AMDD Third Annual Report
June 2002

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Appendix 1.

Staff

Name	Title	Based	Expertise / Responsibility	Effort
Allan Rosenfield	Dean, Co-Principle Investigator	Columbia University	Obstetrics, Policy	Part-time
Deborah Maine	Professor, Co-Principle Investigator, Program Director	Columbia University	Epidemiology, Program Design and Evaluation	100%
Lucille Pilling deLucena	Program Manager	Columbia University	Medicine, Reproductive Health	Part-time
Zafar Ullah Gill	Associate Research Scientist	Columbia University	Medicine, Program Implementation	100%
Ann Paxton	Assistant Professor	Columbia University	Epidemiology, Program Design and Evaluation, Monitoring	80%
Lynn Freedman	Associate Professor	Columbia University	Law, Public Health, Human Rights	50%
Martha de la Fuente	Associate Research Scientist	Netherlands	Medicine, Health Systems, Human Rights	100%
Alicia Yamin	Assistant Professor	Peru	Law, Public Health, Human Rights	50%
Edith Abreu	Business Manager	Columbia University	Finance and Administration	100%
Rebecca Brodsky	Program Coordinator	Columbia University	Travel, Office Management	100%
Katrina Stamas	Program Coordinator	Columbia University	Publications, General Program	100%
Samantha Lobis	Staff Associate	Columbia University	Project Monitoring, Refugee Health, Human Rights	100%
Rachel Waxman	Staff Associate	Columbia University	Project Implementation	100%
Sarah Blust	Graduate Research Assistant	Columbia University	Public Relations, Research, Clerical Duties	50%
Mike Lee (through 12/01)	Graduate Research Assistant	Columbia University	Research, Clerical Duties	50%
Bridget Moneypenny (through 4/02)	Graduate Research Assistant	Columbia University	Research, Clerical Duties	50%

Appendix 2.

Technical Team

Name	Title	Based	Expertise / Responsibility
Patricia Bailey	Senior Lecturer, Columbia University	Family Health International, North Carolina	Maternal Health, Quantitative & Qualitative Research
Karen Beattie	Consultant	EngenderHealth	Reproductive Health, Evaluation, Behavior Modification, Research
Leila Bisharat	Consultant	JSI, Inc.	Health Policy Systems
Judith Fortney	Senior Lecturer, Columbia University	Family Health International, North Carolina	Reproductive Health, Editor of AMDD section in IJGO publication
Martha de la Fuente	Associate Research Scientist	Amsterdam, Netherlands	Human Rights, Women's Health
Sourou Gbangbade	Consultant	Cotonou, Benin	Reproductive Health
Nadia Hijab	Consultant	Development Analysis and Communication Services, New York	Documentation, Development Programs
Grace Kodindo	Consultant	General Reference Hospital N'Djamena, Tchad	Reproductive Health Chief of Obstetrics-Gynecology
Barbara Kwast	Senior Adviser	Netherlands	Epidemiology, Maternal Health
Dileep Mavalankar	Associate Research Scientist	Indian Institute of Management, Ahmedabad India	Reproductive Health, Management Issues
Judith Robb-McCord	Consultant	JHPIEGO, Baltimore, Maryland	Reproductive Health, Training
Harshad Sanghvi	Consultant	JHPIEGO, Baltimore, Maryland	Reproductive Health
Jason Smith	Senior Lecturer, Columbia University	Family Health International, North Carolina	Reproductive Health, Oversees AMDD Technical Assistance Field Trips
Irina Yacobson	Consultant	Family Health International, North Carolina	Medicine, Reproductive Health

Appendix 3.

AMDD Publications and Presentations: Year 3

AMDD New York Staff

Edith Abreu

Publications

Abreu E, Potter D. "Recommendations for renovating an operating theater at an emergency obstetric care facility." *International Journal of Gynecology and Obstetrics,* 75(3):287-94, December 2001.

Lynn Freedman

Publications

Freedman, L.P. "Using human rights in maternal mortality programs: from analysis to strategy". *International Journal of Gynecology and Obstetrics*, 75(1):51-60, October 2001.

Presentations

"Who Does What? A Human Rights Perspective". AMDD International Project Workshop	Bangkok, Thailand February 2002
"Human Rights in AMDD Partnerships". American Public Health Association Annual Meeting	Atlanta, Georgia October 2001
"Human Rights and Women's Health Across the Globe". American Public Health Association Annual Meeting	Atlanta, Georgia October 2001
"Emergency Obstetric Care as a Human Right". Global Health Council Annual Meeting	Washington D.C. June 2001
"Rights-based Approaches to Health". CARE Reproductive Health Technical Advisor Meeting	Atlanta, Georgia June 2001
"Documentation and Representation". Session Leader at the ten-day Women's Global Leadership Institute	New Brunswick, New Jersey June 2001

Zafarullah Gill

Presentations

"Service Delivery". AMDD International Project Workshop	Bangkok, Thailand February 2002

Deborah Maine

Publications

Maine D; Rosenfield A. "The AMDD program: history, focus and structure. Averting maternal death and disability," *International Journal of Gynecology and Obstetrics*;74(2):99-103, August 2001.
Maine D., "How Do Socioeconomic Factors Affect Disparities in Maternal Mortality," *JAMWA*, 5 (4), 2001.

Maine D., "Has Maternal Health Care Become Too Medicalized," Pp. 485-492 in CP Puri, PFA Van Look, G Sachdeva, and C Penhale eds., *Sexual and Reproductive Health Recent Advances, Future Directions, Vol. II.* New Delhi, India: New Age International (P) Limited, Publishers, 2001.

Presentations

"Reducing Maternal Mortality: Our Road and and Responsibilities" Nepal Society of Gynaecologists and Obstetricians (NESOG) Conference Written by Deborah Maine, Delivered by Dr. Sudha Sharma, President, NESOG	Kathmandu, Nepal April 2002
"Who Does What? EmOC Delivery" AMDD International Project Workshop	Bangkok, Thailand February 2002
Maine D, P Bailey. "A proxima fase de 'Maternidade Segura' e o papel de Mocambique." Presented at the National Advocacy Meeting for the Reduction of Maternal and Perinatal Mortality.	Maputo, Mozambique October 2001
"Reducing Maternal Mortality: First Things First" *A discussion paper on strategy in Bangladesh*	August 2001
"AMDD Program: Structure, Strategy, and Indicators" CARE Meeting	June 2001

Anne Paxton

Publications

Bailey P, A Paxton. "Program note. Using UN process indicators to assess needs in emergency obstetric services," *International Journal of Gynaecology and Obstetrics*, 76; 299-305, 2001.

Presentations

"The Association pour la Formation et la Recherche en Gyneco" (Delivered in French) The Second National Consensus Conference, organized by the Association for Training and Research in Gynecology (FARGO), in association with the Direction of Population and UNFPA	Marrakech, Morocco April 2002

Allan Rosenfield

Publications

Rosenfield, A., Crone, E.T., "Family and Reproductive Health." In Koop, C.E., Pearson, C.E. and Schwarz, M.R. (eds), *Critical Issues in Global Health*. San Francisco: Jossey Bass, 2001.
Rosenfield, A. "Maternal Mortality as a Human Rights and Gender Issue." In Murphy, E. and Ringheim, K. (eds), Reproductive Health, Gender and Human Rights: A Dialogue. Washington, DC: Program for Appropriate Technology in Health (PATH), 2001, pp.9-14.
Rosenfield, A., Figdor, E., "Where is the M in MTCT?: The broader issues in mother-to-child transmission of HIV." *American Journal of Public Health* 91: 703-704, 2001.
Rosenfield, A., "Maternal Mortality as a Human Rights and Gender Issue." In Murphy, E. and Ringheim, K. (eds), *Reproductive Health, Gender and Human Rights: A Dialogue.* Washington DC: Program for Appropriate Technology in Health, pp. 9-14, 2001.
Maine, D., Rosenfield, A. "The AMDD program: history, focus and structure." *International Journal of Gynecology & Obstetrics,* 74 (2):99-103, 2001.

Presentations

"The Present and Future Directions of AMDD." Gates Presentation	Seattle, Washington March 2002

<u>Alicia Ely Yamin</u>

Publications

Yamin, A. Book Review of "Safe Motherhood Initiatives: Critical Issues". In Berer, M. & Sundari, T. (eds.) *Women and Health*, 31: (4), 2001.

Yamin, A. "Protecting and promoting the right to health in Latin America: Selected experiences from the field." *Health and Human Rights: An International Journal*, 5: (1), 2001.

Yamin, A. *Conjurando Inequidades: Vigilancia Social del Derecho a la Salud.* Lima: Centro de Asesoria Laboral, 2001.

Presentations

"Cambiando el Paradigma para Abordar la Muerte Materna." ("Changing the Paradigm to Address Maternal Mortality"). Presentation/Briefing to Peruvian Congresspeople. UNFPA.	Lima, Peru November 2001
"Mortalidad Materna: ¿Qué Sabemos Ahora?" ("Maternal Mortality: Where Are We Now?"). Panel presentation at Foro Internacional - Reducción de la Mortalidad Materna: Enfoques desde la salud y los derechos humanos. Centro de la Mujer Peruana "Flora Tristan" - Universidad Nacional Mayor San Marcos.	Lima, Perú. July 2001

"Incorporando una perspectiva de derechos humanos en Programas para reducir la Muerte Materna" ("Incorporating a Human Rights Perspective in Programs to Reduce Maternal Mortality"). Plenary presentation at Foro Internacional - Reducción de la Mortalidad Materna: Enfoques desde la salud y los derechos humanos. Centro de la Mujer Peruana "Flora Tristan" – Universidad Nacional Mayor San Marcos.	Lima, Perú July 2001

AMDD Technical Team	
Patsy Bailey	
Publications	
Bailey P, J A Szaszdi, L Glover. "Obstetric complications: does training TBAs make a difference?" *Pan American Journal of Public Health*, Vol. 11, No. 1, 2002, p. 15-22.	
Bailey P, A Paxton. "Program note. Using UN process indicators to assess needs in emergency obstetric services." *International Journal of Gynaecology and Obstetrics*, 76: 299, 2002.	
Perreira K, P Bailey, E Bocaletti, E Hurtado, S Recinos, J Matute. "Improving recognition of obstetric complications through community- and clinic-based education." *Maternal and Child Health Journal,* Vol. 6, Number 1, 2002: 19-28	
de la Fuente, Martha & Patricia Bailey. "Atendimento de emergencia para gravidez e parto." *Mulher e Saude*, Maio-Agosto, 2001: p. 6-8	
Presentations	
Bailey P, Z Vieira. "Consecuencias del embarazo y aborto entre las adolescents del nordeste de Brasil: 1 ano y 5 anos despues." Paper presented at the Conference on Unwanted Pregnancy and Induced Abortion.	Cuernavaca, Mexico November 2001
Maine D, P Bailey. "A proxima fase de 'Maternidade Segura' e o papel de Mocambique." Presented at the National Advocacy Meeting for the Reduction of Maternal and Perinatal Mortality.	Maputo, Mozambique October 2001
Alegre M, R Luna, E Esquiche, L Tam, P Bailey, M De la Fuente. "Status of emergency obstetric care in Ayacucho, Peru." Paper presented at the 28th Annual Conference for the Global Health Council.	Washington, D.C. May 2001
Terry W, G Barrios, P Bailey. "Met need: issues in measurement and decision-making." Poster session at the 28th Annual Conference for the Global Health Council	Washington, D.C. May 2001

Martha de la Fuente	
Publications	
de la Fuente, Martha & Patricia Bailey. "Atendimento de emergencia para gravidez e parto." *Mulher e Saude*, Maio-Agosto, 2001: p. 6-8	
Barbara Kwast	
Presentations	
"Programme Strategies on the Reduction of Maternal Mortality and Morbidity" Lecture Series at the Royal Tropical Institute in the International Course in Health Development	Amsterdam, Netherlands April 2002
"Process Indicators for Design, Monitoring and Evaluation of Maternal Mortality Programmes" 26th World Congress of the International Confederation of Midwives (ICM) Plenary Presentation	Vienna, Austria April 2002
"Recent Thinking on Maternal Mortality Reduction". Criterion-Based Review of EmOC Workshop Plenary Presentation	India March 2002
"Problems and Possibilities in Safe Motherhood Programmes". Upsala University, Department of Obstetrics and Gynecology Technical Seminar Plenary Presentation	Pretoria, South Africa February 2002

Appendix 4.

Technical Assistance Trips (June 2001 – June 2002)

Amsterdam

From	To	Name	Organization	Purpose
26 Nov. '01	— 2 Dec. '01	Edith Abreu	AMDD	Meeting
26 Nov. '01	— 2 Dec. '01	Patricia Bailey	AMDD	Meeting
26 Nov. '01	— 30 Nov. '01	Lucille de Lucena	AMDD	Meeting
26 Nov. '01	— 1 Dec. '01	Judith Fortney	AMDD	Meeting
26 Nov. '01	— 30 Nov. '01	Lynn Freedman	AMDD	Meeting
26 Nov. '01	— 1 Dec. '01	Sourou Gbangbade	AMDD	Meeting
26 Nov. '01	— 3 Dec. '01	Zafar Gill	AMDD	Meeting
26 Nov. '01	— 02 Dec. '01	Yacobson Irene	AMDD	Meeting
26 Nov. '01	— 1 Dec. '01	Grace Kodindo	AMDD	Meeting
26 Nov. '01	— 30 Nov. '01	Deborah Maine	AMDD	Meeting
26 Nov. '01	— 30 Nov. '01	Anne Paxton	AMDD	Meeting
26 Nov. '01	— 2 Dec. '01	Jason Smith	AMDD	Meeting
27 Nov. '01	— 30 Nov. '01	Allan Rosenfield	AMDD	Meeting
29 Nov. '01	— 02 Dec. '01	Bridget Moneypenny	AMDD	Meeting

Atlanta

From	To	Name	Organization	Purpose
7 Jun. '01	— 7 Jun. '01	Lynn Freedman	CARE	Meeting
7 Jun. '01	— 7 Jun. '01	Deborah Maine	CARE	Meeting
12 Oct. '01	— 16 Oct. '01	Anne Paxton	CARE	Meeting
14 Oct. '01	— 17 Oct. '01	Barbara Kwast	CARE	Meeting
14 Oct. '01	— 15 Oct. '01	Deborah Maine	CARE	Meeting
15 Oct. '01	— 15 Oct. '01	Zafar Gill	CARE	Meeting
21 Oct. '01	— 24 Oct. '01	Deborah Maine		Meeting
7 Apr. '02	— 8 Apr. '02	Allan Rosenfield	CARE	Meeting
8 Apr. '02	— 8 Apr. '02	Lynn Freedman	CARE	Meeting
8 Apr. '02	— 8 Apr. '02	Zafar Gill	CARE	Meeting
8 Apr. '02	— 8 Apr. '02	Deborah Maine	CARE	Meeting

Bangladesh

From	To	Name	Organization	Purpose
29 Jun. '01	— 6 Jul. '01	Zafar Gill	UNICEF	AMDD Fieldtrip
29 Jun. '01	— 6 Jul. '01	Jason Smith	UNICEF	AMDD Fieldtrip
1 Nov. '01	— 12 Nov. '01	Zafar Gill	UNICEF	Meeting
24 Nov. '01	— 03 Dec. '01	Nadia Hijab	UNICEF	AMDD Fieldtrip
25 Nov. '01	— 2 Dec. '01	Sybiile Barth	UNICEF	AMDD Fieldtrip
1 Jun. '02	— 15 Jun. '02	Jason Smith	UNICEF	AMDD Fieldtrip

Ecuador

From	To	Name	Organization	Purpose
14 Dec. '01	— 22 Dec. '01	Martha de la Fuente		AMDD Fieldtrip

Ethiopia

From	To	Name	Organization	Purpose
3 Jul. '01	— 14 Jul. '01	Barbara Kwast	CARE	AMDD Fieldtrip
3 Jul. '01	— 14 Jul. '01	Dileep Mavalankar	CARE	AMDD Fieldtrip
1 Nov. '01	— 13 Nov. '01	Kwast Barbara	CARE	AMDD Fieldtrip

India

15 Jul. '01	— 15 Sep. '01	Kavita Bali	UNFPA	UNICEF	AMDD Fieldtrip
25 Sep. '01	— 28 Sep. '01	Dileep Mavalankar	UNICEF	UNFPA	AMDD Fieldtrip
Late Oct. '01	— Late Oct. '01	France Donnay	UNFPA		AMDD Fieldtrip
Late Oct. '01	— Late Oct. '01	Jean Claude Javet	UNFPA		AMDD Fieldtrip
10 Mar. '02	— 18 Mar. '02	Barbara Kwast	UNFPA	UNICEF	Meeting
11 Mar. '02	— 18 Mar. '02	Dileep Mavalankar	UNFPA	UNICEF	Meeting
18 Apr. '02	— 27 Apr. '02	Deborah Maine	UNFPA	UNICEF	AMDD Fieldtrip
21 Apr. '02	— 27 Apr. '02	Dileep Mavalankar	UNFPA	UNICEF	AMDD Fieldtrip

Ivory Coast

12 Apr. '02	— 21 Apr. '02	Lynn Freedman	RPMM		Meeting
12 Apr. '02	— 20 Apr. '02	Martha de la Fuente	RPMM		Meeting

London

16 Jul. '01	— 20 Jul. '01	Deborah Maine	UNFPA		Conference

Mali

14 Nov. '01	— 26 Nov. '01	Sourou Gbangbade	Save the Children		AMDD Fieldtrip
15 Nov. '01	— 26 Nov. '01	Grace Kodindo	Save the Children		AMDD Fieldtrip

Mexico City

10 Nov. '01	— 18 Nov. '01	Martha de la Fuente			Meeting

Morocco

30 Oct. '01	— 6 Nov. '01	Sybille Barth	UNFPA		AMDD Fieldtrip
30 Oct. '01	— 6 Nov. '01	Nadia Hijab	UNFPA		AMDD Fieldtrip
13 Apr. '02	— 23 Apr. '02	Zafar Gill	UNFPA		AMDD Fieldtrip
13 Apr. '02	— 27 Apr. '02	Samantha Lobis	UNFPA		AMDD Fieldtrip
16 Apr. '02	— 25 Apr. '02	Anne Paxton	UNFPA		AMDD Fieldtrip
21 May '02	— 7 Jun. '02	Samantha Lobis	UNFPA		AMDD Fieldtrip
2 Jun. '02	— 16 Jun. '02	Rachel Waxman	UNFPA		AMDD Fieldtrip
24 Jun. '02	— 28 Jun. '02	Deborah Maine	UNFPA		AMDD Fieldtrip

Mozambique

24 Sep. '01	— 13 Oct. '01	Patricia Bailey	UNFPA		AMDD Fieldtrip
24 Sep. '01	— 6 Oct. '01	Zafar Gill	UNFPA		AMDD Fieldtrip
2 Dec. '01	— 10 Dec. '01	Sybille Barth	UNFPA		AMDD Fieldtrip
21 Mar. '02	— 30 Mar. '02	Patricia Bailey	UNFPA		AMDD Fieldtrip

Nepal

17 Jan. '02	— 29 Jan. '02	Zafar Gill	UNICEF		AMDD Fieldtrip
24 Jun. '02	— 29 Jun. '02	Lynn Freedman	UNICEF		Conference

New York, NY

11 Jun. '01	— 11 Jun. '01	Susan Otchere	AMDD		Meeting
11 Jun. '01	— 11 Jun. '01	Sangeeta Pati	AMDD		Meeting
12 Jul. '01	— 13 Jul. '01	Patricia Bailey	AMDD		Meeting
3 Jul. '01	— 15 Jul. '01	Soledad Guayasmin	AMDD		Meeting

Start	End	Name	Organization	Purpose
3 Jul. '01	— 14 Jul. '01	Kausar Khan	AMDD	Meeting
3 Jul. '01	— 18 Jul. '01	Junice Melgar	AMDD	Meeting
3 Jul. '01	— 9 Jul. '01	Farida Shaheed	AMDD	Meeting
4 Jul. '01	— 11 Jul. '01	Martha de la Fuente	AMDD	Meeting
6 Aug. '01	— 6 Aug. '01	Jason Smith	AMDD	Meeting
1 Oct. '01	— 2 Oct. '01	Jason Smith	AMDD	Meeting
13 Mar. '02	— 13 Mar. '02	Jason Smith	AMDD	Meeting
20 Mar. '02	— 20 Mar. '02	Jason Smith	AMDD	Meeting
10 Apr. '02	— 10 Apr. '02	Patricia Bailey	AMDD	Meeting
10 Apr. '02	— 10 Apr. '02	Jaikishan Desai	AMDD	Meeting
10 Apr. '02	— 10 Apr. '02	Jason Smith	AMDD	Meeting
1 May '02	— 2 May '02	Jason Smith	AMDD	Meeting
7 May '02	— 7 May '02	Patricia Bailey	AMDD	Meeting
09 Jun. '02	— 16 Jun. '02	Grace Kodindo	AMDD	Meeting
17 Jun. '02	— 19 Jun. '02	Patricia Bailey	AMDD	Meeting
18 Jun. '02	— 19 Jun. '02	Milly Kayongo	AMDD	Meeting
			Nicaragua	
9 Jun. '01	— 16 Jun. '01	Patricia Bailey	UNFPA	AMDD Fieldtrip
9 Jun. '01	— 16 Jun. '01	Martha de la Fuente	UNFPA	AMDD Fieldtrip
18 Nov. '01	— 24 Nov. '01	Patricia Bailey	UNFPA	AMDD Fieldtrip
18 Nov. '01	— 24 Nov. '01	Martha de la Fuente	UNFPA	AMDD Fieldtrip
2 Jun. '02	— 8 Jun. '02	Martha de la Fuente	UNFPA	AMDD Fieldtrip
			Peru	
Jun. '01	— Jun. '01	Susan Rae Ross	CARE	AMDD Fieldtrip
5 Sep. '01	— 14 Sep. '01	Martha de la Fuente	CARE	AMDD Fieldtrip
6 Sep. '01	— 14 Sep. '01	Patricia Bailey	CARE	AMDD Fieldtrip
20 Oct. '01	— 29 Oct. '01	Sybille Barth	CARE	AMDD Fieldtrip
21 Oct. '01	— 29 Oct. '01	Nadia Hijab	CARE	AMDD Fieldtrip
10 May '02	— 19 May '02	Patricia Bailey	CARE	AMDD Fieldtrip
14 May '02	— 19 May '02	Zafar Gill	CARE	AMDD Fieldtrip
7 May '02	— 19 May '02	Martha de la Fuente	CARE	AMDD Fieldtrip
			Sri Lanka	
30 May '01	— 9 Jun. '01	Zafar Gill	UNICEF	Conference
25 Jun. '01	— 28 Jun. '01	Judith Fortney	UNICEF	AMDD Fieldtrip
25 Jun. '01	— 28 Jun. '01	Jason Smith	UNICEF	AMDD Fieldtrip
28 Feb. '02	— 9 Mar. '02	Judith Fortney	UNICEF	AMDD Fieldtrip
			Tajikistan	
Jun. '01	— Jun. '01	Annie Clark	CARE	AMDD Fieldtrip
Sep. '01	— Sep. '01	Annie Clark	CARE	AMDD Fieldtrip
14 Jun. '02	— 24 Jun. '02	Dileep Mavalankar	CARE	AMDD Fieldtrip
14 Jun. '02	— 24 Jun. '02	Irina Yacobson	CARE	AMDD Fieldtrip
			Tanzania	
16 Jul. '01	— 30 Jul. '01	Barbara Kwast	CARE	AMDD Fieldtrip
16 Jul. '01	— 30 Jul. '01	Dileep Mavalankar	CARE	AMDD Fieldtrip

16 Jul. '01	— 30 Jul. '01	Susan Rae Ross	CARE	AMDD Fieldtrip
28 Jul. '01	— 10 Aug. '01	Barbara Kwast	CARE	AMDD Fieldtrip
28 Jul. '01	— 10 Aug. '01	Dileep Mavalankar	CARE	AMDD Fieldtrip
13 Nov. '01	— 26 Nov. '01	Barbara Kwast	CARE	AMDD Fieldtrip
			Vietnam	
17 Jun. '01	— 24 Jun. '01	Jason Smith	Save the Children	AMDD Fieldtrip
			Washington, DC	
27 May '01	— 1 Jun. '01	France Donnay	GHC	Conference
29 May '01	— 1 Jun. '01	Edith Abreu	GHC	Conference
29 May '01	— 1 Jun. '01	Patricia Bailey	GHC	Conference
29 May '01	— 2 Jun. '01	Rebecca Brodsky	GHC	Conference
29 May '01	— 1 Jun. '01	Deborah Maine	GHC	Conference
15 Oct. '01	— 15 Oct. '01	Lucille de Lucena		Meeting
28 May '02	— 31 May '02	Rebecca Brodsky	GHC	Meeting
28 May '02	— 31 May '02	Lucille de Lucena	GHC	Meeting
29 May '02	— 31 May '02	Edith Abreu	GHC	Meeting
30 May '02	— 31 May '02	Anne Paxton	GHC	Meeting
05 Jun. '02	— 06 Jun. '02	Rebecca Brodsky	Save the Children	Meeting
05 Jun. '02	— 06 Jun. '02	Deborah Maine	Save the Children	Meeting

Appendix 5.

AMDD Semi-Annual Reporting Sheet
(sample)

Appendix 6.

AMDD Project Background Report
(sample)

Appendix 7.
The UN Process Indicators

Indicators	Minimum Acceptable Level
Amount of EmOC facilities: Basic EmOC Comprehensive EmOC	For every 500,000 population, there should be: At least 4 Basic EmOC facilities. At least 1 Comprehensive EmOC facility.
Geographic distribution of EmOC facilities	Minimum level for amount of EmOC services is met in subnational areas.
Proportion of all births in EmOC facilities	At least 15% of all births in the population take place in either Basic or Comprehensive EmOC facilities.
Met need for EmOC:	100% of women estimated to have obstetric complications are treated in EmOC facilities.
Cesarean sections as a percentage of all births	Cesarean sections account for 5-15% of all births in the population.
Case fatality rate	The death rate among women with obstetric complications in EmOC facilities is less than 1%.

UN Definitions of EmOC Facilities

Signal functions to identify Basic and Comprehensive EmOC facilities	
Basic EmOC Services	Comprehensive EmOC Services
(1) Administer parenteral antibiotics*	(1-6) All of those included in Basic EmOC
(2) administer parenteral oxytocic drugs	(7) perform surgery (cesarean section)
(3) administer parenteral anticonvulsants for pre-eclampsia and eclampsia	(8) perform blood transfusion
(4) perform manual removal of placenta	
(5) perform removal of retained products (e.g., manual vacuum aspiration)	
(6) perform assisted vaginal delivery	

A Basic EmOC facility is one that is performing all of functions 1-6.
A Comprehensive EmOC facility is one that is performing all of functions 1-8.

Parenteral administration of drugs means by injection or intravenous infusion.

Appendix 8.
IMPLEMENTATION STAGES OF EmOC SERVICES

Country:_______________________ Date completed: _________________

FACILITY	PREPARATION							SERVICE DELIVERY				
	FACILITY				STAFF			FUNCTIONING		QUALITY		UTILIZA-TION
	Renovation & Main-tenance	Supplies & Equip-ment	Facility Setup	UN P.I.& Data Collection	Training	Placement	Team Building	On-going readiness	24/7 EmOC	On-site QI process	External Supervision	Improving (yes/no)

Notes:

Implementation Stages of EmOC Services Chart - Explanatory Notes

This table is designed to help project managers and project monitors assess progress in the implementation of AMDD projects, specifically by looking at the progress of each facility within a country project in preparing for and delivering EmOC services. This table can be a useful tool for ensuring that all of the steps of project implementation have been addressed in the project, as well as a way to identify issues that may be in need of particular attention in order to move the project forward. The implementation stages can be viewed as building blocks, each one has its place in building up good quality EmOC services, and they need to be put in place together as a means to achieve that goal. In other words, we need to make sure that the stages are implemented in a complementary manner so that efforts to improve any one aspect of EmOC services rests on a proper foundation.

Project implementation has been divided into two main stages: the **Preparation** stage and the **Service Delivery** stage. Within the preparation stage are the subcategories of facility and staff in order to draw attention to progress in terms of renovation, supplies & equipment, facility setup, data collection and UN Process Indicators (PI), and staff placement, training, and team building. Service delivery is organized into functioning, quality, and utilization. These topics cover issues such as on-going readiness, availability of 24/7 EmOC, on-site quality improvement (QI) process, external supervision, and last but not least whether or not there has been an increase in utilization in EmOC facilities.

Below is an explanation of the considerations within each stage of implementation to help you to fill out this chart in order to determine the implementation status of a project. There are also suggestions of actions to take to address delays that arise at different steps in the project.

If you have any questions concerns about your project's progress in implementation after you have read through these notes and completed the table for the facilities in your project, please fell free to contact Dr. Zafar Gill (zg41@columbia.edu) or Rachel Waxman (rjw99@columbia.edu).

Column 1: Facility

In this column list the facilities to be upgraded for EmOC in the project. Please indicate what level of EmOC care they are to be upgraded to- basic or comprehensive (BEmOC or CEmOC). It may be helpful to list Comprehensive EmOC facilities followed by Basic EmOC, or to list them in geographical groups.

Preparation Stage:

This section helps to determine how the project is moving along in the preparation of the facility and staff for providing EmOC.

Facility

- *Column 2: Renovation and maintenance* – Please indicate if the facility has plans for renovation, if it is under renovation or if renovations have been completed. If renovations are taking longer than planned or have been delayed, try to find out the cause of these delays and plan to follow-up to resolve the matter.

- *Column 3: Supplies and equipment* – Please indicate the progress in procurement of supplies and equipment. Have they been ordered? Received? Delivered to the facilities? Installed? If there have been delays or if delays are anticipated, consider what actions could be taken to overcome the delay, such as involving higher authorities, or ensuring that a technician is available for installation.

- *Column 4: Facility setup* – Facility setup refers to several activities that should occur in tandem (at the same time) with staff team building (see below) and that need to be accomplished in order to advance to a state of on-going readiness to provide EmOC. Once renovations are complete and supplies and equipment are in place there needs to be a room to room assessment of supply and equipment needs and then set up of the facility according to the functions performed in each room where obstetric emergencies are to be treated. Facility setup also refers to setting facility standards and ensuring that all staff are aware of these standards, including the identification and delegation of day to day responsibilities among staff members. A good resource on facility setup as well as team building is "Guidelines for organizing and managing emergency obstetric care facilities in developing countries"- a draft version is available from AMDD New York, please contact Rachel at rjw99@columbia.edu. This resource also includes a checklist of facility standards.

- *Column 5: UN Process Indicators and Data Collection* – In this column, please indicate where the facility is among the steps to prepare the facilities for the collection of appropriate data for the Process Indicators. Have the registers been adapted to include a place to specify complications? Have definitions been set for obstetric complications and have instructions been provided to the staff for filling out registers? Have staff been trained in the calculation and use of the Process Indicators? Are the Process Indicators being calculated regularly in the facilities? Good resources on the Process Indicators include the "Guidelines for Monitoring the Availability and Use of Obstetric Services" (UN Guidelines) and the AMDD workbook on "Using the UN Process Indicators: Questions and Answers." Please contact Anne Paxton (eapaxton@aol.com) or Samantha Lobis (sjl54@columbia.edu) at AMDD New York if you have any questions or concerns.

Staff

- *Column 6: Training* – Note if staff is undergoing training for EmOC, including anesthesia. Make sure that training is competency based and not only for gaining knowledge but also for developing skills to manage obstetric complications.

- *Column 7: Placement* – This section refers to meeting the complete staff/team requirement (EmOC trained or ob/gyn specialist, anesthetist, nurse/midwife, and paramedical staff) in the facility. Transfers, posting, or new recruitment may be needed in preparation for EmOC services. If there are delays in placement, it may be helpful to consult with appropriate authorities or make a formal request for placement of staff.

  - *Column 8:Team building* – As mentioned above this stage should be carried out at the same time as activities to setup the facility. Team building includes the organization of the facility and emergency response teams (FT and ERT); identification, clarification and distribution of roles among the staff; and plans for day to day facility management. Has there been a workshop on team building or is one planned, if not, is there an alternate plan for how these teams will be organized in the facilities? Who is the supervisor or manager responsible for ensuring that the teams are carrying out their duties? How often is s/he assessing the functioning of the teams. A good resource on facility setup as well as team building is "Guidelines for organizing and managing emergency obstetric care facilities in developing countries"- a draft version is available from AMDD New York, please contact Rachel Waxman at rjw99@columbia.edu

Service Delivery Stage

Once the facility and staff are prepared to provide EmOC services, or if they are already providing services, it is important to look at the functioning of the facilities, the quality of care and whether or not utilization is improving in the facilities. These are the categories that make up the second stage of project implementation and ultimately make it possible to say that the project has produced good quality EmOC services that are available to women who experience obstetric complications. In the service delivery stage, there are several useful tools available to help project managers and facility staff to address these issues.

Functioning

This section helps you to determine if the facility is ready at all times to provide 24/7 EmOC services. If not, it will point to the actions that need to be taken to help make the facility fully functional.

- *Column 9: On-going readiness* - Based on the facility setup and team building activities, are the areas for EmOC services being used in the way they were prepared? If equipment, instruments, linen etc. are used, are staff fulfilling their responsibilities in a timely manner so that the rooms are ready for the next patient? Are there systems in place for regular maintenance and cleaning of rooms and equipment, instrument processing and autoclaving, and replacement of linens? Please refer to the facility setup and team building sections above for suggestions and resources.

- *Column 10: 24/7 EmOC* – This is achieved when EmOC services are available to women no matter what time of day or night they arrive at the facility, in other words, 24 hours a day, 7 days a week. In order to assess if EmOC is really available 24/7 it may be helpful to find out who is available outside of the regular business hours for the facility. Is enough staff available to respond to an emergency at 6pm or in the middle of the night? Is there an on-call system or rotation of staff who are required to be available? Is accommodation available for staff who have to stay overnight? How long does it take for a woman to be seen by medical staff? Are the keys available to access the needed rooms or supplies? In a comprehensive facility, how long does it take to assemble the surgical team? To start a blood transfusion? There are most likely other questions that might be relevant to any given facility and its ability to provide 24/7 EmOC services. Based on the responses to these questions, consider ways that you can advocate or suggest actions that can improve the continual availability of EmOC services.

Quality

With regard to quality, there are two activities that can be used to both assess and improve EmOC services: on-site supervision using various Quality Improvement tools, and external supervision.

- *Column 11: On-site QI process* – This stage calls attention to the management activities of supervisors and senior staff Are they providing day to day supervision of staff and the care provided to patients? Have staff been trained in the use of the tools available for quality improvement? There are two tools available from AMDD, the "Leadership Manual for Improving the Quality of Services" and the accompanying "Toolbook" prepared by EngenderHealth and AMDD, and the Criterion-Based Audit. If on-site supervision has not been initiated, what steps are planned to implement on-site QI and when?

- *Column 12: External supervision* - This refers to supervisory visits either by experts from national medical colleges or training hospitals, or by consultants identified by project partners or AMDD project monitors. External supervision should be supportive of facility staff, and provide mentoring and on-the-spot training when necessary. If this has not been initiated, what actions are needed? For example, has contact been made with medical training facilities to identify a supervision team? Is there a schedule of visits to facilities?

Utilization

Column 13: The final consideration in the implementation of EmOC services is whether or not this is having an impact on utilization of services. Based on three of the process indicators, Met Need, the proportion of cesarean sections, and the proportion of births in EmOC facilities, it should be possible to determine if utilization is in fact increasing in a facility. Consider what actions might work to continue to improve utilization by women who experience obstetric complications. Are there particular implementation stages that have not received enough attention? Are all of the building blocks in place for our goal of making good quality EmOC services available? Would it help to conduct focus group discussions to identify if there are other influences on utilization?

Appendix 9.

Averting Maternal Death and Disability (AMDD) Program
Second Annual Project Workshop
Bangkok, 19 - 21 February 2002

The Averting Maternal Death and Disability (AMDD) Program

Bangkok 19 – 21 February 2002

Workshop Report

Implementation

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1. Introduction

The second annual meeting of partners in the Averting Maternal Death and Disability (AMDD) Program brought together more than 200 participants in Bangkok, Thailand. They came together to share experiences in and methods for reducing death and disability due to complications of pregnancy.

"Implementation" was the theme of the Workshop, which was held nearly three years into the 5-year Program. Medical, management, and human rights issues related to implementation were tackled in working sessions. Key policy and emerging issues were addressed in plenary and panel sessions. Teams working in AMDD-supported projects also held separate meetings to review progress and discuss ways of overcoming obstacles.

Participants share the view that women's lives can be saved and health improved if they have access to good obstetric care to treat complications as and when they occur. The majority are involved in projects to increase the availability, utilization and quality of emergency obstetric care (EmOC)

Twice as many participants came to Bangkok as attended the first such Workshop in Marrakech, Morocco, in February 2001. The participants this year came from 21 countries in Africa, 12 countries in Asia, 3 in Latin America, 2 Arab States, and 3 countries in Europe, as well as from the United States. The largest number of participants came from Asia, which was the reason for choosing Bangkok as the conference site even though there are no AMDD-supported projects in Thailand.

As Dr. Allan Rosenfield, Dean of the Columbia University Mailman School of Public Health told the Opening Plenary, "With the help of our partners, we are dedicated to decreasing the number of women who needlessly die from complications of pregnancy. These efforts are long overdue".

Partnerships were the focus of the plenary address by Dr. Gordon Perkin, Executive Director of the Global Health Program at the Bill & Melinda Gates Foundation, who noted that for "partnerships to be successful, they must have a clear and compelling goal". Governments and non-governmental organizations (NGOs) are working towards a shared dream: "giving every woman a safe delivery and a healthy productive life with her family."

The commitment to averting maternal death and disability was clear in the discussions during the sessions and in the corridors. Participants included a minister and several heads of department in national ministries of health; university college deans and professors; presidents of professional associations, including the International Federation of Gynecology & Obstetrics (FIGO); service providers; and project personnel. A list of participants was distributed at the Workshop to support continued networking (for copies send an email to amdd@columbia.edu).

2. Implementation: Working Sessions

"Implementation is more than doing training and buying equipment.
It is delivering good quality services, in a reliable, respectful manner"

Prof. Deborah Maine
Director, AMDD Program

The working sessions covered 14 topics: service delivery; medical audits; infection prevention; quality improvement; gathering and using data; facility management; supplies & equipment; renovation; EmOC training; documentation & communication; and human rights at the facility, in government policy, and in the community.

While all of these issues are important for successful project implementation, **service delivery** and **gathering data** were identified as the two "make or break" issues at this stage of the AMDD Program. All teams from AMDD-supported projects were pre-registered for these two sessions. The other sessions were elective, and participants signed up for them depending on need and interest. Sessions were repeated more than once so that participants had the opportunity to cover as many topics as possible. A total of 41 working sessions were conducted during the Workshop. Simultaneous interpretation into French and Spanish was provided for most topics.

Service Delivery Five sessions were conducted for AMDD-supported project teams. Session leader Dr. Zafarullah Gill, AMDD Associate Research Scientist, said the sessions dealt with the two stages of implementation:

- The preparatory stage, which covers issues such as renovation, maintenance, supplies and equipment, room set up, data collection, placement of staff; and;

- Delivery of services, which covers the functioning of the hospital, ongoing readiness, 24-hour/7-day services, quality improvement, supervision, utilization of services, and analysis of data.

Teams appreciated the structured approach adopted in the sessions, and went into more depth on specific areas. They completed questionnaires on the present status of the facilities in their projects, and set out the specific next steps they would take regarding the problems they faced.

Jason Smith, Senior Scientist at Family Health International noted that useful exchanges took place between project staff and government counterparts from the same country, with the Workshop providing the kind of neutral atmosphere for open discussions that is sometimes difficult to find back home. For example, when the problem of lack of staffing or staff rotation was raised as a major obstacle to progress in enhancing EmOC services, ministry officials pledged to address this upon their return home.

Gathering and Using Data All AMDD-supported projects use the Process Indicators issued in 1997 by UNICEF/WHO/UNFPA for the design and implementation of programs to avert maternal death and disability. Although manuals exist, application in the field on such a scale is new. Moreover, many project and government partners have little experience in the collection and interpretation of data on this subject.

Five sessions on gathering data were conducted for project teams. "The questions were thoughtful and often debate provoking", recalled session leader Anne Paxton, Senior Program Officer for Monitoring and Evaluation at AMDD. "In some sessions, one participant would ask a question and another participant, from another country, would answer. The teams from Peru and Mozambique had a great exchange on examples from their projects, while the teams from India and Sri Lanka were particularly challenging in their questions and observations."

During these sessions, teams worked with experienced facilitators on project data, often staying beyond the formal end of the session. The AMDD Workbook "(Almost) Everything You Want to Know about Using the UN Process Indicators of Emergency Obstetric Services: Questions and Answers" served as a resource during these session. Many issues about the Process Indicators were clarified during the sessions, for example, how to determine the appropriate denominator. Participants went home with a better understanding of how to use the indicators to stay on track in their projects.

In the two "elective" sessions on Using Data, participants were able to work in groups on a case study with a facilitator.

Human Rights *There were six sessions in all, two each on human rights policies, human rights at the facility, and human rights in the community. The sessions were interactive and often very lively.*

In the sessions on policy, participants discussed issues such as the interests of the groups involved, who had the power to change policy, and the kinds of coalitions that could influence

policy. They also discussed why certain policies came into being even when there was not much real evidence to support them. Many policies were simply transplanted from other countries. Participants then broke into small groups and worked through a series of questions about how to provide EmOC services on "Mars", a fictitious country where there is a large population with few professional anesthetists, but several midwives who have been trained to provide the same services successfully.

Session leader Lynn Freedman, Associate Professor at Columbia, urged participants to view the human rights discussion as a question of how to provide the most services to the most people. Within this perspective, if health professionals are unable to train in order to provide good quality services, and patients are unable to receive these services, then this is a violation of human rights.

Some of the issues participants discussed had not previously been thought of as human rights issues. For example, in the session on human rights at the facility, participants discussed the question of accountability. If you fired the nurse because a woman died, was that accountability? These sessions involved role-play: participants had to enact situations – two ideal, and two not – involving a pregnant woman and a midwife (in one group, participants switched genders, with a man acting the part of the pregnant woman).

EmOC Training A good deal of interest was generated in the draft EmOC curriculum circulated at Bangkok, which is intended for team training of obstetricians, anesthetists, and midwives. JHPIEGO's Maternal and Neonatal Health Program prepared the training package, based on preliminary drafts by Dr. Sadiqua Jaffrey, Ms. Imtiaz Kamal and Prof. Tipu Sultan. Dr. Gill facilitated the process. Participants discussed how they might use this in their countries.

Facility Management Three sessions were conducted on facility management. Participants addressed the question of how to transform inputs (equipment, renovation, supplies, training, etc.) into services. Many hospital directors, nursing heads, and medical officers have not been trained in management. Session leader Dileep Mavalankar, Professor at the Indian Institute of Management, noted that several teams were planning management improvement workshops through their projects. The sessions were well attended.

Quality Improvement Two sessions were held on this subject, introducing participants to some of the contents and processes in the manual produced jointly by EngenderHealth and AMDD, *Emergency Obstetric Care: Leadership Manual for improving the Quality of Services* and the companion *Toolbook for Improving the Quality of Services*. Participants also had an opportunity to engage in an exercise on "readiness" for an emergency.

Audit There was great demand for the two sessions on medical audits evidenced by the fact that participants drew their own lines on the sign-up sheet after existing lines had been filled in. After a brief presentation, participants had the opportunity to work in small groups with facilitators on specific topics for audit. Session leader Judith Fortney of Family Health International and the other facilitators urged participants to "pick small things to audit", and not to try to audit deaths since those require a more comprehensive review. Participants were introduced to the draft AMDD *Audit Chartbook* (Judith Fortney, Coordinator; Patricia Bailey, Elizabeth Goodburn, Barbara Kwast, Bridget Moneypenny, contributors).

Documentation and Communication Seven sessions were held on this topic by AMDD consultants Nadia Hijab and Czikus Carriere. After a short PowerPoint presentation, participants selected one of three possible objectives – replicating their project, sharing lessons learned, or influencing policy. They discussed why they had selected that objective, thereby clarifying their aims. They then listed the kind of documentation they would need to achieve this objective, and

whether this documentation was already being done as part of their day-to-day work or whether they needed to do additional documentation. Participants went on to identify the most appropriate audience given their stated objective, and the best media to use to communicate to that audience. Creating a clear definition of the objective was often the most challenging part of the sessions, and there was a lot of iteration between the objective, the kind of documentation necessary, and the intended audience.

Supplies and Equipment Two sessions were held to discuss a common problem affecting project implementation – difficulties in procuring supplies and equipment in a timely manner. In some cases, service providers would be trained on specific procedures, but the equipment would only arrive months afterwards. As a result the skills imparted would have been forgotten. With session leader Lucille Pilling de Lucena participants worked on case studies from AMDD projects to devise ways to deal with the frustrations of procurement and logistics management.

Facility Renovation These two sessions were also interactive, and aimed to impart a broader understanding of the term renovation, involving not just paint and plaster, but appropriate layout of rooms, traffic flow, and suitable surface finishes, among other considerations. Session leaders architect David Potter (Architectural Projects Office Nepal) and Edith Abreu (AMDD Business Manager) invited participants to critique and discuss a layout of an EmOC facility that was considering renovations. Then, the same layout was presented with minor structural changes, demonstrating effective use of space and ways of improving services.

Infection Prevention The two sessions were used to introduce participants to the EngenderHealth Infection Prevention handbook, CD-ROM and supplement on Infection Prevention Practices in Emergency Obstetric Care, inviting them to identify gaps between existing and recommended practices.

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As part of the drive to facilitate implementation, project teams were able to meet and discuss issues together with their AMDD project monitor. In addition, representatives of women's groups and recipients of AMDD Leadership Grants also had scheduled meetings. In all, 22 such meetings were held over breakfast and lunch.

Moreover, as in Marrakech, teams had the opportunity to present their progress in poster sessions, and 27 poster presentations were mounted. These provided opportunities for lively discussions and exchanges of experience. AMDD partners presenting their work included teams from: Bangladesh, Bhutan, Ethiopia, Mali, Morocco, Mozambique, Nepal, Nicaragua, Pakistan, Peru, the Reproductive Health for Refugees Consortium (RHR), the Regional Prevention of Maternal Mortality Network (RPMM), Rwanda, Sri Lanka, Tajikistan, Tanzania, UNICEF/India, UNFPA/India, UNFPA West Africa, Vietnam, and the Women's Group. Poster presentations were also made by the recipients of Leadership Grants: Asha Kiran Hospital, Pakistan; Comprehensive Rural Health Project, India; Emmanuel Hospital, India; Hopital EPC de Metet, Cameroun; Kurni Christian Hospital, Pakistan; Shimantik, Bangladesh; and Solu Hospital, Nepal.

3. Key Policy Issues and Emerging Areas: Plenaries and Panels

"Pregnancy and health are fundamental human rights and under present realities women will keep on dying unless we apply practical and realistic alternative strategies and solutions".

Prof. Tipu Sultan
Dean, Faculty of Anaesthesiology

Two plenary sessions tackled key policy issues relating to EmOC: the question of "who can do what" in providing services, and scaling up. Two panel sessions addressed the emerging international commitment to treat fistula, and to provide EmOC services for refugees.

EmOC Services: Who Can Do What Four panelists discussed the thorny question of having medical procedures performed by trained staff other than obstetricians and anesthetists at the plenary chaired by Dr. Rosenfield.

The Minister of Health of Mozambique Dr. Francisco Songane, an obstetrician-gynecologist, reviewed the country's successful experience in using assistant medical officers as surgical technicians to address the shortage of surgeons and obstetricians in the country. Mozambique has been able to field 41 surgical technicians since 1984, as contrasted to 17 obstetricians since 1975. A comparative study of Cesarean sections conducted by surgical technicians and by obstetricians indicated that the complications after major obstetric surgery were similar for both groups.

Dr. Tipu Sultan, Dean of the Faculty of Anaesthesiology at the College of Physicians and Surgeons, Pakistan, discussed delegation of anesthesia services for EmOC to trained doctors, midwives, and nurses, putting forward a strong rationale: "Specialist anesthesia training takes 2 – 4 years; most low resource countries do not have enough anesthetists; safe anesthesia for EmOC can be provided by non specialist anesthetists". In Pakistan, for example, there was one qualified anesthetist for every 160,000 people.

The human rights dimension of failing to make EmOC available was addressed by Lynn Freedman, who declared, "We must shift our vision from the clinical perspective which asks, 'What is the best possible range of skills I can assemble for this person to be sure she survives' to a focus on the reality of the health care system which will serve the entire population – those who are in the hospital and those who are not".

Angela Kamara, Director of the Regional Prevention of Maternal Mortality (RPMM) Network discussed the role of the midwife in treating post-partum hemorrhage, obstructed labor, sepsis, eclampsia, and abortion. She talked about the debate and controversy over who does what, and the "territory guarding" of the medical profession against midwife inclusion. Yet when emergency situations occur in Africa, MDs are rarely present, particularly in rural settings. The debate specifically focuses on manual removal of the placenta and vacuum extraction. Doctors overlook the fact that it is usually the midwives who train them to do such procedures when they are interns. As she put it, the issue was simple: "A midwife can perform the skills she has been trained to do".

Scaling Up Dr. Adetokunbo Lucas, a long-time supporter of action to avert maternal death, member of the Strategic Advisory Council of the Bill and Melinda Gates Children's

Vaccine Program, and Senior Advisor to AMDD, chaired the plenary on country experiences in scaling up.

Dr. Georges Georgi, UNFPA representative in Mozambique, reviewed efforts to provide obstetric care in Zambezia province in 1995, and the AMDD-supported project launched in Sofala province in 2000. The strength of national commitment can be seen in the fact that the national maternal mortality strategy will focus on EmOC, and the extensive field research underway. Plans to expand coverage to 3 more provinces will involve collaboration with UNICEF, DFID and other donors.

Dr. Edmund Browne, RPMM Programme Coordinator, discussed the ripple effects of RPMM, which moved from teams in three West African countries to 20 in sub-Saharan African countries. RPMM is also spreading within countries. In Guinea, for example, the initiative had moved from one district to five, with plans for an additional five. Lessons for consolidation and sustainability include the "need for a core of committed and dedicated individuals and experts to keep the PMM flame burning in-country", continuous monitoring, without which "interventions decline in quality and effect over time", and maintaining focus. In short, "Think big, start small, act now to grow!"

Susan Otchere of Save the Children listed the components needed for replication: "Good evaluation and documentation of impact; assessment of costs/resources required to put quality EmOC in place; dissemination in policy- and program direction-setting bodies and sharing experiences". She noted that initial program activities had focused at the community, and now there was a real demand for improved services: "Our experience with field colleagues and AMDD suggest we should work on quality [of care] and not only demand – we are well placed to explore and ensure the linkages between the community and the facility".

Agatha Pratt, Chief of the UNICEF/Nepal Health Section noted that scaling up in country required attention to technology (including reporting systems and audits), management, and rights. Scaling across countries needs investment in partnerships and exchange of knowledge and experience.

Displaced Persons and EmOC Susan Purdin, who is with Columbia University and serves as technical advisor to the RHR Consortium on Monitoring and Evaluation, moderated the six-person RHR panel, which covered the heart-breaking problems and difficulties of access to EmOC in conflict situations. Sandra Krause, Director of RHR's Reproductive Health Program, provided an overview of where refugees and displaced persons are today, the RHR focus, and the Minimum Initial Services Package that had been put together to support work in the field, which included a focus on maternal death and disability.

Henia Dakkak, Emergency Obstetric Technical Advisor, discussed the lack of coordination and cooperation amongst major players, especially as regards EmOC, and the non-integration of reproductive health in service provision in conflict areas. In addition, she reviewed issues related to security, staffing, infrastructure, and barriers to access.

"I was alone. I had no family and I am female…I had to live at the back of the camp where it was dangerous and far away from the clinics and distribution. No one spoke up for me"

Quote from IRC refugee staff

More views from the field were provided by Yvonne Harding of the Marie Stopes Society in Sierra Leone, Dr. Cynthia Maung from the Me Tao Clinic at the Thai-Burma border, and Mary Odhiambo from the American Refugee Committee in Liberia. Susan Rae Ross then spoke

about CARE's experience in this field, and highlighted some similarities and differences between relief and development work.

The Challenge of Vesico-Vaginal Fistula Repair A special panel was dedicated to the issue of obstetric fistula, an abnormal passage between the vagina and the bladder or rectum, usually caused by prolonged, untreated, obstructed labor. The panel was chaired by France Donnay, acting chief of the Reproductive Health Branch in UNFPA's Technical Support Division. Ruth Kennedy, Liaison Coordinator at the Addis Ababa Fistula Hospital, spoke about the expanding service and training programs at the hospital. Dr. Festus Ilako, Specialist Outreach Programme Manager with the African Medical Research Foundation, described the technical assistance provided for rural hospitals in several African countries. AMDD is working with all three agencies on programs for fistula repair.

4. AMDD: A Growing Global Movement

In addition to AMDD's existing project and technical partners, representatives of a diverse range of institutions and organizations participated in the Workshop, evidence of the growing global movement to avert maternal death and disability through EmOC. They included governments, development organizations, universities, hospitals, and non-governmental organizations. A selected list of governments and organizations participating in the Workshop is attached as Annex 1.

Partners discussed ways to expand the EmOC agenda into the future. Points included:

- Looking forward from where we are now (implementation) towards what we want in the future (policy change and the diffusion of innovation).
- Using this alliance as a political lobby and supporting strategic action, particularly since one of the UN millennium decade goals is the reduction of maternal mortality.
- Expanding the use of the process indicators to measure progress in availability, use and quality of EmOC services.
- Looking at the experience of other organizations in forging and maintaining an alliance, e.g. by addressing issues of representation, even distribution of credit for success, and setting some common goals.
- Strengthening joint action and speaking with one voice.

A final point was made: the sustainability of programs to avert maternal death and disability must be ensured. Otherwise, "we will not change the field".

Annex 1

Selected List of Governments & Organizations
Represented at Bangkok Workshop

Representatives of Government Ministries and Departments of Health

Afghanistan, Bangladesh, Cameroon, Ethiopia, India, Mali, Morocco, Mozambique, Nepal, Nicaragua, Niger, Pakistan, Rwanda, Sri Lanka, Tanzania, Zimbabwe

Directors or Staff of Hospitals

Bangladesh, Bhutan, Ethiopia, India, Mali, Nepal, Pakistan, Peru, Tchad

Development Organizations, Foundations

The Bill and Melinda Gates Foundation, CARE, DFID, EngenderHealth, Family Health International, Hesperian Foundation, John Snow International, Regional Prevention of Maternal Mortality Network, Reproductive Health for Refugees (RHR) Consortium, PATH, Save the Children, UNFPA, UNICEF

Universities, Medical Colleges

Aga Khan University, Afghanistan; College of Physicians and Surgeons, Pakistan; Dhaka Medical College Hospital, Bangladesh; Dow Medical College, Pakistan; Hue University, Vietnam; John Hopkins University; London School of Hygiene and Tropical Medicine; N.R.S. Medical College, Bangladesh; FR des Sciences Medicales de Cocody, Ivory Coast; University of Aberdeen, Initiative for Maternal Mortality Programme Assessment, U.K.; Columbia University, U.S

Professional Associations, Institutes, NGOs

African Medical and Research Foundation, Kenya; Asha Kiran Hospital Association, India; Centre for Women's Health & Information (CEWHIN), Nigeria; Centro de la Mujer Peruana Flora Tristan, Peru; Emmanuel Hospital Association, India; FIGO (International Federation of Gynecology and Obstetrics); FOGSI, India; Indian Institute of Management; Jamkhed Maharashtra, India; Kunri Christian Hospital, Pakistan; Likhaan, the Philippines; National Committee on Maternal Health, Pakistan; Nepal Society of Obstetrics and Gynecology; NGO Networks for Health; Presbyterian Hospital, Cameroon; Shimantik Urban Primary Health Care Project, Bangladesh; SENDAS, Ecuador; Shirkat Gah, Pakistan; Obstetrics and Gynecology Society of Bangladesh

Annex 2

AMDD Tools & Resources Distributed at Bangkok

Documentation and Communication PowerPoint presentation created by Czikus Carriere and Nadia Hijab. Available in English, French, and Spanish.

Infection Prevention handbook and CD-ROM produced by EngenderHealth; and the supplement on Infection Prevention Practices in Emergency Obstetric Care (draft) produced jointly by EngenderHealth and AMDD.

UNFPA and AMDD, *Reducing Maternal Deaths: Selecting Priorities, Tracking Progress,* Distance Learning Courses on Population Issues, Turin, UN System Staff College, 2002.

Materials Shared in Draft

(Almost) Everything You Want to Know about Using the UN Process Indicators of Emergency Obstetric Services: Questions and Answers, Anne Paxton, Senior Program Officer, Monitoring & Evaluation, AMDD; Deborah Maine, Program Director, AMDD; Nadia Hijab, Consultant; 2002.

Audit Chartbook, Judith Fortney, Coordinator; Patricia Bailey, Elizabeth Goodburn, Barbara Kwast, Bridget Moneypenny, contributors.

Emergency Obstetric Care: Leadership Manual for improving the Quality of Services and the companion *Toolbook for Improving the Quality of Services*, produced jointly by AMDD and EngenderHealth.

EmOC Curriculum, prepared JHPIEGO's Maternal and Neonatal Health Program prepared the training package based on preliminary drafts by Dr. Sadiqua Jaffrey, Ms. Imtiaz Kamal and Prof. Tipu Sultan. Dr. Gill facilitated the process.

AMDD Program Orientation: A Tool for Self-Learning, PowerPoint presentation created by Nadia Hijab and Czikus Carriere (English available in Bangkok, French and Spanish translations commissioned).

For copies of the above materials please contact amdd@columbia.edu
Copies of presentations made at the plenaries and panels are available on the AMDD website
http://www.amdd.hs.columbia.edu/

Appendix 10.

The AMDD Notebook

Appendix 11.

IJGO Bound Articles

Appendix 12.

The AMDD Brochure

Appendix 13.

AMDD Project Snapshots