

## **FIGO SAVING MOTHERS AND NEWBORNS PROJECT**

# **Summary Evaluation**

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## CONTENTS

|   |    |
|---|----|
| ACKNOWLEDGEMENTS .....  | i  |
| ACRONYMS.....   | ii |
| EXECUTIVE SUMMARY .....   | iv |
| <br>  |    |
| 1. INTRODUCTION.....  | 1  |
| 1.1 The Saving Mothers and Newborns Initiative .....                  | 1  |
| <br>  |    |
| 2. METHODOLOGY FOR THE PROJECT EVALUATIONS .....                      | 3  |
| 2.1 Field visits .....  | 3  |
| 2.2 Desk reviews .....  | 3  |
| 2.3 Synthesis report.....   | 4  |
| <br>  |    |
| 3. SYNTHESIS OF EVALUATION FINDINGS.....                              | 5  |
| 3.1 The projects .....  | 5  |
| 3.2 Approaches adopted to reduce maternal and newborn mortality ..... | 6  |
| 3.3 Individual project achievements .....                             | 8  |
| <br>  |    |
| 4. PROJECT MANAGEMENT .....   | 31 |
| 4.1 Mentoring/twinning.....   | 31 |
| 4.2 Log Frames.....   | 32 |
| 4.3 Project and Financial management .....                            | 32 |
| 4.4 Relationship between project teams and FIGO .....                 | 34 |
| <br>  |    |
| 5. KEY CHALLENGES .....   | 35 |
| 5.1 Challenges faced by project teams.....                            | 35 |
| 5.2 Challenges faced by FIGO .....                                    | 40 |
| <br>  |    |
| 6. CONCLUSION AND LESSONS LEARNT .....                                | 42 |
| 6.1 Conclusion .....  | 42 |
| 6.2 Lessons learnt .....  | 43 |

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## ACRONYMS

|       |  |
|-------|--|
| AIP   | ALARM International Programme                              |
| AISFH | <i>Association des Infirmierres et Sage Femmes d’Haiti</i> |
| ALARM | Advances in Labour and Risk Management                     |
| AMRN  | African Midwives Research Network, Uganda Chapter          |
| AOGU  | Association of Obstetricians and Gynaecologists in Uganda  |
| BDSH  | Barau Dikko specialist Hospital                            |
| BEmOC | Basic Emergency Obstetric Care                             |
| CBCA  | Criterion Based Clinical Audits                            |
| CDB   | Croix des Bouquets Health Centre                           |
| CFR   | Case Fatality Rate   |
| CHW   | Community Health Worker                                    |
| CEmOC | Comprehensive Emergency Obstetric Care                     |
| CSO   | Civil Society Organisation                                 |
| EmOC  | Emergency Obstetric Care                                   |
| EmONC | Emergency Obstetric and Neonatal Care                      |
| FIGO  | International Federation of Gynaecology and Obstetrics     |
| IS    | <i>Iniciativas Sanitarias</i>                              |
| KMA   | Kosovo Midwives Association                                |
| KOGA  | Kosovo Obstetrics & Gynaecology Society                    |
| KOGS  | Kenya Obstetrician and Gynaecology Society                 |
| LHW   | Lady Health Worker   |
| MAM   | Moldovan Association of Midwives                           |
| MAP   | Midwifery Association of Pakistan                          |
| MDG   | Millennium Development Goals                               |
| MMR   | Maternal Mortality Rate                                    |
| MoH   | Ministry of Health   |
| MVA   | Manual Vacuum Aspiration                                   |
| NANM  | Nigerian Association of Nurses and Midwives                |
| NGO   | Non Governmental Organisation                              |
| PPH   | Post Partum Haemorrhage                                    |

|       |   |
|-------|---|
| SGU   | <i>Sociedad Ginecotologica de Uruguay</i>                           |
| SHOG  | <i>Société Haïtienne d'Obstétrique et de Gynécologie</i>            |
| Sida  | Swedish International Development Cooperation Agency                |
| SMN   | Saving Mothers and Newborns   |
| SOGC  | Society of Obstetricians and Gynaecologists of Canada               |
| SOGM  | Society of Obstetricians and Gynaecology of the Republic of Moldova |
| SOGON | Society of Obstetricians and Gynaecologists of Nigeria              |
| SOGP  | Society of Obstetricians and Gynaecologists of Pakistan             |
| SPOG  | Peruvian Society of Obstetricians and Gynecologists                 |
| TBA   | Traditional Birth Attendant   |
| UAOG  | Ukrainian Association of Obstetrician and Gynaecologists            |
| VLSA  | Village Loan and Savings Association                                |

## EXECUTIVE SUMMARY

The Saving Mothers and Newborns (SMN) Initiative (2006 – 2011) comprised ten country projects led by professional associations of obstetricians and gynaecologists. The Initiative was funded by Sida and FIGO and managed, at different times, by FIGO (London) and SOGC (Canada).

Individual country associations designed, managed and implemented a range of projects all of which had the purpose of reducing maternal and/or newborn mortality. Depending on the perceived needs of each country, projects were implemented covering a wide number of activities including clinical training, development and introduction of standards, protocols and clinical audit, refurbishment of health facilities, and advocacy for policy and legislative change around abortion.

Country teams were largely voluntary and undertook project work alongside existing clinical and professional commitments. Project management required a steep learning curve in administration and financial management, although support was provided by FIGO staff and in, some cases, by recruitment of part-time project administrators.

A key feature of the SMN Initiative was North-South mentoring by obstetricians and midwives. This resulted in shared learning, additional resources being leveraged and strengthening of project activities and reports. Accessing funding for in-country mentoring visits was a challenge in some cases, but overall the mentoring process was considered useful and added value to the overall initiative. Lessons have been learnt, however, about how to optimise mentoring efforts and benefits and these have been incorporated into on-going FIGO projects.

The majority of projects achieved remarkable results, particularly considering their size and funding, and the voluntary nature of the undertaking. In many cases the scale of achievements (sometimes resulting in national-level uptake of training, audit and, in one case, national change to legislation) were beyond initial expectations. The majority of projects are also continuing beyond the period of funding. In many cases dissemination of project achievements and their integration into wider clinical practice has come about through individual project team members taking on significant positions within national associations, or incorporating lessons learnt during the project into new clinical positions and departments.

The SMN Initiative has also increased the capacity of FIGO itself and broadened its role to enable it to become an active initiator and manager of field-based multi-country projects. Valuable lessons have been learnt both by FIGO and individual project teams particularly around project design, implementation and management, resulting in strengthening of both the clinical capacity of health professionals but also their skills in leadership and project management.

## 1. INTRODUCTION

The International Federation of Gynaecology and Obstetrics (FIGO) brings together professional associations of obstetricians and gynaecologists on a global basis in order to promote the well-being of women and their children and to raise standards of practice in obstetrics and gynaecology.

As the successor to FIGO's Save the Mothers Initiative, the Saving Mothers and Newborns (SMN) Initiative (2006 – 2011) secured 4.6 million US dollars, of which a large part (US\$ 2.3 million) was contributed from the Swedish International Development Cooperation Agency (Sida). The remaining project funds were provided by FIGO.

The SMN Initiative was initially managed by FIGO (London based) but management responsibility was later contracted out to the Society of Obstetricians and Gynaecologists of Canada (SOGC) under the direct supervision (for financial and administrative issues) of Dr. A. Lalonde and the FIGO Saving Mothers and Newborn Health Committee (SMNH) members. Project coordination was undertaken by, at various stages, Margaret Walsh (midwife), Amanda Lee, Moya Crangle (midwife), Caroline Montpetit and latterly Moya Crangle following her return from maternity leave.

FIGO commissioned Options Consultancy Services to provide technical support during the initial stages of the SMN Initiative and to undertake final evaluations of the initiative in each of the ten participating countries. The findings from these evaluations are summarised in this synthesis report. The purpose of this synthesis report is to identify progress made against the project indicators (Box 1) and use the lessons learnt by implementing professional associations to provide FIGO with recommendations for the design and implementation of future initiatives.

### **Box 1: SMN Initiative Indicators**

- Improvements in access to essential obstetrical care services
- Improvements in access to skilled birth attendants
- Improved health facilities
- Lowering of maternal case fatality rate
- The level of community mobilization and participation
- How social and cultural barriers to maternal care have been identified and addressed
- Improvements in collaboration and engagement of health providers, governments, and civil society to understand and prevent maternal and newborn mortality.

### 1.1 The Saving Mothers and Newborns Initiative

The SMN Initiative was launched in 2006 with the goal of reducing maternal and newborn morbidity and mortality, and contributing to the achievement of Millennium Development Goals (MDG) 4 and 5 (Box 2). Secondary objectives included:

1. Strengthening the capacity of national professional associations to engage in maternal and newborn health through the design and implementation of projects in the field.
2. Strengthening cooperation between national associations and national stakeholders involved in safe motherhood and newborn health.
3. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.

**Box 2: Millennium Development Goals**

**MDG 4:** Between 1990 and 2015 reduce by two thirds the mortality rate among children under five.

**MDG 5:** Between 1990 and 2015 reduce by three quarters the maternal mortality ratio.

An additional key feature of the initiative was development of North-South partnerships through the establishment of twinning mechanisms between obstetrics, gynaecology and, where possible, midwifery associations in developed countries and in the ten participating country projects (Box 3).

**Box 3: Countries and Professional Associations participating in the SMN Initiative**

| Region                          | Country  | Participating Professional Associations   |
|---------------------------------|----------|---|
| Africa                          | Kenya    | <ul style="list-style-type: none"> <li>Kenya Obstetrician and Gynaecology Society (KOGS)</li> </ul>   |
|                                 | Nigeria  | <ul style="list-style-type: none"> <li>Society of Obstetricians and Gynaecologists of Nigeria (SOGON)</li> <li>Nigerian Association of Nurses and Midwives (NANM)</li> </ul>          |
|                                 | Uganda   | <ul style="list-style-type: none"> <li>Association of Obstetricians and Gynaecologists in Uganda (AOGU)</li> <li>African Midwives Research Network, Uganda Chapter (AMRN)</li> </ul>  |
| Eastern Europe                  | Kosovo   | <ul style="list-style-type: none"> <li>Kosovo Midwives Association (KMA)</li> <li>Kosovo Obstetrics &amp; Gynaecology Society (KOGA)</li> </ul>                                       |
|                                 | Moldova  | <ul style="list-style-type: none"> <li>Society of Obstetricians and Gynaecology of the Republic of Moldova (SOGM)</li> <li>Moldovan Association of Midwives (MAM)</li> </ul>          |
|                                 | Ukraine  | <ul style="list-style-type: none"> <li>Ukrainian Association of Obstetrician and Gynaecologists (UAOG)</li> </ul>   |
| Latin America and the Caribbean | Haiti    | <ul style="list-style-type: none"> <li>Association des Infirmières et Sage Femmes d'Haiti (AISFH)</li> <li><i>Société Haïtienne d'Obstétrique et de Gynécologie</i> (SHOG)</li> </ul> |
|                                 | Peru     | <ul style="list-style-type: none"> <li>Peruvian Society of Obstetricians and Gynecologists (SPOG)</li> </ul>  |
|                                 | Uruguay  | <ul style="list-style-type: none"> <li><i>Sociedad Ginecologica de Uruguay</i><sup>1</sup> (SGU)</li> <li>Uruguayan Obstetric Midwives Association</li> </ul>                         |
| South Asia                      | Pakistan | <ul style="list-style-type: none"> <li>Society of Obstetricians and Gynaecologists of Pakistan (SOGP)</li> <li>Midwifery Association of Pakistan (MAP)</li> </ul>                     |

<sup>1</sup> Uruguayan Gynaecological Society



## **2. METHODOLOGY FOR THE PROJECT EVALUATIONS**

The final evaluations were undertaken in two ways: field visits and through desk-based reviews. Funding intended to enable country visits to all projects was, in part, used to provide on-going technical and project management support to individual projects. As a result, final field visits were made only to those projects which had continued to face on-going challenges or had achieved exceptional outcomes.

### **2.1 Field visits**

Field visits of 5 days were undertaken in six countries: Haiti, Nigeria, Peru, Pakistan, Uganda and Ukraine.

Prior to the field visits the consultant undertaking the evaluation reviewed written material such as narrative reports, project log frames etc. During the field visit the consultant interviewed project staff, health professionals who had participated in professional development training provided as a result of project funding, and other key stakeholders identified by FIGO. Where possible site visits were also undertaken to participating health facilities. Project mentors were contacted for their views by email.

### **2.2 Desk reviews**

Desk reviews were undertaken of projects in the four remaining participating countries: Kenya, Kosovo, Moldova and Uruguay.

Each desk review took three days and involved a review of written material produced by the project; telephone interviews with key individuals within each project; and email correspondence with other participants and stakeholders, such as project mentors. Progress was assessed against project log frames and baseline reviews undertaken in each country during the first year of the project by a technical specialist from Options Consultancy Services. Where possible the baseline review and final evaluation in each country were undertaken by the same consultant, however, this was not possible for all projects.

Qualitative and quantitative project data were reported in the evaluations and each report was sent to project teams for review, verification and comments prior to submission to FIGO.

Despite substantial time and budget constraints feedback from project teams indicate that the individual evaluations captured the key successes and challenges, and provided constructive recommendations on ways forward for each project team beyond the period of project funding. The evaluation reports also provided information on opportunities and challenges to the sustainability of project achievements in each country. Evaluation reports were sent to all key informants for review, verification and comments prior to submission to FIGO.

## 2.3 Synthesis report

This synthesis report is a requirement of Sida who provided funding for the SMN Initiative. It is also intended to be a useful tool for FIGO by highlighting, as well as the key achievements and challenges, issues that could be considered and strengthened in future multi-country projects.

The report has been produced through a review of all final project evaluations, and key project documents. In addition telephone interviews and email correspondence were used to elicit information from FIGO and SOGC staff, and the Saving Mothers and Newborn Health Committee members, particularly Andre Lalonde, David Taylor, Moya Crangle and Raj Waghela in order to obtain strategic perspectives on both the successes and challenges faced by the SMN Initiative and on how lessons learnt could support future FIGO initiatives.

It should be noted that not all projects reported on all overarching SMN Initiative indicators. This is due to the varying nature and coverage of individual country projects. As a result both overarching indicators and project-specific activities are reported.

### 3. SYNTHESIS OF EVALUATION FINDINGS

This section provides a synthesis of the findings from the ten final evaluations. The purpose of this synthesis is to assist FIGO increase the impact of its future work, and help inform strategic decisions regarding how best to focus future investment of efforts.

#### 3.1 The projects

The overarching purpose of the SMN Initiative was to reduce maternal and neonatal mortality. The ten in-country projects sought to do this in different ways, demonstrating a heterogeneity of objectives and outcomes which reflect both the local contexts within which and for which they were developed; but also the challenges and opportunities facing professional associations undertaking activities outside their normal sphere of professional responsibility. A summary of each of the ten projects is provided in Box 4.

**Box 4: Summary of the ten SMN country projects**

**Haiti: ‘Strengthening the Health Centre of Croix des Bouquets’.** The project aimed to strengthen the health centre of Croix des Bouquets (CDB) through provision of basic emergency obstetric care (BEmOC) and comprehensive emergency obstetric care (CEmOC); develop collaboration with community organisations and partners; and to increase collaboration between the SHOG and the National Ministry of Health.

**Kenya: ‘Improving Quality of Antenatal, Delivery and Postnatal Care through Clinical Audit’.** Criterion based clinical audits (CBCA) were introduced in four facilities to improve quality of maternal and neonatal care. Alongside this the project aimed to improve the accessibility and acceptability of EmOC to women through enhanced community awareness and involvement and to strengthen the capacity of professional societies in Kenya to support national efforts at improving maternal and neonatal health care.

**Kosovo: ‘Reduction of Maternal and Newborn Mortality’.** The overall objective was to enable KOGA and KMA to take an active part in improving the quality of maternal and newborn care through strengthening organizational capacity; assuming a leadership role in the development and implementation of national standards and protocols in regional and university maternities; and to initiate partnerships with other stakeholders or peer institutions such as professional associations in the regions, EU and within FIGO, including women's and clients' groups.

**Moldova: ‘Beyond the Numbers - implementation of new approaches of reviewing perinatal deaths’.** The project aimed to reduce perinatal mortality amongst babies with a gestational age of more than 37 weeks and with a birth weight of 2500g or more by implementing perinatal mortality audits to improve maternal and newborn care.

**Nigeria: ‘Saving Mothers and Newborns in Edo, Amambra and Kaduna States’.** Improved collection and use of data were implemented, particularly through birth register records, fatal outcome records, and clinical audit. Training in EmONC was undertaken to improve the quality of care in three selected hospitals. The project also aimed to strengthen the capacity of SOGON and NANM to improve EmONC services through protocol development and advocacy activities.

**Pakistan: ‘Community Based Interventions to Reduce Maternal and Perinatal Mortality and Morbidity in Rural Sindh’.** The project's objective was to improve provision of EmONC in health care facilities in Thatta District through establishment of effective 24/7 BEmOC; increased community awareness of pregnancy related complications matched by demand for maternal and

child health care; and that project data were used effectively to inform decision-making and policy development.

**Peru: ‘Improving Obstetric and Neonatal Emergency Care in Morropon-Chulucanas Health Network, Piura’.** The project was designed to support the Ministry of Health to operationalize more effectively its commitment to reducing maternal mortality through a holistic and participatory approach emphasising human rights, gender equity and community participation. Technical capacity of the district health network was strengthened to identify and attend high risk pregnancies. The project also aimed to increase in the proportion of deliveries attended by skilled obstetric personnel by raising community awareness of obstetric risks and maternal health.

**Uganda: ‘Reduction of Maternal and Newborn Mortality’.** The objectives of the project were to improve women’s access to and utilization of EmONC; strengthen provision of EmONC services within 6 health units in two districts; and to strengthen the capacity of the AOGU and AMRN to support EmONC.

**Ukraine: ‘EmOC Improvement by Advances in Labour and Risk Management (ALARM) International Program (AIP)’.**<sup>2</sup> The project aimed to develop UAOG and its regional associations’ capacity to deliver AIP; and to roll-out delivery of the Programme in three regions. The project also aimed to develop relationships with key stakeholders in Local Government Administrations (Ministries of Health) and Chief Obstetricians/Gynaecologists in the regions to increase the sustainability of the project.

**Uruguay: ‘To Protect the Life and Health of Uruguayan Women by Reducing Unsafe Abortions’.**<sup>3</sup> The project sought to reduce the number of abortions performed under conditions of risk in Uruguay; reduce maternal morbidity and mortality associated with abortion; and implement a sustainable model at the national level (within a legal context of harm reduction and human rights) for reducing the number of abortions performed under conditions of risk in Uruguay.

### 3.2 Approaches adopted to reduce maternal and newborn mortality

It was originally decided that FIGO would support six projects each having similar key objectives, thus allowing cross-project evaluations of progress and outcomes. This would also have provided some economies of scale in terms of external support provided by FIGO. Early in the design stage, however, it was decided that FIGO should, instead, be responsive to the perceived needs of each country as identified by national professional associations. Three projects from Central South America were also included at the request of FIGO officers. A final project was also accepted in Ukraine. This meant that ten very different country projects were designed and implemented.

Allowing national associations the autonomy to frame projects around key issues of perceived need was costly, in terms of resources, to FIGO but meant that each country association had a strong sense of ownership of their project and that projects were well suited both to the needs of women and newborns in each

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<sup>2</sup> The project was initially funded by USAID, however, funding was cancelled after the second year. The remaining two years were funded directly by FIGO and SOGC.

<sup>3</sup> Also referred to in some documents as: ‘*Iniciativas Sanitarias Contra el Aborto Producido en Condiciones de Riesgo*’ or ‘Health Initiatives Against Unsafe Abortions’.

country. This focussed approach and clear ownership of each project was vital in ensuring the motivation of the, largely, voluntary project teams. It also meant that the overall SMN Initiative moved beyond being a cross-national comparative study of a specific set of emergency obstetric care (EmOC) interventions. Instead it became a catalyst for a range of needs-led, autonomous projects owned and implemented by national associations with a strong sense of ownership of their project and, thus, an increased incentive to design and implement cost-effective approaches to supporting reductions in maternal and newborn morbidity and mortality.

The individual projects utilised a range of approaches to achieve their objectives. The choice of approach was influenced by factors that included the local context, perceived need and potential impact.

For the purposes of this report, project approaches have been arranged under six broad categories (Table 1). These categories are not mutually exclusive and many projects incorporated elements of several approaches.

- **Community level collaboration:** this focuses on strengthening relationships with communities in order to increase demand for and access to health services.
- **Organisational and professional collaboration:** this involved working with civil society organisations and NGOs to leverage funds and resources additional to those covered by the SMN project budget. Collaborations aimed to strengthen relationships between professional associations but also between clinical staff in order to enhance collaborative working and achieve improved health outcomes
- **Advocacy:** activities ranged from engaging with traditional leaders and communities to increase awareness of, and collaborate with, individual projects through to high level advocacy to bring about high-level policy change at local, regional and/or national level.
- **Strengthened clinical services:** this involved increasing provision of human and physical resources, including buildings, referral services and equipment. Human resource capacity was also increased through clinical training in order to achieve direct improvements in provision of care and clinical outcomes.
- **Rights based approach:** Addressing disparities in women's access to skilled birth attendance and to essential obstetric care resulting from women's lack of rights, low status and lack of power, poor access to information and care, restricted mobility, early age of and marriage, the low political priority and resources given to their health, and weak legal and policy frameworks.
- **Institutional strengthening of professional associations** was a cross-cutting theme across all projects. Support and technical assistance was provided by FIGO, members of FIGO's Saving Mothers and Newborn Health (SMNH) committee and project mentors. The key focus was building the capacity of national obstetrics/gynaecology and midwifery associations to conduct projects relevant to the promotion of safe motherhood and maternal health.

Across these different approaches, a wide range of activities were undertaken to increase the capacity of clinical staff, strengthen continuing professional training, increase clinical supervision and reflective practice, increase awareness of, demand

for and access to services; and engage national and local governments in efforts to reduce maternal and neonatal mortality. The following sections describe the overall key areas of achievement and the challenges faced by individual in-country projects, with specific reference to the overall SMN project objectives.

### **3.3 Individual project achievements**

The majority of projects achieved better than expected levels of success against their key objectives, although it was hard to measure impact because of challenges in project teams' understanding of log frames. Progress against objectives was achieved despite very limited budgets and significant constraints on the time of many project team members (volunteerism was a key principle of engagement in the projects). Many projects also faced unexpected external challenges including natural disasters (such as the Haiti earthquake in 2010, and flooding in Pakistan), political fragility and civil unrest, for example in Kenya. It is remarkable that so much was achieved by each project team was remarkable, and a credit to the spirit of volunteerism and professional collaboration. It is also, in large part due to Sida's flexibility in allowing changes to budget lines and, in some cases, the focus of expenditure according to need (for example the purchase of an ambulance in Haiti).

FIGO was also responsive to the needs of project teams in order to optimise project outputs. It provided substantial unpaid support and resources to catalyse project activities. This included providing financial administration and project management support and capacity building; under-taking support visits by in-country members of its SMNH committee, and providing contingency funds to ensure that projects were able to continue in the face of external catastrophes such as the earthquake in Haiti.

The main cross-cutting challenges faced by many project teams; together with specific circumstances that impacted on the progress of individual projects are discussed in Chapter 4. The progress achieved, despite a lack of project experience among the in-country teams, demonstrates the perceived need among dedicated health professionals for projects such as this; and their willingness to commitment substantial amounts of unpaid time and, often, personal resources to achieve improvements in maternal health outcomes. It also demonstrates the demand at community level for maternal and neonatal health services when they are perceived as high quality, culturally appropriate and easily accessible.

The remainder of this section sets out key project achievements in relation to the overall SMN Initiative objectives (see Table 2 for a summary of particularly notable achievements by individual project). Some of these were in line with pre-determined project outcomes; others were reactive responses to specific needs that arose during the course of the project and had a catalytic impact on subsequent progress). Fuller examples of these and other significant project outcomes are highlighted in the boxes inserted throughout the text.

**Table 1: Project approaches and activities**

| Approach   | Main purpose   | Activities   |
|--|--|--|
| <b>Community level collaboration</b>                 | <ul style="list-style-type: none"> <li>Working directly with beneficiaries to increase demand for and access to care</li> <li>Building relationships between project, communities and key local stakeholders</li> <li>Increasing access to services through raising awareness of services available and improvement in access to referral services</li> <li>Awareness raising and knowledge development</li> <li>Building capacity and ownership within communities</li> <li>Increasing access to referral facilities</li> </ul> | <ul style="list-style-type: none"> <li>Word of mouth</li> <li>Community and schools-based outreach</li> <li>Engaging with community- and traditional-leaders, and men</li> <li>Training community members, Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) to recognise danger signs in pregnancy</li> <li>Initiating and supporting a community-based saving scheme (supporting more than 160 communities) to manage funds to ensure access to health facilities</li> <li>Introduction of an emergency referral fund for poor women</li> <li>Construction of 'waiting houses'</li> <li>Recruiting and training local women as midwives</li> </ul> |
| <b>Organisational and professional collaboration</b> | <ul style="list-style-type: none"> <li>Engaging with non-governmental organisations (NGO) to obtain additional funds and resources</li> <li>Collaborating with professional associations to engage in training, implement audits and strengthen service provision</li> </ul>   | <ul style="list-style-type: none"> <li>Construction and rehabilitation of buildings</li> <li>Provision of vehicle and on-call driver to transport referrals</li> <li>Multi-disciplinary training and working</li> <li>Collaborations between nurses, midwives, obstetricians, gynaecologists, anaesthetists and paediatricians</li> <li>Sensitisation of professionals to the needs of peers working in rural settings</li> </ul>  |
| <b>Advocacy</b>                                      | <ul style="list-style-type: none"> <li>Raising awareness of women's rights and entitlements at national level</li> <li>Promoting legislative and policy change</li> <li>Using existing precedents and international protocols/agreements to achieve women centred care and a rights based approach</li> </ul>  | <ul style="list-style-type: none"> <li>Involvement in policy making to amend/enact national policies and legislation, particularly on abortion and women's right to care</li> <li>Engaging with CSOs, international NGOs and government to secure funds and resources, commitments and policy change</li> <li>Engagement with high profile public figures to act as 'champions' of maternal and newborn health</li> </ul>  |
| <b>Strengthened clinical services</b>                | <ul style="list-style-type: none"> <li>Achieving direct improvements in provision of clinical care</li> <li>Working with providers of health services to achieve better clinical outcomes</li> </ul>   | <ul style="list-style-type: none"> <li>Recruitment, training and supervision of staff</li> <li>Provision of medical equipment and medicines</li> <li>Criterion Based Clinical Audit</li> <li>Perinatal Confidential Enquiry Audit</li> <li>Development of clinical standards and protocols</li> <li>Development of training modules and changes to national curricula</li> </ul>   |

|                              |  |  |
|------------------------------|--|--|
|                              |  | <ul style="list-style-type: none"> <li>• Training of trainers</li> <li>• Introduction of and training in ALARM International Programme</li> <li>• International training materials adapted to suit local context</li> <li>• Introduction of 'new' technologies e.g. magnesium sulphate, manual vacuum aspiration, nonpneumatic anti-shock garment, active management of the third stage of labour, manual vacuum aspiration, partogram</li> <li>• Capacity of midwives and nurses enhanced through expansion of roles</li> <li>• Provision of emergency response kits</li> <li>• Introduction of 24/7 emergency response team</li> </ul> |
| <b>Rights based approach</b> | <ul style="list-style-type: none"> <li>• <b>Achieving women-centred, non-judgemental care</b></li> </ul> | <ul style="list-style-type: none"> <li>• Ensuring informed consent for all procedures</li> <li>• Increased cultural sensitivity of staff towards the needs and rights of poor and otherwise marginalised women and newborns</li> <li>• Legislating for women's right to appropriate, evidence-based care particularly in relation to unwanted pregnancy</li> </ul>   |



**Table 2: Summary of notable project achievements**

| Country  | Selected achievements   | Direct impact on project outcomes   |
|----------|---|---|
| Haiti    | <ul style="list-style-type: none"> <li>Primary health clinic transformed into functioning hospital<sup>4</sup></li> <li>Ambulance purchased and on-call driver contracted</li> </ul>                                  | <ul style="list-style-type: none"> <li>Provision of 24-hour EmOC (previously, only out-patient services existed).</li> <li>Appropriate referrals to tertiary care</li> </ul>  |
| Kenya    | <ul style="list-style-type: none"> <li>Uptake of clinical audit extended beyond maternity into general surgery<sup>5</sup></li> </ul>   | <ul style="list-style-type: none"> <li>N/A</li> </ul>   |
| Kosovo   | <ul style="list-style-type: none"> <li>First set of national standards developed by a clinical body produced by national Association and approved by Ministry of Health (MoH)</li> </ul>                              | <ul style="list-style-type: none"> <li>Clinicians trained in ALARM<sup>6</sup> International Programme</li> <li>Quality of clinical care improved</li> </ul>                  |
| Moldova  | <ul style="list-style-type: none"> <li>National registration of all perinatal deaths</li> </ul>   | <ul style="list-style-type: none"> <li>Institutionalisation of clinical audit</li> </ul>  |
| Nigeria  | <ul style="list-style-type: none"> <li>Magnesium sulphate supplied to all State hospitals by Kaduna State Government</li> <li>Cost of magnesium sulphate in reduced by manufacturers</li> </ul>                       | <ul style="list-style-type: none"> <li>Significant reduction (approx. 28%) in maternal mortality due to eclampsia at Kaduna State project site</li> </ul>                     |
| Pakistan | <ul style="list-style-type: none"> <li>Training local women as midwives</li> <li>Renovations led to functioning operating theatre</li> </ul>  | <ul style="list-style-type: none"> <li>Increased demand for services</li> <li>Caesarean sections and general surgery performed</li> </ul>                                     |
| Peru     | <ul style="list-style-type: none"> <li>Presidential attendance at project meeting; public commitment made to preventing abortion-related maternal mortality</li> </ul>  | <ul style="list-style-type: none"> <li>N/A</li> </ul>   |
| Uganda   | <ul style="list-style-type: none"> <li>Paradigm shift in professional organizational thinking led to collaborative working with non-health CSO to achieve improved health outcomes for rural women</li> </ul>         | <ul style="list-style-type: none"> <li>Implementation of community-based saving scheme in over 160 rural communities to ensure women's access to health facilities</li> </ul> |
| Ukraine  | <ul style="list-style-type: none"> <li>Reduction in level of inappropriate clinical interventions during delivery</li> </ul>  | <ul style="list-style-type: none"> <li>Provision of appropriate, evidence-based interventions routinised</li> </ul>   |
| Uruguay  | <ul style="list-style-type: none"> <li>Policy and legislative change</li> <li>Presidential support</li> <li>Creation of a sexual and reproductive health department within MoH, headed by project director</li> </ul> | <ul style="list-style-type: none"> <li>Women's access to appropriate care relating to unsafe abortion embedded in national legislation</li> </ul>                             |

### 3.3.1 Improvements in access to skilled birth attendants

Access to services can be both demand-driven (based on the desire and ability of community members to access health care) and supply-led (based on the ability of health workers to supply quality services). Demand driven perspectives of access are discussed later in the report. This section of the report focuses on the latter, and how the SMN projects increased access to skilled birth attendants through, in some cases, recruitment of new professionals but, more generally, through increasing and up-dating the skills of health professionals working at project sites and, often, in other health facilities covering wider catchment areas.

<sup>4</sup> Currently awaiting formal government approval.

<sup>5</sup> An unintended consequence of transfer of staff trained by FIGO project out of maternity care and into other hospital departments

<sup>6</sup> Advances in Labour and Risk Management

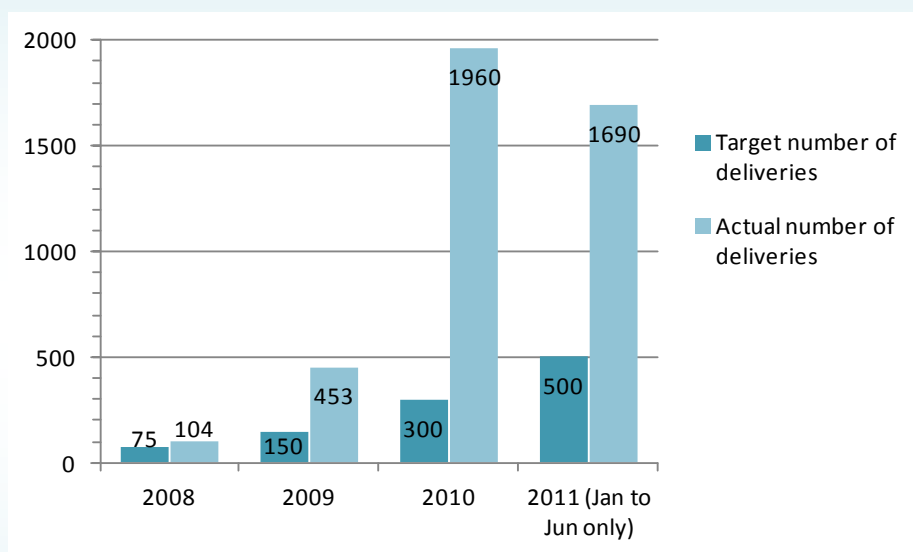
## Recruitment of health professionals

Project budgets were extremely limited and did not generally allow for recruitment of clinical staff. Two projects did, however, recruit new health professionals to increase women's access to skilled care during delivery. In Pakistan nine local women were recruited, trained and, importantly, retained as midwives. In the case of Haiti, staff recruited after the earthquake included: obstetrician-gynaecologists, anaesthetists, nurses and assistants for a newly constructed operating room, additional midwives and security personnel. These costs were covered by SOGC's Earthquake Relief Initiative between January to July 2010 and then by UNFPA between August 2010 and April 2011. Increased access to skilled birth attendants was both one of the key driving factors towards the very substantial increase in institutional deliveries at the health centre. It was, also, however, an essential component in enabling the facility to cope with the increased demand for services owing to the doubling of the population served by the facility due to relocation as a result of the earthquake (Box 5).

### Box 5: Increased access to skilled birth attendants in Haiti

The project was based in the Croix des Bouquets (CDB) Health Centre where, prior to the SMN Project, only antenatal and postnatal out-patient services existed. The project aimed, starting in year 1 (2008), to provide skilled birth attendance to 75 deliveries, increasing incrementally to 500 deliveries in year 4 of the project. This target was massively over-achieved by more than 6-fold in 2010 and 5-fold in 2011.

#### Target and actual number of deliveries per year at Croix des Bouquets:



Reasons for the project's success include: establishment of 24-hour basic emergency obstetric care; expansion of the maternity unit in order to be able to receive a greater number of women (particularly following the earthquake in 2010) and provide caesarean sections 24 hours a day (blood transfusion is available Mon-Fri, 9-5. Outside of these hours women requiring blood transfusion are referred). The number of women living close to the facility increased substantially following the earthquake due to emergency re-location efforts, but CDB is currently the only maternity service that offers care to women free at the point of delivery and this has had a significant impact on increasing demand for services.

Most projects, however, were not able to recruit additional health professionals and, instead, focused on increasing access to skilled birth attendants through increasing and up-dating the skills of existing service providers.

### *Clinical training*

Nine out of the ten country projects invested efforts in clinical training to up-grade and up-date the skills of existing health professionals in order to provide evidence-based care and provide women with access to better skilled staff during delivery. Nearly three thousand health professionals (and in some cases, other professionals) participated in clinical training during the course of the project (Table 3).

**Table 3: Provision of Clinical Training**

| Country               | Profession                       | Topic   | Total Trained  |
|-----------------------|----------------------------------|---|----------------|
| Haiti                 | Midwives                         | <ul style="list-style-type: none"> <li>Active management of third stage of labour</li> <li>Vacuum extraction</li> <li>Post partum haemorrhage,</li> <li>Newborn resuscitation</li> </ul>  | 9              |
| Kenya                 | Multi-disciplinary               | <ul style="list-style-type: none"> <li>Criterion Based Clinical Audit</li> </ul>  | 296            |
| Kosovo                | Doctors                          | <ul style="list-style-type: none"> <li>ALARM International Programme (AIP)</li> </ul>   | 60             |
|                       | Midwives                         | <ul style="list-style-type: none"> <li>AIP</li> </ul>   | 1              |
|                       | Doctors, Midwives                | <ul style="list-style-type: none"> <li>AIP Instructor Training</li> </ul>   | 6              |
| Moldova               | Midwives                         | <ul style="list-style-type: none"> <li>Perinatal audit</li> <li>Partograph and Foetal Heart Rate</li> </ul>   | 255            |
| Nigeria               | Doctors, Nurse-midwives          | <ul style="list-style-type: none"> <li>EmOC</li> </ul>  | 368            |
| Pakistan <sup>7</sup> | Obstetricians, Doctors, Midwives | <ul style="list-style-type: none"> <li>Infection Prevention</li> <li>Appreciative Inquiry Workshops</li> <li>Manual Vacuum Aspiration (MVA)</li> <li>Emergency Obstetric and Neonatal Care (EmONC)</li> <li>Competency Based Trainings</li> </ul> | ? <sup>8</sup> |
|                       | TBA                              | <ul style="list-style-type: none"> <li>Orientation (7-day) workshops</li> </ul>   | 125            |
|                       | Midwives                         | <ul style="list-style-type: none"> <li>Midwifery training</li> </ul>  | 9              |
| Peru                  | Physicians                       | <ul style="list-style-type: none"> <li>EmOC</li> </ul>  | 63             |
|                       | Midwives                         | <ul style="list-style-type: none"> <li>EmOC</li> </ul>  | 122            |
|                       | Nurses                           | <ul style="list-style-type: none"> <li>EmOC</li> </ul>  | 64             |
|                       | Other                            | <ul style="list-style-type: none"> <li>EmOC</li> </ul>  | 249            |
| Uganda                | Doctors, Midwives, Nurses        | <ul style="list-style-type: none"> <li>AIP</li> <li>EmONC</li> </ul>  | 90             |
|                       |                                  | <ul style="list-style-type: none"> <li>EmONC Instructor Training</li> </ul>   | 10             |
| Ukraine               | Doctors, Midwives                | <ul style="list-style-type: none"> <li>AIP<sup>9</sup></li> <li>AIP Instructor Training</li> <li>Post Partum Haemorrhage</li> </ul>   | 473            |
| Uruguay               | Multi-disciplinary               | <ul style="list-style-type: none"> <li>Women-centred care/rights based approach</li> <li>New clinical norms</li> </ul>  | 646            |
| <b>TOTAL</b>          |                                  |   | <b>2,846</b>   |

<sup>7</sup> Training was undertaken by project partners: Pakistan Medical Association, Midwifery Association of Pakistan, Women's Right to Life and Health, National Committee on Maternal and Newborn Health, and UNFPA

<sup>8</sup> Information on exact numbers trained not provided

<sup>9</sup> The number of AIP trainings held exceeded the project indicator due to demand

The majority of training took the form of continuing medical education and acquisition of new skills, particularly through AIP. In Pakistan training was expanded to include Traditional Birth Attendants (TBA). This was an important move since the majority of deliveries are attended by TBAs and their training was an important factor in increasing timely and appropriate referrals to health facilities.

A number of projects, for example Nigeria and Kosovo also invested in Training of Trainers and/or Instructor training. This enabled scaled-up roll-out of training (as a proportion of the number of health professionals in each country). This approach provides value for money, particularly when resources are scarce, and also strengthens the potential sustainability of project efforts through development of a pool of accredited trainers who are not necessarily dependent on project-specific funding to continue their training efforts.

Other projects, for example Ukraine, initiated joint training for doctors and midwives. This multi-disciplinary approach led to empowerment of midwives as a result of being seen successfully training doctors. It also led to midwives and doctors consistently adopting a team approach to management of labour and delivery. Previously, doctors assumed sole responsibility during the labour process, with midwives taking an 'assisting' role. Subsequent to undergoing AIP training, midwives reported feeling more confident to suggest procedures to doctors as well as taking on additional responsibilities.

Taking facility-based deliveries at project sites where clinical staff received training as an indicator of increased access to skilled birth attendants (see later in the report for demand-driven increases in access), then the projects which reported these data show significant increases (Table 4). These ranged from approximately 16% (Pakistan) to 454% (Haiti).

| <b>Table 4: Increased access to skilled birth attendants</b> |   |
|--|---|
| <b>Project</b>   | <b>Approx. % increase in access to skilled birth attendants</b> |
| <b>Haiti</b>   | 454   |
| <b>Pakistan</b>  | 16  |
| <b>Peru</b>  | 87  |
| <b>Uganda</b>  | 28  |

Haiti is, to some extent, an anomaly given its special circumstances. Due to relocation as a result of the 2010 earthquake the population living within the referral district of the CDB Health Centre doubled in size, but even accounting for this, the increase in deliveries is a remarkable achievement.

The other most significant change achieved was in Peru, where a total of 498 health workers were trained in EmOC. However, the clinical training alone does not fully explain the increased uptake of services. Instead, the combination of approaches used in these projects also resulted in demand-led change, stemming from within communities. These projects are excellent examples of how addressing both supply- and demand-side issues results in a greater overall increase in access to skilled birth attendants than focusing solely on a supply-side approach.

### 3.3.2 Increased access to existing, low cost evidence-based technologies, referral services and clinical best practice

Many projects facilitated access to evidence-based, often low-cost, approaches and technologies that had not, prior to the SMN project, been utilized by participating facilities. This section also expands beyond the concept of technologies to cover expansion of nurses' and midwives' clinical roles, and projects' utilization of other new (to them) approaches to increasing access to essential obstetrical services. These include active initiation of referral services, particularly vehicles and drivers and the establishment of emergency funds to cover the cost of referrals.

#### Technologies

'New' technologies were successfully incorporated into clinical practice by projects for which this was an explicit objective. Routine data collection has provided evidence of the extent to which uptake and appropriate use of these technologies (Table 5) impacted on reducing maternal and neonatal deaths (see also Box 6 for an additional example).

#### Box 6: Impact of active management of 3<sup>rd</sup> stage of labour

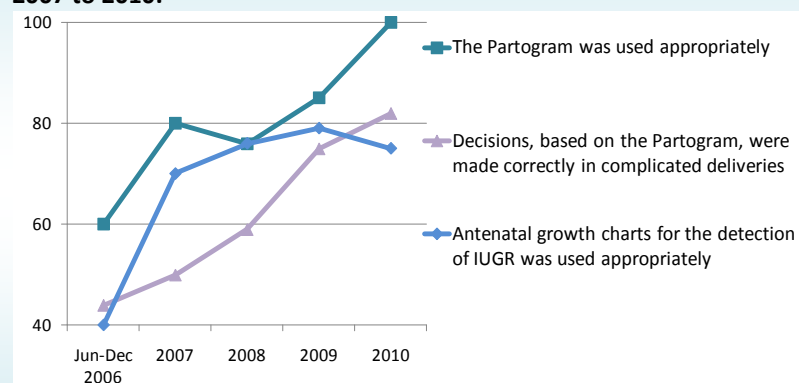
**Volnovaha City Hospital:** "Mother in labour presented with severe shoulder dystocia that was not responding to usual manipulations. As a result of the ALARM training, the Chief Obstetrician utilised algorithms learnt through the training. This resulted in a decision to try to reverse the labour and push the baby back towards the uterus and perform a c-section. This manoeuvre was performed successfully, resulting in a healthy baby and mother". (Final project evaluation report)

**Table 5: Uptake of 'new' technologies by project**

| Project                       | Technology                                     | Outcome (selected examples)   | Means of Verification                          |
|-------------------------------|--|---|--|
| Moldova and Kenya             | Partogram                                      | In Moldova partogram use enabled an almost 100% increase in identification of problems and appropriate clinical decision-making (from 44% of cases pre-2007 to 82% in 2010).  | Perinatal audit                                |
| Nigeria                       | Magnesium Sulphate                             | Case Fatality Rate due to eclampsia at project site in which magnesium sulphate was introduced fell from 35% to 11.1%   | Project monitoring                             |
| Uruguay and Pakistan          | Misoprostol                                    | Maternal deaths secondary to abortion decreased from an average of 4/year up to 2004 to zero/year since 2007. There have also been no deaths secondary to abortion in the entire country in the last 2 years following roll-out of the project model (informed choice regarding the safe use of misoprostol for abortion) (Uruguay)<br><br>In Pakistan, misoprostol was distributed at the community level to prevent postpartum haemorrhage. | Project monitoring                             |
| Haiti, Kenya, Uganda, Ukraine | Active management of the third stage of labour | "Improved active management of 3 <sup>rd</sup> stage of labour is not only improving outcomes of PPH but also preventing PPH in the first place" (Kenya).<br><br>Blood transfusions dropped from 4.36% to 1.03% (Ukraine)   | Final project evaluation<br>Project monitoring |
| Peru                          | Anti-shock garment, MVA                        | Incorporated as standard practice within EmOC and provided training on the use of the garment at facilities.  | Final project evaluation                       |

Increased use of partogram in Moldova and magnesium sulphate in Nigeria was particularly effective in reducing maternal mortality. The impact of their introduction is shown in more detail in Fig. 1 and Box 7 below. In the case of Nigeria, women's access to magnesium sulphate was additionally increased by highly effective advocacy efforts from the project team. This resulted in Kaduna State Government making magnesium sulphate available in

**Fig. 1: Moldova: Increased use of appropriate low-cost technologies for monitoring risk factors in the antenatal and postnatal period from pre-2007 to 2010.**



all public hospitals in the State, while advocacy to drug manufacturers resulted in a price reduction, making it more accessible through private pharmacies in the case of hospital stock-outs. This led to approximately 25% reduction in maternal mortality due to eclampsia at the project site.

#### **Box 7: Introducing Magnesium Sulphate for treatment of Eclampsia in Kaduna State, Nigeria**

*"In 2007, eclampsia was the main cause of maternal mortality (35%) at Barau Dikko Specialist Hospital (BDSH) Magnesium sulphate was not available at BDSH so the project team procured supplies, developed a treatment protocol and trained staff at the hospital and from surrounding nearby referral hospitals. In 2008, CFR due to eclampsia at the facility fell from 35% to 11.1%.*

*When it was clear that the introduction of Magnesium Sulphate was having a dramatic effect, the project team organized advocacy visits to Kaduna State MoH and also to the manufacturers of the drug. The State MoH agreed to purchase Magnesium Sulphate and make it available in all State hospitals. In addition, the Manufacturers agreed to reduce the price of Magnesium Sulphate so greater numbers of patients could afford to buy it privately. This is important as there are periods when the drug is not available in the state hospitals and should assist in sustaining reductions to maternal mortality from eclampsia." (Final project evaluation report)*

### **3.3.3 Improved health facilities**

Health facility up-grading, refurbishing and re-stocking was integrated into the activities of six projects (Table 6). Upgrading facilities and provision of essential drugs and equipment were important to ensure that other strategic project activities such as clinical training, protocols and standards could be adopted and institutionalised. Upgrading and re-stocking also contributed in part to the lowering of the maternal case fatality rate (CFR). Particularly encouraging is the development of a sustainable stock management system for renewable medical supplies and drugs in Haiti; and the continued use of the operating theatre in Pakistan for obstetric and general surgery.

**Table 6: Health facility up-grading, refurbishing and re-stocking**

| Project  | Improvement  |  | Directly Resulting Sustainable Change  |
|----------|--|--|--|
|          | Supplies and Equipment   | Infrastructure   |  |
| Haiti    | Multiple (post earthquake via development partners and other external sources including SOGC Earthquake initiative)  | Facility upgraded to accommodate: adequate generator, waste facilities, latrines, an operating room for maternity and new maternity wing | Development of stock management system for renewable medical supplies and drugs by midwife coordinator   |
| Kenya    | BP machines, foetal scopes, thermometers, urine sticks   |  | Increased utilisation of equipment   |
| Pakistan | All appropriate supplies and equipment for operating and theatre room  | Refurbishment of one operating theatre and one labour room   | Increased use of: <ul style="list-style-type: none"> <li>• Forceps</li> <li>• MVA</li> <li>• Caesarean-sections</li> </ul> Life-saving obstetric surgery performed: <ul style="list-style-type: none"> <li>• Obstetric hysterectomy for post partum haemorrhage (PPH)</li> <li>• Laparotomy for ruptured ectopic pregnancy</li> </ul> (General surgery also being performed as a result of up-grading) |
| Peru     | Purchase of emergency kits   |  | Increased receptiveness and responsiveness to emergency referrals and deliveries   |
| Uganda   | Purchase of: <ul style="list-style-type: none"> <li>• Delivery sets</li> <li>• Caesarean section sets</li> <li>• Protective wear</li> <li>• MVA kits</li> <li>• Neonatal weighing scales</li> <li>• Neonatal Ambu bags</li> <li>• Blood pressure machines</li> <li>• Stethoscopes</li> </ul> An emergency stock of drugs was provided to facilities until government supplies were provided: 3000 vials of oxytocin, 200 vials of magnesium sulphate | Water storage tanks purchased  | Equipment levels rose from 20% in 2006 to 75% in 2009. 100 vials of intravenous 10% Calcium gluconate  |
| Uruguay  |  | Minor changes to ensure client privacy   |  |



### 3.3.4 Lowering of maternal case fatality rate (CFR)

Lowering maternal CFR is fundamental to supporting countries achieve MDG 5. As described above, a range of supply-side (facility based) approaches were used by different projects to achieve this. One of the most significant project activities, however, was multi-disciplinary strengthening of existing clinical skills. The majority of projects focused on continuing medical education of obstetricians and midwives. In some cases, however, traditional birth attendants (TBA) were also trained to recognise danger signs and know when to refer clients to health facilities.

Training alone, however, cannot guarantee that new knowledge is actually implemented, particularly in resource constrained environments. Health professionals in developing countries work in highly challenging environments; often coping with political instability, lack of resources, staff shortages and low levels of motivation and, sometimes, civil unrest and natural disasters. Data collected by the SMN projects indicate that the training was reflected in improved clinical practice and that maternal case fatality rates, as well as many other clinical outcomes, were lowered in project sites where training was a core activity.

One reason why the training had an impact in so many projects is that it was frequently institutionalised within clinical practice through the development and implementation of standards and protocols. Essentially, development of standards and protocols was also generally accompanied by structured dissemination, increased staff awareness, adoption as best practice; and on-going monitoring of levels of uptake. This was not always the case, for example, in Nigeria four protocols were developed but it was noted during the project evaluation that the protocols were not displayed and there was limited awareness among staff of their existence.

The projects in Kenya, Moldova and Uganda made progress towards institutionalising evidence-based best practice by developing and institutionalising clinical audit alongside new standards and protocols (Table 7). This further increased professional accountability for maternal outcomes. Importantly, these projects adopted a no-blame audit approach and involved multi-disciplinary teams. This no-blame approach and, in the case of Criterion Based Clinical Audit (CBCA) <sup>10</sup>, highlighting positive aspects of clinical care fostered reflective practice, shared learning and, thus, continued strengthening of skills.

Individual projects reported reductions in case fatality rates against different criteria. In some instances data are presented as a proportion of total cases, in others against birth weight and gestational age, and in others against causes of maternal mortality. This makes it difficult to show comparative results across projects. Table 8 attempts to present an overall picture of changes over the life of each project but the footnotes should be referred to for an explanation of the data.

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<sup>10</sup> Rather than focusing on causes contributing to death (maternal death audit); CBCA allows staff to consider positive aspects of care that contribute to a woman's survival and health as well as identifying and analysing areas of poor (or sub-standard) care.



**Table 7: Supplementation of Training with Standards, Protocols and Audit**

| Country  | Standards/ Protocols Developed | Focus & Number   | Audit Initiated  | Type of Audit                         | Reported Impact of Audit   |
|----------|--------------------------------|--|------------------|---------------------------------------|--|
| Haiti    | No                             |  | No <sup>11</sup> |                                       |  |
| Kenya    | Yes                            | Antenatal Care x 2<br>Delivery x 12  | Yes              | Criterion Based Clinical Audit (CBCA) | <ul style="list-style-type: none"> <li>Improved active management of 3<sup>rd</sup> stage of labour</li> <li>Complaints procedures put in place for patients/referral centres</li> <li>Routine use of partograph</li> <li>Early detection of complications; early referral to district hospital.</li> <li>Correct diagnosis and management of complications at the Health Facility</li> <li>Improved communication between clinical staff and mothers</li> </ul> |
| Kosovo   | Yes                            | Obstetrics x 7<br>Newborn x 4  | No               |                                       |  |
| Moldova  | Yes                            | Obstetrics ) 15<br>Newborn )   | Yes              | Perinatal Confidential Enquiry Audit  | <ul style="list-style-type: none"> <li>The mean number of cases reviewed increased from 23 to 56 per year</li> <li>The mean number of audit meetings increased from 5 to 12 per year</li> <li>Elaborated standardised Birth Notes, leading to improved data and care</li> <li>Multi-disciplinary presence at audits</li> <li>Development of no-blame culture</li> </ul>  |
| Nigeria  | Yes                            | Obstetrics x 4   | No               |                                       |  |
| Pakistan | Yes                            | Unspecified  | No               |                                       |  |
| Peru     | N/A <sup>12</sup>              |  | No               |                                       |  |
| Uganda   | Yes                            | Obstetrics x 7<br>Newborn x 1  | Yes              | Maternal & Perinatal Death            | <ul style="list-style-type: none"> <li>Development of action plans to improve quality of care</li> </ul>   |
| Ukraine  | Yes                            | Number not specified: <i>"AIP principles are now embedded in clinical protocols"</i> . | No               |                                       |  |
| Uruguay  | Yes                            | Protocols on unwanted pregnancy counselling and care                                   | N/A              |                                       |  |

<sup>11</sup> Three audits were reported to have taken place in 2010; however, these were discussions about cases and no records of the discussion, findings or actions resulting from them were reported.

<sup>12</sup> Protocols and standards pre-existed the project but were not implemented. Now followed as standard practice.

It is not possible to identify statistically significant changes at many sites due to low numbers of deaths. In some cases death rates appeared to increase during the project, for example neonatal deaths at **Kenya Project** sites due to an increased case load of complicated births (rising from 2.57% in 2007 to 4.73% in 2010). This reflected efforts by the project to encourage facility-based deliveries and referral of complicated cases. As a result, caution should be exercised interpreting these data. They should be viewed within the context of overall project achievements.

The **Nigeria Project** reported on the CFR of the most common cause of maternal mortality as a proxy measure of improved maternal health. There is variation across the three project sites (table 8). Unfortunately, the project only provided percentages for CFRs. No detail on numbers was presented but it is understood these were low. Discussions indicated that the annual differences within sites reflected delayed referral of acute cases by private providers of care, particularly TBAs. By the time women reached project sites, their prognosis was poor. The fact that, overall, the 2010 figures reflect a general (and often substantial) reduction of CFR indicates a level of project success. In addition, timely referral to facilities was identified by the project team as a pivotal issue to address. As a result, inclusion of private/other providers was prioritised within the project's EmOC training.

**Table 8: Reductions in case fatality rates for all projects**

| Project                     | Reduction in maternal mortality <sup>13</sup> |                 | % Neonatal Deaths |           | % Perinatal Deaths |            |
|-----------------------------|---|-----------------|-------------------|-----------|--------------------|------------|
|                             | Pre-project/2007 <sup>14</sup>                | 2009/2010       | 2007              | 2010      | 2007               | 2010       |
| <b>Haiti</b>                | Comparative data not available                |                 |                   |           |                    |            |
| <b>Kenya<sup>15</sup></b>   |   |                 |                   |           |                    |            |
| KNH                         | -   | -               | 13.25             | 11.43     | -                  | -          |
| MTRH                        | -   | -               | 3.06              | 4.41      | -                  | -          |
| Pumwami                     | -   | -               | 6.14              | 5.37      | -                  | -          |
| Sabatia                     | -   | -               | 0.00              | 0.19      | -                  | -          |
| <b>Kosovo</b>               | No comprehensive vital registration           |                 | 10.8/1,000        | 7.8/1,000 | 23/1,000           | 19/1,000   |
| <b>Moldova<sup>16</sup></b> | -   | -               | -                 | -         | 49                 | 38.1       |
| <b>Nigeria<sup>17</sup></b> |   |                 |                   |           |                    |            |
| Benin                       | 12.3%   | 11.9%           | -                 | -         | -                  | -          |
| Kaduna                      | 45.8%   | 18.8%           | -                 | -         | -                  | -          |
| Nnewi                       | 83.3%   | 43.1%           | -                 | -         | -                  | -          |
| <b>Pakistan</b>             | 11 <sup>18</sup>                              | 2 <sup>19</sup> |                   |           | 88/1,000           | 23.6/1,000 |
| <b>Peru</b>                 | 313/100,000                                   | 36/100,000      | -                 | -         | -                  | -          |
| <b>Uganda</b>               |   |                 |                   |           |                    |            |
| Kibaale                     | 999/100,000                                   | 458/100,000     | 18.7/1000         | 5.9/1,000 | -                  | -          |
| Kiboga                      | 827/100,000                                   | 363/100,000     |                   |           | -                  | -          |
| <b>Ukraine</b>              | -   | -               | 2.27              | 3.34      | -                  | -          |
| <b>Uruguay</b>              | 4/year  | 0/year          | -                 | -         | -                  | -          |

<sup>13</sup> Not all projects reported against the same criteria

<sup>14</sup> Data are from 2007 where possible. Where not available, data are from 2005 or 2006

<sup>15</sup> As a percentage of total births per site

<sup>16</sup> Perinatal deaths of newborns with a gestational age of >37 weeks of age and birth weight of ≥2500g

<sup>17</sup> % of maternal deaths due to the main causes of mortality: PPH, eclampsia and obstructed labour

<sup>18</sup> Numbers NOT percentage

<sup>19</sup> Numbers NOT percentage

The **Peru Project** also demonstrated reduction in maternal mortality. Between 2007 and 2010, the maternal mortality rate (MMR) in the project area dropped from 313/100,000 to 36/100,000. This change constituted an almost 80% decrease in maternal deaths in this geographical area during the project period. This exceeds the project's objective of reducing MMR by 50%. The 2010 MMR rate was not only significantly below the MMR of 108/100,000 in 2010 for the entire region within which the project was sited, but also below many other parts of Peru with better health indicators overall.

Statistically significant change was reported on a range of obstetrical outcomes in the **Ukraine Project**. Although neonatal mortality rates increased, this was likely to be the result of a change in the Neonatal Registration system that occurred in 2006, when cases from 22 gestational weeks were included in the Neonatal mortality register (reduced from 28 weeks). These cases often require greater medical intervention during premature labour and greater likelihood of neonatal mortality and morbidity due to low birth weight. Neonatal morbidity resulting from asphyxia, however, dropped substantially during the life of the project. This was attributed to improved management of cases of shoulder dystocia. There was also a reduction in maternal trauma leading to haemorrhage and need for blood transfusions. This was attributed to increased use of vacuum extraction and active management of the third stage of labour.

### 3.3.5 Community mobilization and participation

This section of the report addresses progress made by projects in addressing demand-side constraints to accessing care. A range of approaches and methods were used to mobilise communities to utilise health facilities. Several projects, particularly Pakistan, Peru and Uganda, moved beyond sensitising communities about improved services. These projects fully engaged with communities, inviting active participation through direct support and training of TBAs; engaging with key stakeholders and opinion leaders e.g. teachers, to undertake outreach activities or, in the case of Pakistan, negotiating with the community to enable local women to train as midwives. This engagement with communities also helped health professionals to understand social and cultural barriers to accessing maternal care and enabled these to be addressed within the project (see Section 3.3.6 below).

In the case of Uruguay the project team engaged in substantial political mobilisation which resulted in highly significant changes to national policy and legislation around unsafe abortion.

The remainder of this section comprises summary case studies of two projects which invested substantial efforts in very different but highly effective forms of community engagement in order to support achievement of clinical objectives. These efforts are highlighted because of their significance in moving away from a purely clinical focus to show the clear, and very meaningful results that interaction with communities can achieve, particularly in terms of increasing demand for and uptake of services.

## Case Study 1: Pakistan

**Community sensitization:** Community awareness programmes were held periodically throughout the four years of the project. These programmes targeted both women and men within the community. Project activities included community meetings; viewing a movie about maternal and newborn health (Mamta ki hifazat); information, education and communication materials e.g. leaflets and posters in local languages and radio transmissions that discussed the availability of 24 hour EmONC services, danger signs in pregnancy, and promoted the use of health care facilities. Other public health issues relating to pregnancy, childbirth and newborns were also included in the programmes.

**Developing alliances with local leaders:** Political leaders in the community were also approached and involved in the process of community sensitization. This inculcated a sense of ownership which in turn increased opportunities to reach and get acceptance from the local communities and health workers.

**Complementing other community initiatives:** The increase in awareness of MNH cannot be totally attributed to the project since community workers, called lady health workers, (LHW) were also promoting the same messages. Unfortunately no community survey was undertaken to quantify the level of change; however there is indirect evidence of success through increased attendance of pregnant women at health facilities and their awareness of services (Box 8). They also expressed satisfaction about the up-graded services (a key project effort). These results demonstrate the impact that project efforts can have, especially when undertaken in conjunction with other initiatives e.g. LHW, which are also conveying the same message.

### Box 8: Examples of increased uptake of services

*"We are happy with the facilities in Gharo and I bring my daughter in law here".* (Khaira Village woman and a mother in law)

*"All of my eleven children were born at home but this time I chose the hospital as the midwife advised me to."* (Shahida Village woman)

**Engaging with TBAs:** The project also engaged actively with local TBAs. This was an important and effective activity. In collaboration with the Midwifery Association of Pakistan (MAP), training to improve knowledge and skills of TBAs was conducted; they were trained to provide misoprostol in the prevention of postpartum haemorrhage and were provided with delivery kits. Alongside this, they were also encouraged to bring women to hospital in case of danger signs and were offered a minimal financial incentive to do so. There is anecdotal evidence (but no documentation) that this increased referral rates, particularly in the case of complicated deliveries. The project efforts helped TBAs develop trust in the health facility, and increased confidence that these referrals would be received by non-judgmental doctors (Box 9).

### Box 9: Changing attitudes of TBAs

*"Initially the TBAs were scared that they will be held responsible for the complication if they brought the complicated patients to the health facilities".* (Project Director)

*"The project helped them get the credit for saving a life by bringing a woman to the facility timely".* (Project Co-ordinator)

**Recruiting and training local Community Midwives:** The project team made concerted efforts to increase local men's awareness of the need for facility-based deliveries and training local young women as midwives. As a result of these activities nine local women were identified and trained as midwives and are currently providing services in the area, delivering an average of twenty women a month.

## Case Study 2: Uganda

### **Established and trained a network of over 200 Community Health Workers (CHW):**

in response to the findings of a qualitative needs assessment at the start of the project,<sup>20</sup> 239 CHWs including TBAs were trained on registration and follow up of pregnant/postnatal mothers and their newborns; teaching pregnant women to make and follow birth plans; identification of mothers and newborns with danger signs and referring them to health facilities. Regular home visits and follow-up of the women and the newborns was reinstituted. CHWs also maintained a record of activities and submitted these monthly reports to health officials. Whether their motivation will persist beyond the project with the limited resources available remains to be seen, but there were encouraging evidence of continuing commitment (Box 10).

**Box 10:** "We want to continue to work because it is good for our women. Now we don't see dead women or babies in our villages. The mothers are very happy for this programme. We have meetings every month about issues in our villages – we meet in the middle and they [the CHWs] all come" (CHW and Chairperson for Village Health Team in Kibala)

**Established a referral system of women for facility based deliveries:** The successful training of CHWs resulted in an increase in referral of women from the community to health facilities. The project team developed a simple referral form that was supplied to the CHWs. The CHWs completed the forms for women who were being referred to health facilities. No referrals were recorded in 2006 (prior to the project) but by 2010, 40% of women delivering in the facilities had been referred by a CHW. The final project evaluation reported that this figure is likely to be under-reported as some women attend health facilities and do not hand over referral slips.

### **Supported a village health saving scheme to increase women's ability to access funds for transport to hospitals:**

A qualitative needs assessment undertaken by the project team also revealed that cost of transport was a significant barrier preventing women attending facilities for deliveries and other health needs. The project team felt it was important to empower women and communities to save money for emergency preparedness for birth and other health emergencies. As a result they identified a trained individual to volunteer as a coordinator to establish and supervise the village loan savings association (VLSA).

Funding for the establishment of the VLSA was obtained from the Canadian Auto Worker Social Justice Fund. The project team supported the VLSA Project Coordinator (who was trained for this activity by Care International) in his activities.

<sup>20</sup> Joseph Rujumba (July 2007) Qualitative needs assessment for saving mothers and newborns project in Kiboga and Kibaale Districts Uganda.

In the first year, 94 community saving schemes were established in 2 sub-counties in Kiboga, using 50,000 Ugandan Shilling (UgSh). By the time of the final evaluation, a total of 166 VLSAs were running with a turnover of more than 2 million UgSh. This activity successfully supported the hospital transfers of more than 300 pregnant women in less than 3 years. In addition, 4,000 women, more than 1,200 children and over 4,000 men had been supported in meeting health care costs.

***Secured funding for community awareness raising activities:*** the project team secured funding from the MAIA Foundation to cover the costs of community sensitisation activities which complimented the work of Village Health Teams. Local community drama organisations were enrolled to develop plays addressing issues related to maternal health. The dramas aimed to increase awareness of the need to seek professional health care during pregnancy and the importance of facility-based deliveries. Three sessions were held in each district, with a cumulative estimated audience of around 1,600 community members.

### **Case Study 3: Peru**

***Engagement with schools:*** the project team provided teachers and education administrators with advocacy tools (designed by the project team, teachers and community members) aimed at raising community awareness of maternal risk signs. Information was disseminated through parent-teacher forums.

***Use of culturally appropriate tools to reach non-literate audiences:*** The advocacy tools used locally appropriate imaginative and creative training graphics developed by the husband of one of the project team members. These tools helped to extend information to non-literate populations.

Notably, the project's efforts also increased male attendance at and participation in awareness raising events.

#### **3.3.6 Identifying and addressing social and cultural barriers to maternal care**

This section links closely with 3.3.5 above. One purpose of engaging with communities was to identify ways of addressing social and cultural barriers that prevent women accessing maternal care. Three key examples are provided below of innovative and highly effective ways in which projects achieved this. One example (from Peru) illustrates how the project team put in place a very practical solution (another example can be found in the Uganda case study in Section 3.3.5 – the initiation of village savings schemes).

Two examples demonstrate the impact that a paradigm shift among health professionals had on women's experiences of care. These projects demonstrated how changing the social and cultural perspectives of health professionals themselves facilitated women's access to maternity services. This approach is seldom explicitly

addressed but these projects showed that it was highly significant in supporting clinical improvements and improving quality of care.

#### **Case study 4: Waiting houses and a rights-based approach (Peru)**

Although officially prenatal and delivery care are provided without cost in Peru, this does not translate into reality nor provide for emergency expenditure. Associated costs are a major barrier to women attending for facility-based deliveries. The project team established a fund to cover outstanding costs of indigent patients in need of urgent referrals. This enabled an increased number of emergency cases to be treated and referred promptly.

In collaboration with local authorities, “*casas de espera*” (waiting houses) were also established in two outlying municipalities to accommodate women approaching their due date. Two other waiting houses were in the process of construction at the time of the final evaluation. The project team also engaged with local communities to ensure that women coming to deliver at health centres in areas not served by *casa de esperas* were offered temporary accommodation through community partnerships.

These project activities generally focused on a rights-based approach to care. This resulted in greater cultural sensitivity among health staff and enhanced their relationship with the community. Obstetric staff at all levels of delivery facilities appeared to have a better understanding of patients’ rights and were more respectful and accommodating about traditional birthing practices—for example, equipping the delivery room as appropriate for women to give birth kneeling, crouching or standing rather than supine on a table. Staff also allowed ceremonial artefacts and traditional attendants to be present. These efforts, coupled with extended outreach activities, made women feel comfortable about delivering in a health centre and more inclined to seek antenatal care.

As a result of these (and other) project efforts, births attended by skilled personnel increased substantially from an average of 1,550 per year prior to the project, to 2,898 births by the end of 2010.

#### **Case study 5: Rights based approach (Ukraine)**

Provision of AIP training was used as an opportunity to introduce a significant change in health professionals’ approach to and engagement with clients, founded on a rights-based approach to care. Health professionals are now utilising informed consent and engaging women more closely in decisions concerning their care. This contrasts with examples of pre-AIP decision making where intra-uterine devices (IUD) were inserted without the consent, or even knowledge, of women following an abortion; and sterilisations were performed without consent following a second caesarean section birth. Privacy and confidentiality also significantly improved as a result of greater health professional awareness of women’s rights.



### Case study 6: Women-centered approach (Uruguay)

Alongside advocating for, and achieving, legislative change to ensure women experiencing unwanted pregnancies receive appropriate care, the project also held workshops attended by 441 professional and non-professional workers in health centres. The workshops were designed to support participants to clarify their values and modify attitudes from being generally paternalistic and prejudiced against women who had unwanted pregnancies and abortions to one of professional mutual trust and confidentiality. This led to achievement of women-centred care.

As a result of this approach women were empowered to make informed decisions regarding their individual reproductive health. They were provided with sufficient, appropriate and non-judgemental information to take appropriate actions regarding their pregnancy. This was achieved by engaging with health professionals who recognised each woman's right to make her own informed decisions.

Anecdotal evidence indicated that women who received counselling were referring other women to the clinic through word of mouth. An additional project outcome was that project model components: privacy and confidentiality, risk reduction, information provision and client's autonomy right to make personal decisions were, as a result of the project, incorporated into the national curricula for health professionals. Counselling components, based on the project model, for women with unwanted pregnancy are expected to be added within the next couple of years.

#### **3.3.7 Improvements in collaboration and the engagement of health providers, governments, community organizations and civil society to understand why women and newborns are dying and how to prevent it**

All country projects involved some form of collaborative working with other partners. Collaboration, however, took different forms and achieved varying levels of success. One of the projects with the broadest range of collaborative partners, particularly civil society, was Haiti. In large part this was due to the extraordinary circumstances brought about as a result of the earthquake. The number of collaborators and level and quality of contribution varied considerably before and after the earthquake. After the earthquake, all these partners intensified their contribution and others joined. These included: the McArthur Foundation, Relief International, Collaboration Santé International, Canadian Medical Foundation, Superior Medical Ltd, Belinda Stronach Foundation, and others who contributed through the SOGC's Earthquake Relief Initiative. Collaborations typical of the SMN project are described below.

#### ***Professional collaborations: Associations***

All projects were meant to initiate collaborations between professional associations for project management, and planning and delivery of activities. In the majority of projects this was highly successful and led to increased mutual understanding,



sharing of responsibilities and improved communication. Midwives tended to be the clearest beneficiaries: their roles expanded, engagement in activities such as clinical audit increased, and skill levels were updated and expanded.

In a few instances, however, professional collaborations did not materialize in practice, as for example in Nigeria where the engagement of the Nigerian Association of Nurses and Midwives was minimal. This lack of collaboration was particularly disappointing as it significantly reduced the benefits that should have been achieved by projects.

### *Collaboration to achieve practical outcomes*

Several projects identified poor quality/lack of referral systems as a key factor in maternal and newborn deaths and, as a result, developed collaborative relationships with local ambulance services (for example Pakistan and Uganda) to provide subsidized transport (50% subsidy) for referrals from the community to health centres and/or hospitals. In Uganda, the project team collaborated with Care International in the training required to set up the village loan savings association. Box 11 below shows other successful partnerships forged by the Uganda team to leverage additional project resources.

| <b>Box 11: Collaborative partnerships</b>  |  |                          |
|--|--|--------------------------|
| <b>Uganda:</b> Collaborative partners included the Ministry of Health (Uganda), District health officials and the District Health Management Teams in Kiboga and Kibaale Districts, Save the Children's Fund (SCF) 'Saving Newborns Program' and the Department of Obstetrics and Gynaecology, New Mulago Hospital, Kampala. Other resources were mobilized from other institutions for partial funding of these activities, and included: |  |                          |
| <b>Name of alternative funding source</b>  | <b>Activity co-funded</b>  | <b>US\$ Contribution</b> |
| <b>MAIA Foundation</b>   | Community Drama, IEC materials provided                              | 15,800                   |
| <b>Canadian Justice fund</b>   | Voluntary Savings and Loans Scheme                                   | 2000                     |
| <b>SOGC – CIDA Partnership Program</b>   | Training and follow up of administrators for AIP HAS                 | 8000                     |
| <b>Rotary clubs of Kibaale &amp; Walkerton, Canada</b>   | Provision of ambulance for Kibaale district                          | 26,830                   |
| <b>Saving the Newborns programme, Save the Children - Uganda</b>   | Training and follow-up of midwives trained in Essential Newborn care | 12,000                   |

The Peru project demonstrated how stakeholders from different sectors could collaborate to reduce maternal mortality. Two *casas de espera* were established with donated materials on land designated by the local municipality.

### *Collaboration to achieve strategic objectives*

Political collaborations were achieved by the project teams in Pakistan, Haiti and Uruguay. These were effective in raising awareness of and goodwill towards projects among local political leaders and government health officials. In Uruguay this

political engagement led to the achievement of highly significant changes in policy and legislation. The other projects achieved less substantive results. In these cases engagement was more advocacy-focussed than truly collaborative. Advocacy was generally based around accessing increased resources, either human or physical and these efforts were generally unsuccessful.

### *Collaboration to provide clinical training*

Clinical training was not always undertaken directly by project team members. Instead, effective collaborations were developed with NGOs or International NGOs who were better placed to provide training. As a result experienced international trainers supported project efforts, for example in Uganda AIP was undertaken by Save the Children. These efforts show how collaborations can result in highly effective leveraging of resources and skills, and enable different partners to make optimum use of their key skills to increase overall project outcomes and impact.

### *Professional collaborations: Multi-disciplinary working and training*

Multidisciplinary working, in particular between doctors and midwives, led to improved collaboration and outcomes in health for many projects. Involving midwives in issues relating to maternal and newborn health played an important part in improving quality of care and reducing mortality and morbidity rates.

As a way of achieving multi-disciplinary working many projects developed partnerships with other professional associations to lead and attend continuing medical education and clinical training. Successful collaborations not only enhanced project outcomes, as in the case of multi-disciplinary training undertaken by the Peru project, but they also increased the likelihood of, at least some, project activities being sustained beyond the life of project funding. For example, the project team in Moldova collaborated with the Swiss Tropical Institute to modernize and institutionalise the perinatology system and implement anonymous evaluation of near miss cases.

One country team that made particularly good use of the project as an opportunity to forge collaborations between professional associations was Uruguay. The project proposal was written and submitted to FIGO by the Uruguayan Gynaecological Society (SGU). In this, the midwives were given a secondary role due to historical poor working relations and competition for territorial power between the two professions. Both gynaecologists and midwives were passionate regarding women's rights to ethical treatment, regardless of whether abortion was legal or not, but had not worked together as partners on this objective. Changes to this situation were negotiated by FIGO's representative, and the inclusion of midwives as equal partners was a condition of the proposal's approval.

At the end of project funding professional relationships between gynaecologists and midwives had become equitable and respectful. The project had Co-Directors

representing the two professional groups, who worked as a team and collaborated to strengthen all components of the project. The two societies made significant, and successful, efforts to achieve a completely horizontal relationship based on collaboration and division of responsibilities. This included collaborative problem solving during the course of the project.

The Peru project took professional collaboration one step further and invited non-health professionals providers to participate in the training. As a result of this teachers and education specialists collaborated with health centre staff to involve communities in averting maternal emergencies and death through increased awareness of the need for facility-based deliveries and recognition of danger signs during pregnancy and delivery.

### **3.3.8 The acquired capacity of the obstetric/gynaecology and midwifery associations to conduct projects relevant to the promotion of safe motherhood and the improvement of maternal health**

The capacity of the societies engaged in the SMN projects will have been significantly enhanced simply as a result of their necessary leadership (supported by FIGO, the SMNH Committee, SOGC and a raft of other partners). It is also clear, however, that conducting projects of this scale and intensity requires a specific set of skills which are seldom part of those already held by obstetricians, gynaecologists and midwives. As a result, every team has experienced a steep learning curve that has had to be learnt alongside actual implementation of the projects.

It is likely that lessons learnt will be valuable for those who wish to design and undertake similar projects in the future. Indeed, lessons learnt from implementation will be of significant use at the outset of project design. A number of projects were over-ambitious in their scope and coverage due to lack of experience and in-depth knowledge of the time and resources required for effective implementation.

National associations have, in addition, generally achieved enhanced credibility to improve obstetric capabilities in the field and marshal greater attention and commitment to reducing maternal mortality.

Although there is no evidence of this, observation over the life of the projects indicates, however, that these enhanced skills lie largely with individuals. Institutionalisation of knowledge was not an explicit project objective. There are positive exceptions to this, however. For example in Peru SPOG has produced a manual on administrative procedures. This manual has been submitted to FIGO and has been adapted so that FIGO may use it in future maternal health projects.

In Uganda the collaborative component of the project has enhanced the capacity of professional associations to undertake similar projects by affecting a paradigm shift. This has transformed the professional associations from being inward looking organisations established primarily out of concern to ensure the continuing medical

education of their own members, to being outward-looking organisations using their power and influence to affect changes in the districts in order to improve maternal and neonatal health in collaboration with one another. While not demonstrating enhanced capacity in the form of technical skills, this paradigm shift means the professional associations are now much better placed to design and implement projects which address (or at least recognise and take into account) the range of factors that impact on women's access to and experiences of care. This is valuable knowledge and bodes well for any future projects.

One of the key areas in which the capacity of project teams has been increased is in project management. This is an essential component of undertaking projects. The technical skills already possessed by obstetricians, gynaecologists and midwives are essential for successful implementation of technical components of SMN projects. However, these alone are insufficient for projects to be successful. Project management skills are equally essential.

All project teams have had a steep learning curve in project management and have newly acquired skills that will stand them in good stead for future projects. However, whether requiring experienced and busy health professionals to undertake administrative and financial management roles is either value for money or an appropriate use of time is debatable. These issues are discussed in more detail in Chapters 4 and 5.

From the perspective of FIGO, there is evidence that many lessons have been learnt from the SMN Initiative, and several of the challenges discussed in Chapter 5 are reported to have been incorporated into the design and running of the FIGO LOGIC project. This reflective approach indicates an increased capacity within FIGO/SOGC to manage multi-country projects and support progress in strengthening maternal and neonatal health.

## 4. PROJECT MANAGEMENT

### 4.1 Mentoring/twinning

North-South mentoring/twinning between professional associations and individual members of these associations was an innovative and often beneficial component of the SMN Initiative.

FIGO introduced the concept of twinning and mentoring at a joint meeting of project teams and mentors at the start of the SMN Initiative. Despite this, some challenges were encountered due to lack of clarity among some project teams and mentors about the role mentors were expected to fulfil. This resulted in mixed expectations and some frustration on both parts, exacerbated by changes in project teams and lack of communication to new team members. It is felt by FIGO that some of these challenges could have been avoided had there been a larger budget for regular country visits by project mentors. Where it was successful, mentoring contributed to two-way learning, alongside strengthening the capacity of project teams to lead on, particularly, clinical training and the development and implementation of protocols, standards and audit. Although some challenges were faced, the overall contribution of mentoring was to strengthen individual projects both in terms of technical skills, but also in terms of the contributions mentors were able to make in leveraging additional financial and material support, particularly in the case of Haiti.

In some instances technical support from international counterparts was declined when it was available from a national source. This is an important lesson learnt which has been taken on board by FIGO who recognise the future potential for south-south partnerships and mentoring. Box 12 provides specific examples of successes and challenges associated with mentoring.

#### **Box 12: Mentoring successes and challenges**

The Pakistan project team reported that a strong, professionally supportive relationship was formed between the Project Director and the Swedish mentors. Mentors' inputs were much appreciated.

The Ukrain project team also reported clear benefits from international mentoring. For example, during an outbreak of swine flu, mentors were able to provide research-based information on the impact of swine flu during pregnancy. This was then shared with the Donetsk Regional Ministry of Health.

In Haiti, mentors played a valuable role in leveraging emergency funds and resources in the aftermath of the earthquake. However, the technical role of mentors was less well understood by both mentors and the project team. Despite this the inputs from the midwife mentors was practical and valued, and offers of technical assistance from the obstetric mentor were much appreciated, but not felt necessary due to adequate in-country expertise.

The Nigeria project team (and mentors) found North-South collaboration challenging due to lack of formal written feedback or trip notes following mentoring/twinning visits. Some technical advice was perceived as useful and relevant, however, other inputs were not considered appropriate or in keeping with national legislation. This was reported as the catalyst for the breakdown in obstetric mentoring. No twinning midwifery society support could be identified, leaving a further gap in the North-South collaboration.

## 4.2 Log Frames

None of the project teams had previous experience of working with log frames (see Box 13 for a brief description). Support was provided by Options Consultancy Services to help teams develop their initial log frames, and some further assistance was provided during the first year of implementation to adapt/amend log frames where necessary.

### Box 13: Log frames

The use of log frames as a project management tool is a requirement of all international development agencies. A log frame presents information about a project's goal, purpose, outputs and activities in a logical and consistent way that allows for regular monitoring and evaluation of achievements. It can be amended during the life of a project to allow for internally or externally driven changes, but always sets out the goal, purpose, outputs and activities of a project.

A log frame takes the form of a four-by-four table. The rows describe the goal, purpose, outputs and activities; while the columns present a narrative description, objectively verifiable indicators (indicators against which to assess progress), means of verification (how progress will be assessed), and assumptions (external factors that may influence events, either positively or negatively).

All project teams except three (Uganda, Ukraine and Uruguay) found the process of updating log frames time consuming and frustrating and often failed to fully understand the differences between indicators and activities. This resulted in indicators not fully representing expected results.

The three project teams who found the log frame helpful were those who used a simplified log frame approach accompanied by a practical work plan. External support given by consultants or the FIGO Project Manager during log frame amendments led to development of feasible and achievable log frames that project teams found helpful and 'kept us on our toes in reporting to FIGO' (Uganda Project Director).

In retrospect, making revisions to log frames a more iterative process and structuring in regular reviews supported by technical assistance would have helped to increase project team's understanding of log frames as an active management tool and gained greater benefit from them. However, log frames are likely to remain a challenge for clinician-led project teams and should probably be accompanied by a narrative work plan or gantt chart to assist in planning and reporting on project activities.

## 4.3 Project and Financial management

Projects were led and managed by teams that had varying skill sets and often low levels of capacity, due to lack of experience, in project and financial management. Box 14 provides specific examples of the impact this had on implementation of projects, as well as highlighting project management achievements.

**Box 14: Specific examples of project management challenges and achievements**

In Ukraine, the project team comprised solely of the Project Director who was involved throughout the design and implementation stages. It is recognised that the project would have benefited from having a dedicated project administrator/research assistant to manage the logistics of the training activities and to support collection and input of data.

Project management in Peru was described as 'excellent' due to the high level of involvement from the entire project team. The SPOG coordinator for the project has been praised by FIGO for his hard work and role in leading the project from conception. His experience served to both to inform SPOG and motivate its membership to identify other opportunities for similar engagement.

In Uganda the project team's efforts in maintaining strong cohesion and communication were commended by FIGO, particularly as all team members had other multiple roles and full-time commitments. The level of qualification, skill, expertise and commitment among the in-country project team was impressive, as was the support they receive from a high-level steering committee.

The project administrator in Kenya had no previous experience of working with a log frame. This meant that it was not really used as a project management tool. A revised version of the log frame was produced in 2008 with a clearer logic between outputs and a single purpose, and clearer, more measurable indicators were developed. However, the original version of the log frame developed in the project proposal continued to be used for narrative reporting. Had the revised log frame been fully adopted this would have made it a more useful project management tool.

Time capacity for several team members in Nigeria remained a challenge as all project coordinators were employed in full time clinical activities. This led to challenges at almost every stage of the project cycle i.e. project initiation, planning, execution and closure. Although considerable support was provided throughout the project, there is a need for further specific project management technical assistance/mentorship.

All project teams were unfamiliar with financial and administrative management of projects. Many of these challenges were addressed during the course of the projects due to support provided by FIGO staff, its SMNH Committee and SOGC members and staff. This assistance was accelerated during the final two years of the SMN project by recruitment of a part-time Financial Administrator at FIGO who was able to visit some project teams and provide support/training in the use of simple Excel-based financial reporting tools. The FIGO/SOGC Project Manager also played an important role in providing assistance in administrative and reporting arrangements. This was, however, a steep learning curve from project teams.

FIGO recognized the challenge facing project teams and wisely secured resources, or amended budget lines, to support regular in-country financial/administrative support, often through the recruitment of a part-time position. In the majority of cases this strengthened financial management, facilitated transfer of project funds between professional associations and project sites, and reduced the burden of administration and financial management from clinical members of project teams (for example, in Kenya and Uganda). This increased the ability of sites to deliver key activities against their work plans. For other project teams, for example Kosovo, financial reconciliation has remained a challenge.



It is also important to note that, from FIGO's perspective, financial and project management were also challenged by fluctuations in exchange rates, and the range of languages spoken across ten country projects which increased the difficulty of effectively and timely communication and reporting.

#### 4.4 Relationship between project teams and FIGO

FIGO provided support to individual projects based on their perceived level of need. Moldova, Uruguay and Peru received least support, while Kenya, Kosovo and Nigeria received substantial inputs. Their capacity was strengthened, but challenges still remain. However, support was appreciated and helped strengthen relationships between FIGO and national professional associations (see Box 14 for an example).

Due to unavoidable circumstances several changes in the structure of the FIGO Secretariat were viewed by a few project teams as creating communication challenges. SMN Initiative management moved from FIGO to SOGC, while financial management remained in London. Overall there were four changes to the Project Manager position. This was felt by several project teams to lead to some confusion about who to communicate with about various issues.

**Box 14: Example of support provided by FIGO to projects**

*"The SMN Project Manager has visited twice, the FIGO Finance Manager has visited once and the Chair of the FIGO Committee for Safe Motherhood and Newborn Health visited once. There has been frequent email communication between the Project Administrator and the SMN Project Manager and ongoing support to project and financial management of the programme. This support has been highly appreciated by the in country team, and without the intensive input FIGO have put towards the project it is unlikely that the increase in momentum achieved in the final stages of the project would have been achieved."* (Kenya Project Final Evaluation Report)

Communication challenges were further exacerbated by the number of languages spoken by project teams. Efforts were made to overcome this by utilising support from in-country members of the SMNH Committee. During SOGC's management of the Initiative the Haiti project was able to communicate and produce reports in French; and funds were secured for translation of Uruguay and Peru's narrative reports. Reporting in their own language made a substantial difference to these projects. Prior to SOGC's management reports were required to be produced in English which, in some cases, significantly reduced the level and comprehensibility of the information provided. It also reduced the benefit that project teams were able to gain from feedback on these reports. In retrospect it would have been beneficial if funds had been set aside to allow for translation services.

Despite these challenges, however, project teams found FIGO's support valuable and relationships have generally been both positive and strong. FIGO's flexibility to budgetary requests and face-to-face interaction during country visits were much appreciated. The facilitation of an all-countries meeting during the FIGO Congress in 2010 was particularly beneficial in enabling shared learning between projects.



## 5. KEY CHALLENGES

All projects faced significant challenges in successful implementation of their activities. In some cases challenges were external to the project, reflecting the social, cultural and political contexts within which they were situated. In the case of Haiti and Pakistan these were exacerbated by natural disasters in the form of the earthquake and severe flooding.

All projects also faced internal challenges. The majority of these were common to all projects and generally related to project management issues. It is not surprising that these challenges arose. Project teams were inexperienced in project management and implementation, and many were unused to collaborative working in multi-disciplinary teams other than within a clinical context. The fact that project teams were able to overcome and learn from these challenges indicates that their capacity has substantially increased as a result of the SMN project and bodes well for successful implementation of future project.

FIGO itself faced two overarching challenges: how to optimise impact from multiple projects each with a very limited budget (the challenge of balancing depth over breadth); and how to provide appropriate and sufficient support to dedicated but under-capacitated project teams.

Many challenges were successfully overcome either directly, or as a result of flexibility and adaptation of budgets, activities and roles. In other cases the challenges remained, impacting on project progress.

### 5.1 Challenges faced by project teams

#### 5.1.1 Resource constraints

An overarching challenge for all project teams were resource constraints in the form of lack of capacity, human resources, time and budget. The first is a consequence of health professionals undertaking responsibilities requiring new and unfamiliar skills sets; while the others related largely to externally imposed budget constraints.

##### *Lack of capacity*

All projects were led and managed by highly experienced individual obstetricians and, in many cases, midwives. While these individuals are used to high levels of responsibility and working under pressure, their professional skills are seldom directly transferable to project management, which places an emphasis on administration, financial management, and logistics. These issues have been covered in detail in Chapter 4.

In some instances challenges were identified early in the course of the project and a small proportion of funds re-routed to cover the recruitment and salary of a project

administrator. This was a constructive move by FIGO, and good value for money as it freed up project directors to make better use of their existing skills and time.

### *Time*

Project team members were all practicing health professionals and the SMN project was an addition to their existing work-load. Where personnel working on the project were funded on a part-time basis, the funding was either not considered sufficient to cover loss of earnings (for example in Kosovo), or it was subsequently discovered that inputs into the project required far more time than had originally been anticipated. This often led to a conflict of interests, with the project taking time away from other responsibilities. In reality, freeing up time from clinical and other commitments was extremely difficult. That so much was achieved by so many projects speaks volumes for the teams' level of dedication and commitment.

A consequence of these time constraints, however, was that opportunities to institutionalize projects within professional associations were limited. Overall knowledge of the projects remains with key individuals and development of institutional memory has not been ideal. From the perspective of both sustainability of existing activities, and design and implementation of new projects it means that lessons learnt and experience gained remain in the memory of key individuals rather than having built the capacity of the professional associations themselves. This challenge is offset, however, by the prominence within professional associations of many project Directors. For example, in Kenya the project Director is now Director of the national association of obstetricians. In addition, there is anecdotal evidence that attendance at national meetings of professional associations has increased, and this is thought to be, in part, due to interest among members in the learning more about the SMN projects.

FIGO itself has put considerable efforts into raising awareness of the projects at its last International Congress, and further dissemination is planned during the 2012 Congress. As a result, there is evidence that knowledge is slowly being institutionalized within national associations. FIGO's experience in multi-country project management has increased, particularly on the part of its SMNH Committee, key executive members, its financial and project administrators.

### *Budget*

Budget constraints were considerable for every country team. Projects made remarkable achievements given their limited budgets and some projects teams used the FIGO funding of key project activities to leverage additional funds from external stakeholders, for example to fund vehicles and drivers to act as an emergency referral service or to undertake AIP training. This added to the scope and outcome of project activities and is to be commended. However, leveraging funding takes time and effort, thus potentially drawing key individuals' time away from other activities. Overall, however, these efforts represented good value for money and led

to significant increases in the coverage and impact of projects, and enabled the original project funds to achieve substantially more than would otherwise have been possible.

### **5.1.2 Collaboration between professional associations**

A key feature of the SMN Initiative was collaboration between professional associations. In several projects, however, collaboration was based more on good working relationships between individuals rather than on institutional collaboration. Thus, if a key individual left then effective links between the associations were significantly weakened, as in the case of Haiti.

Likewise, while the commitment and contributions of time and effort from specific representatives of professional associations was significant, the involvement of general members was often difficult to achieve. In many instances health professionals' engagement with projects, for example by being trained as Trainers or receiving continuing medical education was not a true measure of the involvement of professional associations. For example, they were often midwives and clinicians who happened to be members of the professional association but were participating in project activities as individuals rather than as representatives of the association.

In some cases, for example Kosovo and Moldova, the level of input into and engagement with the project was reduced by the limited legal and professional scope of midwifery practice. While this makes it difficult to develop the role and profile of midwives, or midwifery associations there is also an argument that change can occur given sufficient motivation and leadership and this should be generated by the professional association itself.

### **5.1.3 Working in resource constrained environments**

The majority of projects were located within severely resource-constrained environments. This resulted in multiple impacts on project activities, for example through shortages of medical supplies, equipment, human resource shortages, demotivated health professionals and high levels of staff turnover.

In some cases these challenges were addressed, to an extent, by diverting project funds to supply equipment and drugs; and improving facility infrastructure. There is evidence that the projects also played a part in motivating staff through access to training and expansion of their roles (although this was sometimes off-set by already poorly paid staff having to pay out of their own pocket to attend training).

Whether or not the benefits of training will be lost due to high staff turnover is less clear. Although newly capacitated staff may be lost from a project facility (as in the case of Uganda); the facility in which they are newly employed should benefit through the transfer and implementation of knowledge and skills into the new working environment. For example in Kenya the transfer of a key member of staff has resulted in clinical audit being adopted within general surgery. In practice, however, this may not always be the case. For example, in Uganda midwives and

doctors are routinely rotated to different geographical areas and clinical departments. As a result clinicians trained on the AIP have been moved to other non-intervention facilities and to departments where the SMN project training was not of direct use. To an extent, this challenge was overcome by increasing the numbers of clinicians trained.

#### 5.1.4 Sustainability

Ensuring the sustainability of project activities and impact is probably the greatest challenge facing the SMN projects, both from a practical and strategic perspective. The apparent lack of sustainability of several projects is, in part, a reflection of the project teams' lack of experience in designing and implementing projects. Greater experience would have meant greater awareness of the need to factor in sustainability from the start of the design process. Had project teams had greater experience they would also have been better able to consider mainstreaming sustainability into project design and focus from the perspective of whether they would be looking to achieve sustained funding of the project (leveraging support and commitment from development agencies, governments and other potential partners can take a long time and require substantial inputs). Some of the activities necessary to achieve sustained project funding are not easy to achieve for small-scale projects led by health professionals. For example, advocacy, networking, leveraging additional resources and commitments and long-term strategic planning would have taken already scarce human and time resources away from the practical, and essential, implementation of project activities. To an extent many project teams did invest substantial efforts into these activities and have succeeded in obtaining continued funding. However, their strength in advocacy has increased as a result of their engagement with the projects rather than being written into the project design and activities from the outset. If this were done in the future it would enable a more strategic approach to be taken to issues of sustainability.

Many projects did achieve remarkable success in ensuring the sustainability of their efforts (eight out of the ten projects are currently continuing), particularly Uruguay where policy and, in particular, legislative change cannot be repealed. This project, however, had a very different focus to the majority of SMN projects which were facility based and placed emphasis on direct improvements to clinical practice.

Many project activities, for example strengthening clinical skills through training, were inherently sustainable in terms of the lasting benefit to individual health care professionals, facilities and the women receiving care. It is hard, however, to sustain improved/best practice if a) resources are insufficient to put improved knowledge into practice; and b) if there is no accountability for adherence to standards and protocols. A number of projects invested substantial, and praiseworthy, efforts into clinical training and development of standards and protocols but without matching this effort with instituting a parallel audit process. Unless this is developed as a 'next step', as is the case in Nigeria and Ukraine, it is likely to reduce the sustainability of improved clinical practice due to a lack of institutionalised on-going learning and

reflective practice. In a few cases, protocols and standards were developed but not displayed in health facilities. This is disappointing and significantly reduces the potential for sustained improvement.

Other projects achieved excellent results but components of their design (alongside external challenges such as lack of government commitment and resource constraints) and activities do not lend themselves to sustainability. For example, the Pakistan project paid for human resources, drugs and supplies in three health facilities. As a result of this there was a significant increase in utilization of services. Although the trained midwives will remain in place, there is no guarantee that supplies of drugs will continue. This carries with it a risk that the whole system may collapse. The local team tried to engage with political leaders, government officials and international donors, but to date have not been promised tangible solutions.<sup>21</sup>

Political change also makes some SMN projects' sustainability uncertain. In Peru a change in regional political power, following the October 2010 elections, created substantial uncertainty for the sustainability of project achievements. Sweeping personnel changes in regional and district health, education and administrative leadership have rendered political support for the project in limbo.

The factors highlighted above validate the need for consideration of sustainability at the project design stage since the sustainability of some activities are dependent on external financial and political factors; while the sustainability of other activities can be an inherent component, and responsibility, of the individual project. In many cases project activities have been sustained beyond the period of project funding due to individual commitment. While this is admirable, from the perspective of funders, however, it is important that sustainability is considered and made an explicit component of project design, implementation and on-going monitoring of progress.

Sustainability is not always easy to assess. For example the Ukraine project made significant steps towards institutionalising its training activities through ensuring that AIP principles were embedded in clinical protocols signed off by the Ministry of Health; and that AIP methodology and content were integrated into post doctorate curricula within Donetsk National Medical University. These were significant achievements. However, AIP principles were not adopted in their entirety in clinical protocols because the protocols were developed through a consensus approach and not all obstetricians involved in their development were exposed to the ALARM training. This means that delivery of best practice obstetric care (as identified by the AIP) may not always be achieved. In addition, AIP is not always referenced as the source of information for protocols. Whilst this does not detract from AIP's influence on clinical practice, it is possible that this may be a challenge in terms of maintaining the integrity of the approach over the long-term.

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<sup>21</sup> SOGP developed a proposal to UNFPA in October 2010 aiming to maintain the higher level of health services achieved. The outcome of the proposal is not yet known.

Low pay scales for medical staff may also impact on the sustained uptake of the AIP if funding to attend courses is not available. This has already been observed in Khmelnytsky Region where fewer midwives took part in training as a result of being unable to self-fund their attendance.

#### **5.1.5 Mentoring**

Benefits obtained from the North-South Mentoring component of the project have been discussed above. It should be noted that benefits work both ways and in several cases a two way flow of knowledge was described by both mentors and project teams.

There have, however, also been significant challenges associated with the mentoring process. These do not relate to the principle of mentoring, which is excellent. Instead the challenges were linked to institutional lack of experience of providing training and a lack of understanding/clarity (despite an initial briefing by FIGO to all mentors and project teams) over mentor roles and responsibilities. Challenges were also encountered due to overall lack of project funds which impacted on the frequency and regularity of mentoring visits. These issues can be easily prevented for future projects and have been put in place in FIGO's ongoing LOGIC project.

#### **5.1.6 Project management tools**

In line with the requirements of International Development Partners, each in-country project worked to a log-frame which sets out the project goal and purpose; activities needing to be undertaken to achieve these; the outcomes each activity should achieve and objective indicators against which progress can be assessed.

Log frames are a valuable project management tool. They are not, however, familiar to health professionals. Support was provided to develop log frames at the outset, and further support was provided during first year baseline visits. Despite this, log frames remained a challenge for project teams who remained unclear/unconvinced about their benefit over more familiar tools such as gantt charts or work plans.

### **5.2 Challenges faced by FIGO**

In its oversight and management of the SMN Initiative, FIGO has faced three significant challenges: its own relative lack of experience in project management, the size of the budget in relation to the number of country projects; and the time required by country teams for support to implement and manage projects.

Over the duration of the Initiative FIGO experienced a steep learning curve in managing multi-country projects. Its inexperience at the outset led to an under-estimation of the time and resources required to support weaker associations. This is discussed below. However, during the initiative it put in place alternative, often voluntary, efforts to provide project management support.

The lack of experience of project teams resulted in a small number of FIGO members, particularly from within the SMNH Committee and in particular the (at the time of the project) Executive Vice-President of SOGC, providing very substantial unpaid inputs of time and effort, including site visits, to support individual projects. This was undertaken alongside pre-existing professional commitments. This led to projects making considerably more progress than would otherwise have been achieved. However, there were significant opportunity costs. These were minimised where possible by site-visits being undertaken by in-country members of FIGO. In the future it would perhaps be beneficial if a greater component of overall project funds were set aside for support from appropriate FIGO committee members, or for external technical assistance, provided on an 'as needed' basis. Greater total funding does not necessarily equate to a proportional increase in achievement; however, targeted allocation of budgets can help optimise both value for money and outcomes. It is not considered that FIGO made any errors in how it allocated its project funds – it is instead felt that in future the Federation may wish to increase its requests for central level funding in order to provide targeted assistance to country teams throughout the life of a project.

The overall budget for the SMN project was not large and the decision to fund ten projects was made in order to optimise the number of associations that would benefit from funding. In practice this led to each project operating within a tight budget which limited activities, human resources and other inputs which, in turn, affected the smooth running of several projects. This was exacerbated by an under-estimation of the support needs of project teams. In retrospect it might have been advisable to have funded fewer projects (particularly those with major resource demands – an exception to this being the Uruguay project which was policy focused) and made more substantial resources available to fund the time of project team members and provide technical assistance, particularly, to strengthen project management skills and address sustainability issues.

In retrospect, however, the decisions made by FIGO were, overall, highly appropriate. It is to be expected that the steep learning curve associated with their management of this project will be off-set by increased capacity to manage future projects. This is already in evidence by the incorporation of many lessons learnt into its management of the current FIGO LOGIC project.

## 6. CONCLUSION AND LESSONS LEARNT

### 6.1 Conclusion

The SMN Initiative has achieved remarkable results utilising scarce resources over a relatively short period of time. All country teams made significant and very positive contributions to maternal and newborn health at project sites and, in many cases, have effected far wider changes, sometimes at national level.

A possible perceived limitation of the SMN project, from a donor perspective, is that the nature of FIGO projects requires volunteerism from clinicians and health professionals who face competing demands on their time. The level of time and energy available for voluntary work are frequently limited by existing workloads and, for many, financial constraints. This prevents the possibility of large-scale roll-out of certain project activities however, as the individual project results show, many significant contributions have been made to improving maternal and newborn health have been achieved at national level. These include strengthening the clinical skills of very substantial numbers of health professionals, including midwives, obstetricians, nurses, and doctors; institutionalising the implementation of standards, protocols and clinical audit; and, in some cases, achieving changing in national policies and legislation.

These results demonstrate how strategic targeting of activities and utilisation of professional associations to implement projects can achieve outcomes far in excess of their nominal targets and for a relatively small financial investment.

The model of volunteerism that underpins FIGO projects is not inherently transferrable or sustainable from the perspective of standard evaluation criteria. But within the specific context of assessing the impact that professional associations can have on maternal and newborn health, the SMN project model is inherently sustainable through the continuing dedication of many health care professionals.

Challenges encountered during the life of the SMN project have been many and varied. These include lack of financial and management skills among health professionals, political and civil unrest, and natural disasters. Those challenges that were external to the projects slowed down progress but ultimately did not prevent significant achievements being made. Internal challenges were largely overcome through substantial on-going support from FIGO and key individual members of the SMNH Committee. Lessons learnt during the SMN project have also been put in place by FIGO and incorporated into the design and implementation of current on-going projects.

As a result of the SMN Initiative the capacity of FIGO to manage multi-country projects has undoubtedly increased. The breadth of FIGO's activities has also increased. It has expanded its traditional role of establishing clinical practice guidelines, providing consumer information, as well as services for its members such



as continuing education and conferences. It is now well positioned to take a lead role in leading and managing development projects, providing multi-disciplinary supportive supervision to health professionals, and playing an important role in supporting and contributing to the efforts of international development partners in reducing maternal and newborn mortality.

## 6.2 Lessons learnt

| ISSUE  | LESSONS LEARNT (FOR WHOM)   |
|--|---|
| <b>Institutionalising multi-disciplinary working within projects</b>   |   |
| Multi-disciplinary collaborations lead to improved outcomes in health.   | <p>During the project design phase an assessment of the motivation of different professional associations to work together would, although having resource implications, help identify potential barriers to achieving joint outcomes, and optimise the strengths of multi-disciplinary working. Request for funding to support this could be included in, and considered by donors, during initial stages of funding agreements, particularly if outputs have the potential to be scaled-up e.g. introduction of clinical audit (FIGO/Donors).</p> <p>Further encouragement to increase the breadth of collaboration between professional organisations would be valuable. Paediatricians and anaesthetists (and others) could be important participants in many projects; particularly those engaged in clinic audit activities, their participation should be encouraged (FIGO).</p>   |
| <b>Volunteerism</b>  |   |
| Projects were dependent on voluntary contributions of time and expertise by already over-stretched and, often, poorly paid health professionals. | <p>The efforts of a very few committed project members can lead to achievement of significant outputs but the opportunity costs are considerable. In addition, projects that are reliant on the good-will of full-time clinicians are susceptible to slippage and challenges in meeting project objectives, due to competing priorities. Limited remuneration for some project staff might be helpful but should be matched with agreed Terms of Reference and should not reduce the inherent value FIGO places on volunteerism, which is essential to these projects (FIGO/Donors)</p> <p>In low-resource settings providing support, financial or in-kind, is an important factor in encouraging sustained and consistent volunteerism over a protracted period of time. (FIGO)</p> <p>If a project is going to be run successfully by volunteers an extremely strong, well connected and dedicated project director, supported by administrative assistance, is essential. That project director then needs continuing and consistent external technical/administrative support (FIGO/Donors).</p> |
| Maintaining motivation   | Maintaining the motivation of voluntary teams is essential. Site visits by member(s) of the FIGO Secretariat were reported as supporting this. In addition, building in funding for visits by SMNH Committee members would have been beneficial (FIGO).   |

| <b>Technical and project management/financial administration assistance</b>       |   |
|---|---|
| Enabling projects to optimise limited funding through targeted support            | <p>An early initial analysis of the capacity of professional associations to manage maternal health projects would enable targeted capacity building to be provided either by FIGO or an external agency (FIGO).</p> <p>Greater technical support at the outset and during project implementation in designing and updating log frames would have been beneficial. This would have required a greater proportion of the overall budget being allocated to technical support and reduced the number of countries able to participate in the Initiative (Donors/FIGO).</p> <p>Utilisation of narrative action plans and/or gantt charts (alongside log frames) would probably assist project teams to keep to schedule and report against activities and project outcomes (FIGO/project teams).</p> <p>Administrative and financial management support are key components for effective implementation of projects. Budget lines for these activities need to be built in to project proposals and these (part-time) positions filled at the outset of projects (FIGO/project teams).</p> |
| <b>Language</b>   |   |
| Providing for the needs of projects working in different languages                | For optimum benefits to be gained by individual projects, and to enable the project management team to provide appropriate feedback and support, it is important that finances be set aside for translation services. This would enable progress reports to set out clearly achievements and challenges; and for optimum benefit to be gained from external technical and project management assistance (FIGO).   |
| <b>Mentoring</b>  |   |
| Strengthening technical skills and shared learning                                | <p>North-South mentoring/twinning could be further supplemented by South-South partnerships (FIGO).</p> <p>The success of mentoring/twinning depends upon the skills and commitment of mentors/twinning societies and their willingness to identify and adapt practice and procedures to the local context without damaging key project objectives. Training in mentoring skills would be beneficial at project outset, together with explicit guidance (Terms of Reference) on expectations, roles and responsibilities – taking into account the voluntary nature of this activity (FIGO).</p>  |
| <b>Exit strategies</b>  |   |
| Exit strategies are a key component to ensuring sustainability of project efforts | <p>Building an exit strategy into project design can help ensure teams are not left with an uncertain future for their activities, and help them to plan appropriately for the future. Funding for a 'transitional' stage at the end of projects for consolidation of achievements and seeking further financial support would be a possible way of achieving this (FIGO/Donors).</p> <p>Exit strategies should also be built into projects' plan of work (Project teams).</p> <p>Exit strategies could include identification, by project teams, of potential collaborators and donors for subsequent activities (Project teams).</p>  |

| <b>Sustainability of projects/project achievements</b>  |   |
|---|---|
| Projects based on voluntary inputs face challenges in terms of sustainability beyond the period of project funding. | <p>Strengthening organisational governance and financial management is essential (Project teams/FIGO)</p> <p>Provision of advocacy training for project teams would strengthen efforts to obtain financial sustainability for the project (FIGO).</p> <p>Building capacity in proposal writing and fund-raising would increase opportunities for project teams to leverage resources for continued implementation of projects (FIGO)</p> <p>Seeking government commitment, and developing relationships with other international development agencies at the start of the project is a key approach to increasing the chance of sustainability, and project teams should be supported to do this (Project teams/FIGO).</p> <p>Project teams should be supported to include on-the-job-performance monitoring and in-service refresher training in their project action plans. To ensure sustained utilisation of new knowledge/skills by health professionals (Project teams/FIGO).</p> |
| <b>Dissemination of project results</b>   |   |
| Dissemination of results to external audiences for knowledge sharing, and advocacy efforts.                         | <p>Structured dissemination of project findings should be optimised in order to share knowledge, support advocacy efforts and to help leverage additional resources (Project teams).</p> <p>Developing a simple database of training participants and key stakeholders would be beneficial in dissemination of technical updates and project achievements (Project teams).</p>  |