logistics		
12.	Is oxytocin available at public facilities that offer maternity services?	More than half the time.
13.	Is oxytocin free of charge to patients at public health facilities?	No Free at some facilities.

[234] Active management of the third stage of labor
[235] Skilled Birth Attendant

14.	How frequently do stock-outs of oxytocin occur at the central/regional levels?	**Sometimes (every 3 to 6 months).**
15.	Is oxytocin currently available at the MOH[236] medical store?	**Yes**
16.	Is misoprostol available at public facilities that offer maternity services?	**Less than half the time.** **Policy not yet clear.**
M&E		
17.	Is AMTSL included in the national HMIS[237]?	**Yes** **In delivery register, but not reported up the national HMIS.**
Programming		
18.	Which activities in PPH prevention and management are being undertaken by the MOH? Briefly specify what is being done.	**1. Development of service delivery guidelines and revision of policies.** **2. National-level clinical trainings.** **3. Monitoring and evaluation.** **4. Training midwives (pre-service education).**
19.	Which activities in PPH prevention and management are being undertaken by USAID-sponsored programs? Briefly specify what is being done.	**1. Advocacy.** **2. Development of clinical training guidelines.** **3. Quality improvement approaches (SBM-R) with facilities.** **4. Maternal mortality audits.** **5. Quality of care study.**
20.	Which activities in PPH prevention and management are being undertaken by other donors or other partners? Briefly specify what is being done.	**1. Up-skilling primary care nurses in midwifery skills.** **2. Commodity security (procurement and distribution of medicines and supplies).** **3. Maternal mortality audits.**
21.	What % of districts are covered by current national PPH programs?	**100%** **Difficult to quantify because different programs have different coverage.**
22.	What % of current SBAs are being reached by programmatic efforts of the current national PPH programs?	**68%**

[236] Ministry of Health
[237] Health Management Information System

Opportunities for Expansion and Scale-Up		
23.	Please describe any potential opportunities that you see for program expansion or scale-up.	**1. Increased funding from government, health transition fund and partners.** **2. Advocacy efforts through high-level representation in CARMMA.** **3. High geographical coverage of facilities and low vacancy rates.** **4. Partner support to commodity security.** **5. Revitalization of community health workers in maternal, newborn and child health (MNCH).** **6. Reproductive health policy revision currently taking place.** **7. Maternal audit guidelines being revised.** **8. Increasing number of partners in MNCH.** **9. Findings from the Quality of Care Study.**
24.	What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	**1. User fees policy implementation: Government has allocated more resources to offset user fees for maternity services.** **2. Misoprostol at lower levels of the health system: Pilot work being supported by partners to generate evidence for policy dialogue.** **3. Weakness in tracking progress: Partners are working on how to collect and report data on adherence to PPH prevention and management.**
Contact Person		
25.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	**Ms. M. Nyandoro** **E-mail: nyandorom@gmail.com** **Tel.: +263772325918**

Section 2: Pre-Eclampsia/Eclampsia (PE/E)		
Policy		
1.	What drugs are approved through national policy/service delivery guidelines for administration as first-line antihypertensives in severe pre-eclampsia/eclampsia (PE/E)?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
2.	What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of severe PE/E?	Labetolol No **Hydralazine Yes** **Nifedipine Yes** **Methyldopa Yes**
3.	What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for severe PE/E?	**MgSO4 Yes** Diazepam No
4.	Is MgSO4[238] on the National EML for: severe pre-eclampsia?; eclampsia?	**Pre-eclampsia Yes** **Eclampsia Yes**
5.	Are midwives authorized to diagnose severe PE/E and administer initial (loading) dose of MgSO4 at lowest-level facility that they work at within the	**Yes**

[238] Magnesium Sulfate

	health system?	
Training		
6.	Do pre-service education curricula include current global management principles for PE/E for all SBA cadres?	**Yes** **If Yes, which cadres?** **Nurses, doctors, midwives.**
7.	Are current global management principles for PE/E included in in-service training courses for SBAs?	**Yes**
Logistics		
8.	Is MgSO4 available at public facilities that offer maternity services?	**More than half the time.**
9.	How frequently do stock-outs of MgSO4 occur at the central/regional levels?	**Rarely (once a year).**
10.	Is MgSO4 currently available at the MOH medical store?	**Yes**
M&E		
11.	Is an indicator to monitor severe PE/E included in the national HMIS?	**Yes** **Number of cases with PE/E (delivery register), number of maternal deaths due to eclampsia (maternity register, maternal death notification form).**
Programming		
12.	Which activities in PE/E prevention and management are being undertaken by the MOH? Please briefly specify what is being done.	**1. Development of service delivery guidelines and revision of policies.** **2. National-level clinical trainings.** **3. Monitoring and evaluation.** **4. Training midwives (pre-service education).**
13.	Which activities in PE/E prevention and management programming are being undertaken by USAID-supported implementing partners? Please briefly specify what is being done.	**1. Policy advocacy.** **2. Development of clinical training guidelines.** **3. Quality improvement approaches (SBM-R) with facilities.** **4. Maternal mortality audits.** **5. Quality of Care Study.**
14.	Which activities in PE/E prevention and management programming are being undertaken by other donors or other partners? Please briefly specify what is being done.	**1. Up-skilling primary care nurses in midwifery skills.** **2. Commodity security (procurement and distribution of MgSO4 and supplies).** **3. Maternal mortality audits.**
15.	What % of districts are covered by current PE/E programs?	**100%**
16.	What % of current SBAs are being reached by programmatic efforts of the current national PE/E programs?	**68%**

Opportunities for Introduction, Expansion and Scale-Up		
17.	Please describe any potential opportunities that you see for program introduction, expansion or scale-up.	1. Increased funding from government, health transition fund and partners. 2. Advocacy efforts through high-level representation in CARMMA. 3. High geographical coverage of facilities and low vacancy rates. 4. Partner support to commodity security. 5. Revitalization of community health workers in MNCH. 6. Reproductive health policy revision currently taking place. 7. Maternal audit guidelines being developed. 8. Increasing number of partners in MNCH. 9. Findings from the Quality of Care Study.
18.	What are the three most significant bottlenecks to scaling up PE/E management programs in your country? Briefly describe what is being done to address the bottlenecks, if anything.	1. User fees policy implementation: Government has allocated more resources to offset user fees for maternity services. 2. Health workers not confident to administer MgSO4: Partners are rolling out in-service and on-the-job training including clinical supportive supervision. 3. Weakness in tracking progress in PE/E programs: Partners are working on how to collect and report data on adherence to PPH prevention and management.
Contact Person		
19.	Contact person who will be responsible for updates to this matrix. Include name, telephone number and e-mail address.	Ms. M. Nyandoro E-mail: nyandorom@gmail.com Tel.: +263772325918

Appendix 3: Completed Scale-Up Maps

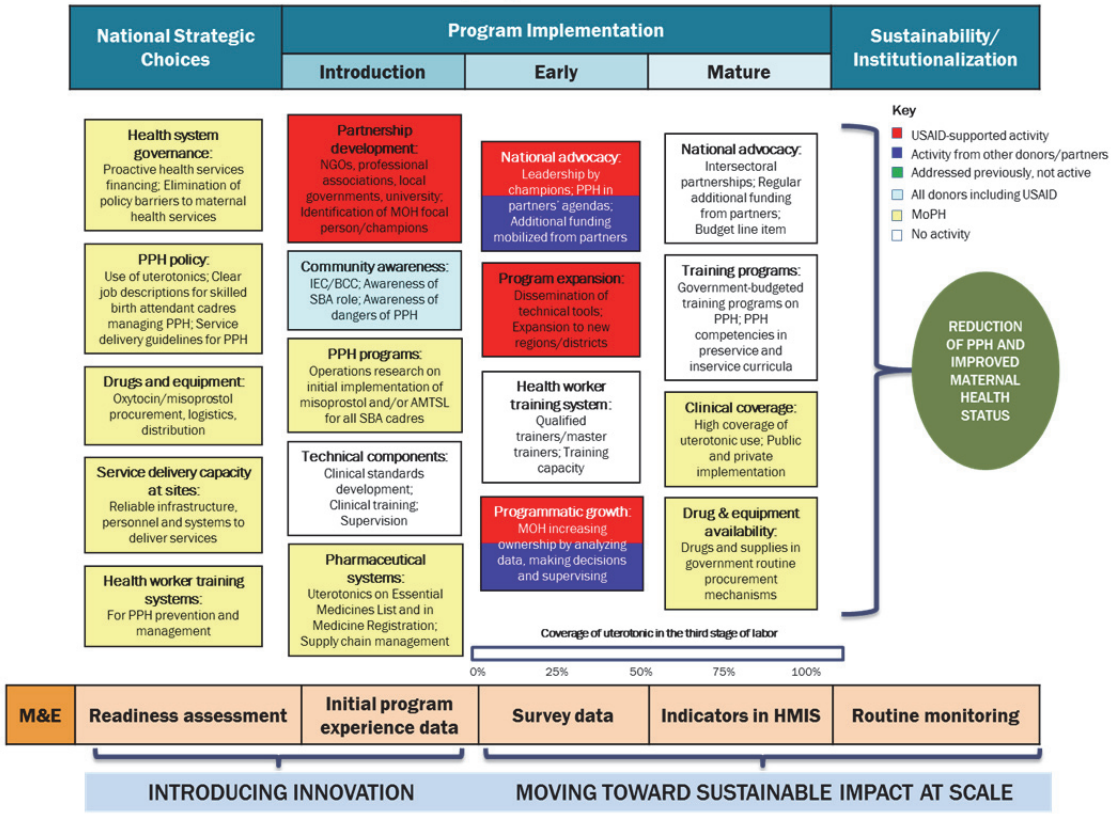
Interpretation of Scale-Up Maps

An integral aspect of MCHIP's documenting national scale-up of programs to reduce PPH and PE/E included the creation of "scale-up maps," visual representations of national policy, rollout and scale-up of PPH and PE/E programs. Thirty-six countries completed scale-up maps in 2012, an increase from the 27 countries in 2011.

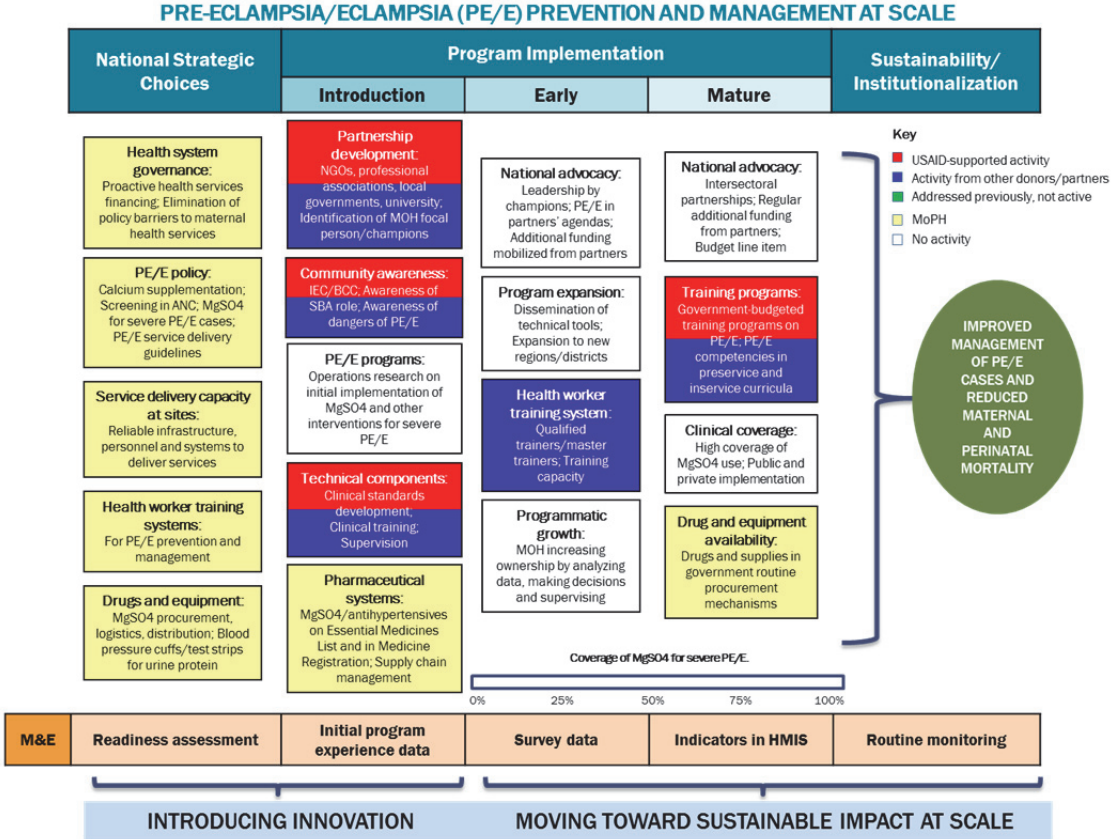
From a global standpoint, the 2012 scale-up maps show that the majority of countries have PPH and PE/E programs. Multiple partners share oversight of these programs; most notably MCHIP/USAID or the local MOH collaborates with other partners.

While the findings outlined above are illustrative of the PPH and PE/E scale-up process in MCHIP countries, there are limitations in the extent to which one can draw conclusions or compare data collected in 2011 and 2012. First, the layout and content of the map were changed in 2012, making comparison across the two years difficult. Second, the process of creating scale-up maps is subjective and most useful for country program managers as an evaluation tool for their programs. As an analytic process, or as a method of tracking change over time globally across many countries, these maps cannot be considered a reliable data source. The quantitative data discussed earlier in this report provide a better analysis of PPH and PE/E programming.

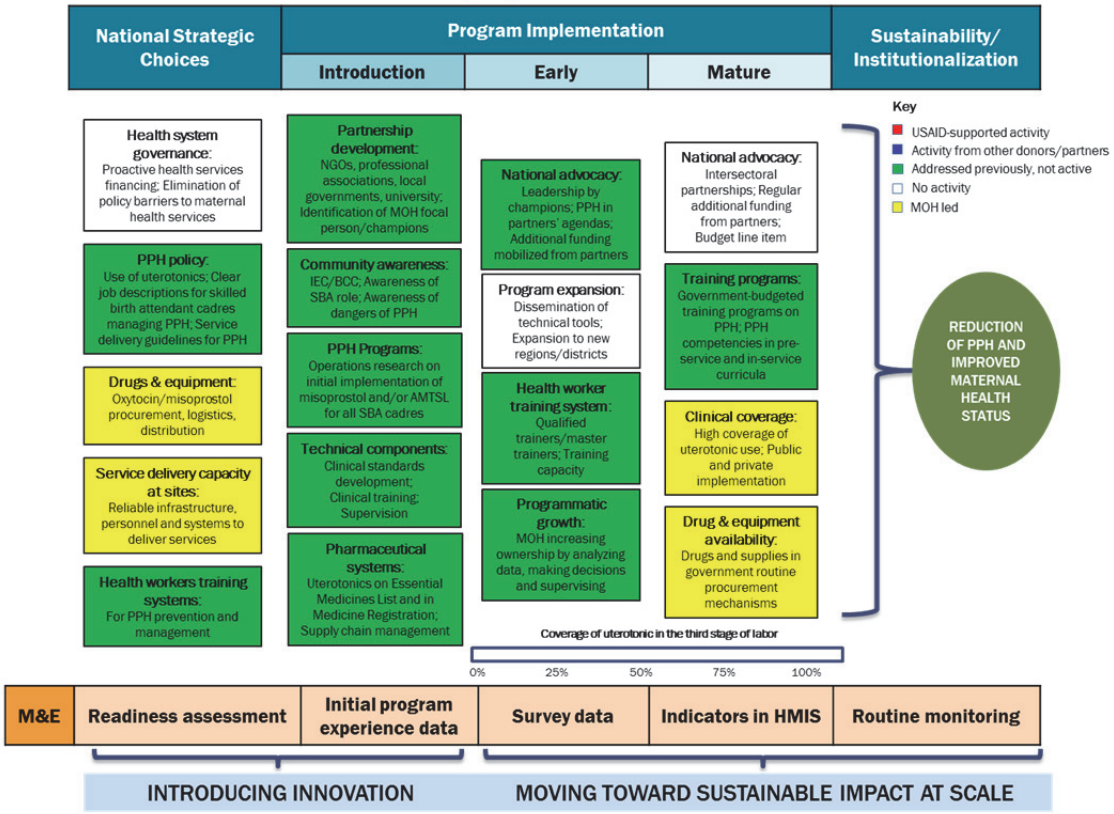
AFGHANISTAN PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



AFGHANISTAN PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



ANGOLA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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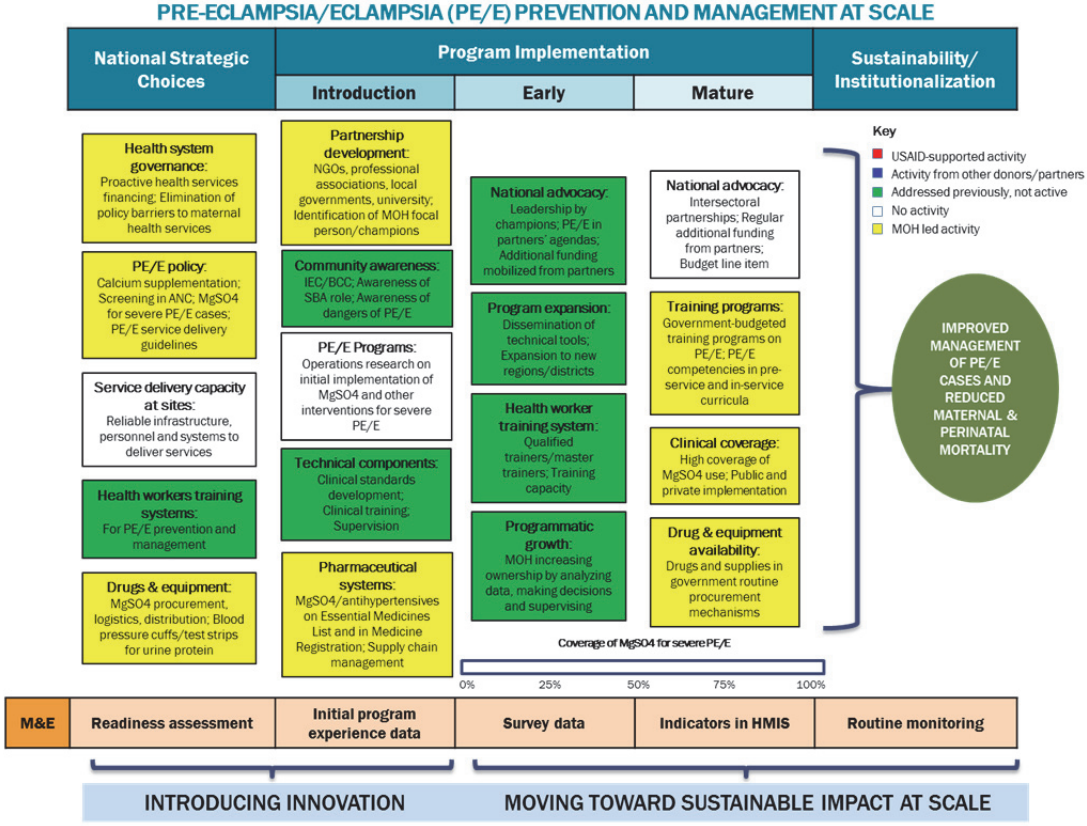
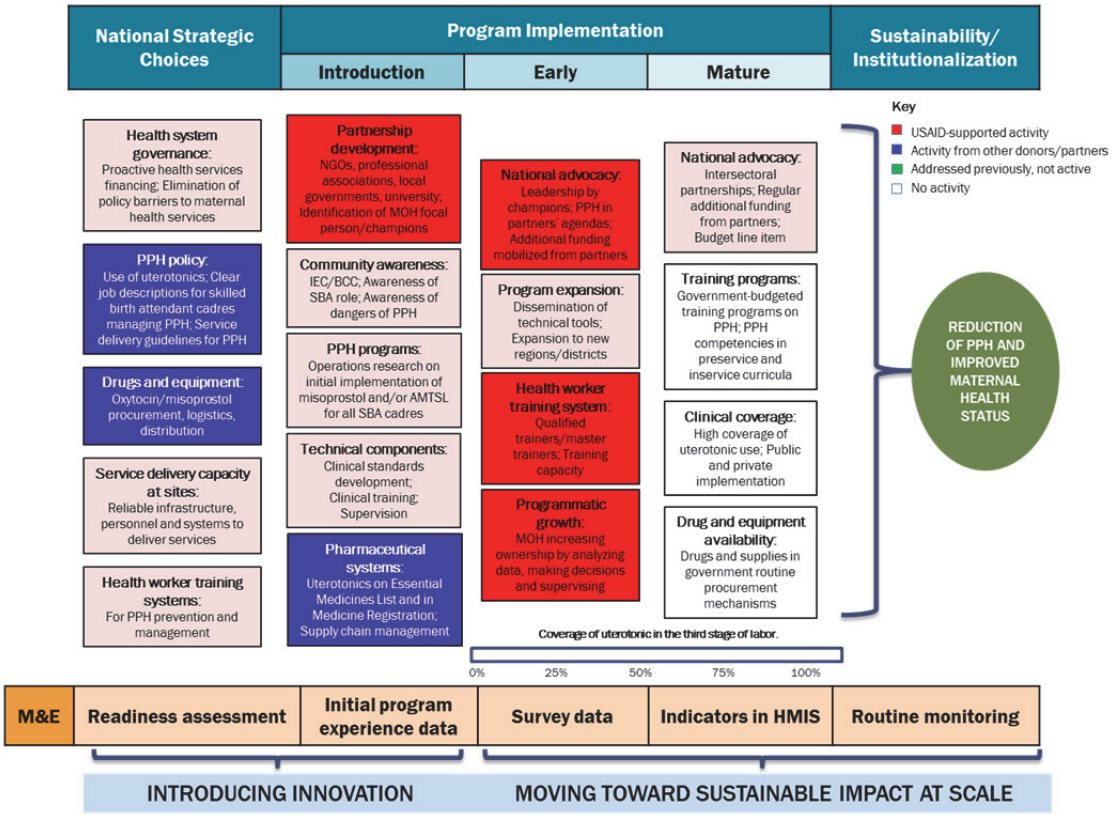


BANGLADESH PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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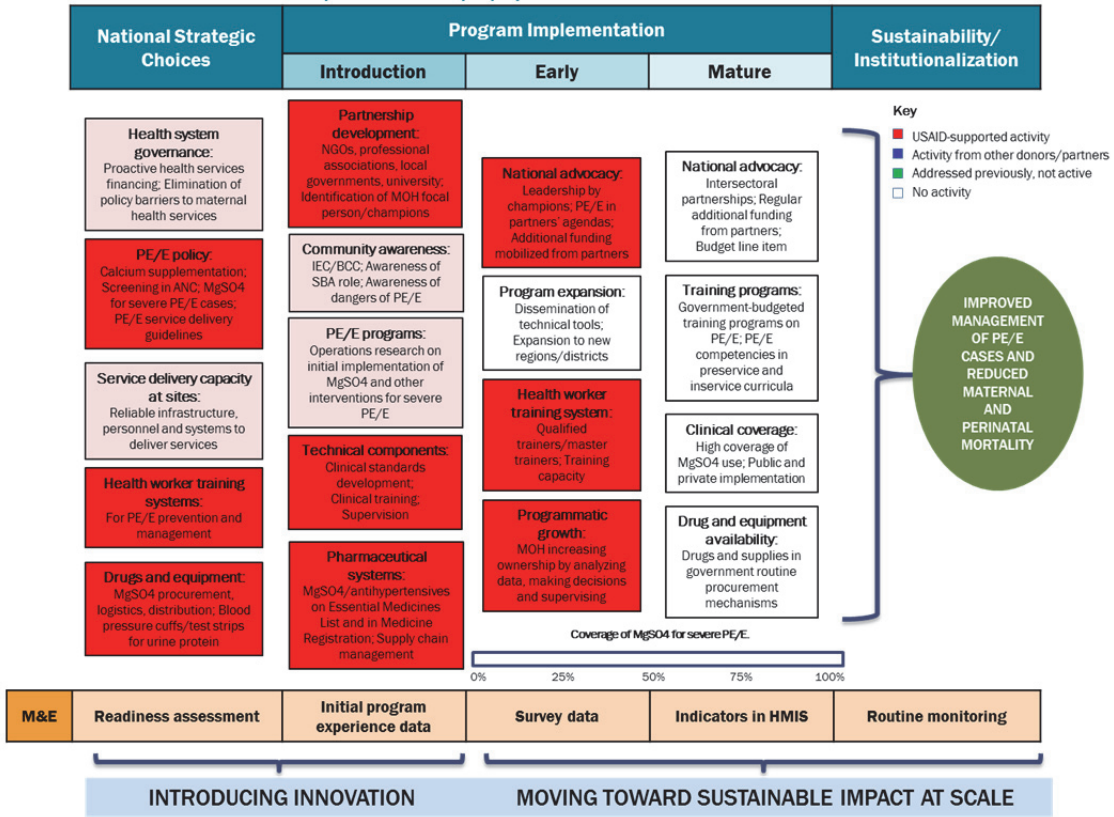

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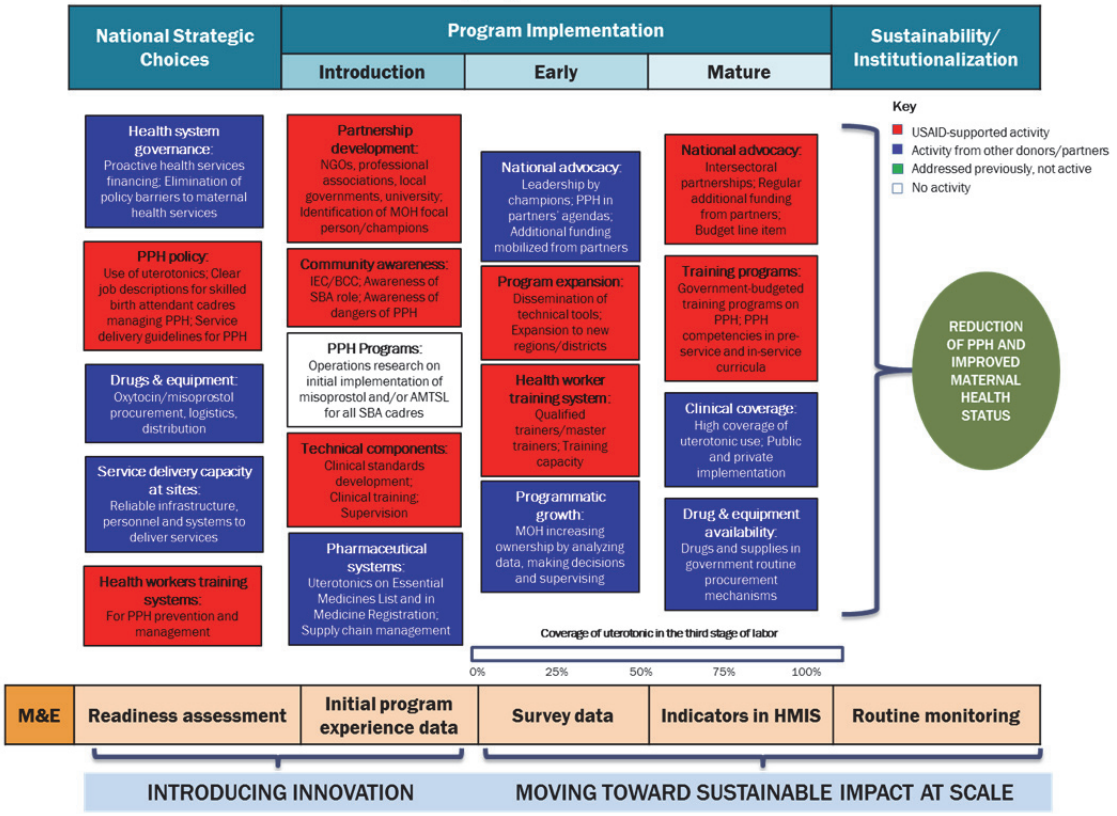

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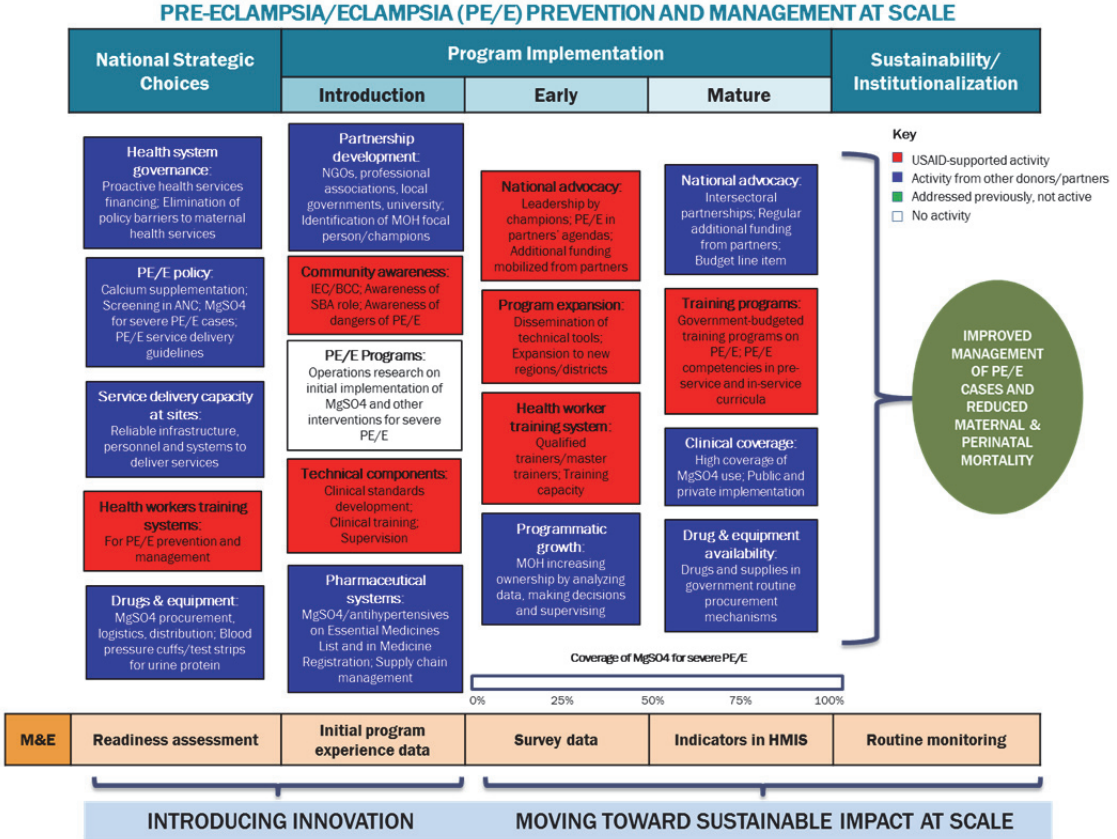
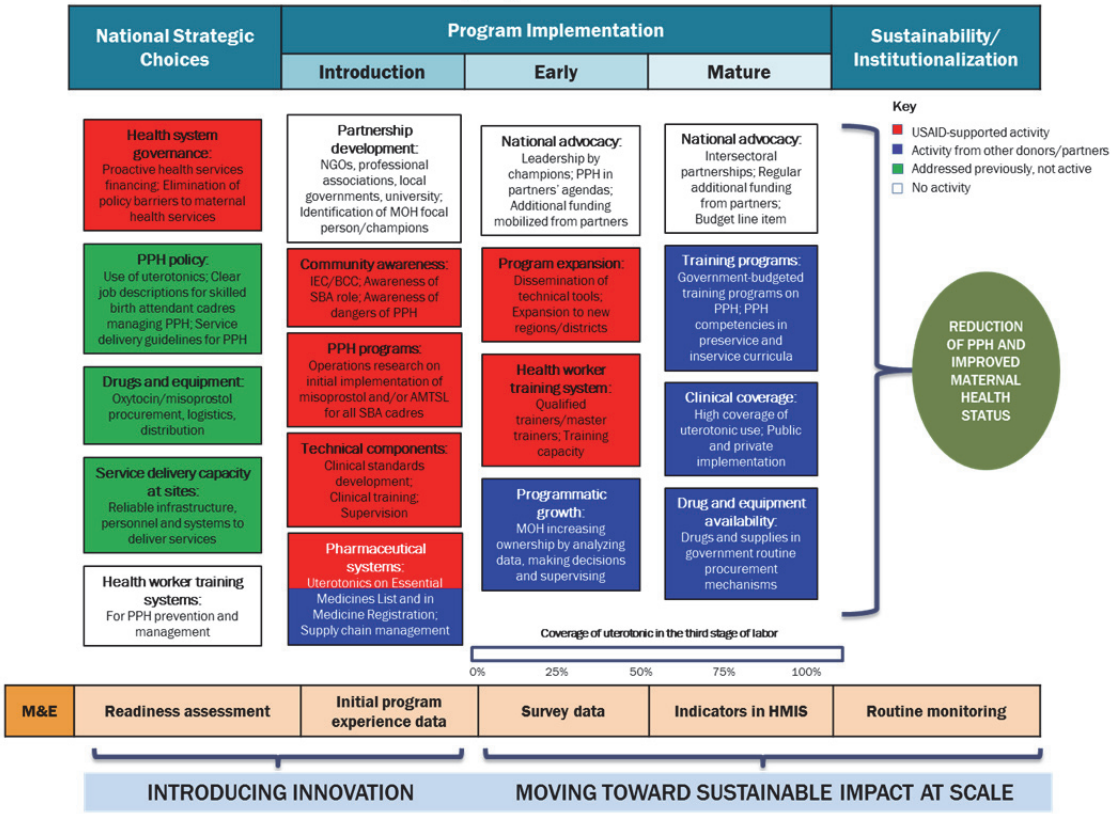
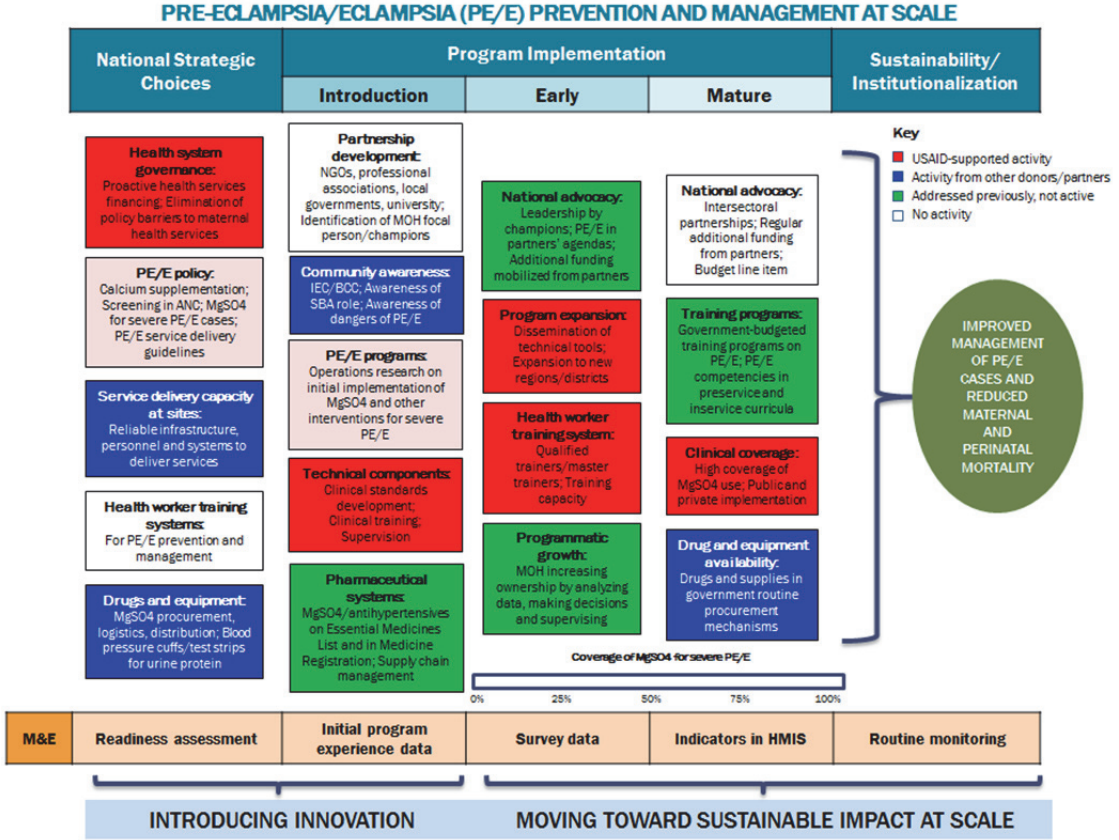


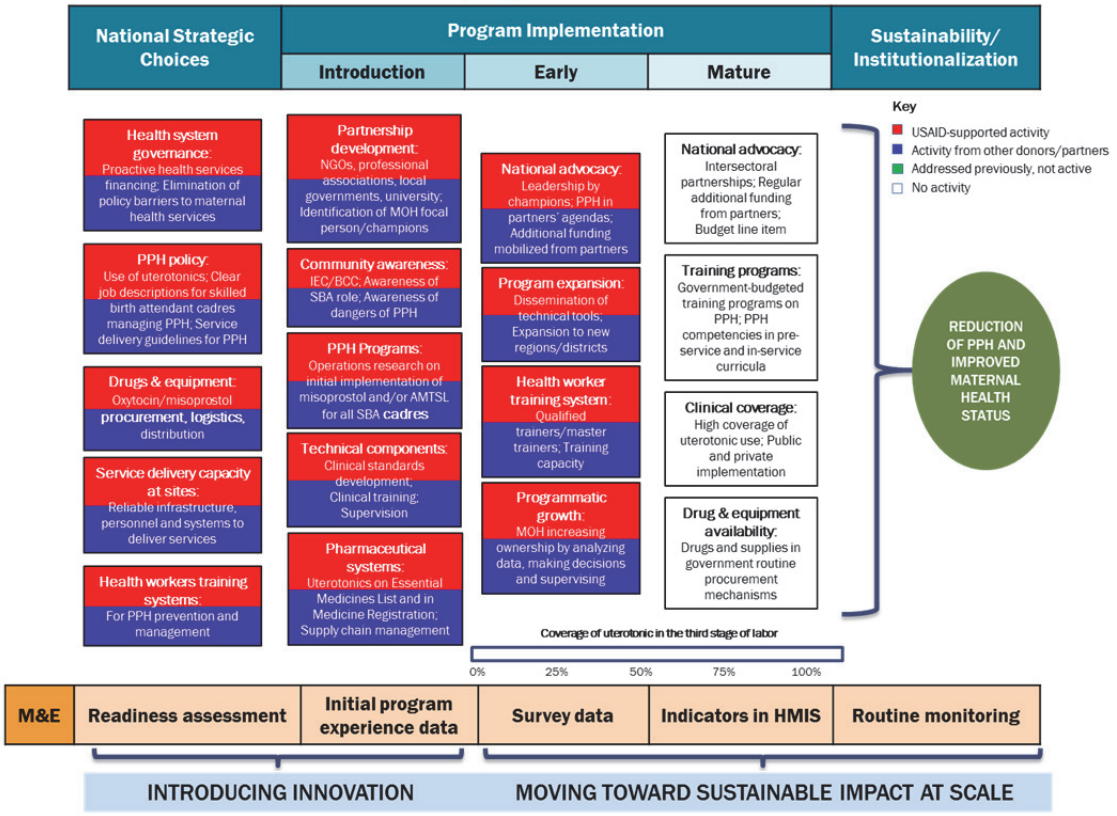
CAMBODIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



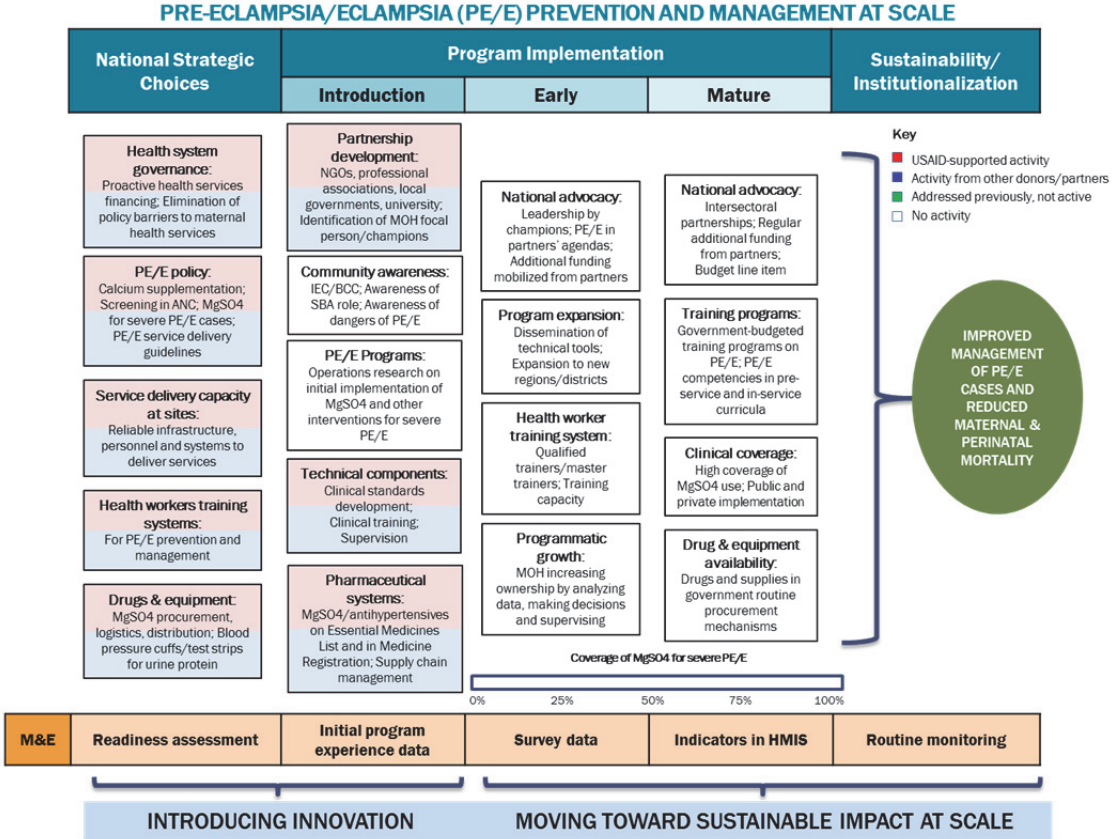
CAMBODIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



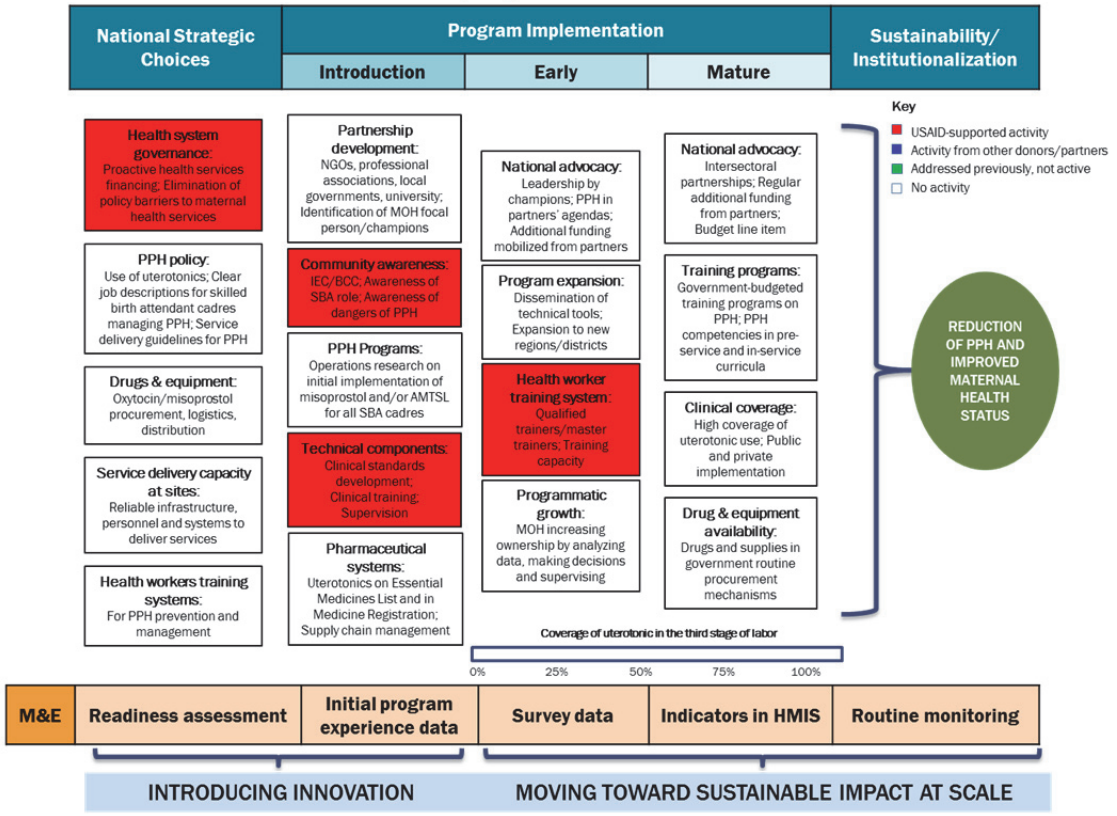
DRC PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



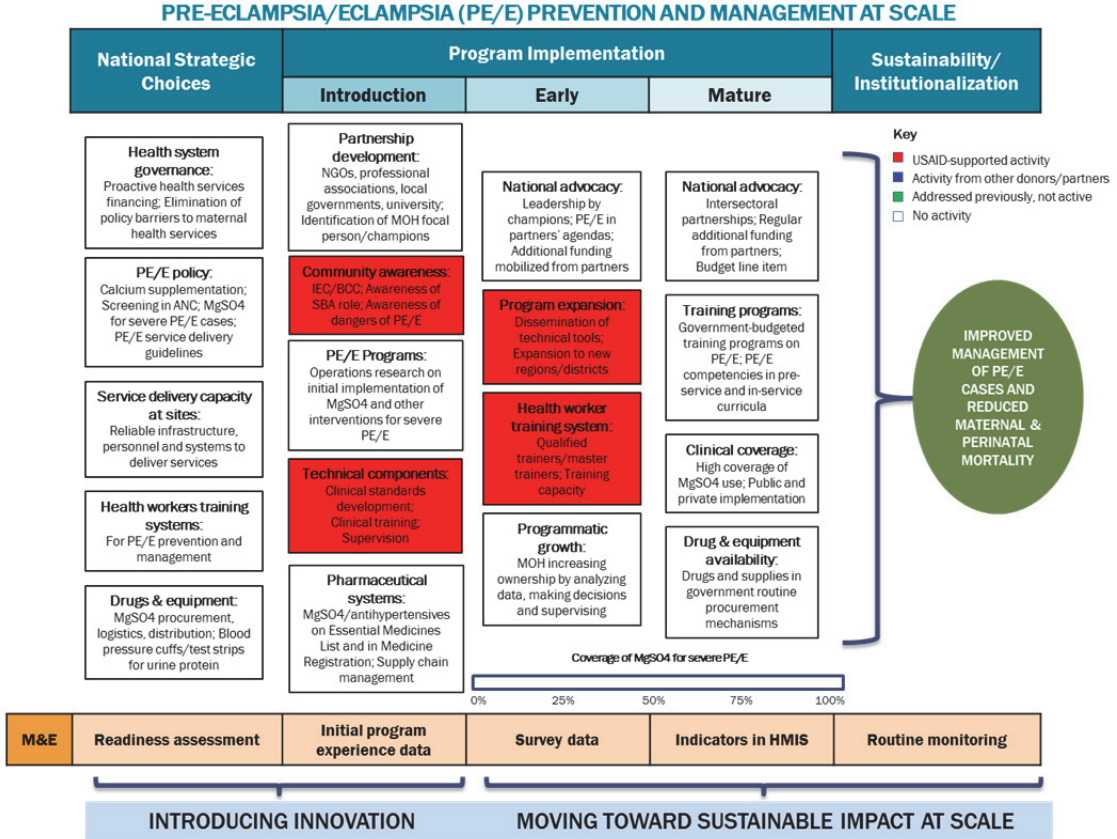
DRC PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



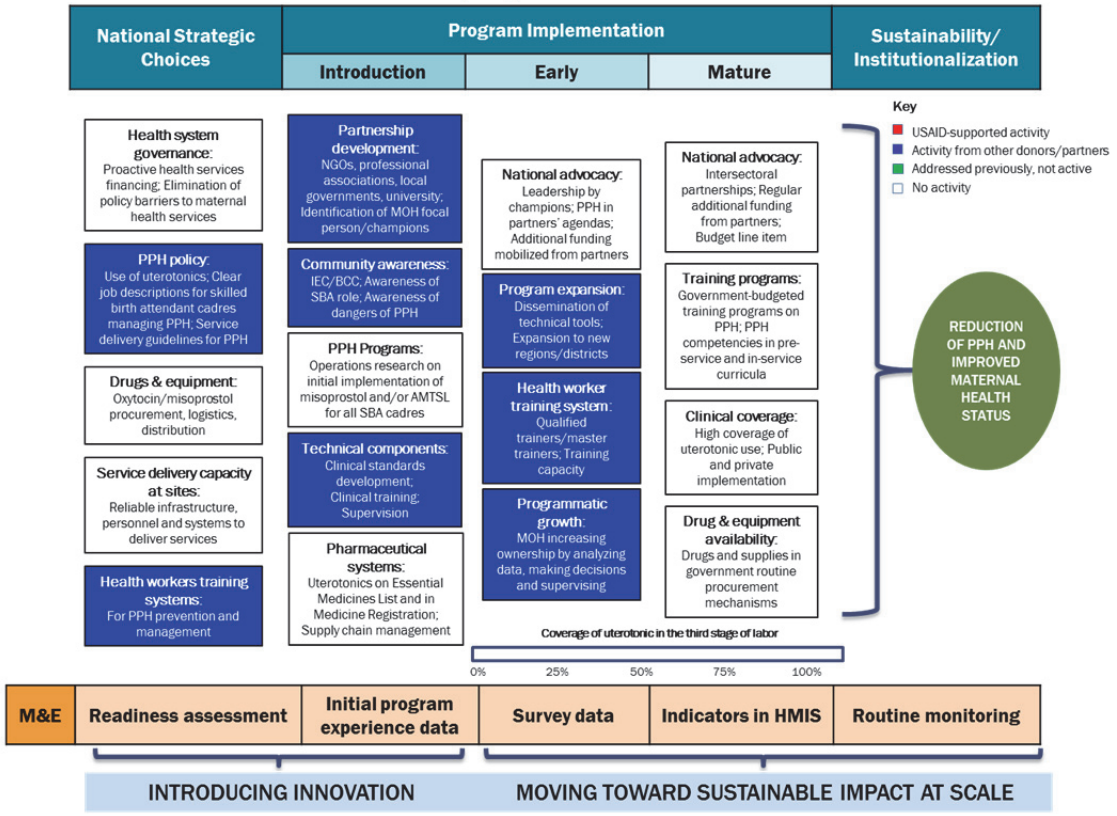
ECUADOR PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



ECUADOR PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



EQUATORIAL GUINEA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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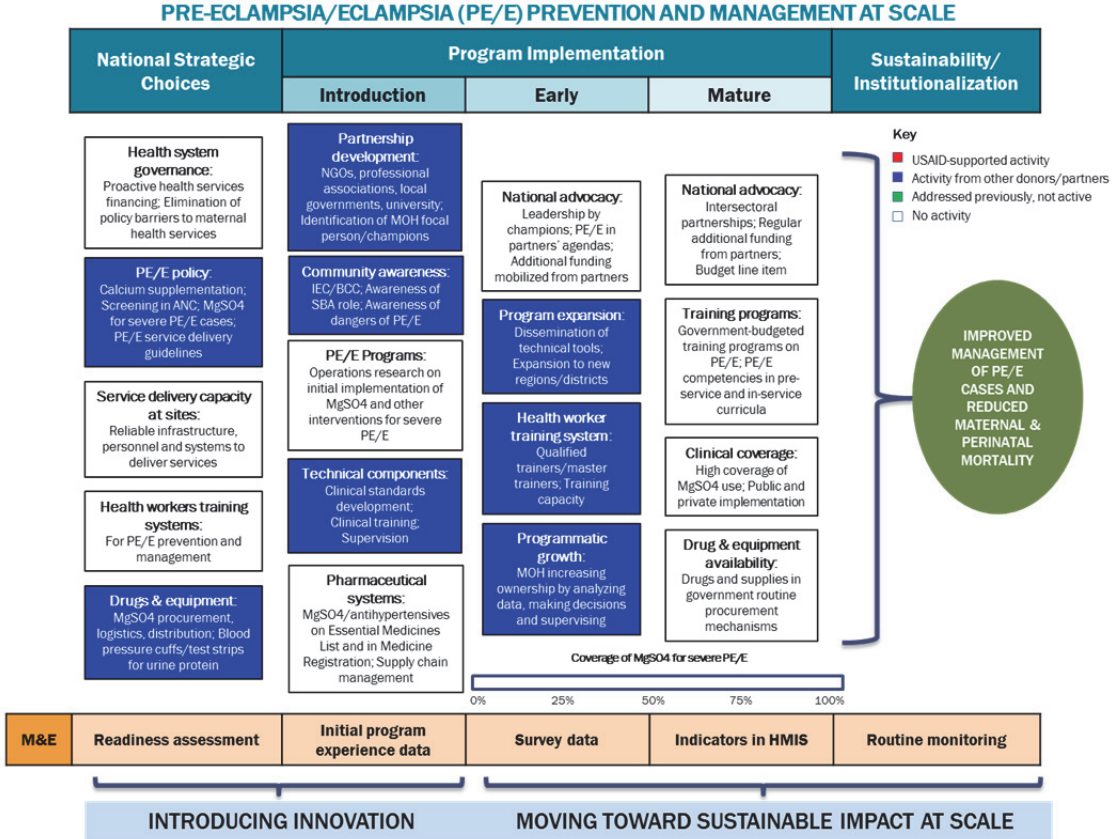

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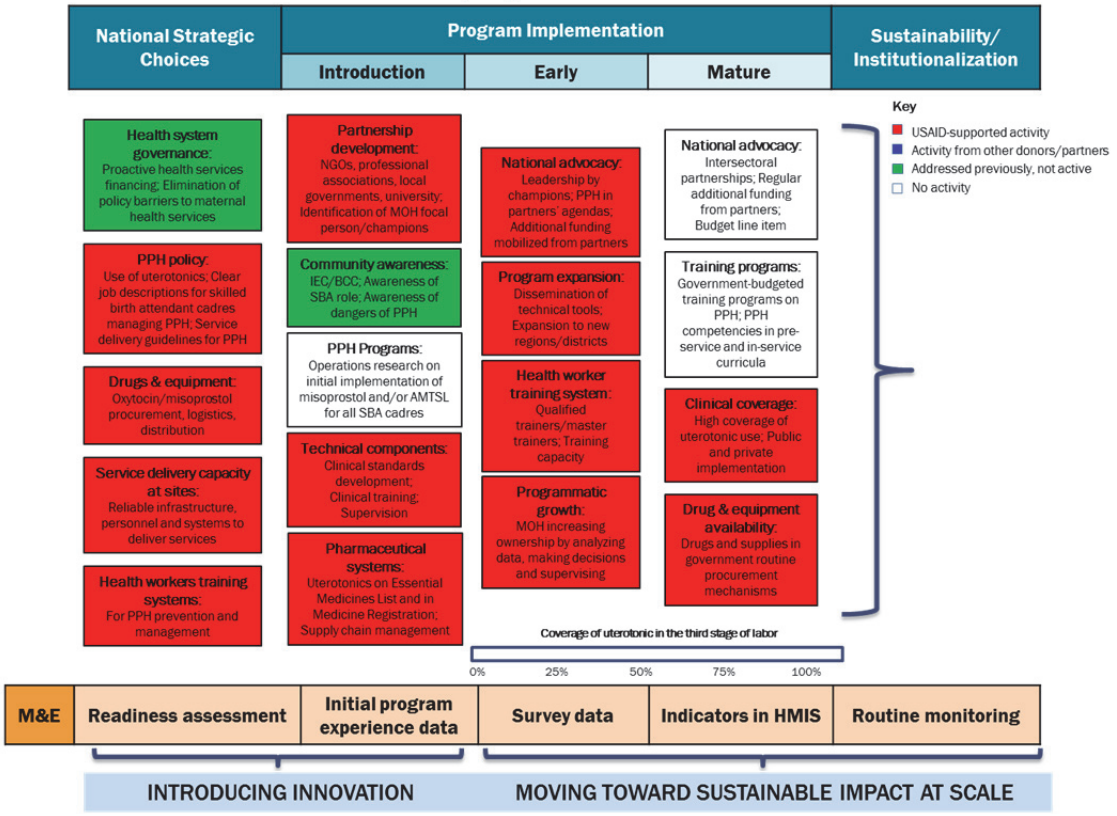

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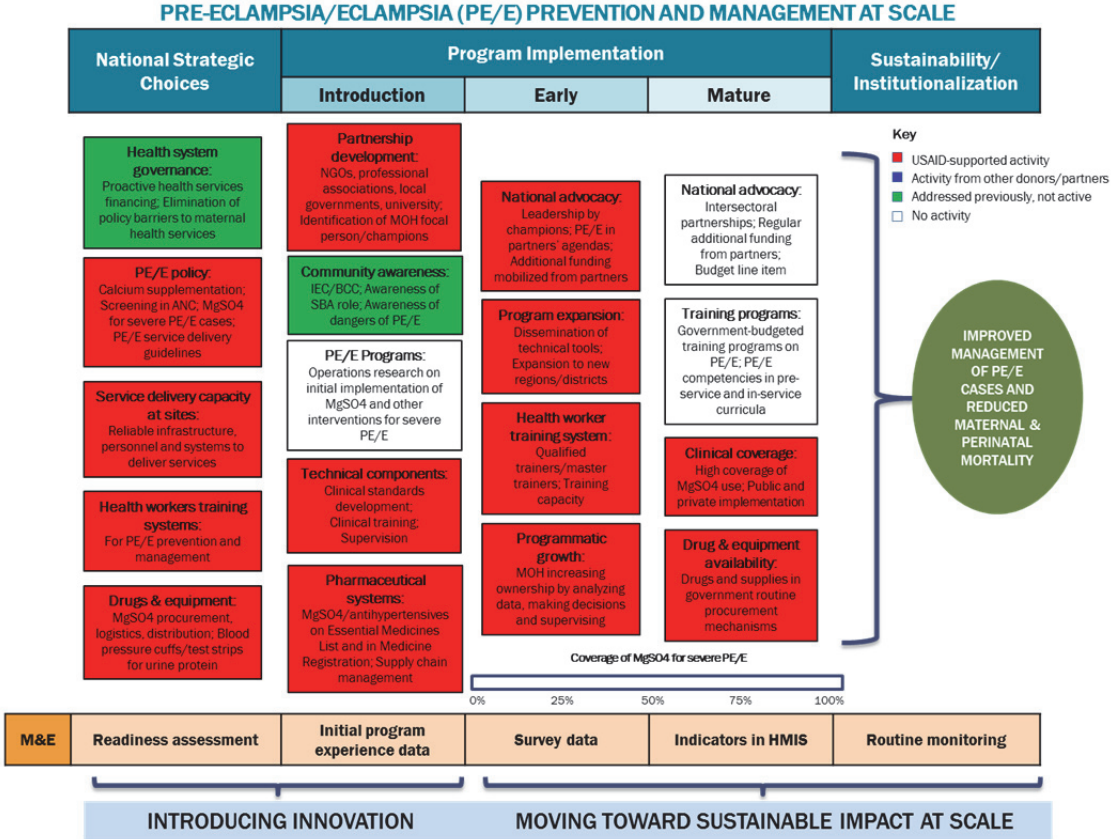
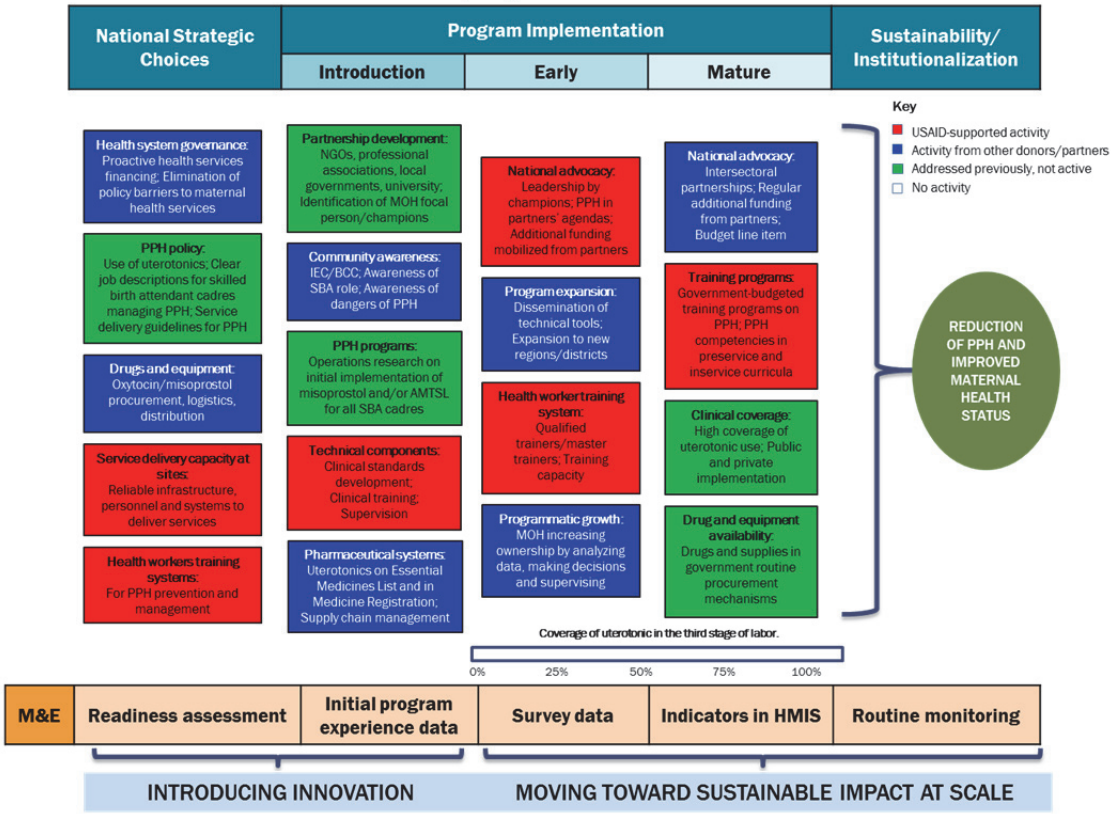


ETHIOPIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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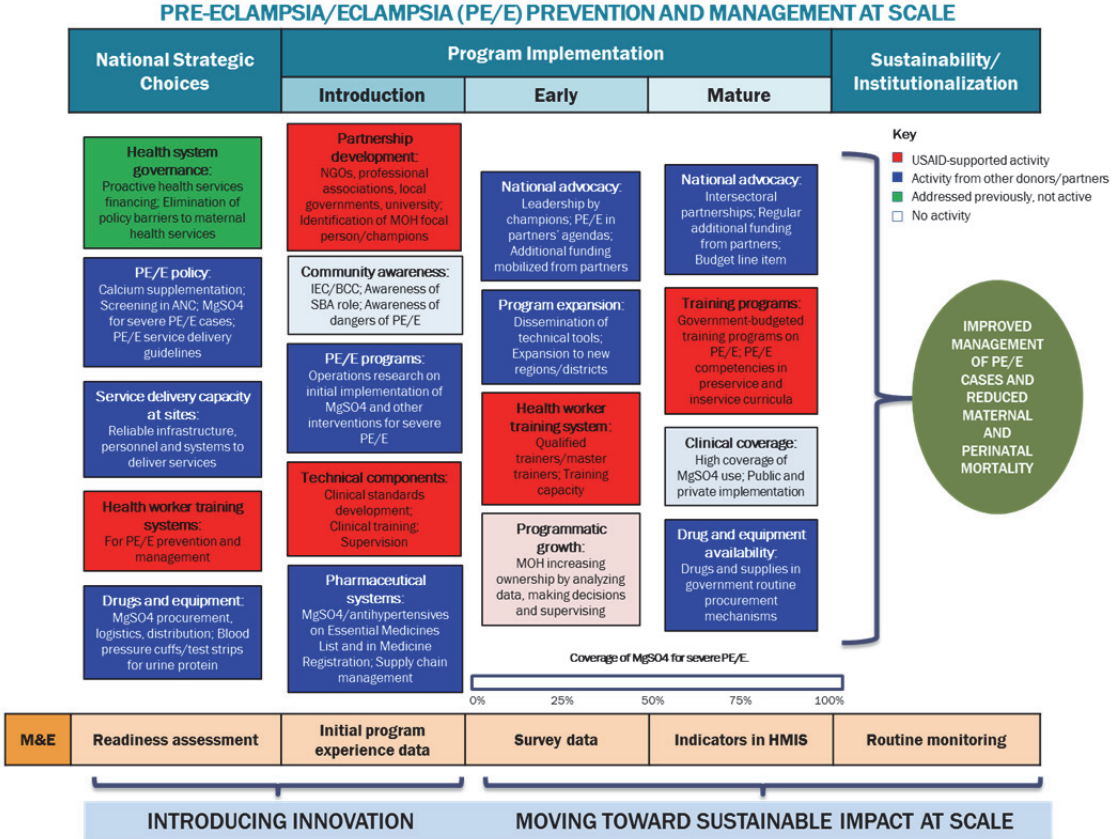
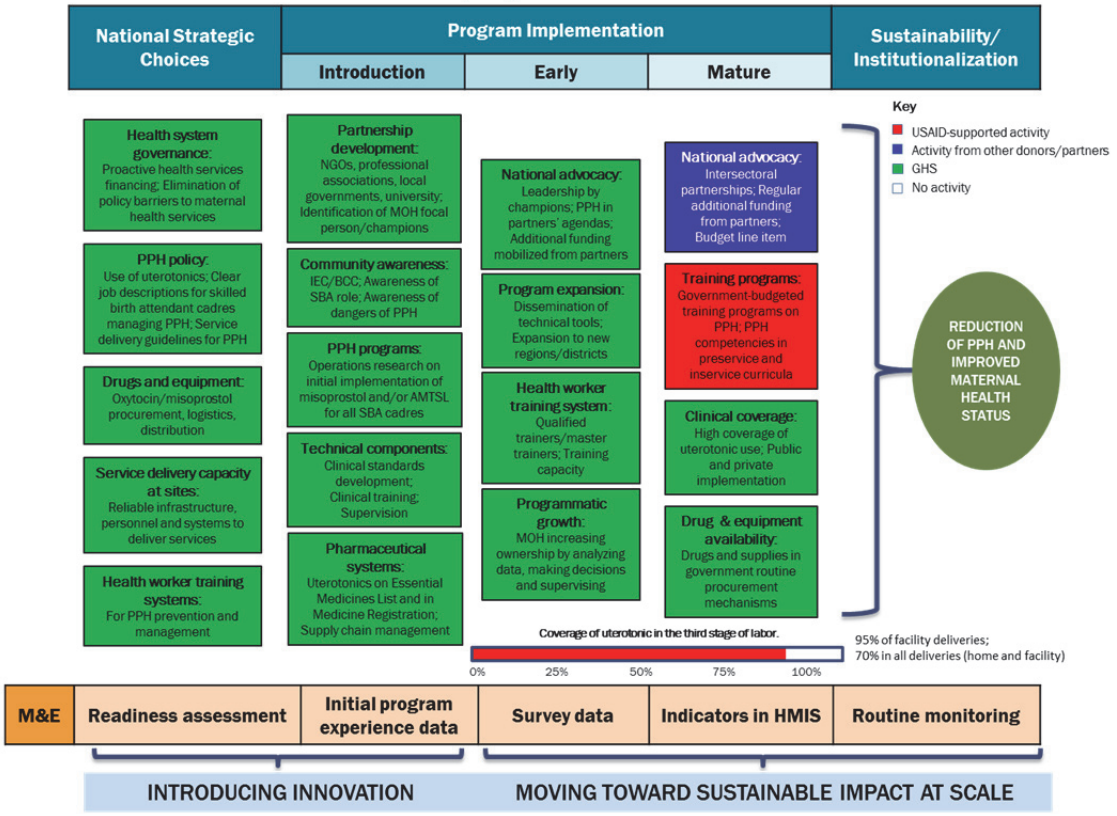


GHANA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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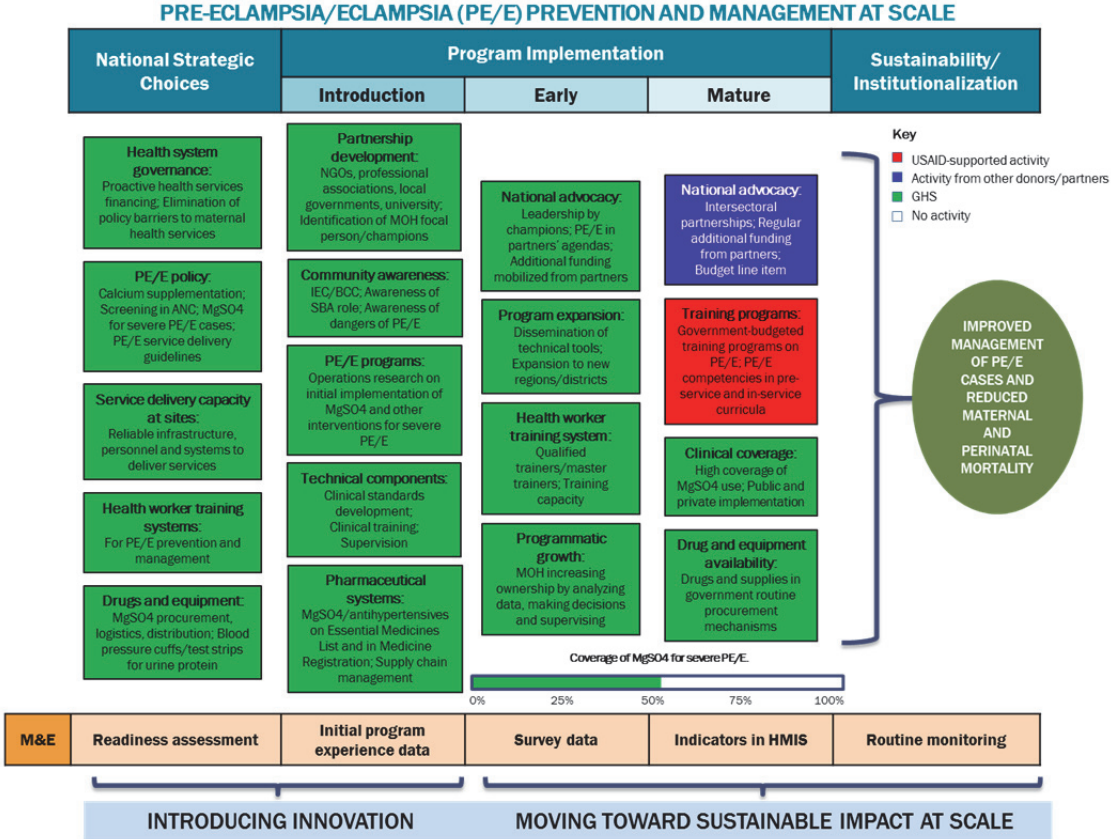
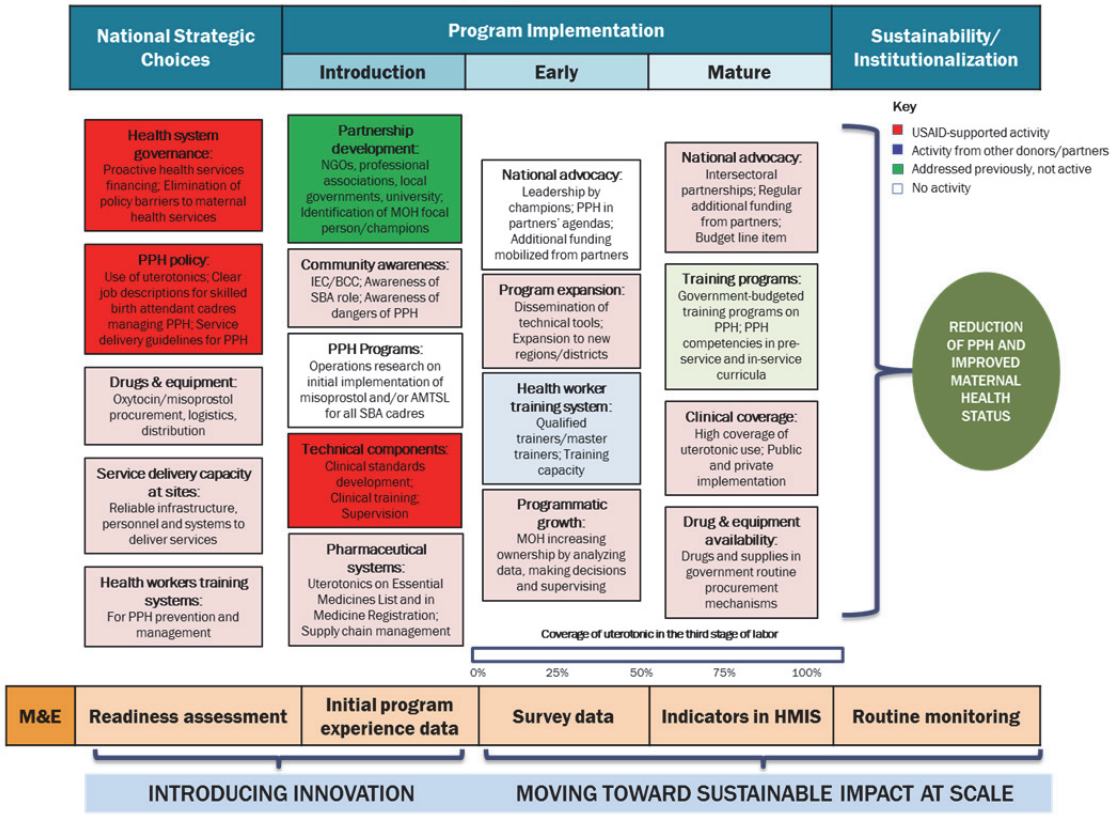
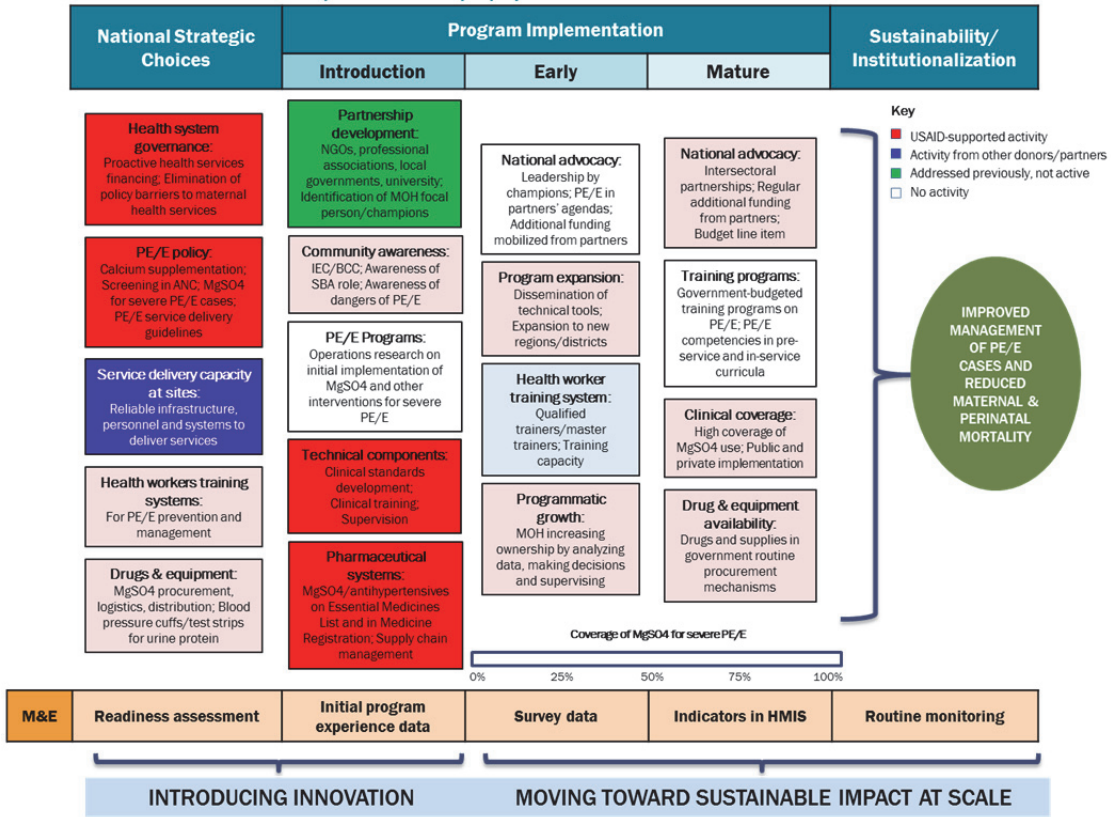


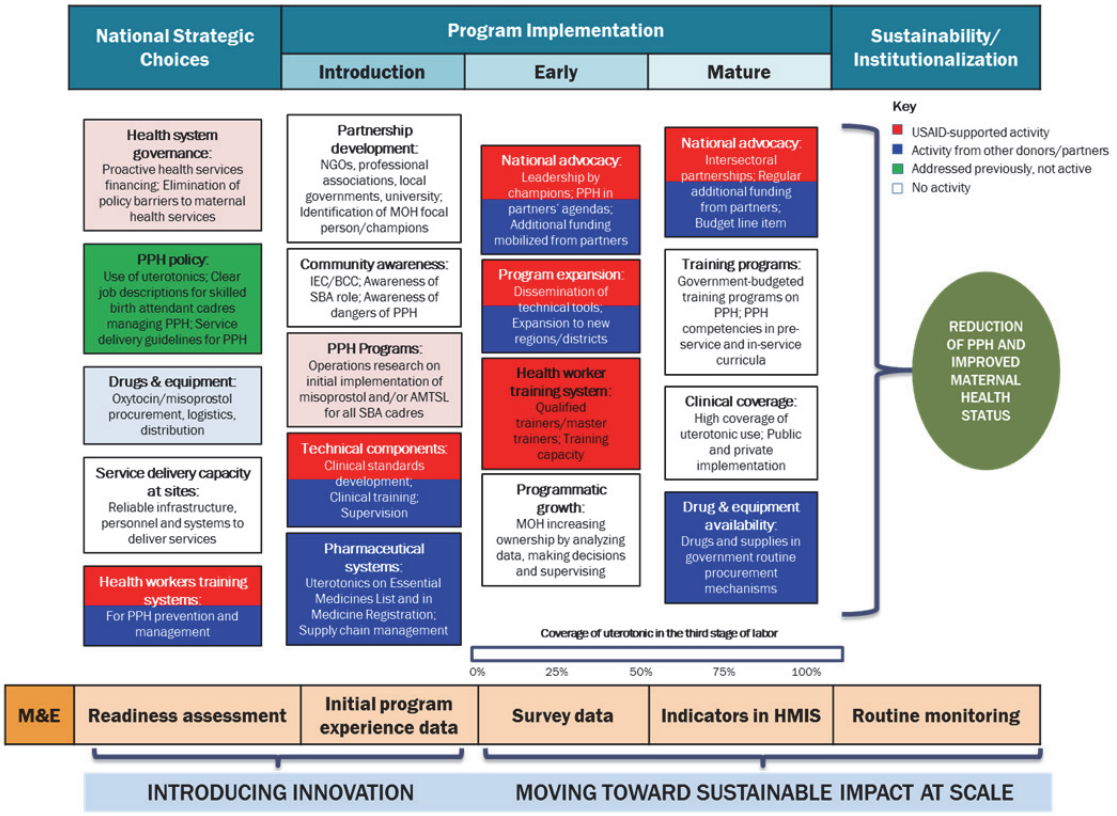
GUATEMALA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



GUATEMALA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



GUINEA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



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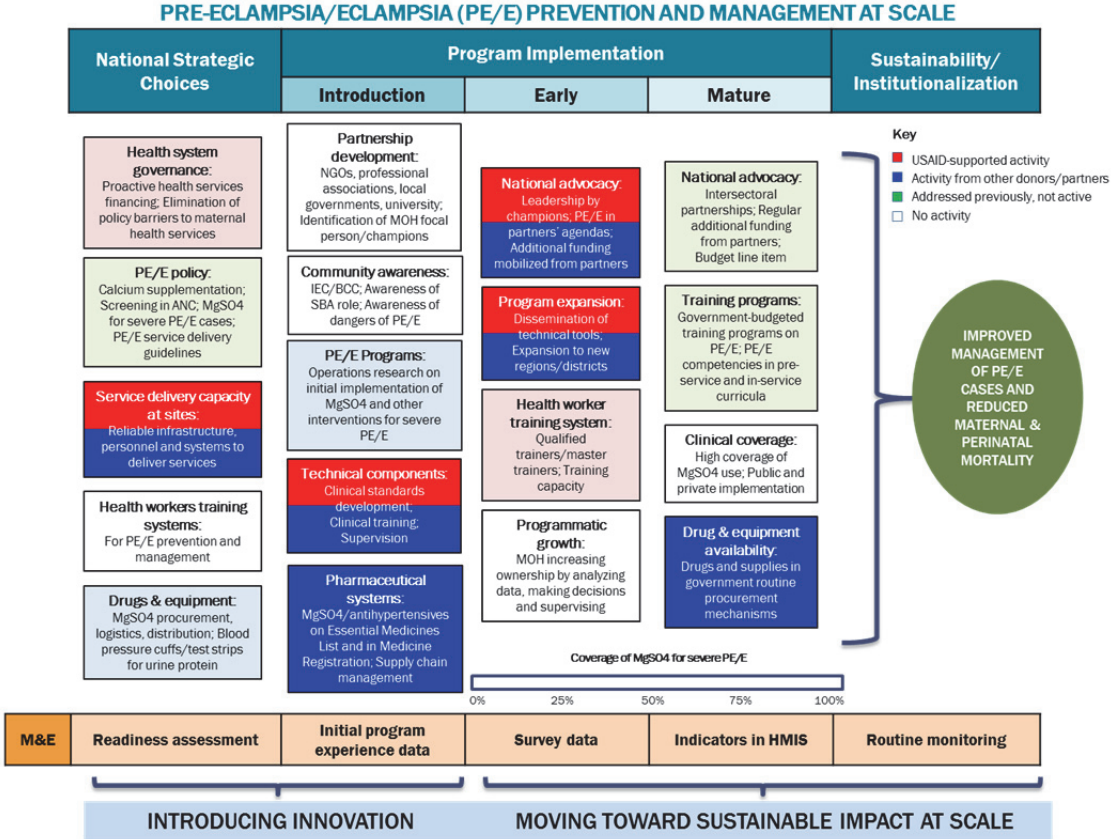
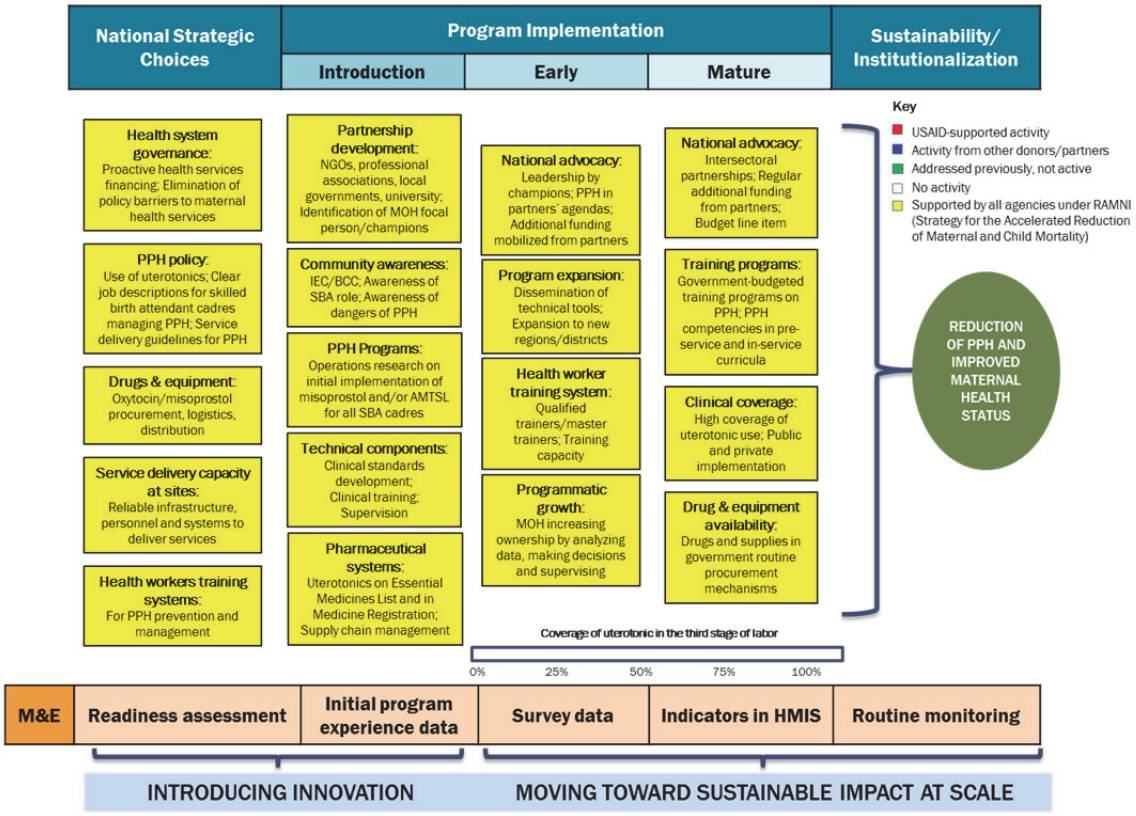
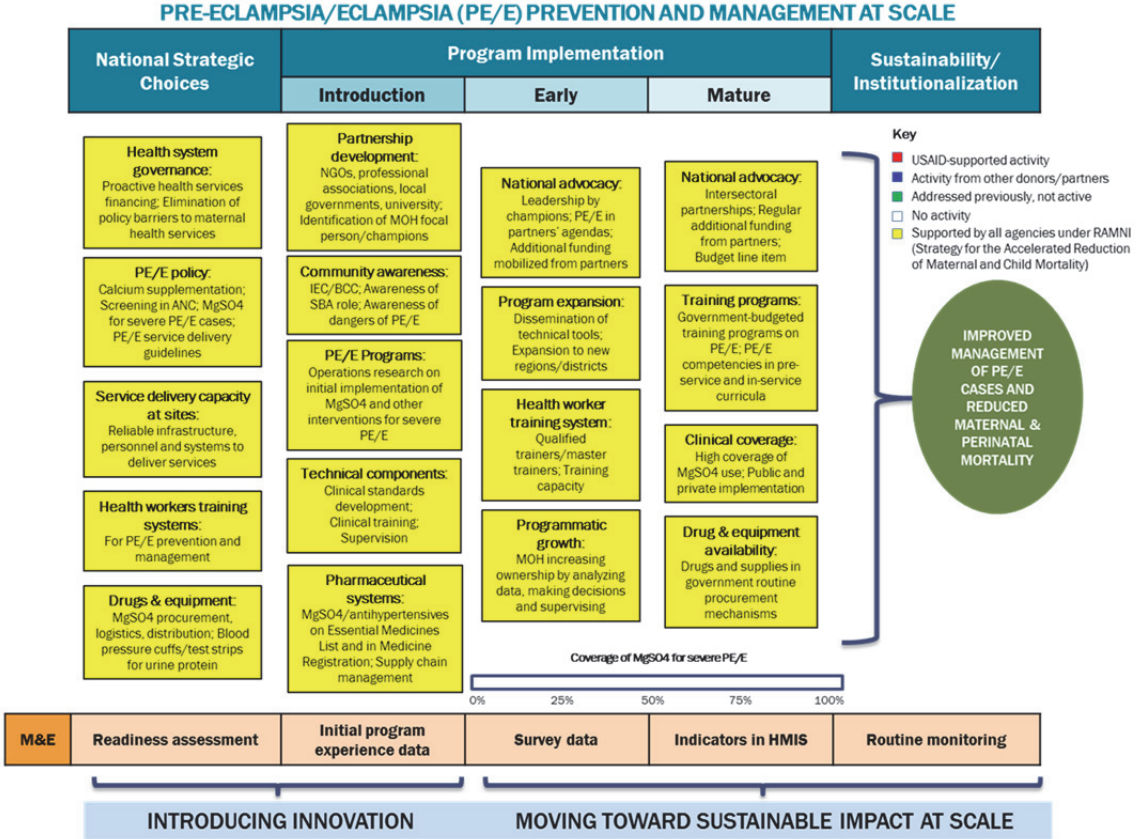


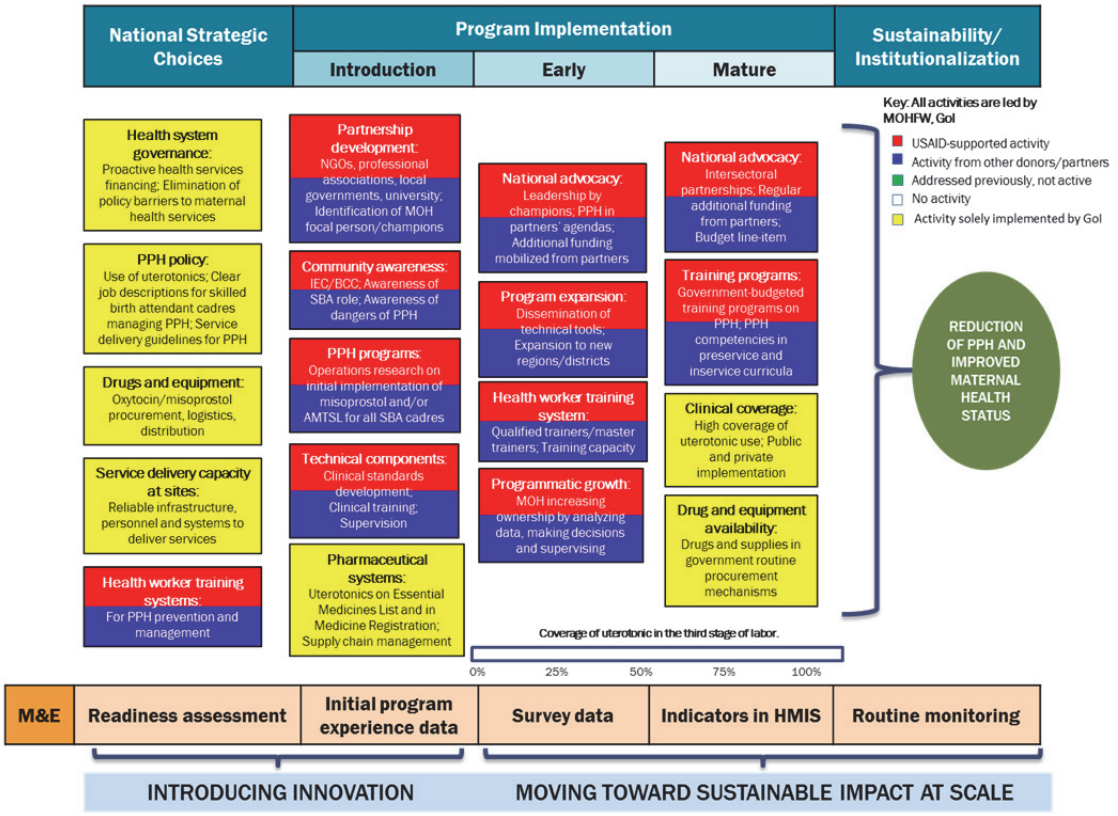
HONDURAS PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



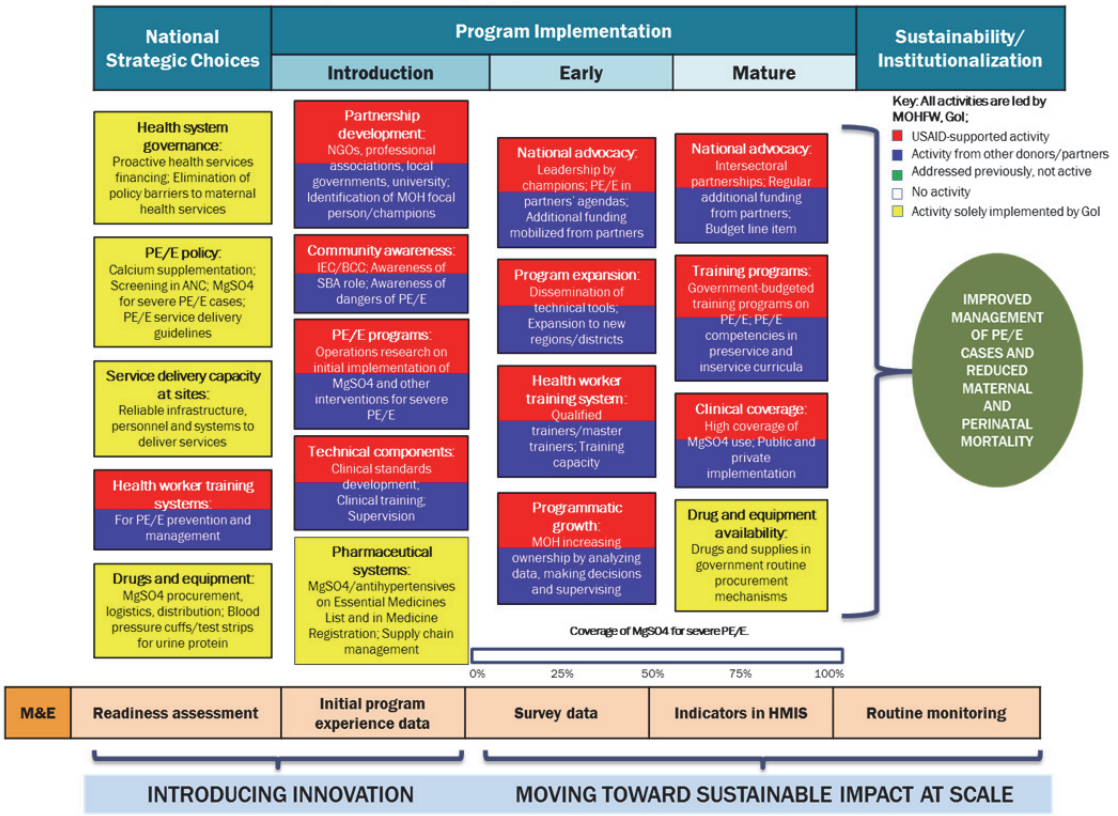
HONDURAS PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



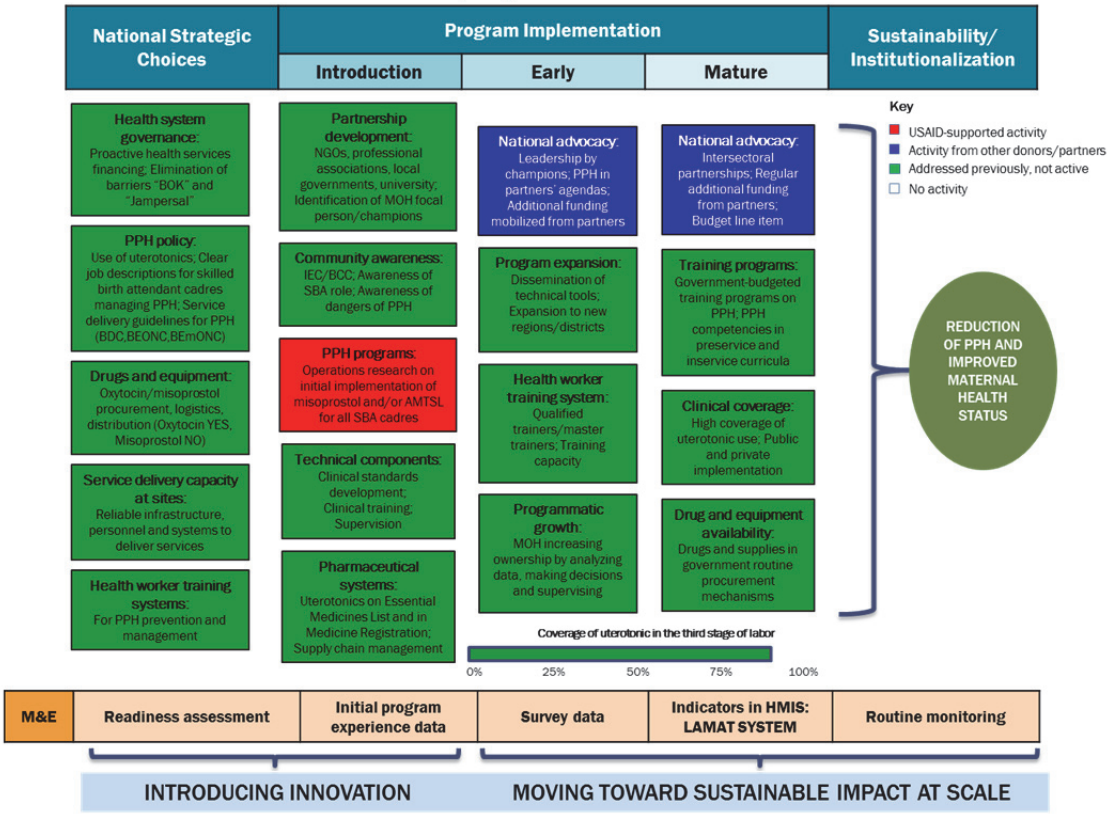
INDIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



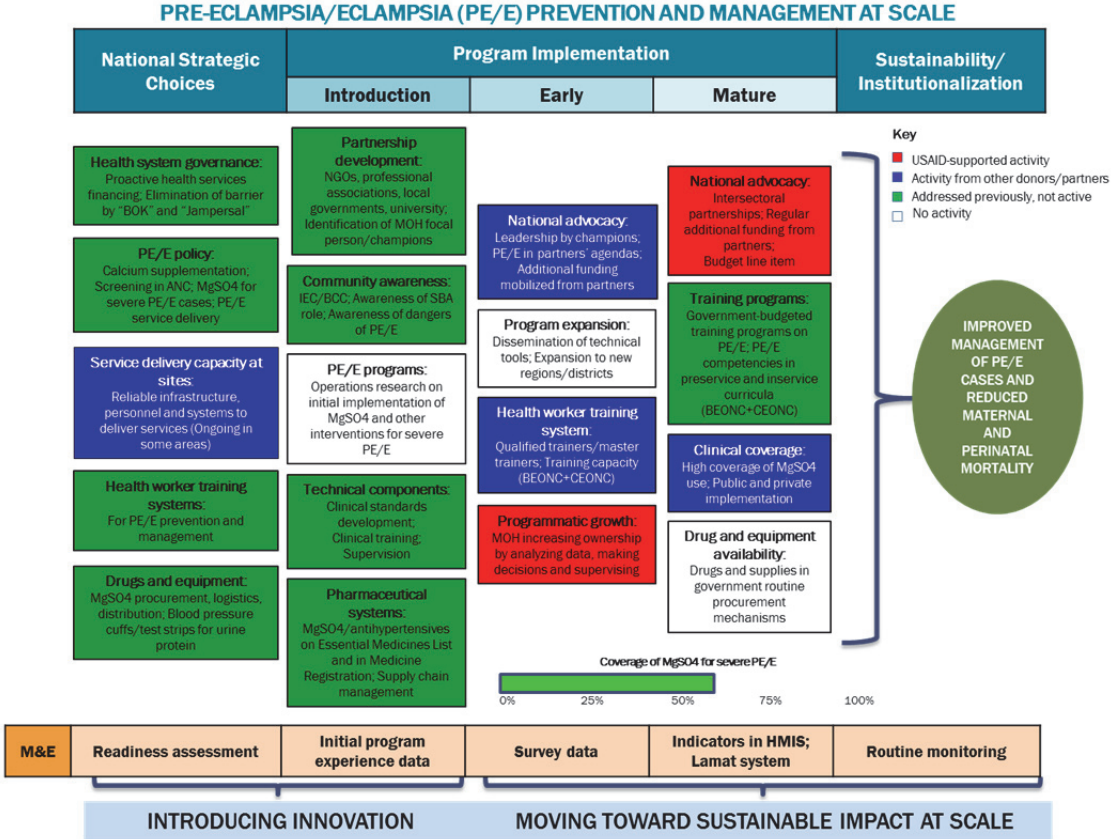
INDIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



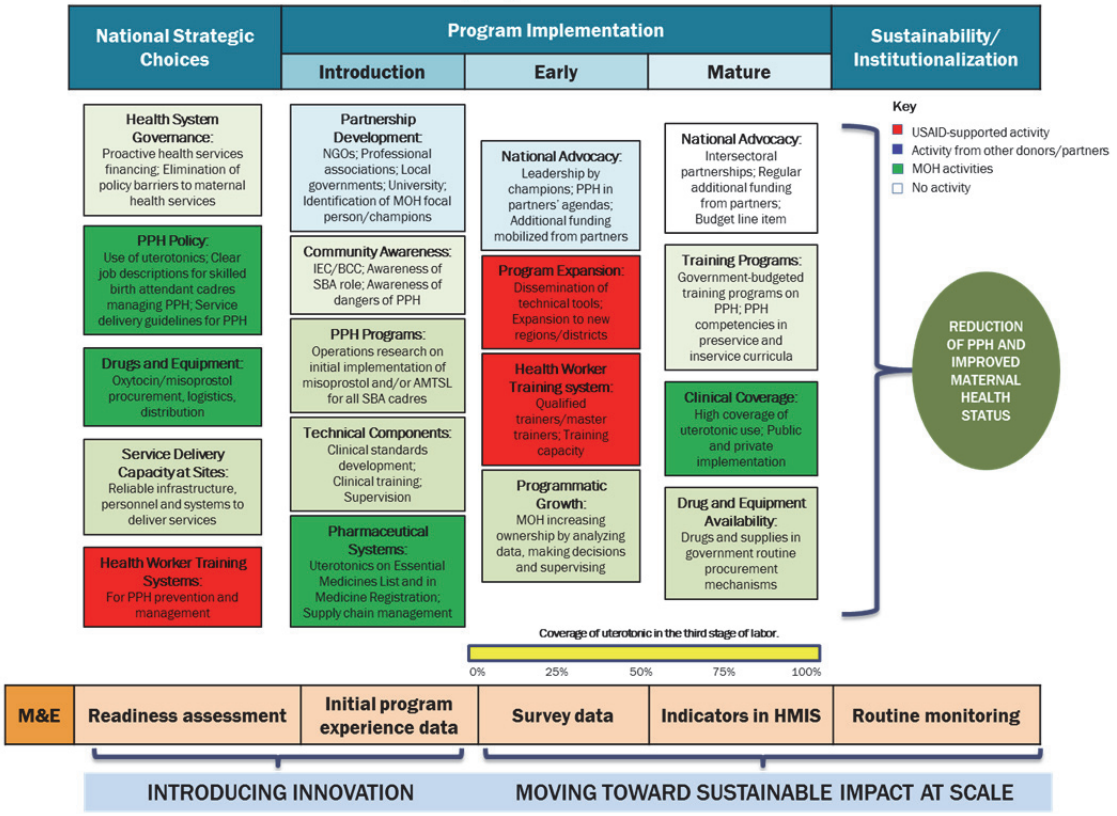
INDONESIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



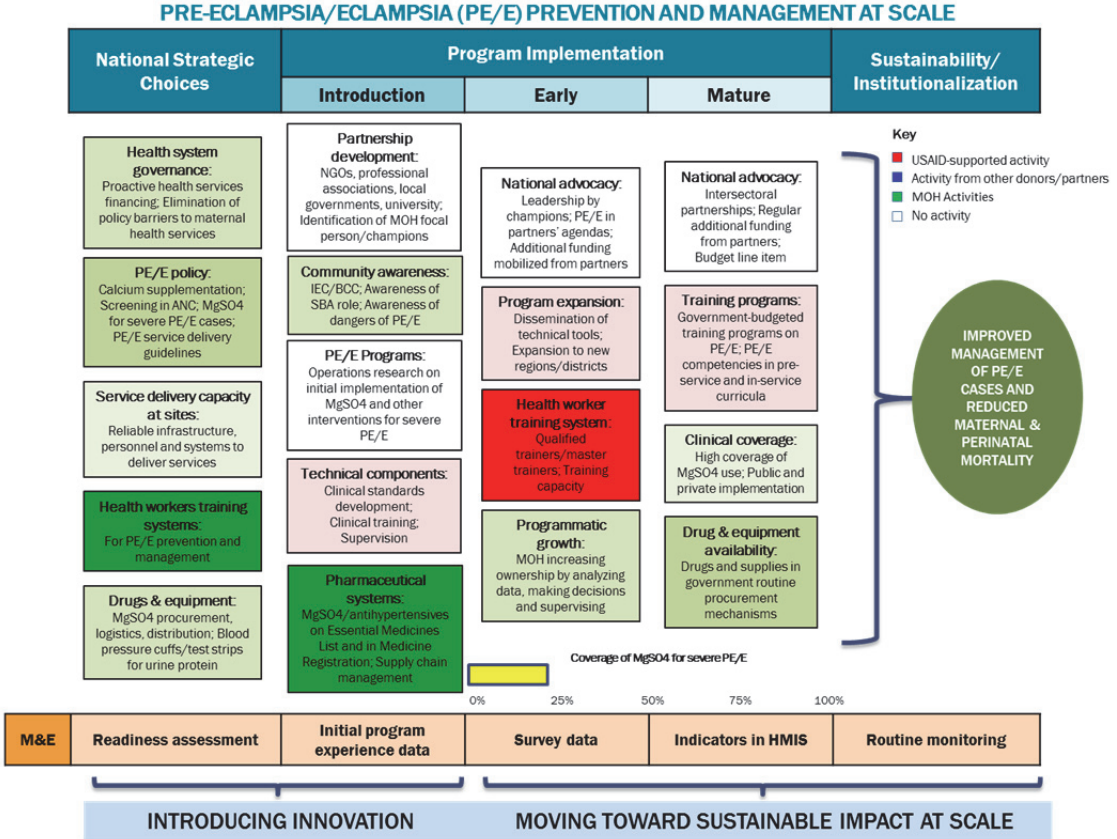
INDONESIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



KENYA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



KENYA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



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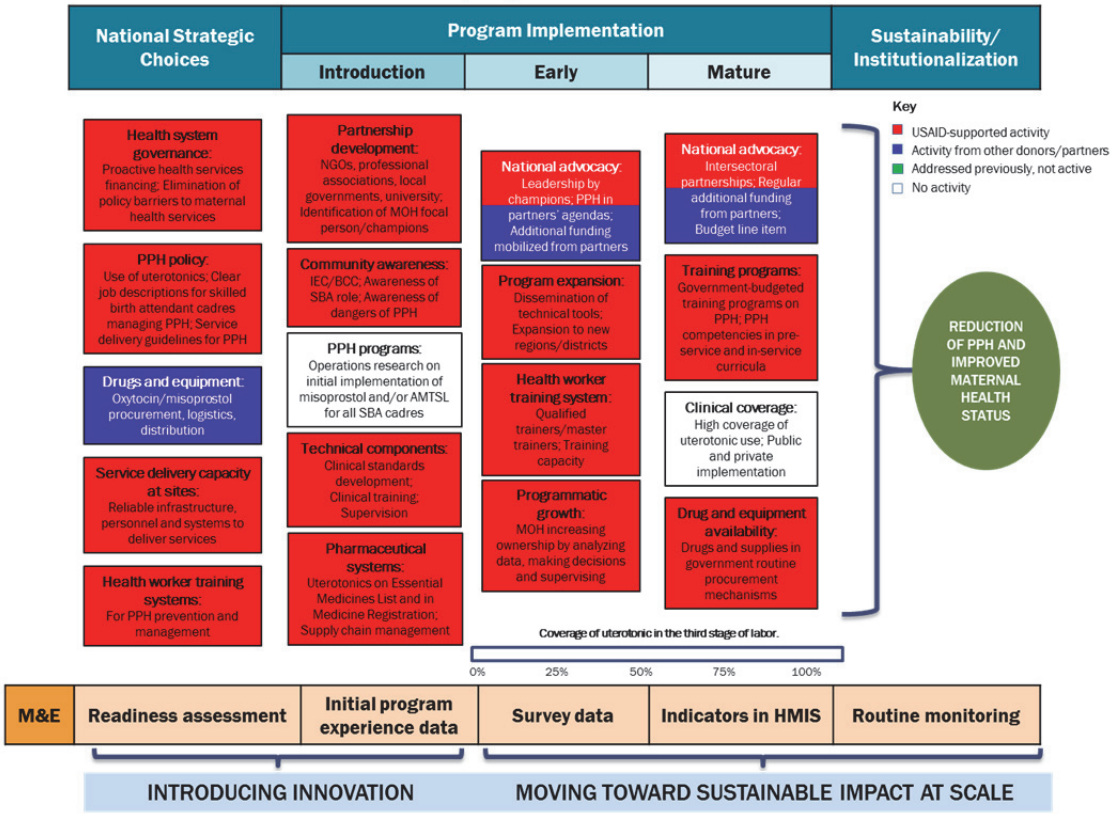
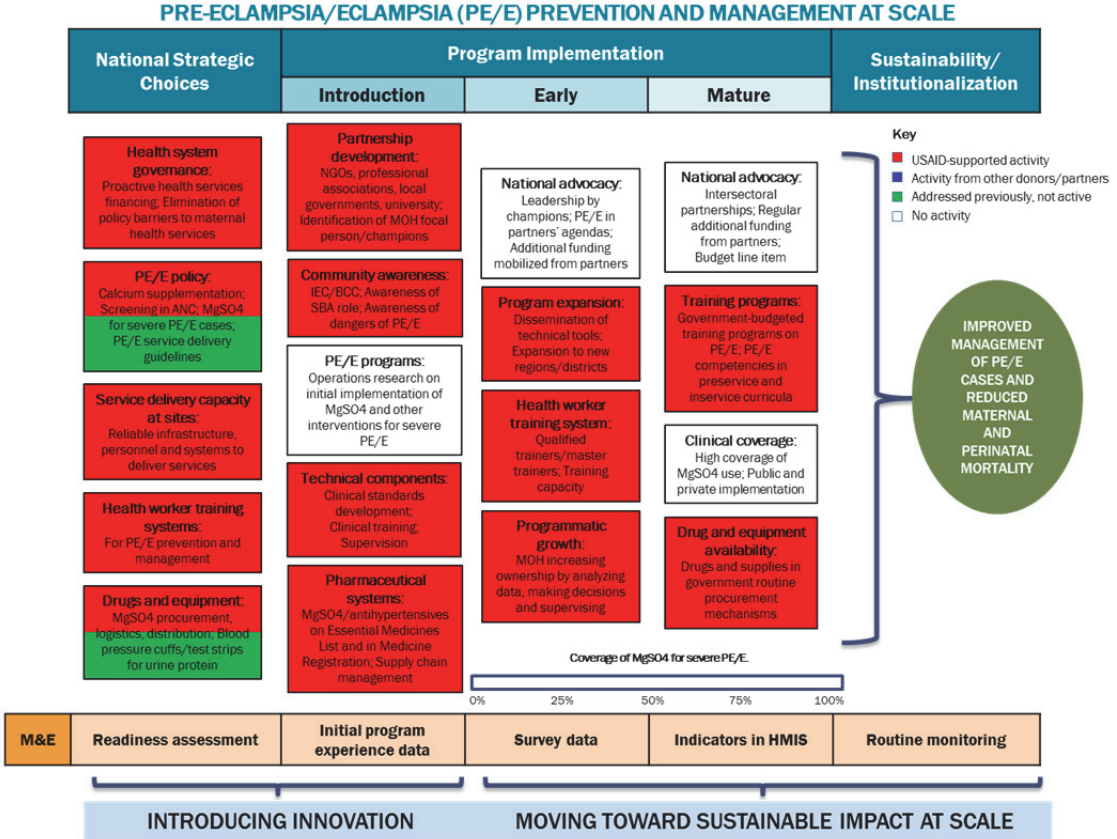
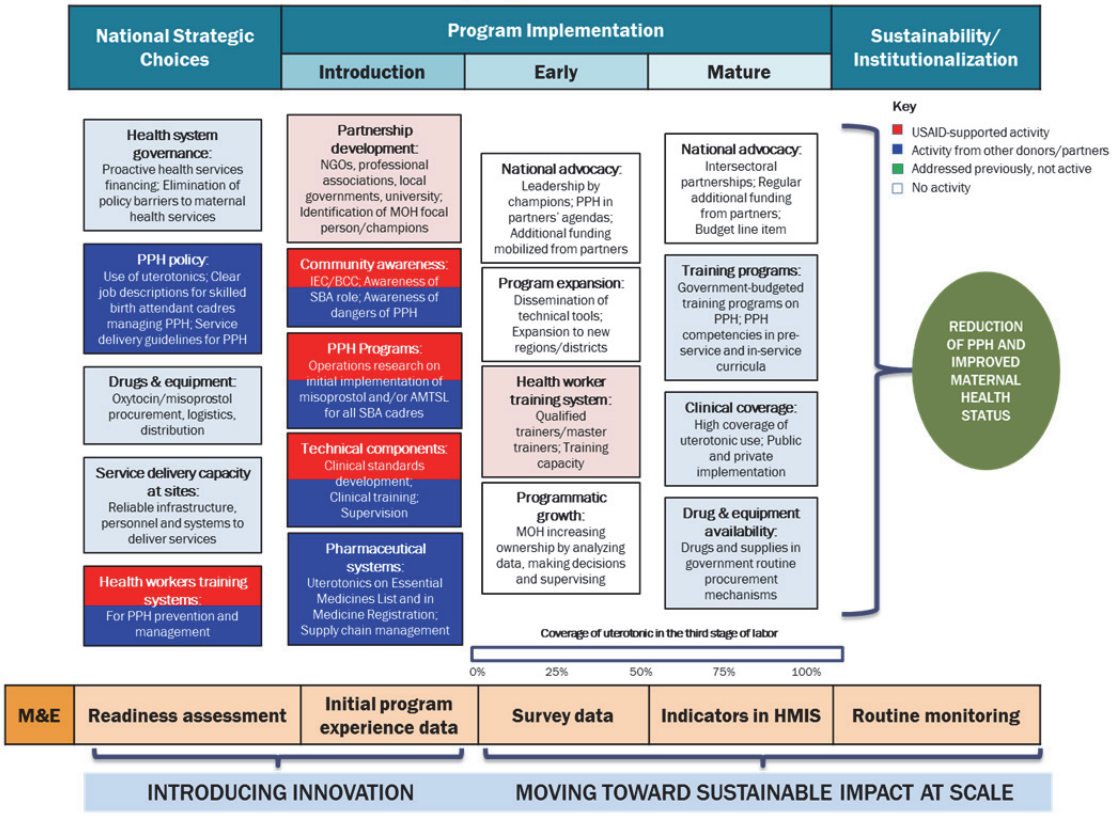


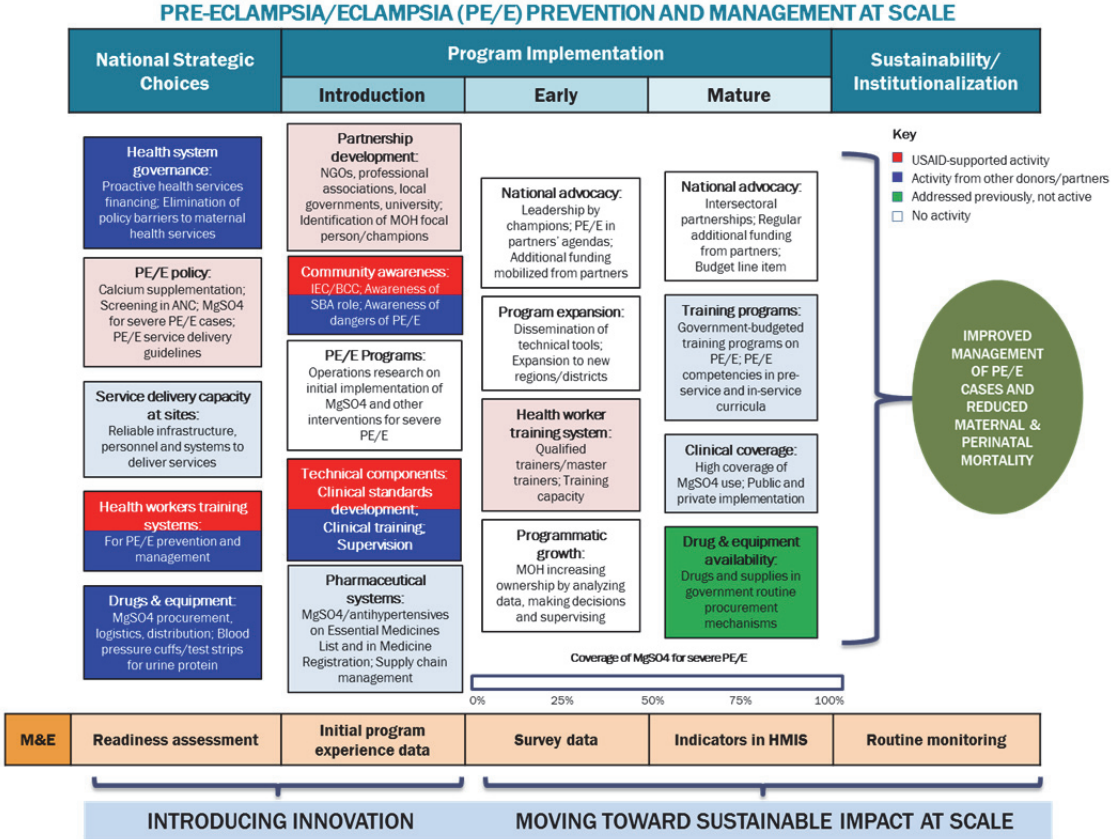
LIBERIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



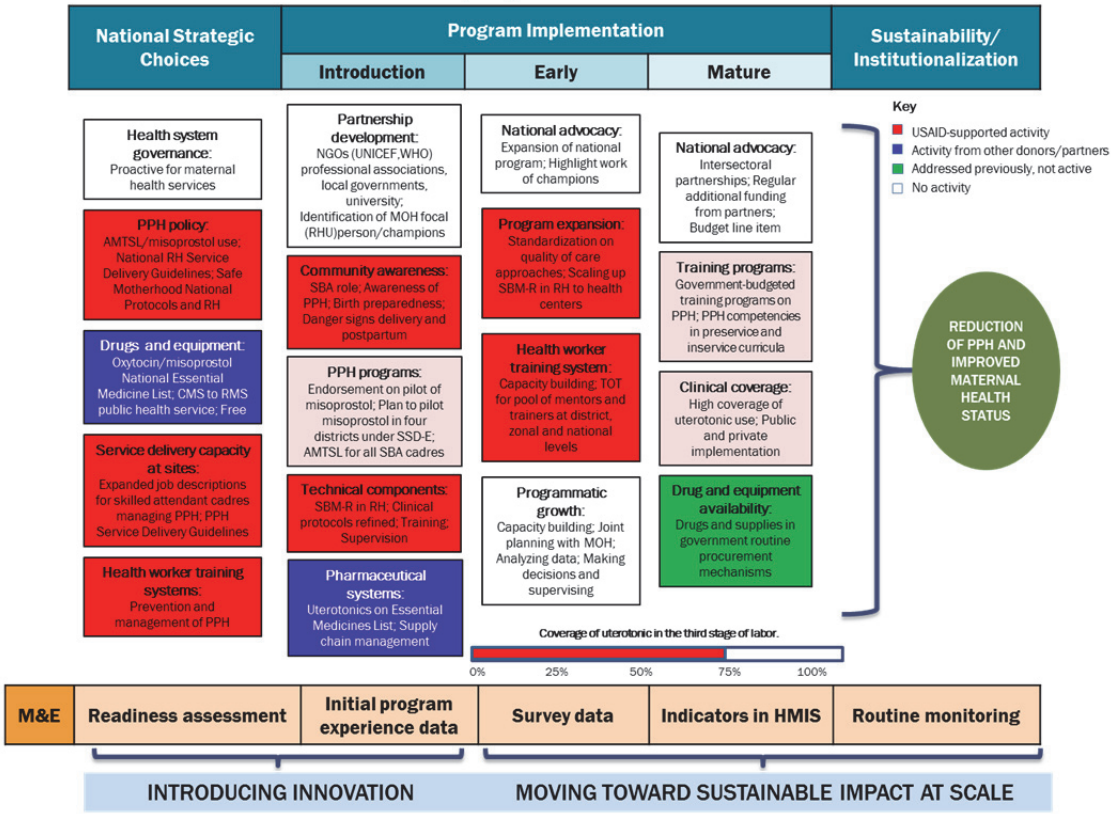
MADAGASCAR PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



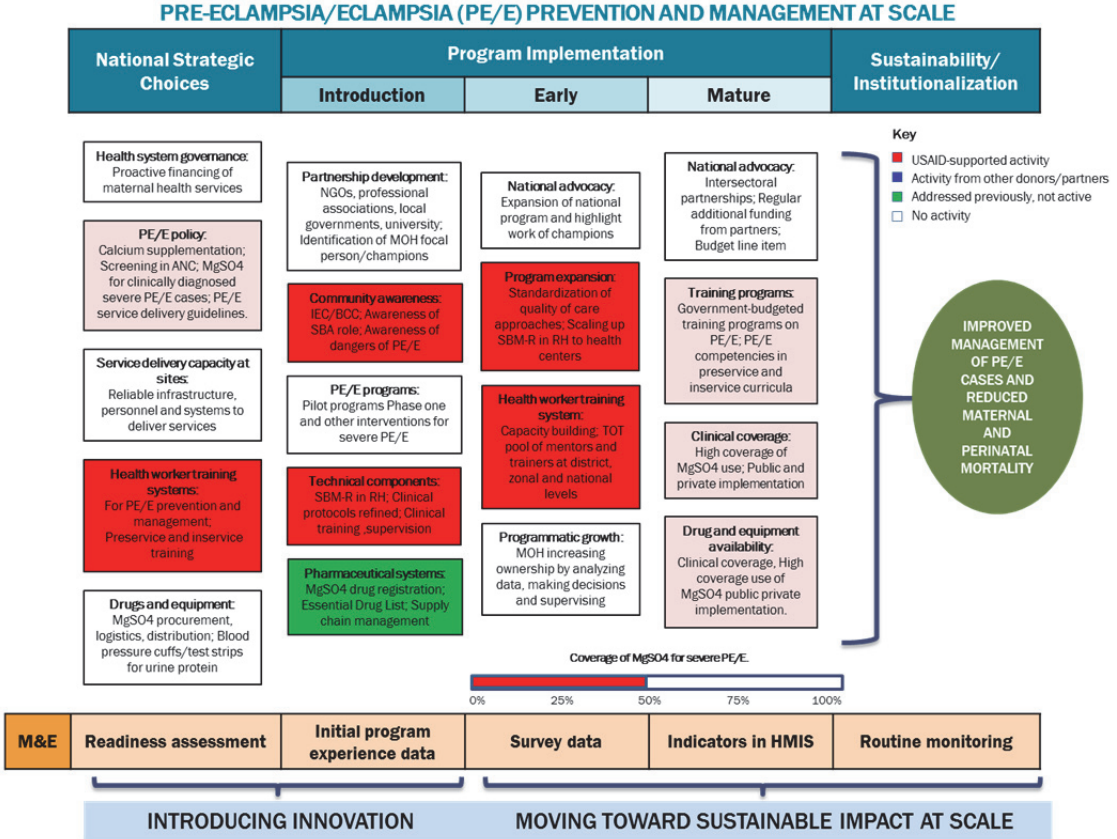
MADAGASCAR PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



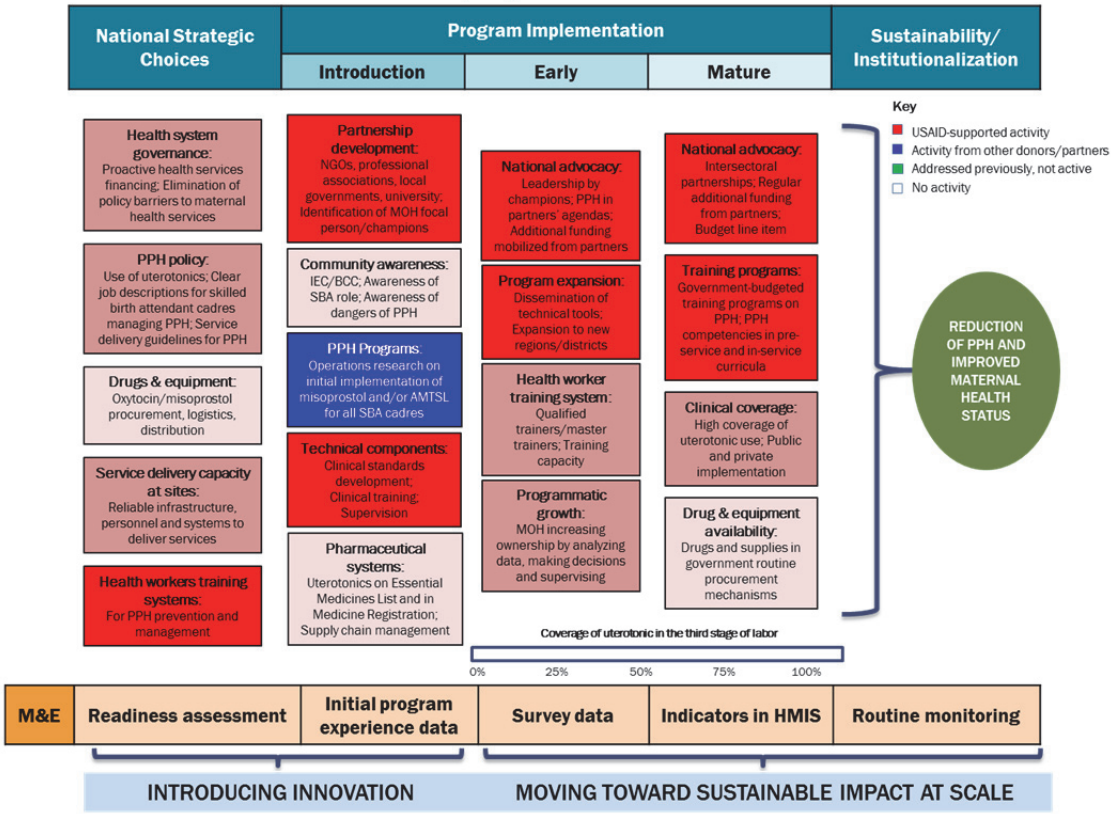
MALAWI PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



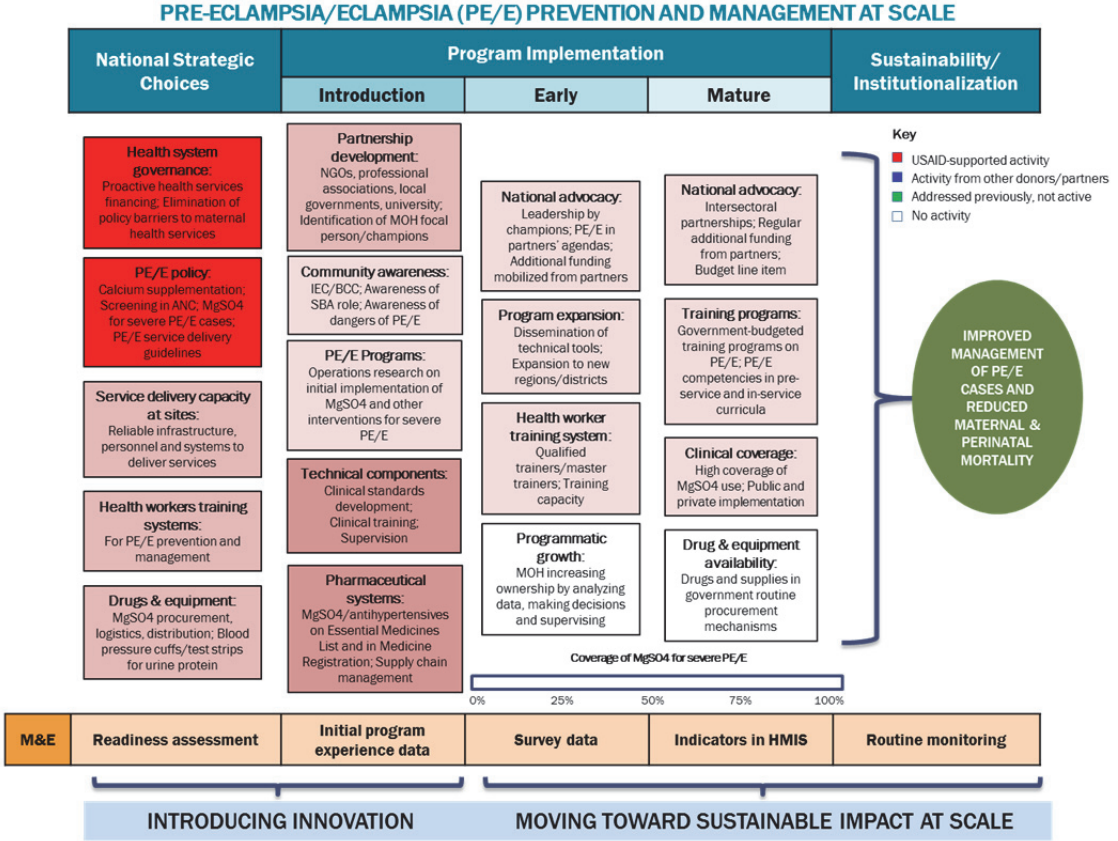
MALAWI PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



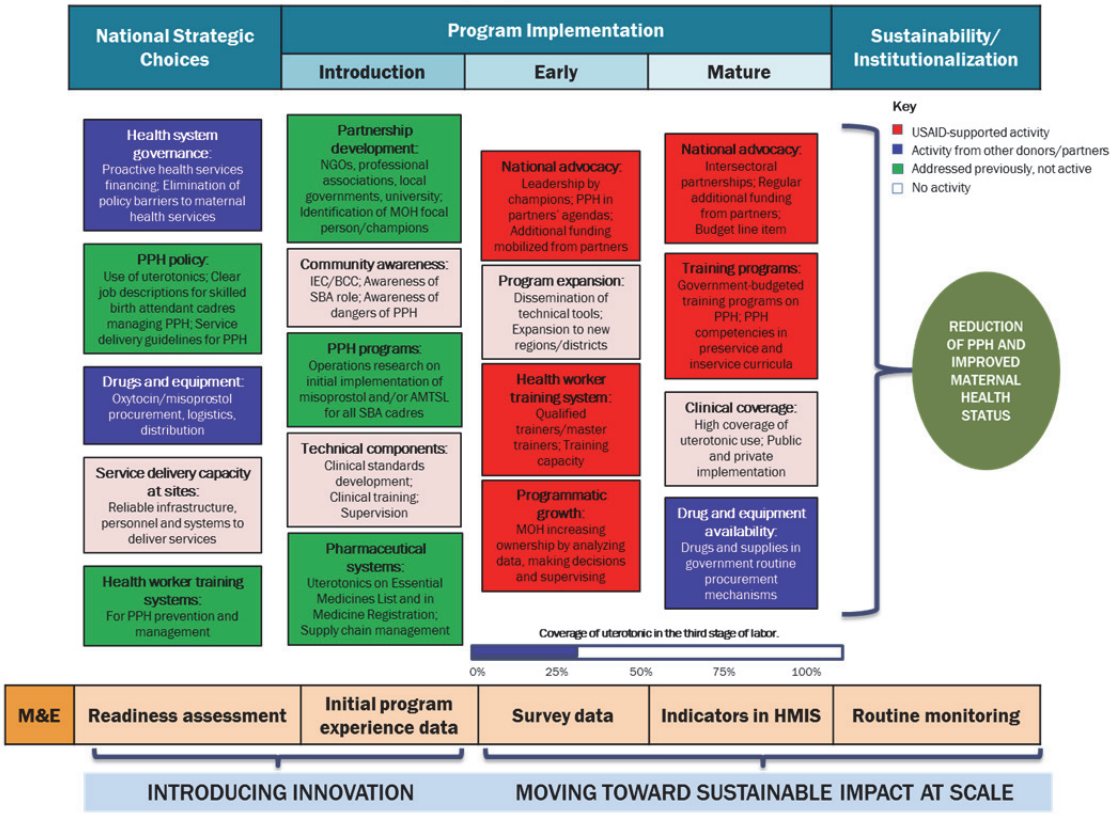
MALI PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



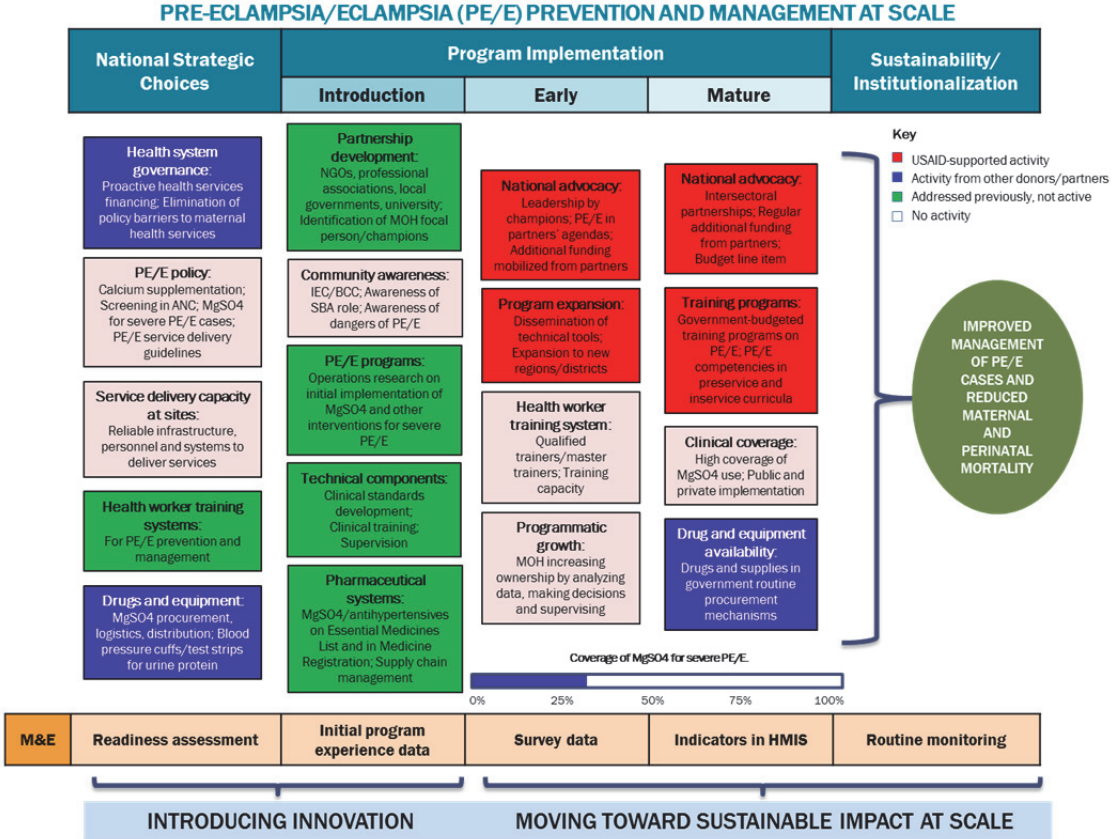
MALI PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



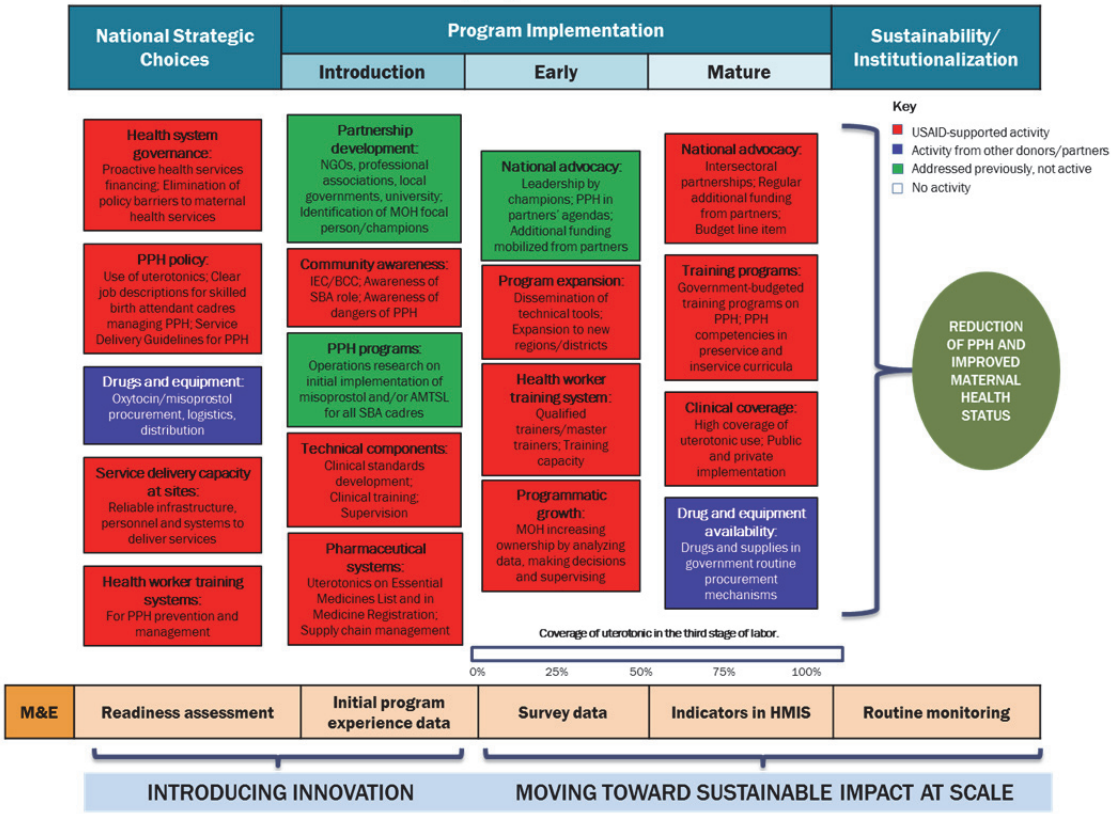
MOZAMBIQUE PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



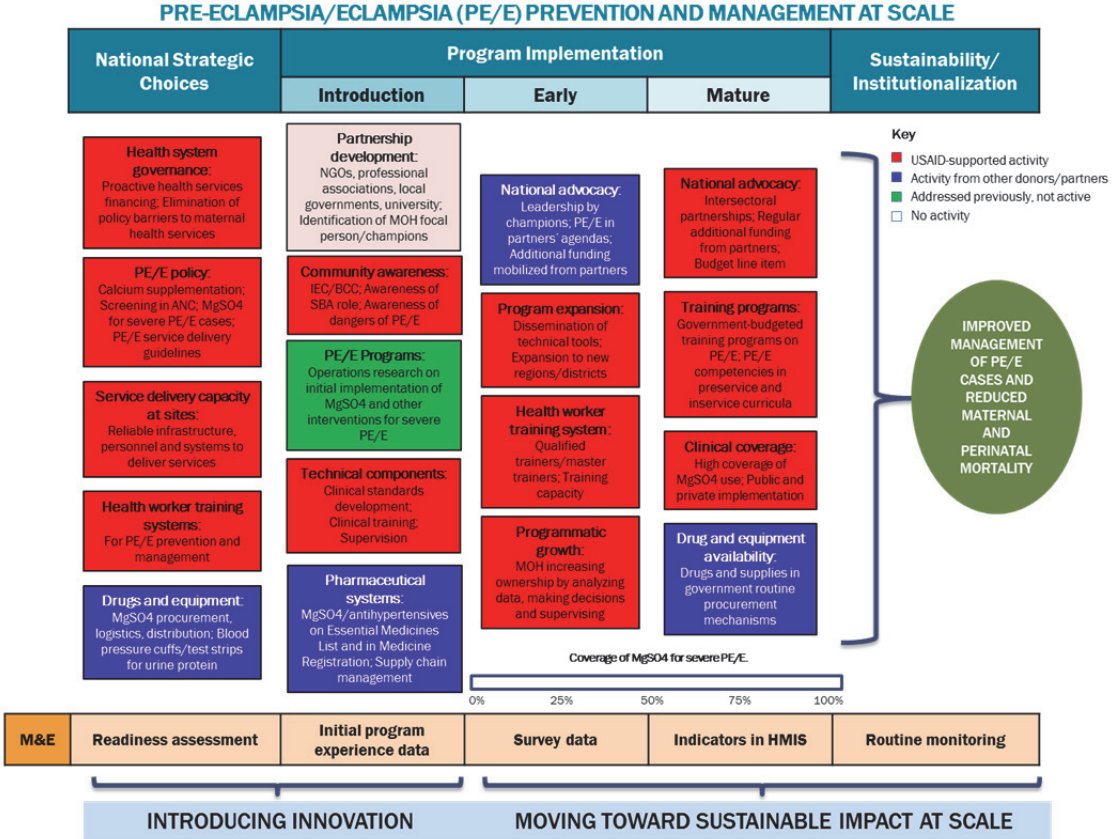
MOZAMBIQUE PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



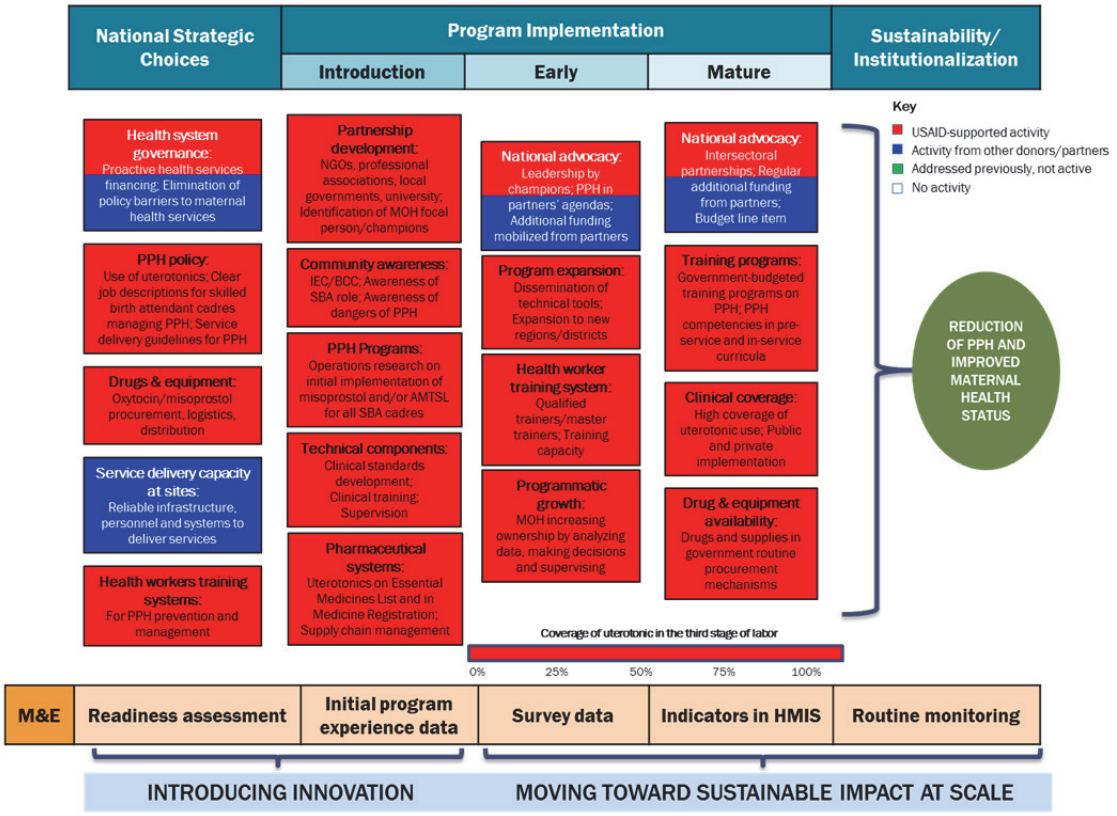
NEPAL PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



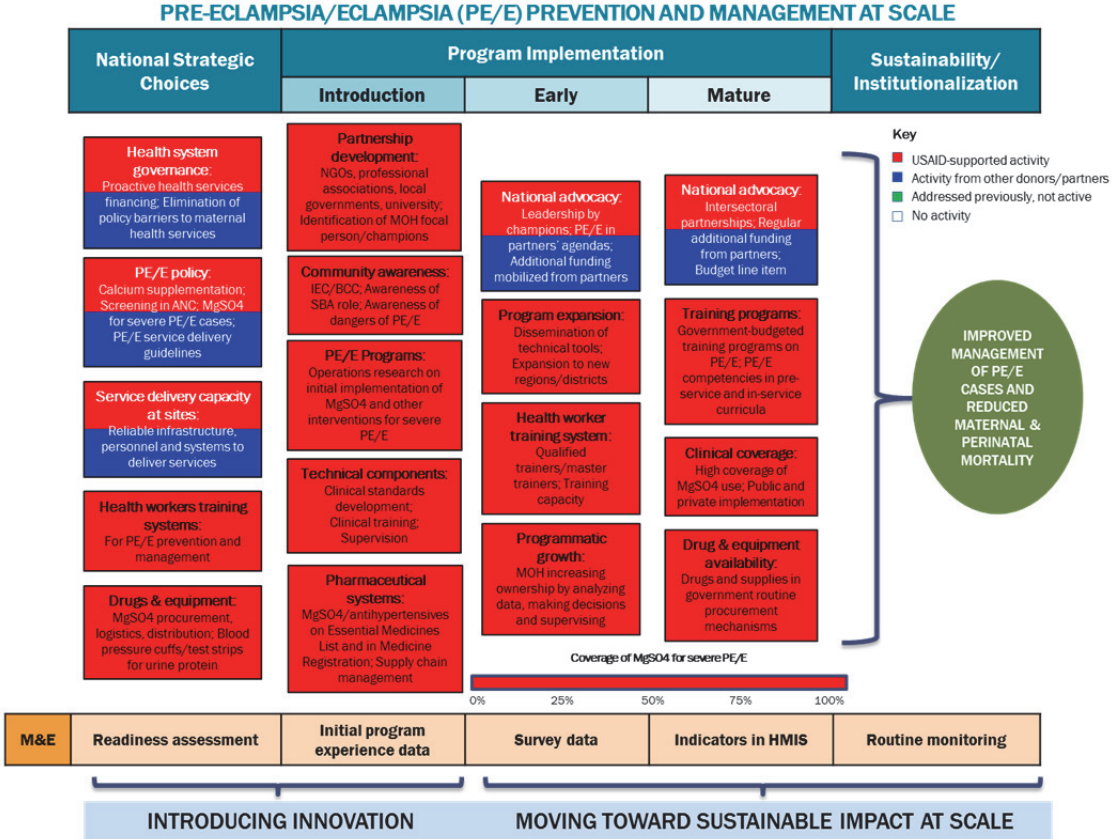
NEPAL PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



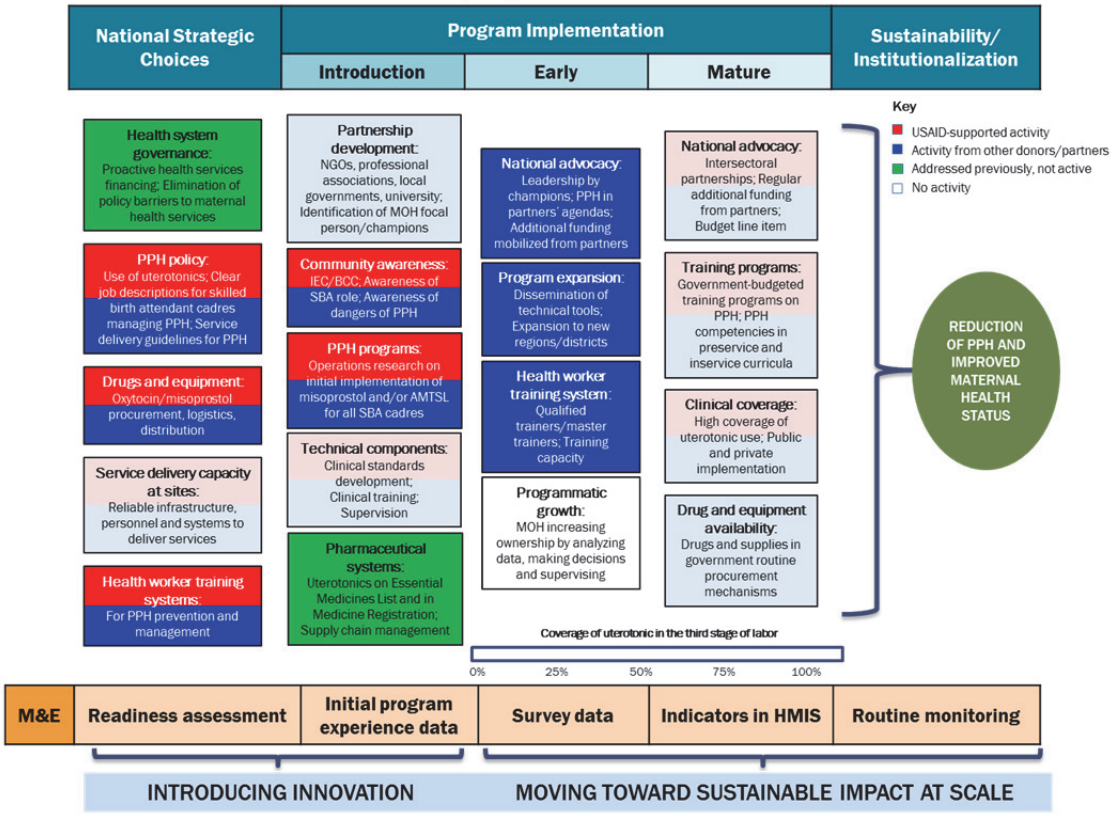
NICARAGUA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



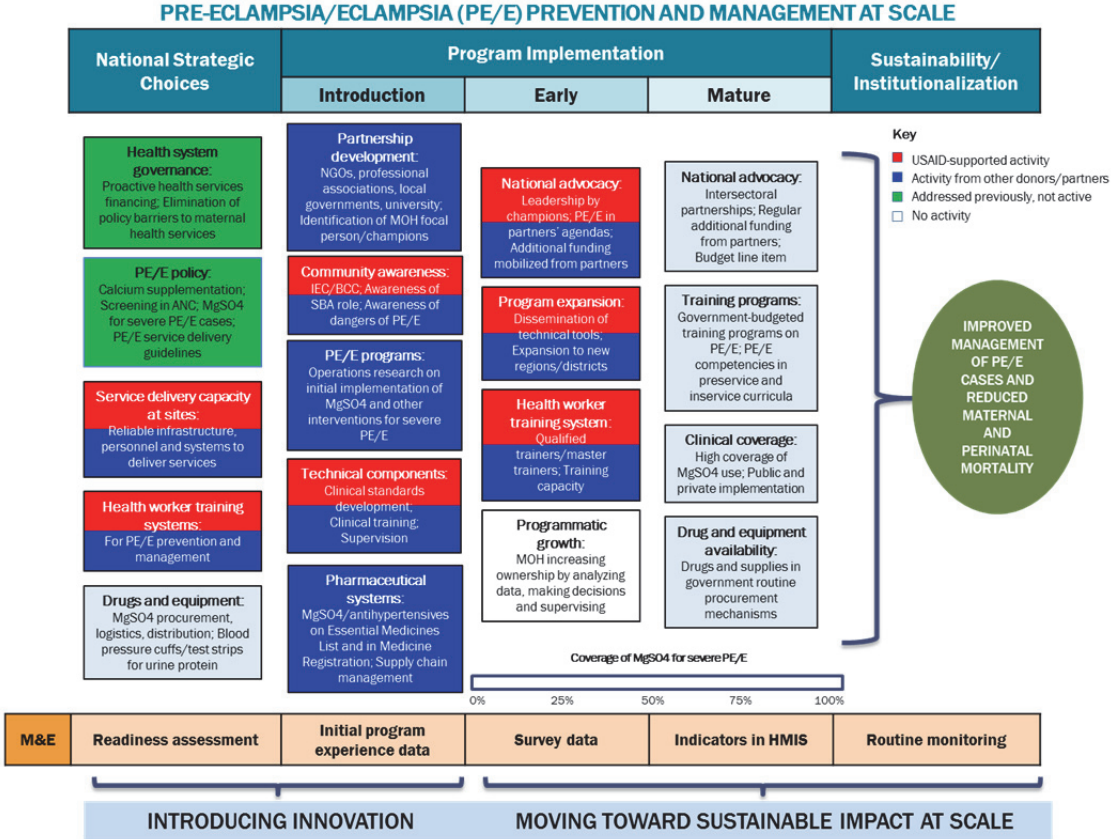
NICARAGUA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



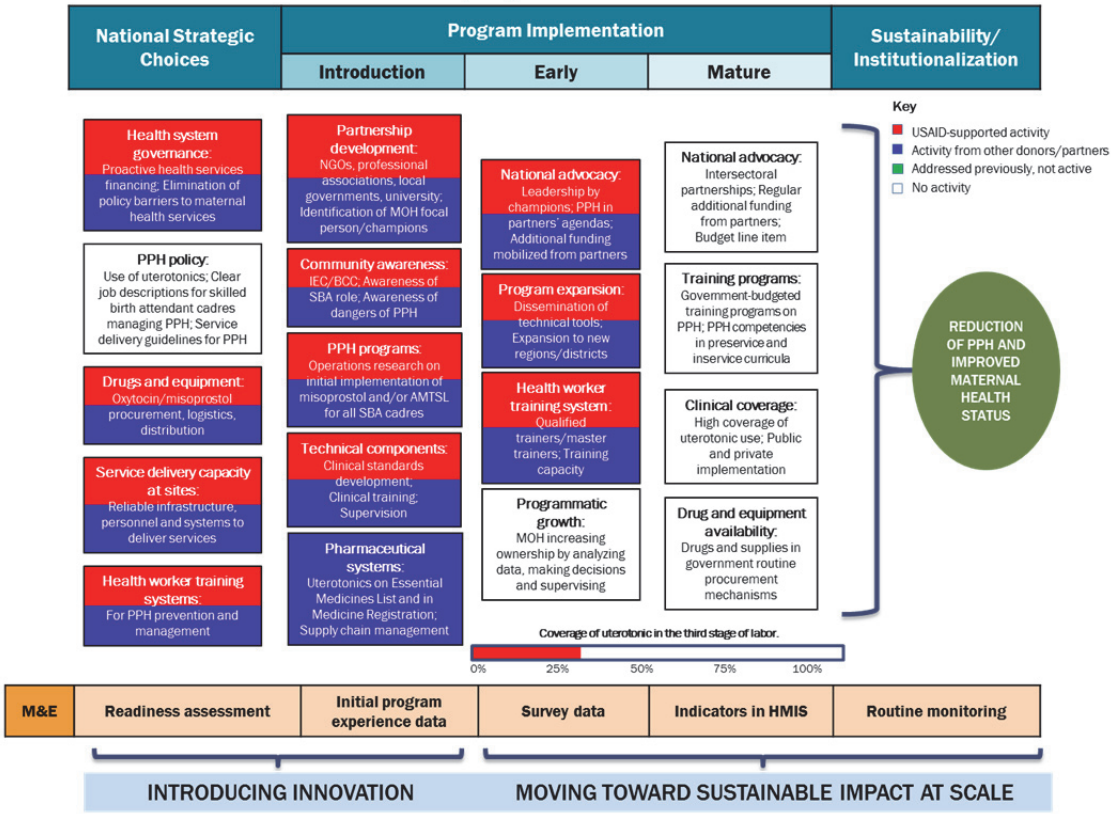
NIGERIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



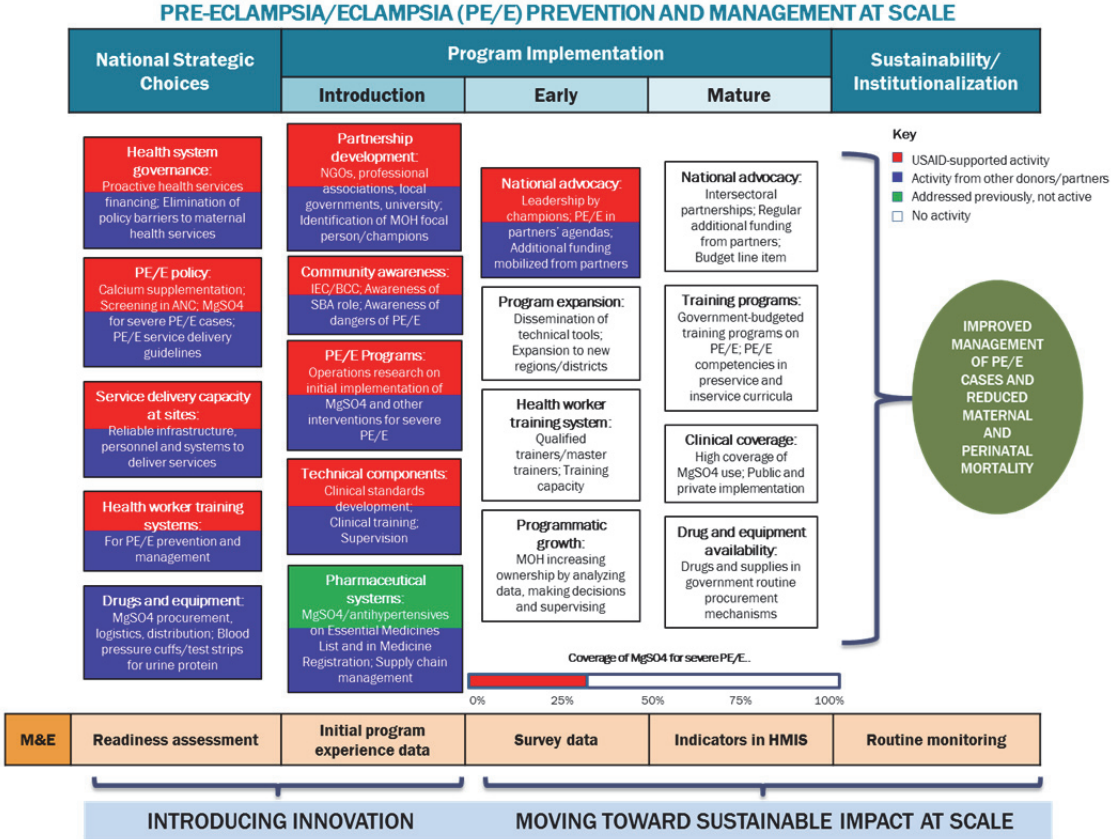
NIGERIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



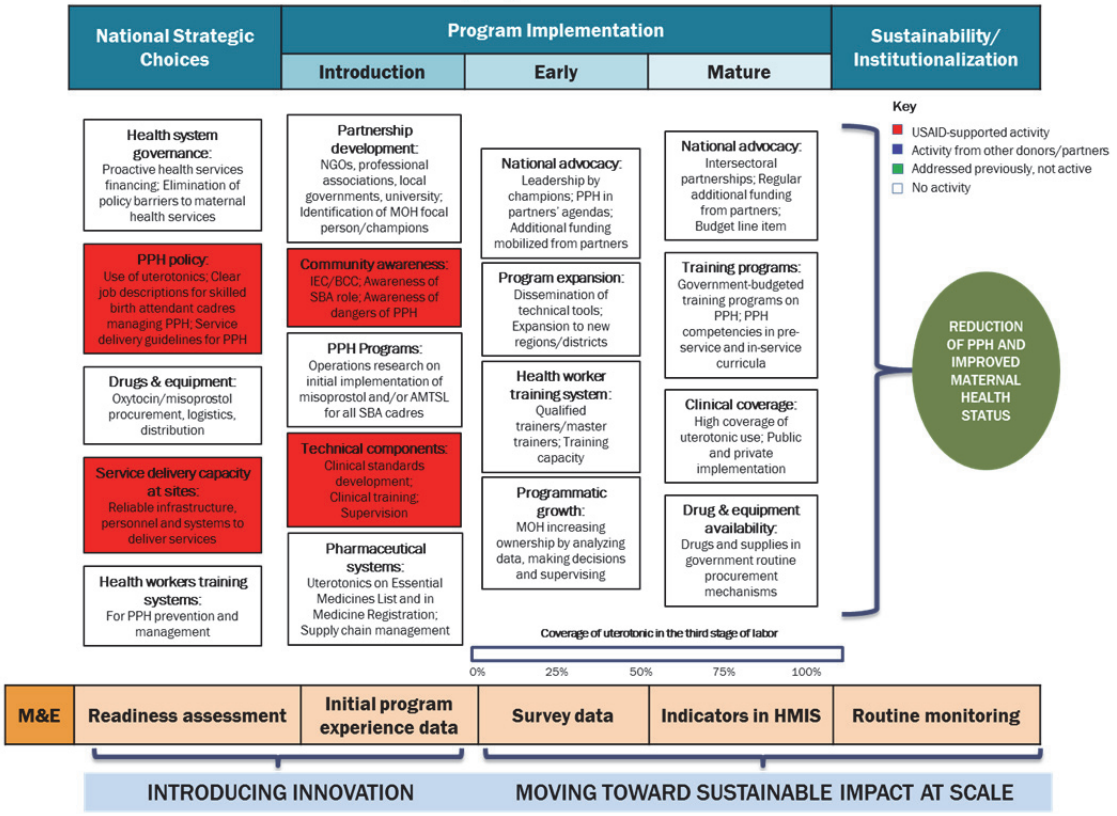
PAKISTAN PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



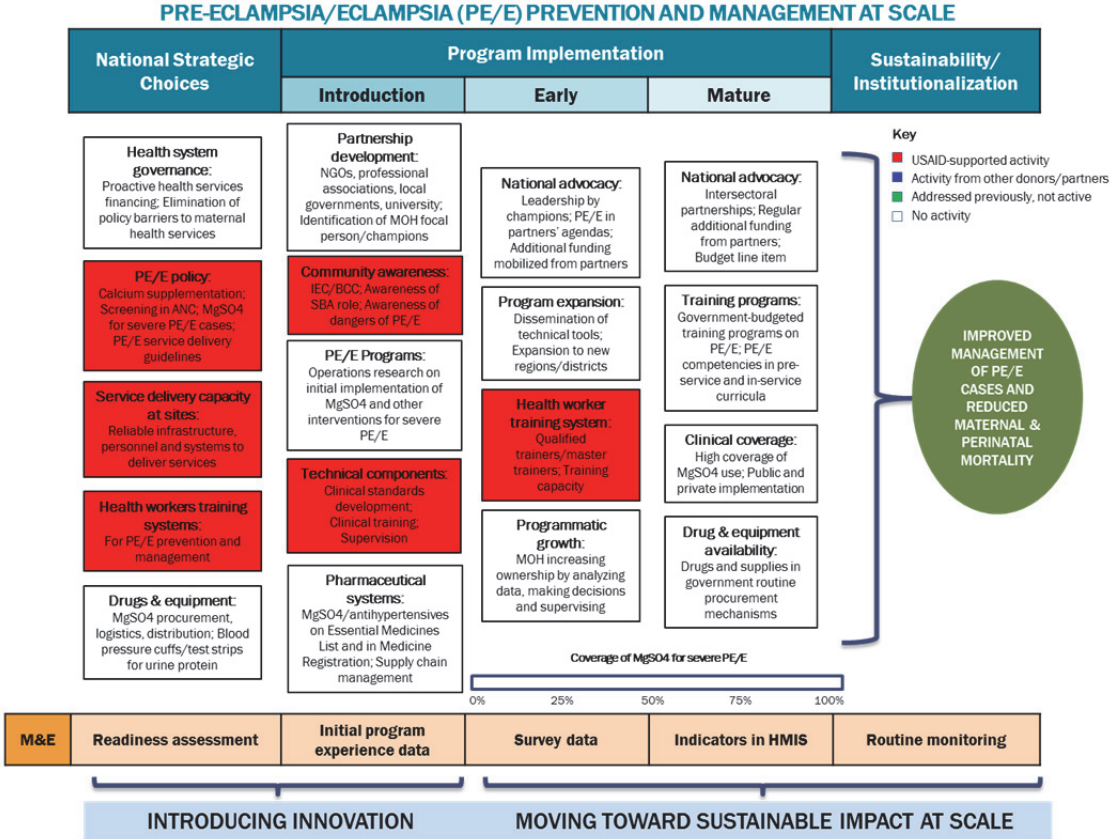
PAKISTAN PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



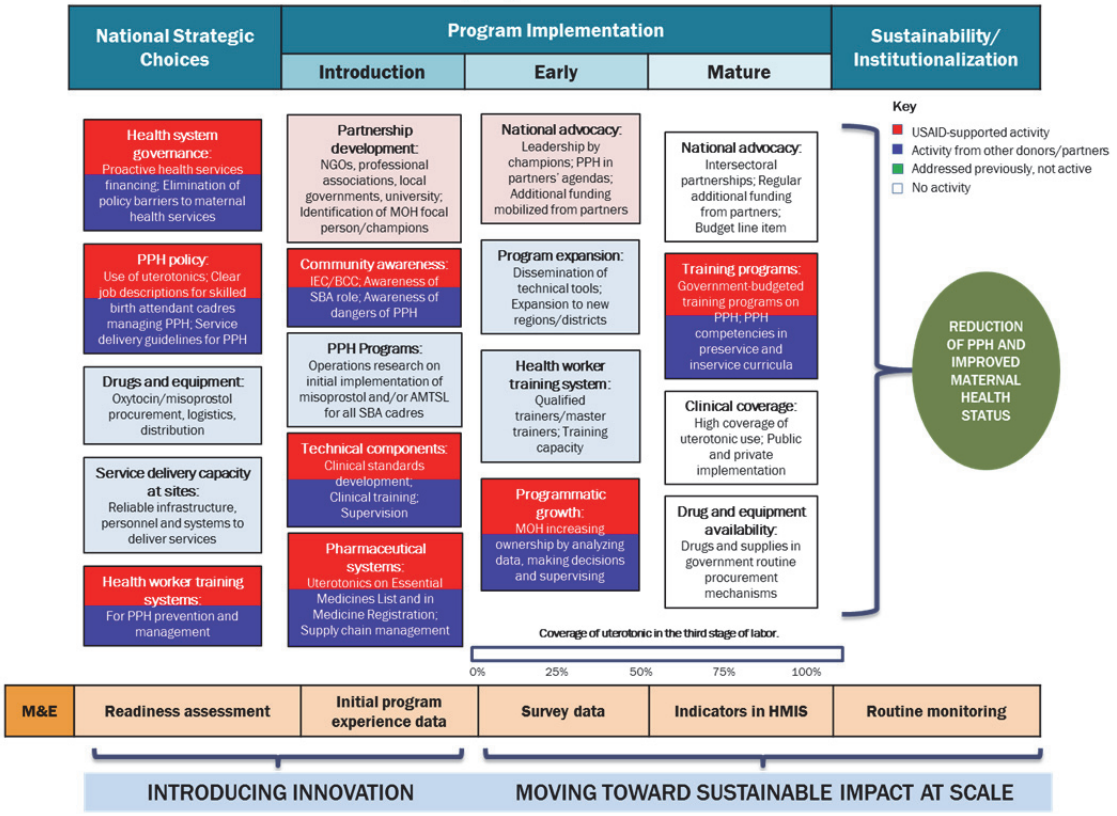
PARAGUAY PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



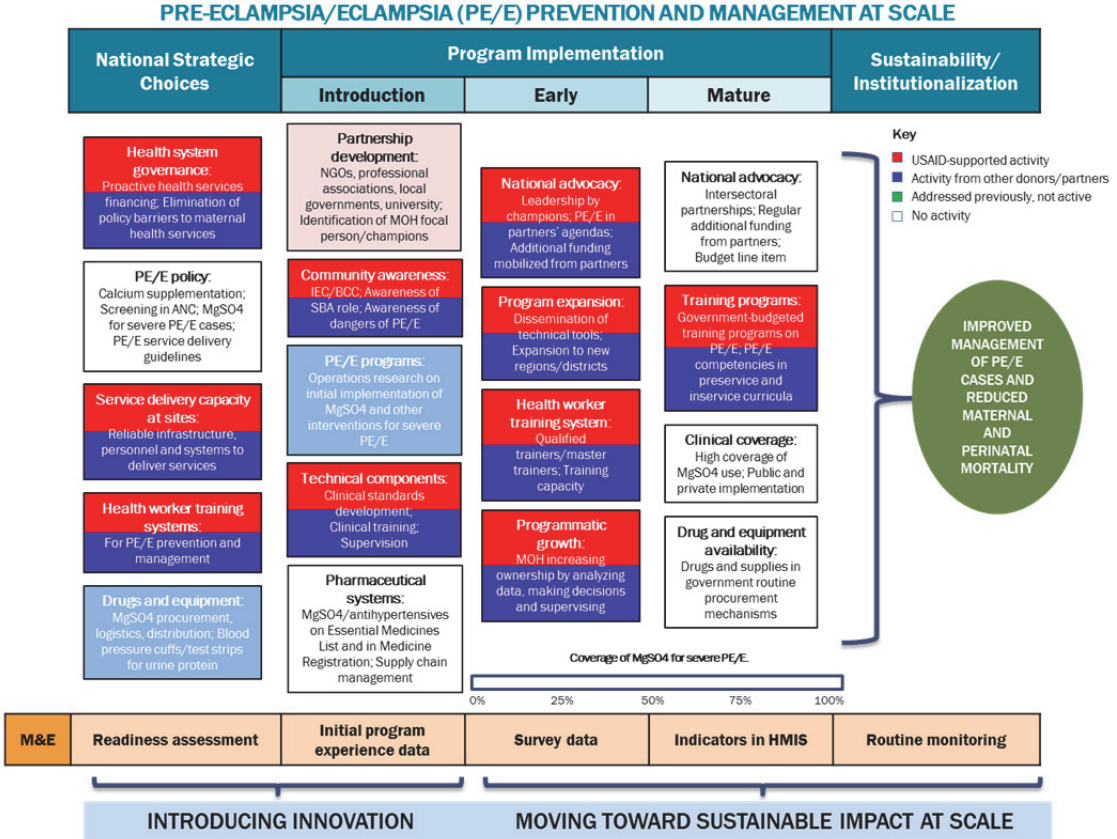
PARAGUAY PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



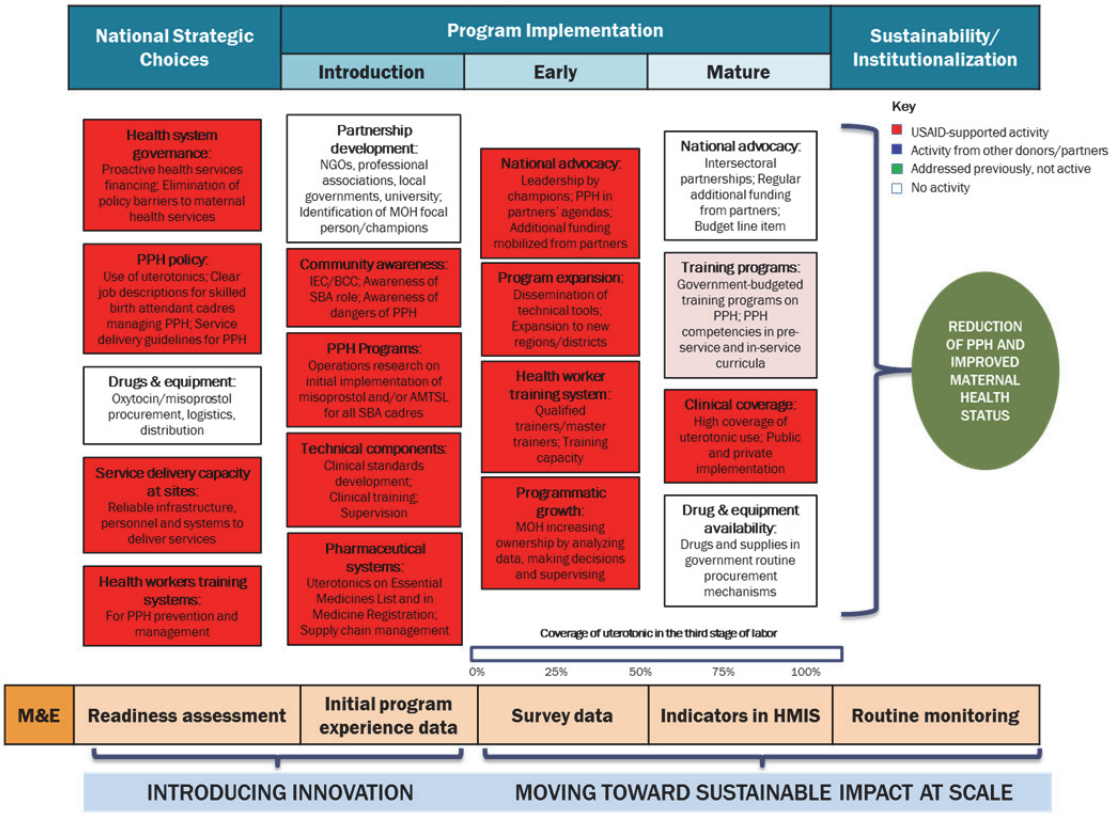
PHILIPPINES PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



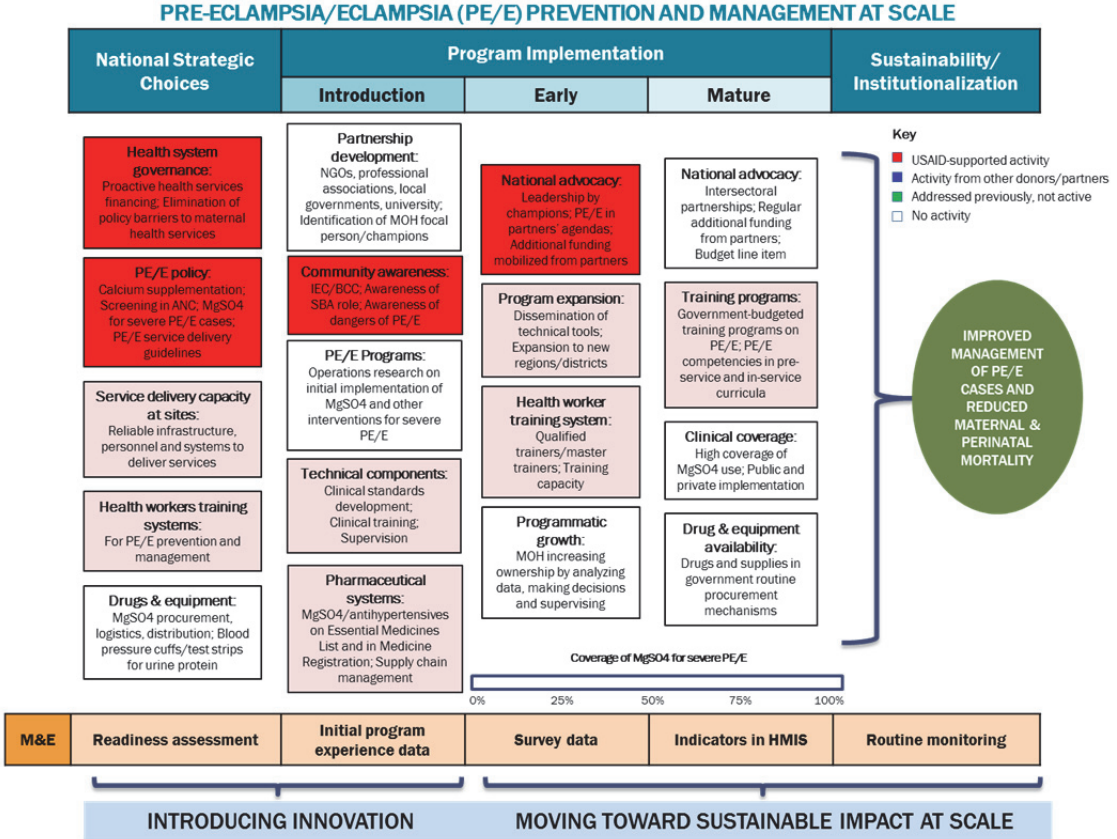
PHILIPPINES PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



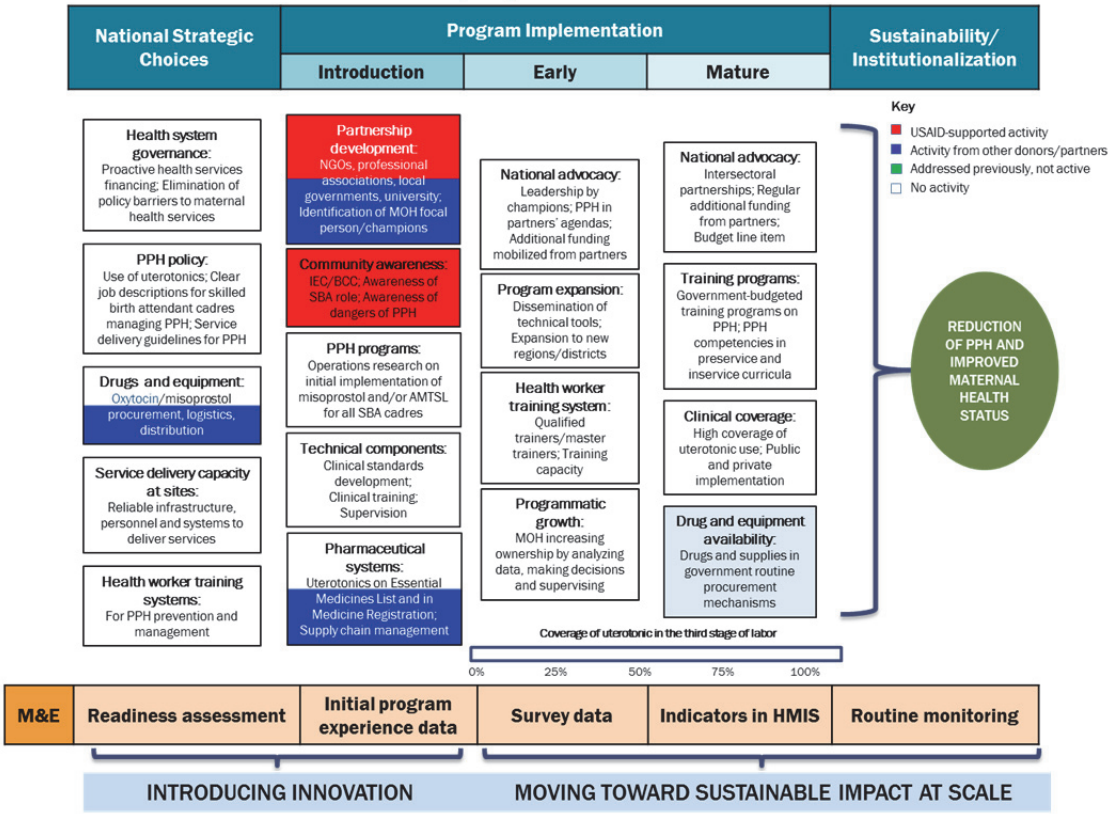
SENEGAL PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



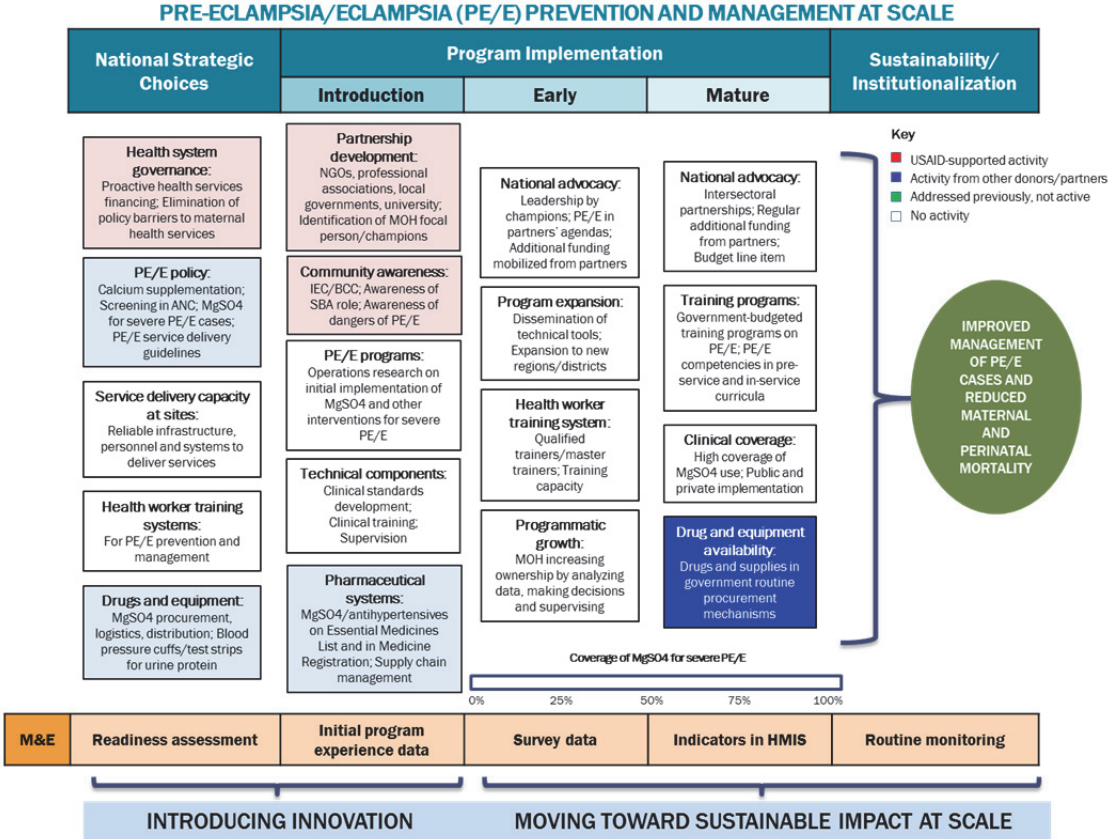
SENEGAL PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



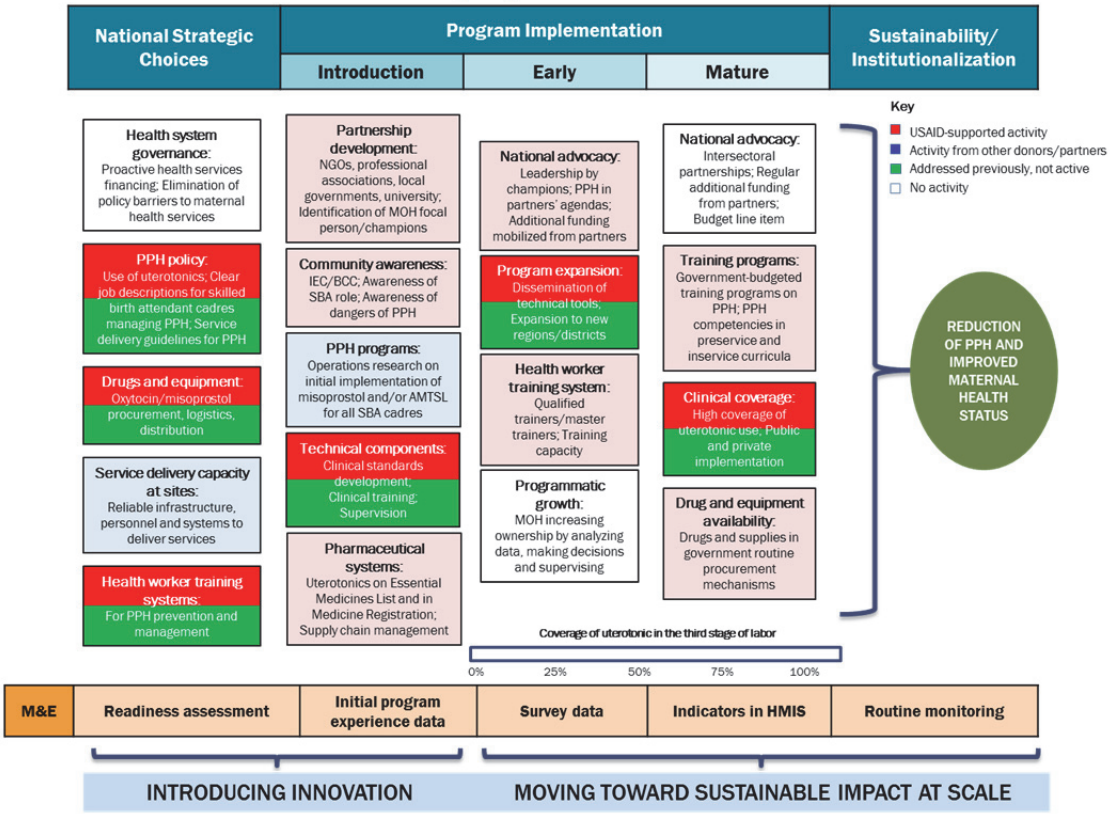
SOUTH SUDAN PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



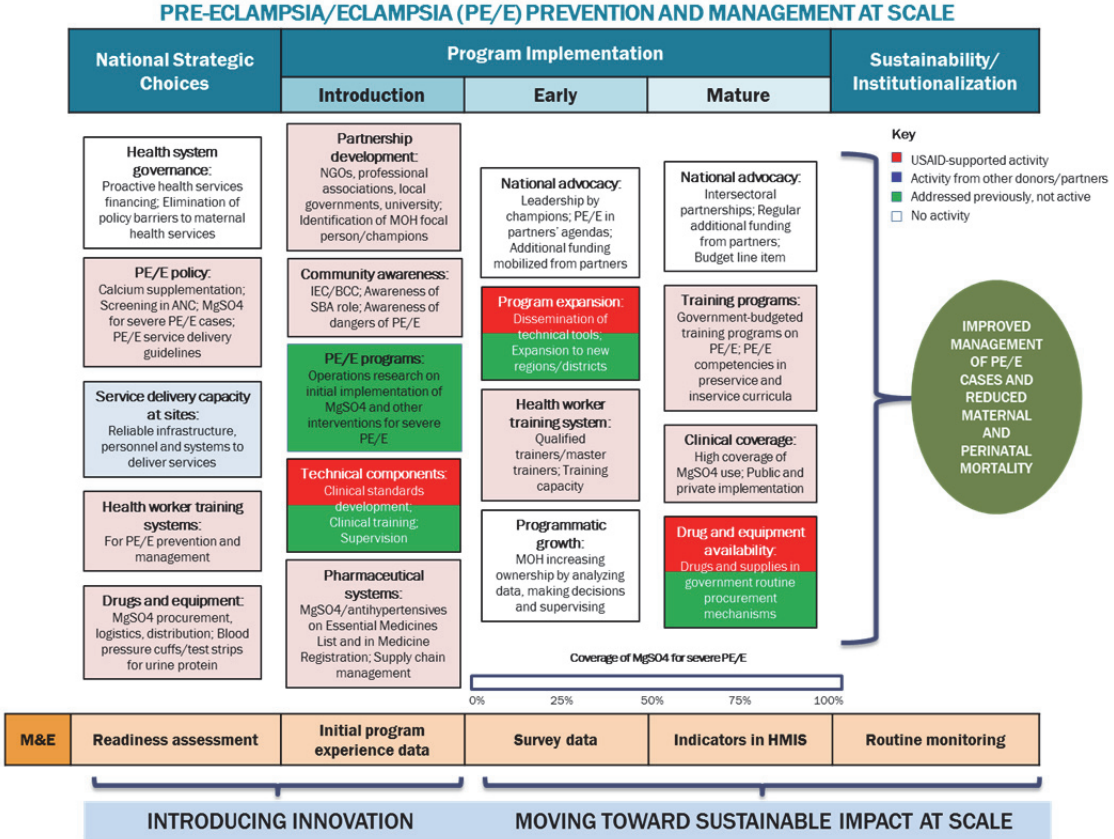
SOUTH SUDAN PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



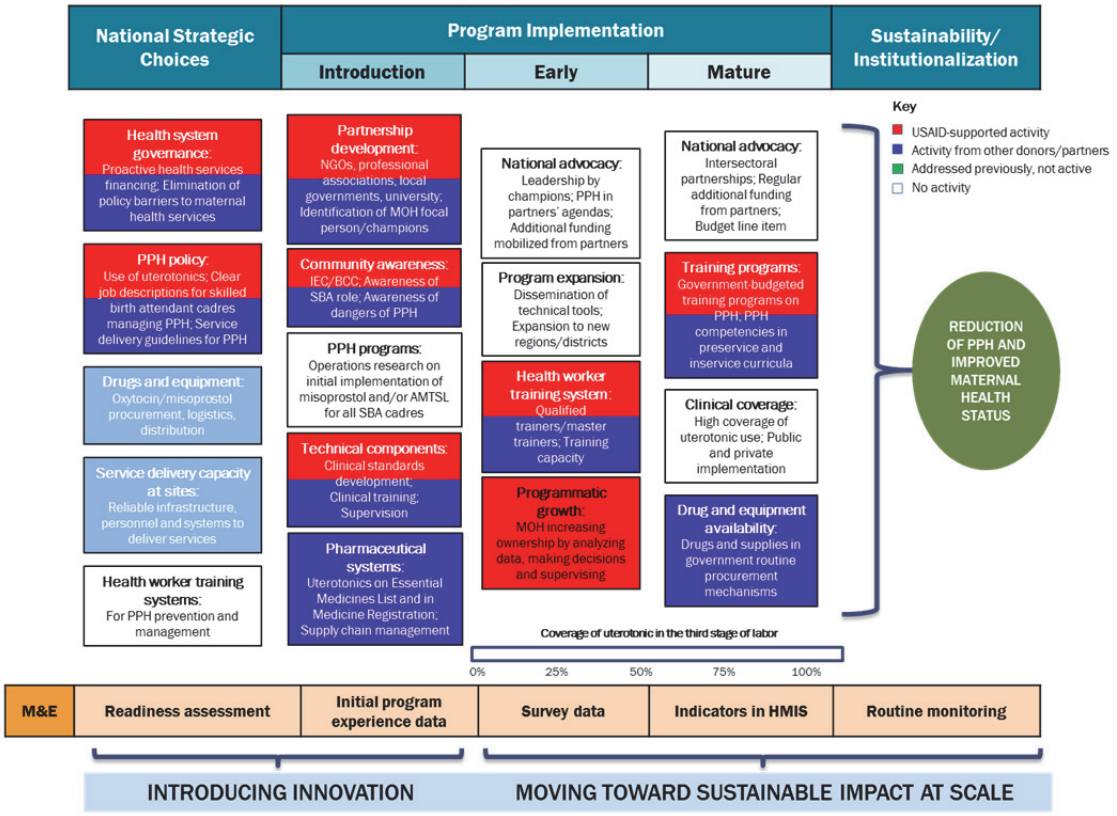
TANZANIA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



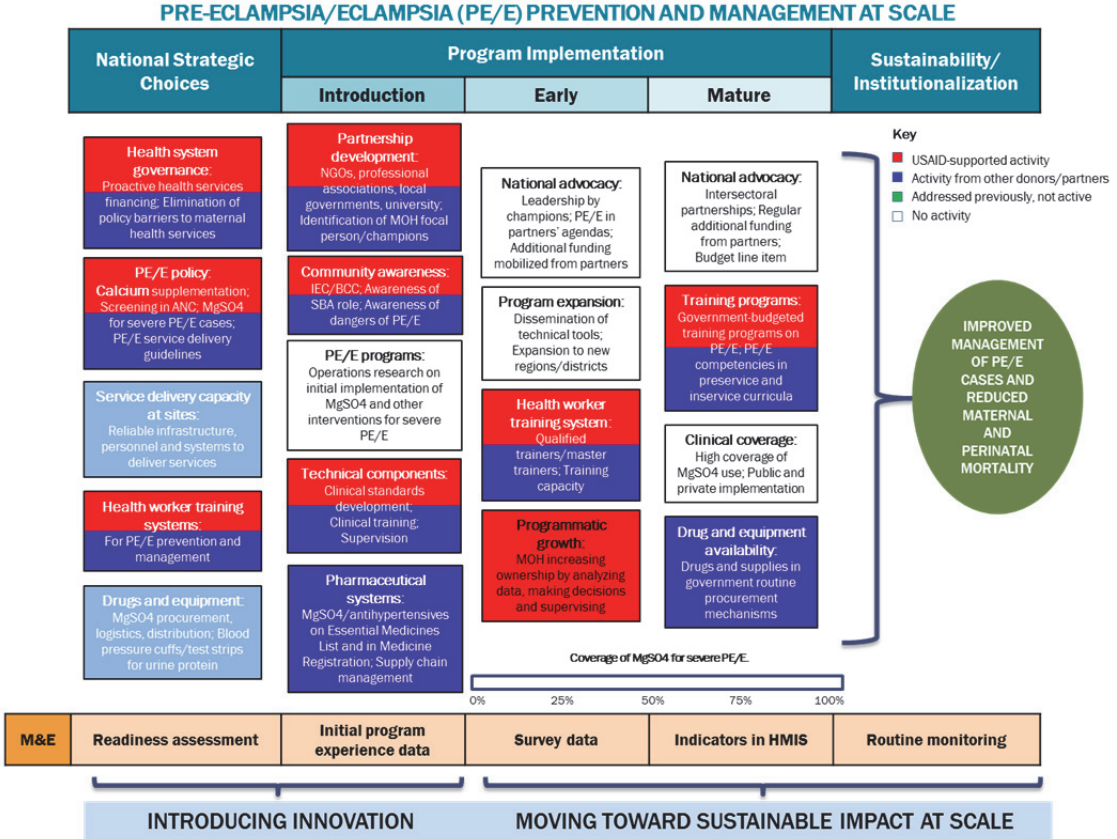
TANZANIA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



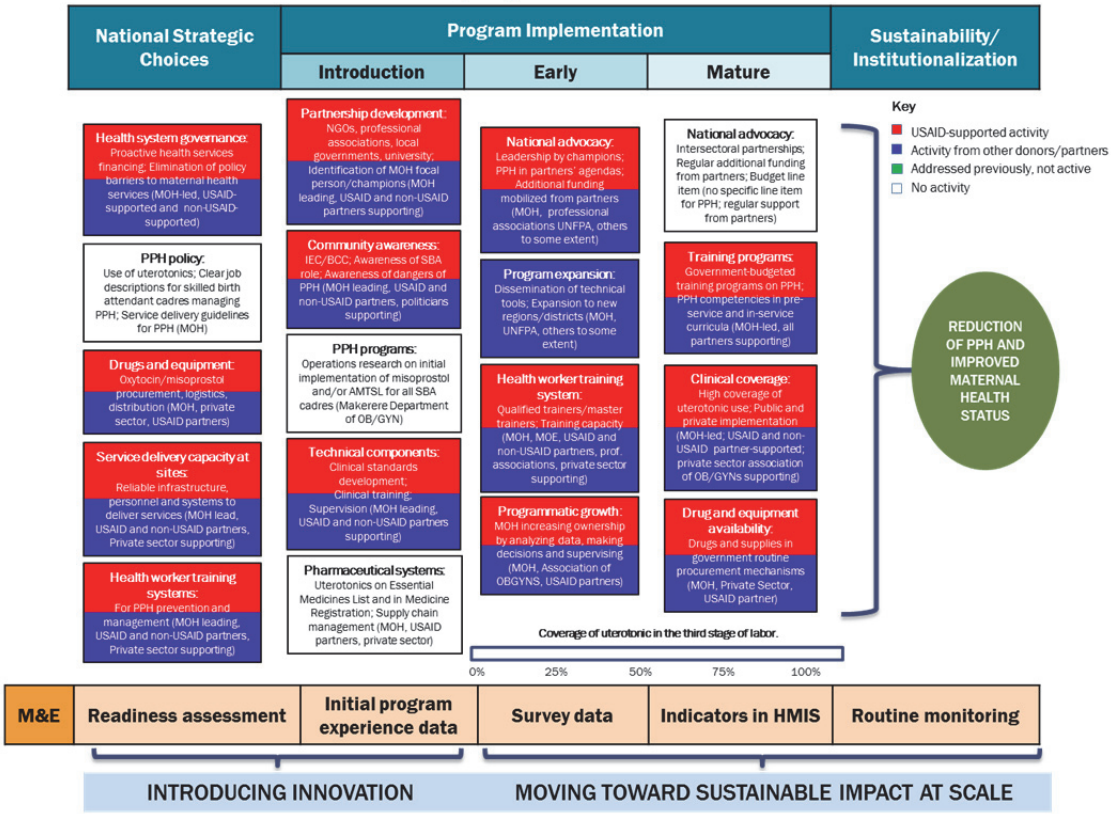
TIMOR LESTE PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



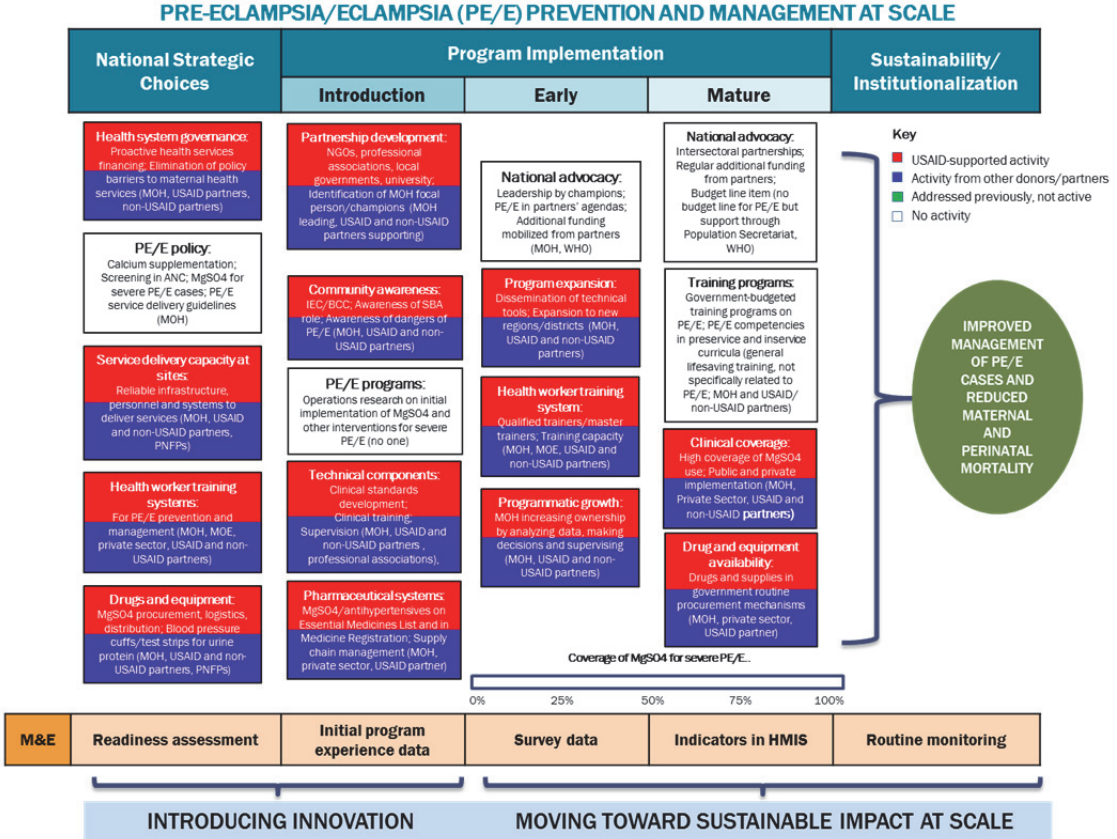
TIMOR LESTE PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



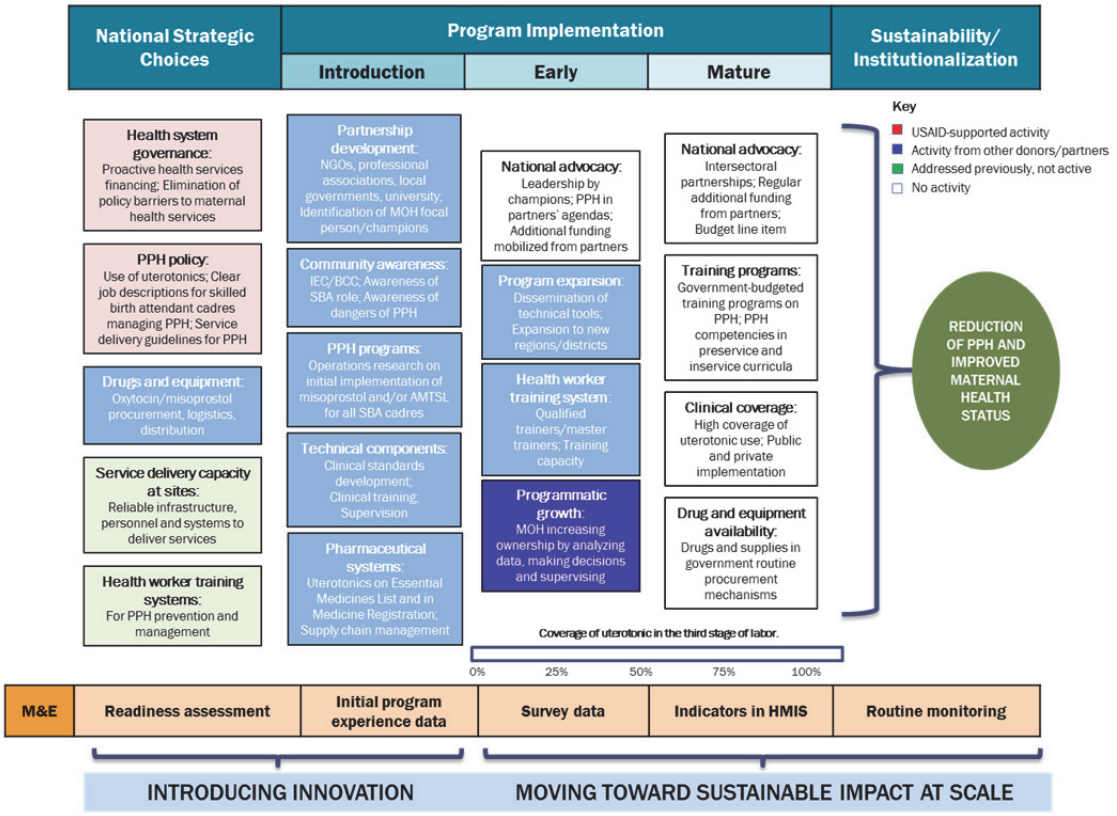
UGANDA PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



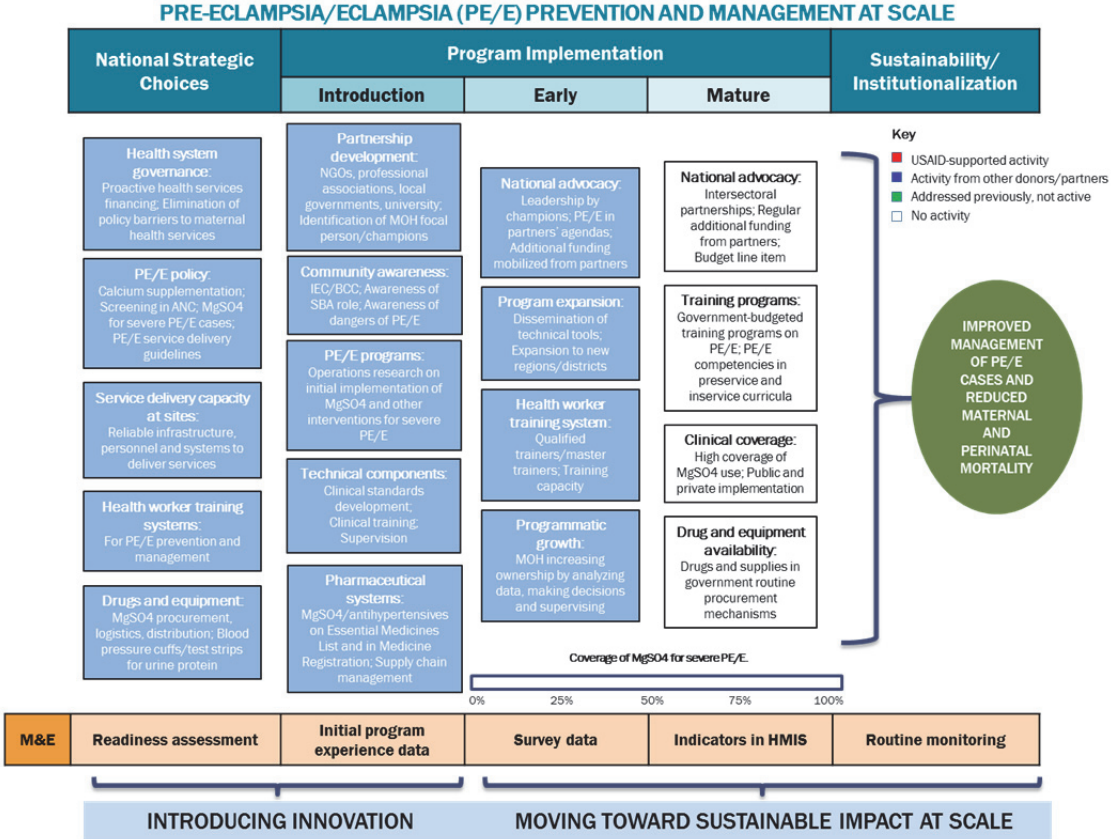
UGANDA PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



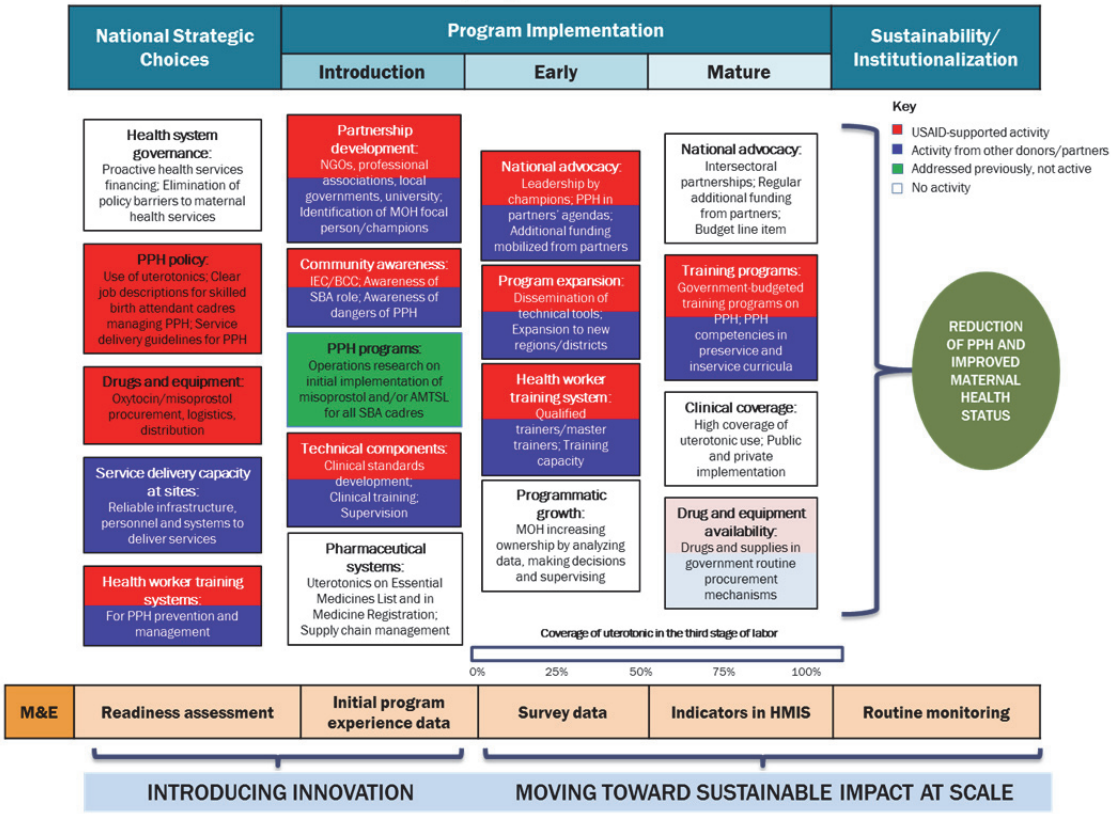
YEMEN PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



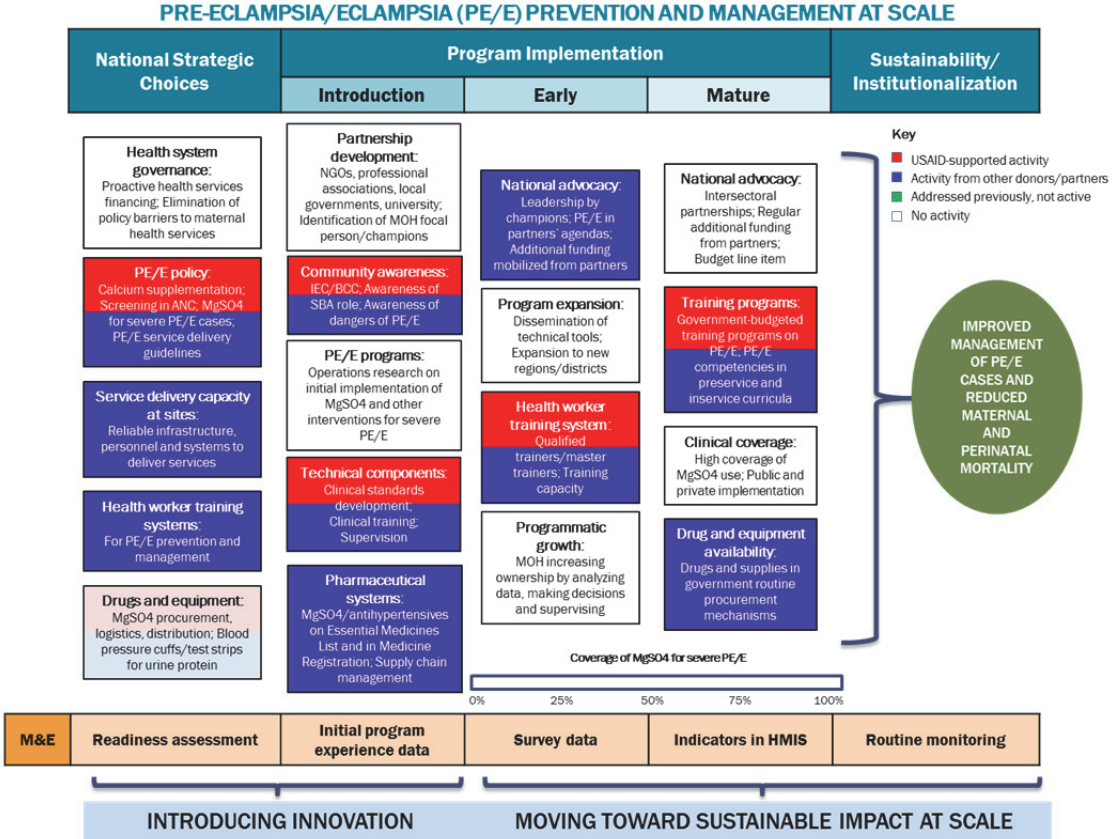
YEMEN PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



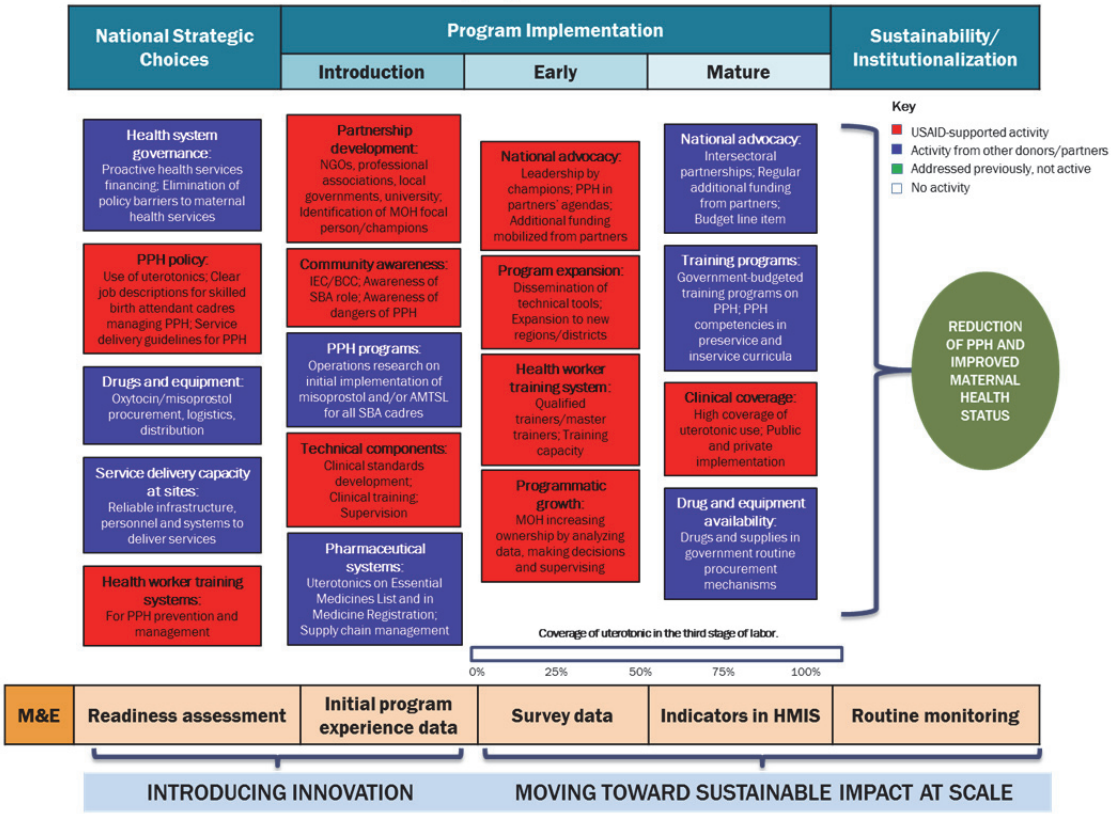
ZANZIBAR PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



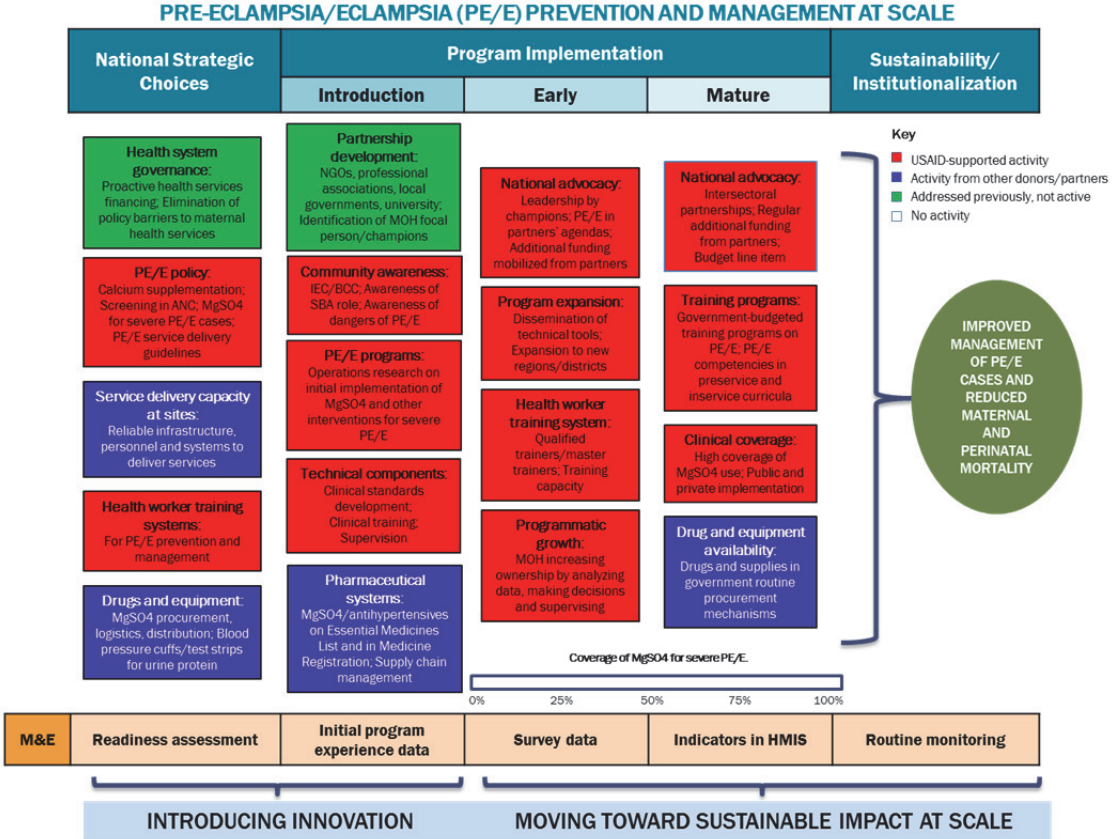
ZANZIBAR PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



ZIMBABWE PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE (PPH) PREVENTION AND MANAGEMENT AT SCALE



ZIMBABWE PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA (PE/E) PREVENTION AND MANAGEMENT AT SCALE



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