FIGO-LOGIC Initiative in Maternal and Newborn Health

Final Annual Review Meeting


Objective 1

Major Performances

- A Working Group of health professionals and other partners working on MNH chaired by ESOG formally established and 9 regular meeting conducted. Twelve participants represented from 11 national and international organizations regularly attended the meeting. Participants discussed on current MNH issues and shared best practices on a regular basis. Finally, designed a joint promotional activity on MNH and broadcasted in one of the popular mass media outlets.

- 2100 Radio Programs Broadcasted via Frequency Modulation 97.1 and the same number Articles Posted in one of the popular local newspaper. The radio transmission is every Thursday morning for 20 minutes while half a page article posting every Saturday in the private newspaper.

- Strengthening of standard Birth and Death Registration of maternal and newborn vital statistics as per the national health management information system was undertaken in nine public hospitals.

- A three day advocacy workshop organized by ESOG in collaboration with FIGO-LOGIC was conducted in Addis Ababa in July 2011. A total of 21 people from Uganda, Cameroon, Nigeria and Ethiopia have attended the workshop.

Opportunities and ways forward

- Creating a good network with potential partners for quality improvement collaboration, best practice sharing, avoiding service duplications and wise use of resources.

- The need to attain the MDG 4 and 5 has created enormous opportunities for maternal health related improvements.

- Undertake promotional activities in the field to influence Maternal and Newborn Health managers and workers.

- Proactive participation and involvement in all MNCH programs in Ethiopia.

- ESOG to be fully engaged in all sexual and reproductive health programs by increasing fund availability and program expansion.
Objective 2

Major Performances

- A total of 30855 deliveries, from which 28281 were live births have been properly registered in designated log books between May 2011 and October 2012.
- For two consecutive years, a one day Technical Updating Training of professionals from the public health facilities, was conducted. The training was provided for more than 88 health professionals represented from the pilot health facilities.
- An institutional based Maternal Death and Near Miss Review was initiated in nine public hospitals. Selection of facilities made in collaboration with the regional health bureaus. The public hospitals were selected from four major regions (Addis Ababa, Oromiya, Southern Nations Nationalities and Peoples and Amhara).
- Five Satellite Health Centers linked with each hospital, which aimed at strengthening referral linkages. A six member of Technical Review Committee was established; whose members selected from the hospital relevant departments.
- Validated categorical diseases Definition for Near Miss cases was made. Standard questionnaire designed and agreed upon to use.
- A total of 2797 Near Miss and 215 Maternal Deaths were reviewed between May 2011 and October 2012. A six months (May-Oct 2011) preliminary analysis of maternal deaths and Near Miss was made and communicated at different events.
- It has successfully been working with the public hospitals to ensure confidence and sustainability of the review practices. The fact that hospital staff have not been reluctant to report cases nor have feared punitive actions is a credit to the successful management of the implementation processes.
- A one day Maternal Death Review Ethiopian Initial Experiences Sharing Workshop conducted in June 2012. A total of 96 people participated from Africa Member Associations (Nigeria, Uganda, Mozambique, Burkina Faso and Cameroon) and from the public Hospitals, regional Health Bureaus and other partners.

Challenges

- Maternal Death and Near Miss cases review process not yet nationally incorporated into the routine maternal health programs.
- This would require a lot of ground work and discussions with health facility managers and staff to initiate maternal death and near miss review practices nation wide.
- The fact that a lot of patients are referred; lack of routine autopsy and poor record keeping makes a challenge in conducting maternal deaths and near miss cases review process.

Opportunities and ways forward

- Making joint efforts to institutionalize and incorporate MDR & NMR into the national maternal health programs.

Lesson Learnt

- In Ethiopia in spite of the high maternal mortality rate; health facility records are usually incomplete and the causes of some maternal deaths in maternity registers are inaccurate. The condition creates difficulty to compile the information on maternal deaths. However, exploring information in the course of maternal death review processes from clinical records, social and health systems; provides evidences for local and national decision making on the interventions needed to reduce maternal morbidity and mortality.
Objective 3

Major Performances

- A baseline and project end organizational capacity improvement assessment conducted in collaboration with the SOGC. Following the baseline assessment: 3 prioritized activities identified, an OCIP developed and properly accomplished.

- A FIGO-LOGIC Annual Review Meeting organized by ESOG in collaboration with FIGO-LOGIC was conducted in Addis Ababa in October 2010.

- A biannual and midterm Monitoring and Evaluation of the project done by external consultants. The consultant team conducted the midterm evaluation in March 2012 and the final review report was delivered to ESOG.

- The second ESOG Strategic Plan 2011-2016 was developed and endorsed by the General Assembly held in January 2012.

Opportunities and ways forward

- ESOG as an organization shall be committed to mobilize all available resources and make use of reliable expertise and capacities towards the improvement of Maternal and Newborn Health in Ethiopia.