International Federation of Gynecology and Obstetrics
Fédération Internationale de Gynécologie et d'Obstétrique

FIGO
Saving Mothers and Newborns Initiative

Annual narrative report prepared for the Swedish International Development Cooperation Agency (Sida)

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Final report.

Over a five-year period the International Federation of Gynaecologists and Obstetricians conducted a Sida-funded project of ten countries whereby ob/gyn professional societies implemented projects in their own countries designed to increase accessibility to services and improve maternal and newborn health. As well, these projects provided the opportunity for these professionals associations to strengthen their organizational capacity and demonstrate themselves as leaders in their country in promoting safe motherhood and Newborn health and in many cases reducing maternal newborn mortality and morbidity.

The project ranged from reducing maternal mortality due to Ecclampsia , PPH, dystocia ; creating and implementing guidelines for the most common causes of MM ; prevention of unsafe abortion, community provision of Essential and Emergency Obstetrical care ,upgrading skills of health professionals ,perinatal mortality audits, reducing unnecessary interventions and responding to a dramatic earthquake in providing full Obstetrical care.

This document is the final report to be submitted to Sida which marks the end of the Saving Mothers and Newborn Initiative. This report summarizes all of the FIGO-led activities, describes the successes and lessons learnt and states to what extent the objectives of the Initiative have been achieved. As well the report demonstrates the results of each of the SMN Projects that were funded by Sida.

FIGO would like to express its gratitude to Sida for providing the funds to implement the Saving Mothers and Newborn Initiative.

Thank you.

Andre Lalonde MD. Chair FIGO committee on SMNH, director of the project

Hamid Rushwan MD ,Chief executive FIGO

Moya Crangle FIGO program director/coordinator

Introduction

Over the last five years, the goal of the FIGO Saving Mothers and Newborn Initiative has been to contribute to the reduction maternal and newborn morbidity and mortality and to the achievement of MDG goals 4 and 5 in a series of low-income countries. Secondary objectives of the project include:

1. Strengthening the capacity of national professional societies to engage in maternal-newborn health through the design and implementation of projects in the field;

2. Strengthening cooperation between FIGO and national societies, and also between societies in regions or of different economic levels;

3. Strengthening cooperation between national societies and national stakeholders involved in safe motherhood and newborn health;

4. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.

Summary of FIGO's approach

The project was designed by the SMNH committee. It asked all low resource countries to submit a concept paper on a 4 year project to reduce maternal and newborn morbidity and mortality. Out of 22 applications 12 were asked for a full submission and given a small grant to complete the applications. Projects had to be low cost, run by the Obs/gyn society members, engage with other health care professionals and address major issues in mother newborn health.

The committee selected 6 countries. Sida had committed 2.3 million dollars towards these projects. FIGO executive asked that 3 more countries in Latin America be added and committed 750,000 to the budget. One final country was added Ukraine with initial funding from USAID, FIGO and SOGC.

Under the direction of the Chair of FIGO's Safe Motherhood and Newborn Health Committee and Chief Executive of FIGO, the Project Manager dealt with the day to day issues of the countries as well as organizing and hosting meetings at regular intervals of the project life, review of narrative reports and writing and submission of annual reports to Sida. The Project Manager and the members of the SMNH committee provided management support to the projects. As well, the Project Manager would work closely with FIGO's Finance Officer to ensure proper reporting of finances and discuss issues pertaining to budgets and activities. The Finance Officer provided technical support to the projects.

The Project Manager would also participate in FIGO's Safe Motherhood and Newborn Health Committee. The Committee met four times a year, usually by teleconference and annually at a face-to-face meeting. The Project Manager would update the committee on each of the countries or on particular issues that arose throughout the life of the SMN Initiative. They oversaw the development of the initiative as well as provided input and ideas. SMNH Committee members were present at the initial

meeting in London as well as at the mid-term meeting in South Africa and used other meetings to follow-up on the initiative.

Finally, the Project Manager was responsible for the coordination of the external evaluation of the SMN Initiative, Options consultancy, setting up contacts, provision of information and review of reports.

In order to disseminate information about the SMN Initiative, the Project Manager ensured that project information was made available and updated on the FIGO website. As well, during the last three years of the project, information and country profiles of the SMN Initiative were included in the regular publishing of the FIGO newsletter.

The table on the next page shows the timeline of all the FIGO-led activities throughout the course of the project.

Timeline of FIGO-led activities:

2006	2007	2008	2009	2010	2011
April: London administrative meeting to execute the initiative, formalize log frames with project coordinators, FIGO staff and SMNH committee members ***November:*** Kuala Lumpur meeting. Projects reviewed, discussion of baseline indicators and measuring progress of projects and strengthening professional associations.	***January***: Project manager hired: Margaret Walsh ***May***: London 2-day meeting: Project fully initiated. Included project staff from all countries, mentors and twinned societies. Focus of meeting: establishing relationships, reflecting on the process of team development, reviewing the process of development & implementation of the log frame. ***October***: Women Deliver Conference, London. Presentation made to describe the project and to describe collaborative efforts being made. ***December***: Baseline evaluations by Options begin.	***March***: New Project Coordinator, Amanda C. Lee ***July***: Baseline evaluations by Options completed.	***April***: Re-aligned budget ***May***: FIGO contracts SOGC to manage project. Project manager, Moya Crangle ***June***: IJOG Article: "Safe motherhood and newborn health: FIGO initiatives 2006–2010" ***July***: Support visit by manager to Kenya ***August***: Support visit by financial administrator to Kosovo ***September***: Support visit by manager to Nigeria ***October***: Mid-Term Meeting in Cape Town Presentation of six country projects at FIGO Congress JOGC article published: "A report on the FIGO Saving Mothers and Newborns	***February***: Support visit by manager to Kenya ***March***: Support visit by financial administrator to Kenya ***April***: Support visit by manager to Kosovo ***June***: Women Deliver, Washington Meeting. Pakistan, Haiti, Peru, Uruguay. Opportunity to share experiences. ***July***: Project manager takes one year leave. Replaced by Caroline Montpetit ***November***: Final evaluations by Options begun.	***August***: Manager, Moya Crangle Returns Haiti and Kenya Projects close ***November***: Final evaluations by Options completed. ***December***: Final report to Sida submitted.

			Project"		

The meeting agendas and/or meeting reports are available in Annex 1.

Each country had a different start-up and end date. A summary of country activities that required the support of FIGO are detailed in the table below.

Time-line of country-specific activities:

	Start up date	End Date	Options evaluation	Option final evaluation
Haiti	1 July 2007	30 June 2011	December 8 – 11, 2008	Site visit: Aug 31 – Sept 3, 2011
Kenya	1 July 2007	31 August 2011	July 6 – 11, 2008	Desk review: September 26 – 30, 2011
Kosovo	1 January 2007	31 August 2010	Jun 30 - July 4, 2008	Desk review: March 29 – 31 2011
Moldova	1 December 2006	31 October 2010	June 16 – 20, 2008	Desk review: February 22 – 24, 2011
Nigeria	15 January 2007	14 January 2011	December 10 – 14, 2007	Site visit: March 21-24, 2011
Pakistan	1 November 2006	31 October 2010	June 23 – 28, 2008	Desk review: November 22 – 30, 2010
Peru	1 December 2006	1 December 2010	April 28 - May 1, 2008	Site visit: February 14 – 17, 2011
Uganda	1 July 2007	30 April 2011	December 10 – 13, 2007	Site visit: May 16 – 20, 2011
Uruguay	1 July 2006	31 August 2010	July 14 – 19, 2008	Desk review: September 2 – 17, 2010

Twinning Mechanism

One component of the SMN Initiative was a twinning mechanism between Northern and Southern countries. Through this twinning mechanism, mentors from the high-income country were identified and paired with the country director/co-director. The mentors were meant to contribute to the implementation of the projects through support: visits, email exchanges, discussions. The idea was to help strengthen organizations by providing them the opportunity to learn from each other through sharing information and experiences. As well, they were intended to be the contact person from the high-income country to assist with the visibility of the project. Although there was initial workshops regarding the roles and responsibilities of the twinned societies and mentors at the initial meeting in London, 2007, throughout the project many individuals would report that they were not sure what the twinning and the mentorship were about. A document that outlines the roles and responsibilities is included in Annex 2.

The majority of twinnings and mentoring were successful. Individual results are described under each country. The table below lists which countries were twinned together as well as identifies the director and the mentor to each project.

Personnel of the SMN Initiative:

Country	Project Director/Co-Director	Twinning country	Mentor(s)
Haiti	Dr Lauré Adrien	Canada	Dr René Laliberté Ms Charlotte Landry
Kenya	Dr Omondi Ogutu	UK	Dr Tony Falconer Prof Will Stones
Kosovo	Assoc ProfDr. Shefqet Lulaj Dr Albert Lila	Canada	Dr Ferd Pauls Ms Cathy Ellis
Moldova	Dr Stratulat Petru	UK	Prof Jason Gardosi
Nigeria	Dr James Akuse	Denmark	Prof Staffan Bergström
Pakistan	Dr Razia Korejo	Sweden	Dr Bo Möller
Peru	Dr Juan Trelles Dr Eduardo Maradiegue	Spain	Prof Luis Cabero Roura
Uganda	Dr Frank Kaharuza	Canada	Dr Jean Chamberlain Ms Ann Lovold
Uruguay	Dr Leonel Briozzo Ms Ana Labandera, Midwife	Canada	Dr Andre Lalonde

The Impact of the SMN Initiative on FIGO

Successes for FIGO

- Conducted different projects in 10 countries using strategies such as perinatal audits, guidelines and protocols development, unsafe abortion, community mobilization, provision of maternal and newborn health care, training and deployment of health care professionals to address the major causes of maternal mortality. The successes are reported in each country project below.

- Development of positive and nurturing relationships between the national associations and FIGO. This project provided a forum between FIGO and its membership to discuss the needs, realities and challenges faced by low income countries to improve maternal health.

- Legitimized the membership of national associations to the international association. In a sense, the project showed national associations that FIGO can offer opportunities to its member countries.

- With a limited budget and time, FIGO supported the implementation of different country projects. Each country project chose different goals, activities which reflected their realities. Projects were in very different geographic areas such as Eastern Europe, Sub-Saharan Africa, South America and the Carribean.

- The ability to be sensitive and respond appropriately to different country needs as well as flexible to the changing environments.

- Contributed to raise the profile of itself and its national professional organizations through their ability to contribute to the global campaign to improve maternal and newborn health.

- Able to learn from this experience and had increased its organization, management and administrative capacity.

- Successful administrative and financial management of multi national projects in different languages, within a limited time frame and across complicated exchange rates.

- Raised the profile of the entire organization as a player and contributor to the solutions for Safe motherhood and newborn.

- Became a strong international partner with other agencies in addressing MDG 4-5 in particular.

Challenges for FIGO

- FIGO previously had limited experience with project management and the multiplicity of different projects added to the challenge.
- The unexpected yearly turnover of Project Managers was difficult not only for personnel at the country level but also for the reporting on the project to the donor.

- The people implementing the project were busy clinicians working in spare time and frequently had little previous experience. However they showed remarkable adaptation and responded to the many challenges. FIGO had to adjust all the time to this environment. Communication was a challenge which was overcome with the participation of the SMNH committee.

- The budget for the overall SMN Initiative was very small for so many countries. This meant that there was less capability to properly support the countries with field visits and for FIGO to have more face-to-face contact with everyone involved in the Initiative.

- FIGO added 3 countries to the 6 original countries selected and supplemented the budget by 750,000.00

- Due the lack of experience in project management, reports arriving from the countries needed extensive review. Sometimes due to the language barrier, the report was difficult to interpret. Some projects had difficulties to report on their log frames and indicators, however with the help of Options and project manager this was simplified and rectified. Some projects were unable to decide what information is useful and what is not useful. There were masses of paper generated through reports.

- There were different start up and end dates to the project. This was not a huge challenge, however it complicated reporting.

- Financial management was difficult across so many countries with different exchange rates. However in the final two years an experienced finance officer at FIGO was crucial for the successful financial management of the projects.

- At the start of the project the project manager was situated in London with little day to day support since the overall person responsible was in Ottawa. After two years it was decided to have the

project manager located in Ottawa who improved supervision, communication and general support to the countries.

HAITI

Setting up basic and comprehensive emergency obstetric care in a health centre in the district of Croix-des-Bouquets

La Société haïtienne d'obstétrique et de gynécologie (SHOG) in collaboration with other local partners such as the Ministry of Health (MOH) and the Association des Infirmières et Sages-femmes d'Haïti (AISFH) has provided quality obstetric care within a public health center located at Croix-des-Bouquets. Before the project, the center offered only antenatal and post natal care. With improvements made through this project, 24-hour care is being provided with the availability of basic emergency obstetric care and cesarean section. Blood transfusions are available on site during office hours and outside of these times women are referred to another center.

The remarkable success of this project which faced the most severe adversity is nothing short of miraculous and is due to outstanding contribution of men and women in Haiti and Canada. Converting an outpatient unit into a maternity hospital is a challenge in any country but even more in a country with a non functional health system in a humanitarian crisis.

Three days after the earthquake the project director was able to locate staff and bring them back to the hospital to provide maternity care. Many of the staff were in shock and scared to enter any building. After discussions with his Canadian counterpart he secured an apartment next to the hospital to house staff, many had lost their home, family members etc. The central hospital in Port-au-Prince had been taken over by NGOs and there were no maternity units open. Emergency funds and equipment were mobilized and sent to the maternity.

Key activities:
Improvement of physical infrastructure, housing for staff post earthquake, new maternity and operating rooms water, generator, facilities to deal with bio-medical waste, purchase of ambulance, provision of drugs, equipment and supplies as well as provision of staff (security, cleaning, ambulance driver, obstetricians, anesthetists, midwives). There has been some training on neonatal resuscitation, post partum hemorrhage, active management of the third stage of labour and vacuum extraction.

Project Dates: July 1st 2007 – June 30th 2011

Overall cost of project: $ 300,069

Project staff: Since the expansion of the maternity, the project has had between 13-36 paid staff.

Project Director: Dr Lauré Adrien

Twinned Professional Association: Society of Obstetricians and Gynaecologists of Canada

Mentors: Dr. Rene Laliberte and Ms Charlotte Landry, RM

Results of Twinning:

Extremely positive. The SOGC had already established a relationship with SHOG through its 'Partnership Project'. Of particular note was the incredible support that the SOGC provided to SHOG and the Croix-des-Bouquets after the massive Haiti earthquake in January 2010. They were able to mobilize funds and equipment / supplies / medications and provide moral support. The SOGC also ensured support was available to the mentors to visit the project and fulfill their duty as mentor.

Project Highlight:
The pouring in of support and fundraising money in response to the earthquake allowed the opening of a functional operating theatre. The ability to provide cesarean to women at Croix des Bouquets was a huge feat and one of the few centers operational immediately after the earthquake.
The maternity has been officially recognized as a facility qualifying for the 'soins obstetricaux gratuits' (SOG) Program. This is a WHO managed program which aims to provide free services for women in public institutions by offering reimbursement of their transportation costs to / from the hospital, as well as by eliminating use fees and providing free medication.

Successes:
This project was able to provide maternal and neonatal health care around the clock by providing salaries and accommodation for staff.
Throughout the course of the project, the quantity and quality of care increased and data collection improved.
The project team has established many collaborative relationships with different organizations that contributed skills, money or time to improve facilities and the quality of care provided. The relationship between SHOG and SOGC was one of mutual respect and vital to the post earthquake situation.
Establishing links with the midwifery school to provide student midwives clinical placements.

Challenges:
The demand for maternal health services increased so quickly that on a couple of occasions the unit couldn't accept any new admissions. It was estimated that the new maternity would increase slowly the number of women delivering; the earthquake led to large displacement camps to be established at its doorstep. Over 4,000 women were delivered there mostly in 2009 to mid 2011 .These women would not have had any place to deliver otherwise. There were five maternal deaths in last two years, four of them due to very late transfer or arrival at the maternity.

The workload was so demanding that there proved little time to implement complete use of partogram. However active management of the third stage of labor was done in over 85% of deliveries. Ten percent of newborns required resuscitation, there was no time for formal/recorded audit sessions, continuing medical education linkages within the community and the formal recording of meetings and discussions suffered.

The inability of the Haitien government to fulfill their commitment of staff salaries was compounded by the presence of non-governmental organizations and international organizations who offered larger salaries; this created financial strains on the maternity.

FIGO authorized the purchase of a vehicle which served for transport of women, personnel and that decision proved to be wise and critical when the earthquake struck.

Sustainability:
The issue of the sustainability of the maternity within the CDB Health Center is one which concerns everyone involved in the project, especially in light of the challenges faced by the country to meet the basic health needs of its population before the earthquake, and even more after the devastating event.

When the project was first conceived back in 2007, its sustainability was foreseen by ensuring that:

- The maternity was implemented within a public health institution already supported by the MSPP;
- All interventions implemented were done with the full knowledge and support of the MSPP;
- The majority of staff hired where MSPP paid health professionals (unfortunately, MSPP proved unable to maintain these after the first year).

Throughout the expansion period of the maternity after the January 2010 earthquake, efforts were made to maintain the MSPP involved in the initiative and to link the expansion of the services to the Government's health strategy and policies related to maternal and newborn health. Efforts were also made (and continue to be so) to ensure that when possible, MSPP resources (for ex. essential drugs and supplies, etc.) are accessed to maintain the services. The fact that the maternity has been officially recognized as a facility qualifying for the 'soins obstetricaux gratuits' (SOG) Program also facilitated that process.

The project recognizes that the ability of the MSPP to fully assume responsibility of the maternity in the near future is slim due to the challenges the country faces in rebuilding its health system. The CDB FIGO project was undertaken as a development project before the earthquake, but which following it has taken more of "a humanitarian" nature in light of the total collapse of the country's health system. Reconstruction will take time and will need to be supported for many years. SHOG's hope is that as the health system is being rebuilt and strengthened, the work done to ensure the availability of quality maternal and newborn health services at the CDB Health Center will be fully integrated into it. Closing an essential health service that is so desperately needed is something the SOGC / SHOG cannot envision. For this reason, SOGC and SHOG are committed to continue to support the initiative for the long term and are looking at developing a longer term strategy to do so. The project was successful in securing a grant from the MacArthur Foundation for the next year and funds are presently being pursued through UNICEF.

Results:
The maternity at Croix-des-Bouquets went from doing no deliveries to have provided perinatal care to 4207 women over the course of the project who otherwise would have received no care . In the first half of the project, the signal functions for basic emergency obstetric care became available except for removal of retained products. After the earthquake the facility attained comprehensive emergency obstetric care status but still has some technical problems to resolve. At the present time Blood in Port au Prince comes from a central bank, Families are sought as immediate donors because of the poor blood supplies, Donors are often brought by the maternity emergency vehicle to the blood center and return with the fresh blood for transfusion.

In the first half of the project, the centre was able to refer cases they couldn't handle and ensured that women received needed care. The proportion of cases referred out of the centre decreased over time, reflecting that the centre was better equipped to deal with complicated cases.

The number of cases referred by traditional birth attendants had increased, however the proportion of cases rose marginally (from 2% to 4%). This was due to the clinical overload and this was countered by a visit to all the displaced camps advising them of the available services.

The maternity is now a hospital providing complete emergency obstetrical care to a population that had no care available after the earthquake.

Logframe:

Objective:

To make basic and emergency obstetric care available to pregnant women during childbirth and immediate postpartum period at Croix des Bouquets health centre.

Output 1: To make basic and comprehensive emergency obstetric care services available at Croix des Bouquets

Indicators	*Expected Results*	2008	2009	2010	2011 (Jan-Jul)
Number of deliveries	year 1: 75 year 2: 150 year 3: 300 year 4: 500	104	453	1960	1690
Number of women who had AMTSL (%)	All deliveries	0 0%	428 94%	1588 81%	1463 87%
Number of cases referred by TBAs	year 1: 20 year 2: 40 year 3: 60	…[a]	1	46	69
[a] No cases documented					

Output 2: To create an infrastructure that will provide access to emergency obstetric care, basic and comprehensive (pre-and intra immediate partum post) including care of the newborn and immediate resuscitation

Indicator	Expected results	2008	2009	2010	2011
Number of new midwives recruited to work at Croix des Bouquets (number of midwife months covered for under the project)	4 (= 48 midwife months per year, mm)	5 (36mm)	0 (63mm)	2 (65mm)	0 (55mm)
Number of deliveries with complications treated [a]	15% of all deliveries	11 (11%)	173 (38%)	274 (14%)	93 (6%)
Number of postabortion care cases reported		0	0	33	76 [b]
Number of cases referred to other centres for comprehensive emergency obstetric care	25/ year	0	199	63 **	36
Number of neonates resuscitated (i.e. with apgar score ≥ 7)	Less than 20% of all newborns	10	32	162	140

[a] The figures represented here have been amended based on what is reported about post-abortion cases in the narrative report which states: "Were offered care for postabortion complications was 76 women representing more than double (33) compared to the same period last year". Thus, the postabortion care cases have been subtracted to enable calculation of a proportion to measure this activity against the target set of 15% of all deliveries.

Output 3: Train health professionals so they can provide EmOC quality.

Indicator	Expected results	2008	2009	2010	2011
Number of midwives trained to acquire additional knowledge and skills emergency obstetric care, including neonatal resuscitation.	4	0	1	1	0
Number AMTSL training sessions for midwives	At least one complete course / yearly updates for midwives	0 [a]	0	1	1 [b]
Number of visits by project staff to oversee operations to ensure the quality of clinical practice as part of emergency obstetric care	30	1 visit /wk + phone calls [c]	2-3 visits /wk + daily phone calls [d]	2 visits / week + daily phone calls [e]	2 visits / week + daily phone calls [e]
Women whose labour was followed with the partograph (%)	100% of all women	90 87%	421 93%	1206 62%	1143 68%
Number of sessions to review the near misses and / or maternal deaths	12 during the whole project	0	0	3	0
[a] Full maternity services were not yet available.					
[b] Training in resuscitation in the delivery room conducted by the Midwife Mentor.					
[c] Weekly visits and daily phone calls by the project director. [d] 2 to 3 visits a week and daily phone calls by the project director. [e] 2 visits per week and daily phone calls.					

Output 4: To increase collaboration between the SHOG, the association of midwives and the Ministry of Health

Indicator	Expected results	2008	2009	2010	2011
Number of members involved in the project from: SHOG AISFH Ministry of Health	A representative from each organisation.	 1 1 2[a]	 4 … 6 [b]	 Not specified [c]	 Not specified [c]
Number of joint meetings between the SHOG / AISFH and the Ministry of Health to discuss issues related to motherhood Health Centre CDB	Two for the duration of the project	6	> 1	~ 20 [d]	3
Number of presentations made by the Ministry of Health, SHOG, or	One time each year for the	1 [e]	7 [f]	> 10 [g]	2 [h]

association of midwives related to the project by the Maternity Health Centre in CDB at national and international forums.	duration of the project				
[a] One from SHOG, one from AISFH, at least 2 of the Ministry of Health (sometimes more at different meetings)					
[b] Four from SHOG; at least 6 of the Ministry of Health					
[c] SHOG is represented by the Executive Director but the Executive Board includes all the midwives who participate in the project (7 since 2010)					
[d] This includes all staff from the maternity unit in their capacity as clinicians, decision makers, partners, etc.					
[e] Calgary, Alberta, Canada					
[f] 1 in Halifax, Nova Scotia, Canada; 1@ Cape Town, South Africa ; 5 @ Port au Prince, Haïti.					
[g] Includes field visits with representatives of UN agencies (UNFPA, UNICEF) and others (JHPIEGO, MSF, COHI. Relief International, Love a Child, Merlin, etc.					
[h] One at the SHOG Congress in May 2011 and at the 2010 AGM in Montreal.					

Output 5: To develop collaboration and linkages with community agencies and partners to mobilise the population towards the use of emergency obstetric care

Indicator	Expected results	2008	2009	2010	2011
Number of briefings / education with community partners / groups and projects related to the Maternity Health Centre in CDB	At least 1 per year	1 [a]	0	4	1 [b]
Number of TBAs trained to recognize danger signs during pregnancy and labour		0	0	0	0
[a] Meeting with Traditional Birth Attendants					
[b] With the person in charge of UCS					

Operating Room at Croix des Bouquets:

First Cesarean Delivery Performed:

Kenya
Improving the quality of maternal and perinatal health care services in four health facilities

The Kenya Obstetrics and Gynaecology Society (KOGS) worked to improve the quality of maternal and newborn health services in three hospitals (Kenyatta and Pumwani in Nairobi, as well as Moi Teaching and Referral Hospital in Eldoret) and in one health center (Sabatia health Center in Eldoret) through the implementation of criterion-based clinical audits. The project also aimed to increase demand for services by involving civil society in community-based activities.

Key activities: development of standards and protocols, training in criterion-based audits, implementation of criterion-based audit at facility level, community sensitization, a before and after research component

Project Dates: July 1 2007 – August 31, 2011

Overall cost of project: $151, 917

Project staff: There was one project coordinator throughout the life span of the project. In the last year and a half a financial officer was hired to support the project administrator for one day per month.

Project Director: Dr Omondi Ogutu

Twinned Professional Association: The Royal College of Obstetricians and Gynaecologists (UK)

Mentors: Dr. Anthony Falconer and Prof. Will Stones

Results of Twinning:
The Royal College of Obstetricians and Gynaecologists were able to support the field visits of Dr Falconer to Kenya. The relationship between the mentors and the project secretariat was quite positive. Prof Stones became involved in the project at the half way mark when it was determined that the project was in dire need of help. As he is located in Nairobi and sits on the SMNH Committee he was an obvious choice. He was very supportive and offered good feedback to the project personnel. As well, he was able to go to the two sites outside of Nairobi and offer support and feedback to the people working there. His visit was much appreciated.

Project Highlight:
The project volunteers reported that visiting the other sites was a highlight for them. They appreciated learning about what working conditions were like, the challenges and successes in health service delivery. This activity provided them the opportunity share experiences and ideas between the sites. This also provided an incentive for them to continue volunteering for the project and made them feel appreciated.

Successes:
The furnishing of essential equipment and supplies for the delivery of obstetric care was improved. Such items included sphygmomanometers, urine sticks, stethoscopes and partographs.

At one of the project meetings, all sites identified a common issue of poor communication between the sites and their referral centers. Over the course of the project, staff has been increasing communication with referral centres by holding training sessions about their project and sharing standards and protocols.

As part of the project, job aids and protocols were created and displayed in the facilities. Training sessions about the job aids and protocols were performed as part of their implementation.

Project management improved over the second half of the project. The project secretariat within the Kenya Obstetrician and Gynaecology Society accepted and acted upon constructive advice in order to avert a pre-mature closure to the project. The project secretariat was able to maintain motivation and momentum among project volunteers through the use of incentives and volunteer recognition. Communication between the sites and the secretariat improved with the creation of a quarterly narrative report form. Increased the number of meetings where all teams meet.
And finally, the secretariat strengthened the technical capacity of health professionals to conduct criterion based clinical audit by recruiting junior members of the ob-gyn society to provide support to the teams in the creation of measurement tools and evaluation of criteria.

Challenges:
There was a delayed start up to the project and, once started, the progress of the implementation of the activities was very slow. There were a variety of reasons for this:

- Post-election violence
- Management structures were not in place: the project had hired a midwife with no project management experience. She did not participate at the initial meeting in London and therefore lacked information necessary to get the project going. As well, the KOGS secretariat was very busy and not able to devote too much time to the project manager to support her and the project. This left the project manager on her own without much guidance.
- Poor communication. The sites were not aware that there was money available for project activities to take place. It wasn't until the July 2009 meeting that this information was presented to them.
- There were no salaries paid to project volunteers at the sites. To compensate for this it was suggested that the sites provide 20% work time to volunteers in order to implement project activities. This proved very difficult as the workload at the facilities was too great to allow this. There wasn't much incentive for the volunteers to contribute to the project. Despite this, volunteers proved to be energetic and keen of the initiative.
- The turn-over of staff trained in criterion-based clinical audit required repeated trainings at the sites.

It was determined from the beginning of the project that civil society would be involved in the project. However, in rural areas civil society did not exist as it did in Nairobi. Of the civil society that did initially participate a lot of them stopped contributing as they had expected to receive money but later learnt that there was no project money coming to them.

Sustainability:
The Options evaluation addresses the issue of sustainability well in their report:

> "Whilst the sustainability of the project per se is not assured due to lack of continued funding, there have been some notable achievements which should continue beyond the period of project funding. There is now a cadre of professionals trained in CBCA who are a resource for KOGS and the Ministry of Health's Reproductive Health Department. The central team are

communicating about the project at conferences and are developing briefing papers to disseminate the project findings more widely. There has also been an influence on improving professional culture through the language of audit which is non-personalised and an effective way of creating self awareness around quality. This cultural change may have longer term impacts in the projects sites. Finally, there is sustainability around the ongoing use of CBCA as a mechanism for improving quality of care within the facility sites in Kenya:

MTRH: clinical audits have been built into the performance contracts of the departments. They are continuing to undertake audits and the hospital administration has agreed for them to develop a standard around PNC.
KNH: The process of audit has encouraged the administration to try to become ISO certified and they have successfully approached JHPIEGO to provide funding for this.
Sabatia: Clinical audits have been built into the performance contracts of the departments
Pumwami: Audits are continuing and staffs are working to complete the PPH standard. Hospital management are aware that standards are beneficial to the hospital and the team have trained other departments of the hospital in clinical audit. The hospital management are looking to achieve other standards."

Results:
There is now a group of health professionals proficient in the criterion based clinical audits as a means to improve the quality of care. The project has allowed the opportunity to this group to improve their technical capacity to perform criterion based-clinical audits. As well, the project has provided the professional association and the midwife project coordinator to build their skills in the design, implementation and management in a maternal health project.

Logframe:
Many parts of the original logframe were adjusted in 2009 to reflect the financial re-alignment that occurred that same year.

Goal: to contribute to reducing maternal and neonatal mortality and morbidity in Kenya

Maternal deaths as a % of total births per site

	2007	2008	2009	2010
KNH	not available	1.24%	0.83%	0.97%
MTRH	0.33%	0.37%	0.41%	0.25%
Pumwami	not available	not available	not available	not available
Sabatia	0%	0%	0%	0.38%

Neonatal deaths as a % of total births per site

	2007	2008	2009	2010
KNH	Not available	13.25%	14.57%	11.43%
MTRH	3.06%	2.34%	3.21%	4.41%
Pumwani	6.14%	6.23%	6.71%	5.37%
Sabatia	0.00%	0.00%	0.20%	0.19%

Outputs for purpose 1: To improve the quality of maternal and neonatal health care services in Kenyan Project facilities

1. Professional associations together with MOH and civil societies develop National Standards for antenatal, delivery and postnatal care that are in line with women's needs and reproductive rights.
2. Capacity developed within health care facilities to use the process of clinical audit to evaluate care
3. Clinical Audit used as a tool to improve quality of care

Indicators:

1. Standards of care developed, debated and agreed on antenatal, delivery and postnatal care.
    - The standards of care were revised in 2008 and ensured that included the development of standards for antenatal and postnatal care. There are 14 in all.
2. Number of trainings to carry out criterion-based clinical audit nationally and number of people trained at project sites
    - Throughout the life of the project, there were a total of 2 criterion-based clinical audit trainings held at the national level. The project also held 3 workshops/meetings throughout the life of the project as an opportunity for project volunteers to learn from each other and work on specific skills (i.e.: how to develop a robust measurement tool). Each project site carried out their own trainings, for a total of 296 professionals trained in criterion-based clinical audits:
        - Kenyatta: 123 professionals
        - Moi Teaching and Referral Hospital: 47 professionals
        - Pumwani: 84 professionals
        - Sabatia: 42 professionals
3. Number of audit cycles completed
    - Kenyatta: 3 audit cycles
    - Moi Teaching and Referral Hospital: 4 audit cycles
    - Pumwani: 2 audit cycles
    - Sabatia: 5 audit cycles
4. Number of standards met
    - Kenyatta: 3 audit cycles
    - Moi Teaching and Referral Hospital: 4 audit cycles
    - Pumwani: 2 audit cycles
    - Sabatia: 5 audit cycles
5. Number of structure or process criteria identified as substandard and successfully addressed
    - Kenyatta: 2
    - Moi Teaching and Referral Hospital: 3
    - Pumwani: 1
    - Sabatia: 5
6. Proportion of structure of process criteria identified as substandard and successfully addressed.
    - Kenyatta: 66%
    - Moi Teaching and Referral Hospital: 75%
    - Pumwani: 50%
    - Sabatia: 100%

Outputs for purpose 2: To improve the accessibility and acceptability of EOC to women

1. A working relationship is established with users of services, women's groups and civil rights based groups
2. A working dialogue is established between participating health care facilities and the community they serve
3. Community awareness of the importance of antenatal, delivery and postnatal care is raised
4. Community awareness of the importance of emergency preparedness is raised and an emergency fund put in place

Discussion:

- Attempts were made at all sites to locate and work with civil society groups to sensitize their communities about making pregnancy safer.
- Community work in Nairobi was more successful as the project volunteers from Kenyatta and Pumwani worked together with the organization Men for Gender Equality Now (MENGEN) and held community sensitization workshops. From this work a committee was formed in the constituency called Dagoretti. The group managed to secure funds from the Community Development Funds and secured an ambulance to help refer women from the community to health facilities.
- Moi Teaching and Referral Hospital and Pumwani raised awareness through women's groups, radio and talk shows. MTRH also held a parade that drew people from the surrounding areas of Eldoret to inform them of safe motherhood.
- The three hospitals worked with referral sites to provide continuing medical education in the form of introducing standard setting and related protocols that had been developed through the project.

Indicators:

1. Proportion of women in project communities able to correctly identify danger signs of pregnancy, labour and pueriperium (This information was collected through a baseline and endline data analysis.)

Project Site	Baseline	Endline
Kenyatta National Hospital	88%	99%
Pumwani Maternity	80%	89%
Sabatia	31%	69%
Moi Teaching and Referral Hospital	73%	98%

2. Number of communities with evidence of Community funding system for obstetric emergency care
    - All communities have access to a Constituency Development Fund and the project volunteers tried, some successfully and some not, to access this. Pumwani and Kenyatta managed to make an ambulance available using these funds. Sabatia was able to hire more nurses. Moi was unsuccessful as access to these funds in their region was highly political.
    - None of the communities actually set up a fund for emergency transfer.
3. Number of communities with evidence of a functional Community transport plan
    - No plan was developed and presented by any of the project sites.
4. Proportion of referrals arriving from periphery health centre with a still birth
    - The project sites did not measure this and as such the information was not included in the narrative notes. There is mention in the narrative notes that staff noticed that women were coming from the community or referral centers in better condition than before the project.
5. Proportion of referrals arriving from periphery health centre in moribund condition

- The project sites did not measure this on this and as such the information was not included in the narrative notes. There is mention in the narrative notes that staff noticed that women were coming from the community or referral centers in better condition than before the project.

Outputs for purpose 3: To strengthen the capacity of professional societies in Kenya to support national efforts at improving maternal and neonatal health care

1. Strong working relationship between the professional organizations with Kenya established
2. Strong working relationship between the UK and Kenya professional organizations involved in improving maternal and neonatal care established
3. Strong working relationship between Kenyan Professional Associations and the Reproductive Health Unit, MOH Kenya

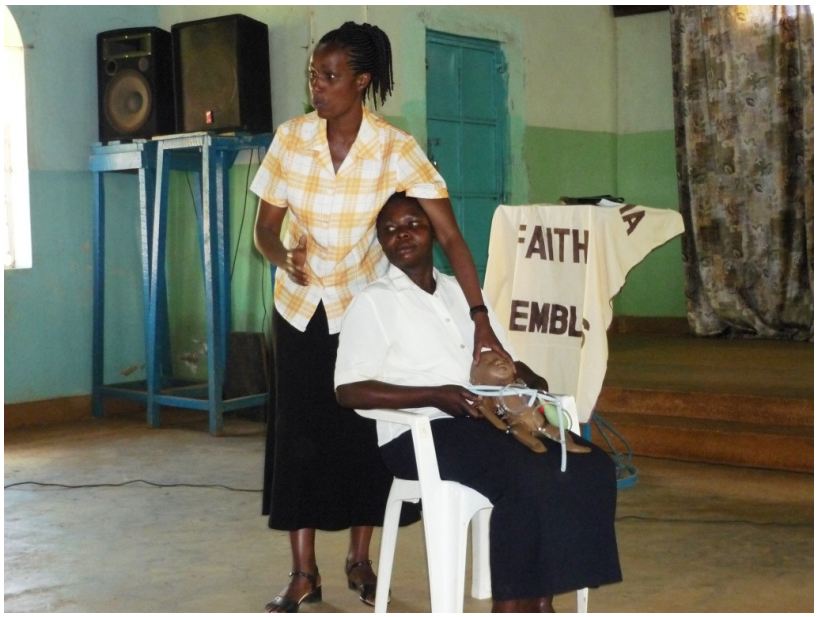
Indicators:

1. Multidisciplinary composition of Steering groups
   The National Joint Steering Committee (NJSC) oversaw the project and included members from KOGS, the midwifery association, Department of Reproductive Health, NCWK (National Council of Women of Kenya), MENGEN (Men for Gender Equality Now), NCAPD (National Coordinating Agency For Population and Development), MYWO (Maendeleo Ya Wanawake Organization), FIDA (Federation of Women Lawyers). This group met at least once a year however, over time, members left the committee because there was no monetary compensation to their involvement.
2. Multidisciplinary composition of Group working to set Standards
   It was the NJSC that was involved in determining and setting the standards at the national level.
3. Audit teams in facilities composed of a representative mixture of professionals from the various groups
   All the sites had audit teams consisting of doctors and midwives.
4. Collaborative activities completed
   At the sites, the volunteers ensured that there was representation from all departments involved in maternal health care present at activities.
5. Successful project management
   This was measured through: activities completed, reports (financial and narrative) submitted on time, reports properly completed. All four sites managed to implement activities pertaining to audit and community sensitization during the second half of the project. Both the Kenyan Project Manager and the FIGO project manager can attest to this. A mechanism for the transfer and accountability of funds was put in place and was successful. A narrative report form was created for the sites to help them communicate to the Kenyan Project Manager. Narrative reporting improved during the project, but submissions were generally late and the forms quite often were scant with information. The purchase of computers and modems for the project sites allowed better communication and reporting from the four sites to the project secretariat.
   The Kenyan Project Manager's reports were initially blank. With support from the FIGO Project Manager, the information on the report forms was adjusted and reporting improved.
6. Strong and active representation on RH Interagency Coordinating Committee
   This was not achieved during the project.
7. Increased technical assistance provided to other MOH activities in the area of maternal and neonatal care.
   The Maternal and Neonatal Health Committee comprises of all reproductive health associations from the Ministry of Health in the Division of Reproductive Health and other donors. KOGS is a

member of this committee. Of particular note: in 2010 the Kenyan government drew up a new Constitution to replace the one dated from 1963. The government consulted KOGS regarding the issue of abortion.

At the final dissemination meeting of the project, KOGS ensured the presence of representatives from the MOH to learn of project.

TRAINING AT MOI TEACHING AND REFERRAL HOSPITAL:



DELIVERY OF SUPPLIES TO KENYATTA NATIONAL HOSPITAL:

Kosovo

Capacity building for reduction of maternal and newborn mortality in Kosovo

The overall objective was to strengthen the capacity and sustainability of the Kosovo Obstetrical Gynaecology Association (KOGA) and the Kosovo Midwives Association (KMA), to take an active part in improving the quality of maternal and newborn care in Kosovo through continuing medical education. Activities were focused in the regional hospitals of Gjakova and Prizren, as well as the tertiary centre of University Clinical Centre of Kosovo (UCCK) in Pristina.

Key activities: development of protocols, continuing medical education, development of strategic plan, training, community sensitization, development and implementation of an antenatal record book (pregnancy passport), development/implementation of health information system.

Project Dates: 1 January, 2007 – August 31, 2010

Overall cost of project: $88,500

Project staff: 3

Project Director: Assoc Prof Dr. Shefqet Lulaj (Dr Albert Lila)

Twinned Professional Association: The Society of Obstetricians and Gynaecologists of Canada

Mentors: Dr Ferd Pauls and Ms Cathy Ellis, RM

Result of Twinning:
Positive. The SOGC financially supported the visits of both the ob/gyn mentor and the midwife mentor. Dr Pauls had an extremely good relationship with Dr Lila that developed over time through visits, emails and phone calls. When the FIGO staff had difficulty with the project, they were able to call on Dr Pauls to help intervene. The mentor relationship was one of trust and friendship.

Project Highlight:
The collaborative conference hosted by KOGA and RCOG in May 2010, Eurovision, was a huge event and success for the project. Not only did KOGA successfully fundraise over 20,000 euro, but they were able to put together a strong scientific programme to offer to their members.

Successes:
An organisational capacity assessment helped KOGA to identify their strengths and weaknesses and implement the following activities:

- Election for a KOGA President
- Creation of a Strategic Plan for 2008-2018
- Development of a member's database
- Establishment of a KOGA web site to update members on KOGA activities

KOGA's activities focused on training in advocacy training, emergency obstetric care. A big success was the building of a team of local instructors in the AIP.

Development and implementation of eleven clinical standards have been developed through the support of the project.
KOGA managed to produce two newsletters for its members during the course of the project.

Challenges:
This was KOGA's first opportunity to design, implement and manage a funded project. As mentioned in the annual reports of 2009 and 2010, financial and project management was a huge challenge with the Kosovo project. The project staff never centralized all the information of project activities and it is difficult to ascertain if any records were kept. Attempts were made to resolve management issues through increased emails, phone calls and visits by FIGO staff to Kosovo. The project was never able to rectify the problems. As such, the decision to end the project prematurely was made in August 2010. The last activity that occurred was a visit by the project mentor, Dr Ferd Pauls, in February 2011. Funds for this trip were provided by SOGC and by the mentor himself. This final visit was an event to mark the end of the project and discuss potential activities that KOGA would take on as their own.
Despite constant follow-up by FIGO, financial issues were never resolved.

Sustainability:
Dr Albert Lila has been excellent at making contacts in and outside Kosovo in order to promote KOGA and gain sponsorship for CME activities. Dr Lila has been very strategic and motivated to ensure continuing medical education for his colleagues and within his professional association. There is no doubt that he will make CME activities available in Kosovo. Although the twinning will not continue with the SOGC, the Royal College of Obstetricians and Gynaecologists of the United Kingdom has expressed a desire to work with KOGA.
At the last visit of the project mentor to Kosovo (February 7-18, 20110) there was discussion of the KOGA rolling out the AIP into neighbouring Albania. Not also would this make KOGA regional leaders in emergency obstetric training, but would also provide the opportunity to generate income for the professional society. UNFPA had agreed to fund the course.

Results:
It is very difficult to determine what impact this project had on maternal health in Kosovo. Case fatality rates were not available from the three sites that were involved in the project.

Logframe:
Purpose: To strengthen the capacity and sustainability of professional associations improve the quality of maternal and newborn care in Kosovo
Note: in the last narrative report that KOGA submitted, they reported that the perinatal mortality rate was 20.1% in 2007 and 19.1% in 2010.

Output 1: Organization capacity of KOGA and KMA strengthened.

Indicators for output 1:	2007	2008	2009	2010
Number of staff trained in project cycle management	2	7	0	5
Number of projects awarded	1	2	3	1
Number of times KOGA has been in media	10	15	20	25
Number of meetings between KOGA and women's groups/local practitioners and communities	4	4	4	6
Proportion of KOGA members sensitized in Sexual and Reproductive Health and Rights		15-32%	22-47%	>50%

Proportion of KMA members sensitized in Sexual and Reproductive Health and Rights		5-10%	7.5-115%	>25%

Output 2: Improved maternal and newborn care in three pilot sites

Indicators for output 2:		2007	2008	2009	2010
Number of national standards and protocols developed		0	11	11	11
Number of protocols implemented per site	Gjakova	0	11	Reinforced with case review & CME	Reinforced with case review & CME
	Prizren			11	11
	Pristina		11	11	11
Number and proportion of staff trained in AIP at each site	Gjakova	Not reported	Not reported	Not reported	Not reported
	Prizren	Not reported	Not reported	Not reported	Not reported
	Pristina	Not reported	Not reported	Not reported	Not reported
Percent increase in post test scores at each training	Gjakova	Not reported	Not reported	Not reported	Not reported
	Prizren	Not reported	Not reported	Not reported	Not reported
	Pristina	Not reported	Not reported	Not reported	Not reported
Number of pregnancy passport distributed	Gjakova	2,500	2,55	2,500	2,500
	Prizren	4,000	4,000	4,000	4,000
	Pristina	5,000	10,000	10,000	10,000
Proportion of women with a completed pregnancy passport at each project site	Gjakova	5%	15%	20%	30%
	Prizren	10%	15%	20%	25%
	Pristina	0%	10%	17%	25%

Notes to Output 2: Gjakova and Pristina both had one AIP course delivered in their institutions.
The pregnancy passport was an initiative of UNICEF.

Output 3: Partnerships developed with other stakeholders or peer institutions such as professional associations in the regions, EU and within FIGO, including women's and clients' groups

Indicators for output 3:	2007	2008	2009	2010
Number of collaborative activities	4	6	7	4
Number of partnerships created	3	5	7	4

Note for Output 3: Memorandum of Understanding have been signed with RCOG and KOGA to undergo activities for 2011. An MOU has also been signed with the Albanian Society for Obstetrics and Gynaecology for the two societies to hold a joint conference.

Project Staff and Mentors Meeting:

MOLDOVA

Beyond the numbers: implementation of new approaches of reviewing perinatal deaths in the Republic of Moldova

Working with the Moldovan Association of Midwives and the Association of Perinatal Medicine, the Society of Obstetricians and Gynaecology of the Republic of Moldova have been implementing perinatal mortality audits as a means to improving maternity and newborn care throughout the country. The general aim of this project is to reduce perinatal mortality amongst babies with a gestational age of more than 37 weeks of age and with a birth weight of more than 2500 g in the Republic of Moldova.

Key activities: development of audit tools, training in audit, implementation of audit committees, review of cases, production of protocols, training and dissemination of information.

Project Dates: 1 December 2006-31 October, 2010

Overall cost of project: $ 84,344

Project staff: 4

Project Director: Dr Stratulat Petru

Twinned Professional Association: The Royal College of Obstetricians and Gynaecologists (UK)

Mentors: Professor Jason Gardosi

Result of Twinning:
The RCOG wasn't highly visible in this project. However, the relationship between the mentor and the project team was very positive. Professor Gardosi was in regular contact and had several visits to Moldova to help with the implementation of perinatal audits. He was also present at the project's final dissemination meeting. This was a relationship of mutual respect and understanding.

Project Highlight:
Host of a two day international and multi-disciplinary conference entitled "Quality in Perinatal Care" in June 2010. This dissemination event led to the project staff receiving requests from neighbouring countries to share their expertise in the implementation of audits as a way to improve perinatal care.

Successes:
1. Establishment of a National Committee for Confidential Enquiry in Perinatal Death
2. Implementation of a no blame confidential process to improve maternity and neonatal health care.
3. Changed attitudes among clinicians to appreciate evidence based practice.
4. Recognition of the value of midwives as experts in confidential enquiry.
5. Development of other partnerships with Swiss Tropical and Public Health Institute, Swiss Agency for Development and Cooperation, University Hospitals of Geneva and Basel

Challenges:

1. Involvement of the twinned obstetrical and midwifery associations. There was no midwife mentor and the obstetric mentor took it upon himself to be engaged in the project (as he had a prior relationship with project members). There was no strong relationship developed between the professional societies of the two countries.

Sustainability:
Although there presently isn't any record that documents the continuation of this project, it appears that the project is quite likely to continue. An email received from the project staff dated September 6, 2011 states: "until now we continue to collect all cases of perinatal deaths in normal birth weight babies from maternities and to select some of them to be discussed during audit sessions. Yet in September will be organized two sessions in two perinatal centers of level II."
With the high number of professionals instructed in the audit process combined with a low cost of implementation with results that show good impact it seems that this project is one of the projects most likely to be sustained.

Results:
Moldova has a total of 38 health facilities that offer maternity and neonatal health care services. This project conducted 257 perinatal deaths audits involving 325 professionals from all of these 38 institutions. In total, 88% of the perinatal deaths that reviewed were deemed unavoidable. As such, appropriate action was taken to prevent such tragedies from occurring again. This resulted in an increased and proper use of antenatal growth charts, partographs, fetal heart rate monitoring and improved neonatal resuscitation.

Logframe:

Project Goal: Reduction of perinatal mortality among newborns with a gestational age ≥37 weeks and a birth weight≥2500g in the Republic of Moldova.

Indicator: number (and proportion %) of perinatal death in fetus/newborns with birth weight ≥2500 and gestational age ≥ 37 weeks

Indicators	Before 2007	2007	2008	2009	2010
Total number of neonatal deaths	575	535	540	537	502
Number (proportion %) of perinatal death in newborns with birth weight ≥2500 and gestational age ≥ 37 weeks	282 (49%)	244 (46%)	205 (37.9%)	201 (37.4%)	191 (38.1%)

Output 1: To increase the capacity of the Partner Societies in the analysis of the perinatal death cases and the elaboration of the recommendation for reduction.

Indicator	Baseline (before 2007)	2007	2008	2009	2010
1. Number (%) of Partner Societies' members instructed to use audit tools & methodology	OB: 10 (3.5%) MW: 6 (1.23%) PN: 9 (6.9%)	OB: 79 (27.7%) MW: 44 (9.1%) PN::52 (40%)	OB: 29 (10.2%) MW: 26 (5.4%) PN: 20	0	OB: 150 (52%) MW: 55 11.3%) PN: 100 (76%)

			(15.3%)		
2. Number of meetings on perinatal auditing	5	16	11	8	13
3. Number of perinatal deaths cases discussed	23	75	54	40	65
4. Number of joint meetings of societies	1	4	7	3	2
5. Number (proportion) of institutions where annual auditing is implemented	3 (8%)	24 (63%)	11 (29%)	38 (100%)	38 (100%)
6. Proportion society members that carried out the expertise of cases at the auditing meetings	OB: 12 (4.2%) MW: 8 (1.6%) PN: 10 (7.7%)	OB: 42 (14.7%) MW: 21 (4.3%) PN: 33 (25.4%)	OB: 33 (11.6%) MW: 15 (3.1%) PN: 31 (23.8%)	OB: 39 (13.7%) MW: 8 (1,6$) PN: 9 (6.9%)	OB: 45 (15.8%) MW: 7 (1.4%) PN: 12 (9.2%)
7. Proportion members of societies that participated at the auditing meetings	OB: 41 (14.3%) MW: 26 (5.4%) PN: 25 (5.15%)	OB: 116 (40.7%) MW: 101(20.8%) PN: 103 (97%)	OB: 97 (34%) MW: 56 (11.55) PN: 60 (46%)	OB: 42 (14.7%) MW: 16 (3.3%) PN: 39 (30%)	OB: 57 (20%) MW: 25 (5.1%) PN: 20 (15.4%) FD: 4 Pathologists:12

Output 2: To increase the number of partner societies' members that are able to apply cost-effective interventions, as recommended by WHO

Indicator	Baseline (before 2007)	2007	2008	2009	2010
1. Increase in the appropriate use by staff of Antenatal growth chart to detect IUGR (proportion %)	40	70	76	79	75
2. Increase of staff counseling pregnant women, regarding monitoring of fetal movements (proportion %)	20	50	55	71	75
3. Increase appropriate use of Partogram by staff (proportion %)	60	80	76	85	100
4. Increase of correctly made decisions, based on the Partogram, in complicated deliveries (proportion %)	44	50	59	75	82
5. Increase of FHR monitoring every 30 minutes during the first stage of labor (proportion %)	44	50	70	75	100
6. Increase of proper FHR monitoring during second stage	8	40	50	78	85

of labor (proportion %)					
7. Increase of adequate neonatal resuscitation according to the standards (proportion %)	34	76	72	74	78
8. Increase of analyzed cases of perinatal death with reference to new protocols (proportion %)	38	49	63	67	73
9.Proportion of deliveries in the non-horizontal position	1	3	6	8	9

Output 3: To increase the role of midwives in offering antenatal and intrapartum care

Indicator	Baseline (before 2007)	2007	2008	2009	2010
1. Number (proportion) of midwives instructed in perinatal audit meetings	7 (1.4%)	26 (5.4%)	33 (6.8%)	0	78 (16.1%)
2. Number (proportion) of midwives participated at CME courses (Partograph, FHR monitoring)	0	50 (10.3%)	17 (3.5%)	20 (4.1%)	24 (4.9%)
3. Proportion of midwives that assisted physiological deliveries	-	-	-	99.2	99
4. Number (proportion) of midwives at audit sessions	2 (0.4%)	16 (3.3%)	2 (0.4%)	14 (2.9%)	7 (1.4%)
5. Number (proportion) of midwives participating in auditing sessions	10 (2.1%)	43 (8.9%)	21 (4.3%)	9 (1.85%)	25 (5.15%)
6. Proportion of midwives that filled out the Partograph	5	15	20	88	85

Audit Sessions In Moldova:

NIGERIA
Saving mothers and newborns in Edo, Amambra and Kaduna States

The Society of Obstetricians and Gynaecologists of Nigeria's SMN Project took place in three facilities, each located in a different state: University of Benin Teaching Hospital in Edo State, Nnamdi Azikwe University Teaching hospital in Nnewi, Amambra State and Barau Dikko Specialist Hospital in Kaduna, Kaduna State. The aim of the project was to reduce maternal mortality through capacity building of professional societies and strengthened cooperation between national societies to increase the availability and quality of Emergency Obstetric Care in three hospital sites in Kaduna, Amambra and Edo States.

Key activities: data collection, development and provision of training material, training in emergency obstetric care, development and implementation of protocols, development of an advocacy tool kit, advocacy activities. Through their activities such as emergency obstetric and neonatal care training and advocacy they contributed to decreased maternal and neonatal mortality and morbidity. A large component of the project was data collection and analysis at the three sites.

Project Dates: January 2007- December 31st 2010

Overall cost of project: $247,511

Project staff: 8

Project Director: Dr James Akuse

Twinned Professional Association: The Nordic Federation of Obstetricians and Gynaecologists

Mentor: Dr Steffan Bergstrom resigned in 2008. FIGO tried to find another representative from the Nordic Federation of Obstetricians and Gynaecologists but was unsuccessful.

Result of Twinning:
The relationship with the NFOG wasn't very strong, although the society did manage to help support individuals attend the FIGO Congress in Cape Town. There was a fall out between the mentor and project staff and the NFOG was uncommunicative when attempts were made by FIGO to find a replacement mentor.

Project Highlight:
The introduction of magnesium sulphate resulted in a drastic decrease in the case fatality rate for eclampsia. Although the project team managed to get the government to ensure the drug in hospitals, they also approached manufacturers of the drug to reduce its cost in the country so that it would be less expensive to people who had to get it from a pharmacy.
The project team also reported, in person, that their ability to participate in the FIGO congress was a valuable experience to them to meet other societies and share experiences at the international level.

Successes:
Data Collection

- Improved quality of maternal health data to better understand the true nature of maternal and newborn health issues.
- Prospective data collected and in excess of 20,000 birth register entries from across the three project sites.
- All maternal deaths at the three sites have been recorded and routine audit of fatal outcomes carried out for each death.

Training
- Across the project life, 373 doctors and midwives have received training on emergency obstetric care.
- Fifteen standardised training modules have been developed and subsequently adopted by SOGON for national use.

Advocacy
- An advocacy toolkit titled 'To work together to save the lives of mothers and newborns' was developed
- Through its advocacy work, SMN Nigeria / SOGON has been represented at national and local levels.
- Increased recognition of SOGON as well placed to support Government policy / direction in relation to maternal and newborn health.

Challenges:
Reporting of activities and on the logframe was difficult. It did improve over time, especially when the project realized that it was their lack of reporting that contributed to their budget being cut. It was thought at FIGO that there was inactivity at the project. As well, logframes and work plans were not used as management tools. This seemed to improve after the FIGO staff visit in September 2009.

The distances between the three sites were very large which made communication difficult and increased travel costs for the purpose of meetings and advocacy work. As well, the work of the hired, part-time midwife was difficult to supervise as she had to visit each of the sites. It was hard to know what she was doing, when in the end she was terminated because she hadn't performed sufficiently. As with many of the other project, training had to be repeated as those who were trained were frequently transferred to other facilities.

Sustainability:
On September 3, 2011, the project directed commented on the sustainability of the project in an email: "The Labor Room Delivery registers we developed at the beginning of the project are now being used in many hospitals. The Mannequins are being used in the training of the rural midwifery scheme which SOGON/Federal Ministry of Health are spearheading to take skilled midwifery to rural Nigeria. So what we did was to lay a strong foundation to build on. In November we are holding a workshop during our annual conference at Ibadan where a guest speaker from Aberdeen UK, Prof Julia Hussein, will present a lead paper on Maternal Audit. SOGON is working with the Federal Government to eventually institutionalize enquiries into maternal deaths as is being done in the UK. Our protocols are up on Sogon website and are freely available to all. Visit the website at www.sogon.org".

Results:
This project had a good research component and generated information that allowed them to identify the main causes of death as well as how the project should work to improve outcomes. As such, the team identified that cases were arriving at their facilities in poor condition, many times from one of the referral centres. This made them realize that it was not sufficient to work just within the three facilities but to also include personnel from the referral centres. The project managed to demonstrate a

decrease in case fatality rates make change due to advocacy efforts and develop an emergency obstetric course that met their needs.

Logframe:
Goal: To contribute to the reduction of maternal and neonatal morbidity and mortality in three States.

The most recent DHS reports that the Nigerian maternal mortality rate has reduced to 545/100,000 live births in whereas it was reported to be 800 per 100,000 live births by WHO in 2000.

Purpose: To improve maternal and neonatal outcomes in selected three states.

Output 1: To improve the quality of emergency obstetric and neonatal care in three hospitals (one in each state)
Indicators for Output 1:

1. 10% decrease in case fatality rates (CFR) of 3 maternal morbidities and 1 neonatal morbidity (eclampsia, Postpartum Haemorrhage - PPH, obstructed labour and neonatal asphyxia)

Benin	2007	2008	2009	2010
Eclampsia	7.3%	13.3%	11%	8.6%
PPH	5.0%	5%	19%	3.3%
Obstructed Labour	0	0	0	0
Kaduna	2007	2008	2009	2010
Eclampsia	35%	11.1%	17.9%	7.1%
PPH	7%	4.4%	19.6%	4.1%
Obstructed labour	3.8%	2.9%	0	7.6 %
Nnewi	2007	2008	2009	2010
Eclampsia	50.0%	22.2%	29.3%	23.1%
PPH	33.3%	9.5%	22.0%	20%
Obstructed labour	0	0	0	0

2. Percent (%) increase in the number of women with obstetrics complications attending the 3 hospitals
   This was not monitored throughout the project and as such, there are no results available.

3. Number of health personnel trained in Emergency Obstetric & Newborn Care (EmONC) in the 3 States and in the referring health centres

   In 2007 the project identified documents to be used for the training which resulted in combining the training material of Jhpiego and the ALARM International Programme.
   There were 6 trainings of 15 participants (2 at each site) prior to the project collecting the data below.
   The people who were involved at these trainings were all from the project sites.
   Over the course of the project there were a total of 373 health care professionals trained in emergency obstetric care and in the protocols that were developed. The training included midwives, paediatricians and obstetricians.

Initially training was only for staff at each of the three sites. It was determined during the project that women requiring care were arriving in poor condition from referral or private clinics. It was then decided to extend the training to those "outside the gates of the hospital".
The breakdown of the trainings is provided below.

Project site	staff trained: 2008	staff trained: 2009	staff trained: 2010
Benin	15 internal	6 internal / 49 external	40 internal / 10 external
Kaduna	15 internal	20 internal / 35 external	25 internal / 30 external
Nnewi	15 internal	20 internal / 35 external	16 internal / 42 external

There were two training of trainer courses provided during the project life. March 2008 (13 were trained). April 2010 (9 trained, 3 from each site) it was noted that the majority of the staff trained as trainers in the three sites had been transferred out of the sites.

4. Percent (%) increase in post test scores (there were 11 trainings in total: there were 17 altogether)

TRAINING	BDSH (% increase and date)	UBTH (% increase and date)	NAUTH (% increase and date)
1st training	11% (2008)	14.3% (2008)	9.1% (2008)
2nd training	40.2% (Feb 09)	22.7% (Feb 09)	13.2% (Feb 09)
3rd training	37.7% (June 09)	22.6% (July 09)	12.8%(June 09)
4th training	28% (Nov 09)	24.4% (Nov 09)	14.9%(Dec 09)
5th training	-	24.2%(June 10)	13.64%(July10)
6th training	-	29.5%(Dec 10)	9.24%(Oct10)

Output 2: To strengthen the capacity of professional associations (SOGON & NANM) to improve EmONC services

1. Update of SOGON website (http://sogon.org/), including:
   Protocols for PPH, eclampsia, obstructed labour have been developed and are available on website. The website has been updated. There is no way to track who and how many people have been browsing the site.

2. Advocacy
   The advocacy tool was developed in 2008 is a PowerPoint presentation that describes the situation of maternal health in Nigeria, lists the causes of maternal deaths and indicates what is necessary to improve women's health. SOGON also provides a list of demands from the government. It was used when visiting the Minister of Health, the First Lady and other stakeholders.
   1. Commit 15% of the national budget to health
   2. Timely release and monitoring of funds
   3. Create a budget line for reproductive health services
   4. Allocate at least 10% of the health budget to RH, including:
      - 25% for EONC
      - 5% for contraceptive commodities security
   5. Domestication of Integrated Maternal Newborn and Child Health (IMNCH) Strategy

6. Deployment of National Youth Service Corps doctors and other health workers to the rural communities
7. Support and implement Community Midwifery Scheme:
    - Establish more midwifery schools
    - Deployment to the rural health centers with appropriate incentives to ensure retention
8. Ensure access of our women to Emergency Obstetric and Neonatal Care Services:
    - Capacity building
    - Provision of essential EONC commodities e.g. Magnesium sulphate, oxytocics and misoprostol
    - Efficient and effective blood transfusion services.

Results of Advocacy:

Results of advocacy activities were not monitored or reported.

Date		Purpose	Result
2009	Minister of Health	To invite MoH to work with SOGON	Asked by MoH to submit a document to outline how to improve maternal/newborn health. Community Midwifery Scheme
2009	First Lady of Nigeria		Statement made to include SOGON members on Safe Motherhood Committees at community level
2010	The new first Lady	Sensitization to the issues of Safe Motherhood in Nigeria	Maintain the society's profile

The Minister of Health requested a proposal from SOGON to make suggestions of how to improve maternal and newborn health. SOGON then produced and submitted a document called: "Practical Steps to Reduce Maternal and Neonatal Mortality in Nigeria". The Ministry of Health had a meeting of all stakeholders on September 29, 2009.

The First Lady of Nigeria instructed that all 36 state/local government hospitals ensure the inclusion of SOGON members on their committees.

The project successfully demonstrated to the Kaduna government the decreased case fatality rate of eclampsia at the Barau Dikko Specialist Hospital with the introduction and training in the use of magnesium sulphate. The CFR fell from 35% to 11%. The project pressured the government to ensure a continual supply of the drug to the hospital, which is currently happening.

Advocacy and community also occurred at the community level and included sensitization of religious leaders, youth leaders and women leaders informing them that women do not need to die in labour and that that maternal death is often preventable. Other topics included family planning, male involvement, skilled attendant at delivery and prevention of HIV/AIDS. Birth preparedness and emergency readiness in the community (eg: ambulance, referral).

Advocacy Workshop Attendants:

PAKISTAN

Community based interventions to reduce maternal and perinatal mortality and morbidity in rural Sindh

The Society of Obstetricians and Gynaecologists of Pakistan (SOGP) aimed to improve women's access to health care in sub-district Taluka by improving maternal and newborn health care services in three facilities Sheikh Zayed Medical Centre (comprehensive EmONC) and the Rural Health Centre in Gharo (Basic EmONC) and the Basic Health Unit in Ghariwah (antenatal, postnatal and newborn care as well as emergency referrals).

Key activities: provision of in-service training of staff and pre-service training of local midwives, on the job clinical supervision, payment of salaries, provision of equipment, supplies and drugs, improvement of referral systems, community sensitization.

Project Dates: 1 November 2006 – 31 October 2010

Overall cost of project: $360,275

Project staff: There was 5 project staff (one was a local project manager) who received monthly stipend. As well, the project paid staff at the health facilities to ensure that maternal and newborn health services were available. This resulted in a total of 14 people to provide services ranging from cleaning the floors to performing a cesarean.

Project Director: Dr Razia Korejo

Twinned Professional Association: The Swedish Association of Obstetrics and Gynaecology and The Swedish Association of Midwives

Mentor: Dr Bo Möller

Result of Twinning:
Positive. The Swedish Association of Obstetricians and Gynaecologists ensured support to mentors (ob/gyn and midwives) to go a couple of times to Pakistan so that a twinning relationship could be developed. As well, the association ensured that Pakistani project staff were able to attend the FIGO Congress. The mentors and project staff developed good professional relationships and a feeling of mutual respect and understanding were developed between the two. The mentors took a keen interest in the development and progress of the project.

Project Highlight:
The project is proud to report that they were able to train nine young women from the project region to become midwives.
An article appeared about the project in the journal of the Northern Federation of Obstetricians and Gynaecologists. The citation is:
Report on the FIGO-SOGP Saving the Mothers and Newborn Health Project in Pakistan. An NFOG concern. Acta Obstetricia et Gynecologica Scandinavica December 2010

Successes:
Health Management Information System was implemented and data collected throughout the project. This is important as there was no system of record keeping prior to the project. Comprehensive maternity care became available in this region, including referral. As well, the project invested in a final research evaluation and paper to demonstrate the improvements made in the delivery of maternal and newborn health services using a case control comparison design that included household surveys and health facility assessments. An overview of results of this study is included in Annex 3.
The twinning between the Swedish ob/gyn and midwifery associations and SOGP was highly successful and described as a professional relationship in the spirit of collaboration at the Mid-Term meeting in Cape Town. The Midwives Association of Pakistan was involved in training of traditional birth attendants.
There was no staff turnoff during the project which could indicate that working conditions were favourable and satisfactory to staff.
And finally it is important to note that the project leaders were committed, highly motivated and hard working individuals.

Challenges:
The flood added extra pressure to the project as Sindh province received a high number of internall displaced people.
It was difficult to find doctors to work in the project area as it is a rural location. This meant that appropriate accommodation had to be found and was very difficult.
Insufficient staff to compile, analyze and report on collected data made it slow and difficult to strengthen the health information system.

Sustainability:
The biggest challenge to this project is sustainability. Although midwives have been trained, there is no guarantee that they will be able to work in an enabling environment where they have access to medications and supplies.
Follow-up correspondence with the project representatives was attempted in September 2011 to see how well the project had progressed in securing more funding but there was never a response.

Results:
Three health facilities, including referral mechanisms between the three sites, were strengthened. The project met its expectations in terms of set indicators.

Logframe:
Goal: To contribute to the reduction of maternal and perinatal mortality and morbidity in Taluka Mir Pur Sakro of Thatta district.

Population served: The estimated population served by 3 project health facilities was 78119 persons (in 2007), 79397 persons (in 2008), 81186 persons (in 2009) and 83020 persons (in 2010).

	Baseline (2006)	2007	2008	2009	2010
MMR (number of deaths)	11	3	2	2	1
PMR	88/1000	72.34 (Gharo) 64.62 (SZMC)	49.41 (Gharo) 33.62 (SZMC)	25.05 (Gharo) 34.01 (SZMC)	22.44 (Gharo) 38.11 (SZMC)

NMR	88/1000	*LHW data N/A.	*LHW data N/A	*LHW data N/A	*LHW data N/A

* LHW data is not comprehensive and only covers 30% catchment population.

Purpose: To improve provision of emergency obstetric and newborn care in the community and health care facilities in Thaluka Mir Pur Sakro of Thatta District.

Indicator	Baseline (2006)	2007	2008	2009	2010
Number (%) of deliveries performed by MWs in community (served by 3 health facilities	Data NA	Total # of del. 1494 # of del. Performed by M/Ws 615 (41.16%)	Total # of del. 1496 # of del. Performed by M/Ws 432 (28.87%)	Total # of del. 1420 # of del. Performed by M/Ws 330 (23.23%)	Total # of del. 1627 # of del. Performed by M/Ws 320 (19.66%)
# (%)of all deliveries in the community occurring at a health facility	509	854 (39.75%)	1028 (45.75%)	1067 (47.61%)	1277 (59.61%)
Proportion of women who deliver by caesarean section	-	3.86	8.36	7.63	7.37

Output 1: Effective 24/7 essential obstetric, and basic and comprehensive EmOC services established in the project area

Indicator 1: Emergency Obstetric Care Signal Functions

By the end of first year, one facility is providing Basic, and one facility is providing comprehensive EmONC services to communities in the catchments area (The original logframe listed indicators such as the number of pregnant women booked, the number of deliveries conducted, the number of complicated cases received and the number of C/S performed. The following data includes information on these indicators as listed in the following three tables).

SZMC Mirpur Sakhro

Indicator	Baseline (2006)	2007	2008	2009	2010
Case fatality rate	Data NA	3	1	1	1
Total number of deliveries	299	619	684	588	787
SVD	299 (Presumably)	531	450	377	571
Live Birth	299	579	661	568	757
Stillbirths	7	40	23	20	30

(fresh/macerated)					
Caesarean section	-	83	188	171	158
Vacuum	-	3	19	27	46
Forceps	-	2	27	13	12
Uterine evacuation	63 (D&E)	78(D&E) 1 (MVA)	90 (D&E) 27 (MVA)	97 (D&E) 33 (MVA)	57 (D&E) 40 (MVA)
Blood transfusion	-	21	47	42	50
# of referrals received from Gharo or Ghariwah by ambulance	0	7 (Gharo) 28(Community)	15 (Gharo) 67 (Community)	18 (Gharo) 102(Community)	24 (Gharo) 107(Community)
Number of ANC visits	562	1865	1661	1707	3366
Pre-eclampsia/ Eclampsia	-	2	0	3	3
APH	-	7	47	35	31
PPH	-	21	18	22	18
Perpural Sepsis	-	5	3	0	2
No of women with obst. Complications treated at facility	-	118	256	231	212
Est. no of women with obst. Complications in defined geographical area	-	322.24 (15% of est. Live births used as proxy for all births or pregnancies 2148.27)	337.03 (15% of est. Live births used as proxy for all births or pregnancies 2246.93)	336.11 (15% of est. Live births used as proxy for all births or pregnancies 2240.73)	321.28 (15% of est. Live births used as proxy for all births or pregnancies 2141.91
Proportion of women using essential or Emoc services	-	36.62	75.96	68.73	65.98
Number of trained midwives	2 (Govt employed)	3 (Project employed), 1 (UNFPA) 2(Govt employed)	3 (Project employed), 1 (UNFPA) 2(Govt employed)	2(Project employed), 2(Govt employed)	1(Project employed), 2(Govt employed)

RHC Gharo

Indicator	Baseline (2006)	2007	2008	2009	2010
Case fatality rate	NA	Not mentioned in facility data	Not mentioned in facility data	Not mentioned in facility data	Not mentioned in facility data
SVD	210	235	344	Total # of del. 479	Total # of del. 490

				SVD 423	SVD 420
Live Birth	205	220	327	470	479
Stillbirths (fresh/macerated)	5	17	17	12	11
Vacuum	-	0	0	56 (after training)	70 (after training)
Forceps	-	Not mentioned in facility data	Not mentioned in facility data	Not mentioned in facility data	Not mentioned in facility data
Uterine evacuation	2 (D&E)	18 (D&E)	7 (D&E) 4 (MVA) after training	12(D&E) 7 (MVA) after training	6 (D&E) 12 (MVA) after training
Number of ANC visits	1076	1433	2011	2090	1823
APH	-	0	0	2	3
PPH	-	0	0	4	5
Perpural Sepsis	-	0	0	0	1
Referrals sent	1	13	18	24	72

BHU Ghari Wah

Indicator	Baseline (2006)	2007	2008	2009*	2010
CBA OPD	699	725	2287	6250	3788
Antenatal care	75	79	384	670	1378
Post natal care	3	7	19	31	128
Referral sent	0	3	16	119	200

Indicator 2: 10% increase in number of women using essential obstetric or EmOC services reporting being satisfied with the service

A patient patient satisfaction survey was used to gather this information. All three facilities met the expected result of this indicator. Patient satisfaction rose by 22% at SZMC, 26% at RHC Gharo and by 58% at BHU Ghari Wah.

Facility	2007	2008	2009	2010
SZMC Mirpur Sakhro	56%	70%	79%	78%
RHC Gharo	45%	62%	70%	71%
BHU Ghari Wah	17%	35%	73%	75%

Indicator 3: Number of trained midwives

By the end of project, 10 trained community midwives are working effectively in the community and are able to correctly report warning signs of eclampsia

Output 2: Increased awareness and demand in communities regarding maternal and child health care and survival, especially awareness of pregnancy related complications

Indicators	Baseline (2006)	2007	2008	2009	2010
# of women trained to recognize dangers signs in pregnancy and labour	n/a	400	800	1000	1200
# of women trained to provide basic newborn care to their children	n/a	400	800	1000	1200
% women able to identify the danger signs in pregnancy and labour	n/a	40 – 60%	40– 60%	40 – 60%	40 – 60%

Number of deliveries occurring in each facility	Baseline (2006)	2007	2008	2009	2010
SZMC	299	619	684	588	787
Gharo	210	235	344	479	490
Chari Wah		-	-	-	-

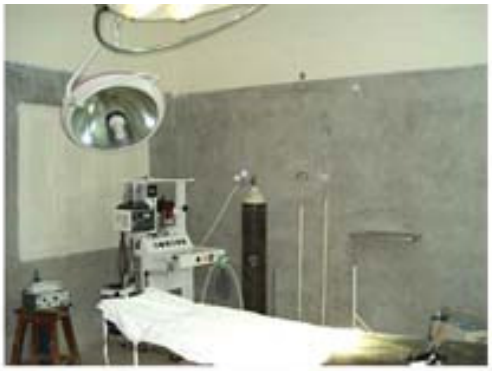
Indicator: % increase in number of cases delivered in each facility	Baseline (2006)	2007	2008	2009	2010
SZMC	299	107%	128%	96.65%	163.21%
Gharo	210	11.90	63.80	128.09	133.33
Ghari Wah	-	-	-	-	-

Output 3: Project data is effectively used for making decisions and informing policy.

At the end of the project, a 111 page report was submitted to FIGO. This report included a retrospective case-control study was performed to evaluate whether this project made any impact on maternal, newborn and child mortality and morbidity. Each intervention facility was matched to a control (RHC Jung Shahi, BHU Chatto Chand and THQ Sujawal) to compare services. As well, the evaluation contained a qualitative component to assess the impact of activities such as community sensitization. Details of the study are provided in the Annex 3. The study used methods such as household survey, health facility assessment and focus groups. Overall the services were shown to be better in the intervention area but recognized that there is still room for improvement. As well, in the intervention area, women were shown to be better informed and equipped to deal with complications, more likely to seek care and recognize the signs of pregnancy complications. The project was able to demonstrate the value of investment in primary health care services to governments but also a means to acquiring more funds from other donors.

Community Education:

Functional Operating Room:



PERU

Saving mothers and newborns in Morropón – Chulucanas, health region of Piura, Peru

The SMN Project in Peru provided technical expertise to help implement the Ministry of Health's (MINSA) strategy to reduce maternal and newborn mortality in the Morropón – Chulucanas Health Network. The Peruvian Society for Obstetricians and Gynaecologists (SPOG) work focused on nine health facilities in this region.

Key activities: training, supervision visits, maternal death audits, implementation of protocols and guidelines and community sensitization, workshops and strategic meetings with government.

Project Dates: 1 December 2006-31 December 2010

Overall cost of project: $297,495

Project staff: 3

Project Director: Dr Eduardo Maradiegue, Dr Juan Trelles (coordinator)

Twinned Professional Association: Sociedad Espanõla de Ginecología y Obstetricia

Mentor: Profesor Luis Cabero Roura

Result of Twinning:
The Spanish Society managed to support the role of the mentor to visit the project during the first half of the project. The mentor was involved well in the project and offered a lot of insight to the project team.

Project Highlight:
The Morropón - Chulucanas Health Network received an award called "The Anonymous Heroes—Saving Mothers' Lives Award" for 2009. This award was established by Sarah Michalko, the granddaughter of the founder of Pathfinder, to recognize the extraordinary efforts made by people and organizations who work to save the lives of women during pregnancy, childbirth, and postpartum.

Successes:
There was an extremely high level of coordination, led by SPOG, between the political, health and university authorities Health Professional Regional Association of Physicians, Midwives and Nurses and Regional Direction of MOH. They worked together with the Health Network to implement the national strategy to improve maternal health outcomes. As well, many alliances were created between local and international organizations such as UNFPA, Pathfinder International, International Planned Parenthood and Fundación Educación para la Salud Reproductiva (ESAR).

Challenges:
Politics are very strong in the network. There was a change in staff at health centres when new politicians were elected. This contributed to a high turn-over in staff as well as health authorities in the network and meant that project advances were lost and/or slow.

The attitudes of the health providers were very resistant to change. Initially, they did not want to follow the norms and standards of care that were set by SPOG. Over time and with much dedication the project team was able to improve this. It also took a lot of work with health authorities to get them to commit to the project.

Sustainability:
The sustainability of this project is uncertain as the midwife who was in charge of the implementation of the project has been moved out of maternal health and a new midwife has replaced her. This new midwife is from outside the region and doesn't show any commitment to the project.
As well, the elections from earlier this year meant that there were many people who were part of the project at various levels of the project (government, administration, health system, clinically) removed from their posts and replaced with other people.

Results:
This was a well managed project that comprised many dedicated people.
Health care became improved and more accessible throughout the health network. As well, the project worked to sensitize communities and in schools.

Logframe:

Aim: Contribute to decrease maternal and neo-natal mortality rate at the Morropon-Chulcuanas Health Network
Indicator: Maternal deaths

	2007 (baseline)	2008	2009	2010
Number of maternal deaths	09	04	07	2
Maternal mortality ratio	196.9	103.9	181.8	36.5
Number of neonatal deaths	77	42	49	48
Neonatal mortality rate	22.3	9.65	11.26	11.1
Prevented deaths	44	92	76	78

Both the maternal and neonatal deaths were reduced in the network throughout the project.

Purpose: Improvement of obstetric emergency care at the Morropon-Chulucanas Health Network of DISA Piura
Indicator 1: Number and Percentage of attended obstetric emergencies

Indicators	2007 (base line)	2008	2009	2010
Number (%) of obstetric emergencies assisted	598	509	579	___

Indicator 2: Maternal deaths at each site

EESS	2007			2008			2009			2010		
Name of facility	RNB	Maternal deaths	MMR	RNB	Maternal deaths	MMR	RNB	Maternal deaths	MMR	RNB	Maternal Deaths	MMR
Pacaipampa	526	2	380	422	1	237	422	5	1184			
Chulucanas	1299			1366	1	73.2						
Frias	756	1	132	304		304	354	1	282	109	1	917

Chalaco	238	2	840	194								
Lalaquiz	70			53			53					
Salitral	52	1	1923	108			108	1	925			
Yamango	138	1	724	122	1	819						
Massa	73			67			67	1	1492			
Matanza	265			300			300	1	333			
Canchaque										89	1	1123

Output 2: Effective and quality obstetric care, 24 hours/days a week, in the intervention area.

Indicators for Output 2.	2007 (base line)	2008	2009	2010
1. # trained staff:				
Doctors	28	13	22	13
Midwives	50	34	38	22
Nurses	19	15	30	15
Other	97	62	90	
2. % of trained staff in the network	38.9	24.9	36	
3. # (%) health facilities which offer maternal care 24 hours a day	09	09	09	09
4. # waiting homes implemented				02

Indicator 5: Proportion of trained staff in the network

Training dates (2007)	% increase	Training dates (2008)	% increase	Training dates (2009)	% increase	Training dates (2010)	% increase
Doctors (28)	23.45%	Doctors (13)	19.01%	Doctors (22)	17.75%	Doctors (22)	10.2%
Midwives (50)	16.87%	Midwives (34)	15.48%	Midwives (38)	12.5.%	Midwives (38)	16.1%
Nurses(19)	19.75%	Nurses (15)	26.22%	Nurses (30)	27.79%	Nurses (30)	17.7 %

<u>Output 2</u>: Increased awareness and demand of maternal health care in the community.

In the final year of the project, there information sessions in the community that spoke about reproductive rights, danger signs in pregnancy and where to seek help and sexual violence.

Indicators for Output 2	2007 (base line)	2008	2009	2010
1.Number of sensitization workshops for the community				41
2.Number of sensitized women				780
3.Proportion of women who identify correctly pregnancy problems and when/where to seek help				60%
4.Number of births at	Network 1078	Network 1218	Network 958	Network 858

health facilities	Hosp 850 Total 1928	Hosp1274 Total 2492	Hosp 980 Total 1938	Hosp. 2040 Total 2898

<u>Output 3</u>: Increase in the organizational capacity of the SPOG to promote the MOH strategy

Indicators for Output 3	2007 Base line	2008	2009	2010
1. Number of workshops planned	5	3	3	
2. Number of trained instructors		82		
3. Number of workshops carried out		3	1	
4. Number of collaboration activities		13		
5.Number of networks / links to other organizations		10		
6.MVA workshops				2
7.Trained instructors				50
8.Anti-shock training				1
9.Trainees				45

Indicator 10: Number and type of networks and links to other organizations and established groups. SPOG was able to achieve 14 links to other organizations. They brought all these organizations together to work on implementing the National Strategy for Maternal Health in the Health Network of Morropon-Chulucanas.

INSTITUTIONS	ROLE
MOH	Rector / institutional support
DIRESA PIURA	Institutional support / collaborative work / operative plan
MORROPON-CHULUCANAS HEALTH NETWORK	Institutional support / collaborative work / operative plan
Morropon-Chulucanas Health Network Staff	Team work
Medical Association of Piura	Institutional support / training of trainers
Association of Obstetricians of Piura	Institutional support / training of trainers
Nurses' Association of Piura	Institutional support / training of trainers
PROMSEX	Sexual and Reproductive Rights Workshop
FARMAGE	Support to carry out the activities.
IPAS	MVA Workshop: training / logistics
Pathfinder International	Logistic support / MVA workshops / Anti-shock garments workshops / Sarah Faith Award
Provincial City Halls of Chulucanas and districts	Education / commitment
Local Education Management Unit (UGEL) M-Ch	Training / team work
PAHO	Logistic support / educational material

OBSTETRIC TRAINING:

IMPROVED DELIVERY ROOMS:

UGANDA
Saving mothers and newborns: Kiboga-Kibaale Project

The Association of Obstetricians and Gynaecologists of Uganda (AOGU) and the African Midwives Research Network (AMRN) Uganda chapter worked to improve women's access to and utilization of EmONC and on strengthening the provision of EmONC within six health facilities in Kiboga and Kibaale districts. Their efforts focused on supply and demand sides of maternal health services.

Key activities: provision of supplies and equipment, training of staff and health administrators, supervisory visits by project volunteers, community sensitization and mobilization, project management and financial management of project staff

Project Dates: 1 July 2007-30 April 2011

Overall cost of project: $208,376

Project staff: 4

Project Director: Dr Frank Kaharuza

Twinned Professional Association: Society of Obstetricians and Gynaecologists of Canada

Mentors: Dr. Jean Chamberlain and Ms. Anne Lovold, RM

Result of Twinning:
Positive: The Uganda project reported that there was a strong support from SOGC. The two associations had a previous relationship through a CIDA-funded partnership project. The SMN Project allowed the relationship to continue and strengthen. There was good contact between the mentors and the project. Dr Chamberlain is a member of the SOGC and happens to live in Kampala. Ms Lovold had visits supported by the SOGC to visit the project. She also helped the project in the procurement of an ambulance.

Project Highlight:
During the course of the project, the AOGU identified that health administrators in the two districts lacked knowledge on maternal health issues as well as the provision of essential inputs for the proper delivery and provision of maternal health services. As such, the AOGU worked with their counterparts at the SOGC to develop a training for administrators to ensure maternal health service needs were addressed. This three day workshop has become known as the AIP HAs (ALARM International Program for Health Administrators).The feedback from this workshop was very positive from the perspective of the participants and the facilitators.

Successes:
This project was able to establish effective partnerships and linkages with other civil society organizations to work collaboratively together on the issue of maternal health. The AOGU also reported

that this project allowed their organization and that of AMRN to strengthen their relationships through working together. The project had a positive effect on their relationship.
As part of the relationships built, the AOGU was able to raise funds from other sources.
Lastly, the project provided the opportunity to the AOGU to present three papers at the FIGO congress in Cape Town and therefore increase their visibility and viability as a professional association.

Challenges:
The Uganda project was one of the four projects whose funds were decreased when FIGO realigned its' budget in 2009. This resulted in many activities being decreased and was demotivating for staff.
As well, the project reported the following challenges:

- Difficult to get commitment from members of AOGU and AMRN to volunteer to project. This resulted in a high turnover of project team members
- Delayed start of the project due to financial processes
- Transport challenges for the project team and volunteers going from Kampala to the project sites. This would require several days away from home.

Sustainability:
Project staff has received training in project and financial management as well as proposal writing and data collection. The project team has been writing proposals in order to obtain new funds to continue the activities that were started at project sites over the last five years. Through the Centre of Disease Control in Uganda, there are presently funds available that have been earmarked for maternal health projects. The association is pursuing this avenue so that they may continue working in Kiboga and Kibaale and introduce maternal death audits into the project sites.

Results:
The project was able to demonstrate the following results from their project:

- Reduction of facility based MMR Kibaale 999/100000 in 2006 to 458 in 2010, Kiboga 827 in 2006 to 363 in 2010.
- Increase in facility deliveries from 30% and 51% in 2006 to 41% and 68% in Kibaale and Kiboga respectively.
- Increased community referrals from near 0% to 40% in 2006 and 2010 respectively.
- Increased number of health workers with improved skills from 20% in 2006 to 78% by 2009.
- Improved equipment levels from 20% in 2006 in 2 to 75% in 2009

The project also invested in a final "Participatory Project Evaluation". This evaluation reported the following:

"The project has made a positive contribution towards strengthening the capacity of six health facilities to deliver EmOC and ENC services in the two districts. This was through training, support supervision, mentoring, supply of buffer drugs and theatre equipments. These interventions were appreciated by health workers and district officials.
The project initiated a community maternal and newborn care component in the two districts. Although this component started late it has been appreciated by community members, health workers and district officials as a potential mechanism to increase access to maternal and newborn care services in the target districts.
The project contributed towards strengthening AOGU and AMRN though making members active, training and creating linkages with other partners including Rotary international, Save the Children Uganda and the Uganda Paediatric Association.

Overall, there was increased utilization of health facilities for delivery services which contributed to the general decline in maternal mortality at the target health facilities."

Logframe:

Indicators to measure Goal: to reduce maternal and perinatal mortality and morbidity in Kiboga and Kibaale district by 2010

	Baseline (2006)	2007	2008	2009	2010
Still birth rate [a]					
1. Kiboga Hospital	40	30.5	20.5	21.6	50
2. Bukomero	3	2.64	2.1	4.7	12.4
3.Ntwetwe	3	4.6	4	3.8	29
4.Kagadi Hospital	76	83	18	74[c]	49
5.Kibaale	36	17.4	7.4	7	27
6.Kakumiro	40	26.4	14.5	5	12
Maternal mortality rate [d]					
1. Kiboga Hospital	827	513	250	245	363
2. Bukomero	314	146	135	117	0
3.Ntwetwe	...[b]	0	0	0	0
4.Kagadi Hospital	999	911	477	775 [c]	458
5.Kibaale	...	0	0	0	0
6.Kakumiro	666	293	0	0	0
Neonatal mortality rate [d]					
1. Kiboga Hospital	18	21.1	4.5	13.5	11.0
2. Bukomero	13	0	4.2	2.35	0
3.Ntwetwe	...	0	2.6	0	0
4.Kagadi Hospital	25	20	2.7	9.6 [c]	17.8
5.Kibaale	...	0	0	3.5	6.8
6.Kakumiro	...	0	0	0	0

[a] SBR seemed to rise in the last year. This was probably due to challenges in maintenance and replacement of resuscitation equipment, staff turnover and lack of adequate skilled staff in neonatal resuscitation, especially the hospitals

[b] No proper records where available then and only improved in the subsequent years from interventions by the volunteers and the MoH which provided new registers in 2008 which improved documentation and recording keeping.

[c] Kagadi had an increase in all the indicators 2009, due to the departure of their only doctor; however the situation improved after the recruitment of new medical officers in 2010 and is expected to only get better.

[d] The project team hypothesis that the HCIVs had no deaths because of an improved assessment and early referral system, particularly of women who required surgery, and from HC IV providers increased ability on managing most of the complicated cases.

Indicators to measure Purpose: To improve women's access to and utilization of emergency obstetric care and essential newborn care & to improve EmOC and ENBC services in Kiboga and Kibaale

	Baseline (2006)	**2007**	**2008**	**2009**	**2010**
No. of (%) of women with (expected) complications accessing EmOC [b]:					

1. Kiboga Hospital	425 (28 %)	480 (32 %)	144 (9.6 %)	384 (25.6%)	306 (22.6%)
2. Bukomero	...	98 (9.8%)	202 (20.2%)	215 (21.5%)	190 (92%)
3.Ntwetwe	...	90 (9%)	102 (10.2%)	150 (15%)	30 (7.8%)
4.Kagadi Hospital	452 (151 %)	400 (133%)	144 (48%)	565 (188%)	305 (122%)
5.Kibaale	...	10 (1%)	19 (1.9%)	32 (3.2%)	18 (11.5%)
6.Kakumiro	...	0	2 (33%)	4 (66%)	21 (11.2%)
No. of births occurring at facilities					
1. Kiboga Hospital	1549	1948	2001	2447	1896
2. Bukomero	483	680	478	850	866
3.Ntwetwe	553	428	742	522	721
4.Kagadi Hospital	1851	1866	2516	2580	1882
5.Kibaale	298	528	542	578	586
6.Kakumiro	232	682	346	393	409
Case Fatality Rate					
1. Kiboga Hospital	2	2.08	3.4	1.56	0.12
2. Bukomero	...	...	0.9	0	0
3.Ntwetwe	...	...	0	0	0
4.Kagadi Hospital	1.8	...	4.6	3.5	0.12
5.Kibaale	...	...	0	0	0
6.Kakumiro	...	...	0	0	0

[a] Number of women with expected complications was calculated by estimating the number of pregnancies in the area (total population in area x 5% multiplied by 0.15(15%) which is the fraction of expected complicated cases from all the expected births.

Indicators to measure Output 1: Capacity of AMRN and AOGU to support emergency obstetric and newborn care services strengthened.

	Baseline (2006)	**2007**	**2008**	**2009**	**2010**
No. of EmOC instructors trained:	30	0	0	0	0
No. of trained EmNC instructors:	0	0	10	0	0
No. of supervisors trained:					
Ob/Gyns	0	0	9	6	8
Midwives	0	0	10	10	8
No. of CME sessions provided[a]:					
1. Kiboga Hospital	0	0	9	5	4
2. Bukomero	0	0	2	1	2
3.Ntwetwe	0	0	2	1	2
4.Kagadi Hospital	0	0	9	5	4
5.Kibaale	0	0	1	2	2
6.Kakumiro	0	0	2	2	2

[a] A CME was given each time a team of volunteers visited the facility, however there were fewer CMEs in the HC IVs due to lack of quorum some times.

Indicators to measure Output 2: Appropriate maternal and neonatal care provided by 6 health centres

	Baseline (2006)	**2007**	**2008**	**2009**	**2010**
No. of visits by volunteers to supervise clinics to ensure quality health care at each facility[a]:					
1. Kiboga Hospital	0	0	10	5	4

2. Bukomero	0	0	10	5	4
3.Ntwetwe	0	0	10	5	4
4.Kagadi Hospital	0	0	10	5	4
5.Kibaale	0	0	10	5	4
6.Kakumiro	0	0	10	5	4
Proportion of staff trained at each of the six sites[b]:					
1. Kiboga Hospital	5 (26%)	10 (50%)	10 (52%)	15 (78%)	12 (60%)
2. Bukomero	1 (16%)	10 (50%)	4 (66%)	5 (82%)	5 (60%)
3.Ntwetwe	1 (16%)	2 (33%)	4 (66%)	5 (83%)	3 (60%)
4.Kagadi Hospital	5 (21%)	2 (33%)	14 (60%)	2 (84%)	18 (72%)
5.Kibaale	0	8 (35%)	4 (66%)	5 (82%)	3 (60%)
6.Kakumiro	0	2 (33%)	4 (66%)	6 (85%)	4 (66%)
Number of protocols implemented at each site:					
1. Kiboga Hospital	0	0	5	7	7
2. Bukomero	0	0	3	5	5
3.Ntwetwe	0	0	3	5	5
4.Kagadi Hospital	0	0	5	7	7
5.Kibaale	0	0	3	5	5
6.Kakumiro	0	0	3	5	5
[a]The number of visits reduced in 2010, because of the revised budget in 2008 and an exit strategy to empower the facility health workers on use of the interventions established and protocols without the monthly supervision.					
[b] Over the life of the project we trained 60 health workers in ALARM . Of these about 45 were from the 6 health units and the others from the other health units in the district. We were not able to train all the staff during that time; however the number of those trained increased in all the facilities.					

Indicators to measure Output 3: Community mobilized to access emergency obstetric and newborn care in Kiboga and Kibaale districts

	Baseline (2006)	**2007**	**2008**	**2009**	**2010**
No. of women sensitized to recognition of danger signs in pregnancy:					
Kiboga area	0	0	0	907	1769
Kibaale area	0	0	0	381	1457
No. of information sessions:					
Kiboga area	0	0	19	8	25
Kibaale area	0	0	15	6	22
No. of women referred by CHWs to seek antenatal medical help at each site[a,b]:					
1. Kiboga Hospital	0	0	0	20	183
2. Bukomero	0	0	0	40	361
3.Ntwetwe	0	0	0	166	625
4.Kagadi Hospital	0	0	0	25	758
5.Kibaale	0	0	0	36	354
6.Kakumiro	0	0	0	28	314
No. of women referred by CHWs to seek postnatal medical help at each site:					
1. Kiboga Hospital	0	0	0	16	20
2. Bukomero	0	0	0	20	77
3.Ntwetwe	0	0	0	70	83
4.Kagadi Hospital	0	0	0	13	130
5.Kibaale	0	0	0	10	52
6.Kakumiro	0	0	0	12	21
[a] The referrals only started in June 2009, after the training and mobilization of the CHWS under the FIGO project as safe motherhood ambassadors. The women were referred for reasons ranging from bleeding, high blood pressure,					

fever, and complications in labour to starting antenatal care. We were able to make a simple community referral form which could be retained at the health facility so that we would know the exact number of those who reached the facilities. This worked well and actually at the community level it was seen as a passport to quick attention at the facilities. It did not only strengthen the link between the community and the facilities but also improved the status of the CHWs in the communities.
[b] The figure is much bigger in 2010 because they were engaged for the whole year.

Community education:

Continuing Medical Education:

URUGUAY
Protecting the lives and health of Uruguayan women by reducing unsafe abortion

The SMN Project in Uruguay aimed to reduce morbidity and mortality resulting from unsafe abortion by scaling up confidential pre and post abortion counseling to women to six health centres. The project work was complemented by epidemiological and social research anthropological study to evaluate the behaviors and relationships between health care professionals and users.

Key activities: training to provide objective counseling in the area of abortion/unintended pregnancy, community sensitization, monitoring and evaluation (research component to project), advocacy

Project Dates: 1 July 2006-31 August 2010

Overall cost of project: $298,460

Project staff: 3

Project Director: Dr Leonel Briozzo, Ms Ana Labandera (Associate Director)

Twinned Professional Association: Society of Obstetricians and Gynaecologists of Canada

Mentors: Dr. André Lalonde, Midwife Melandia (Sweden)

Results of Twinning:
Positive. The SOGC provided a supportive role to this project. Dr Lalonde was quite visible in his role as mentor but the midwife mentor never visited. There was some confusion around who the midwife mentor was as there was one from Spain who was appointed at the beginning of the project and who was able to visit once. At some point a midwife from Canada was introduced and corresponded with the local midwifes.

Project Highlight:
The project succeeded in changing attitudes of health care professionals towards women suffering from unsafe abortion. The project had been launched at the time that women in hospital for an unsafe abortion were arrested in her bed. Abortion was illegal in the country and the government and HCOP were not favorable to the plight of women in this condition. The project was instrumental in completely changing the attitudes of HCP and providing women at the hospital and in the population at large with accurate info on unsafe abortion and on the only safe medication known for abortion.
This is a spectacular success in a region that has strong anti abortion laws.
The highlight was the participation by the new President of Uruguay Mr. Jose Mujica to the dissemination meeting where he announced the new division on sexual reproductive health and stated "no women in Uruguay should die of complication of unsafe abortion" underlining the autonomy of the women to take a decision.

The success of this project led to the creation a new department in the Ministry of Health called "Strategic Initiatives Programmes" and the head of this department is Dr Leonel Briozzo. The project was also very successful in their advocacy efforts.
As well, the project provided a forum for obstetrical and midwifery professional associations to become strategic partners and work together.

Successes:
Health care providers trained to provide confidential, neutral counseling in unwanted pregnancy. This was a huge feat as many health care providers are against abortion and felt uncomfortable dealing with this issue. As such, the providers learned to give informed choice to women with unwanted pregnancy, to discuss the pros and cons of continuing the pregnancy, providing information about unsafe abortion, providing information about the use and availability of misoprostol, providing information about what to expect with misoprostol and signs of symptoms of when a woman should seek care, provision of family planning and encouragement of women to come back to the clinic after an abortion. This model fit with the morals of clinicians who were opposed to therapeutic abortion as it absolved them from their involvement in the actual procedure. There role was only to provide the information.
Communities were empowered and learned of their sexual and reproductive rights surrounding unwanted pregnancy. This led to an increased attendance at health facilities and satisfaction around care provided.
Quality care was observed in the majority of health centres offering this care.
The Ministry of Health will be implementing the model throughout the entire country.

Challenges:
It was originally difficult to obtain by-in about the project to members of the Uruguayan Society of Obstetricians. There was much division about the ethics surrounding abortion. As many members are older, it is believed that as they will retire newer and younger clinicians will replace them and the model will be generally accepted by the society.
A large international meeting was organized with over 350 parliamentarians, human right activists, doctors, midwives, lay people and anti-abortion persons and reporters. There were strong emotional discussions during the two day meeting.
The cost of misoprostol is very high. The project worked to secure access to the drug and ensure safety in its use.
The project reported that their biggest challenge still is to help women make the best decisions more freely, more responsibly, and in a more informed way – in other words, with more awareness.

Sustainability:
The model of care to provide women with unintended pregnancies has been adopted into Uruguayan law. The Ministry of Health is also working to assure national availability of the model. This is probably the most sustainable project of all the SMN Projects.

Results:
The following information is cited directly from the 2010 narrative report:
1- REGARDING THE PROPOSED HYPOTHESIS:
It is concluded that the hypothesis is valid; that some steps have been taken towards a transformation of the sanitary relationship, beginning with the promotion of including women who are experiencing an unwanted or non-accepted pregnancy in the health system. This has caused a decrease on the risk and damage of women living an unwanted pregnancy, which, on turn, has contributed, along with other

changes, to a sharp decreasing tendency on the maternal mortality at the national level, having influenced the public policies level of sexual and reproductive health.

2- RESULTS BASED ON THE PROPOSED OBJECTIVES:

2a- Decrease on maternal mortality due to unsafe abortion.

The maternal morbi-mortality rates have decreased in the zone influenced by the project. During the time of the study, no maternal deaths were reported in the territorial divisions where the project was developed, compared with the remaining territory of the country, where two maternal deaths occurred. Though we cannot link this relation as a cause-effect, we do believe that it is important to consider that it is precisely the zone influenced by the project where the great majority of the population of our country lives.

2.b- Decrease of morbidity and complications due to this practice

During the period of the analysis, and intimately related with the previous issue, the number of admissions to an intensive care center due to complications of an unsafe abortion has been less than half of those in the zone where the project was not implemented. Linking the decrease in mortality and in severe complications, which require the admission to ICU due to abortion, we can observe a clear consistency regarding the benefit on behalf of women at the zone influenced by the project.

2.c- Decrease in unwanted pregnancies

During the time of the study, the number of institutional uterine vacuum extractions has been constant. The decrease in vacuum extractions was not an expected result, but its increase may have been an unwanted result of the intervention.

2.d- Decrease of the need of women to decide a voluntary abortion

The majority of users interrupt the pregnancy (53%), while more than 20% consciously decides to continue with the pregnancy. 10% were not pregnant or presented an embryo and fetal pathology. Help is provided in order to make a conscious decision, specially avoiding the risk and damage of an unsafe abortion.

2.e Evaluation of the project's application methodology

Almost all the users who decide to interrupt their pregnancy do it through the use of misoprostol: it proves that, based on evidence, the "Lower risk abortion" is a safe and effective alternative used by women who make a consultation.

2.f- Contraceptive advise is given to almost 80% of the users, and almost 100% of them use an effective and safe contraceptive method, which increases the possibility of reducing the need of having new voluntary abortions, since the need for an abortion decreases.

3- REGARDING THE PROJECT'S COMPONENTS

3.a- At a professionals and teams level. Multi-disciplinary health teams were formed in each selected center. All teams are committed towards the sexual and reproductive rights. The effective regulation is known and applied almost in all the cases. Based on the professionals' performance and values, a major commitment to the autonomous user's decisions is found.

3.b- The users know, trust and use the services. The evaluation of the users' perception is very satisfactory. A change is seen regarding the respect of confidentiality, the fear of being reported, misinformation and lack of support from the health team.

3.c- In every center, sexual and reproductive health services have been implemented, and when the project ends, they will continue with this work. This makes them natural referents in the new development stage of the services in the whole Health Integrated National System.

3.d- A significant contribution has been made to the change on the public discourse regarding unsafe abortion. The visibility of the sanitary problem on unwanted pregnancy has clearly contributed to its inclusion in the effective legislation and regulations, making women with an unwanted or non-accepted pregnancy, visible (and not invisible as it has been until now).

3.e- Thus, Uruguay may be the only one in the world in which, in spite of a restrictive and anachronistic legislation regarding abortion (Act 9763 of the year 1938), the same has a modern legislation on behalf of human, sexual, and reproductive rights, which makes the woman with an unwanted pregnancy, a person subject to rights and, particularly, subject to her non-negotiable right to comprehensive health care, whichever her situation might be.

Logframe:

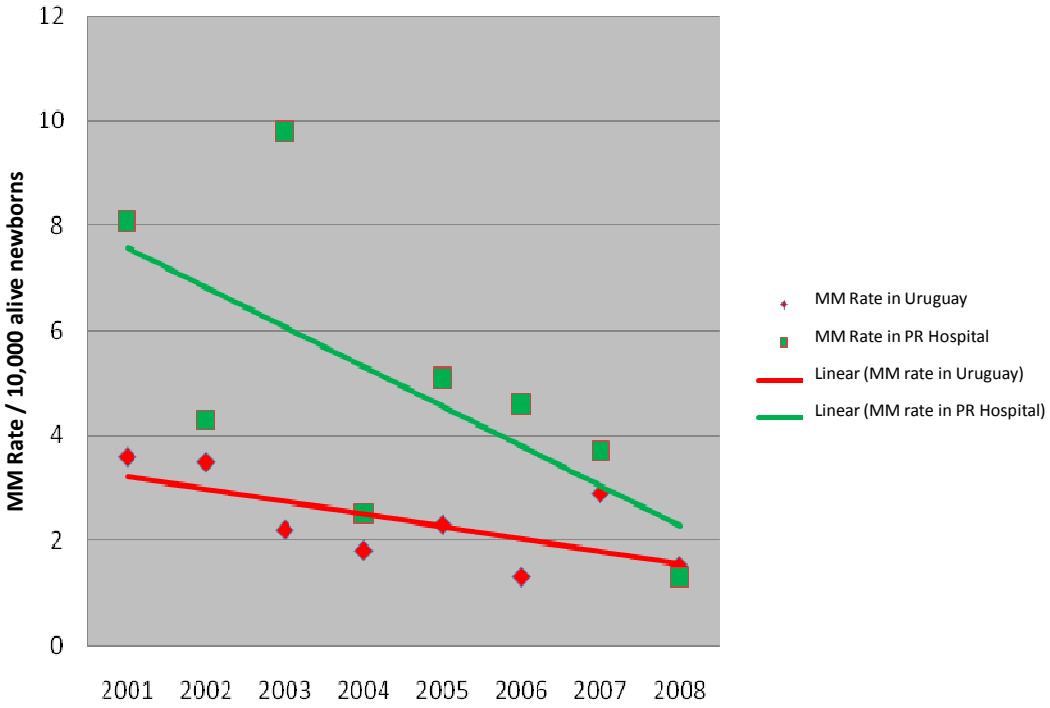
Goal: To protect the health of women while pregnant, giving birth, and during the post-partum period in Uruguay

Purpose: To demonstrate the impact of the implementation of the Health Initiatives Against Unsafe Abortion model by applying the 2004 ministerial regulation in sex centres (70% of the population) and improving the relationship between the health professionals and the users

Indicator 1: Maternal mortality from unsafe abortion declines in the study areas

Data collected throughout the projects shows that maternal mortality in the one project site is declining faster than that of the rest of the country. In the chart below, the red line represents maternal mortality in all of Uruguay while the green line depicts maternal mortality at the Pereira Rossell Hospital.
When data is compiled from all project sites, it shows that the project sites have a lower maternal mortality ratio than the rest of the country.

MATERNAL MORTALITY RATE IN URUGUAY AND PR HOSPITAL 2001-2008



Maternal mortality due to abortion in the study area (1/01/2007-31/10/2009):

Geographic area	Live births	Maternal deaths	MMR	Number (%) maternal deaths due to unsafe abortion
Area of intervention	56108	12	2.1	0 (0)
Rest of country	39256	9	2.3	2 (22%)
Total	95364	21	2.2	2 (9.5%)

Maternal morbidity due to abortion in the study area (1/01/2007-31/10/2009):
During this period there were four admissions to the intensive care unit in the study area, due to abortion. There were two hysterectomies performed due to abortion.
The number of dilation and curettages didn't decreased (the data below was collected May 2007 until August 2009).

	Baseline	2007	2008	2009
Number of D&Cs		1602	1433	1343

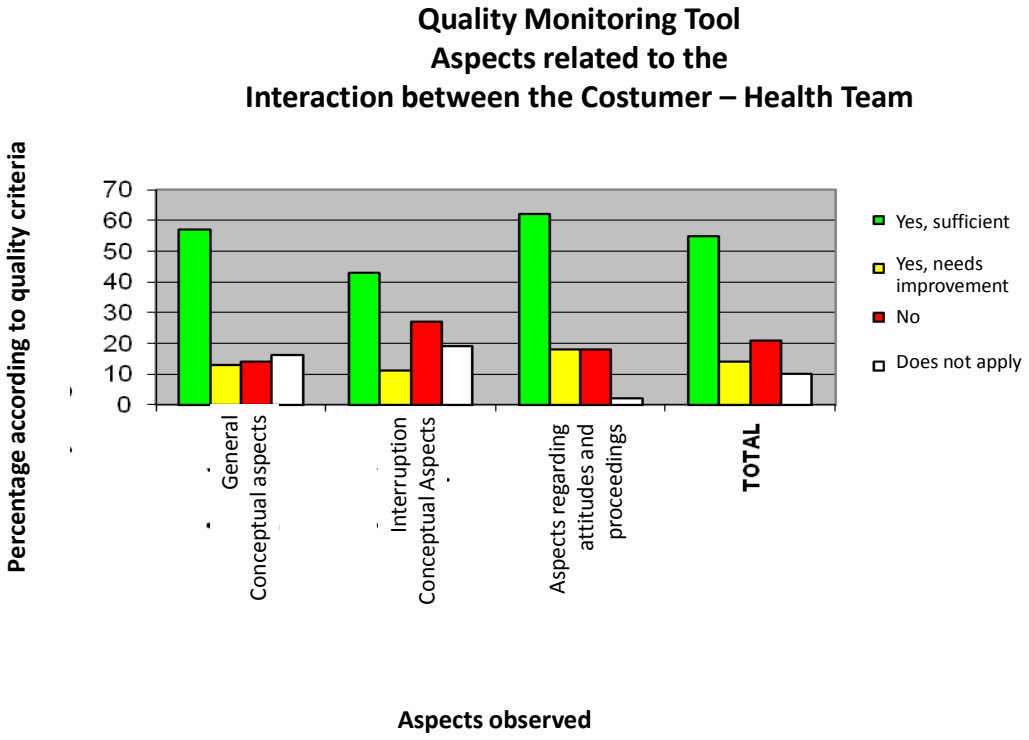
Outputs
1. Committed professionals: To change the relationship between the health professionals and the users to emphasize confidentiality and trust in the six centers.

Indicator 1: number of people trained in pre and post abortion counseling:
Over the course of the project there were 1240 professionals and non-professional workers in health centres were trained in the IS model of care for unwanted pregnancy. A break-down of the trainings is provided in the chart below. There were also six (6) coordinators trained to ensure quality of care at the facilities.

TRAINING on the IS Model of FIGO Project	Number of health team and professionals trained
Pilot Plan 2006 Courses FIGO Workshops (6 Centers “2007-2008”)	237 159 441
Post-Congress Course 2008	35
Certified Course 2009	14
Fellowship	5
FIGO Course (Recertification 2009)	18
CHPR Course (fellows and grade 2) 2007	25
Course for Gynecology Fellows (September 2008)	15
Course in F. Diaz Polyclinics 2010	19
Seminars for Midwives (2008-2009)	272
	1240

Indicator 2: proportion of trained staff able to provide quality service

Project staff evaluated the quality of counseling by observing the user-professional interaction. The observed consultations were carried out at different points of care: initial and subsequent counseling and post-abortion. The chart below that approximately 55% of the time, women received adequate care. A patient satisfaction survey was also employed to evaluate the quality of care. It reported that 95% of the users were satisfied with the care they received. Ninety percent indicated that they received precise and complete information about misoprostol. Ninety percent stated that their privacy was respected.



Indicator 3: number of events, publications that address women's sexual and reproductive rights
Over the course of the project there were 19 events (presentations, conferences, press conferences, CME) and 10 publications. Many health professionals were relied upon to help accomplish this type of activity, thus demonstrating their commitment to this cause**.**

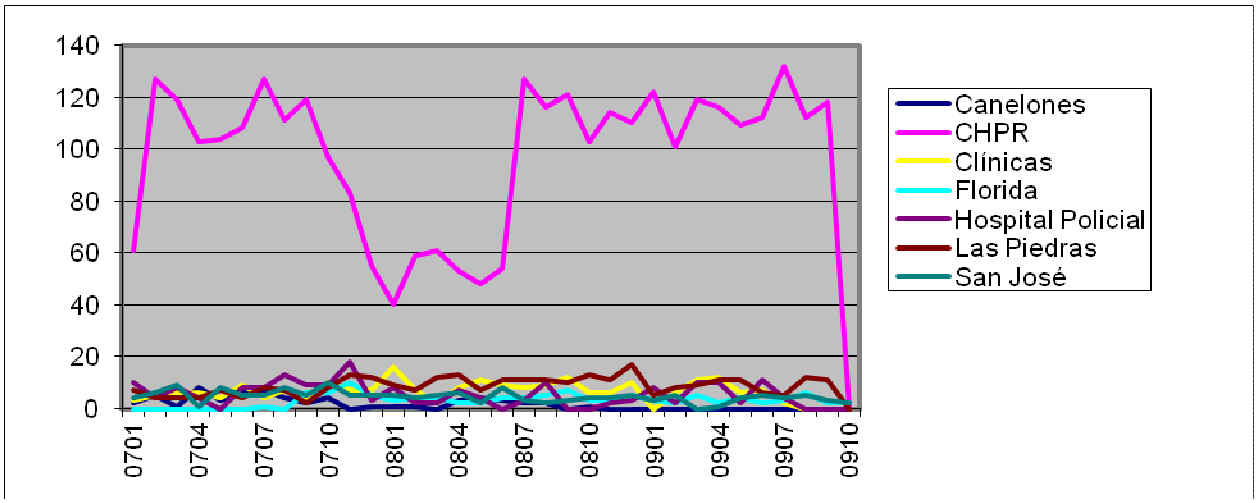
Output 2: Improved access to quality abortion counseling services to women

Indicator 1: Proportion of women who are aware of pre-abortion counseling services
In the end, this indicator was not formally measured. However in the "Qualitative Socio-Anthropological Analysis of October 2009, there is a mention that users of the counseling service are "in general, not acquainted with the counseling services".

Indicator 2: the number of women using the services per year (Data collection started in May 2007 and ended in August 2009)

Name of health center	Baseline 2006		2007		2008		2009		Missing	
	pre	post	pre	post	pre	post	Pre	post	Pre	Post
Total number of women			550	202	1219	337	770	193	9	
1.Pereira Rossell Hospital			537	195	1118	295	690	162		
2.Jardines del Hipodromo			0	0	4	0	3	2		
3.Giordano			0	0	15	8	12	7		
4.Centro de Salud de la Costa			13	7	9	1	2	0		
5.Las Piedras			0	0	22	8	17	3		
6.Canelones			0	0	0	0	2	1		
7.Florida			0	0	30	13	24	9		
8. San Jose			0	0	21	12	20	9		

Indicator 3: number of women seeking dilation and curettage from unsafe abortion
There is no significant reduction in the number of women receiving a dilatation and curettage from unsafe abortion.



ABORTION COUNSELING:

DISSEMINATION MEETING:

CONCLUSION

The Saving Mothers and Newborn Initiative provided FIGO an opportunity to show itself as a leader in the field of maternal health globally. FIGO feels confident to say that the overall initiative was a success despite the fact that measureable results were not always available to demonstrate this. As well, this report should be read alongside the Summary Evaluation report provided by Options. The overall summary and each of the country reports by Options are also submitted to Sida as one of the conditions listed in the initial contract between Sida and FIGO. The Terms of Reference where defined to ensure that the list of project indicators (that were listed in the initial contract) were reported on. A copy of the terms of reference is included in Annex 4.

As stated in the Summary Evaluation:

"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."

FIGO's Results:

Goal: To contribute to the reduction maternal and newborn morbidity and mortality and to the achievement of MDG goals 4 and 5 in a series of low-income countries.

- The nature of all the activities performed has improved the quality of care provided as well as improved access to health care. These activities included audit, emergency obstetric training, provision of emergency obstetrical care, development and implementation of protocols, changes in altitudes towards abortion care, strong advocacy at the highest government offices, and reduced mortality from post partum hemorrhage, eclampsia and dystocia and many more.
- Many country projects were able to quantify their impact on the reductions of maternal and newborn mortality and morbidity included: Pakistan, Peru, Moldova, Nigeria, Uruguay, Uganda, Kenya and Kosovo. In one case, Kenya, the SMN Initiative produced indirect results which will also have an impact on long term reduction of maternal and newborn morbidity and mortality.

Secondary objectives of the project include:

1. Strengthening the capacity of national professional societies to engage in maternal-newborn health through the design and implementation of projects in the field;
    - National professional societies were strengthened through the SMN Initiative. For some associations this was their first opportunity to take on such projects and the experience provided them an opportunity to gain visibility in their country whether within government, media, the general public and/or civil society.

- As well, the project allowed national societies to develop their capacity to manage maternal health projects. The projects in each country were led by clinicians, many of whom had little or no experience with managing projects. Technical support was provided throughout the project by Options, FIGO and SMNH committee to help project personnel with the implementing of their project, reporting finances and introduced them to management tools such as log frames and work plans (gantt charts).
- Some countries also used their funds to pursue workshops and courses on proposal writing and project management skills. Uganda is a prime example of this.

2. Strengthening cooperation between FIGO and national societies, and also between societies in regions or of different economic levels;
    - The project allowed national societies to come into more contact with counterparts from other parts of the world as well as with the FIGO secretariat. There were two all-country meetings that occurred during the life of the project and a final meeting is expected at the FIGO Congress in Rome October 2012. These meetings were highly appreciated by project personnel as it gave them to opportunity to share experiences and learn from each other. As well, it provided them with the opportunity to network and make connections for potential collaborations in the future that would also work towards improvement of maternal and newborn health.
    - Some countries had little or no previous contact with FIGO and the project provided opportunities for national societies to become more engaged with their international counterpart. Also at these meetings, project personnel were provided a glimpse of the inner workings of their international association through meeting members of FIGO's SMNH Committee. It allowed members to realize the value of their membership.
    - Of particular note, the project personnel at the country level were grateful of their involvement in the project as it afforded them the opportunity to attend FIGO Congress as well as present their project to the FIGO membership. For many of the people in the project, the opportunity to attend and participate in this type of venue is only a dream.

3. Strengthening cooperation between national societies and national stakeholders involved in safe motherhood and newborn health;
    - In some countries the project created a forum for the ob/gyn and midwifery associations to come together and work collaboratively.
    - The project also encouraged projects to work with other civil society organizations in order to address other aspects of maternal and newborn health, especially issues that are embedded at the community level.

4. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.
    - This secondary objective is difficult to report on as many of the national professional societies already were involved in provision of technical support to Ministries of Health. However, the project did increase the legitimacy of these associations to have the backing of FIGO and the

recognition of Sida. In some countries, such as Uruguay, the excellent results of the project lead to the creation of a division of sexual reproductive health in the ministry and the government hired the project coordinator to lead this effort.

Lessons learned for FIGO:

1. Strong financial support at FIGO head quarters was essential and critical.

2. FIGO has shown, in the management and support of this initiative that it is a key partner in the global campaign to reach MDG 4 and 5. These projects are unique projects for professional organizations, who in the past were only acting on medical issues. Now donors and government have the proof that they can be relied upon to effect critical changes at the country level.
3. FIGO can count on members of their key committees to participate in major initiatives in their regions.

4. The support of Haiti project was a first on the ground initiative of FIGO in support of a humanitarian crisis.
5. Increased financial resources could have lead to more technical support regarding financial and administrative management skills throughout the project. Working with Options was a very positive experience and there could have been more of their presence throughout the project to ensure that logframes were followed, reflected upon and reported on.

6. With the given funding, in retrospect, there could have been fewer countries involved in the SMN Initiative. The recent FIGO LOGIC Project has secured more reasonable funding. However the gains in all 10 countries far outweighs the problems encountered.

7. Funding did not adequately support project management centrally and on the ground support

8. Capacity and flexibility in administrative and financial management were a key to the success of these projects.

9. As part of the overall management of the SMN Initiative, FIGO itself should have prepared a log frame to measure its own achievements against and a work plan to gauge progress in the implementation of the project.
10. The Uruguay project on unsafe abortion in Latin America has shown an innovative, creative solution to address the unsafe abortion issue in countries with very restrictive laws on abortion.

ANNEX 1: MINUTES AND/OR AGENDAS FROM MEETINGS

LONDON MEETING MAY 13 & 14, 2007
DANUBIUS HOTEL, REGENTS PARK, 18 LODGE ROAD, LONDON NW8 7JT
FIGO INTERNATIONAL SMNH MEETING

Aim of the Meeting: To provide a forum for exploring the process of implementing the projects, reviewing progress and planning for the future.

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Sunday May 13th

0745 to 0815hrs Registration
0815hrs Welcome
Review of Agenda ~ Dr Lalonde.

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0845 to 1200hrs: FIGO Safe Motherhood & Newborn Health Projects ~ presentations by each Project
Chair: Dr Lalonde & Dr Pius Okong
Rapporteur: Ms Margaret Walsh
Individual report from each of the countries highlighting their success, challenges, and how each is reaching their outcomes. 15 minutes for each presentation.
Project countries: Haiti, Kenya, Kosovo, Moldova, Nigeria, Pakistan, Peru, Tanzania, Uganda, Ukraine & Uruguay.

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1200 to 1230hrs: Monitoring & Evaluation ~ Overview of M&E activities & working with Log Frames
Facilitator: Dr Louise Hulton.
Rapporteur: Ms Margaret Walsh

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1230hrs to 1330hrs Lunch

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1330hrs to 1530hrs Group A, B & C Meeting
Group A: Project Directors
Aim: To review leadership roles of the project directors, and share experiences (including integrating the technical roles of "twins") of the projects.
Chair: Dr Pius Okong & Dr Andre Lalonde
Rapporteur: Dr Romeo Mendendez
Presentation: Role of Project Directors
Dr Pius Okong

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Group B: Project Researchers
Aim: The FIGO Monitoring and Evaluation Framework - How to strengthen your LF.
Chair: Professor Will Stones.
Rapporteur: Dr Shereen Bhutta
Presentation: Role of Project Researchers
Ms Margaret Walsh & Dr Louise Hulton.
Facilitator: Options Consultant Dr Louise Hulton
In attendance: Ms Margaret Walsh, Ms Rachel Grellier ~ Options consultant

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Group C: Project Mentors, Twinning Presidents, Twinning Midwives.
Aim: To review strategies for strengthening ways of working together to
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support the Projects & Professional Societies/Associations.
Chair: Dr Ferdinand Pauls
Rapporteur: Dr Matt Carty
Presentation: Role of Midwives in the twinning experience by Ms Kathy Herschderfer
In attendance: Dr Bruno Carbonne Ms Liette Perron
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1600hrs to 1730hrs Reporting Back: Key messages from Group A, Group B & Group C.
30 minutes each group
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1730hrs to 1930hrs Individual Project Clinics
Options Consultants.
20 minutes to be allocated to each project to meet with Louise Hulton & Rachel Grellier.
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1930hrs Evening meal in Hotel Restaurant.
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Monday May 14th
0745hrs to 0815hrs: Registration.
0815hrs: Introduction to second day ~ Dr Lalonde
0830 to 0900hrs: Capacity Building
Presenter: Dr Pius Okong
0900 to 0930hrs: Sexual Reproductive Rights.
Presenter: Dr Romeo Menendez
1000 to 1030hrs: Financial Management of Projects.
Presenter: Prof. Arulkumaran
0930 to 1000hrs: Measuring Maternal Mortality in low-resource settings.
Presenter: Dr Zoe Matthews
1040 to 1100hrs: Roles & responsibilities.
SMNH Committee Chair,
FIGO SMNH Project Coordinator,
Options Consultant,
FIGO Administrative Director
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1100 to 1300hrs: Projects meeting: individual project teams meet to review progress, discuss challenges and consider how to incorporate key messages from each of the presentations into the projects.
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1300 to 1400hrs Lunch
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1400hrs to 1630hrs Reporting back by individual projects
Each project to present key points from the Projects Meeting. 10-12 minutes each
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1630 to 1700hrs Concluding event:
Review of what has been achieved over the past 2 days.
Access to support ~ troubleshooting
Outline of future plans.
Concluding summary from Dr Lalonde.

Evaluation form to be completed.
1700hrs Close.

SMNH Participants for International Meeting 13th & 14th May 07 London

Name	Project
Twinned Society President/Vice Presidents	
Professor S Arulkumaran RCOG	Moldova Kenya
Dr Donald Davis SOGC	Haiti Kosovo Uganda Ukraine
Dr Charotta Grunewald Swedish Society	Pakistan
Dr Morten Lebech Danish Society	Nigeria
Project Society Presidents	
Dr John Okaro	Nigeria
Dr Miguel Gutierrez Ramos	Peru
Project directors	
Dr Omondi-Ogutu	Kenya
Dr Albert Lila	Kosovo
Dr. Stelian Hodorogea	Moldova
Dr James Akuse	Nigeria
Dr Razia Korejo	Pakistan
Dr. Eduardo Maradiegue Mendez	Peru
Profesor Lema	Tanzania
Dr. Leonel Briozzo	Uruguay
Dr Frank Kaharuza	Uganda
Dr Iryna Mogilevkina	Ukraine
Project researcher & Project Midwives	
Dr. Harry Beauvais	Haiti
Dr. Hadiza Galadanci	Nigeria
Dr Edwin Were	Kenya
Ms Berisha	Kosovo
Dr Shershah Syed	Pakistan
Dr Othman Kakaire	Uganda
Dr Dan Kaye	Uganda
Dr Fabián Rodríguez	Uruguay

Mentors	
Dr. René Laliberte	Haiti
Dr Matt Carty	Kenya
Dr Ferdinand Pauls	Kosovo
Professor Jason Gardosi	Moldova
Dr Bo Moller	Pakistan
Professor Luis Cabero Roura	Peru
Dr. Vyta Senikas	Ukraine
Twinned Midwives	
Mrs. Charlotte Landry	Haiti
Dr Grace Edwards	Moldova
Ms Sue Jacobs	Moldova
Ms Ann Lovold	Uganda
Dr Eileen Hutton	Ukraine
SMNH Committee Members	
Chair Dr André Lalonde	
Dr Pius Okong	
Dr Shereen Bhutta	
Ms Kathy Herschderfer	
Prof. Will Stones	
Professor Bruno Carbonne	
Dr Hector Romeo Menendez	
SMNH Project Coordinator Ms Margaret Walsh	
Guest SMNH Committee Member Ms Liette Perron	
Options Evaluation Consultant Dr Louise Hulton Ms Rachel Grellier	
FIGO Secretariat Staff Ms Marie-Christine Szatybelko	

MEETING FOR MENTORS, PROJECT MANAGERS, RESEARCHERS AND COMMITTEE MEMBERS NOVEMBER 5TH, 2006: KUALA LUMPUR, MALAYSIA

Summary of discussions

Chairs: Drs. J. Liljestrand and A.B. Lalonde

Participants:

L. Briozzo (Uruguay)	Prof. Karuso (Nigeria)
F. Okonofua (Executive Director)	O. Ogutu (Kenya)
H. Gladance (Nigeria)	A. Salias (Uruguay)
R. Korejo (Pakistan)	V. De Fuentes (Uruguay)
S. Bhutta (Pakistan)	G. Arribelte (Uruguay)
C. Fuchtner (SMNH Committee)	L. Adrien (Haiti)
K. Herschderfer (ICM)	J. Beyeza (Uganda)
J. Karanja Gatheru (Kenya)	A. Lila (Kosovo)
P. Okong (SMNH Committee)	S. Hoxha (Kosovo)
S. Lulaj (Kosovo)	F. Pauls (Canada)
N.R. van der Broek (UK)	L. Perron (Canada)

Rapporteur : Liette Perron, Canada

Opening of Meeting and Welcome

The meeting was opened by Dr. A.B. Lalonde. Further to his welcoming words, the meetings participants were asked to present themselves.

Short review of projects by each project:

URUGUAY:

- Project Title: **To Protect the Life and Health of Uruguayan Women – Reducing Abortion under Conditions of Risks**
- Project Goal: To reduce maternal and newborn mortality and morbidity
- Specific Objectives:
    - Reduce the number of abortions performed;
    - Reduce the number of abortions performed under conditions of risk;
    - Implement a sustainable model at the national level that is transferable within similar legal contexts.
- Update on activities:
    - Project initiative 6 months ago;
    - Currently proceed with the collection of base line data and the development and implementation of guidelines in the hospitals.
    - Ministry of Health very much involved in the implementation of the guidelines.
    - Launching of the project coincide with the upcoming election. Thus, an important opportunity to advocate around the issue.

KOSOVO:

- Project Title: **Reduction of maternal and newborn mortality in Kosovo**
- Project Goal: To strengthen the capacity and sustainability of professional associations to take active part in improving the quality of maternal and newborn care in Kosovo
- Specific Objectives:

- Strengthen the organizational capacity of KOGA and the Kosovo Midwife Association (KMA) regard to the following: project management skills, communication capacities, development and maintenance of partnerships based on participator decision making processes, working with the sexual and reproductive health approach;
- Assuming a leadership role in the development and implementation of national standards and protocols related to maternal and newborn care in regional and university maternities in Kosovo;
- Initiate partnerships with other stakeholders or peer institutions such as professional associations in the regions, EU and with FIGO, including women's and clients' groups.

- Update on activities:
  - LFA accepted by FIGO and KOGA is waiting to receive contract as to proceed with signature.
  - KOGA and KMA are in the preparation phase: the project's steering committee was established; KOGA also looking how to ensure that this project works in synergy with another initiative undertaken by Dartmouth University which intends to make use of the ALARM International Program.

NIGERIA:

- Project Title: **FIGO's Saving Mothers and Newborns Health Project**
- Project Goal: To contribute to the reduction of maternal mortality and neonatal mortality
- Specific Objectives:
  - To strengthen the capacity of professional associations (SOGON and NANM), community leaders and civil society to design and implement programs for the improvement of EMOC services in the states;
  - To stimulate awareness of the need for the improvement of EMOC among policy makers and service providers in the 3 states;
  - To improve quality of EMOC in 3 hospitals in 3 states over a 4 year period;
  - To increase women's awareness and use of EMOC and referral services at the community level.
- Update on activities:
  - Three preparatory meetings held to date.
  - LFA approved and awaiting for the release of the funds;
  - Project sites: 3 hospitals in 3 states.

UGANDA:

- Project Title: **Saving Mothers and Newborns Project**
- Project Goal: To contribute to the reduction of maternal and perinatal mortality and morbidity
- Specific Objectives:
  - To strengthen the capacity and credibility of the two professional associations of ob/gyns and midwives in Uganda to be leaders in maternal and newborn health care;
  - To strengthen provision of emergency obstetric care and essential newborn care in Kiboga and Kibaale districts;
  - To promote community participation in reduction of maternal and perinatal morbidity and mortality in Kiboga and Kibaale districts.
- Update on activities:
  - Three preparatory meetings held to date;
  - Support of all stakeholders, including Ministry of Health obtained.
  - Project launched on Oct. 20, 2006.
  - LFA approved; awaiting contract and funds to initiate activities.

PAKISTAN:

- Project Title: **Community Based Interventions to Reduce Maternal and Perinatal Mortality and Morbidity in Rural Sindh, Pakistan**
- Project Goal: To contribute to the reduction of maternal and perinatal mortality and morbidity in two sub-districts of Thatta district
- Specific Objectives:
    - To increase awareness in the community regarding pregnancy-related complications, and the need to avail skilled care during pregnancy and labor;
    - To improve essential and emergency obstetric, as well as newborn care in the community and health facilities;
    - To monitor and evaluate the impact of these interventions on maternal on maternal and perinatal mortality and morbidity, both at the community as well as facility level;
    - To disseminate widely the findings and lessons learned from the project for improved policy planning and programming
- Update on activities:
    - UNICEF/UNFPA will be providing some medical equipment / supplies for the health facilities

PERU:

- Project Title**: Comprehensive Action to Save Mothers and Newborns**
- Project Goal: Reduce the maternal mortality in at least 50%, in the geographical jurisdiction of the Morropon-Chulucanas Health Services Network in Piura, in a 3-year period
- Specific Objectives:
    - Improve the organizational and care processes in the Morropon-Chulucanas network, surpassing the fulfillment of 80% of the quality standards (processes) of maternal and perinatal health care services, and essential obstetric and neonatal functions in all facilities in the network and hospitals where patients may be transferred (Sullana Hospital, Santa Rosa de Piura Hospital, Integrado Cayetano Heridia Hospital);
    - Increment childbirth care by expert professionals in obstetric and neonatal emergency function in more than 90% of all births in the community of Morropon-Chulucanas;
    - Reduce the unsatisfied demand for obstetricians to zero in the most critically poor areas of Morropon-Chulucanas;
    - Strengthen the ability of the Peruvian Society of Ob/Gyn t work in alliance with other obstetric associations, the community and the Ministry of Health in actions to save mothers and newborns in Piura.
- Update on activities:
    - Steering group formed and project director recruited.
    - Awaiting the funds to implement the initiative.

HAITI:

- Project Title: **Setting up Basic Emergency Obstetrical Care and Comprehensive EOC in a Health Center in the District of Croix-des-Bouquets in Haiti**
- Project Goal: Provide access to maternal and neonatal health services (BEOC and CEOC)
- Specific Objectives:
    - Create infrastructure that will offer access to BEOC and CEOC services (pre partum, intra partum and immediate post partum) including immediate newborn care and resuscitation;
    - To increase the collaboration between SHOG and the Ministry of Health;

- To develop the collaboration and links with community organizations and partners to mobilize the population towards to use of EOC services

- Update on activities:

KENYA:

- Project Title**: Improving Quality of Antenatal, Delivery and Postnatal care through Clinical Audit**
- Project Goal: To contribute to reducing maternal and neonatal mortality and morbidity in Kenya
- Specific Objectives:
  - To improve the quality of antenatal, delivery and post-natal care offered at centres in Kenya offering basic and comprehensive emergency obstetrical care
  - To improve the accessibility and acceptability of EOC to women
  - To strengthen the capacity of professional associations in Kenya to support national efforts at improving maternal and neonatal health care
- Update on activities:
  - Signed contract; awaiting funds to initiate the initiative.

UKRAINE:

- Project Title: **Improving Emergency Obstetric Care in Ukraine: Strengthening the Capacity of the Ukrainian Ob/Gyn Association (UAOG) Through Introduction of the ALARM International Plus Program**
- Project Goal: Strengthen the capacity of UAOG to improve the quality of emergency obstetric care in Ukraine using ALARM International Plus Program approaches
- Specific Objectives:
  - Strengthen UAOG's organization structure regarding its capacity to be involved in promoting and conducting Continuing Medical Education (CME) activities related to emergency obstetric care and family planning in Ukraine.
  - Build UAOG's capacity to promote and implement the ALARM International Plus Program as one of its major CME programs;
  - Strengthen the capacity of UAOG to integrate a rights-based approach within their program, including the ALARM International Program.
- Update on activities:
  - This project is support by the Capacity Project (funded by USAID) and is currently in its second year of activities.

Other discussion points:

- Importance of all to continue to recruit volunteers to sustain the country initiatives;
- Need to proceed with the collection of credible baseline data;
- Possibility of modifying and strengthening the indicators (both qualitative and quantitative indicators) as we proceed with the implementation phase;
- Encouragement to bring in the midwives, even in countries where they are less organized. ICM can assist with this, if needed.
- Issue and challenge of measuring progress of the country initiatives at two levels:
  - SMNH project level
  - Strengthening the professional associations' level.

  Currently, most of the effort has been focused at measuring progress at the SMNH project level (although Kenya as already identified some indicators at that level and these will be share with others.) FIGO will explore the issue further within its committee and will be in contact with the partners with regards to suggestions.

1. Project management: principles and practice

PPT presentation made by Dr. A.B. Lalonde.

Other discussion points:

- An appeal to all member project teams: In an effort to strengthen the communication links between FIGO SMNH Committee and Project Management team (project managers, researchers and mentors), when receiving an email, to please confirm reception (within 1 or 2 days) even if more time is need to pull together the necessary info. Also, a request that all professional associations provide their associations' email addresses.
- Critical to the success of the initiatives:
    - Communication between all involved;
    - Support from the professional associations' Executive Committees – this can be facilitated through regular reporting and further, involving Executive Committee members in the initiatives, especially the promotional activities.
    - Reporting (both narrative and financial) responsibilities – to FIGO, who in turn will collate the country reports into one which will be submitted to the funders.
- Importance that all communications between FIGO and national project teams also c.c. the mentors.
- Reporting responsibilities to FIGO:
    - FIGO will make clear in future communications procedures re: when reports are due and where (or to whom) they should be sent;
    - Financial reports will be sent to Bryan Thomas, Administrative Director, FIGO Headquarter
    - Narrative reports will be sent to Bryan Thomas who will circulate to Co-chairs of committee and monitoring group.

2. Role of national societies, mentors and twinning societies

Dr. C. Fuchtner reviewed with all the roles and responsibilities of national societies, mentors and twinning societies (as per FIGO document entitled "Saving Mothers and Newborn Projects – Responsibilities and Functions of national society of ob/gyn, mentor and twinning society")

Other discussion points:

- Twinning societies from higher resource countries can provide support to their counterparts in lower resource countries by assuming expenses related to the annual visits of mentors to the project sites.
- Mentors are to be seen as contributors and participants in the implementation of the country initiatives. They can also assist with increasing the visibility – nationally and international of the country initiatives. Their annual visits to the country initiatives can also provide the country team a great opportunity to review progress made and evaluate impact. Agreement reached that mentors do not micro manage the projects.
- FIGO is aware that some twinning arrangements are not happening or functional. Thus discussions are being held about the possibility of changing "twinning societies" and / or mentors.

3. Role of midwives associations

Ms. Kathy Herschderfer, ICM Secretary General spoke of the need to ensure a real collaboration between the national ob/gyn and midwife associations. Also reconfirmed that ICM can assist in strengthening this collaboration to ensure the success of the country initiatives.

4. Review of funding

Dr. F. Okonofua, FIGO Executive Director provided following update with regard to the funding of the FIGO Saving Mothers and Newborn Projects:

- Funding as been secured for 10 out of the 12 approved initiatives. FIGO is continuing to seek funding for the two remaining country initiatives in Ethiopia and Tanzania.
- Importance of tracking the in-kind contribution (financial and professional) in each country initiatives. Should be 30% of the total budget.
- New opportunities for fundings are opening, especially in light of new initiatives (ex. malaria and pregnancy). These funds could potentially supplement current investments.
- FIGO is currently looking at accessing greater funding for the organizational capacity component of the SMNH country initiatives.
- FIGO is to disburse the project funds twice a year. A mechanism is currently being developed to permit the national societies to request their next disbursement when 80% of their last disbursement has been spent.
- Funds will only be provided on the conditions that all reports (financial and narrative) are completed and submitted to FIGO.
- FIGO commits to proceed with the first disbursement soon.

5. Monitoring and Evaluation:

Drs. J. Liljestrand reminded participants of the following:

- That the M/E is part of the LFA.
- That the FIGO SMNH Committee is currently exploring how it will measure progress re: strengthening professional associations.

6. Next meeting:

The next meeting is scheduled for January 2007 in London, UK for the SMNH committee only. FIGO will provide exact dates as soon as possible.

Note: The RCOG will be holding on January 22nd, 2007 a full day "International Consultancy Training Course." This one-day meeting aims to raise awareness among members about the work of the RCOG International Office. It will particularly focus on:
international health issues in relation to maternal and neonatal health, modalities of international development programmes and consultancy skills development. (For more information: (http://www.rcog.org.uk/index.asp?PageID=101&ConferenceID=2290.) It was suggested that the next SMNH Project Teams' meeting be schedule to permit interested members to participate to this event.

Report prepared by L. Perron (SOGC)

November 17, 2006.

CAPE TOWN MEETING AGENDA AT FIGO CONGRESS

Cape Town, South Africa

Location: Westin Grand Hotel in the Da Gama/Diaz Room

Date: Sunday October 4, 2009 from 0800-1600

8:00 Welcome: Dr A Lalonde

Country Presentations: 15 minutes each. Please reserve questions until the end of each session.

8:15 – 8:30 Haiti
8:30 – 8:45 Kenya
8:45 – 9:00 Kosovo
9:00 – 9:15 Moldova
9:15 – 9:30 Nigeria
9:30 – 10:00 Questions pertaining to the first five countries
10:00 – 10:30 Refreshment Break
10:30 – 10:45 Pakistan
10:45 – 11:00 Peru
11:00 – 11:15 Uganda
11:15 – 11:30 Ukraine
11:30 – 11:45 Uruguay
11:45 – 12:15 Questions pertaining to the last five countries
12:15-13:00 Lunch
13:00 – 14:00 Mr Raj Waghela, Financial Administrator: Presentation on Finances with a question period
14:30 – 14:45 Ms Moya Crangle, RM-Project Manager: SMN Project: What's next?
14:45 – 16:00 Open discussion: Trouble shooting session
16:00 Wrap-up

SMN Project Attendance List

Sunday October 4, 2009

Dr. Laure Adrien, Haiti
Dr. Omondu Ogutu, Kenya
Mrs. Joyce Oduor, RM, Kenya
Dr. Albert Lila, Kosovo
Dr. Stelian Hodorogea, Moldova
Dr. James Akuse, Nigeria
Dr. Luis Tavara, Peru
Dr. Miguel Gutierrez, Peru
Ms Lucy Del Carpio (MoH), Peru
Dr. Frank Kaharuza, Uganda
Dr. Dan Zaake, Uganda
Dr. Iryna Mogilevkina, Ukraine
Dr. Leonel Briozzo, Uruguay
Dr. Rene Laliberte, Mentor
Dr. William Stones, Mentor
Dr. Ferd Pauls, Mentor
Ms Charlotta Grunewald, Mentor
Dr. Ulf Högberg, Mentor

Dr. Jean Chamberlain, Mentor
Dr. André Lalonde, Mentor, SMNH Chair
Dr. Pius Okong, SMNH Committee Member
Dr. Claudia Hanson, SMNH Committee Member
Dr. Shereen Bhutta, SMNH Committee Member
Dr. Carlos Fuchtner, SMNH Committee Member
Ms. Agneta Bridges, RM, SMNH Committee Member
Dr. Hadiza Galadanci, Nigeria
Dr. Okey Ikpeze, Nigeria
Dr. Razia Korejo, Pakistan
Dr. Shershah Syed, Pakistan
Dr. Juan Trelles, Peru
Dr. Jerker Liljestrand, SMNH Committee Member
Dr. Bruno Carbonne, SMNH Committee Member
Dr. Romeo Menendez, SMNH Committee Member
Mr. Raj Waghela, FIGO
Ms Moya Crangle, FIGO
Ms Astrid Bucio, SOGC
Ms Liette Perron, SOGC

Ms Ingela Wiklund, Mentor
Dr. Luis Cabero, Mentor

Report from Project Manager of Cape town meeting agenda at FIGO Congress

October 4, 2009

This meeting was the first time that all projects got together since the initial meeting of the initiative in London, UK in May 2009. It provided an opportunity for all projects to learn from each other as well as understand some of the managerial issues that have presented since the beginning of the project. There were at least 1-2 representatives present from each country project, as well as members from the SMNH Committee. In total there were 45 people at the meeting.

Morning Session:

Country Presentations: Each country presented a 15 minute presentation that provided an update of their project, challenges, successes and exit strategy. Time was also provided to ask questions.

Afternoon session:

Mr Raj Waghela provided an update of the financial situation of the project. There was a considerable amount of time discussing 'in-kind' contributions. Ms Moya Crangle gave a presentation about the issues that the SMN Project management would be focusing on during the second half of the project, such as improvement of narrative reporting, promotion of the initiative and development of exit strategies for each project.

The final session was a 'trouble shooting' session regarding issues that had been presented in some of the projects. Two major issues emerged: how to get activities done when relying on the volunteerism of staff as well as how to involve the professional associations in the projects. Some ideas were presented. All countries were invited to provide feedback about the day. So far, countries have been very positive about this meeting and think that there should be more.

Throughout the week: Individual Country Meetings of the SMN Project

The SMN Project Manager spent 1.5 hours with each country project to learn of ways that FIGO may provide support to each project from now until the end of their contracts. There was also discussion regarding exit strategies for each of the projects

ANNEX 2: ROLE OF MENTOR

FIGO Safe Motherhood and Newborn Health Project.

Introduction

The overall goal of the project is to contribute to reducing maternal and newborn mortality and morbidity rates within nine low resource countries. The objectives of each project include a range of interventions to improve access and enhance the quality of health services, to introduce effective interventions, establish systems of clinical auditing and to increase access to skilled attendants in nine low resource countries. Across all the nine projects, a shared objective is to strengthen the capacity of national professional societies committed to maternal and newborn health. Similarly, working in collaboration with local stakeholders in the context of the individual projects and ensuring long term sustainability of interventions to improve the health of women and newborn forms a central objective for each project.

Each project works closely with the national obstetric and gynaecological society. Each project has made links with the national midwifery association. To enhance and strengthen the capacity of national obstetric and gynaecology societies and midwifery associations, a process of twinning societies and associations was adopted. Central to this framework of support is the role of the mentor.

The overarching principles of roles and responsibilities are outlined below.

Roles and Responsibilities:
National society of obstetrics and gynaecology
Role/Responsibilities:

1. Manage the project activities and funds in an accountable way, in collaboration with the national midwifery association. Establish responsibilities related to the progress of the project (advisory group, coordinator, accounting, communications etc).
2. Involvement of project researchers to develop the baseline study.
3. Involvement of all stakeholders in the process of planning and implementation of the project.
4. Interact with twinning society and association, suggesting areas in which help is needed, particularly as regards capacity strengthening. (twinning society to budget)
5. Initiating and implementing project related activities according to updated plan.
6. Regular meetings to monitor and discuss progress and problems.
7. Semi-annual report to FIGO (condition for next portion of funds).
8. Contacts with FIGO SMNH Manager& FIGO SMNH Committee Chair/Co-Chair.
9. Contribute to visits by external evaluator.
10. Explore opportunities to disseminate experiences, highlighting strengths and challenges.

National Midwifery Associations
Responsibilities/functions:

1. Contribute to managing the project activities and funds in collaboration with the national obstetrics and gynaecology society.
2. Interact with twinning society and association, suggesting areas in which help is needed, particularly as regards capacity strengthening.

3. Initiating and implementing activities according to updated plan.
4. Regular meetings to monitor and discuss progress and problems.
5. Communicate with FIGO SMNH Manager& FIGO SMNH Committee Chair/Co-Chair.
6. Contribute to visits by external evaluator.
7. Explore opportunities for dissemination of experiences, highlighting strengths and challenges.

Mentor

Responsibilities/functions

1. Negotiate objectives of mentor role with project team.
2. Communicate with the project at least every two months.
3. Communicate with FIGO SMNH Manager every three months in relation to objectives as mentor and involvement with project. Communicate with FIGO SMNH Committee members and with own national (twinning) society.
4. Plan and implement an annual visit to the project.
5. Provide a written report on the annual visit and disseminate this to the project, FIGO SMNH Manager, FIGO SMNH Committee Chair/Co-Chair, own national society and twinned national society & association.
6. Actively seek opportunities to disseminate experiences with other mentors and societies & associations.

Twinning Society & Association

Responsibilities/functions

1. Support the twin society & association in strengthening the capacity of the organisation.
2. Generate funding to facilitate this support, where possible. Contribute human resources to support the achievement of negotiated objectives with the twinned society & association.
3. Communicate with FIGO SMNH Manager& FIGO SMNH Committee Chair/Co-Chair on a six monthly basis.
4. Communicate with the project at least every three months.
5. Plan and implement a visit to the project at least twice during the four year project cycle.
6. Provide a written report on the project visit and disseminate this to the project, FIGO SMNH Manager, FIGO SMNH Committee Chair/co-chair, own national society and twinning national society & association.
7. Actively seek opportunities for dissemination of experiences, highlighting strengths and challenges.

ANNEX 3: PAKISTAN: COMPARISON OF HEALTH CARE PRACTICES AMONG PREGNANT WOMEN LIVING IN CONTROL & INTERVENTION AREA

Focus Group Discussions - Thatta District

Factors	Control	Intervention
Pregnant Woman Care Practices	Majority of women have awareness regarding care practices during pregnancy, onset of delivery and after child's birth	Majority of women go for regular checkups during pregnancy, onset of delivery and after child's birth
Understanding and Opinion Regarding Antenatal Checkups	Majority of women are convinced that ANC check-ups are necessary for maternal and child health and half of them seek care from public hospitals because medicines and ultrasound have no charges	Majority of women have awareness to consult trained care providers for ANC and seek care from private clinics due to the better provision of care, equipment and medicines
Peers Permission and Decision-Makers in the Family for Seeking ANC	Greater part of the population visit hospitals for ANC with their husbands' permission and inform mother-in-law	All most every women visits health facility and there is no such prohibit behavior seen from their spouses and elders, they permit women to seek care while pregnant
Care Seeking Behavior (Choice of Health Facility/care provider)	Majority of women have low knowledge about health care setup and still in practice to consult with the TBAs, Dias for antenatal care, delivery and postnatal period	By and large pregnant women consult both the private and public health facilities for antenatal care, delivery and postnatal care
Role and Demand of Midwives / TBAs	Greater number of women still satisfied with the services of "Dais" and "TBAs" because of the availability within area majority delivers at home	The role of "Dias" and "TBAs" have been reduced during the past few years, almost all women consult with doctors and trained health care provider for seeking care
Number of Antenatal Visits	Majority of women normally visit 2 times during pregnancy	Majority of women seek antenatal checkups 4 times during pregnancy
Burden on Pocket for Accessing Care at the Nearest Facility	Majority of women do not afford the fee of private hospitals and clinics	Most of women cannot afford the fee of private hospitals and clinics
Knowledge about the Complications and Recognition of Danger Signs	Increasing number of women are aware of complications occur during pregnancy which includes low/high blood pressure, anemia, edema, iron deficiency	Majority of women are well aware of complications arising during pregnancy which include anemia, lethargy, excessive bleeding and severe vomiting
Antenatal Care	Major complications during pregnancy from which almost all women suffers is anemia, lethargy, excessive bleeding	Majority of women suffers from "Severe Anemia" and graded as number one complication during pregnancy
Intra-partum Care	By and large women suffers from fits and excessive bleeding	Majority of women suffers from excessive bleeding, hypertension and premature rupture of membrane

Postnatal Care	Majority of women undergo from fits, high fever, evil's eye, severe backache, anemia and lower abdominal pain	Majority of women experience complications which includes fits, convulsion, excessive bleeding, high fever, backache, lower abdominal pain and anemia
Birth Preparedness	Majority of women make necessary measure before delivery which includes; availability of transport, arrangement of funds and selection of hospital	Almost all women arrange transport, hospital, clinic, care provider in the light of nature of delivery either normal or c-section
LHWs' Visit	LHW's visits home frequently and give suitable advices and medicines to women and infant.	LHWs visit regularly give necessary advice, consultation and maternal checkups as well as provide medicines to newborn and women.
Immediate and Newborn Care Practices	Majority of women do not follow newborn care practices and mostly deliver at home	By and large women follow immediate and newborn care practices and mostly deliver at hospital or clinics.
Use of Clean Delivery kit	"Dai" uses sterilized blade or scissor and clean delivery kit	Clean delivery kits are mostly use in hospital and clinics
Bathing, Drying and Warming	Majority of women give shower immediately but they have awareness to dry newborns as soon as possible and wrap them in soft and warm cloth	Almost all women avoid giving bath to infant soon after delivery, they have sufficient awareness about care practices, normally infants are dried as quickly as possible and wrapped in soft and warm cloth
Cord Care	Half of the women still apply home remedies over umbilical cord like mustard oil, surma	By and large women do not apply home remedies over cord and tend to follow the prescribe practice to dry and fall it naturally
New Born Checkups	Majority of women are knowledgeable about newborn checkups but do not visit government hospital due to inadequate facilities & equipments, they are also unable to afford fee of private clinics	Few women prefer to visit only private clinics for newborn check because of the availability of doctors and equipments, Government hospital do not have sufficient facilities, equipment and medicines
Normal Weight vs. Low Birth Weight	Less number of infants has normal weight of 2.5kg	Majority of infants has normal weight of 2.5kg
Newborn Complications, Danger Signs and Care Seeking	Majority of infants suffers from fits and high fever within 40 days of delivery	By and large infants suffer from diarrhea, fits, umbilical cord infections and abdominal distension after delivery
Colostrums Feeding	Majority of women administer colostrums to the infant soon after delivery	Half of women give and half do not give colostrums as the first feed to their infants due to the pressure of mother-in-law

"Exclusively" Breast Feeding	"Exclusive breast feeding" is misunderstood among majority women and they do not count water as separate from the breast milk	Majority of nursing mothers give exclusive breast feeding to their infants. Still women do not follow absolute breast feeding and also administer semi solid foods to infant in first 6 months

Comparison of Intervention and Control Facilities
(THQ, RHC and BHU) District Thatta

Factors	Health Facilities Audit	
	Intervention	Control
General information	All facilities have qualified physicians and para-medical staff. At Taluka level facility the catchment population varies but at the primary health facilities the serving population was almost equal.	All facilities have qualified physicians and para-medical staff. At Taluka level facility the catchment population varies but at the primary health facilities the serving population was almost equal.
Overall Staffing/Human Resource	Fortunately number of essential staff (Physicians and Para-Medics) both at secondary and primary level facilities was satisfactory and they also performing well in discharging their obligations even on-call during night except BHU Gariwah where in-attention prevails almost at levels. However non availability of senior medical persons was highlighted at primary health facilities.	Number of essential staff (Physicians and Para-Medics) both at secondary and primary level facilities was almost satisfactory but dedication is questionable at RHC Jungshahi where in-attention prevails was at all levels. Non availability of senior medical persons was highlighted at primary health facilities.
Availability of Maternity Services	Although services and facilities are better at SZMC however THQ Sujawal attracts more clients. RHC Gharo is functioning so good that clientele is double than the RHC Jungshahi. All health facilities offer antenatal and postnatal care services during day-time and deliveries are conducted 24 hours all weekdays except for BHU.	Despite the fact that the catchment population of THQ is almost half than the SZMC however it attracts double the clients. Although the catchment population is almost equal at RHC level but the RHC Jungshahi attracts half of the clients than RHC Gharo. All health facilities offer antenatal and postnatal care services during day-time and deliveries are conducted 24 hours all weekdays except for BHU.
Planning and Management	The planning and management at THQ and RHC level were satisfactory however at BHU level the concept of planning and management was not yet defined nor followed.	Although overall planning and management at THQ Sujwal was satisfactory but the essential drug list was not found whereas at RHC the planning and management was in order but the service package was not available. At BHU health facility the planning and management was not yet defined nor

		followed.
Information on records	The training and preparation of HMIS reporting has been done at THQ and RHC level however the primary health facility do not have ample resources for HMIS conscription and reports.	The training and preparation of HMIS reporting has been done at THQ and RHC levels but the previous reports were missing at THQ. At primary health facility there were no resources for HMIS conscription and reports were found.
Patient Referral	SZMC continue refers serious maternal cases to JPMC / Civil Hospital Karachi so as the case with RHC. No referral done at BHU level.	The referral of maternal cases was not seen at THQ however RHC refers few cases to DHQ Thatta. No referral done at BHU level.
Morbidity data	At SZMC only 2 maternal deaths and 3 stillbirths are reported and at RHC 6 stillbirths occurred whereas BHU does not cater maternity and delivery services.	The morbidity data at THQ Sujawal recorded 67 stillbirths whereas at RHC morbidity data were not available. BHU does not cater maternity and delivery services.
Laboratory	Laboratories are available at all levels except at BHU. Necessary lab tests are done and proper record is maintained.	At THQ lab tests facilities are more than the SZMC but record maintenance was nil at THQ. The RHC offers very limited laboratory services and BHU has no lab services.
Bio – Safety Measures	The state of bio-safety measures at SZMC was very poor. At RHC Lab meets almost all necessary precautions to meet the bio safety measures.	A very well organized and hygienic laboratory is run at THQ meeting all requirements of bio-safety measures however the condition was completely contrary at RHC.
Transport	Transport facility was available at THQ and RHC to facilitate pregnant women for referral and transport in emergencies. No transport available at BHU level.	Transport facility was available at THQ and RHC to facilitate pregnant women for referral and transport in emergencies. No transport available at BHU level.
Drugs and Supplies	All necessary drugs and other important supplies were available at all level health facilities.	All the necessary drugs and other important supplies were available at all level health facilities. But the supplies at THQ were inadequate.
Disease Management Protocols	All necessary disease protocols were displayed in all health facilities however the number of these protocols was limited at BHU Gariwah.	All necessary disease protocols were available and displayed in the premises of all health facilities.
Waste Disposal	The waste disposal mechanism was very poor at THQ and BHU but it was reported that at RHC the waste is usually set on fire and then put into pit-holes.	The waste disposal mechanism was very poor at all health facilities.
Maternal Health	The status of maternal care at SZMC was excellent. In comparison with THQ Sujawal, Six times higher number of pregnant women seeking care from SZMC proves the standard of services while the catchment	Mater care at THQ Sujawal was good but the number of pregnant women sought care was very low in comparison of SZMC while the catcment population is double than Mirpursakro. Similarly, the maternal

	population is half then THQ Sujawal. There is also no comparison of good quality of maternal care of RHC Gharo with RHC Jungshahi. The number of pregnant women seek care from BHU was higher but quality of care was not good.	care situation was also good at RHC but has no comparison of high standard of RHC Gharo. The number of pregnant women seek care from BHU was lower than the BHU Gariwah but the quality of care was good at BHU Chhattochand.
Basic and Comprehensive Emergency Obstetric Care	The basic and comprehensive EmOC services were available 24 hours at SZMC whereas the services limited to basic EmOC at RHC. The BHU does not cater EmOC services. Additionally trained human resource was available at SZMC and RHC health facilities to cope with any maternal emergencies.	The basic and comprehensive EmOC services were available 24 hours at THQ. The services are almost nil at RHC except the availability of some drugs and trained human resource. BHU does not cater EmOC services.
Neonatal Health	At THQ and RHC although the neonatal services were satisfactory however the phototherapy lights were not available. At BHU the neonatal service was limited to vaccinations. Only one death reported at SZMC. The record of deaths and newborns complications was not found at RHC and BHU. However RHC Gharo has certain staff to handle the neonatal emergencies.	At THQ and RHC although the neonatal services were satisfactory however the phototherapy lights were also not available at any of these facilities. At BHU the neonatal service was limited to vaccination. The record of deaths and newborns complications was not found at RHC and BHU. Also trained staff was not available at either facility to handle emergencies.
Inpatient Care	In-patient care service was offered at THQ and RHC. Both the THQ and RHC have sufficient number of maternity and children beds for in-patient care service.BHU does not offer any in-patient services.	In-patient care service was offered at THQ and RHC. Both the THQ and RHC have sufficient number of maternity and children beds for in-patient care service.BHU does not offer any in-patient services.
Wards	The wards for women and children were available at SZMC and RHC. The wards were kept in excellent condition at RHC Gharo. No ward was available at BHU level.	Although wards for women and children were available at but the condition of the wards was unsatisfactory. BHU does not enclose any wards.
Emergency Preparedness	The THQ satisfactorily meets emergencies. The emergency preparedness was not up to the standard at RHC and BHU. The CPR equipment was available at SZMC.	The state of emergency preparedness at THQ, RHC and BHU were not up to the mark. The CPR equipment was not also found at any of these health facilities.

Operation Theatre	The operation theatre was available at SZMC with one room and OT table though it was not in good condition. On the other hand at RHC Gharo the OT was not in working condition and BHU Gariwah does not have any OT. The data record shows 2868 operations ,170 C-sections, 10 hysterectomy and 105 D&Cs moreover the facility has one postoperative room. Such data for RHC and were not available because none of them does not run any OT.	The operation theatre was available at Sujawal with one room and OT table though it was not in good condition. On the other hand the OT was not in working condition at RHC Jungshahi and BHU Chhattochand does not have any OT. The record shows zero operations, 104 C-sections and no hysterectomy and D&Cs at THQ. Such data for RHC and were not available because none of them does not run any OT.
Sterilization	The sterilization of instruments was done in autoclave for 1-2 hours. Fumigation was properly done at SZMC and RHC Gharo.	The sterilization of instruments was done in autoclave for 1-2 hours. Fumigation was not seen for THQ Sujawal.
Main Emergency	The main emergency performing good at SZMC with 2 beds only. The staff and other important services were available for 24 hours a day while at RHC main emergency have 12 beds but with time limitation, lastly BHU does not handle emergency patients and has only pharmacy available.	The function of main emergency at THQ and RHC was not up to the standard despite the fact that 7 and 8 beds in emergency room are available respectively.
Outpatient Department	The OPD at SZMC, RHC Gharo and BHU are striving hard to run a better OPD but unfortunately no such measures found at any of the health facility.	The OPD at THQ, RHC and BHU was also in bad shape ad no measures found to make any improvement in its condition.

ANNEX 4: **FIGO SMN INITIATIVE: OPTIONS FINAL EVALUATION**

Terms of Reference

Vision:

FIGO would like to engage Options to undertake a final evaluation, in the form of a critical review, of the Saving Mothers and Newborn Project and to provide a report to submit to funders (Sida) that summarizes and states to what extent the objectives of the project have been achieved.

FIGO recognizes that measuring the maternal health impact of this project is not feasible. However there may be areas/examples where this has occurred. In this case, vignettes could be provided in the report to illustrate this.

This final evaluation needs to take into consideration and highlight in the report the fact that the project has had limited funding.

Objectives:

- To evaluate the acquired capacity of the ob/gyn and midwifery societies to conduct projects relevant to the promotion of safe motherhood and the improvement of maternal health
- To report on and evaluate the following indicators that were listed in the initial project proposal:
    - Improvements in access to essential obstetrical care services and new technologies
    - Improvements in access to skilled birth attendants
    - Improved health facilities
    - Lowering of maternal case fatality rate
    - The level of community mobilization and participation
    - Improvements in access to health facilities with basic equipment, supplies and medication for basic obstetrical care services and new technologies such as tamponade and uniject
    - How social and cultural barriers to maternal care have been identified and addressed
    - 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
- To describe what the project has meant to each country project and professional society as well as FIGO as an organization
- To list the lessons learnt for FIGO
- To present the successes, difficulties and shortcomings of the project, together with a discussion of possible remedies and future direction for each country's project

Scope of work:

- Ten countries of which:
    - Field visits to five countries
        - Peru, Uganda, Pakistan, Haiti and Nigeria
        - Visit and interview project staff (within project secretariat and sites)
        - A critical review of any written material (narrative reports etc), and other evidence individuals in the project can cite to support the endline review
- Desk review of five countries
    - Kosovo, Kenya, Moldova, Uruguay and Ukraine
        - A series of phone interviews with key individuals within each project including the partners etc
        - A critical review of any written material (narrative reports etc), and other evidence individuals in the project can cite to support the endline review

Interviews with mentors, FIGO staff and SMNH Committee members as necessary

Deliverables:

- Report of ten individual country evaluations
- Report of an overall summary of the initiative

Timeline:
Project evaluation dates are as follows:
April 2010: Ukraine (they will be doing their final evaluation in March 2010)
August 2010: Uruguay, Pakistan
February 2011: Uganda, Nigeria, Kosovo, Peru, Moldova
August 2011: Kenya, Haiti

The Options final evaluation will be submitted to FIGO no later than August 31, 2011.