

# AMDD

## NOTEBOOK

Meeting Challenges, Making Changes, Saving Lives

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### DEAR COLLEAGUES

Early in my career, in the late 1960s in Thailand, when I was working with the Ministry of Public Health and Family Planning, the prescription of oral contraceptives was restricted to physicians. We conducted a study on using midwives to distribute contraceptives, based on a checklist. The findings revolutionized family planning in Thailand – the number of sites where women could get pills soared to 3,500 – and beyond, since the checklist was used in other countries.

As this issue of AMDD Notebook reports, there are experiences from many parts of the world of non-physicians doing a variety of procedures. If we're really interested in providing 24-hour coverage 7 days a week to save women's lives, we've got to look at creative ways of delivering such care.

There is little rationale to limiting the provision of anesthesia to physicians or the performance of Caesarean sections to obstetricians. Any person who can perform an appendectomy or repair a hernia can easily be trained to do C-sections.

The key element is well supervised and carefully prepared training programs. Such programs should especially focus on practical experience in the technique one wishes to impart.

Sadly, there is still unwillingness to look at the best way to deliver services in resource-poor settings. The resistance is fed by a belief that only physicians can provide such services, or that anything else is "second-rate" medicine and "we don't want to offer our people second-rate medicine".

Yet, the hard facts show that quality care can be provided. In many settings, there are no laws relating to delegating these types of service; it's more a question of medical practice. It is well within the purview of ministries of health in many countries to take the policy decisions necessary to delegate in order to broaden the emergency obstetric care skills base.

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## THE AMDD PROGRAM

The AMDD Program was launched in 1999 at Columbia University's Heilbrunn Center for Population and Family Health, Mailman School of Public Health, to work with developing countries on improving the availability, quality and utilization of EmOC.

The basic premise of the AMDD program is that most of the obstetric complications that lead to maternal death can neither be predicted nor prevented, but the vast majority of women can be saved through prompt treatment. AMDD addresses three inter-connected areas: technical expertise, good management, and respect for human rights.

AMDD has established partnerships with organizations that already have field operations. These partners are now implementing AMDD-supported projects in close to 50 countries, including:

United Nations Children's Fund (UNICEF): projects in Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka.

United Nations Population Fund (UNFPA): projects in India, Morocco, Mozambique, and Nicaragua.

Regional Prevention of Maternal Mortality (RPMM) Network: teams and projects in 19 sub-Saharan African countries.

CARE: projects in Ethiopia, Rwanda, Tanzania, Peru, and Tajikistan.

Save the Children: projects in Mali and Vietnam.

Reproductive Health for Refugees (RHR) Consortium: projects in 12 countries.

Among the key Program tools are the process indicators developed at Columbia University and issued by UNICEF, the World Health Organization (WHO), and UNFPA.

AMDD technical partners include:  
Family Health International  
John Snow International  
Indian Institute of Management at Ahmedabad  
JHPIEGO  
EngenderHealth (formerly AVSC International)

*The AMDD Program is funded by the Bill and Melinda Gates Foundation*

## GOOD PRACTICES

### Decontamination: Getting the Timing Right

Most hospitals boil or autoclave reusable instruments, such as artery forceps, needle holders, catheters, and gloves. Used instruments have to be washed thoroughly to remove any blood or other patient tissue before they are sent for autoclaving. It is now recommended that these instruments be chemically decontaminated before they are washed to prevent inadvertent infection of staff during cleaning. This is especially important given the increasing incidence of HIV and other blood-borne infections such as hepatitis B. Because this recommendation is relatively new, not many hospitals have set up systems to decontaminate instruments.

Dipping instruments in a 0.5% (half percent) chlorine solution for 10 minutes kills most viruses and many bacteria. However, most hospitals that have developed a system of decontamination do not time the process. If the instruments remain longer in the chlorine solution than necessary, they are likely to be damaged. This is especially true for rubber items. On the other hand, if they remain in the solution for less than 10 minutes then the process is not fully effective.

The labor room in **Ngudu Hospital in Tanzania**, which is assisted by CARE and AMDD, has developed a good system of decontamination. As in other hospitals that have started decontamination, the labor room has two covered buckets partly filled with chlorine solution ready for dipping instruments after use. What is innovative is that the hospital has provided a small timer, which is commonly used in laboratories. So when the nurse or the doctor puts the used instruments in the chlorine bucket, they set the timer to ring after 10 minutes. At that point, the instruments are removed and then washed.

Dr. Sutani Rugowe and his team in Ngudu Hospital have creatively shown how the decontamination process can be perfected using an inexpensive laboratory timer that costs around five dollars. This small investment effectively helps protect hospital staff from accidentally contracting dangerous infections. I highly recommend replication of this innovation: it is the right of staff to be protected in the best possible manner.

Timers should also be used when instruments are boiled or autoclaved as time is an important control parameter. If the boiling or autoclaving is less than the required time, the sterilization process may not be complete and patients could be put at risk of infection. If the process is too long, this wastes expensive fuel. We can learn a lot from this innovation in a remote hospital in Tanzania.

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### Patient Privacy: Key to Dignity

The concept of human dignity underpins human rights: every person, simply by virtue of being human, is entitled to be treated with dignity. On more utilitarian grounds, establishing an environment where patients are treated with dignity and respect may enhance a facility's use by the community.

Privacy is a dimension of care often mentioned by medical practitioners in discussions about patient's rights. As Dr. Luis Vega-Centeno, Coordinator of the CARE FEMME project supported by AMDD in **Peru**, put it, "For me, human rights are three things: privacy; the right to know what the diagnosis is; and the right to see his/her medical history."

Obst. Lidia Alvarez Enrique often acts as officer in charge of the Tambo Health Center, located in the province of La Mar in the central highlands of Peru. As she saw it: "Patients have the right to privacy; the right to be respected as women, and the right to be well treated by staff – to demand good treatment and be satisfied." She gave the example of a young woman

who had suffered complications after delivery, and who was in both physical and psychological distress. Even though the woman was poor, the center had assigned her a separate area in which to recover.

Indeed, patient privacy is one area where simple and inexpensive ways to promote the dignity of patients. In Joypurhat Hospital in **Bangladesh**, Civil Surgeon Dr. Anwar Ali has placed screens to give women privacy in the labor room, which has been set up close to the Operation Theater just in case of complications. He plans to extend the labor room and to change the entrance to provide for more privacy from the common hall. The hospital has also added separate toilets for female patients.

In Ngudu hospital in **Tanzania**, venetian blinds were placed on the windows in the labor room in order to offer patient privacy while at the same time allowing for light and ventilation. Placing a window above eye level can achieve the same goal, offering women a private place to give birth and incorporating dignity and respect into overall design of the facility.

## Q & A MONITORING OBSTETRIC SERVICES

By Anne Paxton

*This column addresses questions arising in using the UN Process Indicators to monitor progress in the provision of crucial obstetric services.<sup>1</sup> Anne Paxton is an epidemiologist who has worked in Asia and Africa. She is a Senior Program Officer for Monitoring and Evaluation at AMDD.*

**Q:** Which registers should be used to gather the data on births, maternal deaths, C-sections and obstetric complications?

**A:** To calculate the UN Process Indicators, data need to be collected routinely in facilities. Virtually all health facilities record some kind of routine data in the form of registers and patient records. The quality of these data varies greatly, as do the types and numbers of registers and records used. The facility data required to formulate the UN Process Indicators include number of:

- Deliveries,
- Complicated cases,
- C-sections, and
- Maternal deaths.<sup>2</sup>

Data on deliveries, C-sections and maternal deaths are commonly collected by health facilities, although not always in the same register. Data on births are easily found on an admissions register, a labor and delivery register, or a maternity ward register. The operating theater register is usually the most complete record of data on C-sections. Data on maternal deaths may be found on a discharge register unless there is a separate register for all deaths in the facility.

Gathering data on complications is less straightforward. Facility registers, even those in the maternity wards, generally do not have a place to record obstetric

complications, in which case a column for this information must be added. Hospital and project managers should resist the urge to create a new, separate register devoted to obstetric complications or other data for the UN indicators. It is more useful to the facility to improve and revitalize existing registers than to create more administrative work for busy clinicians. Women with complications may be treated in the labor or maternity ward (for example, women with prolonged labor) while women with postpartum sepsis may be seen and treated in a gynecology or female ward. Data on complications from abortions or ectopic pregnancies may also be found in a female ward.

Facility staff should do an analysis of the flow of women through a facility and where and how data on them are recorded, especially on obstetric complications and maternal deaths, before choosing which registers to use for collecting data for the Process Indicators. Patient records such as the "bed head ticket" or patient file can be useful in validating the data on the registers, and checking for completeness and accuracy. However, these patient records are too cumbersome to be used for routine data recording, and should not be used as a substitute for patient registers. Registers that are found to be the most complete and accurate on the key variables should be used preferentially over other registers that might also contain some of this information.

1. The UN Process Indicators are set out in the *Guidelines for Monitoring the Availability and Use of Obstetric Services* developed in 1997 by Columbia University and UNICEF, and issued by UNICEF, WHO, and UNFPA.

2. Data on the key obstetric interventions practiced in an EmOC facility, called "signal functions," are also used in the UN Process Indicators, but these data will be discussed separately in a future column.

# Broadening the Emergency Obstetric Skills Base

*AMDD Documentation Consultant Nadia Hijab reviews efforts to broaden the EmOC skills base and delegate responsibility, drawing on additional research by AMDD Program Coordinator Katrina Stamas.*

In many developing countries, the number of obstetricians is too small to deal with the obstetric complications that arise, and most obstetricians are based in major cities. Anesthetists are another group of medical professionals in very short supply. The problem is exacerbated by restrictions in some countries of the performance of life-saving procedures to certain specializations – even procedures that can be effectively performed by non-specialists. The challenge is to balance needs, abilities, safety and professionalism in order to provide emergency obstetric care (EmOC).

The debate is not restricted to developing countries. In November 2001, the Bush administration rejected a Clinton administration proposal to let nurse-anesthetists work unsupervised in hospitals. The 8 January 2002 edition of *The New York Times* ran “for” and “against” pieces by opposing professional groups.

Deborah Chambers, President of the American Association of Nurse Anesthetists, argued for, citing, among other things: nurse-anesthetist malpractice insurance premiums had decreased 50% over the past decade; and in “two-thirds of the nation’s rural hospitals nurse anesthetists are the sole providers of anesthesia. There’s a shortage of physicians who want to work in these hospitals”. Dr. James Cottrell, President of the American Society of Anesthesiologists argued against: “When you are on that table in the operating room, you want the best trained person available – and you deserve it”.

Richard Lilford, Chairman of the Institute of Epidemiology and Health Services Research, argued in 1993 that changing the organization of maternity services made “economic sense for Britain”, which had about 35,000 midwives and 910 obstetricians.<sup>1</sup> Midwives should be allowed to care for women before, during and after labor, unless complications arose requiring an obstetrician. Midwives could spot problems “as effectively as doctors”: the “tort system is a powerful incentive to refer when appropriate, and clinical audit should not only maintain but enhance current standards. These measures, rather than tribal insistence that doctors have the monopoly on vigilance, will enhance standards”.

## Nurse Anesthetists in Asia and Africa

In many countries, there may be no qualified anesthetists at district hospitals. In India, medical officers or surgeons administer anesthesia, as do nurses in countries such as Bhutan, Ethiopia, Indonesia, Malaysia, Malawi, Morocco, Nepal, Tanzania and Zambia.

In November 2001, participants at a workshop convened in Bangladesh by the UNICEF Regional Office for South Asia (ROSA) and AMDD (see related article page 6), achieved consensus regarding the training of nurses as anesthetists. They agreed that administration of Ketamine anesthesia without muscle relaxants, spinal and local anesthesia could be delegated and that doctors and nurse/midwives could learn the skills for these functions in a six-month period.

At an earlier UNICEF ROSA regional review meeting in June 2001, participants discussed ways in which necessity imposed delegation. Dr. G. P. Dhakal of **Bhutan** reported that nurses were trained as anesthetists in response to the acute shortage of doctors. The Government of Bhutan gave policy clearance and, since Bhutan had no training institutes, the Government of Pakistan agreed to train the team for a six-month period. Afterwards, the nurses were teamed with an anesthetist for a year. They are now doing an excellent job, according to Dr. Dhakal, with not a single complication due to anesthesia.

Dr. L. K. Pathak of **Nepal** reported on experiences with delegating care to the appropriate level where it could be safely provided, such as training nurses in basic EmOC. When doctors resisted, he had retorted,



*Buzi Hospital Director Silva Chirondo is a surgical technician.*

Photo by CZIKUS CARRIERE

1. British Medical Journal, Vol. 307, 7 August 1993, pp. 339-40.

2. F. Vaz, S. Bergström, M. da L. Vaz, J. Langa and A. Bugalho, “Training medical assistants for surgery” in Bulletin of the World Health Organization, 1999, 77 (8).

3. See S. M. White, R. G. Thorpe, and D. Maine in *The Lancet*, September 12, 1987, pp. 612-3.

“If the doctors can give assurance that they will go to remote areas, then I will stop the process of training nurses. Post-abortion complications are a big problem in the hospitals too and nurses were trained to care for these cases also. There are only 52 anesthetists in Nepal – can we wait until anesthetists qualify to serve remote areas? Again we trained staff nurses and have developed a curriculum for them.”

In **Ethiopia**, CARE, with support from AMDD, is collaborating with the Ministry of Health on a three-year EmOC project targeting three hospitals in the Oromia region, where the maternal mortality ratio is estimated to be 871 per 100,000 live births, and where a Needs Assessment highlighted the insufficient number of trained health personnel. The project staff decided to address this gap through a team training approach to ensure, at the minimum, a team of an obstetric surgeon, anesthetist, and instrument nurse in each. During the three-months training, completed in July 2001, nurses became skilled in “usage of simple and safe anesthesia” for both routine and emergency operations. The trainees made a commitment to remain at their posts for two years; they had been selected for their “mature personality”, kindness, honesty and good judgment.

## Surgical Technicians in Africa

In **Mozambique**, the Government established a professional category of *tecnicos de cirurgia* (surgical technicians), mid-level health workers trained to perform surgical procedures to deal with both obstetric emergencies and war-related casualties in rural areas where some 70% of the 17 million people still live. The first *tecnicos* were trained in 1984, and overall around 40 have taken the three-year course. An assessment conducted in 1995 of 10,258 surgical interventions conducted by 14 *tecnicos* showed that “low rates of complication occurred and postoperative mortality amounted to 0.4% and 0.1% in emergency and elective interventions respectively”.<sup>2</sup>

In spite of the success of this experience, there have been problems in finding interested recruits and a course planned for 2001 had to be postponed. The preconditions are demanding: the technicians must have mid-level medical training as well as some years of practice. At a national meeting in June 2001, the Ministry of Health announced its decision to reduce preconditions to attract recruits, and to consider broadening the pool of recruits beyond medical technicians (themselves in short supply) to include MCH nurses.

There have been other experiences in training mid-level professionals to perform surgery, for example nurses in rural Zaire.<sup>3</sup> The founder of a hospital in Karawa trained the first nurse-surgeon in the 1950s. Of 321 C-sections performed at Karawa over an 18-month period in 1985-86, 278 were by nurse-surgeons. There were two deaths, a fatality rate of 1%. ■

## Surgical Technician in Operation

Buzi is a well-managed rural hospital in Sofala Province in Mozambique, serving a dispersed population of 150,000. Hospital Director Silva Chirondo is also the surgical technician, his first posting after graduation in 1996. When he arrived, the operation theater had been closed for three years, even though the equipment was in place, because the last doctor had left. “I reopened the theater and started work”, Chirondo recalled. Now the Central Hospital in Beira sees only three referrals a year from Buzi because most can be managed there.

The hospital handles some 30 deliveries a month, with three maternal deaths occurring on average in a year, “By the time they get here they are in shock and we can’t save them. We used to have radios in all the health centers, but they have broken down due to lack of maintenance. We could save many lives if the centers were able to radio in an emergency, and we could send the ambulance”.

Together with other members of his team, Chirondo participated in EmOC training organized at Beira Hospital by UNFPA, with the support of AMDD. This has increased the nurses’ confidence – they no longer call on him as often as they used to. He is a big advocate of his profession: “I’m trying to motivate the nurse to take up this course. Whenever we conduct a C-section, we invite her to assist”.

He adds, “I always liked surgeries. I used to work as a medical assistant. Once, during the war period, I had to treat a pregnant woman with complications. I radioed the hospital but no one could come to fetch her, and both she and the baby died. I realized that if I knew how to operate I could have saved both of them. It was then I decided to take the course”.

Is he happy in Buzi? “I ended up being happy. The work is very satisfying, especially with pregnant women. We had unbelievable maternal mortality statistics, so I was not sure we were going to save lives. But we see our patients get up and walk.”

## South Asian Experts Develop EmOC Curriculum

In November 2001, participants in a workshop convened by the UNICEF Regional Office for South Asia (ROSA) and AMDD in Dhaka, Bangladesh, reviewed and revised a draft curriculum on EmOC for doctors, nurses, and midwives, so as to address gaps in national training. The 40 participants also agreed on steps to develop a curriculum for anesthesia functions.

JHPIEGO's Maternal and Neonatal Health Program prepared the draft package based on preliminary material by Dr. Sadiqua Jaffrey, Ms. Imtiaz Kamal and Prof. Tipu Sultan, which were developed at the request of AMDD Senior Technical Officer Dr. Zafarullah Gill.

The workshop was declared "midwife friendly" and the enthusiasm about this aspect was palpable. Imtiaz Kamal of Pakistan declared, "I am glad I lived to see this day when obstetricians and midwives sat around the same table and discussed and agreed upon their respective roles in saving mother's lives ... I felt it was a revolutionary meeting".

The meeting began with presentations about EmOC priorities, challenges and training resources in the different countries. Ms. Dale Davis of UNICEF ROSA noted the coming together of technology, management and human rights in "a whole systems approach to transform emergency obstetric care into a dynamic effort to save women's lives". Dr. Harshad Sanghvi presented the draft, and covered the principles of adult learning as well as the strengths and limitations of competency-based training. He emphasized that learning must be "innovative, exciting and fun". Participants agreed that the "sage on the stage" had to become the "guide on the side".

Summarizing workshop outcomes, Dr. Yasmin Ali Haque of UNICEF Bangladesh noted that participants had "dedicated more than 900 person hours to examining the issue of competency based training for saving women's lives" and "generated immense energy". The first training program is scheduled for mid-2002. A team from each of six Asian countries will undergo a 20-day program, and then receive the materials to continue EmOC instruction back home. The full syllabus involves five weeks of group-based course work, three months of self-directed clinical practice, and two weeks of on-site supervision. The training will be extended to other countries.

## West Africa: EmOC Needs Assessments Attract Support

The Governments of five West African countries – Cameroon, Ivory Coast, Mauritania, Niger and Senegal – have conducted nationwide needs assessments on the availability and use of EmOC services, with the support of UNFPA and AMDD. The assessments, which use the UN Process Indicators as the basis for data collection, identified the sites most in need of expansion of obstetric services, and enabled the design of program proposals for discussion with governments and donors.

The initiative has already attracted support: funding has been mobilized in three of the countries, with good prospects of funds being secured for the other two. Given success to date, the exercise will be replicated in The Gambia, Gabon and Guinea Bissau.

In October 2000, a methodology workshop in Dakar for maternal health programmers in both government and UNFPA launched the assessments. The decision to hold the workshop was a lesson learned from the experience of needs assessments previously conducted in Morocco and Malawi. In addition, before the assessments began in each country, teams reached consensus on definitions for obstetric complications, and defined and tested data collection strategies.

Both public and private health facilities were included in the study, and national teams coordinated activities at the local, regional and national levels. Investigators used trained paramedical personnel to collect data. UNFPA, AMDD, and three independent consultants provided technical assistance. A second sub-regional workshop was held to present the data and discuss plans to address some of the problems identified.

The assessments showed that, while coverage of comprehensive services was satisfactory at the referral level, the number of basic EmOC facilities was insufficient in all countries. The use of both comprehensive and basic EmOC services was far too low. The rate of C-sections was often below the minimum threshold of 5% of all births in the population, as recommended by the UN process indicators, even in urban areas. Interventions are being designed to address these findings.

## New Partners

The AMDD Program continues to forge new partnerships in the endeavor to avert maternal death and disability. Recent partnerships include: IPAS, Inc. to increase post-abortion care service delivery points in Ayacucho, Peru, in conjunction with the ongoing CARE FEMME project supported by AMDD; and The Hesperian Foundation to support the revision of its 1995 publication *A Book for Midwives*. Among other improvements the new edition will include all basic EmOC functions. AMDD has also established a technical partnership with John Snow, Incorporated/USA to provide technical assistance for the overall AMDD Program and projects in developing countries.

## The 2nd D in AMDD

### Dealing with Disability, Repairing Fistula

By AMDD Program Coordinator Katrina Stamas

A collaborative international partnership to take action on fistula has been forged by the United Nations Population Fund (UNFPA), the International Federation of Gynecology and Obstetrics (FIGO), and AMDD. Fistula is an abnormal passage between two cavities – vagina/bladder, vagina/rectum – which leads to leakage between them. Improving EmOC services will greatly help to prevent this pregnancy-related disability, yet skill in fistula repair is necessary for cases that do occur, as well as to treat the thousands of women already suffering from this terrible condition.

Although fistula repair is relatively simple, the cost of some \$400 on average is prohibitive for most poor women, and services are usually not available in rural areas. As a result, this pregnancy-related disability has devastating physical and social consequences, including isolation and banishment from family and community.

The overarching objectives of the multi-agency initiative, according to Dr. France Donnay of UNFPA, are to improve access to quality care for afflicted women and to facilitate the social integration of women who have received treatment as well as those who remain affected.

Among the first activities, direct support will be provided to two existing centers for fistula repair, the Family Life Center in Nigeria and the Addis Ababa Fistula Hospital. Planned activities include funding for renovation, expansion of sites, and staff training. The facilities

will collaborate with local health delivery systems on user fees and raise funds from African and international donors to offer free or subsidized fistula repairs.

AMDD has already made a grant to the Addis Ababa Fistula Hospital for 2001 as part of this effort. In Ethiopia, where 3 out of every 1,000 pregnant women are estimated to develop fistula, the Hospital staff operate on about 1,200 women yearly. The grant will help the Hospital to extend services by setting up four part-time satellite facilities, each covering an under-served area in the north, east, central and south-west Ethiopia. A mobile team from Addis Ababa will visit these sites at least once a year, and will stay for 10 days to perform repairs while training local specialists in the procedure.

The demand for training at this renowned facility is so great that 33 trainees are already booked through November 2004. Most will be from Africa, but a few are from Pakistan – and some of the doctors based in African countries are European or American. There is even a doctor from as far away as Nicaragua.

During the rainy season, when the caseload is less, the Hospital does not accept doctors for training. Rather, they make use of the time for outreach training, which is particularly rewarding because staff can be trained as teams in familiar environments. The Hospital has recently begun to train nurses in post-operative fistula care.

AMDD is also supporting fistula repair training at the Bugando Medical Centre in Tanzania through the CARE FEMME project. Hospital Director Dr. Charles R. Majinge is committed to improving quality of EmOC services in rural areas, and a team from Bugando was sent to the Addis Ababa Fistula Hospital for training.

For more information on the hospital see UNFPA's website <http://www.unfpa.org/modules/populi/issues2001/april/feature3.htm>

### “One Woman Took Seven Years to Reach Us”

Ruth Kennedy, Liaison Coordinator of the Addis Ababa Fistula Hospital tells the little-heard stories of women with fistula, who are arriving in larger numbers as word of services spreads.

“The first day, she sits alone watching the smiles of the other patients who all leak urine like she does, and experiencing the gentleness of the nurses who are not bothered by the offensiveness of the injuries. The next day she finds a friend who speaks her language, and she starts to talk and the heart pain eases. She has suffered more trauma in her short life than most of us have known in our whole life. Often, she is married young, lives under the authority of a mother in law, and has become pregnant while a young teenager. She suffers prolonged obstructed labor, resulting in a dead baby and injury to her vagina, bladder, and/or rectum, and leaking of her body waste products. Cast off by the husband and his family, she returns to her family, who do not know what to do with this sick smelly daughter. A separate room is provided outside. She is totally alone for the first time in her life.

Last year we opened another ward – a former store-room – just to house the women coming. Often, we have the women with obstetric fistulae stay in small rented rooms in the neighborhood, until we have space available for them. They eat their meals and spend the

day with us here in the hospital compound. When we have space, even half a bed, they are delighted. It is no problem to share a bed, both are wet, but the human contact is special for these outcast women.

If patients are self-referred or sent by a friend who herself has been through our hospital care system, they may arrive quite weak. This means being carried in by relatives, badly infected, dirty, smelly, with high parasite level, severe infections (sometimes septicemia), unable to walk due to either generalized weakness or severe nerve contractures.

To journey to the hospital is exceedingly difficult for most of our patients. In some areas missionaries help them, kind neighbors contribute towards the journey, or the family sells a cow, sheep or family heirloom. Some women will beg a little then travel a little way then beg again and so on until they reach here. One woman took seven years to reach us.

It costs on average \$400 to cover a three-week period with surgery at the Fistula Hospital. At the Addis Ababa Fistula hospital, we provide free treatment for all our patients without exception.”

## Leadership Grants

Two more AMDD Leadership Grants were awarded in 2001. The recipients are the Shimantik Urban Primary Health Care Project in Dhaka, Bangladesh, and the Kunri Christian Hospital in Sindh, Pakistan.

AMDD established its Leadership Grant Program, which is managed by AMDD Senior Technical Officer Dr. Zafarullah Gill, to help institutions in developing countries that already provide obstetric services but need some assistance to start or strengthen EmOC. Financial assistance of up to \$40,000 can be provided. Institutions selected can also request technical assistance from the AMDD network of specialists.

There are two main criteria for selection: a history of providing services in under-served areas with a substantial target population, and the capacity to improve access to or quality of EmOC. To date, grants have been awarded to Emmanuel Hospital Association, India; Hospital EPC De Metet, Cameroon; the Asha Kiran Hospital, Orissa, India; Solu Hospital, Phaplu, Nepal; and the Comprehensive Rural Health Project, Jamkhed, India. Application forms are posted on the AMDD website [www.amdd.hs.columbia.edu](http://www.amdd.hs.columbia.edu)

AMDD Notebook visited Shimantik's Khilgaon Comprehensive Reproductive Health Care Center in December 2001. Shimantik, an NGO, was established in 1979 in Shylet in Eastern Bangladesh by "some of those who participated in the war of liberation and thought they should do something for health, welfare, education in their country", recalled Dr. Ahmad Kabir, who heads the Advisory Board. It now has 122 staff members, and supports literacy, micro-credit, and service delivery in its rural home base.

Shimantik is unusual in providing obstetric care in low-income urban areas; many NGOs tend to work in rural areas. It has four clinics in Dhaka serving some 240,000 people; each clinic has two satellite teams for home visits. The Khilgaon clinic was opened in October 2000 and introduced 24-hour service in August 2001. Patients hear about the services as a result of the field workers' visits or are referred by other clinics.

"In August we became fully equipped for safe delivery", Project Manager Dr. Mizanur Rahman explained. Their physician, paramedic and nurse had completed their training at the Obstetrics and Gynecological Society of Bangladesh.

Dr. Syeda Bakr performed her first caesarean section at the clinic in November 2001, with a consultant on hand to support her. She is committed to staying with the clinic for three years after her training.

UNFPA covered the costs of the training and provided the necessary equipment. The AMDD grant will be used to upgrade services at the four clinics to provide comprehensive EmOC.

Photo by CZIKUS CARRIERE



The Shimantik Khilgaon team in their newly equipped operation room.

## Awards

### Barbara Kwast: Royal College Fellow



In September 2001, Barbara Kwast was made a Fellow ad eundem (for merit) of the Royal College of Obstetricians and Gynaecologists (RCOG) in London, one of only a few midwives to receive this recognition. This award is given to people who have, the certificate stated, "made a significant contribution to the advancement of the science and art of obstetrics and gynaecology".

Dr. Kwast, a citizen of the Netherlands, is Senior Adviser to the AMDD Program. She has worked in over 30 countries, with the longest assignments being in Malawi, Nigeria, and Ethiopia, where she both taught obstetrics and contributed to curriculum and institutional development in obstetrics.

Dame Lorna Muirhead, President of the Royal College of Midwives and a member of the Council of the RCOG, introduced Dr. Kwast for admission to the RCOG, and concluded by saying: "Reading about the work of Doctor Kwast in the developing world has been a humbling experience."

Dr. Kwast, who has an impressive list of publications, continues her crusade for safe motherhood as an advisor to international institutions, including UNFPA, the World Health Organization, and FIGO.

### Deborah Maine Receives Carl Shultz Award

Deborah Maine received the prestigious Carl Shultz award at the 2001 American Public Health Association (APHA) annual conference in Atlanta. Carl S. Shultz was a pediatrician and public servant who helped create and implement the Federal Family Planning Program commonly referred to as Title X. At the



first meeting of the Population Section of APHA in 1976, Dr. Shultz proposed the establishment of this award. He died soon after the idea had been accepted, and Section members decided to honor his memory by naming the award for him. The award has since been given to those making a difference in the field of reproductive health in various parts of the world. The first Carl Shultz award was given in 1977 to Christopher Tietze. Allan Rosenfield received the award in 1995, and presented this year's award to Dr. Maine, as well as to Henry P. David.

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