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Partners Newsletter

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LETTER FROM THE EXECUTIVE DIRECTOR

Dear Partners,

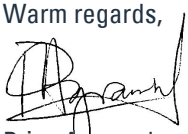
Merck for Mothers is proud to celebrate the conclusion of our first year of country programs with new partners and program launches in India, Zambia, Senegal, Uganda, and the United States. Through our programs in these priority countries, and through *Merck for Mothers'* Global Giving Program in more than 20 additional countries around the world, we've embarked on a collaborative journey to accelerate progress in reducing maternal mortality.

We are deeply encouraged by the innovation and excitement that you are bringing to the communities where you work and the global community at large. With a breadth of creative approaches and the collective depth of expertise among all of our partners, we have a great deal to look forward to and much to share.

We are equally delighted to share this inaugural newsletter which will serve as a platform to facilitate partner-to-partner learning and help connect you with maternal health resources, information about other partners and programs, and lessons learned. We will also keep you updated on some of the latest *Merck for Mothers* milestones – both big and small – along the way. Special thanks to our friends in India who suggested the development of this newsletter.

We look forward to seeing many of you shortly at our Partners Meeting in Delhi where we will have the opportunity to explore the remarkable work you are undertaking and wrestle with challenges, such as sustainability and quality of care. Until then, thank you for your continued commitment and please do not hesitate to reach out to me with any questions or feedback.

Warm regards,



Priya Agrawal
Executive Director

AMPLIFYING WOMEN'S VOICES TO IMPROVE QUALITY OF CARE

Coupling mobile health (mHealth) with a crowdsourcing strategy could engage and empower women to become advocates for quality care and shape the delivery of maternal health services in India.

Mobile phones are ubiquitous in India. The country has one of the fastest growing telecom networks in the world, with more mobile phone users than the whole of Africa. Women, including those in rural areas, are among India's millions of subscribers. So when the White Ribbon Alliance for Safe Motherhood India (WRAI) saw how Gram Vaani - a social technology company - began leveraging mobile phones for local community empowerment, such as establishing a rural agricultural mobile network with women, it wanted to explore the potential of this technology to empower women around their maternal health care.

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IN THIS ISSUE

SPOTLIGHT
on Dr. Dorothy Balaba

DELIVERING HEALTH SERVICES TO UGANDAN COMMUNITIES

Through the MSD for Ugandan Mothers (MUM) program, Dr. Balaba and PACE are collaborating with the Association of Obstetricians and Gynecologists Uganda, Save for Health Uganda and TransAid to explore the ability of local private health providers and health businesses to deliver affordable, high-quality, and equitable maternal care to women in Uganda.

"I believe that for us to do something, for us to make a difference, we must have motivation, and motivation comes from sharing vision…"

When Dorothy Balaba Byansi, MD, MPH started working as a physician at the national referral hospital in Uganda several years ago, she was confronted with endless lines of patients. Many of them were unaware they had preventable health conditions – it was this realization that inspired Dr. Balaba to take a much broader approach to improving health care in Uganda.

"I realized that I could contribute more to my country if I went out in the field, out into the community…I thought if I got to the root problems, then I would help prevent people from having to go to the health sector [unnecessarily]." Since that time, Dr. Balaba has been sharing her vision of community development, change and empowerment. She has served as the Vice Chair on the board of directors of the Regional AIDS Training Network, and she was the Executive Director of Traditional and Modern Health Practitioners Together Against AIDS (THETA), where she expanded access to HIV prevention services across 16 rural districts of Uganda.

Dr. Balaba now oversees a thriving network of reproductive and maternal health services as the Country Manager for Reproductive Health for the Program for Accessible Health, Communication and Education (PACE), the local Ugandan affiliate of Population Services International (PSI). One of Dr. Balaba's many roles has been recruiting private providers to join the franchised ProFam network, which was established in 2008 to increase women's access to reproductive health services. "You visit the clinic owners and the providers and tell them by joining a franchise, you can make a difference in so many people's lives. By just talking to them and providing them with information on the vision of the franchise, you can make a very big difference in people's lives." As of 2012, PACE reports that the ProFam network of 160 clinics has served more than 12,000 clients and conducted more than 90,000 total visits.

Dr. Balaba has also been expanding the range of supplies and services ProFam offers its communities. "When we came in to start the core franchise, we were looking at how we could increase the contraceptive prevalence rate…Since the private sector was not offering long-term family planning methods, we started off by ensuring that the private sector provides the whole range of family planning methods. Once we set up [the network] for family planning we realized there was a very big opportunity to expand further. Now, with the *Merck for Mothers* support, we are trying to integrate maternity services. We are really looking at the infrastructure, the quality – quality is a very big issue in the private sector. So now our core emphasis is to offer quality maternal and newborn services. We really see this as an opportunity to offer a comprehensive package."

LAYING THE FOUNDATION FOR MATERNITY WAITING HOMES

Africare's program in Zambia is involving communities to make facility-based deliveries a reality for mothers in remote areas.

By: Paul Chimedza,
Country Director, Africare/Zimbabwe & Zambia

Across the challenging terrains of Zambia, Africare, in partnership with the University of Michigan, is looking to build new maternal health solutions. Since many women experience difficulties in reaching health facilities before they go into labor, Africare is using community-based participatory research to investigate the potential for Maternity Waiting Homes (MWHs) to respond to that challenge. MWHs are residential facilities located at or near health facilities where women in the late stages of pregnancy can stay before they go into labor.

Our research team is currently in the Eastern Province of Zambia, engaging community members, leaders and service providers to assess the need for MWHs and discuss ways in which MWHs can become self-sustaining, community-driven facilities.Our findings will inform the design of a MWH model that is acceptable, effective, and sustainable in order to increase access to safe delivery services.

Vocal support of traditional leaders is emerging as a critical factor in the engagement of communities. One research participant, Chieftainess Mwanjabantu, serves as both a leader and an inspiration to her community. Four years ago, the Chieftainess mobilized her community to build a one-room waiting shelter after seeing a number of women in her village, including her own two daughters, die while giving birth. Her strong commitment to improving maternal health galvanized community support and participation for Africare's ongoing research.

Merck Fellows Lisa Meehan (left) and Darrell Penn (right) meet with Chieftainess Mwanjabantu (middle).

AMPLIFYING WOMEN'S VOICES (con't)

As one of the four *Merck for Mothers* partners in India, WRAI is leading the charge to plan a new mHealth platform enabling women to rate the quality of maternal health care they receive. In the program design, radio campaigns and other offline communications channels would inform women of a free phone line they can call to rate the services they receive from public and private facilities and get information about quality of care. The system, which is currently in development, would work like this:

- Women calling the line would be asked to rate the quality of maternal care they received based upon a pre-programmed Interactive Voice Response scorecard.
- The same phone line would also provide information to women about what constitutes quality care.
- Participants' feedback and stories would then be published on the phone system for others to access, so that women who call seeking information can listen to comments and determine which health facility they want to access.
- The participants' feedback would also be synthesized so that health officials and health providers can use it to improve care -- creating a full feedback loop.

Maya Devi, a woman from the Ranchi district, tests the mobile phone system.

WRAI and Gram Vaani are currently field testing a prototype and engaging stakeholders to help with the design process. They are speaking to women, asking for their perspectives on quality maternal health care. Health provider associations, government officials, private providers and community members are also helping to develop quality measures that are equally important to women, households, providers and policy makers.

WRAI envisions building a rich database of information while empowering women to influence the standard of care for maternal health. With the simple and already common tools of a mobile phone and a cellular subscription - this could become a grassroots movement for millions.

Q&A

LEARNING FROM THE U.S. SAFE MOTHERHOOD INITIATIVE

Cynthia Chazotte, MD has served as the Vice Chair of the Albert Einstein College of Medicine's Department of Obstetrics & Gynecology and Women's Health in New York since 2006. Donna Montalto is the Executive Director of the American College of Obstetricians and Gynecologists - District II, based in Albany, New York. Together, they are implementing programs to strengthen the quality of maternal health care in the U.S.

In the United States (U.S.), maternal mortality remains an enigmatic issue. Despite being a country that spends more on childbirth-related care than any other nation, the U.S. ranks 47th in its maternal mortality rate, behind the rest of the developed world and countries such as Bosnia and Kuwait. With significant racial and geographic disparities, the U.S. continues to see preventable maternal mortality and morbidity. Leading killers in the U.S. are similar to the rest of the world, and include embolism, obstetric hemorrhage, and hypertension. To combat these issues, from 2001-2009, the American College of Obstetricians and Gynecologists and the New York State Department of Health (NYSDOH) collaborated on the Safe Motherhood Initiative to review maternal deaths and elevate maternal mortality as a public health issue.

In this interview, Dr. Cynthia Chazotte and Donna Montalto talk about some of the lessons learned from the Safe Motherhood Initiative in New York State and how they are informing current *Merck for Mothers* programming.

Q: What are the greatest lessons you learned from the Safe Motherhood Initiative?

Dr. Chazotte: On-site maternal mortality reviews and interviews with the providers and the caregivers really helped inform us about the issues. We learned a great deal about communication handoffs, cultural issues – issues way beyond how many milliliters of blood the patient received. This helped us figure out what educational process we needed to use to comprehensively review maternal mortality issues and outcomes.

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LEARNING FROM THE U.S. SAFE MOTHERHOOD INITIATIVE (con't)


Dr. Cynthia Chazotte

Ms. Montalto: The patient and family perspective that you capture when you go on site to the institution itself is not something you will find in a chart. The importance of that is learning about cultural barriers and family interaction with women who either just gave birth or are just about to give birth. By being on site, by doing the reviews, by studying why the woman dies, we also learned critical things about protocols and guidelines which we now are in the position of developing. As we read the medical charts, we learned why care might not have been provided or why obstetric staff didn't recognize an issue right away.

Q: Moving into the work that you are currently doing in New York State -- implementing maternal mortality surveillance systems and integrating protocols into practice within obstetric hospitals -- what are you most excited about?

Dr. Chazotte: We know a lot about the treatment of hypertension, we know a lot about the stages of hemorrhage, but our approach to the issues are not standardized. Through the *Merck for Mothers* project, we are using evidence-based guidelines to help hospitals, to help providers -- and that's the most exciting for me. We're not just going to come in and say, okay, these are the bundles, these are the guidelines…Hospitals and providers are part of the development of the guidelines. So it is theirs and they own it. I've been involved in many other collaborations where it comes from the top down and you just get an unfunded mandate. This project is so different.

Ms. Montalto: Just in the first six months of the project, we see the same incredible amount of enthusiasm from the level one hospitals (regional care) as we do from the academic centers, the regional perinatal centers and the tertiary centers. The willingness and desire to improve maternal care in all the urban centers in New York State – it's exciting. I do not want to underestimate the difficulties in the process – there's a lot of dissention – yet we walk out with agreement and consensus. The process of consensus-building yields enthusiasm because everybody has a stake in owning the protocol when it gets to their institution, and that is critically important.

Q: What do you hope to hear from the other Merck for Mothers partners who are working in Uganda, Zambia, India, Senegal? What are some lessons you think the U.S. can potentially learn from those in the Global South?

Dr. Chazotte: I think some of the issues in our state will overlap with the issues in the developing world, and those have to do with resources that are limited by geography. New York is a huge state. We have level one hospitals far distances from hospitals that can provide the sort of regional care that is necessary. So I think that regionalization and transport are issues that we have in common, that we can learn from each other.

FEATURE

STANDARDS-BASED MANAGEMENT AND RECOGNITION: A TOOL TO IMPROVE THE QUALITY OF MATERNAL HEALTH SERVICES IN FACILITY-BASED SETTINGS

Jhpiego offers a glimpse of how Standards-Based Management and Recognition, an internationally recognized resource for quality improvement, can be used for maternal health programs.

By: Vikas Yadav, National Program Manager with Jhpiego India

What is SBM-R?
Standards-Based Management and Recognition (SBM-R) is a practical management approach pioneered by Jhpiego to standardize and improve the quality of health services. Generally implemented at the level of a health facility or institution, the SBM-R approach follows four basic steps:

Step 1: Setting performance standards that are constructed around clearly defined service delivery processes or a specific content area. Standards are developed by first identifying the services to be improved, defining the core and support processes for the provision of these services, and then creating operational performance standards for each process. The standards should be based upon scientific evidence (e.g., technical reference materials, service delivery guidelines), and they should incorporate the opinions of frontline providers, managers, and clients. Each standard should have a set of verifying criteria, such as the steps or resources needed for a particular practice or management approach. These standards are then presented in the form of an assessment tool, which is used to evaluate the performance of a health facility or institution. The standards act as both a clinical update and a practice adherence tool, since they can tell a provider what practices to perform and explain how to perform these practices.

Step 2: Implementing the standards in a streamlined and systematic manner. The implementation of standards starts with an assessment of a health facility or institution using the previously developed assessment tool. The highlight of this approach is that assessments are done with equal participation from service providers and managers of health facilities at each step of the defined process. During these assessments, evaluators conduct an analysis to identify gaps and prepare focused action plans that are subsequently implemented with support from program staff.

Step 3: Measuring progress to guide the improvement process towards these standards. Periodic internal assessments are done using the same assessment tool to measure progress against the earlier assessments. Mid-course corrective actions are made in the action plans, if needed.

Step 4: Rewarding achievement of standards through recognition mechanisms. Partial improvements are rewarded during the process using a combination of measures, including feedback and social recognition (e.g., ceremonies, symbolic rewards). A facility that achieves global compliance (with the performance standards) is acknowledged through a recognition mechanism involving institutional authorities and the community.

Where has it been used?
Jhpiego's field experiences with SBM-R began in 1997 with the PROQUALI project, which focused on improving reproductive health in 29 health care facilities across two states of Brazil. Gradually, we expanded SBM-R to 20 countries. In India, we are currently implementing the approach in more than 10 states. We are seeing highly encouraging results with SBM-R in strengthening pre-service nursing and midwifery education, and improving family planning service delivery and quality of intra-partum and immediate postpartum care.

Adapting SBM-R to private care
Using the approach, we developed clinical standards for improving intra-partum and immediate postpartum care primarily for implementation at public sector health facilities. These are being modified and adapted for use at private sector facilities through consultations with private sector representatives, state government officials and Jhpiego staff. The aim is to make these standards concise and focused on essential practices.

Despite common perceptions that private sector providers offer better quality care, most of these providers receive few or no clinical updates on essential practices. Moreover, their practices – in many cases – are not in sync with the national guidelines for intra-partum and immediate postpartum care. Thus, our program's continued implementation of the SBM-R approach will not only benefit these providers through clinical updates but also standardize care with high-impact and evidence-based practices across public and private sector facilities.

To download the full field guide, please visit http://www.jhpiego.org/files/SBMR%20FieldGuide.pdf.

IMPACT

SEEING THE IMPACT: CHANGING BEHAVIOR, SAVING LIVES

An early success story from PACE Uganda shows that small actions can make large impacts.

By: Goretti Masadde, Deputy Director Sales and Marketing with PACE Uganda

Sabirah, a mother of four, lives with her family in the remote village of Ibulanku in a mud and wattle house. Access to the nearest health center, Ibulanku Community Health Center, is a tedious and laborious 30 kilometers away on a rough, pot-holed road. The boda-boda (local term for a small motorcycle taxi) is the only readily available means of transport in the area, yet it can be quite expensive.


Sabirah and her baby in Ibulanku, Uganda.

Sabirah had always preferred traditional birth attendants and never gave birth in a health center until she met a Taata Ambassador from the MSD for Ugandan Mothers Program (MUM Program). Maama and Taata Ambassadors are local community health workers who educate and counsel women on family planning and safe motherhood and sell clean delivery kits. Sabirah recounted her story:

> "I was at home and Mr. Kibira (a Taata Ambassador) visited me. He asked me if I had attended antenatal care and I told him that I had never gone anywhere even for my three previous children. At first, I was hesitant to go, but after a subsequent discussion with him, I accepted to go to the health center for checkups. The service providers there treated me very well, checked my pregnancy, and realized my baby was not fine. I was advised to regularly come for checkups, which I did until I eventually had my baby by caesarian section. If it had not been for Mr. Kibira's advice, probably my child and I would have died. I'm very thankful.
>
> The Taata ambassador told me that I might have given birth to the three children safely in the small clinics and with the traditional birth attendant, but that past experience does not make me an expert at giving birth. Each pregnancy/ child might have their problems, and who knows – the one I was carrying might be different. Indeed, the pregnancy would have easily killed me if I had not seen the Taata Ambassador."

Buduuma Silver, a nurse at the health center, notes that mothers like Sabirah have increasingly come to access services at Ibulanku Community Health Center due to the increased education and demand created by the Maama and Taata Ambassadors in the community. The center is ready to receive mothers with well-trained medical staff and equipment to provide maternal health services and continue saving lives.

75+ partners

30+ programs

26 countries around the world

Thank you for your partnership.