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Misoprostol Policy and Scale-Up for the Prevention of Postpartum Hemorrhage in Mozambique

Country Report

August 2016

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Cover Photo: A Makwa woman, 38 weeks pregnant, in Maputo, Mozambique. © 2015 Arturo Sanabria, Courtesy of Photoshare

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MISOPROSTOL POLICY AND SCALE-UP FOR THE PREVENTION OF POSTPARTUM HEMORRHAGE IN MOZAMBIQUE

COUNTRY REPORT

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ACRONYMS

ACOG	American Congress of Obstetricians and Gynecologists
AMOG	Associação Moçambicana de Obstetras e Ginecologistas
AMDD	Averting Maternal Death and Disability Program
ANC	Antenatal Care/Consultation
APE	Agente Polivalente Elementar [Community Health Worker]
ASH	African Strategies for Health
CBD	Community-Based Distribution
CHW	Community Health Worker
CSO	Civil Society Organization
FIGO	International Federation of Gynecology and Obstetrics
HRH	Human Resources for Health
HDI	Human Development Index
ICM	International Confederation of Midwives
IEC	Information, education, and communication
INE	National Statistics Bureau
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goals
MMR	Maternal mortality ratio
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
PPH	Postpartum hemorrhage
PSI	Population Services International
RCOG	Royal College of Obstetricians-Gynecologists
SSA	Sub-Saharan Africa
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
USAID	US Agency for International Development
VSI	Venture Strategies Innovation
WHO	World Health Organization

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1. EXECUTIVE SUMMARY

Introduction

Despite a 43 percent global decline in the maternal mortality ratio (MMR; maternal deaths per 100,000 live births) from 1990 to 2015, the number of annual maternal deaths remains unacceptably high, particularly in low- and middle-income countries where 99 percent of these deaths occur.[1] Postpartum hemorrhage (PPH), or severe bleeding following childbirth, is the leading cause of maternal mortality in low-income countries and the primary cause of nearly one quarter of all maternal deaths globally each year.[2]

The vast majority of deaths due to PPH can be effectively prevented or treated with uterotonics such as oxytocin and misoprostol, used to induce contractions or greater tonicity of the uterus.[3] Oxytocin is the most widely used uterotonic and is recommended by the World Health Organization (WHO) for use immediately after childbirth to reduce the risk of bleeding. However, oxytocin requires both refrigeration and administration via injection by a skilled provider, making it challenging to administer in resource-poor settings or in areas where the majority of women deliver at home. In a region where more than 50 percent of births occur without attendance by skilled health personnel, access to an alternative uterotonic or intervention for the prevention of PPH is critical to achieving maternal mortality reduction in Africa.[4]

Over the past decade, the use of misoprostol for PPH prevention has gained attention as a valuable strategy in settings where skilled birth attendance is low. Findings from numerous studies, reviews, and evaluations of the distribution of misoprostol at the community level overwhelmingly support its use as safe, effective, and feasible in the absence of a skilled birth attendant.[5],[6] As a result, the intervention has been included in various global clinical guidelines and, in 2012, WHO released a recommendation for the administration of misoprostol for PPH prevention by a lay health worker in the absence of a skilled birth attendant.[7] Misoprostol is inexpensive, can be administered as a tablet, and does not require cold chain storage, making it an important intervention for the millions of women giving birth at home or in health facilities without reliable electricity, refrigeration, or qualified health providers. Despite this body of evidence and growing global consensus of the benefits of using misoprostol to prevent PPH, few countries in Africa have adopted national policies or service-delivery guidelines for the scale-up of this intervention.[8]

In an effort to enhance understanding of the processes behind the development and adoption of policies and subsequent implementation of guidelines around community-based distribution of misoprostol for PPH, the United States Agency for International Development (USAID)'s Bureau for Africa and its African Strategies for Health (ASH) project, implemented by Management Sciences for Health (MSH),

[1] WHO. Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015.
[2] ibid
[3] WHO and UNICEF. Countdown to 2015: Maternal, Newborn, & Child Survival, Decade Report (2000 – 2010).
[4] UNICEF. State of the World's Children 2015.
[5] Smith, JM et al. "Misoprostol for Postpartum Hemorrhage Prevention at Home Birth: An Integrative Review of Global Implementation Experience to Date." *BMC Pregnancy and Childbirth* 13 (2013):44.
[6] Hundley V et al. "Should Oral Misoprostol Be Used to Prevent Postpartum Hemorrhage in Home-Birth Settings in Low-Resource Countries? A Systematic Review of the Evidence." *BJOG* 120 (2013):277-287.
[7] WHO. WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage. Geneva (Switzerland): World Health Organization (WHO); 2012.
[8] ibid

conducted a review in three African countries. The *Review of National Policies for Community-Based Distribution of Misoprostol for Prevention of Postpartum Hemorrhage and Subsequent Status of Scale-Up* study explored the policy-making process and subsequent roll-out of the intervention in three countries which have national policies in development or in place: Madagascar, Mozambique, and Nigeria. This report details the study findings and recommendations from Mozambique.

Study Approach

Study Goal

The overall goal of this study was to identify common factors which influenced and enabled policy development for community-based distribution of misoprostol and to document the various successes and challenges related to implementation in an effort to develop recommendations for establishing a favorable policy and implementation environment in other African countries.

Methodology

Between April 2015 and April 2016, ASH conducted desk research, site visits, and interviews with 11 key informants engaged in the policy development and/or implementation processes in Mozambique. The document review included policy documents, research and technical reports, program implementation reports, and training curricula. Key informant interviews were conducted with key stakeholders including the Ministry of Health (MOH), professional bodies, donors, civil society organizations (CSOs), and community leaders.

The study applied the policy triangle framework[9] to analyze the key determinants of policy development and adoption, including policy content, context, actors, and processes, and the interaction between these components. The status of implementation and scale-up of community-based distribution of misoprostol was documented through key benchmark indicators representing each of the six WHO Health Systems Building Blocks. Each indicator addresses an issue(s) critical to achieving effective impact at scale in a sustainable manner.[10]

Country Context

Despite a 65 percent decline in its MMR between 1990 and2015, Mozambique continues to face high rates of maternal deaths, which are exacerbated by high rates of malaria, tuberculosis, and HIV.[11]An estimated 5,300 maternal deaths occurred in Mozambique in 2015 and nearly one quarter of these deaths were due to PPH.[12] While only 54 percent of women receive assistance from a skilled birth attendant at the time of delivery, more than 90 percent of women receive at least one antenatal care (ANC) visit during pregnancy.[13] Substantial inequities in health indicators persist between population subgroups (e.g. between richer and poorer women; and between urban and rural women).

[9] Walt G and Gibson L. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy Planning* 9.4 (1994): 353-370.
[10] WHO. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. 2007.
[11] WHO. 2015. Levels and Trends for Maternal Mortality: 1990 to 2015. Geneva: World Health Organization. http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/
[12] ibid
[13] UNICEF. 2014. State of the World's Children 2015. Geneva: UNICEF http://www.data.unicef.org/resources/the-state-of-the-world-s-children-report-2015-statistical-tables

Key Findings and Recommendations

Policy Development

The emergence of Mozambique's national policy for community-based distribution of misoprostol for the prevention of PPH was greatly facilitated by leadership from the national government which enabled a favorable and supportive policy environment. In 2007, a national needs assessment revealed PPH was the leading cause of maternal mortality in Mozambique.[14] This spurred the MOH to accelerate efforts to address PPH and significantly reduce the burden of maternal deaths in the country. In 2009, in response to a request from the MOH for research to demonstrate the effectiveness of misoprostol for prevention of PPH at the community level, the Association for Obstetrics and Gynecology in Mozambique (Associação Moçambicana de Obstetras e Ginecologistas, or AMOG), Venture Strategies Innovations (VSI), Population Services International (PSI) and the Bixby Center for Population, Health and Sustainability at the University of California at Berkeley conducted an operational research study to demonstrate that distributing misoprostol to women during ANC visits and by traditional birth attendants (TBAs) at delivery were appropriate strategies to increase protection against PPH in the context of Mozambique's health system. To reduce deaths due to PPH, the study focused on educating women on birth preparedness and distributing misoprostol for the prevention of PPH at home births. Findings from the research study showed that both ANC and TBA distribution resulted in protected births at virtually all home deliveries taking place in the study sites, and demonstrated that misoprostol was a feasible and acceptable intervention to address PPH at the community level.[15] The results motivated policy makers to scale up the intervention nationwide, and in 2014, Mozambique formally launched the *Strategy for the Prevention of Post-Partum Hemorrhage at Community Level.*

Respondents indicate that leadership from AMOG played a critical role in building the case for misoprostol for PPH prevention in Mozambique. AMOG is at the forefront for supporting community-based interventions in Mozambique, has a wide membership of experienced providers and scholars promoting the judicious use of misoprostol, and a long-established relationship with the MOH with a history of assisting in policy decision-making. Informants cited the professional association as playing a critical role in generating evidence, advocating for, and designing the national misoprostol policy. Involvement from partners, including USAID's Maternal and Child Health Integrated Program (MCHIP) and the United Nations Population Fund (UNFPA), was also cited as important for policy development, particularly to ensure policy alignment with global agendas for the reduction of maternal mortality. Mozambique's fairly unchallenging policy development process demonstrates the effective interaction between actors and context in facilitating a favorable policy environment.

Implementation & Scale-Up

Following the final endorsement of the national policy and strategy in 2014, a two-year 35 district roll-out phase was initiated in April 2015. The initial roll-out was conducted in six districts and by September 2015, trainings to cover the remaining 29 districts began with plans for implementation in January 2016. The MOH is leading the implementation and scale-up which has ensured that existing structures are used. Local health staff, community health workers and TBAs have been engaged and therefore no new staff needed to be hired.

[14] Ministério da Saúde. Avaliação de Necessidades em Saúde Materna e Neonatal em Moçambique (Parte 1). Maputo. 2009.
[15] VSI, AMOG, Bixby Center, and PSI. Community-based Prevention of Postpartum Hemorrhage with Misoprostol in Mozambique: Final Report. 2011.

Because of its expertise and important role in the pilot and development of the policy, AMOG was identified as a key partner to provide technical advice, monitoring and supervision. The role of this professional association in advocating for advancing implementation and scale-up was critical. With the support of partners including USAID, UNFPA, WHO, and AMOG, the MOH is developing training packages, data collection tools and information, education and communication (IEC) materials for TBAs and other community health workers. The MOH and partners supported provincial directorates to design their local plans of action. Supervision and technical support trips to the provinces and districts are conducted jointly by the MOH, AMOG and relevant partners. While findings from the initial six districts are meant to inform future scale-up, respondents from districts which have begun implementation cited that at the time of this study, they had not yet been required to provide data or feedback on their implementation experiences and are eager to hear results from other districts. Respondents were particularly interested in information and data on use of misoprostol for other indications, impact on number of institutional births, general perception amongst beneficiaries and health personnel, and stock-out issues.

Table 1. Summary of Key Recommendations

Policy Development	Implementation and Scale-Up
▪ Ensure evidence is used to inform policy development and adoption processes. ➢ Local operations research showed misoprostol as an effective strategy to address PPH in the context of Mozambique's health system. ▪ Identify and engage passionate national champions who can effectively advocate at the highest levels. ➢ Openness to a high degree of coordination among different plans and strategies within the health sector contributed to an enabling policy environment in Mozambique. ▪ Engage various types of stakeholders from the beginning of the process. ➢ Involvement from a range of stakeholders including national and local governments, NGOs and CSOs, donors, research institutions, professional associations, and community members, facilitated ownership and buy-in and ensured interests and concerns were heard and addressed throughout the process.	▪ Incorporate a phased implementation strategy. ➢ A phased approach in Mozambique coupled with support from the MOH for the use of existing systems (i.e. antenatal care visits and traditional birth attendants) can facilitate the implementation of the strategy. ▪ Include a formal mechanism for documenting experiences as well as monitoring and evaluation which facilitates frequent and regular reviews of data. ➢ A lack of documentation during the initial roll-out has led to delays in the phased implementation. With partner support, the MOH is developing training materials and tools for monitoring and supervision. ▪ Use advocacy and community mobilization efforts, including engaging traditional and religious leaders and the media, to increase knowledge and support for the intervention. ➢ A community awareness campaign on birth preparedness and PPH prevention accompanied the education sessions provided at ANC visits during the research, and proved successful in gaining acceptability for the intervention.

2. BACKGROUND

Under the Millennium Development Goals (MDGs) adopted by the international community in 2000, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. Despite tremendous progress towards reducing maternal deaths worldwide, every day an estimated 830 women continue to die from preventable causes related to pregnancy and childbirth. In 2015, the Sub-Saharan African (SSA) region alone accounted for 66 percent of all maternal deaths and had the highest regional MMR at 546. An estimated 34 percent of maternal deaths in SSA are due to PPH.[16]

In settings where the administration of oxytocin is not feasible, misoprostol provides a safe and effective alternative for the prevention and treatment of PPH. Misoprostol is included in the WHO Model List of Essential Medicines for the prevention of PPH as well as in various global clinical guidelines including guidelines from the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the American Congress of Obstetricians and Gynecologists (ACOG), and the Royal College of Obstetricians-Gynecologists (RCOG). Furthermore, WHO's 2012 recommendations[17] for the prevention and treatment of PPH include the administration of misoprostol by a lay health worker in the absence of a skilled birth attendant. However, few countries in Africa have adopted national policies or service delivery guidelines for the scale-up of this intervention.

In 2011 and 2012, "A Global Survey on National Programs for the Prevention and Management of Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia" found that, of 20 African countries surveyed, misoprostol was on the essential medicines list for prevention of PPH in 16, 11 countries had conducted pilots on community-based distribution, but only four, including Mozambique, were beginning to scale-up the use of misoprostol at home births through the ratification of national policies.[18]

While several studies identify the challenges of and barriers to the transition from evidence to policy implementation for community-based distribution of misoprostol, there is presently no published literature reviewing the policy success stories.

3. COUNTRY CONTEXT

The east African country of Mozambique is the world's 36th-largest country with a projected population in 2016 of approximately 26 million of which nearly 40 percent are between the ages of 15 and 39.[19] The country is characterized by one of the lowest densities of health workers worldwide, with 64.5 medical doctors and nurses per 100,000 people.[20] To address the low density of physicians, nurses, and midwives available to provide essential health services particularly in rural, underserved areas, the MOH developed a national community health program in 1978. Through community health workers (Agentes Polivalentes Elementares, or APEs) basic services are delivered to the most remote and marginalized

[16] WHO. Trends in Maternal Mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015.
[17] WHO. WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage. Geneva (Switzerland): World Health Organization (WHO); 2012.
[18] Smith J, Currie S, Perri J, Bluestone J and Cannon T. "A Global Survey on National Programs for the Prevention and Management of Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia." *Maternal and Child Health Integrated Program.*
[19] WHO Country Profile Mozambique, 2015.
[20] Relatório Anuál 2011, Ministry of Health, Directorate for Human Resources for Health cited from http://www.afro.who.int/en/mozambique/country-programmes/health-systems/human-resources-for-health.html

communities.[21] A period of civil war, lasting from 1976 until 1992, caused significant destruction of health infrastructure and disruption in the delivery of health services including the APE program.[22] With strong donor support, the country has experienced rapid economic expansion over the past decade, however, only a moderate impact on poverty reduction has been achieved, and the geographical distribution of poverty remains largely unchanged. Health system infrastructure continues to be a significant challenge, and facilities face frequent commodity stock outs and lack basic amenities. It is estimated that more than half of facilities (55 percent) are without electricity and 41 percent without running water.[23]

Intensified efforts towards Millennium Development Goal 5[24] have led to a 65 percent decline in the MMR between 1990 and 2015, however, Mozambique continues to face high rates of maternal deaths (408 maternal deaths per 100,000 live births).[25] PPH contributes to over 25 percent of these deaths; and HIV is also a leading cause of indirect mortality among mothers (causing 19 percent of maternal deaths).[26] The majority of women, particularly those living in rural areas, deliver at home without a skilled health provider, and the proportion of women giving birth in health facilities remains low.[27] Between 2009-2013, more than 90 percent of women received at least one ANC visit, however only 50 percent received all four visits recommended by WHO.[28]

Mozambique has one of the highest fertility rates in SSA at 5.9 births per woman and 6.6 births per woman in rural areas.[29] Use of modern contraceptive methods remains low at 12 percent, and unmet need for contraception remains high at 28.5 percent among married women aged 15–49.[30] Mozambique also has the world's 10th highest rate of child marriage.[31] The 2011 Demographic and Health Survey data found that nearly 40 percent of girls were married before the age of 19 and 14 percent before the age of 15.[32] Of the girls married before 15 years, 39 percent had their first child before the age of 15.[33] These early marriages pose serious health risks for young mothers and their newborns: teenage mothers are more likely to die during pregnancy than mothers in their twenties, and their newborn babies are more likely to have low birth weight.[34]

[21] Advancing Partners & Communities. 2013. Country Profile: Mozambique Community Health Programs. Arlington, VA
[22] Context Analysis: Close to Community Providers in Mozambique. Reach Out, May 2014. http://www.reachoutconsortium.org/media/1834/mozambiquecountryanalysisjuly2014compressed.pdf
[23] WHO Regional Office for Africa. WHO Country Cooperation Strategy, Mozambique, 2009–2013.
[24] Goal 5 aimed to improve maternal health through the following targets: 5a) reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and 5b) achieve, by 2015, universal access to reproductive health.
[25] Mocambique Inquérito Demográfico e de Saúde 2011. Instituto Nacional de Estatística Ministério da Saúde Maputo, Moçambique MEASURE DHS/ICF International (Assistência Técnica) Março 2013.
[26] WHO Global Health Observatory, 2016.
[27] JHPIEGO and Save the Children. Final Report. Maternal and Child Health Integrated Program (MCHIP) for Mozambique. September 2015. http://www.mcsprogram.org/wpcontent/uploads/2016/02/MCHIP_Moz_FinalReport.pdf
[28] UNICEF. 2014. State of the World's Children 2015. Geneva
[29] Mocambique Inquérito Demográfico e de Saúde 2011. Instituto Nacional de Estatística Ministério da Saúde Maputo, Moçambique MEASURE DHS/ICF International (Assistência Técnica) Março 2013..
[30] ibid
[31] Hodges, A. 2016. Child Marriage and Adolescent Pregnancy in Mozambique: Policy Brief. UNICEF, UNFPA, and the National Coalition to Eliminate Child Marriage in Mozambique.
[32] Mocambique Inquérito Demográfico e de Saúde 2011. Instituto Nacional de Estatística Ministério da Saúde Maputo, Moçambique MEASURE DHS/ICF International (Assistência Técnica) Março 2013.
[33] Ibid.
[34] Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Vos T, Ferguson J, Mathers CD. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet*, 2009, 374:881–892.

4. STUDY OBJECTIVES & METHODOLOGY

Study Objectives

The *Review of National Policies for Community-Based Distribution of Misoprostol for Prevention of Postpartum Hemorrhage and Subsequent Status of Scale-Up* study explored the policy-making process and subsequent roll-out of the intervention in three African countries which have national policies in place for the use of misoprostol at home births for prevention of PPH: Madagascar, Mozambique, and Nigeria.

The purpose of this study was to identify the key determinants contributing to the development and adoption of policies, to determine the current status of implementation and scale-up of the intervention, and to identify successes and challenges in the subsequent national roll-out and scale-up of the intervention. The study findings provide practical recommendations for countries beginning policy development and adoption, and/or national roll-out of community-based distribution of misoprostol for PPH. Specific study objectives were to:

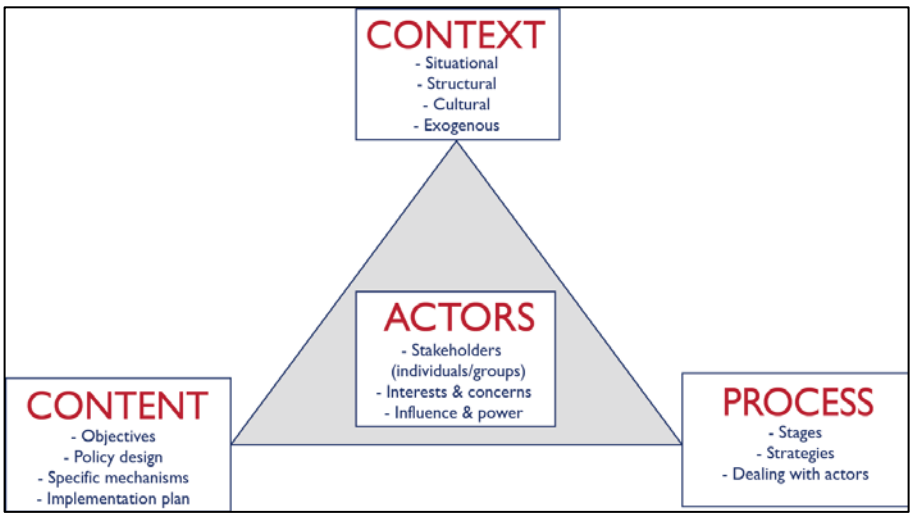
1. Analyze the policy-making process for national policies on community-based distribution of misoprostol for PPH prevention;
2. Identify key facilitators and enablers critical to policy development and adoption;
3. Ascertain progress towards scale-up of the intervention since policy adoption as measured by specific benchmark indicators; and
4. Identify successes and challenges to policy development and implementation.

Conceptual Framework and Strategic Indicators

Policy Review

To analyze the policy-making process, the study applied the policy triangle conceptual framework (Figure 1). The framework theorizes that policy is influenced by a multitude of factors and the interactions between them. The study reviewed various components in Mozambique, including the situational and structural contexts around the policy, stakeholders' interests and influence, the content of the policy, its objectives and design, as well as the process by which the policy was developed.

Figure 1. Policy Triangle Conceptual Framework



Source: Walt, G and Gibson, L. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy Plan. (1994) 9 (4): 353-370.

Status of Implementation and Scale-Up

The status of implementation and scale-up of community-based distribution of misoprostol was documented based on indicators representing each of the WHO Health Systems Building Blocks (Table 2). Each indicator addresses an issue(s) critical to achieving effective impact in a sustainable manner.

Table 2. WHO Health Systems Building Blocks

Building Block	Indicator
Governance*	▪ Is community-based distribution of misoprostol for the prevention of PPH included in current national strategies and practice guidelines? ▪ Is community-based distribution of misoprostol for the prevention of PPH included in both national and subnational implementation plans?
Finance	▪ Is community-based distribution of misoprostol for the prevention of PPH included in MOH budgets?
Health Information	▪ Does the MOH currently collect, report, and use appropriate indicators/information on community-based distribution of misoprostol for prevention of PPH?
Commodities & Supplies	▪ Is misoprostol currently procured and distributed in sufficient quantities as part of the national logistics system?
Human Resources	▪ Are the appropriate health worker cadres authorized to distribute misoprostol? ▪ Do the appropriate in-service and pre-service curricula include community-based distribution of misoprostol for prevention of PPH?
Service Delivery	▪ Is community-based distribution of misoprostol for prevention of PPH included in MOH supervision schedules? ▪ Is misoprostol available for distribution at the community level?

**A national policy indicator is not included here given this is a criterion for inclusion in the study and thus all countries have a national policy in place.*

Study Methodology

The study was conducted through the development of a qualitative retrospective case study developed through use of two methods: document review and key informant interviews.

Document Review

A document review provided an initial overview of policy development and current status of implementation. Documents included national policies, strategies, clinical guidelines, technical working group notes, training curricula, etc. The document review also included a brief stakeholder analysis in an effort to identify initial key informants, to understand their position/role with respect to the policy process, and to gain a clear understanding of stakeholder interests (i.e. what are the perceived drivers/facilitators for policy implementation success as it relates to each stakeholder).

Key Informant Interviews

Semi-structured interviews were conducted with 11 stakeholders engaged in the policy development and implementation processes in each country. These stakeholders included representatives from government, multilateral organizations, donors, NGOs, and CSOs.

5. POLICY DEVELOPMENT: KEY FINDINGS

A policy can be defined as a deliberate system of principles to guide decision-making. This section describes the policy development process for community-based distribution of misoprostol for PPH in Mozambique through components of the policy triangle framework: policy context, actors, processes, and content.

5.1 Context

For more than a decade, the Mozambican government has intensified efforts to address maternal mortality. In 1998 a first nation-wide Safe Motherhood needs assessment[35] was done, which was followed in the same year by a systematic review of the causes of maternal deaths.[36] This influenced the MOH to formulate a national strategy—which was adopted in 2000—to reduce the maternal morbidity and mortality and neonatal mortality.[37] This document served as the basis for identifying and testing interventions to reduce maternal mortality in Mozambique. It emphasized the need for strengthened health services for the provision of basic and emergency obstetric care, with an adequate referral system, community involvement, and an improved data collection system.

A national needs assessment conducted in 2006-2007 highlighted two alarming facts that helped spur the Mozambican government towards targeted efforts to reach women at the community level.[38] The needs assessment showed that PPH continued to be the primary obstetric cause of death and highlighted that only one third of births among rural women were attended by a skilled birth attendant. In response to these findings, the MOH subsequently prioritized the identification of high-impact, community-based maternal health interventions that can reach women with limited access to formal health services, and commissioned research to demonstrate the effectiveness of misoprostol for the prevention of PPH at the community level in Mozambique. Led by AMOG in collaboration with partners, the research demonstrated that misoprostol distribution during ANC visits to women and by TBAs at delivery was an appropriate strategy to increase protection against PPH.[39] In recognition of these findings, as well as the growing global support for this intervention, a range of stakeholders continued support for the development of a policy that would address PPH at the community level. In 2013, Mozambique formally approved the *Strategy for the Prevention of Postpartum Hemorrhage at Community Level* (Annex 2).

5.2 Actors

A number of actors, including key individuals, organizations, and the government, contributed to the policy development process in its various stages. Motivated by their specific interests and prevailing concerns, these organizations and individuals played varying roles in shaping the development and approval of national policy for community distribution of misoprostol. In particular, the MOH created an enabling environment for the content development and direction of the strategy. Other key actors included NGOs and civil society groups, donors, research organizations, and health professional associations. The roles of these stakeholders, along with their concerns and motivations, during the policy development process, are summarized in Table 3.

[35] Ministerio Da Saude. (10-4-1999) Avaliacao das necessidades para uma maternidade segura em Mozambique - 1999.
[36] Ministerio Da Saude. (1999) Revisão de Mortes Maternas em Moçambique 1998-1999.
[37] Ministerio Da Saude and Departamento de Saude da Comunidade. (2000) Estrategias para a redução da morbimortalidade materna e neonatal.
[38] Ministério da Saúde. Avaliação de Necessidades em Saúde Materna e Neonatal em Moçambique (Parte 1). Maputo. 2009.
[39] VSI, AMOG, Bixby Center, and PSI. Community-based Postpartum Hemorrhage with Misoprostol in Mozambique Final Report. May 2011.

Table 3. Actors Concerns and Motivations

Actor	Role(s) in Policy Development	Prevailing Concerns or Motivating Factors
Ministry of Health	▪ The MOH provided a favorable policy environment through involvement in local operations research and advocacy for community-based approaches.	▪ Reaching women and families at the community level was a key motivating factor driving MOH involvement. ▪ A supportive environment for coordination among different plans and strategies within the health sector and existing systems contributed to an enabling policy environment in Mozambique. ▪ Concerns that misoprostol use may lead to a decrease in institutional births were addressed through local operations research.
Donors and UN agencies	▪ Donors provided financial support to conduct and disseminate findings from local operations research. UN Agencies provided financial support for purchase of misoprostol for use in research study. ▪ Provided input into policy design.	▪ Ensuring sufficient supervision systems were in place for the proper use of misoprostol at the community level was a concern cited by some partners and donors and contributed to a delay in implementation.
Researchers and research organizations	▪ Carried out the local, context specific operations research. ▪ Served as key spokespeople in communicating the findings of the operations research and generating support for a national policy based on local findings.	▪ Evidence generated at the local level supporting the safety and acceptability of misoprostol for PPH was critical motivation for a number of stakeholders throughout the process.
Professional health associations	▪ AMOG played a critical role in building the case for misoprostol for PPH prevention in Mozambique. ▪ Participated in producing evidence and assisted the MOH in designing the national policy.	▪ AMOG's involvement was important for addressing concerns around the correct administration of misoprostol by non-skilled health workers, such as TBAs and community health workers.

5.3 Process

The policy development process in Mozambique was influenced throughout three distinct stages: (1) prioritization by MOH and preliminary advocacy efforts, (2) operations research, and (3) stakeholders' engagement.

Stage 1 - Prioritization by MOH and Preliminary Advocacy Efforts: Understanding the maternal mortality burden and needs for addressing it was cited as a critical step towards the development and adoption of a community-based intervention for PPH prevention. Since the early 2000s

and in support of the MDG targets, the MOH intensified efforts towards addressing the high burden of maternal mortality. In recognition of Mozambique's needs assessments, which showed that hemorrhage remained a main cause of maternal death and that less than 20 percent of women delivered in health facilities, the MOH understood the limitations of current strategies to address PPH and identified misoprostol's use in home births and in rural communities as a key intervention to address the high burden of deaths.

Concerned by significant shortcomings in hospitals and by the evidence that the majority of women were delivering at home and without skilled birth attendants, the MOH advocated for the importation, sale, and distribution of misoprostol for all obstetric indications, a request approved in 2009 by the Department of Pharmacy within the MOH. Nevertheless, local evidence was requested to show the effectiveness and feasibility of community-based distribution of misoprostol for the prevention of PPH. As implementation of the operational research began in 2009, the MOH initiated the review of all maternal and reproductive health policies where misoprostol has the potential to be included. A reportedly strong and well-structured planning cycle in Mozambique provided an enabling environment for the inclusion and integration of new policies and strategies.

Stage 2 - Operations Research: In early 2009 AMOG, VSI, PSI, and the Bixby Center for Population, Health and Sustainability at UC Berkeley undertook operational research to demonstrate that misoprostol distribution during ANC visits to women and by TBAs at delivery were effective strategies to increase protection against PPH in the context of Mozambique's health system.[40] The study aimed to educate women on birth preparedness and increase access to a uterotonic drug regardless of the place of delivery (home or facility), leading to a reduction in PPH, referrals to higher level facilities, and reduced maternal mortality.

The research was conducted in three sites (Chokwé, Namacurra, and Nacala-Porto/Nacala-a-Velha) in four districts over a period of twelve months. Health facilities providing ANC services took part in the study, and TBAs were trained in the administration of misoprostol at home deliveries. Findings indicated that high coverage of misoprostol can be achieved through distribution by TBAs and at ANC visits, paired with a community awareness campaign on the importance of facility deliveries. Misoprostol was self-administered by women who had received the medicine coupled with birth preparedness education during ANC visits. TBAs used misoprostol in all of the deliveries they attended in the study sites, and women delivering with TBAs reported taking the correct dose at the correct time at a home delivery.[41] Furthermore, women reported high levels of acceptability for using misoprostol across all three research sites.

In light of these findings, researchers called on MOH officials to support the nationwide scale-up of misoprostol distribution through ANC visits and at deliveries with TBAs.

Stage 3 – Stakeholder's Engagement: The evidence from the operations research study specific to context provided the basis for extensive advocacy and engagement of key stakeholders to support community-based distribution of misoprostol and its scale-up throughout Mozambique. Through national dissemination meetings, the development of policy and advocacy briefs, and engagement with the media, the findings were widely disseminated to a broader group of stakeholders including donors and NGOs. During and immediately after the operations research, AMOG successfully secured media coverage and has now developed a more pro-active strategy that includes regular radio and television slots paid for by

[40] VSI, AMOG, Bixby Center, and PSI. Community-based Prevention of Postpartum Hemorrhage with Misoprostol in Mozambique: Final Report. 2011.
[41] Ibid.

the MOH.[42] Engagement and support for the use of misoprostol at the community level from partners including USAID's MCHIP and UNFPA, was cited by respondents as important for policy development, particularly to ensure policy alignment with global maternal mortality recommendations.

During this stage, however, a number of concerns relating to community distribution of misoprostol were raised by some partners and donors specifically whether sufficient supervision systems were in place to ensure proper use of misoprostol at the community level. According to key informants, these concerns led to a delay in funding support for implementation from some donors until demonstrated controls were put into place. The engagement of a wide range of stakeholders in the discussions and process, including national and local governments, NGOs and CSOs, donors, research institutions, and professional associations, facilitated ownership and buy-in and ensured interests and concerns were addressed throughout the process.

5.4 Content

The main objective of the *Strategy for the Prevention of Postpartum Hemorrhage at Community Level* is to promote the use of misoprostol for the prevention of PPH on women delivering in the community across 35 districts through a phased approach (Annex 2).[43]

The strategy supports distribution of misoprostol via trained community health workers or APEs, through TBAs, and through ANC visits. It includes a community mobilization component to promote facility-based births, and to increase the proportion of pregnant women receiving their first ANC visit before 16 weeks gestation in order to complete the WHO-recommended four ANC visits before delivery. Training of TBAs and APEs includes early identification and timely referral in case of complications during home births and calls for the establishment of a community-based transport scheme, to be managed by community leaders and village health committees, to transfer women experiencing obstetric complications to higher levels of care. The strategy also supports the establishment of a management and logistical control system, between health facilities and community, to prevent misoprostol stock-outs.

Included as an integral part of the strategy is a phased implementation plan. The detailed plan of action is focused on phase one of implementation, and includes a monitoring and evaluation framework to assess progress against targets by district, roles and responsible partners for the implementation in the selected phase one districts, and an estimated cost/budget for implementation of phase one.

While the strategy and implementation plan are led by the MOH, AMOG is identified as a key implementation partner to support management and implementation. In collaboration with partners such as USAID, UNFPA, and WHO, AMOG provides assistance in the design of training materials and tools, data collection, and roll out of the strategy to provincial directorates.

[42] FIGO. Saving Mothers and Babies: The Role of Strong Professional Associations. http://www.figo.org/sites/default/files/uploads/project-publications/LOGIC/Final%20Version%20of%20LOGIC%20publication%20for%20print.pdf

[43] República de Moçambique, Ministério da Saúde. Estrategia para a Prevenção da Hemorragia Pós-Parto a Nível da Comunidade. Maputo, 2013.

6. STATUS OF SCALE-UP: KEY FINDINGS

The status of implementation and scale-up of community-based distribution of misoprostol in Mozambique was assessed through indicators representing each of the WHO Health Systems Building Blocks: governance, finance, health information, commodities and supplies, human resources, and service delivery. Each indicator addresses an issue(s) critical to achieving effective impact in a sustainable manner.

According to respondents, the implementation and roll-out of Mozambique's policy on community distribution of misoprostol has initiated, though experienced some delays due in part to poor resourcing and a lack of documentation of initial implementation experiences. Following the strategy's approval in 2013 and formal launch in 2014, the start-up period took longer than expected, with activities beginning in April 2015 in an initial six districts covering two provinces: Inhambane and Sofala. Trainings to cover the remaining 29 districts under phase one began with plans for implementation in January 2016. Findings from the initial six districts are meant to inform future scale-up, however, at the time of this study, respondents from these districts cited that they have not yet been required to provide data or feedback on their implementation experiences though are eager to hear results from other districts. Respondents noted particular interest in information regarding the use of misoprostol for indications other than PPH prevention, data on the impact of this strategy on the number of institutional births, information about the acceptability and general perception amongst beneficiaries and health personnel, as well as management of the medicine including stock-out issues.

6.1 Governance

Key governance indicators

- Is community-based distribution of misoprostol for the prevention of PPH included in current national strategies and practice guidelines?
- Is community-based distribution of misoprostol for the prevention of PPH included in both national and subnational implementation plans?

Successful implementation and scale-up of evidence-based health interventions depends upon effective stewardship, accountability, engaging stakeholders, and setting shared strategic direction.[44] Policy development for the use of misoprostol at the community level took place over several years, led by the MOH with support from partners. The process was evidence-based, consultative, and engaged several stakeholders including those responsible for implementation. The availability and feasibility of using existing systems for the distribution of misoprostol at community level (i.e., procurement, ANC, CHWs and TBAs) was noted as an enabling factor for gaining MOH support for implementation and scale up. The strategic document includes community-based distribution for misoprostol for PPH prevention and is accompanied by a detailed implementation plan. Despite some delays, a phased roll-out plan has been initiated across 35 of 128 districts.

[44] Leadership, Management, and Governance Project. Governance. 2016. Available at: http://www.lmgforhealth.org/expertise/governing.

6.2 Finance

Key financing indicator

- Is community-based distribution of misoprostol for the prevention of PPH included in MOH budgets?

In order for a policy to be effective, it needs to be adequately resourced and funded as part of national or subnational budgets. According to the WHO, health financing is the "mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care."[45]

In the case of Mozambique's policy for community distribution of misoprostol, respondents cited poor resourcing as hindering progress in ensuring the procurement and availability of misoprostol for PPH. Initially, USAID was the key partner for funding and supporting strategy implementation through MCHIP; however due to concerns surrounding controls and monitoring for distribution, financial support was delayed until these controls were established. USAID, through the Maternal and Child Survival Program (MCSP), is currently providing financial support for implementation through a sub-agreement with AMOG and activity support. Additional donor support, particularly related to the procurement and management of the medicine, as well as for training of TBAs, is provided by UNFPA. Other partners such as PSI contribute to training, monitoring, and implementation. At the time of writing the report, misoprostol for prevention of PPH had not been included within the MOH budget.

6.3 Health Information

Key health information indicator

- Does the MOH currently collect, report, and use appropriate indicators/information on community-based distribution of misoprostol for prevention of PPH?

The collection, processing, and use of health information – including process and outcome indicators – is critical for supporting evidence-based decision making and is a cornerstone for ensuring both individual and public health outcomes.[46] Data surrounding the distribution of misoprostol in Mozambique is collected at numerous points: the national procurement system, ANC registers, and in the community by the community health workers and TBAs. Based on respondents' feedback, there has been limited collection of data to monitor the availability and use of misoprostol for PPH.

Respondents from the six districts where implementation has begun cite the need for documentation efforts that facilitate knowledge exchange among districts. Given the current status of implementation it is of great importance to initiate a process of documenting the experiences taking place in the

[46] Adapted from: http://www.phinnetwork.org/Resources/HIS.aspx

implementation districts; the process must pay particular attention to the fears expressed by the different experts involved throughout process.

6.4 Commodities & Supplies

Key commodities & supplies indicator

- Is misoprostol currently procured and distributed in sufficient quantities as part of the national logistics system?

A consistent and reliable supply of commodities and health technologies depends on the following core functions: quantification (forecasting and supply planning to identify sufficient quantities); procurement (identification and purchasing of quality-assured and effective products); and distribution (storage, inventory management, and transport).[47] Misoprostol is registered in Mozambique's essential medicines list for its PPH indication, signaling MOH commitment to procure and distribute misoprostol as part of the national system. At the time of this study, however, misoprostol was procured by UNFPA and distributed via the national procurement and logistics system.

6.5 Human Resources

Key human resources indicators

- Are the appropriate health worker cadres authorized to distribute misoprostol?
- Do the appropriate in-service and pre-service curriculum include community-based distribution of misoprostol for prevention of PPH?

With a low density of physicians, nurses, and midwives to provide essential health services particularly in rural, underserved areas, community health workers play a critical role in delivering basic services to the most remote and marginalized communities. Three cadres of health workers are involved in the community-based distribution of misoprostol for PPH: maternal and child health nurses, who are engaged to distribute misoprostol during ANC visits; TBAs, who are trained to distribute misoprostol and support birth preparedness; and the APEs, who, as part of the national community health worker program work with the TBAs in support of this intervention. AMOG has recently finalized and signed a Memorandum of Understanding with the MOH to further identify the following as areas where AMOG's expertise could be directed: training, support supervision, the development of clinical guidelines and policies, the implementation of maternal mortality audits, and research.[48] Furthermore, AMOG recently received funding to provide technical support at the provincial and district levels, monitoring and supervision, and for the development of training packages and IEC materials.

[47] Essential Medicines for Maternal Health: Ensuring Equitable Access for All. Family Care International. 2014. http://www.familycareintl.org/UserFiles/File/Essential_Medicines_Maternal_Health.pdf
[48] AMOG Strategic Plan 2011-2016 http://figo-toolkit.org/wp-content/uploads/2012/08/3.16_Toolkit_AMOGstrategicPlan.pdf

6.6 Service Delivery

Key service delivery indicators

- Is community-based distribution of misoprostol for prevention of PPH included in MOH supervision schedules?
- Is misoprostol available for distribution at the community level?

The delivery of health services combines various inputs (money, staff, supplies, equipment and medicines) to ensure that specific health interventions are available and can be effectively provided at the facility and community level.[49] In the case of Mozambique, respondents cite that misoprostol is available over the counter at drugstores. The operational study in Mozambique used three different distribution strategies, resulting in similar distribution rates regardless of whether TBAs, ANC providers, or both, were the distributing cadre(s). Markedly higher coverage rates were achieved with TBAs as the distributing cadre (73.5 percent compared to 16.2 percent for ANC only).[50]

7. RECOMMENDATIONS AND CONCLUSION

A range of factors were cited as influential in the development, adoption, and subsequent implementation of Mozambique's policy for community-based distribution of misoprostol for PPH. With regards to the policy development, a critical determinant was cited as the engagement and leadership from the MOH. However, government support alone was not sufficient for policy adoption; the availability of local research as well as broad-based support from national and international stakeholders was also important to bring about the necessary policy and regulatory decisions for the effective adoption and subsequent implementation of the policy. Informants cited AMOG as playing an important role in generating evidence and supporting policy design. Involvement from other partners, including MCHIP and UNFPA, was also as particularly important to ensure policy alignment with global maternal mortality recommendations. Mozambique's policy development process demonstrates the effective interaction and collaboration between partners in facilitating a favorable policy environment.

The implementation and roll-out of Mozambique's policy on community distribution of misoprostol has shown promising lessons, despite some delays during phase one. Implementation has largely been limited to the initial roll-out in six districts in two provinces, though trainings to cover the remaining districts have begun and plans for continued implementation are ongoing. Continued support from key stakeholders and partners, particularly in the areas of documentation, monitoring and evaluation, and evidence-based decision-making, can inform the roll out and ensure phased implementation continues across the country.

[49] Adapted from: http://www.who.int/topics/health_services/en/

[50] Smith JM, Gubin R, Holston MM, Fullerton J, Prata N. Misoprostol for postpartum hemorrhage prevention at home birth: an integrative review of global implementation experience to date. BMC Pregnancy and Childbirth. 2013;13:44. doi:10.1186/1471-2393-13-44.

The following recommendations provide specific actions to support the effective scale-up and roll-out of misoprostol for PPH at the community level:

- A **phased approach to the national implementation strategy involving all actors** allows for regular assessment and revision of strategies, and can ensure fears and concerns related to the operationalization and funding constraints of the strategy and implementation plan are addressed throughout the process.
- Engaging **various types of stakeholders** from the beginning of the process, including government stakeholders, professional associations such as AMOG, research institutions and universities, donors, and implementing partners, creates ownership and buy-in and ensures interests and concerns are heard and addressed throughout the process.
- Include a **formal mechanism for monitoring and evaluation** which documents implementation experiences and operational challenges, facilitates frequent and regular reviews of data for decision-making, and encourages knowledge exchange among implementation districts.
- **Strengthening community involvement and the large community-based network of health workers,** including TBAs, can be effective strategies to expand universal access to uterotonics for PPH prevention.

In order to successfully address the leading cause of maternal mortality in the region, attention must be paid to the key determinants of policy adoption and subsequent implementation outlined in the findings from this study. The experience of Mozambique reveals an often complex process influenced by a range of factors, requiring sustained commitment and action from a range of stakeholders. Despite delays, the implementation of community-based distribution of misoprostol for PPH has shown promise, with plans in place for expansion into 35 districts. The experience from Mozambique offers recommendations for countries looking to adopt community-based distribution of misoprostol for PPH prevention, and lessons for facilitating a more efficient and effective policy change, and inform future development and implementation design.

ANNEX 1. KEY INFORMANT INTERVIEWS – CONSENT FORMS AND GUIDANCE

CONSENT FORM

Key Informant Consent Form

About this consent form
Please read this form carefully. This form provides important information about participating in this research study. If you decide to participate in this study you will be asked to sign this form. A copy of the signed form will be provided to you for your record.

Participation is voluntary
You are invited to take part in this research because you have been identified as an individual who is knowledgeable about community-based distribution of misoprostol in your country. It is your choice whether or not to participate. If you choose to participate, you may change your mind and terminate the interview at any time. There are no identified risks or benefits to participating in this study.

What is the purpose of this research?
Specifically the study seeks to identify the key determinants contributing to the development and adoption of national policy on community-based distribution of misoprostol for prevention of postpartum hemorrhage (PPH) at homebirths; to determine current status of implementation and scale-up of the intervention; and to identify successes and challenges in the subsequent national roll-out and scale-up of the intervention. The study findings will result in the development of practical recommendations for countries beginning policy development and adoption, and/or national roll-out of community-based distribution of misoprostol.

Statement of Consent
I have read the information in this consent form including risks and possible benefits. All my questions about the research have been answered to my satisfaction. I understand that I am free to withdraw at any time without penalty or loss of benefits to which I am otherwise entitled.

I consent to participate in the study.

SIGNATURE

Your signature below indicates your permission to take part in this study.

_____
Name of Participant

_____
Signature of Participant

_____
Date

KEY INFORMANT INTERVIEW GUIDE FOR KEY POLICY DEVELOPMENT STAKEHOLDERS

Key Informant Interview Guide
Policy Development

1. Name and designation (Record interviewee's Name, organization, designation, email address, telephone number, and gender)

2. KII for _____Duration of KII _____

Key Reminders to the Facilitator/Interviewer:

1. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and his/her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.
7. Although we will have interviewer questions lined up and in a certain order, do not be afraid to deviate if the conversation takes you in a different order. It is entirely possible that a person may start talking and end up answering any number of questions without specifically being asked. It is also likely that someone may introduce a subject not included in the questions -- let him/her talk (within reason!). The whole point is to allow the person to tell his/her story, including their particular knowledge, opinions, and experiences. Give them the space to say what they need to say. If the person deviates completely from the topic, then do pull them back by referring to the questions.

Welcome
Thank you for accepting the invitation to take part in this meeting. You have been asked to participate as your knowledge, experience, and point of view are important. We realize you are busy and very much appreciate your time.

Introduction
My name is _____ and I am a consultant working for the African Strategies for Health (ASH) project funded by USAID's Africa Bureau. The ASH project is conducting a study in four countries in sub-Saharan Africa which have national policies in place for community-based distribution of misoprostol for prevention of postpartum hemorrhage. Specifically the study seeks to identify the key determinants contributing to the development and adoption of national policy on community-based distribution of misoprostol for prevention of postpartum hemorrhage (PPH) at homebirths; to determine current status of implementation and scale-up of the intervention; and to identify successes and challenges in the subsequent national roll-out and scale-up of the intervention. The study findings will result in the development of practical recommendations for countries beginning policy development and adoption, and/or national roll-out of community-based distribution of misoprostol.

You have been identified as a key informant who was engaged, in some manner, in the development or approval process of the national misoprostol for prevention of postpartum hemorrhage policy. During this interview, you will be asked to answer some questions regarding your role in this process as well as your opinions and insights on the policy-making process. We are very interested in learning about your perception and experience in the policy development process. This discussion will take approximately 45 minutes to 1 hour.

Do you have any questions or concerns?

Anonymity
We would like to record the interview, if you are willing, to better enable data analysis. We will record the interview only with your consent, and will ask that no personal identifiers be used during the interview, to ensure your anonymity. Please feel free to say as much or as little as you want. You can decide not to answer any question, or to stop the interview any time you want. The tapes and transcripts will become the property of project.

If you so choose, the recordings and recording-transcripts (or copy of notes taken) will be kept anonymous, without any reference to your identity, and your identity will be concealed in any reports written from the interviews.

This interview was designed to be approximately 45 minutes to one hour in length. However, please feel free to expand on the topic or talk about related ideas. Participation in this study will involve no costs or payments to you.

If you agree to participate in this study, please provide your written consent (hand consent form to interviewee).

Leading Questions

Introductory	• What do you believe first initiated the national discussion on establishing a policy for community-based distribution of misoprostol? (*ask for as much detail as possible)* • When was that? • Who was involved from the outset?
Content	• What is the content of the policy?
Process	• How would you describe the various stages of policy development for this particular policy? • How long did the overall process take from the very initial stage to final adoption?
Stakeholders	• Who was engaged in these stages and in what capacities?
Process	• What were some of the key challenges throughout the policy-making process and how were they addressed and overcome? • Who were the key players in addressing these challenges?

Stakeholders	• How would you describe the government's leadership of and advocacy for establishment of this policy? • Who were some of the key individuals or units engaged in this process from within the government? • Were there any particular bodies (such as a working group) that were specifically formed/tasked to support the policy process?
Stakeholders	• Who were some of the key external parties involved? (UN agencies, donor governments, NGOs, etc.)
Stakeholders	Do you believe that there was one national "champion" (could be individual or organization) who helped to lead this process? If so, who? Why do you believe they were critical in the process?
Context	• Do you believe the policy environment was conducive to the adoption of this policy at the start of the process? • If yes, why? • If not, what changed and how did it change?
Context	• In what ways did the structure/system of your national government influence the policy development process? *(probes: decentralization, legislature system, etc.)*
Context	• Describe some of the key contextual issues that you feel positively or negatively influenced the policy process? *(probes: cultural beliefs, financial issues, etc.)*
Content	• How important was the role of evidence-based data in the policy-making process? • What kind of data was available, what was requested, and what was presented? • To whom?
Content	• From your perspective, what are the expected outcomes of the policy on national level health outcomes, if implemented correctly/successfully?
Summary	• What do you believe were the key factors that lead to the adoption of the national misoprostol policy? • What do believe are the successes and failures of this particular policy? • If you had to make 2-3 key recommendations to a neighboring country seeking to develop and adopt a national community-based distribution of misoprostol policy, what would they be?

Conclusion

Thank you for participating. This has been a very useful discussion. Your opinions, knowledge, and insights will be a valuable asset to this study. I would like to remind you that any comments featuring in this report will be anonymous.

Do you have any final questions or concerns?

Thank you again and we will be in touch soon to invite you to a Stakeholders Validation Workshop to take place in the coming weeks.

KEY INFORMANT INTERVIEW GUIDE FOR KEY IMPLEMENTATION & SCALE-UP STAKEHOLDERS

Key Informant Interview Guide
Implementation & Scale -Up

1. Name and designation (Record interviewee's Name, organization, designation, email address, telephone number, and gender)

2. KII for _____Duration of KII _____

Key Reminders to the Facilitator/Interviewer:

1. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and his/her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.
7. Although we will have interviewer questions lined up and in a certain order, do not be afraid to deviate if the conversation takes you in a different order. It is entirely possible that a person may start talking and end up answering any number of questions without specifically being asked. It is also likely that someone may introduce a subject not included in the questions -- let him/her talk (within reason!). The whole point is to allow the person to tell his/her story, including their particular knowledge, opinions, and experiences. Give them the space to say what they need to say. If the person deviates completely from the topic, then do pull them back by referring to the questions.

Welcome
Thank you for accepting the invitation to take part in this meeting. You have been asked to participate as your knowledge, experience, and point of view are important. We realize you are busy and very much appreciate your time.

Introduction
My name is _____ and I am a consultant working for the African Strategies for Health (ASH) project funded by USAID's Africa Bureau. The ASH project is conducting a study in four countries in sub-Saharan Africa which have national policies in place for community-based distribution of misoprostol for prevention of postpartum hemorrhage. Specifically the study seeks to identify the key determinants contributing to the development and adoption of national policy on community-based distribution of misoprostol for prevention of postpartum hemorrhage (PPH) at homebirths; to determine current status of implementation and scale-up of the intervention; and to identify successes and challenges in the subsequent national roll-out and scale-up of the intervention. The study findings will result in the development of practical recommendations for countries beginning policy development and adoption, and/or national roll-out of community-based distribution of misoprostol.

You have been identified as a key informant who can provide insights into the implementation and scale-up of the national misoprostol for prevention of postpartum hemorrhage policy following adoption. During this interview, you will be asked to answer some questions regarding your role in this process as well as your opinions and

insights on the policy-making process. We are very interested in learning about your perception and experience in the policy development process. This discussion will take approximately 30 minutes to 1 hour.

Do you have any questions or concerns?

Consent/Anonymity
We would like to record the interview, if you are willing, to better enable data analysis. We will record the interview only with your consent, and will ask that no personal identifiers be used during the interview, to ensure your anonymity. Please feel free to say as much or as little as you want. You can decide not to answer any question, or to stop the interview any time you want. The tapes and transcripts will become the property of project.

If you so choose, the recordings and recording-transcripts (or copy of notes taken) will be kept anonymous, without any reference to your identity, and your identity will be concealed in any reports written from the interviews.

This interview was designed to be approximately 30 minutes to one hour in length. However, please feel free to expand on the topic or talk about related ideas. Participation in this study will involve no costs or payments to you.

If you agree to participate in this study, please provide your written consent (hand consent form to interviewee).

Leading Questions
(Note: questions may be adapted/omitted dependent upon relevance to specific interviewee)

Introduction	• Is community-based distribution of misoprostol for the prevention of post-partum hemorrhage currently being implemented in your country? • If yes, is it being implemented by the public health system? • Please describe the national strategy for roll-out/scale-up of this intervention? • In how many districts is community-based distribution of misoprostol currently being implemented? • Is implementation being supported by any external stakeholders (donors, NGOs, etc.)? If yes, who?

Governance	• Is there are stand-alone implementation plan for community-based distribution of misoprostol for the prevention of PPH? • Is community-based distribution of misoprostol for the prevention of PPH included in current relevant national strategies? • If so, which ones? • Is community-based distribution of misoprostol for the prevention of PPH included in current relevant practice guidelines? • What specifically changed in these strategies/practice guidelines following the adoption of the national policy? • How long after the national policy was adopted were these changes made in national strategy and practice guideline documents? • Is community-based distribution of misoprostol for the prevention of PPH included in both national and subnational implementation plans? • Please describe what specifically is included in the implementation plans. • How long after the national policy was adopted were these changes made in national and subnational implementation plans?
Finance	• Is community-based distribution of misoprostol for the prevention of PPH included in the relevant MOH budgets at the national and subnational levels? • If yes, do you believe this policy is adequately financed for effective implementation? Explain. • If no, what have been the barriers/challenges to inclusion in the relevant budgets?
Health Information	• Does the MOH currently collect, report, and use appropriate indicators/information on community-based distribution of misoprostol for prevention of PPH? • If yes, at what levels? • What information is collected? • How is it currently being used and how is it intended to be used? • Has the program been assessed/evaluated by any stakeholder? • If yes, please describe (who, when, where, how, etc.)
Commodities & Supplies	• Is misoprostol currently procured and distributed as part of the national logistics system? • Is it procured in sufficient quantities? • Explain the supply-chain process for getting the misoprostol to the cadre of health worker distributing.
Human Resources	• Are the appropriate health worker cadres authorized to distribute misoprostol? • Do the appropriate in-service and pre-service curriculum include community-based distribution of misoprostol for prevention of PPH? • Please describe/explain. • If yes, how long after the national policy was adopted were the curriculum adapted?
Service Delivery	• Is community-based distribution of misoprostol for prevention of PPH included in MOH supervision schedules? • If yes, who is responsible for conducting supervision? • Is supervision happening on a regular basis?
Community Engagement	• Have local communities been engaged in the implementation/scale-up process? • If so, how? (*probes: community mobilization approaches, etc.)* • If not, why not?

	• Do you think community engagement is helpful for effective implementation and scale-up? • Why or why not?
Summary	• What do you believe have been the successes and challenges to effective implementation of community-based distribution of misoprostol in your country? • Do you believe community-based distribution of misoprostol is currently being implemented at scale? • If yes, is this sustainable? Why or why not? • If no, what do you believe it will take to achieve implementation at scale?

Conclusion

Thank you for participating. This has been a very useful discussion. Your opinions, knowledge, and insights will be a valuable asset to this study. I would like to remind you that any comments featuring in this report will be anonymous.

Do you have any final questions or concerns?

Thank you again and we will be in touch soon to invite you to a Stakeholders Validation Workshop to take place in the coming weeks.

ANNEX 2. STRATEGY FOR THE PREVENTION OF POSTPARTUM HEMORRHAGE AT COMMUNITY LEVEL

República de Moçambique

Ministério da Saúde

Estratégia para a Prevenção da Hemorragia Pós-Parto a Nível da Comunidade

2014-2015

FICHA TÉCNICA

Título: ***Estratégia para a Prevenção da Hemorragia no Pós-Parto a Nível da Comunidade.***

Ministério da Saúde - 2013

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Revisão técnica: AMOG

Instituições colaboradoras: USAID, MCHIP-Jhpiego, VSI, OMS e UNFPA

INDÍCE:

LISTA de ACRÓNIMOS

ACS	Agentes Comunitários de Saúde
AMOG	Associação Moçambicana de Ginecologistas&Obstétras
APE's	Agentes Polivalentes Elementares
CMAM	Central de Medicamentos e Artigos Médicos
COEB	Cuidados Obstétricos de Emergência Básicos
COEC	Cuidados Obstétricos de Emergência Completos
DEPROS	Departamento de Promoção para a Saúde
DFC	Departamento de Formação Contínua
DPS	Direcção Provincial de Saúde
DSMC	Departamento de Saúde da Mulher e Criança
HPP	Hemorragia Pós-Parto
MISAU	Ministério da Saúde
OMS	Organização Mundial da Saúde
ONG	Organização Não Governamental
PTs	Parteiras Tradicionais
SDSMAS	Serviços Distritais de Saúde, Mulher e Acção Social

PREFÁCIO

Perto de 2015, ano estabelecido para o alcance dos Objectivos de Desenvolvimento do Milénio, ainda existem muitos desafios para o cumprimento das metas que foram estabelecidas. O Objectivo 5, relativo à Saúde Materna, que institui a redução da mortalidade materna em 75% (3/4), está longe de ser alcançado a nível global pois ainda muitas mulheres morrem por complicações durante a gravidez ou parto que podem ser prevenidas. A Hemorragia Pós-Parto (HPP) é uma destas complicações, contribuindo para 31% das Mortes Maternas a nível global (cerca de 100.000 mortes anuais).

Moçambique não está longe desta realidade. A análise feita na Avaliação Nacional de Necessidades em Saúde Materna e Neonatal em 2008, sobre as mortes maternas ocorridas nas Unidades Sanitárias, mostra que a HPP contribuiu para 30.7% de todas as mortes maternas institucionais no país, não sabemos contudo quantas mais, de entre as mulheres que tiveram o seu parto na comunidade, morrem por esta complicação obstétrica.

Para fazer face a esta problemática, o Ministério da Saúde desenvolveu esta Estratégia para a Prevenção da Hemorragia no Pós-Parto a nível da Comunidade, baseando-se nas recomendações da Organização Mundial da Saúde que preconiza a utilização de uterotónicos durante o terceiro estadio do trabalho de parto para todas as mulheres. Assim, aonde o parto é feito por pessoal não qualificado, como Parteiras Tradicionais e Agentes Comunitários de Saúde, a OMS recomenda a administração de Misoprostol, com o apropriado treino do pessoal que vai administrar esta droga.

Esta Estratégia deve guiar a implementação de intervenções a nível nacional para prevenir a hemorragia pós-parto (HPP) a nível da comunidade tendo como grupo alvo de provedores de saúde as Parteiras Tradicionais, Agentes Comunitários de Saúde e APE's.

Neste contexto, encorajo todos os intervenientes nesta estratégia a darem a sua contribuição visando o alcance dos resultados preconizados para a redução da incidência da hemorragia pós-parto (HPP) a nível da comunidade.

O Ministro da Saúde

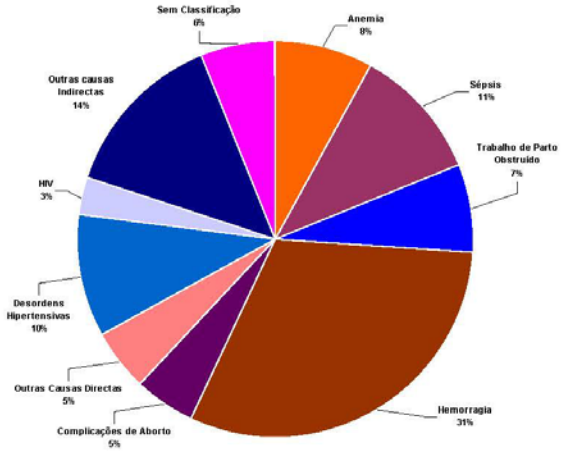
Dr. Alexandre Lourenço Jaime Manguele
(Medico, Especialista em Saúde Publica)

Secção 1: Introdução:

A Hemorragia Pós-Parto (HPP) é definida como uma perda de sangue de cerca de 500 ml ou mais durante as primeiras 24 horas após o parto, e se a perda de sangue for de 1000 ml ou mais durante o mesmo período de tempo, é considerada uma HPP severa. Esta condição pode levar a mulher à morte em menos de 2 horas.

A HPP ocorre em aproximadamente 2% de todas as mulheres que têm parto, sendo uma das principais causas de morte materna no mundo, contribuindo para 31% destas mortes (cerca de 100.000 mortes anuais [1]). Nos países em desenvolvimento cerca de 14 milhões de mulheres, ou seja 26 mulheres por minuto, passam por uma hemorragia obstétrica.

Gráfico 1: Causas de Morte Materna



Adaptado da: OMS Análise das Causas de Morte Materna: Uma Revisão Sistemática. The Lancet, vol 367, Abril 1, 2006.

A HPP contribui também significativamente para a morbilidade e incapacidade materna, assim como para outras condições maternas severas associadas com a perda substancial de sangue, incluindo choque e disfunção ou falência orgânica [2].

A atonia uterina é a causa mais comum de HPP, contudo o trauma genital (lacerações vaginais e cervicais), ruptura uterina, retenção de produtos placentares, ou alterações da coagulação podem também causar HPP. Embora a maioria das mulheres que tem uma HPP não apresente factores de risco ou uma causa clínica previamente identificável, as gravidezes múltiplas e a grande multiparidade estão associadas a um risco aumentado desta patologia. A HPP pode ser agravada por uma anemia pré-existente, e nestes casos, a perda de um pequeno volume de sangue pode resultar em complicações clínicas graves.

Para a prevenção da HPP causada por atonia uterina, a Organização Mundial da Saúde (OMS), recomenda a utilização de uterotónicos durante o terceiro estadio do parto para todas as mulheres

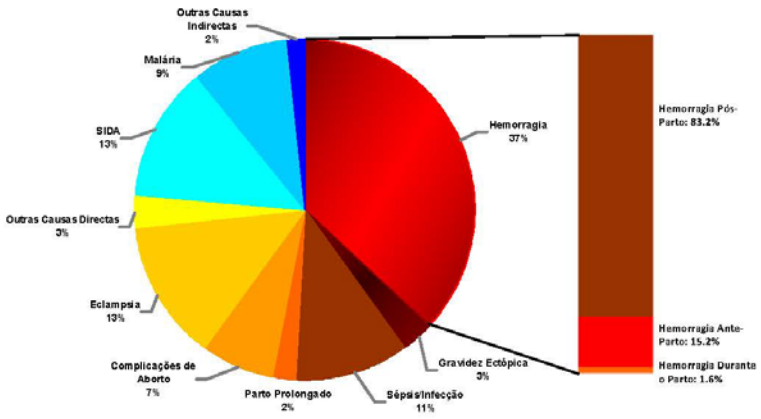
[1] Khan et al. WHO Analysis of causes of maternal death: a systematic review. The Lancet, March 28, 2006.
[2] WHO recommendations for the prevention and treatment of postpartum haemorrhage. 2012.

[2]. A droga de eleição deve ser a Oxitocina ou o Misoprostol, contudo em lugares onde a Oxitocina não está disponível pode ser utilizada a Metilergometrina (que deve ser evitada em mulheres com transtornos hipertensivas). Em lugares aonde o atendimento ao parto é feito por pessoal não qualificado, como Parteiras Tradicionais e Agentes Comunitários de Saúde, é recomendada a administração de Misoprostol, com o apropriado treino do pessoal que vai administrar esta droga.

Secção 2: Contexto em Moçambique:

Em Moçambique, de acordo com dados da Avaliação Nacional de Necessidades em Saúde Materna e Neonatal realizada em 2008, que fez uma análise de todas as mortes maternas ocorridas nas Instituições de Saúde, a HPP contribuiu para 30.7% de todas as mortes maternas, e para 83.2% de todas as causas de hemorragia obstétrica (Gráfico 2). As principais causas da HPP foram a ruptura uterina (55.9%), a atonia uterina (35.7%), a retenção placentar (3.3%) e outras causas (5.2%).

Gráfico 2: Causas de Morte Materna *(Avaliação Nacional de Necessidades em Saúde Materna e Neonatal, MISAU, 2008)*



Para reduzir o número de casos de HPP e de condições maternas severas decorrentes, o Ministério da Saúde tem vindo a rever e actualizar periodicamente as normas e guiões nacionais de Atenção ao Parto e Complicações Obstétricas, e a implementar intervenções tais como os Cuidados Obstétricos de Emergência Básicos (COEmB) e Completos (COEmC) desde 1995, assim como, desde 2009, a implementação da Iniciativa Maternidade Modelo que promove a implementação de COEmB e COEmC numa perspectiva de humanização e melhoria da qualidade dos Serviços com base em padrões de desempenho.

As principais acções indicadas para a prevenção e manejo da HPP são:

- A realização do manejo activo do terceiro período do parto para todos os partos institucionais, utilizando a Oxitocina como droga de eleição [3] para a prevenção da atonia uterina;

[3] No relatório sobre "Quality and Humanization of Care Assessment – Study of Maternal and Newborn Care in Mozambique's Model Maternities" (Relatório: Janeiro de 2013) a Oxitocina estava disponível em 88.4% das Unidades Sanitárias estudadas.

- O preenchimento completo e a utilização do partograma para monitoria do trabalho de parto e tomada atempada de decisão para reduzir os casos de ruptura uterina;
- A vigilância constante e cuidadosa da mulher especialmente nas duas primeiras horas após o parto;
- O manejo atempado e correcto dos casos de hemorragia obstétrica e das condições maternas severas decorrentes.

No entanto, tendo em consideração que a cobertura de partos institucionais, ou assistidos por pessoal qualificado, é de 54.3% ([4]), significando que cerca de 46% dos partos são assistidos na comunidade, maioritariamente por parteiras tradicionais, a Associação Moçambicana de Obstétras&Ginecologistas (AMOG), junto com a Venture Strategies Innovations (VSI), levaram a cabo, entre 2009-10, um estudo piloto para avaliar a efectividade de distribuição de Misoprostol para a prevenção da HPP a nível comunitário, através de dois métodos de distribuição: na consulta pré-natal, por enfermeiras de saúde materno-infantil (ESMI), e na comunidade, por parteiras tradicionais.

Este estudo decorreu em 4 Distritos e envolveu 11.927 mulheres cujos resultados permitiram concluir que a distribuição através da Consulta Pré-Natal ou através das Parteiras tradicionais tem potencial de aumentar significativamente o número de mulheres que recebem uma droga uterotónica, principalmente das grávidas que tiveram parto fora da Unidade Sanitária já que todas tomaram Misoprostol para prevenção da HPP. Ficou também demonstrado que para os partos domiciliares, o Misoprostol é uma droga segura e efectiva fortemente aceitável pelas mulheres.

Para o Ministério da Saúde (MISAU) a prevenção e manejo da HPP nas unidades sanitárias é uma prioridade, incluindo intervenções que possam prevenir mortes e morbilidade por HPP na comunidade. Desta forma, considerando as recomendações da OMS para a Prevenção e Tratamento da HPP, os resultados e lições aprendidas do estudo realizado no País sobre o Misoprostol, o MISAU decidiu desenvolver uma Estratégia para a Prevenção da HPP a nível da Comunidade, que guiará a implementação de intervenções com esta finalidade.

Numa primeira fase de 2 anos (2013-2015) esta estratégia será implementada em 35 distritos (Lista em Anexo 1) que foram seleccionados de acordo com os seguintes critérios:

- Alta percentagem de partos a nível da comunidade;
- Acesso razoável às Unidades Sanitárias no caso das mulheres que tenham complicações durante obstétricas durante o parto;
- Existência de Casas de Espera nas Unidades Sanitárias;
- População ou densidade populacional do distrito;
- Existência de Parteiras Tradicionais que trabalham com a Saúde, e de APEs.

[4] Mozambique, IDS 2011.

Secção 3: Finalidade, Objectivos, Resultados Esperados e Principais Intervenções:

Esta Estratégia tem como finalidade:

> ***Reduzir a incidência da hemorragia pós-parto (HPP) a nível da comunidade através da utilização do Misoprostol para a sua prevenção.***

Os objectivos, resultados esperados e principais intervenções a serem implementadas são:

Objectivo 1: Promover a utilização do Misoprostol para a prevenção da HPP nas mulheres que têm parto na comunidade em 35 Distritos do País, numa primeira fase de 2 anos.

Resultados Esperados:

1.1 APE's e Parteiras Tradicionais treinados para realizar a prevenção da HPP através da correcta utilização do Misoprostol;

1.2 Assegurada a distribuição de Misoprostol na Consultas Pré-Natais e pelas PTs/APEs nos distritos seleccionados, assim como a educação e aconselhamento sobre a utilização correcta desta droga;

1.3 Monitorada a distribuição do Misoprostol tanto a nível da Consulta Pré-Natal como da Comunidade (APEs e PTs);

Principais intervenções/Actividades:

- Elaborar um pacote de formação para as PTs, APEs e Agentes Comunitários de Saúde sobre a hemorragia pós-parto e a sua prevenção através da correcta utilização do Misoprostol;
- Desenvolver materiais de IEC nas principais linguas locais para distribuição às mulheres, sobre o uso correcto do Misoprostol no terceiro período do trabalho de parto, onde quer que este ocorra, para a prevenção da hemorragia pós-parto.
- Realizar o levantamento das comunidades, APEs e PTs que operam a nível das comunidades/aldeias seleccionadas dos distritos definidos;
- Elaborar um plano provincial/distrital para a formação dos APEs e PTs identificados sobre a prevenção da HPP e utilização correcta do Misoprostol;
- Incluir a distribuição do Misoprostol nos Livros e Fichas de Registo da Consulta Pré-Natal;
- Assegurar que a mulher grávida que recebe Misoprostol nas US seja identificada, através do registo da distribuição desta droga na Ficha Pré-Natal ou na Caderneta de Saúde da Mulher;
- Rever a ficha de recolha e reporte de dados da PT e do APE para incluir o registo da utilização do Misoprostol a nível da comunidade;

Objectivo 2: Promover a utilização da Consulta Pré-Natal e o Parto Institucional nos 35 distritos, assim como melhorar as condições de referência entre a Comunidade e as Instituições de Saúde, nas comunidades com maior número de população dentro dos 35 Distritos seleccionados.

Resultados Esperados:

2.1 Aumentada a sensibilização da comunidade para a promoção da realização da 1ª CPN antes das 16 semanas de gestação e para o cumprimento do calendário de pelo menos 4 CPN por gravidez, assim como para o aconselhamento e mobilização das mulheres grávidas para o parto institucional;

2.2 APE's e Parteiras Tradicionais treinados para a identificação e referência atempada de casos de complicações durante o parto a nível da comunidade (principalmente na presença de factores que possam conduzir a uma HPP);

2.3 Implementadas acções a nível das comunidades com maior número de população, envolvendo Lideres Comunitários e Comités de Saúde da Aldeia, para o estabelecimento de sistemas de transporte comunitário para as grávidas e parturientes com complicações obstétricas;

2.4 Monitorada a referência de casos de complicações obstétricas da Comunidade para as Instituições de Saúde;

Principais intervenções/Actividades:

- Incluir a identificação e referência atempada de casos de complicações durante o parto a nível da comunidade (principalmente na presença de factores que possam conduzir a uma HPP) no pacote de formação para as PTs, APEs e Agentes Comunitários de Saúde;
- Incluir nos materiais de IEC a serem distribuídos às mulheres, mensagens de sensibilização para promover o atendimento e cumprimento do calendário das Consultas Pré-Natais, assim como para a sensibilização e promoção do parto institucional. Estes materiais e mensagens serão divulgados pelos APEs, PTs, outros agentes comunitários de saúde e pelas Brigadas Móveis de Saúde;
- Incluir, na ficha de recolha e reporte de dados da PT e do APE, a referência de grávidas para o parto institucional, assim como a referência de complicações obstétricas;
- Realizar o levantamento das experiências bem-sucedidas sobre o envolvimento da Comunidade e dos Comités de Saúde da Aldeia na implementação de sistemas de transporte comunitário. Estas experiências serão discutidas com a Comunidade e os Comités de Saúde de Aldeias seleccionadas dentro dos distritos definidos;
- Explorar a possibilidade de aquisição do dispositivo pneumático anti-shock para utilização a nível da comunidade, utilizando a experiência levada a cabo pela Pathfinder em alguns distritos e US do país.

Objectivo 3: Assegurar a disponibilidade de Misoprostol, nas quantidades necessárias para a prevenção e tratamento da HPP, evitando a ruptura de stock desta droga nas US e Comunidades seleccionadas dos distritos definidos.

Resultados Esperados:

3.1 Assegurada a previsão adequada das necessidades e a aquisição de Misoprostol para a prevenção e tratamento da HPP a nível da comunidade, tanto para a distribuição nas Consultas Pré-Natais como pelas PTs/Agentes Comunitários de Saúde/APEs;

3.2 Assegurada a gestão e controle logístico do Misoprostol, assim como a sua distribuição regular para as US e Comunidade.

Principais Intervenções/Actividades:

- O "Task-Force" de Bens e Produtos para a Saúde Reprodutiva fará a estimativa da previsão de necessidades em Misoprostol para a implementação desta Estratégia, considerando a população do distrito, o número de grávidas e de partos previstos, assim como as coberturas da CPN e do Parto Institucional em 2011 e o seu crescimento até 2015.

- Desenvolver actividades de advocacia junto aos principais parceiros de cooperação para assegurar a aquisição da quantidade necessária de Misoprostol como uma droga cuja utilização será expandida.

- A Central de Medicamentos e Artigos Médicos (CMAM), como elemento da Task-Force de B&P para a SR, irá desenvolver e implementar um plano para assegurar a gestão, controle logístico e distribuição do Misoprostol.

Objectivo 4: Assegurar o estabelecimento de uma gestão efectiva (incluindo a monitoria e avaliação) e o financiamento necessário para a implementação desta Estratégia aos vários níveis.

Resultados Esperados:

4.1 Assegurada a incorporação desta Estratégia como uma das intervenções prioritárias dentro das políticas, planos e estratégias nacionais do MISAU na área da Saúde Materna, Neonatal e Infantil;

4.2 Garantida a integração efectiva da implementação desta Estratégia dentro dos processos regulares de gestão de programas a todos os níveis do MISAU;

4.3 Assegurado o envelope de recursos financeiros necessários para a implementação da primeira fase da Estratégia;

4.4 Assegurada a Monitoria e Avaliação da implementação da primeira fase da Estratégia.

Principais Intervenções/Actividades:

- Aquando da revisão do Plano Nacional Integrado para a Alcance dos ODMs Nº 4 e 5, e da Estratégia Nacional para a Redução da Mortalidade Materna e Neonatal, esta Estratégia será incluida como uma das suas intervenções prioritárias;

- Fazer a divulgação desta Estratégia a todas as Províncias, assim como prestar apoio às DPS para garantir a integração efectiva da sua implementação dentro dos seus processos regulares de gestão de programas, que incluirá:

  - ✓ O levantamento das ONGs e Parceiros que operam a nível da comunidade nos distritos/localidades seleccionadas, para assegurar uma gestão e coordenação efectiva com estes parceiros;

  - ✓ A elaboração de um Plano de Actividades por Província e respectivo Orçamento, considerando os levantamentos realizados em cada distrito seleccionado (após a identificação especifica das US, Comunidades, PTs e APEs);

  - ✓ A identificação de profissionais a nível de cada Província e dos parceiros locais que trabalham a nível dos Distritos seleccionados, para a sua formação como formadores para fazerem a capacitação das PTs/APEs/ACSs;

- Realizar um encontro com os principais parceiros de cooperação, quer a nível central quer a nível provincial/distrital, coordenado pelo MISAU, para discutir as necessidades, custos e apoio de cada parceiro, a fim de assegurar o envelope de recursos necessários para a implementação do Plano de Implementação da Estratégia na província;

- Realizar encontros periódicos, aos vários níveis, para monitoria e avaliação da implementação da Estratégia;

Secção 4: Implementação Operacional da Estratégia:

Por consenso foi seleccionada a Associação Moçambicana de Ginecologistas & Obstétras (AMOG) como Parceiro Nacional Ponto Focal que irá apoiar o Departamento de Saúde da Mulher e Criança (DSMC) na gestão e implementação da Estratégia. É papel principal deste parceiro, em conjunto com o DSMC e com o apoio de parceiros como a USAID, MCHIP, UNFPA, OMS e VSI:

1. Elaborar o pacote de materiais para o treino das PTs/APEs/ACSs, e de materiais de IEC para divulgação de mensagens a nível das Consultas Pré-Natais e Comunidade;

2. Rever e actualizar a ficha de recolha de dados para a PT/APE/ACS para incluir dados sobre a oferta de Misoprostol e referência de complicações obstétricas (principalmente casos de HPP);

3. Apoiar as províncias na elaboração dos planos de acção, orçamento e previsão de

necessidades, assim como na inclusão deste plano de acção nos Planos de Acção Provinciais para 2014 e 2015;

4. Fazer a formação dos Formadores para a capacitação das PTs/APEs/ACSs;
5. Realizar visitas de supervisão e apoio técnico às províncias e distritos (e quando necessário a algumas comunidades);
6. Assegurar o cumprimento do plano de monitoria a avaliação (Secção 6).

Com já referido, para assegurar uma coordenação e implementação operacional efectivas, será discutida e analisada com as Direcções Provinciais de Saúde e Serviços Distritais da Saúde, Mulher e Acção Social, a selecção e o envolvimento de ONGs Nacionais ou Internacionais que trabalham com as comunidades dos Distritos seleccionados principalmente para a implementação de actividades como a formação e supervisão regular de PTs e APEs, assim como para assegurar a distribuição e controle do Misoprostol a ser distribuído a estes Agentes Comunitários de Saúde.

Neste documento é apresentado um Plano Geral de Actividades da Estratégia com a finalidade de fornecer orientações para o processo de elaboração do Plano de Acção Detalhado a nível de cada Província.

4.1 Plano Geral de Acção:

Objectivos/Principais Actividades	Responsabilidade	Cronograma																							
		2014												2015											
		Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec	Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec
OBJECTIVO 1: Promover a utilização do Misoprostol para a prevenção da HPP nas mulheres que têm parto na comunidade em 35 Distritos do País, numa primeira fase de 2 anos.																									
Actividade 1.1: Definir critérios de selecção e seleccionar as Comunidades em cada Distrito *(inclui a elaboração de um Guião para o mapeamento e selecção).*	- DSMC e AMOG - DPS - SDSMAS																								
Actividade 1.2: Fazer o mapeamento das comunidades/aldeias com maior número de população em cada Distrito	- DPS - SDSMAS																								
Actividade 1.3: Fazer um mapeamento das PTs, APEs e de outros agentes comunitários de saúde que operem a nível das comunidades/aldeias seleccionadas.	- DPS - SDSMAS																								
Actividade 1.4: Desenvolver/rever materiais de IEC para a utilização correcta do Misoprostol.	- AMOG - DSMC - Parceiros																								
Actividade 1.5: Reproduzir os materiais de IEC.	Idem																								
Actividade 1.6: Assegurar a distribuição dos materiais de IEC a cada Parteira Tradicional e APE que operam nas comunidades/aldeias seleccionadas.	Idem - SDSMAS e Resp das US																								
Actividade 1.7: Rever os materiais do Pacote Integrado de Formação Nº 1 (Intervenções a nível da Comunidade) para incluir um Módulo sobre a HPP, prevenção e utilização correcta do Misoprostol.	- AMOG - Grupo de Trabalho do Pacote 1 - DSMC																								
Actividade 1.8: Fazer a formação (2 dias) das PTs e APEs seleccionados, sobre a HPP, prevenção e utilização correcta do Misoprostol.	- SDSMAS - ESMI Resp das US de Referência para as Comunidades Seleccionadas - Formadores Provinciais - AMOG e DSMC																								
Actividade 1.9: Fazer visitas/encontros regulares com as PTs e APEs (1 vez por trimestre) para discussão dos sucessos atingidos, constrangimentos, discussão de casos de morte e de referências, solução de problemas e reabastecimento de Misoprostol.	- SDSMAS - ESMI Resp das US de Referência para as Comunidades Seleccionadas																								

Objectivos/Principais Actividades	Responsabilidade	Cronograma																							
		2014												2015											
		Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec	Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec
Actividade 1.10: Incluir a distribuição de Misoprostol no Livro de Registo da Consulta Pré-Natal e Ficha Mensal de Reporte de dados do SIS.	- DSMC - AMOG - Parceiros do Grupo de Trabalho dos Livros de Registo	Nov 2013																							
Actividade 1.11: Distribuir Misoprostol a nível da CPN nas US seleccionadas.	- ESMI Resp das US de Referência para as Comunidades Seleccionadas																								
Actividade 1.12: Rever e actualizar a ficha de recolha e reporte de dados das PTs e APEs para incluir a utilização do Misoprostol.	- AMOG - DSMC - Parceiros																								
Actividade 1.13: Discutir, definir e implementar uma metodologia de registo para a identificação pessoal da mulher que receber Misoprostol, quer a nível da CPN, quer a nível da comunidade.	- AMOG - DSMC - Parceiros																								
OBJECTIVO 2: Promover a utilização da Consulta Pré-Natal e o Parto Institucional nos 35 distritos, assim como melhorar as condições de referência entre a Comunidade e as Instituições de Saúde, nas comunidades com maior número de população dentro dos 35 Distritos seleccionados.																									
Actividade 2.1: Incluir no Pacote de Formação para os APEs, PTs e ACSs aspectos para a identificação e referência atempada de casos de complicações obstétricas durante o parto a nível da comunidade.	- AMOG - Grupo de Trabalho do Pacote 1 - DSMC																								
Actividade 2.2: Incluir no pacote de materiais de IEC, mensagens de sensibilização para promover o atendimento e cumprimento do calendário das Consultas Pré-Natais, assim como para a sensibilização e promoção do parto institucional.	- AMOG - Grupo de Trabalho do Pacote 1 - DSMC																								
Actividade 2.3: Incluir na ficha de recolha e reporte de dados da PT e do APE, a referência de grávidas para o parto institucional, assim como a referência de complicações obstétricas.	- AMOG - DSMC - Parceiros																								

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Objectivos/Principais Actividades	Responsabilidade	Cronograma																							
		2014												2015											
		Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec	Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec
Actividade 2.4: Fazer o levantamento das experiências bem-sucedidas sobre o envolvimento da Comunidade e dos Comités de Saúde da Aldeia na implementação de sistemas de transporte comunitário a nível do País.	- SDSMAS - ESMI Resp das US de Referência para as Comunidades Seleccionadas - Parceiros Locais																								
Actividade 2.5: Realizar encontros com os Líderes Comunitários e Comités de Saúde da Aldeia para discutir e acordar sobre o modelo de transporte comunitário a ser adoptado.	Idem																								
Actividade 2.6: Realizar encontros com as ONGs e Parceiros identificados a nível provincial/distrital para discussão e envolvimento/apoio ao modelo de transporte comunitário acordado com os Líderes Comunitários e Comités de Saúde da Aldeia.	- DPS - SDSMAS																								
OBJECTIVO 3: Assegurar a disponibilidade de Misoprostol, nas quantidades necessárias para a prevenção e tratamento da HPP, evitando a ruptura de stock desta droga nas US e Comunidades seleccionadas dos distritos definidos.																									
Actividade 3.1: Realizar um encontro da Task-Force de Bens e Produtos para a Saúde Reprodutiva para discutir e acordar sobre a previsão e quantificação de necessidades de Misoprostol (quer para distribuição a nível da CPN como da Comunidade).	- DSMC - AMOG - Task Force de Bens e Produtos para a SR - CMAM	Dez 2013																							
Actividade 3.2: Realizar actividades de advocacia junto aos Parceiros de Cooperação (UNFPA, VSI, Banco Mundial e outros) para assegurar um compromisso financeiro para a aquisição de Misoprostol.	- DSMC - AMOG	Dez 2013																							
Actividade 3.3: Discutir e acordar sobre um sistema efectivo para a distribuição de Misoprostol às PTs e APEs seleccionados.	- CMAM - AMOG - DSMC	Dez 2013																							
Actividade 3.4: Assegurar a distribuição do Misoprostol para os Distritos e US seleccionadas, utilizando o mesmo canal logístico de distribuição da Oxitocina.	- CMAM - AMOG - DSMC																								

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Objectivos/Principais Actividades	Responsabilidade	Cronograma																							
		2014												2015											
		Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec	Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec
OBJECTIVO 4: Assegurar o estabelecimento de uma gestão efectiva (incluindo a monitoria e avaliação) e o financiamento necessário para a implementação desta Estratégia aos vários níveis.																									
Actividade 4.1: Assegurar a inclusão desta Estratégia como uma intervenção prioritária dentro do Plano Nacional Integrado para a Alcance dos ODMs Nº 4 e 5, e da Estratégia Nacional para a Redução da Mortalidade Materna e Neonatal.	- DSMC - AMOG	Dez 2013																							
Actividade 4.2: Fazer a divulgação da Estratégia a nível de todoas as Provincias.	- DSMC - AMOG - Parceiros de Cooperação de Nível Central	Dez 2013																							
Actividade 4.3: Elaborar o plano de actividades e orçamento detalhado em cada Província.	- DPS - AMOG - Parceiros																								
Actividade 4.4: Realizar um encontro com os parceiros de cooperação a nível central, e um encontro em cada província com os parceiros que operam a nível provincial e distrital para discutir o seu apoio às necessidades identificadas.	**A Nivel Central** - DSMC - AMOG **A Nivel Provincial/Distrital** - DPS - SDMAS - AMOG																								
Actividade 4.5: Definir com os parceiros de cooperação e ONGs (tanto com os de nível central como os de nível provincial/distrital) os mecanismos para o desembolso e justificação dos fundos.	Idem																								
Actividade 4.6: Identificar os formadores/supervisores provinciais (profissionais do SNS e os parceiros locais).	- AMOG - DPS - SDMAS	Dez 2013																							

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Objectivos/Principais Actividades	Responsabilidade	Cronograma																							
		2014												2015											
		Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec	Jan	Fev	Mar	Abr	Mai	Jun	Jul	Ago	Set	Out	Nov	Dec
Actividade 4.7: Fazer a formação dos Formadores/Supervisores Provinciais para assegurar a formação e apoio/supervisão das PTs/APEs/ACSs.	- AMOG - DEPROS/RESP																								
Actividade 4.8: Realizar visitas de supervisão e apoio técnico para assegurar uma boa gestão da implementação da Estratégia (nível central: pelo menos 1 vez por semestre a cada província; nível provincial: pelo menos 1 vez por trimestre a cada distrito).	**A Nivel Central** - AMOG **A Nivel Provincial/Distrital** - DPS - Grupo de Formadores/Supervisores Provinciais - SDMAS																								
Actividade 4.9: Implementar o Plano de Monitoria e Avaliação definido.	**A Nivel Central** - AMOG **A Nivel Provincial/Distrital** - DPS																								

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Secção 5: Sustentabilidade da Estratégia.

A sustentabilidade de muitas estratégias e programas tem constituído um grande problema para a saúde pública devido ao risco de descontinuidade das intervenções, principalmente porque, por um lado, as intervenções e actividades são implementadas de forma vertical sem estarem incorporadas em mecanismos de gestão e de prestação de serviços já estabelecidos, e por outro lado, principalmente nos países em desenvolvimento, os recursos financeiros existentes a nível dos orçamentos de estado para a saúde não são suficientes para responder às necessidades de uma vasta gama de programas, levando à dependência financeira de doadores e parceiros, que por sua vez também dependem dos orçamentos dos seus governos ou organizações para apoio a programas de saúde a nível externo.

No entanto, factores tais como a relevância, legitimidade e correcta insersão do programa ou estratégia em mecanismos já estabelecidos, assim como a garantia de uma gestão eficaz e a capacidade de adaptação às mudanças considerando o contexto político-institucional, podem influenciar de forma positiva a continuidade das intervenções, criando fundamentos mais robustos para garantir uma sustentabilidade, mesmo que durante um determinado período a sua implementação dependa de fundos externos.

A redução da mortalidade materna em Moçambique é um "assunto" que está na Agenda do Governo ao mais alto nível. Sendo a HPP uma das principais causas de morte materna, as intervenções para a sua prevenção fazem parte do Plano mais amplo do Ministério da Saúde para reduzir a mortalidade materna envolvendo várias Direcções Nacionais, Departamentos e Parceiros. Assim, durante a implementação da primeira fase desta estratégia serão desenvolvidos todos os esforços para que as intervenções e respectivas necessidades em recursos sejam inseridas nos mecanismos de gestão, financiamento, coordenação e de prestação de serviços já existentes.

Para tal, será assegurado desde o início:

- O envolvimento, coordenação e integração de várias Direcções Nacionais (principalmente a Direcção Nacional de Saúde Pública e a Direcção Nacional de Assistência Médica), assim como de outros Sectores/Departamentos do MISAU, tais como:
  - ✓ O Departamento de Formação Contínua (DFC) – para a gestão da formação de recursos humanos;
  - ✓ O Departamento de Promoção para a Saúde (DEPROS) - para a gestão de aspectos de promoção de saúde, envolvimento comunitário (como os Comités de Saúde), e de formação de APE's, PTs e ACSs para garantir que a prevenção da HPP faça parte dos TdR destes agentes comunitários de saúde;
  - ✓ A Central de Medicamentos e Artigos Médicos (CMAM) – para a previsão de necessidades e a gestão da cadeia logística para a aquisição e distribuição de Misoprostol e de outros bens e produtos que sejam necessários;
- Integração das actividades comunitárias definidas na estratégia em iniciativas de provisão de serviços de base comunitária já existentes a nível de cada província/distrito;

- Planificação de recursos financeiros para a continuidade das intervenções, após o término da 1a fase que terá financiamento externo, como por exemplo, a aquisição e distribuição do Misoprostol;
- Revisão e integração dos aspectos de M&A e da informação necessária nos instrumentos de recolha, análise e reporte de dados já existentes.

Secção 6: Monitoria e Avaliação

A monitoria da implementação do Plano de Acção estará sobre a responsabilidade do MISAU, através do Departamento de Saúde da Mulher e Criança (DSMC), com apoio do Parceiro Nacional identificado como Ponto Focal. A monitoria basear-se-á nos sistemas existentes, como a análise mensal/trimestral dos dados colhidos através do SIS (Componente Materna: Livros e Fichas de Resumo Mensal das Consultas Pré-Natal e da Maternidade), análise dos dados reportados pelas PTs e APEs (e compilados nos relatórios distritais), relatórios das supervisões, relatórios das Províncias e Distritos seleccionados, relatórios ou actas de encontros, de reuniões de coordenação, relatórios trimestrais sobre o progresso na implementação da estratégia, relatórios das formações e outros.

O Plano de M&A foi definido a partir da grelha de resultados que vincula a Finalidade da Estratégia aos Objectivos e Resultados Esperados. Em função dos níveis, foram definidos para medição, indicadores de resultado, produto, processo e insumos. No processo de selecção foram tomados em conta indicadores que podem ser colhidos através dos meios já referidos. No entanto, o Plano de M&A apresentado neste documento terá que ser revisto e completado, após a elaboração e compilação dos Planos Provinciais que fornecerão detalhes importantes para rever algumas metas (conforme referido no Plano de M&A nas páginas 22 a 25).

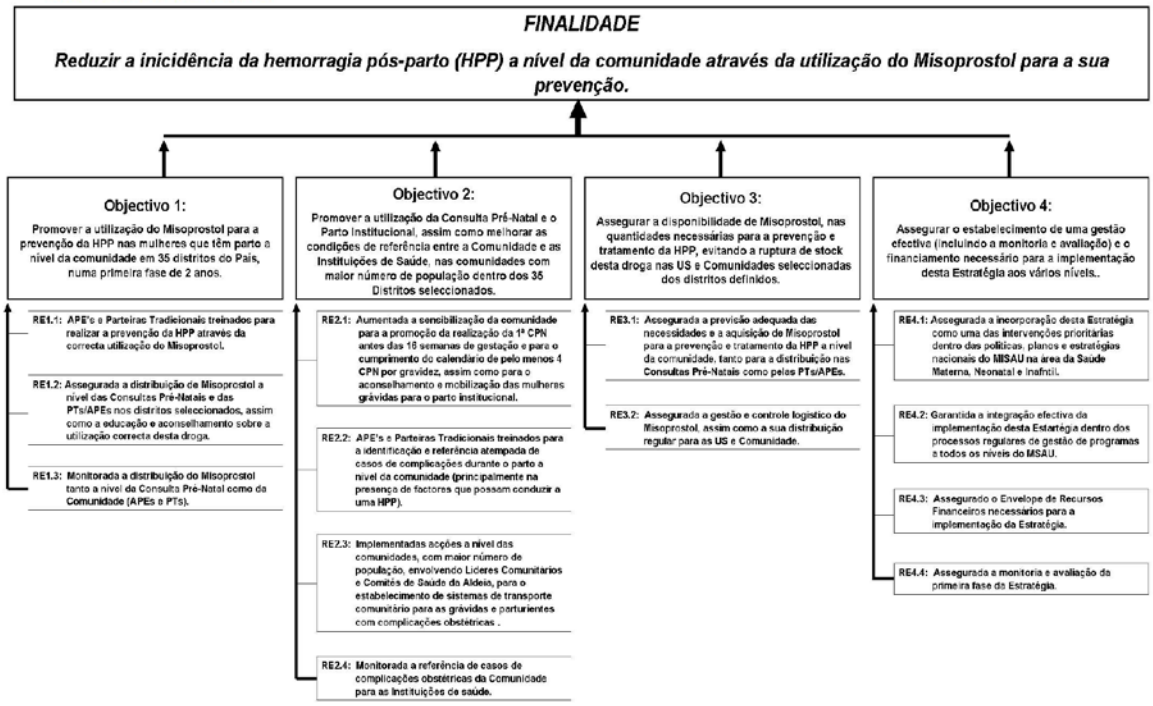
Os relatórios dos encontros, reuniões de coordenação, visitas de supervisão e de formações permitirão ter informações adicionais sobre os progressos na implementação do plano e das actividades definidas.

Como linhas de base de dados e informação, serão utilizadas as projecções (a partir do censo 2007) da população nos distritos seleccionados para o cálculo das gravidezes e partos previstos, assim como dos dados do SIS sobre coberturas atingidas para a Consulta Pré-Natal e Partos Institucionais, o que permitirá propor metas a serem atingidas até Dezembro de 2015.

No final da primeira fase desta estratégia (Dezembro de 2015) será elaborado um relatório final sobre os sucessos e progressos alcançados, constrangimentos, boas práticas e lições aprendidas. Este relatório irá servir como base para a revisão da estratégia e definição da segunda fase de expansão.

A página a seguir apresenta a Grelha de Resultados. O Plano de Monitoria e Avaliação contendo os indicadores a serem medidos é apresentado nas páginas 22 a 25.

6.1: Grelha de Resultados



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