

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](mailto: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 Money Penny, 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 Money Penny, 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](mailto:amdd@columbia.edu)  
Copies of presentations made at the plenaries and panels are available on the AMDD website <http://www.amdd.hs.columbia.edu/>