

AMDD

NOTEBOOK

Meeting Challenges, Making Changes, Saving Lives

Issue 5

October 2002

DEAR COLLEAGUES

The 2nd AMDD Workshop, held in Bangkok last February, was a wonderful introduction to the impressive work that AMDD and all its partners are doing to improve the availability, quality, and utilization of emergency obstetric care (EmOC) around the world.

I was honored to join you, participate in the meeting and talk with many of you individually about your work. As Chairman of the Department where AMDD is based, I look forward to an on-going involvement with the program.

One of the exciting results documented in the AMDD annual report for Year 3 is how effectively, even in such a short time, projects have been able to attract new funding to expand and develop services; create momentum for policy change; and develop new partnerships focused on EmOC.

AMDD inputs—projects, assessments, technical assistance, training materials and documents—result in a multitude of exciting outputs that carry the work of averting maternal death and disability forward. These inputs provide leverage to help projects to scale up, to become part of organizational and governmental systems, and be sustained over time.

This issue of the Notebook provides examples of such leveraging (page X). As the program progresses, so too will the scope and depth of this effect. We look forward to hearing from you with more stories and examples and to continuing our work together in improving women's health on a global scale.

Leslie L. Davidson, MD, MSc (Epid)

Professor of Clinical Population and Family Health

Chair, Heilbrunn Department of Population and Family Health

Mailman School of Public Health, Columbia University

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THE AMDD PROGRAM

The Averting Maternal Death and Disability (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 Emergency obstetric care (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: medical, management, and 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:

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)

JHPIEGO

EngenderHealth

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

GOOD PRACTICES

Emergency Drugs: Access and Control

In labor rooms, emergency drugs must be present at all times even though they are not used very frequently. As a result, drugs are often not available or have already expired when an emergency occurs. If they are kept under lock and key to control access, the keys may not be immediately accessible during the emergency – which may cause life-threatening delays. Thus, it is important to provide quick access to the emergency drugs while still maintaining control over their use.

At New York Presbyterian Hospital (Greenberg Pavilion), the emergency drugs, supplies and instruments are stored in a small closed trolley with wheels. This emergency drug trolley is kept at the drug dispensing station located centrally in the obstetric suite, and can be pulled easily (in about 15 seconds) to the labor room or delivery room if an emergency should occur. The trolley has all of the common emergency drugs, ambu-bags, larygo-scope, IV cannulae, and other emergency supplies and instruments.

Two small innovations make this trolley special. First, it has a small plastic locking device, which is like a clip that can be pressed across the door. Once closed, this device cannot be opened. If the drugs are needed, the plastic lock must be cut with a small scissors or twisted by hand and broken off. This makes access to the contents very easy since no key is needed.

Control over unauthorized use is achieved because each plastic lock bears a unique number that is entered in a register kept on the trolley. Anyone who breaks the lock for emergency use is required to log the emergency in the register. After the emergency, the items used are replenished and a new lock is installed. The identification number of the new lock is entered in the register. Every morning the nurse on duty must check to see if the lock is intact and must counter sign the register to show that it was checked. This discourages unauthorized use of the emergency medicines.

The second innovation is even simpler. On the front of the trolley, the expiration date of the earliest expiring medicine is written in very large letters (about 48 font size) on a piece of paper that is secured with tape. The expiration date of the medicines is thus immediately clear to staff. Nurses must replace the drugs with fresh stock on or before the expiry date, and put a new label on the trolley. This practice ensures that there are always fresh drugs in the emergency trolley.

These innovations can easily be used in developing countries. Writing the expiration date in bold numbers

does not cost anything and can be done anywhere. A register costs a minimal amount. While the closed trolley may cost somewhat more than an open trolley, it is a one-time investment that will save money because it prevents the unauthorized use of medicines.

As for the plastic locking device, it does not cost much, but may not be readily available in developing countries. However, a strong thick thread can serve as a lock. It can be knotted in such a way that it has to be cut in order to open the trolley door. As the thread cannot be numbered, one must paste a paper strip bearing a serial number, date and the signature of the head nurse across the door of the trolley, so that this strip is



torn when the door is opened, which will immediately show that the trolley has been opened. Every time the trolley is opened, this must be recorded in the register, and a new paper seal attached after the drugs and supplies have been replenished.

In sum, this practice provides easy access to emergency drugs, supplies and instruments while keeping tight control over unauthorized use.

Dr. Dileep V. Mavalankar

*Senior Management Advisor, AMDD Program,
Indian Institute of Management, Ahmedabad*

THE DISAPPEARING ART OF ASSISTED VAGINAL DELIVERY

Patsy Bailey, Columbia University Senior Lecturer and MCH Evaluation Specialist at Family Health International, wrote this piece drawing on observations during field visits conducted on behalf of the AMDD Program.

WHO estimates that 8% of maternal deaths in developing countries are due to prolonged and/or obstructed labor (WHO 1996). Without the appropriate management a woman can die from a ruptured uterus or from infection, and the infant can die from asphyxia. Obstructed labor can also lead to vesico-vaginal and/or recto-vaginal fistulas, a common condition in sub-Saharan Africa.

One of the key elements in the provision of EmOC care is assisted vaginal delivery with the use of vacuum extraction or forceps (Maine et al. 1992; WHO 1996). However, recent needs assessments for EmOC in some Latin American countries, carried out under the AMDD Program, show that operative vaginal delivery is rarely performed at any level of health care and no longer is taught in many medical schools.

In fact, assisted vaginal delivery may be quite limited in many Latin American countries and in several West African countries. This does not appear to be the case in the United States, Europe or Australia (Learman 1998; Read et al, 1994). The preference for vacuum extraction over forceps has long dominated European obstetrics while in the US the use of forceps appears to have declined over the past 10 years while use of vacuum increased. However, the operative vaginal delivery rate has remained stable at 10-12% of live births (Learman 1998).

Trend data show that in most countries the cesarean delivery rate is increasing while the vaginal operative delivery rate is decreasing (Notzon 1990). Although

we lack trend data for vaginal operative deliveries from Latin American countries, the needs assessments supported by AMDD showed that equipment was outdated and was no longer in use. A decline in use was further suggested by hospital staff, who reported that only older practitioners had any experience in vaginal operative deliveries and that cesarean deliveries are replacing the use of forceps and vacuum delivery.

The reasons given for reluctance to perform assisted vaginal delivery include the trauma that could be suffered by the newborn and the mother. Possible maternal complications include tears to the genital tract and may require repair. Yet these complications generally disappear within hours or weeks (WHO et al. 2000). A review of vacuum extraction versus forceps concludes that less maternal trauma and less general or regional anesthesia are associated with the use of the vacuum extractor, as well as more vaginal deliveries and fewer cesarean sections (Johanson et al 2001).

Assisted vaginal delivery is certainly not a substitute for cesarean delivery, but it can reduce the growing number of cesareans, particularly in Latin America where some of the highest rates in the world occur (Notzon 1990). Where these procedures are rarely used, not coincidentally, the incidence of cesarean delivery is on the increase; this is observable especially in urban and private facilities. In 1998 in Managua the cesarean delivery rate was 25%; in 1996 the rate in

Continued on next page

VAGINAL DELIVERY (continued)

Metropolitan Lima was 16% (DHS data). WHO recommends that cesareans as a proportion of all births fall within the range of 5 and 15%.

Assisted vaginal delivery reduces the morbidity and risks associated with cesarean delivery while reducing the costs of obstetric care. Vacuum extraction can be taught to mid-level practitioners such as midwives,

thereby increasing coverage. In addition, assisted vaginal delivery would allow women to give birth closer to home in mid-level facilities when hospitals are not easily accessible or are overcrowded. These are all good reasons to advocate for renewed attention to assisted vaginal delivery in countries where this has been allowed to fade away. ■

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Making Time for New Equipment

Rwanda is a country with many hills, poor roads, and few vehicles. In fact, in some places there are vehicles only on market days. Like other countries in Africa and Asia, transportation is especially expensive in the case of medical emergencies. People are so poor that they often cannot afford to pay for an ambulance. They frequently transport relatives with obstetrical complications on a hammock hanging from their backs, walking up and down hills to reach a referral hospital.

Transport problems are one reason why it is important to ensure that EmOC is available within easy reach of women who may experience obstetric complications. Under the CARE-AMDD project, facilities are upgrading EmOC services in the Gitwe, Kabgayi, and Remera-Rukoma districts in the Gitarama region. All three facilities are government referral hospitals and were previously functioning.

Field visits during the spring of 2002 revealed that, in several facilities, vacuum extraction machines were left in the corner, unused. Instead, women with retained placentas were being referred to another hospital, which required several hours of arduous transport on a stretcher. When facility staff were asked about the machines, they said that staff had not been trained in the procedure, because there was "no time for instruction".

This issue was discussed with the regional Health Director who recognized that there was no policy against nurses or midwives performing vacuum extraction. There was, however, a shortage of qualified nurses with these skills. The Director agreed that nurse-midwives should be trained in these life-saving procedures, and there are plans for training, including the possibility of posting an obstetrician from Kigali at one of the facilities for three months to provide hands-on training in this procedure.

Other findings during the field visits were that there were many cases of ruptured uterus in the region, because of the traditional practice among families of giving women oxytocic herbs, which are believed to speed up delivery, but which can lead to ruptured uterus. This problem had been partially addressed in Kabgayi hospital where the CARE-AMDD project has helped to build a comfortable waiting area for relatives of women in labor. They are thus prevented from having direct contact with the women in labor, and therefore cannot provide them with the potentially harmful oxytocic herbs.

Meanwhile, one of the facilities has also been referring all cases of ruptured uterus in spite of the serious problems with transport. The obstetrician from Kigali will also train the doctor in charge of emergencies on surgery for ruptured uterus.

Dr. Grace Kodindo
Chief of Obstetrics-Gynecology Unit
General Reference Hospital, N'Djamena, Tchad
AMDD Technical Team



This column addresses questions that arise in using UN process indicators to monitor progress in the provision of crucial obstetric services. 1 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: What is the basis for the estimate that, of a given population of pregnant women, at least 15% will develop complications in pregnancy, delivery and postpartum?

A: Several of the UN Process Indicators used to gauge the availability, utilization, and quality of Emergency Obstetric Care (EmOC) are calculated using the following estimate: in a given population of pregnant women, at least 15% will develop severe, direct obstetric complications.

For example, Indicator 3 - the proportion of all births that should take place in EmOC facilities - is set at a minimum level of 15%. Indicator 4 - Met Need - is calculated using an estimate of expected complications of 15% in the denominator. Many people have asked how this 15% estimate of maternal complications was derived, and whether or not it is applicable to all situations.

The estimate of 15% was proposed in an early version of the Process Indicators¹ and later adopted by a Technical Working Group assembled by the World Health Organization in 1993². At this meeting, it was agreed to establish 15% as the estimated minimum proportion of pregnant women who require medical care in order to avoid death or disability.

In epidemiological terms, this 15% can be thought of as the combined incidence of the main causes of direct obstetric deaths. The severity of most of these obstetric complications, such as hemorrhage, sepsis, complications of abortion, prolonged/obstructed labor and eclampsia/severe pre-eclampsia, can range from mild to life-threatening.

One of the reasons for setting a global estimate of maternal morbidity is that it is extremely difficult to measure in practice. First of all, there are practical difficulties associated both with research undertaken in clinical settings and with survey research. For example, many women bleed postpartum; some bleed heavily. In textbooks, hemorrhage is often defined as loss of blood more than 500 ml. But this is neither easy nor practical to measure in a clinical setting. Moreover, it presupposes that the woman has been in a hospital setting from the

beginning of the blood loss, rather than having arrived well after bleeding began. Survey methods for estimating maternal morbidity are not used due to problems of validity. What seems the most obvious and straightforward method of gathering information on the subject - asking women about their experience - produces surprisingly poor results.³

In addition, the exact grouping of obstetric complications included in a study and how they are defined operationally influences the results of the study. For example, a study in six West African countries in the mid-1990s included only obstetric complications that led to hospitalization, death, or a medical intervention (such as cesarean section, hysterectomy or blood transfusion).⁴ Complications of abortion were not included in the study. The incidence of severe maternal morbidity found in this study was roughly 6% of pregnancies. Including medical treatment in the definition of a complication in countries where large proportions of women do not have access to medical care may be one reason why this estimate is so low.

Another coordinated series of studies defined a life-threatening morbidity as malaria, hemorrhage, eclampsia ("fits/convulsions") and ruptured uterus anytime during pregnancy through the postpartum period⁵. Life-threatening morbidity was reported in 4.7% of pregnancies in the Indian sample, 10.7% in the Egyptian sample, and 32% in the Bangladeshi sample.

It is important to appreciate that 15% is only an estimate, and it is likely that there are, in fact, variations in severe maternal morbidity from place to place. Certainly, the frequency of complications of abortion alone will vary depending upon policies and practices regarding safe abortion. However, with the Process Indicators we are not trying to measure morbidity or mortality in a population, but rather the level of EmOC services that are so often lacking for women. The usefulness of the estimate is that it is a benchmark against which to measure change and improvement in utilization of emergency obstetric care. ■

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2. WHO, Indicators to Monitor Maternal Health Goals: Report of a Technical Working Group, Geneva, 8 - 12 November 1993, Geneva, 1994.

3. Stewart K, M Festin. Validation study of women's reporting and recall of major obstetric complications treated at the Philippines General Hospital. International Journal of Gynaecology & Obstetrics, 1995, 48 Suppl:S53-66.

4. Prual Aet al. Severe maternal morbidity from direct obstetric causes in West Africa: incidence and case fatality rates. Bulletin of the World Health Organization, 2000, 78(5):593-602.

5. Fortney JA and JB Smith, editors. The Base of the Iceberg: Prevalence and Perceptions of Maternal Morbidity in Four Developing Countries. Family Health International, 1997.

LEVERAGING RESOURCES

EXPANDING SERVICES, PROMOTING POLICY CHANGE, DIFFUSING KNOWLEDGE

Project partners have used AMDD funds, technical advice, and materials to develop and expand EmOC services for women, promote policy change, and diffuse knowledge to the growing global network to avert maternal death and disability. Lucille Pilling de Lucena, RN, MPH, AMDD Program Manager, Katrina Stamas, AMDD Program Coordinator, and Nadia Hijab, AMDD Documentation Consultant, review progress in these different areas. The text provides some highlights while the table gives a more comprehensive overview.

Expanding Services

UNICEF, UNFPA, CARE, and Save the Children are now incorporating EmOC into their ongoing maternal health programs, successfully expanding access to EmOC in different parts of the world. UNICEF's work in Afghanistan is just one example. The former UNICEF Regional Representative for South Asia is now Special UN Deputy Representative to Afghanistan, and was instrumental in establishing EmOC as one of the three health priorities for the UNICEF program in the country. Afghanistan is now part of the UNICEF-AMDD EmOC network in South Asia.

Indeed, UNICEF is now demonstrating a strong global commitment to EmOC. In March 2002, Carol Bellamy issued a call to reduce maternal mortality world-wide. She stated that UNICEF's "efforts to reduce maternal mortality in the [South Asia] region are currently focused on ensuring that every woman has access to emergency obstetric care services."

In the State of Rajasthan, India, UNFPA/AMDD project advocacy and discussions with the state Health Secretary resulted in a provision in this year's budget to support emergency obstetric and surgical services in all sub-district hospitals in Rajasthan's 32 districts (the UNFPA/AMDD project covers 7 districts). At the local level, AMDD and UNFPA staff worked with government, hospital doctors and the district health team to raise substantial financial support from the private sector to renovate a hospital and to solve pre-existing management problems.

Save the Children is expanding services to new sites in Mali and Vietnam, the countries where their AMDD-funded projects are located. Save the Children is starting new EmOC programs in Pakistan and Guinea.

Promoting Policy Change

The Government of Bhutan had a policy that only physicians could administer anesthesia. This meant that populations in rural areas, where doctors don't want to be posted, had little access to emergency services. Acting on suggestions that had been voiced at AMDD conferences and meetings, the Bhutanese government initiated an in-country training program for nurse anesthetists. After training, nurses were paired with an anesthetist for a year and now deliver anesthesia in rural hospitals. In addition, policy clearance was given to extend blood-grouping facilities

Personal Experiences in Leveraging EmOC

At the beginning of the project, it was difficult and frustrating to visualize any changes in a complex hospital environment, where the facilities were in bad condition; staff were not motivated and have different individual interests; and there were a lot of management problems. But after a year and half of project implementation, things are changing:

Staff in the obstetric ward have changed a lot in their respect for the patients and competence in handling cases. There is a strong team spirit among different levels of staff in the obstetric ward. Now, whenever we visit the facilities, the midwives want to talk to us about the changes they are seeing. The senior obstetricians are providing important information to the media about the improvements in care and the need for similar programs elsewhere in the country. The staff are now good advocates for the program.

Over the months, we have shared what we learned and the materials we received with the Ministry of Health. It was difficult to get their attention at the start, but now we are considered a major player in EmOC, represented on the national reproductive task force. We were able to influence some of the programmatic approaches by sharing the lessons we learned from program implementation, as well as from the technical assistance and materials we received from AMDD.

We participated actively in the group working on the national curriculum/guideline on EmOC, which included the Ministry of Health, UNICEF, WHO, the Ethiopian obstetrics society, and the obstetrics department of the medical faculty. We helped bridge the gap in understanding regarding the content of these materials. Now the Ministry comes to us for lessons learned and materials. We also presented the project at East, Central and South African obstetrics society meetings, which generated valuable discussion among participants. We have been approached by donors like USAID, World Bank and the Netherlands to discuss our work, and there is donor interest in being involved in future.

Dr. Solomon Tesfaye
Project Director, CARE Ethiopia

to peripheral health centers. The combination of competent technical staff and a blood supply enables provincial health centers to treat obstetric emergencies in isolated areas. (An unintended outcome: the

Government of Bhutan appreciated the AMDD needs assessment process so much that they have instituted a similar assessment and planning process in other ministries).

The Regional Prevention of Maternal Mortality (RPMM) Network has actively promoted policy change on EmOC through its network in 19 sub-Saharan countries. In addition to the examples given in the table, it is worth noting that the RPMM Director has headed a committee of the Interagency Group for Safe Motherhood to develop guidelines for country-level support in developing countries. The RPMM network

also partners with IPAS to implement strategies to address complications of abortion in Africa, as well as with WHO-AFRO on a task force on strategies to reduce maternal mortality.

Diffusion of Knowledge

UNFPA has contributed to the diffusion of EmOC information by: producing a distance learning course on reducing maternal deaths; developing a series of web pages promoting EmOC and the UN Process Indicators with impressive hyperlinks; coordinating a

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EXAMPLES OF LEVERAGING SERVICES, POLICY CHANGE, KNOWLEDGE

	Expanded Services
Bangladesh	The Japanese aid agency JICA has agreed to provide 47 sets of key EmOC equipment as well as additional supplies, through the Government-UNICEF project supported by AMDD.
Ethiopia	The life-saving skills training supported by CARE, AMDD and ACNM has drawn attention to the importance of this type of training, and was featured in the press and on television. This in turn created a demand for life-skills training in other hospitals. The Netherlands Government also has expressed interest in replicating the training in a project they fund in another area of Ethiopia.
Pakistan	The \$75 million Women's Health Project launched in January 2002 by the government, Asian Development Bank, and the Organization of Petroleum-Exporting Countries, incorporates the AMDD model for EmOC into the program design. Two of the UNICEF-AMDD supported facilities have started schools of midwifery by mobilizing resources from the private sector and other sources.
Guinea	The Minister of Health leads the local RPMM team, dedicated to improving quality of and access to EmOC. The Ministry has upgraded facilities in four districts with plans to expand to 10; the ministry of Defense has provided an ambulance.
Sri Lanka	The Government convinced the Asian Development Bank to provide about \$20,000 to conduct EmOC needs assessments in newly accessible former conflict areas, following the recent peace accords. Senegal UNICEF
Senegal	UNICEF sponsored life-saving skills training organized by RPMM; a Spanish NGO donated an ambulance to project.
Tanzania	UNICEF is providing ambulances for the CARE-AMDD project. This complements the installation of radio communication between health centers and the referral hospital in two districts and promotes access to emergency services in remote areas.
Vietnam	Part of the Save the Children-AMDD project has involved upgrading the skills of EmOC trainers at the Hanoi and the Hue medical schools. The result is not just better quality training for providers at the facilities supported by the project, but for all providers passing through these two institutions, which provide training for two-thirds of the country. West Africa AMDD-supported
West Africa	AMDD-supported national needs assessments, conducted by UNFPA, led to funds to develop projects and improving EmOC services in Mauritania and Senegal. They also led to the initiation of additional needs assessments in Gabon, Guinea Bissau and Guinea, funded by UNFPA.
	Policy Change
Bangladesh	The AMDD-supported UNICEF initiative created sufficient visibility to bring about change in policy regarding procurement practices. There now is a standardized national list and logistical system for supplies and equipment for EmOC services. This means that supplies and equipment will be ordered and distributed on a regular basis, thus reducing expenses and avoiding shortages
Sierra Leone	Through RPMM efforts, the Ministry of Health reproductive health policy gives priority to improving quality of and access to EmOC. The majority of the policy makers are RPMM network members, and the vice president of the country has agreed to be the local RPMM team patron. There are efforts nationwide to equip district hospital and improve staff skills, supported by UNFPA, UNICEF and WHO.
Zambia	The minister of health and other policy makers, as a result of RPMM interventions, endorsed strategies to reduce maternal mortality by improving quality of and access to EmOC.
	Diffusion of Knowledge
India	Criterion-based audit workshops by AMDD staff for district level officers in projects supported by UNICEF and UNFPA has generated demand from medical college professors for similar training, with a view to incorporating this methodology in their hospitals and in the curricula for training graduates. In another development, the Emmanuel Hospital Group in India, an AMDD leadership grant recipient, invited a team of 1 doctor and 2 nurses from the Addis Ababa Fistula Hospital to go to India to train doctors in fistula repair and care of fistula patients. The Coryell Foundation funded the trip.
Africa region	RPMM convened a regional workshop in Cote d'Ivoire, co-sponsored with AMDD, for national teams of doctors, midwives, anesthetists, social scientists, community physicians, and lawyers on "Preventing Maternal Deaths as a Human Rights Issue".. RPMM convened another regional workshop in Zimbabwe on EmOC methodology for 19 national multi-disciplinary teams.

LEVERAGING RESOURCES (continued)

report and meeting on obstetrical fistula; and citing EmOC projects in the UNFPA executive report for 2001.

AMDD is one of 12 partner institutions collaborating with UNFPA and the Development Gateway Foundation on the POP/RH Portal, an Internet initiative focusing on population and reproductive health. Meanwhile, three regional UNFPA centers have requested distance learning training modules for EmOC training - Thailand, Botswana and Uganda, and the AMDD/UNFPA project in Mozambique has translated Module 2 "Using Indicators to Assess Progress in Reducing Maternal Deaths" of the Distance Learning Course into Portuguese for distribution to all Lusophone countries.

In Peru, CARE organized meetings at the Ministry of Health in Lima in May 2002 to brief officials about their programs to improve maternal health in rural areas. The Ministry representatives were particularly interested in the managerial strategies employed in the AMDD-supported CARE project (Foundations to Enhance the Management of Maternal Emergencies – FEMME) to increase access and utilization of EmOC in Ayacucho, especially in the clinical protocols, wall flowcharts that synthesize the steps of clinical

management, and the UN process indicators. They were also interested to learn how the health staff at EmOC facilities had simplified record-keeping, especially for the admission, hospitalization and follow-up of patients treated at EmOC facilities. Another important issue was the collaboration between the project, the Regional Health Directorate in Ayacucho, and the National Maternal and Perinatal Institute to provide training on EmOC to doctors and midwives.

As a result of the Ministry's interest, CARE project staff and partners were invited to participate in the National Workshop to Exchange Experiences for Safe and Healthy Motherhood which took place in Lima in May. Participants included high-ranking Ministry officials, representatives from PAHO, UNFPA and UNICEF, as well as maternal and child health program representatives from the 34 Regional Health Directorates from across the country. The Ayacucho Regional Health Director presented the FEMME project. The Ministry requested that each Regional Directorate representative be given a set of the EmOC protocol guidelines and flowcharts. ■

A FIRST FOR GELEMSO



At the start of the summer of 2002, AMDD received the picture of the first baby born by cesarean section in the hospital in Gelemso, Ethiopia. When the CARE-AMDD project began, there was only one small health facility in this district, which provided minimal services. In 2000, a district hospital was built but did not function because of staffing and management problems. Site visits by CARE and AMDD technical staff focused on resolving the problems, working with hospital staff and the ministry of health. The first C-section signifies that it is now a functioning, comprehensive facility – although still the only one for a population of 1.6 million with about 72,000 births every year. ■

FIGO-AMDD AWARD

The FIGO-AMDD Distinguished Community Service Award was established in 2001 to recognize health professionals who have made special efforts to prevent the needless deaths of women due to pregnancy and childbirth. Some of the award funds a reception at which the awardee is honored for his or her contribution. The bulk, \$5,000, is granted to the recipient's facility to help improve services.

Dr. Lilit Poghossian, a 2002 awardee, put the \$5,000 grant towards the repair of the roof of the Gumri maternity in Gumri, Armenia. The 50-bed maternity handles around 1,500 deliveries a year, serving not just the population in its catchment area but also the Armenian population across the border in neighboring Georgia. C-sections account for some 10% of births in the hospital, while the fatality rate has been between 1.2% and 1.7% over the past four years. While the grant covered a good part of the renovation, more funds are needed to complete the roof repair project, and Dr. Poghossian is approaching donors.

Dr. Poghossian's June reception was the first festivity to be held after an earthquake affected the region, which is seriously economically deprived. The 109 people present included Gumri maternity staff, representatives of the mayor's office, and other medical professionals and dignitaries, and the ceremony was broadcast on Armenian television. ■

AVERTING MATERNAL DEATH AND DISABILITY (AMDD)

HEILBRUNN DEPT. OF 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](http://www.amdd.hs.columbia.edu)