AMDD NOTEBOOK

Meeting Challenges, Making Changes, Saving Lives

Issue 1 June 2001

DEAR COLLEAGUES

We're happy to introduce the first issue of *Notebook*, the newsletter of the Averting Maternal Death and Disability (AMDD) Program, which was established in May 1999 thanks to a generous grant from the Bill and Melinda Gates Foundation.

AMDD supports efforts in developing countries to save pregnant women's lives by providing Emergency Obstetric Care (EmOC). *Notebook* reports on field experience, technical issues and good practices in making EmOC available to women who experience obstetric complications. It aims primarily to serve teams in AMDD-funded projects, but we hope it will be of interest to the broader health and development communities as well.

During the first year, we established partnerships with six agencies that already had field operations. We were convinced that, by so doing, we would achieve results more quickly, broaden the community of agencies dealing with EmOC, and avoid costly investment in building yet another field network.

By the Program's second year, partners were implementing 19 AMDD-supported projects, most of which had completed needs assessments and were designing or implementing interventions. We have just convened the first AMDD Project Workshop that brought together 100 people involved in AMDD to learn from each other's experience.

Now, at the start of the third year, we have even more to communicate about the AMDD Program. Through *Notebook*, we plan to

- Support information-sharing, networking, and problem-solving on EmOC among country teams,
- Provide useful information on people and publications,
- Recognize innovation and commitment, and
- Demonstrate the AMDD approach, strategies and techniques.

We welcome your comments and feedback on—and contributions to—*Notebook*.

Allan Rosenfield and Deborah Maine
Principal Investigators

INSIDE . . .

Good Practices....2
The FIGO-AMDD Partnership....3
Marrakech Workshop....4
From the Projects—Pakistan, Kenya, Peru....6
Leadership Grant Program....8

THE AMDD PROGRAM

The AMDD Program was launched in 1999 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 know-how, management capacity, and respect for human rights.

AMDD has established partnerships with organizations that already have field operations:

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 (IIMA)
EngenderHealth (formerly AVSC International)

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

GOOD PRACTICES

Protocols on the Wall: Report from India

In order to reduce the risk of post-operative infection. It is important to sterilize surgical equipment properly for use in Cesarean sections and other operations and to ensure that the operation theater is clean. In most developing countries, these tasks are the responsibility of workers such as ward attendants and cleaning staff. Since, in many hospitals, such staff have the least education and no training, as well as high turn over rates, these vital functions are sometimes not properly performed, leading to increased risk of infection after operations.

The district hospital in Osmanabad, State of Maharashtra, India, has set up a very interesting system to ensure proper sterilization of equipment. In the new operation theater complex, hospital managers have set up a special room for equipment sterilization, with three big autoclave machines. The management painted on the wall, in big letters and in the local language, all the instructions on how to sterilize the equipment. Thus, staff members can follow the instructions regardless of training or availability of supervision.

The management also set up a system to record all the packs of equipment put into the autoclaves. The register requires details such as the number, date, and type of pack. Each pack carries two Sterilization Indicator Color Strips (that change color on proper autoclaving), which carry a date and number. One strip is taken out after autoclaving and stuck in the register as proof that the pack was properly sterilized. The person who does the sterilization, his/her supervising nurse, and the doctor-in-charge sign the register. If post-operative infection develops, the management can track the autoclaving record to check who did the procedure and whether it was done correctly.

These are examples of setting "standard operating procedures," a common management practice in industry. The cost of these good practices is small, but they could bring substantial benefits.

Dileep Mavalankar
Indian Institute of Management at Ahmedabad
AMDD Technical Team

THE FIGO-AMDD PARTNERSHIP

Soon after it was launched, the AMDD Program established a close working partnership with the International Federation of Obstetrics and Gynecology (FIGO). This has already borne fruit in three important areas: information-sharing, networking, and recognition of special contributions.

Information-sharing: The IJGO Journal

The most recent initiative is the forthcoming special quarterly section in the International Journal of Gynecology and Obstetrics. The 25-page section is called "The Keystone for Averting Maternal Death and Disability" because, as Editor Judith A. Fortney explains, "The arch of safe motherhood consists of many stones...but the arch will fall down - mothers will die - if they do not receive prompt, adequate treatment when they suffer life-threatening complications during pregnancy, delivery or the puerperium."

Thus, the focus of articles will be on programs or interventions, particularly in developing countries, that are intended to improve the availability and quality of EmOC. For further information or instructions to authors contact keystone@columbia.edu.

Networking: The Pre-Congress Workshop

A workshop on "Emergency Obstetric Care For All Women: A Social Responsibility for Obstetricians" was organized on 30-31 August 2000, a few days before the triennial FIGO Congress in Washington, D.C., by the WHO/FIGO Alliance for Women's Health in collaboration with the Mailman School of Public Health at Columbia University. Some 200 participants learned about progress in the projects supported by the FIGO Save the Mothers Fund, which links professional obstetrics and gynecology societies in five developed countries with similar societies in eight developing countries. Projects use the UN process indicators to assess needs and then design interventions to address gaps.

Yasmin Ali-Haque from UNICEF Bangladesh and Monica Oguttu from the Kenya Team of the RPMM Network made presentations about AMDD-sponsored projects. Working groups examined how to enhance the role of obstetricians as providers of health care, team leaders, and social advocates. Allan Rosenfield presented the Workshop Report to the FIGO Congress.

Recognition: The Community Service Awards

AMDD and FIGO have established the Distinguished Community Service Awards to recognize health professionals who made special efforts in the battle to prevent the needless deaths of women due to pregnancy and childbirth. Part of the award is a $5,000 grant to the recipient's facility to use in improving services, and part goes to fund a national seminar and reception to present the awardee's work.

AMDD Program Director Deborah Maine presented the first awards at the triennial FIGO Congress, saying, "All too often, rewards and prestige in the field of obstetrics are gained through the use of high technology in urban private practice. Today, we honor these public health heros. These are some of the people who save women's lives in crowded public hospitals and in remote rural clinics, day after day, night after night, year after year." The first year's awardees are:

Hugo Rodriguez Ferrucci, who provides obstetric care in the Amazon jungle area of Peru (nominated by the Sociedad Peruana de Obstetricia y Ginecologia);

Grace Kodindo, who heads the main referral emergency obstetric facility for N D'Jamenaa, Chad (nominated by UNFPA New York);

Alex Mathews, who has headed obstetrical and gynecological services in several states in Malaysia (nominated by the Obstetrical & Gynaecological Society of Malaysia);

Keith McCallum, who provides emergency care for isolated women, both indigenous and non-indigenous, in the desert region of Western Australia (nominated by the Indigenous Women's Health Committee of the Royal Australian & New Zealand College of Obstetricians and Gynaecologists);

Ahmed Bayoumi Shokry, who works to improve obstetric care in the Governorate of Sohag, one of Egypt's most deprived areas (nominated by UNICEF Egypt);

Nara Vudhikamraksa, who provided EmOC at the Khon Kaen Hospital in Thailand for 28 years until her retirement in 1999 (nominated by the Royal Thai College of Obstetricians and Gynaecologists). ■

PROJECT TEAMS FIND COMMON GOALS IN MARRAKECH

"It was surprising to meet people from different countries who all have the same goal. The strength we obtained will make us revisit our strategy."

— Juliana Bantambya
Participant

"We're so focused on trying to save one woman's life that we forget there is a big picture," declared Joseph Thomas, one of the 100 participants in the first AMDD Project Workshop convened 19-21 February 2001 in Marrakech, Morocco. "I'm glad to know about the big picture of the AMDD Program," said the Leadership Grant awardee.

This sentiment reverberated throughout the workshop, which provided the first opportunity for representatives from all 19 AMMD-supported projects to meet and compare notes with one another, as well as with the core Columbia University Team, representatives of partner agencies, and technical experts. Participants traveled to Marrakech from 25 countries and spoke a host of languages. Simultaneous French-English, Spanish-English, and French-Spanish interpretation was provided.

Discussion group on middle management

Opening Session

Mustafa Tyane, Director of the Moroccan Ministry of Health's Population Unit, formally opened the conference, together with the AMDD Program Principal Investigators Allan Rosenfield and Deborah Maine. The opening session was also addressed by UNFPA Country Representative for Morocco, Vincent Fauveau, and Adetokunbo Lucas, a member of the Strategic Advisory Council of the Bill and Melinda Gates Children's Vaccine Program, and a Senior Advisor to the AMDD Program.

After the opening, participants found a variety of opportunities for exchange of experience and learning: through formal presentations, working group sessions, project poster sessions, country team meetings, studies, and informal documentation.

Poster Sessions

For many participants, the poster sessions were the most exciting part of the three-day workshop. Drawing on the data from their needs assessments and using a variety of visual materials, including photographs, maps, charts, and diagrams, teams set up posters on all 19 projects in an open-air pathway under the clear blue Marrakech sky.

After lunch and during coffee breaks, sipping sweet mint tea and nibbling diet-destroying sweets, participants had the opportunity to consult with team representatives at their poster stands. The pathway was crowded with clusters of people participating in what one person referred to as "mini-seminars" by teams as far afield as Tajikistan, Mozambique, and Peru. In many cases, teams shared materials about progress and lessons learned.

As RPMM West Africa Coordinator Edmund Browne put it, "We were quite excited about the poster sessions – they refreshed our own ideas and helped us to know what others are doing around the globe".

Prior to their arrival in Marrakech, country teams had provided information on the status of their project, which was compiled in a "Project Snapshots" booklet that all participants were able to take home. The day after the workshop, UNFPA and the Moroccan Government organized field trips to visit health facilities affiliated with the AMDD program. Dozens of workshop participants were able to take advantage of this opportunity.

Plenary Sessions

Subjects covered in the plenary sessions were: Upgrading EmOC Services, presented by

Zafarullah Gill; Management, Judith Graeff; Human Rights, Lynn Freedman; Monitoring and Evaluation, Elizabeth Goodburn; and Documentation, Nadia Hijab. Copies of these papers are available on www.amdd.hs.columbia.edu.

Poster session - Mali - L-R: L. Jamisse (Mozambique), A. Bagayoko (Mali), D. Maine (NY), M. Ba (Mali), B. Mbaydonadji (Cameroun), A. Kayo (Mali)

The plenary sessions were amplified in small working group discussions, whose insights will be followed up through the Program and in future newsletters. A list of 16 cross-cutting issues emerged from the working group sessions, and sign-up sheets were posted for participants interested in continuing the discussion. The three issues that had the largest subscriptions – management information systems, protocols and technical supervision, and quality improvement – will be the subjects of e-mail study groups for the next year, with AMDD technical team members as facilitators.

Between sessions - L-R: H. Wijemanne (Sri Lanka), P. Zam (Bhutan), V. Karunaratne (Sri Lanka)

As Lilia Jamisse, Family Health Director of the Government of Mozambique put it, "The most important aspects were human rights and management. Maternal death and disability is a direct manifestation of gender inequality and violence against women. Therefore, human rights must be incorporated. In management, team building is essential for a network of functioning health centers".

Dinesh Agarwal, Team Manager of the Technical Support Unit of UNFPA India, noted, "Human rights are especially important. How do we really get this into our program." Several participants mentioned the importance of the session on monitoring and evaluation to their work, while others appreciated discussion on ways to improve services.

Juliana Bantambya, Assistant Project Manager for CARE, Tanzania, remarked, "It was surprising to meet people from different countries who all have the same goal. The strength we obtained will make us revisit our strategy and improve quality of service. During group discussions every participant was able to express and explain the problems they were experiencing".

Country Team Meetings

During the course of the Workshop, time was set aside for each country team to meet with its respective AMDD monitor to discuss progress to date, future plans, technical assistance needs, and field visits. In addition, partner organizations, representatives of women's human rights groups (invited from Ecuador, Pakistan and the Philippines), and Leadership Grant recipients took the opportunity to hold their own meetings.

Participants had diverse professional backgrounds: project officers and managers in development organizations; health officials, managers, project officers, and information analysts in health ministries; members of university faculties; obstetricians, gynecologists, and midwives; directors of hospital departments and clinics; evaluation specialists; management experts; and experts from many other fields.

In spite of the diversity of their backgrounds, people found they had many things in common, and, in particular, their commitment to the goal of reducing maternal death and disability. ■

PAKISTAN: BRINGING IN EmOC

Area: Sindh Province, three districts
National Partner: Ministry of Health
Project Partner: UNICEF

To anyone else, this would have seemed a mission impossible: introducing EmOC at the Qatar Hospital in the Orangi slum where three million people live. But since Shershah Syed, Associate Professor of Obstetrics and Gynecology, was transferred to the hospital six months ago, he has, with the support of UNICEF and Government, shaken up the department, which now handles 10 to 15 deliveries a day (up from zero). The Qatar Hospital is one of the targeted facilities under the Women's Right to Life and Health project being implemented by the Government of Sindh in collaboration with UNICEF. The measures to introduce EmOC included:

- Gaining recognition by the College of Physicians and attaching the hospital to the medical college so that interns can work there.
- Organizing staff transfers from other wards to the maternity ward, to address the freeze on staffing in the Province.
- Making some renovations to the labor room, providing women-only toilets, and a private room to examine female patients.
- Establishing a school of midwifery at the hospital to address the lack of nurses; 30 students have now joined and will be qualified within two years.
- Holding a weekly meeting to discuss patients. "Other departments - medicine, surgery - are now also starting to do something like that," Dr. Syed noted.
- Training ambulance drivers on how to deal with emergency cases (including the fact that deliveries can be emergencies).

The collaboration with UNICEF and the national partnerships with the Pakistan Medical Association and the National Committee on Maternal Health, have helped move things forward. But many problems persist, including delivery of equipment and the need for more staff (such as anesthetists), which make progress slower than planned.

The project's aim is to replicate this experience in other areas, and to feed the results into the national health system. There are few direct interventions dealing with women's health in Sindh Province. They include the UNICEF-Government Women's Right to Life and the National Programme for Family Planning and Primary Health Care, which is coordinated in Sindh Province by Husna Memon, Deputy Director/General Health in the Province.

As UNICEF Project Officer Asif Aslam pointed out, "We conducted an analysis of women's health in Pakistan and found that there were hundreds of research papers but not a single intervention program. That's what the Sindh Government wants to change," ■

KENYA: KEEPING ON TRACK

Area: Siaya and Bondo Districts, Nyanza Province
Project Partner: Regional Prevention of Maternal Mortality (RPMM)

In Siaya and Bondo districts in Nyanza Province, the road from village to hospital is usually a bumpy red streak, dusty in the dry season, and impassable during the rains. Facilities often lack fuel for generators, water for operations, supplies and equipment, and the right mix of skills amongst staff to deliver EmOC.

After conducting their needs assessment, the PMM team was "ready to give up; things just looked too bleak," team member Monica Oguttu recalled in her office at the Kisumu Medical Educational Trust in the provincial capital. "But then, we became more determined to carry on. Most of us come from this province, and these are our people. We had to find a way to deal with these issues". Find ways they did, and they quickly posted some impressive results.

But perhaps the most interesting question this group addressed is: how do volunteers commit to a project, undertake tasks and deliver quality results on time, even though they all have other full-time jobs? All the teams in the RPMM Network - 19 to date - are volunteers, and some have had more success with internal team-building than others. Here are some findings from the work of the Kenya PMM Team, much of which tallies with the advice the RPMM Network gives participating teams, as Director Angela Kamara pointed out.

- The Kenya PMM Team addressed attendance at meetings early on; now members who miss a meeting must call to get updates and assignments.
- The Team also addressed people's reluctance to get involved unless there are financial benefits. Complete transparency over the budget and budget decisions helped to address this issue.
- There is a clear division of roles and labor; and decisions are made as a Team, an approach encouraged by Team Leader Solomon Orero; publication is done as a Team.
- The Team identified areas where resources could be stretched during the needs assessments, and used grant funds provided by the RPMM Network to train and pay research assistants to help undertake surveys and tabulate results.
- Members integrated PMM activities into their daily work routines wherever possible. The RPMM Network provided technical assistance as necessary, as did former RPMM East Africa Coordinator Khama Rogo.
- They had access to an office in the project area to use as a base; Monica Oguttu effectively acts as the Coordinator for PMM, gently but firmly.
- They were able to use an organization's vehicle: "otherwise PMM would be paralyzed; no one would use their own car on these roads."
- Members found satisfaction in project results and their own personal and professional growth through teamwork. Chris Oyoo at Kisumu Hospital noted that infections had gone down in Siaya, and referrals are no longer so late. Plus, "I'm now involved in continuing education outside our provincial hospital. I first learned about 'social medicine' through PMM". ■

PERU: ENLISTING PARTNERS

Area: Northern Ayacucho Department: six provinces, pop. 412,494
National Partner: Ministry of Health
Project Partner: CARE

The CARE project in Peru, launched in April 2000 to improve EmOC in the northern part of Ayacucho Department, is building on an existing network of relationships and establishing new ones. Ayacucho is one of the country's poorest areas with some of the worst health and social indicators. It covers both mountainous and jungle regions where population settlements are widely scattered and facilities are difficult to reach. The Ministry of Health recently established the reduction of maternal mortality as their number one priority for 2001- 2005.

In ongoing CARE development projects, local coordinating bodies bring together municipal government, community-based organizations and NGOs. The new AMDD-sponsored project will use these bodies to promote women's human rights by, among other things, helping to organize referrals to facilities for women with obstetric complications.

Through such networks of partners, project staff can identify and capitalize on existing resources in the project area, one of the project's main strategies, explained Project Team Manager Marco Alegre. Some of the resources are found in unexpected places - for example in Vinchos district, an area with an unusually high number of maternal deaths.

"When the government made reduction in maternal deaths a priority," Elena Esquiche, the Team's community and human rights organizer, recalled, "The doctor and midwife looked for solutions; they realized that the local police had resources like motorcycles, cars, and radio transmitters, which could be used to speed up referrals." This unusual partnership with the police will now be replicated elsewhere throughout the project.

In fact, the Project Team has just completed mapping institutions in the area and the ways in which they can be brought into the effort to

Continued on page 8

. . .PERU PARTNERS (cont.)

reduce maternal deaths. The inventory, conducted by Elena Esquiche and CARE consultant Cesar Canales, covered local resources in the networks that could enhance communication and referral. The Team used a participatory approach in conducting the inventory: NGOs, organized groups such as Clubes de Madres, Vaso de Leche, authorities, police, military, churches, and others were are called together for a meeting in which the project presented the importance of local organization to respond to obstetric emergencies.

The participants mapped their resources, with distances measured in time between facilities, and made lists of what resource each authority or organization could provide. According to Canales and Esquiche, community members were responsive to the idea that "we the community are also responsible for these women with emergencies". For the first time they were able to say "Well, this is what we as a group can do for this cause". The military even promised the use of helicopters.

The Project Team also used the strategy of pulling several partners together during its needs assessment. The Ayacucho Health Bureau was involved in the design of the needs assessment and data collection involved the Health Ministry, colleges of nurses and midwifery, health facilities managed by universities, the private sector, and the police. Overall, 32 service sites/health care facilities were involved, yet the assessment took just two months from design to collection - "record time", according to Patsy Bailey, from Family Health International who is on AMDD's Technical Team.

The assessment identified serious problems. For example: out of 32 facilities studied, only one qualified as a provider of EmOC, basic or comprehensive (only two had protocols relating to obstetric emergencies); there were a high number of complications from unsafe abortions; and registers were of uneven quality.

The value of including a wide range of partners in the assessment means they can be involved in the search for solutions. The involvement of partners also shifts the focus from "blame" for the problem to action, Team members point out. ■

LEADERSHIP GRANT PROGRAM

The main AMDD partners are governments and major international organizations. At the same time, the AMDD Team recognizes that many health professionals are making extraordinary efforts to save women's lives in facilities with overstretched resources. We have therefore established a Leadership Grant Program to help institutions in developing countries that are already providing obstetrical services but need some financial or technical assistance to start or strengthen EmOC. The duration of projects is expected to be about three years, and financial assistance up to $40,000 can be provided. Institutions selected can also request technical assistance from the AMDD network of specialists.

To date, the following institutions have been awarded grants: Emmanuel Hospital Association, (India); Hospital EPC De Metet (Cameroon); and the Asha Kiran Hospital, (Orissa, India). Representatives from these three institutions participated in the first AMDD Workshop in Marrakech. Two more applications are being processed: Solu Hospital, Phaplu, Nepal, and the Comprehensive Rural Health Project, Jamkhed, India.

There are two main criteria for selection: a history of providing services in underserved areas with a substantial target population, and the capacity to improve access to or quality of EmOC. Applications are posted on the AMDD website:

http://www.amdd.hs.columbia.edu ■

Averting Maternal Death and Disability (AMDD)
Heilbrunn Center for Population and Family Health
Mailman School of Public Health, Columbia University
60 Haven Avenue, B-3, New York, NY 10032
Fax: (212) 544-1933 Website: http://www.amdd.hs.columbia.edu