Saving Mothers & Babies
the role of strong professional associations
Acknowledgements

Several people and organizations have contributed to the writing and editing of this publication.

Thank you to:
Helena Andrews (FIGO LOGIC)
Charlene Bruneau (FIGO LOGIC)
Alison Dunn
Liette Perron (SOGC)
Bart Vander Plaetse (FIGO LOGIC)
Hamid Rushwan (FIGO)
David Taylor (FIGO LOGIC)
and the FIGO Member Associations of
AMOG, AOGU, ESOG, FOGSI, NESOG, SOGOB, SOGOC, and SOGON.

The publication also draws on the external evaluation reports produced by HLSP.

Design by:
Giant Arc Design

Photo credits:
Sanjit Das / Panos Pictures
Jenny Matthews / Panos Pictures
Mads Nissen / Berlingske / Panos Pictures
Mikkel Ostergaard / Panos Pictures
Caroline Penn / Panos Pictures
Ami Vitale / Panos Pictures
Contents

01 / Foreword
Hamid Rushwan, Chief Executive of FIGO

01 / Acronyms

02 / Executive Summary

03 / Introduction

04 / Section 1
05 / What can Health Professional Associations do for maternal and newborn health in low-resource countries?
08 / FIGO LOGIC and Member Associations

12 / Section 2
13 / Organizational capacity building
16 / Lessons learnt

24 / Section 3
25 / Influencing policy
29 / Lessons learnt

34 / Section 4
35 / Influencing practice
37 / Lessons learnt

39 / Section 5
35 / Conclusion and lessons learnt
35 / Appendix 1: Guidelines and protocols developed
Foreword

Hamid Rushwan, Chief Executive of the International Federation of Gynecology and Obstetrics

The International Federation of Gynecology and Obstetrics (FIGO) works towards the promotion of women’s health and improving the practice of obstetrics and gynaecology globally.

One of the priority areas for FIGO’s work is maternal and newborn health. The impact of the high rates of maternal and newborn morbidity and mortality in low- and middle-income countries is of international concern. Global initiatives for their reduction have also been pursued since 1987 by the Safe Motherhood Initiative, followed by the International Conference on Population and Development (ICPD) held in Cairo in 1994. The Millennium Declaration in 2000 resulted in the development of the Millennium Development Goals (MDGs). MDGs 4 and 5 address the reduction of child mortality and the improvement of maternal health.

Although there is only a short time left for achieving the MDG targets, a number of countries, especially in Sub-Saharan Africa and South-East Asia, are still not going to achieve these targets, and more concerted efforts need to be made to improve the situation.

FIGO has been working with international stakeholders towards the promotion of maternal and newborn health. At the national level, FIGO feels it is essential to strengthen Member Associations in low- and middle-income countries so that they can play an active role in advocating and implementing policies and practices for the reduction of maternal and neonatal mortality and morbidity.

FIGO introduced the Leadership in Obstetrics and Gynaecology for Impact and Change Initiative (LOGIC) for this purpose. The project was funded by a grant from the Bill & Melinda Gates Foundation over a time scale of five years (2008-2013). Eight countries from Africa and South-East Asia were selected for the Initiative.

This document reviews the achievements of this important FIGO initiative and confirms that professional organizations, when strengthened, can play important roles in advancing the health of women in general and maternal and newborn health in particular.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMOG</td>
<td>Associacao Mocambicana de Obstetras e Ginecologistas</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>AOGU</td>
<td>Association of Obstetricians and Gynaecologists of Uganda</td>
</tr>
<tr>
<td>(B) EmOC</td>
<td>(Basic) Emergency Obstetric Care</td>
</tr>
<tr>
<td>CEW</td>
<td>Community Extension Worker</td>
</tr>
<tr>
<td>ESOG</td>
<td>Ethiopian Society of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>FOGSI</td>
<td>The Federation of Obstetric and Gynaecological Societies of India</td>
</tr>
<tr>
<td>FIGO</td>
<td>International Federation of Gynecologists and Obstetricians</td>
</tr>
<tr>
<td>HPA</td>
<td>Health Professional Association</td>
</tr>
<tr>
<td>LOGIC</td>
<td>Leadership in Obstetrics and Gynaecology for Impact and Change in Maternal and Newborn Health</td>
</tr>
<tr>
<td>MA</td>
<td>Member Association</td>
</tr>
<tr>
<td>MDR</td>
<td>Maternal Death Review</td>
</tr>
<tr>
<td>MPDR</td>
<td>Maternal and Perinatal Death Review</td>
</tr>
<tr>
<td>MSS</td>
<td>Midwifery Service Scheme</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal and Newborn Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NESOG</td>
<td>Nepalese Society for Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>NMR</td>
<td>Near Miss Review</td>
</tr>
<tr>
<td>OCIF</td>
<td>Organizational Capacity Improvement Framework</td>
</tr>
<tr>
<td>PPH</td>
<td>Post-Partum Haemorrhage</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
</tr>
<tr>
<td>SOGC</td>
<td>Society of Obstetricians and Gynaecologists of Canada</td>
</tr>
<tr>
<td>SOGOB</td>
<td>Société des Gynécologues et Obstétriciens du Burkina Faso</td>
</tr>
<tr>
<td>SOGON</td>
<td>The Society of Gynaecology and Obstetrics of Nigeria</td>
</tr>
<tr>
<td>SOGOC</td>
<td>Society of Gynaecologists and Obstetricians of Cameroon</td>
</tr>
</tbody>
</table>
Between 2009 and 2013, the FIGO LOGIC (Leadership in Obstetrics & Gynaecology for Impact and Change) Initiative, funded by the Bill & Melinda Gates Foundation, strengthened the organizational capacity of eight national Member Associations (MAs) of Obstetricians and Gynaecologists in Africa and Asia, to improve policy and practice in maternal and newborn health.

The participating MAs were:

- Société des Gynecologues et Obstetriciens du Burkina Faso (SOGOB)
- Society of Gynaecologists and Obstetricians of Cameroon (SOGOC)
- Ethiopian Society of Obstetricians and Gynaecologists (ESOG)
- The Federation of Obstetric and Gynaecological Societies of India (FOGSI)
- Associação Moçambicana de Obstetras e Ginecologistas (AMOG)
- Nepal Society of Obstetricians and Gynaecologists (NESOG)
- Society of Gynaecology and Obstetrics of Nigeria (SOGON)
- Association of Obstetricians and Gynaecologists of Uganda (AOGU)

The end of project self-assessment results revealed that all MAs had made major gains in capacities. The MAs had either revalidated or defined their organizational vision, mission and values and identified their strategic directions for the next five years. Most had enhanced their governance practices, some by reviewing or updating their governing documents and/or formalizing their Board or Executive Committee meetings.

Their administrative systems had been strengthened by centralizing their information...
management practices, strengthening their financial management systems by establishing formal accounting systems, and implementing policies and procedures. MAs had established basic human resources management practices that were more transparent and fair. They had also improved their communication with members by redesigning or updating their websites and using means such as group emails to share information related to upcoming activities, opportunities and resources.

All had either established functional secretariats or upgraded the capacity of their secretariat to support the project activities and any other initiatives of their associations. All of them made major gains in relation to the number and diversity of partners and activities. All the MAs had agreed or signed Memorandum of Understandings with their Ministry of Health and other major stakeholders. They had also strengthened collaborations with other professional associations and developed and disseminated position statements in collaboration with new partners.

As a result of their strengthening, all MAs established good working relationships with Ministries of Health and all have regular and scheduled opportunities to engage in dialogue around national maternal and newborn health policy and plans. All the MAs also extended their networks and developed strategic partnerships with key stakeholders.

A number of MAs established regular access to the press and media, to influence public opinion and indirectly exert influence on the Government to adopt new policies or adapt existing ones.

The MAs’ contributions to Maternal and Newborn Health practice towards achieving the United Nations Millennium Goal targets became more strategic and focused to include:

- Assuming leadership in support of supervision activities
- Developing clinical guidelines
- Implementing Maternal Death Reviews and/ or Near Miss Reviews
- Training health professionals (health administrators, physicians, midwives, nurses, and community workers) on a variety of reproductive health issues
- Reviewing and updating medical curricula.
Introduction

Every year around the world, an estimated 287,000 women die in pregnancy and childbirth\(^1\), and 5.6 million babies die just before or after delivery\(^2\). Ninety-nine per cent of all maternal deaths occur in developing countries, the majority in sub-Saharan Africa and Southern Asia. Eighty-five per cent of all global maternal deaths take place in these two regions and 56 per cent of maternal deaths occur in sub-Saharan Africa alone.\(^3\)

The vast majority of maternal deaths are preventable, yet many women - especially in sub-Saharan Africa and Southern Asia - are dying as a result of complications in pregnancy and childbirth. The survival chances and health of a newborn baby are closely linked to the health and well-being of its mother, and quality care for the unborn and newborn child is part and parcel of safe labour and delivery practices.

National Health Professional Associations (HPAs), such as professional associations of obstetricians and gynaecologists, have a pivotal role to play in saving the lives of mothers and their newborn babies. Initially, professional associations begin as learned societies and provide continuing medical education while some go on to act as professional bodies that regulate their members’ professional performance in the public interest. More mature societies evolve and expand their influence on national health policy and practice. This latter role was the focus of the FIGO’s Leadership in Obstetrics and Gynaecology for Impact and Change (LOGIC) Initiative in Maternal and Newborn Health.

During 2009–2013, FIGO Leadership in Obstetrics and Gynaecology for Impact and Change (LOGIC) worked with eight Professional Associations of obstetricians and gynaecologists in sub-Saharan Africa and Southern Asia. The initiative built the associations’ capacity, to enable them to better respond to the crises in Maternal and Newborn Health (MNH) in their countries through influencing policy and improving practice. This publication documents aspects of their progress and lessons learnt.

---


\(^2\) UNICEF (2012) State of the World’s Children, New York: UNICEF; and


\(^3\) WHO (2012) ibid.
What can Health Professional Associations do for maternal and newborn health in developing countries?

The Joint Statement of the Partnership for Maternal, Newborn and Child Health says: “Strong professional organizations provide leadership. They set standards of education, practice and profession competency assessment and can work together with governments and other stakeholders in setting and implementing health policies to improve the health of women, newborns, children and adolescents.”

The challenge in developing country contexts is that often Health Professional Associations do not have the capacity to do this kind of work effectively. They may lack the time, resources, skills, incentives or the structured support of a functional and credible organization to contribute significantly to reducing maternal and newborn deaths.

With this in mind, FIGO LOGIC set out to empower eight FIGO Member Associations (MAs) in their aspiration to improve maternal and newborn health policy and practice. Strengthening organizational capacity was the critical starting point.

FIGO's Leadership in Obstetrics and Gynaecology for Impact and Change (LOGIC) Initiative in Maternal and Newborn Health, funded by the Bill and Melinda Gates Foundation, ran between October 2009 and October 2013.

FIGO was well placed to lead this initiative. It is the worldwide umbrella organization for 125 national professional associations of obstetrics and gynaecology and oversees a vast and effective network in the global and regional reproductive health domain. In 2006-2011, FIGO led the ‘Saving Mothers and Newborn Initiative’ in ten developing countries where professional associations of obstetricians and gynecologists implemented projects designed to increase accessibility to maternal and newborn health services. It also provided associations with the opportunity to strengthen their organizational capacity and demonstrate themselves as leaders in their countries to promote safer mother and newborn health.

---

FIGO recognised the need to strengthen the organizational capacities of national professional associations of gynaecology and obstetrics to enable them to effectively influence policy and clinical practice. FIGO LOGIC worked directly with eight Professional Associations of obstetrics and gynaecology in sub-Saharan Africa and Southern Asia. The participating FIGO Member Associations were from Burkina Faso, Cameroon, Ethiopia, India, Mozambique, Nepal, Nigeria and Uganda.

FIGO LOGIC Member Associations

Société des Gynécologues et Obstétriciens du Burkina Faso (SOGOB)
SOGOB was established in May 1992 and is recognised by the Government. It has both a constitution and a list of internal rules of operation. SOGOB has 96 members, nearly all of Burkina Faso’s 106 Obstetricians.
www.sogob-bf.org

Society of Gynaecologists and Obstetricians of Cameroon (SOGOC)
SOGOC was established in 1989. It works to ensure access to quality, affordable reproductive health services for all and to optimize standards of practice in obstetrics and gynaecology in Cameroon. SOGOC has 160 registered members.
www.sogoc.org

Ethiopian Society of Obstetricians and Gynaecologists (ESOG)
ESOG was established in 1992. It works to promote and enhance sexual and reproductive health through evidence-based and cohesive action of the society with active participation of its members and broad national and international partnerships. ESOG has 247 registered members.
www.esog.org.et

The Federation of Obstetric and Gynaecological Societies of India (FOGSI)
FOGSI was established in 1950. It has 216 member societies and 27,000 members. FOGSI is a key technical partner of the Government of India; the Ministry of Health and Family Welfare.
www.fogsi.org

Associacao Mocambicana de Obstetras e Ginecologistas (AMOG)
AMOG was established in 2006 and works to promote excellence in the practice of obstetrics and gynaecology through education, advocacy and research. AMOG currently has 60 members.
www.amogmz.org

Nepalese Society for Obstetricians and Gynaecologists (NESOG)
NESOG was established in 1989 and is seen as the source of technical expertise in maternal and newborn health by both government and civil society. It currently has 310 members.
www.nesog.org.np
The Society of Gynaecology and Obstetrics of Nigeria (SOGON)
SOGON was established in 1965 and works to promote the health and well-being of Nigerian women and newborn and to improve the practice of gynaecology and obstetrics in the country. It has 895 members throughout the Federal Republic of Nigeria.

www.sogon.org

Association of Obstetricians and Gynaecologists of Uganda (AOGU)
AOGU was established in 1985. AOGU provides leadership and influence in sexual and reproductive health in Uganda, and works in close partnership with the Ugandan Ministry of Health to improve reproductive, maternal and newborn health. It has over 140 members, of which one third are active in AOGU activities.

www.gynuganda.com
Maternal, newborn and stillborn death rates in the FIGO LOGIC countries

<table>
<thead>
<tr>
<th></th>
<th>Maternal deaths per 100,000 live births in 2010&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Newborn deaths per 1,000 live births in 2010&lt;sup&gt;6&lt;/sup&gt;</th>
<th>Still born deaths per 1000 births (&gt;1000g or &gt;28 weeks) in 2008&lt;sup&gt;7&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>500</td>
<td>35</td>
<td>29</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>300</td>
<td>38</td>
<td>26.3</td>
</tr>
<tr>
<td>Cameroon</td>
<td>690</td>
<td>34</td>
<td>25.7</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>350</td>
<td>35</td>
<td>25.8</td>
</tr>
<tr>
<td>Mozambique</td>
<td>490</td>
<td>39</td>
<td>28.6</td>
</tr>
<tr>
<td>Nigeria</td>
<td>630</td>
<td>40</td>
<td>41.9</td>
</tr>
<tr>
<td>Uganda</td>
<td>310</td>
<td>26</td>
<td>24.9</td>
</tr>
<tr>
<td>South Asia&lt;sup&gt;8&lt;/sup&gt;</td>
<td>220</td>
<td>33</td>
<td>26.7</td>
</tr>
<tr>
<td>India</td>
<td>200</td>
<td>32</td>
<td>22.3</td>
</tr>
<tr>
<td>Nepal</td>
<td>170</td>
<td>28</td>
<td>23.7</td>
</tr>
</tbody>
</table>


<sup>8</sup> Afghanistan, Bangladesh, Bhutan, India, Iran (Islamic Republic of), Maldives, Nepal, Pakistan, Sri Lanka

FIGO LOGIC objectives

FIGO LOGIC had three clear objectives to support the MAs to:

1. strengthen their capacity to be an effective organization
2. influence national policies on maternal and newborn health
3. work to improve MNH clinical practice.

In relation to the first objective, the FIGO LOGIC Initiative built on work developed and implemented by one of FIGO’s Member Associations: the Society of Obstetricians and Gynaecologists of Canada (SOGC), which has extensive experience of organizational capacity development of national professional associations in a number of countries.

The SOGC developed an Organizational Capacity Improvement Framework (OCIF), a participatory methodology to guide professional associations through their capacity strengthening efforts. SOGC’s OCIF has guided and supported the organizational capacity development efforts undertaken within the FIGO LOGIC Initiative.

‘The FIGO LOGIC experience has revealed our capabilities and helped us to explore and develop our capacity as a professional health association. SOGON has witnessed a transformation and things will never be the same again.’

SOGON, Nigeria
Section 2
The ability of FIGO LOGIC Member Associations to influence maternal and newborn health (MNH) policy and practice relied on their ability to strengthen their overall organizational capacity. This increased capacity would allow them to improve the management of their expanding programs and projects, enhance their performance and ensure the long-term sustainability of their association. The capacity development process was guided by SOGC’s Organizational Capacity Improvement Framework (OCIF), a ‘learn as you apply’ approach. It considers capacity building as an incremental and ongoing process which must be led by the association and involve the most active people within the association, including the elected officials.

The approach requires MAs to consider and take action to strengthen their capacity in the following five core dimensions:

1. Its culture: vision, mission and organizational values and the benefits and rewards made available to members, most active members and staff
2. Its operational capacity: governance and leadership at management level, strategic directions, human, financial and project management capacities, communication practices and infrastructure
3. Its performance: effectiveness and efficiency in implementing its activities, relevance as a professional association, and overall financial position
4. Its external relations and how the association is perceived: environment within which its functions, legal and political framework, linkages and networks, and ownership and participation
5. Its function: membership services, promotion of quality and standard of care, promotion of the profession, and capacity to influence MNH practice and policy.

The OCIF followed this approach:

- Facilitating at the beginning of the project organizational capacity assessments which permitted each association to consider their association’s current capacities against the five core dimensions of the OCIF
- Providing technical support for the development and implementation of improvement plan to move the association toward greater capacity
- Facilitating end of project organizational capacity assessments permitting the associations to measure their progress and provide further insight as to what needed attention within their next cycle.
Organizational capacity assessments

In 2010, baseline organizational capacity self-assessments were undertaken with the eight MAs participating in the initiative. The exercises were completed through two-day participatory workshops bringing together members of each association’s Board or Executive Committee, other association leaders and association and project staff. The workshops were designed to:

- Provide an opportunity for all to gain greater knowledge and understanding as to what is ‘capacity development’ and what makes professional associations strong and sustainable
- Complete the assessment tool as a group
- Review and validate the findings of the assessment, identify the association’s strengths and weaknesses and agree on the way forward to build greater capacity.

The initial assessments helped to provide some base-line data, and another self-assessment took place at the end of the project. External evaluators undertook an independent baseline assessment and reviewed progress during the mid-term review. The initial assessments showed that the associations were strongest in the core dimension of their external relationships and how they were perceived and to some extent, their function. Most of them evolved in an environment where:

- Their contribution to MNH was possible and even hoped for
- They had already initiated some work in this field, for example, trainings of health professionals in post-abortion care, prevention and treatment of Post-Partum Haemorrhage (PPH)
- They were beginning to build their networks and linkages with major stakeholders in the field and further
- They were to some extent already involved in activities to promote quality and standard of care.

Challenges

The major challenges the MAs faced were in the core dimensions of culture, operational capacity and performance. Although some of the MAs already had some key elements in place before the project started, among the many weaknesses collectively, were:

- A lack of clearly defined and disseminated organizational vision, mission and values
- Weak governance practices (for example, holding regular Board/Executive Committee meetings, ensuring quorum, documenting major discussion points and decisions, etc)
- Highly-involved elected officials in the operationalization of the associations’ activities, at times to the detriment of their governance responsibilities
- Lack of strategic focus
- Weak or non-existent administrative systems related to information, membership data, financial and human resources
- Poor project management skills
- Poor communication practices with internal and external stakeholders
- Poorly equipped national secretariats with limited capacity to support the work of the associations
- Vulnerable financial positions.

Capacity building support to MAs

In light of the difficulties the MAs faced, FIGO LOGIC made available a host of capacity building options, through technical and financial support. Some components such as training in financial management, project planning and advocacy were provided to all the MAs through international training and exchange opportunities. Others were tailor-made to meet the specific needs of each association. These included:

- Support for the development and dissemination of strategic plans, including the development of vision, mission and value statements
- Support for the recruitment of core association and project staff
- Support for the revision of the constitution and other governing documents
- Support to the establishment of administrative systems, mainly financial and human resources
- Support for the development and/or updates to the association’s website
- Resources for the development of promotional material, for example, banners to disseminate their vision and mission, organizational profiles, and strategic plans
- Financial support to establish and/or upgrade the capacity of national secretariats
- Support for annual scientific congresses.

Major issues facing the MAs

The MAs needed to deal with a number of issues to move forward with their plans to improve their organizational capacities. These included:

- Difficulties in undertaking a greater number of activities, within and outside the association, at the same time with limited human resources
- Difficulties in recruiting in-country consultants with the necessary experience (for example for the strategic planning process and website design)
- Once the strategic plans were ratified, following through with their full implementation and monitoring
- Responding to the increased number of requests for collaboration and participation
- Mobilizing and managing a greater number of active members involved in the operationalization of the activities of the association
- Ensuring that the organizational capacity gains made in the life of FIGO LOGIC were maintained after the end of the project.
End of project organizational capacity self-assessments

At the beginning of 2013, end-of-project organizational self-assessments were undertaken with seven of the MAs\(^\text{10}\). The exercises, conducted through participatory workshops, brought together new and older elected officials, association leaders and staff. The workshops focused on completing the 2013 self-assessment, reviewing and comparing the results with those of 2010, and finally identifying priorities for the next capacity building cycles.

The end of project self-assessment results revealed that all associations felt they had made major gains in strengthening capacities in all core dimensions of the OCA. All had either revalidated or defined their organizational vision, mission and values and identified their strategic directions for the next five years. Most had enhanced their governance practices, some by reviewing or updating their governing documents and/or formalizing their Board or Executive Committee meetings.

Many had greatly improved their administrative systems by centralizing their information management practices, strengthening their financial management systems by establishing formal accounting systems, and implementing policies and procedures. Many had established basic human resources management practices that were more transparent and fair. They had also improved their communication with members by redesigning or updating their websites and using means such as group emails to share information related to upcoming activities, opportunities and resources.

All had either established functional secretariats or upgraded the capacity of their secretariat to support the project activities and any other initiatives of their associations. All of them made major gains in relation to the number and diversity of partners and activities. All the MAs had agreed or signed Memorandum of Understandings with their Ministry of Health and other major stakeholders. They had also strengthened collaborations with other professional associations and developed and disseminated position statements in collaboration with new partners.

Finally, the associations’ contributions to MNH practice at national level became more strategic and focused to include:

- Assuring leadership in support of supervision activities
- Developing clinical guidelines
- Implementing Maternal Death Reviews (MDR) and/or Near Miss Reviews (NMR)
- Training health professionals (health administrators, physicians, midwives, nurses, and community workers) on a variety of reproductive health issues
- Reviewing and updating medical curriculum.

\(^{10}\) FOGSI did not have a post-intervention capacity assessment because the capacity improvement undertaken during the initiative was limited to the development of a vision and mission.
FIGO LOGIC Toolkit for organizational capacity strengthening

The FIGO LOGIC Toolkit with organizational capacity strengthening resources and tools for health professional associations was developed in collaboration with SOGC.

It is designed for health professional associations that are initiating organizational changes for the first time, and for those seeking additional support to enhance selected organizational capacities. The Toolkit brings together a collection of information, resources and tools for anyone interested in fostering organizational change within a health professional association, either through the conduct of occasional activities, or by initiating a more thorough capacity building process.

Using the Toolkit will lead to better understanding of what makes an organization strong; what the different elements of organizational capacity building are; how a change process can be initiated; and how practical activities can be conducted to support such change processes.

The Toolkit is available in English, French and Spanish on www.figo-toolkit.org
Lessons learnt about organizational capacity building

- The participatory approaches at the beginning and end-of-project self-assessments provided an opportunity to consider how the MAs functioned through an 'organizational capacity lens'. The results stemmed from their own assessment and not the evaluation of an external consultant, meaning there was greater ownership and buy-in from those involved with the association.

- Strategic planning exercises, including the development of mission, vision and values statements proved important means by which the associations could define who they were and what they aspired to do. They also allowed them to define their priorities for the next few years. The MAs then had a means to ensure that their capacity building efforts continued beyond the life of FIGO LOGIC.

- Linking capacity building with access to concrete resources, whether financial or technical, galvanized and mobilized the MAs. It permitted to them to notice, in considerably short period of times, substantial improvements in the way they worked which was then reflected in their enhanced credibility in the field.

- The establishment of an equipped and staffed national secretariat outside hospital and university settings proved an important step for associations seeking to establish their identity as professional associations. It further facilitated their efforts to institutionalize their overall administrative systems and contributed to the organization of their activities.

- Most of the MAs have secured funding independent of LOGIC to secure their activities beyond the life of the initiative. If governments and donors invest in MAs, they will see increased engagement and contribution to national efforts to improve MNH policy and practice.

- Investing in organizational and technical capacity simultaneously provided a real opportunity to the MAs to assume concrete leadership in the field. Greater organizational capacity (for example, a functional secretariat, greater project management skills and strategic plans) facilitated the associations’ ability to contribute to the development or review of clinical guidelines, the implementation of Maternal Death and Near Miss Reviews and further expand their reach in trainings and Continuing Medical Education in the field.
Section 3
Influencing policy

With ongoing efforts to build their capacity, the MAs worked hard to influence policy and take part in national policy dialogues concerning maternal and newborn health. Their goal at the outset of the initiative was to encourage the adoption of national policies, strategies and actions to improve maternal and newborn health. This included increasing human resources, financing, evidence-based clinical practice, education and review processes such as Maternal Death Reviews (MDRs) and Near Miss Reviews (NMRs). They also wanted to increase the visibility of maternal and newborn health in the media.

What did the MAs achieve?

Some of the MAs were already active in the area of policy influencing before FIGO LOGIC began. For others, it was a new activity. According to the Mid Term Review, conducted by an independent evaluator in 2012, “LOGIC certainly appears to be a positive and catalytic influence on progress. MAs profiles and reputations appear to be growing at national and regional levels.”

The quality and nature of relationships between MAs and Ministries of Health in their respective countries varied greatly. Some had long-standing and respected relationships, often through high profile individuals. Others were at an earlier stage of development and sought to build new or stronger relationships.

Overall, the MAs increased their public profiles and successfully further engaged in policy dialogues about maternal and newborn health.

All eight MAs now have Memorandums of Understanding (MOUs) guiding their relationship with their respective Ministries of Health and are able to engage in dialogue about maternal and newborn health. All of them are formal members of national Maternal and Newborn Health Working Groups or Committees.

‘LOGIC annual events were the best networking time to learn lessons from the different countries. In addition having the panel of experts working with us was a wonderful mentor-peer relationship.’

AOGU, Uganda
In Mozambique, Associação Moçambicana de Obstetras e Ginecologistas (AMOG) used research results to influence government policy on the use of misoprostol in the prevention of Post-Partum Haemorrhage (PPH).

Maternal mortality is high in Mozambique at 599 deaths per 100,000 live births. Many pregnant women cannot access healthcare services and in rural areas, skilled birth attendants are present at only one third of births. Misoprostol is an effective drug in the prevention of PPH. It is widely accepted and listed in essential drug lists (WHO and country level) though in many countries only applicable when the other methods of PPH prevention are out of stock. Because of its effectiveness, and ease of use – available in tablet form - it is a promising addition certainly for rural, hard-to-reach and resource-limited communities. More commonly used drugs, such as oxytocin to reduce PPH need refrigeration and are administered through injections.

Prior to FIGO LOGIC, AMOG had joined with other partners to undertake operational research about the effectiveness of misoprostol to treat PPH. Findings showed that misoprostol distribution during antenatal care visits and by Traditional Birth Attendants at delivery were very effective strategies to assure availability of misoprostol during facility and home based deliveries. Over 90 percent of women who attended antenatal clinics took misoprostol home and nearly all of them correctly self-administered the drug after delivering at home. In effect, 99 percent of home deliveries were covered with misoprostol, including 5 percent of women who did never attend ANC and received misoprostol from a TBA. Over 96 percent of women find misoprostol at delivery an acceptable intervention for preventing PPH.

FIGO LOGIC then supported AMOG to disseminate the research findings to key stakeholders including the Government. AMOG and partners presented the research to the Cabinet and Minister of Health and in principle they have accepted the scaling up nationwide of the use of misoprostol. AMOG also advocated, alongside other partners, for the registration of misoprostol, and since then, two brands have been registered.

11 Venture Strategies Innovations, PSI and the Bixby Center for Population, Health and Sustainability at the University of California, Berkeley

12 Community-based Prevention of Postpartum Hemorrhage with Misoprostol in Mozambique, Final Report, MAY 2011 (Link to online version?)
SOGOB decided to form closer working relationships with other national stakeholders to influence key players and policy making in maternal and newborn health in Burkina Faso. The project steering committee went well beyond its original mandate. It expanded its membership and is now involving the Executive Board of SOGOB, the Mother and Child Health Department at the Ministry of Health, the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), Family Care International (FCI), JHPIEGO, an affiliate of Johns Hopkins University, and Professional Associations of midwives, paediatricians and anaesthesiologists. Discussion focused on LOGIC-supported activities, and the committee became a national platform, able to hold debate and take decisions on policy and practice.

The Ministry of Health, with support from UNICEF, UNFPA, WHO and professional associations inclusive of SOGOB, finalized its first comprehensive strategy in reproductive health, “Policy and standards in Reproductive Health”, affirming the countries commitments to the International Conference on Population and Developments Action Plan of 1994 and subsequent international commitments. SOGOB has been the lead contributor to the main section of the document, on maternal health; and has followed up by authoring clinical guidelines corresponding to the different sections of the policy document.

‘SOGOB is seen as a unique source of expertise in obstetrics and gynaecology and its contribution to policy development and training activities in the area of MNH is greatly respected by a wide group of stakeholders.’

Mid Term Review

---

13 Burkina Faso Mid-Term Review country annex, 5.4
**SOGOC, Cameroon:** Joining forces through a Memorandum of Understanding

Signing a Memorandum of Understanding (MoU) might not sound like an extraordinary event, but it has transformed the way that SOGOC is able to work with and influence the Ministry of Health. SOGOC and the Ministry of Public Health (MoPH) signed the MoU in 2010, and this opening has permitted SOGOC to attend and participate in meetings with the Ministry and other key stakeholders such as UN agencies. Due to the influence that SOGOC has had at these meetings, the MoPH now has greater support for Maternal Death Reviews to the extent that Cameroon’s Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Plan of Action is likely to include MDRs in 2013.

The MoPH, UNFPA and WHO are all engaged in continuing to promote and support MDRs and SOGOC is currently drafting a training manual and other logistics in preparation.

![The SOGOC team, Cameroon / Photo OGOC](image)

**ESOG, Ethiopia:** Engaging in dialogue with key stakeholders

ESOG has been influencing policy through strengthening partnerships, exchanging information and collaborating with a wide range of stakeholders. The Working Group of Health Professional Associations and other Partners working on maternal, newborn and child health issues meets every six months in Ethiopia. The organizations that form this working group include: the Ethiopian Society of Obstetricians and Gynecologists, Ethiopian Pediatrics Society, Ethiopian Nurses Association, Ethiopian Midwives Association, Ethiopian Public Health Association, Addis Ababa University: Health Science College, Ethiopian Society of Anesthesiology, Ethiopian Medical Association, World Health Organization, UNFPA, UNICEF, Federal ministry of Health and the Packard foundation.

At the meetings, each organization presents updates on its current activities, and discusses best practices in maternal and newborn health. In 2012, the group made recommendations to the Government about key activities in ‘Behavior Change Communication’ about maternal and newborn health, especially home deliveries.
In 2010 AOGU developed an advocacy plan with partners to increase the national budget for reproductive health. In collaboration with partners such as Save the Children, the United Nations Population Fund, and the White Ribbon Alliance, AOGU helped to influence the Ugandan Government to commit to increasing funding for reproductive health through lobbying Parliament. The Uganda Health Budget was supplemented by UGSHS 49B shillings\textsuperscript{14}, which went towards salary enhancement for health workers.

AOGU provided the keynote address at a breakfast meeting with the First Lady, the executives of Corporate and Parliamentarians. It also presented the status of maternal health services to the Ugandan Women’s Parliamentary Forum and signed the petition to Parliamentarians as part of the larger civil society to increase funding to the health sector. AOGU found that once Parliamentarians understood the key messages about maternal and newborn health, they became strong advocates.

\textsuperscript{14} This corresponds to 18.6 Million USD. (www.oanda.com, accessed on 3 June 2013)
**NESOG, Nepal: Task shifting for Emergency Obstetrics Care (EmOC) services**

NESOG has, for some years, been conducting training programmes for medical officers on national reproductive health guidelines and task shifting for EmOC services. NESOG members have also been involved in training programs for Skilled Birth Attendants. As part of FIGO LOGIC, NESOG wanted to influence government policy on task shifting and held formal and informal meetings with various government authorities. The influencing process was facilitated by the then Health Secretary, Dr Sudha Sharma, a NESOG past President. Also, many NESOG members have roles in influential bodies such as the Family Health Division, National Health Training Centre, WHO, DFID, Support to the Safe Motherhood Programme, UNFPA, and Jhpiego. NESOG also has a very good relationship with other organizations like the Nepal Medical Association, Perinatal Society of Nepal, Nursing Association of Nepal and Midwifery Society of Nepal, and they also helped to carry out the activities, such as training of medical doctors and mentoring them in the pilot district of Dhankuta.

---

**SOGON, Nigeria: Evidence-based policy on skilled human resources**

In Nigeria, SOGON is working to influence national policy on the development of Skilled Human Resources for maternal services based on the latest evidence from the Nigeria Demographic and Health Survey 2008. They made significant input into the development of the curriculum, training and manual for the deployment of midwives under the Midwifery Service Scheme (MSS).

SOGON has collaborated with other stakeholders on high-level advocacy to Executives and Legislative arms of Government. It has actively pushed for task shifting in Nigeria and for the policy document to review the definition of Skilled Birth Attendants (SBAs) to include Community Extension Workers (CHEWs) who are to be further trained to the proficiency of providing Basic Emergency Obstetric Care (BEmOC). Doctors are also trained to Provide Comprehensive Obstetrics Care at the secondary health facilities.

In the quest to increase SBAs at delivery, SOGON has initiated the Voluntary Obstetricians Scheme. This will help deploy obstetricians and gynaecologists to primary and secondary healthcare facilities on a voluntary basis. The Scheme has the support of the National Primary Healthcare Development Agency (NPHDA) and the United Nations Population Fund. A Memorandum of Understanding will be signed with NPHCDA when it is implemented.
FOGSI worked in partnership with the Maternal Health Division of the Ministry of Health and Family Welfare to embark upon an ambitious nationwide programme of capacity building and task shifting in Emergency Obstetric Care (EmOC). Other key partners included JHPIEGO, Macarthur Foundation, Averting maternal deaths and disabilities and Avni Health Foundation.

The Ministry of Health and Family Welfare required an update of the EmOC curriculum as it was out dated and new scientific evidence of the management of maternal emergencies was now available. There was also an urgent need to synchronize a new EmOC curriculum with other programme training modules.

FOGSI, with funding from FIGO LOGIC, was able to support the development of the new curriculum by forming a National Core Group and identifying a high quality team to carry out research and build the curriculum. It was a challenge to manage the various partners and health divisions of the Government of India throughout the process. FOGSI committed resources to make it happen and identified the right set of people and organizations to manage the changes. The final EmOC curriculum has been released for pilot implementation across all the 35 national EmOC training centres.
Engaging with the media

Engaging with the media is a key way to influence public opinion and indirectly put pressure on the government to adopt new policies or adapt existing ones.

In Uganda, AOGU briefed journalists about key Mother and Newborn Health issues in Uganda. This resulted in a newspaper article in Uganda’s leading daily newspaper, ‘New Vision’ entitled, ‘The time a mother is likely to die...’ The article built on AOGU’s analysis of Maternal and Perinatal Death Review (MPDR) data from AOGU/FIGO LOGIC-supported hospitals from 2009 to 2011 and highlighted findings from a report. Mothers tend to die at times when the midwives are changing shifts and appropriate handovers are not done; hospitals tend to be short of supplies towards the end of the fiscal year when funds are lacking; hospitals do not have sufficient numbers of skilled health workers or adequate access to blood and other supplies; many pregnant women do not attend appropriate antenatal care (ANC), and many pregnant women delay seeking medical care. The article also highlighted some of the proposed solutions including increasing staff levels; ensuring access to blood supplies; availability of protocols on how to handle emergencies; care for critically ill mothers; and encouraging women to attend ANC.

In Ethiopia, ESOG engaged with the media in a different way by producing newspaper articles and radio slots on key maternal and newborn health issues. Over 160 articles on sexual and reproductive health and MNH were published in the weekly newspaper Addis Admas’ Saturday. A similar number of radio slots on the same topics were broadcast on FM Addis 971 for 20 minutes every Thursday morning. The broadcasts reached audiences in Addis Ababa and villages and towns located within a 100 km radius. ESOG has started a radio spot announcement with Radio Fana broadcasted for one minute three days a week for three consecutive months. ESOG paid for about two thirds of the cost of these media outputs, while the broadcaster cover one third. While long-term sustainability of the media coverage needs to be considered, ESOG has so far managed to secure funding for these media outputs from two funders.

In Mozambique, AMOG had several ad-hoc engagements with the media and got spontaneous coverage during and immediately after their research on use of misoprostol. AMOG has now developed a more pro-active strategy and obtained regular slots for TV and radio coverage paid for by the Ministry of Health.

In Cameroon, SOGOC conducted a situational analysis of media space on reproductive health issues. They also facilitated a workshop on unsafe abortions with journalists.

---

15 New Vision, The Time A Mother is likely to die, by Carol Natukunda, 5 November 2012 http://www.newvision.co.ug/news/637057-the-time-a-mother-is-likely-to-die.html

Lessons learnt about influencing policy

Experiences from the LOGIC initiative confirm that MAs influence policy-making and in fact are key players in the actual policy making process.

- In each of the countries, MAs are endowed with powerful, well-connected and highly committed individuals who do advocate and lobby, even if this is not always part of a formal plan or strategy. When advocacy becomes a more formalized activity, supported and catalyzed by a strong organization, these ‘natural advocates’ need to be on board. They need to be provided with opportunities to use their skills to implement the society’s advocacy strategy.

- The reach and degree of power coming from an organization with a clear profile and established credibility surpasses individual capacities. Advocacy for complex matters such as MNH will likely need to be complex too. A well thought through strategy with target groups, a dedicated person driving the process and a timed approach is needed. Often success comes only after years of concerted efforts.

- MAs have used a number of approaches illustrated by the previous examples: making use of written, spoken and visual media; approaching and convincing individual members of elected policy making bodies so they become ‘advocates by proxy’; using operational research to obtain more convincing and locally proven arguments; and establishing of clear roles and responsibilities in a memorandum of understanding have all been effective. The quality and targeting of messages through the media is important.

- MAs have benefitted hugely from getting involved in strategic networking and partnering with other key stakeholders. This has allowed them to build effective relationships, ultimately strengthening advocacy for everyone concerned. Building a credible body of professionals behind advocacy efforts is critical to the MA’s success in influencing policy change.

- Advocacy can be risky too and MAs have experienced potential pitfalls. Honest inputs into advocacy and the influencing of policy-making processes and individuals have put associations and individual members in the wrong spotlight. In some cases their attempts became suspicious or even subversive in the eyes of authorities. The use of language matters; ‘advocacy’ can be seen as confrontational and threatening, but ‘influencing’ has a more positive connotation.
As part of FIGO LOGIC, and with their growing capacity, the MAs worked to improve clinical practice in the area of maternal and newborn health. At the outset, they sought to make significant contributions to the implementation of policies, and aimed to monitor and evaluate the implementation of national policies, health strategies and plans. They planned to contribute to clinical standards, guidelines and protocols and review processes to improve clinical practice.

What did the MAs achieve?
The two main areas where MAs made progress were to develop clinical guidelines and protocols and to promote and carry out Maternal Death and Near Miss Reviews.

Clinical guidelines and protocols
All of the FIGO LOGIC MAs have been involved in the revision and development of clinical guidelines and protocols. “These activities have increased as a result of MAs being more proactively engaged in technical working groups and advocacy opportunities.” (Mid Term Review, 2012 p14) For many of the MAs, signing an MOU with Ministries of Health also facilitated this process.

<table>
<thead>
<tr>
<th></th>
<th>Policy documents</th>
<th>Clinical guidelines &amp; protocols</th>
<th>Training material</th>
<th>National Review reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

A full list of the guidelines and protocols that each MA developed is listed at the end of this document.
Maternal Death Reviews

It is possible to prevent most maternal deaths and disabilities with known and effective interventions, but it requires the right kind of information on why women are dying or facing lifelong disabilities. It is not enough to have information on the overall levels of maternal mortality and morbidity. Health policy makers and practitioners need to understand the underlying factors to be able to prevent future deaths and disabilities.

The World Health Organization publication “Beyond the Numbers - Reviewing maternal deaths and complications to make pregnancy safer” (200417) provides critical information about conducting a Maternal Death Review (MDR). A facility-based MDR is a, “qualitative, in-depth investigation of the causes of and circumstances surrounding maternal deaths” in health facilities, while a Near Miss Review is the, “identification and assessment of cases in which pregnant women survive obstetric complications” (Lewis, 200318 p.33). The lessons learned from MDRs/NMRs lead to recommendations for improvements in care to prevent future deaths and disabilities. It is not a process for handing out blame or shame, but exists to identify and learn lessons to help ensure that mothers are healthy in the future.

Gynaecologists and obstetricians, together with other healthcare professionals, have an important role to play in improving mother and newborn health policy and clinical practice. This includes the implementation of findings and recommendations coming out of MDR and NMR processes.

Facility-Based Maternal Death Reviews

‘A qualitative, in-depth investigation of the causes of and circumstances surrounding maternal deaths occurring at health facilities. Deaths are initially identified at the facility level but such reviews are also concerned with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable.’ (WHO 2004)

The same process of in-depth investigation can be used for perinatal death, and near miss reviews of maternal and perinatal death.


FIGO LOGIC and Maternal Death Reviews

Before FIGO LOGIC, some MAs were already involved in Maternal Death Reviews (MDRs) to varying extents. Most of the MAs have highlighted MDRs as important processes at country level and promoted them to their Ministries of Health. MAs also worked closely with a variety of stakeholders to implement MDRs and, in some cases, Near Miss Reviews (NMRs) and Maternal and Perinatal Death Reviews (MPDRs). These other actors include Ministries of Health, relevant health authorities, hospital management in selected hospitals and other partners such as multilateral institutions.

Examples of maternity care improvements resulting from MDRs in FIGO LOGIC countries

<table>
<thead>
<tr>
<th>Systems</th>
<th>Resources</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved referral pathways</td>
<td>Ambulances</td>
<td>Note Keeping</td>
</tr>
<tr>
<td>24-hour care</td>
<td>Blood Banks</td>
<td>Partogram use</td>
</tr>
<tr>
<td>New guidelines</td>
<td>Laboratories</td>
<td>Increase in Guideline use</td>
</tr>
<tr>
<td></td>
<td>Neonatal Units</td>
<td>Targeted Skill Enhancement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved Staff Morale</td>
</tr>
</tbody>
</table>
## MA activities in MDR 2009-2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Training</th>
<th>Scale Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>MDR training of trainers</td>
<td>National roll out of MDRs (with UNFPA)</td>
</tr>
<tr>
<td>Cameroon</td>
<td>MDR guideline/curriculum tested</td>
<td>Proposal to MoPH, UNFPA and WHO for MDR expansion</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>MDR/NMR training at pilot facilities</td>
<td>MOH proposal to extend MDR/NMR to 40 facilities</td>
</tr>
<tr>
<td>India</td>
<td>MDR 4000+ Health workers</td>
<td>MDR: National software developed</td>
</tr>
<tr>
<td></td>
<td>NMR Definition/Curriculum/Tools/Process</td>
<td>NMR: National Policy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Indian Colleges</td>
</tr>
<tr>
<td>Mozambique</td>
<td>MDR mentoring/training at province level</td>
<td>National roll out of MDR (training of trainers and mentoring)</td>
</tr>
<tr>
<td>Nepal</td>
<td>MPDR training at pilot facilities</td>
<td>Analysis for presentation to MoH</td>
</tr>
<tr>
<td>Nigeria</td>
<td>MDR National Strategic Plan</td>
<td>Seeking endorsement at National Health Council 2013</td>
</tr>
<tr>
<td></td>
<td>MDR tool consensus</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>Training in community-based MPDR</td>
<td>National lead for Maternal and Perinatal Death Review</td>
</tr>
</tbody>
</table>
Improving practice: stories from the MAs

**SOGOC, Cameroon: Maternal Death Reviews**

SOGOC has established MDR Committees in six hospitals in Cameroon. Staff who have been trained in MDR and now sit on the MDR Committee at the Yaoundé Central Hospital (CHY), said that the MDR, “catalysed staff in to consulting with more senior obstetricians to discuss planned management of cases before taking a decision.

It has already allowed the committee to highlight systemic issues and forward them to the director of the hospital. This has allowed them to lobby for review of the emergency kits to ensure they were complete.”

*Mid-Term Review p15*

The MDR Committee in Yaoundé Central Hospital (CHY) appreciates the potential of MDRs to reduce maternal mortality. They understand that although there is a culture of ‘no blame’ in MDRs, it makes all individuals aware of their responsibility. It also leads staff into consulting with more senior obstetricians and allows them to discuss the planning and management of cases before taking a decision. The committee is able to highlight systemic issues and bring them to the attention of the hospital director.

**ESOG, Ethiopia: Maternal Death Reviews and Near Miss Reviews**

ESOG collaborated with the Federal Ministry of Health of Ethiopia to introduce facility-based Maternal Death Reviews (MDRs) and Near Miss Reviews (NMRs) in a number of hospitals and satellite health centres in 2011. ESOG is currently supporting the implementation of MDRs and NMRs in nine public hospitals and 45 health centres in four regions of Ethiopia.

ESOG has successfully been working with the public health facilities to ensure that health workers own the process. Hospital workers have not been reluctant to report maternal deaths or near misses, nor have they feared punitive action. This is credit to ESOG and the way they successfully managed the introduction of MDRs and NMRs. ESOG has found that the MDRs and NMRs provide a good learning experience for staff if the reviews are done in a participatory manner.

*FIGO LOGIC Mid-Term Review Synthesis Report, 2012, p15*
FOGSI, India: Near Miss Reviews implemented across India

In 2010, the Maternal Health Division of the Ministry of Health and Family Welfare began implementing Maternal Death Reviews (MDR) in all the States in India. However, Near Miss Reviews can also provide important insights into risk factors and possible ways to prevent maternal deaths. The development and implementation of a uniform National Near Miss policy framework and programme was therefore critical. However, it was a challenge to define the criteria for a Near Miss case within a policy framework. FOGSI worked with a range of partners including the Ministry of Health and Family Welfare (Maternal Health division), Mahatma Gandhi Institute of Medical Sciences and Systems and Program Management, Development partners, national associations of Pediatrics/Nursing/Midwifery/Neonatology/Anesthesia, National Institute of Health and Family Welfare, National Health systems resource center and Six Medical colleges. Together, the team firmed up the definitions, tools and criteria for a national policy framework. Key steps included the formation of a national technical group, finalising the policy framework, ensuring clarity in definition, criteria for case selection, and identifying tools for reporting.

FOGSI learnt that progress on development is fast when the Government and other stakeholders have the same agenda and are keen to improve well being of women. Having the right people in the team is critical to a successful outcome.

SOGOB, Burkina Faso: piloting ‘respectful care’

SOGOB, with support from FIGO LOGIC and Family Care International (Burkina) has piloted the reinforcement of ‘respectful care’ skills in three health facilities. A participatory process took place, which allowed facility staff to self-diagnose their quality of care, acknowledge responsibility and commit to a set of ten behaviours on respectful care.

The main commitments made by staff are to improve the ‘welcome’ to the facility, provide support and information during labour, accept accompanying family members during labour, and respect privacy. These can be modified after each subsequent evaluation. High turnover of staff, frequent technical dysfunctions and inadequate infrastructure are hindering quality of care, including respectful care and merit urgent analysis and attention. Respectful care allows improving the quality of patient management by linking best practices with human care.
**AOGU, Uganda: Rolling-out Maternal and Perinatal Death Reviews**

AOGU worked with the Ugandan Ministry of Health (MoH) and other partners to implement Maternal and Perinatal Death Reviews (MPDRs). AOGU agreed a Memorandum of Understanding with the MoH which, among other things, gave them responsibility for overseeing MPDR implementation.

AOGU has been training service providers at regional referral hospitals in how to conduct MPDRs since 2007. As part of FIGO LOGIC, AOGU supported one national hospital (Mulago) and three regional referral hospitals (Fort Portal, Masaka and Mbarara) since 2009. This included helping the hospitals to conduct quality MPDRs and to act on the information and recommendations emerging from the process. AOGU compiled and analysed MPDR data from the AOGU/FIGO LOGIC supported hospitals from 2009 to 2011 and the MPDR teams at the hospitals made over 500 recommendations to improve services. AOGU is also providing training and support to other hospitals, including in the Kabarole, Kibaale, Kamwenge and Kyenjojo districts.

AOGU is an active member of the National MPDR Committee, which includes key partners working on MPDRs in Uganda. AOGU updated MPDR tools, which were approved by the National MPDR Committee and are available for national and regional referral hospitals to use online.

---

**AMOG, Mozambique: developing guidelines for maternal and newborn health**

AMOG helped the Ministry of Health develop a manual containing maternal and newborn child health guidelines relating to family planning, emergency obstetric care, antenatal and post partum care, screening of cervical cancer and comprehensive abortion care. They are also involved in the implementation of these guidelines through training of trainers at provincial and district level, for example in the introduction of modern family planning methods.
**NESOG, Nepal: Near Miss Review Study**

NESOG carried out Near Miss Review (NMR) Studies in selected hospitals of the Kathmandu valley. A NMR steering committee guided the process and sent an initial research proposal application to the Nepal Health Research Council. The committee held meetings with a nine research institutions in Nepal in order to get their approval. NESOG then conducted a workshop in Kathmandu with NESOG members to raise awareness about maternal deaths and Near Miss Reviews. FIGO LOGIC consultants, Professor Gwyneth Lewis and Dr Marian Knight, supported the process and the workshop allowed participants to discuss recent scenarios of near miss deaths, NMR techniques and epidemiological research design.

The Steering Committee finalized the protocol and identified lead reporters in each hospital. A standard questionnaire was developed for analysis of specific conditions and a workshop helped to decide and finalize the research tool for data collection. Data collection started in January 2012. The focal persons of all the institutions had regular monthly meetings where all the Near Miss forms were collected and discussed in detail. The results were analyzed with help of a statistician. Finally the NMR study result was shared during the 11th International NESOG conference on 5-6 April, 2013.

**SOGON, Nigeria: harmonizing approaches to Maternal Death Reviews**

SOGON engaged in the rich federal debate on methods and approaches to Maternal Death Reviews. They worked to bring together different stakeholders such as federal agencies implementing MDR’s and donors with specific interests in MDR. Together, they worked to review existing guidance and templates for MDR, gain exposure to best practices from other countries (Ethiopia, South Africa, and UK) and to come to an agreement for one approach for the Federal Republic if Nigeria. The Ministry of Health has accepted this harmonization in principle, but the debate still needs to take place at the National Health Council. This is a federal level forum that brings together the Health Commissioners from all of Nigeria’s states.
Lessons learnt about influencing practice

Experiences from the LOGIC initiative confirm that associations influence practice and clinical care, through working directly with Ministries of Health and with a range of other stakeholders.

- MAs have moved beyond performing solely as assuring centres of excellence where their members work. They now use their skills and expertise in processes such as the writing of guidelines and setting of standards that ultimately improve the health of women and newborns throughout the whole national health system.

- Having the support of a professional association on issues that are sensitive or perceived as threatening to its members (such as task-shifting or introducing new drugs such as misoprostol), moves a large number of stakeholders from the position of ‘antagonizers’ or ‘neutral doubters’ to supporters and eventually inspired implementers.

- It is important for the MAs to strategically position themselves. Except in the case of piloting interventions, their strength lies not in implementation at the local level and micro-management of facilities, but rather in service provision as a resource to other organizations that are better positioned for field implementation. This can be in the role of trainers (of trainers), mentors of teams that implement innovations, or as members of integrated supervision teams.

- MDRs and NMRs deliver data that empower local teams to excel. It is not primarily a data-producing process leading to an overview of causes of death at regional or national level. It is first and foremost an opportunity for local management and the clinical team to learn both from its shortcomings and from its effective approaches, in an attempt to reduce the former and replicate the latter.

- As MDRs are re-emerging as a priority intervention in the reduction of maternal and neonatal mortality, the experience of FIGO-LOGIC has shown that the MAs are natural leaders both in the process of fine-tuning the approach, guidelines and tools, and in the process of its national rollout and achieving lasting impact at scale.
Conclusion

Health Professional Associations operate at different levels of organizational capacity, with varying depth and breadth of focus on issues that go beyond the traditional focus of being learned societies. FIGO LOGIC has demonstrated that with external support, the focus of a national obstetric and gynaecologic association and its effectiveness and impact on major issues in public health (such as MDG 4 and 5) can be significantly broadened and enhanced.

- The organizational capacity of Health Professional Associations in low-resource countries can be significantly increased within a short period of time and with relatively few resources.

- With external support, Health Professional Associations can become credible and respected partners with ministries and other national stakeholders.

- The signing of a Memorandum of Understanding with the Ministry of Health and/or other stakeholders, and the formulation of a strategic plan for the Health Professional Association are pivotal steps towards becoming an influential partner.

- With enhanced organizational capacity and formal partnerships, Health Professional Associations are able to influence policy, lead on contentious issues and guide and support health practice improvements.
Appendix 1.

List of guidelines & protocols developed

**SOGOB, Burkina Faso**
Policy and Standards in Reproductive Health
Protocols in Reproductive Health
- Maternal and neonatal health
- Maternal health- gynaecological care
- Newborn, child and adolescent Health
Training in EmONC
Training module in Maternal and Neonatal Death Reviews
Protocols:
- Third trimester bleeding
- Severe pre-eclampsia and eclampsia
- Use of magnesium sulphate
- Post partum haemorrhage
- Use of misoprostol
- Anemia in pregnancy
- Snakebite in pregnancy

**SOGOC, Cameroon**
Draft situational analysis ready
Draft publication of MDR activity for the Yaoundé Central hospital

**ESOG, Ethiopia**
Guidelines on Family Planning
Training materials for
- Misoprostol Use for Health Extension workers in three local languages
- Basic Emergency Obstetric Care
- Comprehensive abortion care
- Management Guideline for Survivors of Sexual Assault

**FOGSI, India**
EmOC Curriculum, MDR software to record, analyse and generate National/State/District reports
NMR Definition/Criteria/Tools/Process guidelines

**AMOG, Mozambique**
MDR tools and guidelines
Post abortion care guidelines
Antenatal care guidelines
Contraception and family planning guidelines - modern methods
Ante partum, delivery and postpartum care
Use of misoprostol in obstetrics and gynaecology

**NESOG, Nepal**
Guidelines for hypertensive disorders in pregnancy: diagnosis, evaluation and management
Guidelines for the management of recurrent pregnancy loss

**SOGON, Nigeria**
Protocol on the management of (pre)-eclampsia
Protocol on the management of post-partum haemorrhage
MDR guidelines

**AOGU, Uganda**
The national policy guidelines, and Service Standards for Sexual and Reproductive Health and Rights
The first LOGIC report of the Maternal Mortality reviews in three referral hospitals in Uganda 2009-11,
The national MM reviews 2009-2011
Maternal and Perinatal Death Reviews (MPDRs) - Health Workers Trainers Guide
‘Leadership is about creating a way for people to make something extraordinary happen.’