The role of health professional organizations in improving maternal and newborn health: The FIGO LOGIC experience

David J. Taylor
Emeritus Professor of Obstetrics and Gynecology, University of Leicester

ABSTRACT

The FIGO Leadership in Obstetrics and Gynecology for Impact and Change (LOGIC) Initiative in Maternal and Newborn Health improved the internal and external capacity of eight national professional organizations of obstetrics and gynecology in six African and two Asian countries. The initiative was funded by a grant from the Bill and Melinda Gates Foundation and had three key objectives: to support the eight FIGO member associations to strengthen their capacity to work effectively; to influence national policies on maternal and newborn health; and to work toward improving clinical practice in this area. Through improved capacity, and underpinned by Memoranda of Understanding with their governments, the associations influenced national policy in maternal and newborn health, impacted clinical care through the development of over forty national clinical guidelines, delivered national curricula, trained clinical and management staff, and led the development of national maternal death and near-miss review programs.

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1. Introduction

Every year, hundreds of thousands of women and millions of babies die during pregnancy, birth, and just after birth. In 2012, the Maternal Mortality Estimation Inter-Agency Group—a collective that comprises WHO, UNICEF, UNFPA, United Nations Population Division, and The World Bank—worked in collaboration with academics from the University of California to assess trends in maternal mortality. This analysis revealed a fall in the number of women worldwide who had died from complications during pregnancy and childbirth, from a total of 546,000 deaths in 1990 to 287,000 deaths in 2010 [1]. Although this decline in mortality was hailed as progress, the rates recorded by low-income countries remained dire, with Sub-Saharan Africa and South Asia accounting for 85% of all maternal deaths globally. The maternal mortality ratio recorded in 2010 was 500 deaths per 100,000 live births in Sub-Saharan Africa and 220 deaths per 100,000 live births in South Asia. It is estimated that 5–6 million babies die during late pregnancy or during the first week of life [1].

The vast majority of these deaths are preventable through improving the health and well-being of women and facilitating their access to quality maternity services. However, investment in these is a low priority in low-resource countries. The reasons for low prioritization of women’s health care arise from lack of awareness of the scale of the problem. First, the challenges to improve such care are perceived as too difficult or too expensive to solve, which they are not. Second, the case for investment has not been well made, particularly the benefits to the long-term strength of a nation’s social and economic development from the health and well-being of women and children. Finally, and perhaps most importantly, women have historically lacked advocates to promote their agendas, needs, and demands among policy makers. However, it has been argued that one national organization above all others could advocate and overcome the reasons for low prioritization of women’s health care, namely the national professional associations of obstetrics and gynecology [2].

The Partnership for Maternal, Newborn and Child Health recognized the potential contribution that health professional associations can make in a statement in 2007: “Strong professional organizations provide leadership. They set standards of education, practice and professional 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. However, the ability of professional associations to make such contributions depends on individual organizational and institutional capacities at country level. This is especially true in resource-poor settings, where the vast majority of maternal, newborn and child deaths and morbidity occur” [3].

Arising out of that stimulus, FIGO developed the organizational capacity of the national obstetric and gynecologic associations operating in eight African and Asian countries through its Leadership in Obstetrics and Gynecology for Impact and Change (LOGIC) Initiative in Maternal and Newborn Health [4]. Participating in this initiative enabled the...
national associations to contribute to improvements in maternal health policy and practice.

2. The FIGO LOGIC Initiative

The eight participating professional associations recruited to FIGO LOGIC were: the Society of Gynaecologists and Obstetricians of Burkina Faso (SOGOB) [5]; the Society of Gynaecologists and Obstetricians of Cameroon (SOGOC) [6]; the Ethiopian Society of Obstetricians and Gynaecologists (ESOG) [7]; the Federation of Obstetric and Gynaecological Societies of India (FOGSI) [8]; the Mozambican Association of Obstetricians and Gynaecologists (AMOG) [9]; the Nepal Society of Obstetricians and Gynaecologists (NESOG) [10]; the Society of Gynaecology and Obstetrics of Nigeria (SOGON) [11]; and the Association of Obstetricians and Gynaecologists of Uganda (AOGU) [12]. The FIGO LOGIC Initiative had three clear objectives to support the mission of these associations: (1) to strengthen their capacity to be effective organizations; (2) to influence national policies on maternal and newborn health; and (3) to work to improve clinical practice in the area of maternal and newborn health.

2.1. Capacity building

The main approach to strengthening organization capacity was through the Organizational Capacity Assessment (OCA) and Organizational Capacity Improvement Framework (OCIF) of the Society of Obstetricians and Gynaecologists of Canada (SOCC) [13]. The approach is strongly participatory, working with key stakeholders within the associations, not only elected officers, but also senior management and finance staff. It is based on a process of self-examination against standards in repeated cycles of self-assessment, action, and learning. The OCIF tool has many similarities to organizational audit/assessment tools used in health facilities in many countries, but it is used as a self-assessment tool to ensure ownership, both of the issues identified but also for achieving change to rectify them. The tool enables the team undertaking the initial assessment to score against each standard and for scores to be consolidated by clusters in the following five areas: culture, operational capacity, performance, external relations, and function.

A review of the pre- and post-initiative OCA results indicated that all the associations made improvements with major gains in all areas. In the core dimension of “culture,” the associations proved successful in enhancing considerably their association’s vision, mission, and values. In the core dimension of “operational capacity” and “function,” enhanced capacity was noticeable in the areas of strategy and financial management, where four of the seven associations started from a very low baseline (Burkina Faso, Cameroon, Mozambique, and Nigeria) [9]. In the core dimension of “function”, strengthened capacity was particularly in the areas of advancing professional practice, which feeds off the innate expertise of the officers and members of the associations. More modest gains were made in the core dimensions of “performance” and “external relations/how the association is perceived.” Specific successes were witnessed in the formulation or updating of a strategic plan; review of the constitution; the development of financial strategies; improved financial management systems; increased membership; updated members’ directory; increased income to the associations, for example through follow-up of payment by members; improved skills in grant writing; postgraduate training; holding training courses, workshops, and conferences; better communication with members [10]; publication of newsletters; and review and/or dissemination of code of ethics.

2.2. Policy influence

The improved operational capacity of the associations led directly and indirectly to an increased network and increased recognition as stakeholders. This success created a larger environment, within which they can influence and determine maternal and newborn health at national level and guide, accompany, mentor, and supervise at operational levels. Some general examples are given here.

All the eight participating associations signed a memorandum of understanding (MOU) with their ministries of health [6] and, in addition, signed MOUs with key partners. All became active members of governmental technical working groups and have regular scheduled opportunities to influence maternal and newborn health (MNH) policy—significantly more than they did before the start of the FIGO LOGIC Initiative. Seven completed advocacy training and have developed advocacy strategies.

The associations influenced policy to achieve specific outcomes, such as policies having been adopted or piloted, notably in relation to over 40 national guidelines and maternal death and near-miss reviews (MD/NMRs). The associations also helped to raise public awareness about MNH issues, such as the importance of skilled birth attendants and attendance for prenatal care. Quantification of the attribution of association input is difficult as the associations form part of a wider group of stakeholders. In any case, the fact that they belonged to that group of influencing stakeholders, and are explicitly recognized as such by a wide range of stakeholders at national level, is a success in itself.

All the associations now have a functioning relationship with the relevant departments and groups within the ministry of health in their country. For example, the associations regularly attend technical working groups and are recognized as important partners in the development of over 40 guidelines and policy documents. In many cases the associations were the leading partner. In addition, FIGO LOGIC project steering committees were enhanced to support these relationships in, for example, Burkina Faso, Cameroon, and Ethiopia.

Although it was only formed in 2006, AMOG now sits on a number of governmental committees and working groups, of which the Sector-Wide Approaches (SWAp) group is the most important, since funding decisions for MNH are taken here. This forum, in addition to AMOG having access to the Cabinet and the Minister of Health, facilitated the presentation of work undertaken by AMOG on the successful use of misoprostol in the prevention of postpartum hemorrhage (PPH) in women delivering at home. With Pathfinder International, Venture Strategy International, and the USAID Maternal and Child Health Integrated Program and LOGIC, AMOG will be a leading partner in the roll-out of community-based self-administration of misoprostol for the prevention of PPH. In addition, AMOG plays a leading role in the development of clinical guidelines and maternal death review (MDR) policy in Mozambique.

AOGU, in collaboration with partners such as Save the Children Fund, UNFPA, and the White Ribbon Alliance influenced the First Lady, the Ugandan Women’s Parliamentary Forum, and a range of Parliamentarians to lobby for increased funding to reproductive health in Uganda. This advocacy resulted in the annual MNH health budget being increased by $30 million to enhance the number and salaries of health workers [12]. During FIGO LOGIC, AOGU became the leading influencer of a national policy in MNH through the Sexual and Reproductive Health guidelines in 2012 and AOGU’s strength and effectiveness was recognized by being awarded the contract to lead a national program of maternal and perinatal death reviews (MPDR) in 2013.

Aising out of the FIGO LOGIC project steering groups, three member associations (ESOG, SOGOB, and SOGOC) have developed effective and respected multiagency platforms for sharing information, collaborating, and coordinating efforts in MNH. In Ethiopia, the Working Group of Health Professional Associations and other partners meet every six months. The organizations include ESOG, the Ethiopian Pediatrics Society, the Ethiopian Nursing Association, the Ethiopian Midwives Association, the Ethiopian Public Health Association, Addis Ababa University, Health Science College, the Ethiopian Society of Anaesthesiologists, the Ethiopian Medical Association, WHO, UNFPA, UNICEF, the Packard Foundation, and the Federal Ministry of Health. In 2012, the first outcome of the group was recommendations about key activities in behavior, change, and communication relating to maternal and newborn care, particularly at home deliveries. In Burkina Faso, a similar body comprising SOGB, the Mother and Child Health
Department at the ministry of health, WHO, UNFPA, UNICEF, Family Care International, Jhpiego, and the professional associations of midwives, nursing, pediatricians, and anesthesiologists.

In Nigeria, SOGON’s influence and advocacy were effective on a number of fronts. SOGON was a significant influencer in the development of the successful Midwifery Service Scheme, contributing to the curriculum, training manual, and national training of midwifery returnees. SOGON has collaborated with other stakeholders in high-level advocacy to the Executive and Legislative Arms of Government to support task shifting in maternity services. During 2012 and 2013, SOGON has been working with the Federal Government on a strategy for a national program of MDRs [11]. This was finally ratified at a meeting of the Federal National Council of Health in August 2013.

Several member associations identified developing relationships with the media as a way of increasing public knowledge of MNH issues and influencing policy and increased investment. Four have achieved regular exposure for public education (AOGU, ESOG, FOCSI, NESOG). ESOG’s work with the media was particularly extensive. Over 160 articles on sexual, reproductive, and maternal health have been published in the weekly newspaper “Addis Admas Saturday.” A similar number of items were broadcast on FM Addis 97.1 every Thursday morning to an audience within a 100-km radius of Addis Ababa. Recently ESOG has started a radio broadcast on Radio Fana three days a week. AOGU published a series of articles in “New Vision,” a national newspaper. Of particular note, was an article sensitizing the public about MDR and specifically calling for an end to the culture of blame associated with maternal deaths. This article was in response to a minister calling for all events of maternal death to be reported to the police. Hitherto, NESOG in Nepal had given frequent, but irregular exposure to maternal health topics in the press and media. NESOG now has an agreement with Radio Segomarita for a radio broadcast on maternal health issues three days a month. Recently NESOG developed a TV advert, which promotes the importance of child girl nutrition and a talk show on safe motherhood. Of note, NESOG has completed a film advocating action against female feticide, which was launched by the Minister of Family Health in August 2013.

2.3. Clinical practice improvement

Two instruments were selected by the associations to influence clinical practice: evidence-based guidelines and maternal death and near-miss reviews. Over 40 national clinical guidelines/policy documents and training of health professionals were developed.

AMOG partnered with the ministry of health to develop a manual of MNH guidelines related to family planning, emergency obstetric care, prenatal and postpartum care, screening for cervical cancer, and comprehensive postabortion care. The third edition of the Sexual and Reproductive Health and Rights policy guidelines of Uganda published in 2012 was the result of the joint efforts of the ministry of health and AOGU. This significant document covers every aspect of reproductive health, including family planning, maternity care, and cancer care. SOGON contributed over 30 chapters to the revision of the norms and protocols in MNH and also contributed (as a full member of the steering committee) to the evaluation of emergency obstetric and newborn care (EmONC) conducted in 2011. SOGON played a leading role in the issue of a joint “Declaration of Commitment” by all major partners in MNH, which declares to enhance maternal and newborn care through improvements in compassionate care. Working with Family Care International, SOGON is undertaking a national training program in this endeavor. The participatory process encourages clinical staff to self-diagnose the quality of their caring and respect for patients and their relatives and then commits to a set of 10 behaviors compatible with respectful care. SOGON provided training support for several government priority areas in MNH, providing training for heads of district hospitals (district level medical doctors) and anesthetic nurses to allow them to cover emergency cesarean deliveries, training health providers to insert intrauterine contraceptive devices, and providing pedagogic skills training for tutors of midwifery. SOGOC was the major contributor to the development of the national midwifery curriculum for the eight newly established midwifery schools and colleges. The renaissance of midwifery in Cameroon comes after a 20-year period without any educational/training centers for midwifery. FOCSI, with the Government of India, revised the national curriculum for emergency obstetric care (EmOC) training. This was adopted and is being implemented across all 35 EmOC training centers.

Several of the member associations described improvements in maternity services through implementation of maternal death and near-miss review.

Mozambique has a multidisciplinary National Audit Committee for Maternal, Perinatal and Neonatal Deaths devoted to the development of MDRs, at which AMOG has two representatives. This Committee oversees the activities of the provincial, district, and hospital-based MDRs, processes, and documentation. With the support of LOGIC, AMOG has played the leading role in harmonization of the data collection forms and training of clinical and allied staff in the processes. The AMOG tool has been chosen for nationwide roll-out. With representatives from the ministry of health, AMOG visited South Africa in 2013 to explore the development of National Confidential Enquiries into Maternal Deaths.

MPDRs were initiated in Uganda in 2006, since when AOGU has been an active member of the National MPDR Committee. Through LOGIC, AOGU extended MPDR to four regional hospitals, work—which assisted not only local improvements in care—but also led to AOGU being asked to revise the national documents and tools, and then in 2013 being contracted by the Government of Uganda to lead the national program of MPDR. This program is being implemented initially in the 14 tertiary regional centers. Plans are in place to extend reviews into the surrounding communities, for which AOGU has been prepared and received training through LOGIC.

ESOC, with the Federal Ministry of Health of Ethiopia and the support of LOGIC introduced facility-based MD/NMR in nine regional hospitals and their 45 satellite health centers. Impressive improvements in care have been brought about, such as better case record information; better note retrieval; extension of services to 24 hours, seven days a week; the development of shift rosters; assignment and capacity building of midwives; written referrals; improved linkages with health centers; decreased unnecessary referrals; improved team spirit; increased use of partographs; improved blood availability; initiation of intensive care services in three centers; and the purchase of ambulances [7]. The next challenge for ESOC is the integration of this successful program into the MDRS system, which is being implemented in Ethiopia.

FOGSI, with other partners, had assisted the Government of India to develop a system and guidelines for MDRs. With LOGIC support, FOGSI piloted the tools and systems in two districts of Rajasthan, Jhunjhunu and Sikar. Training of 3392 staff was undertaken in 155 sectors, two district hospitals, two subcenters, and 34 primary health centers. The findings were analyzed and presented to the district and state authorities and the systems modified in response. AOGU was asked to revise the national documents and tools, and then in 2013 being contracted by the Government of India to lead the national program of MPDR, which has been inserted and incorporated into the national maternal and child health tracking system—a major achievement [8]. In addition, the Ministry of Health of India has been asked to develop a national NMR program under LOGIC, with the support of LOGIC and the Government of India. The definitions, criteria, tools, and guidelines have been developed and are now being piloted in six medical colleges.

MPDRs are well established in Nepal. With LOGIC support, and through the Family Health Department, NESOG has developed a novel program of NMR in 14 facilities in the Kathmandu valley, with a view to national roll-out.

SOGON with governmental, UN agencies, donors, and professional partners received training in MDRs through two training workshops under the auspices of LOGIC. SOGON then devised a curriculum and
strategy for the national roll-out of MDRs, which was taken to the Federal Ministry of Health. The Federal strategy was approved in August 2013. The program is to be piloted in six states with the support of a new donor to the tune of US $300 000.

Through LOGIC, SOGOC developed MDRs in Cameroon, initially in Yaounde, Douala, and Bertoua. With the Ministry of Public Health, WHO, and UNFPA, SOGOC has developed a national curriculum and training manual based on those devised by the Institute of Tropical medicine, Antwerp, Belgium, on behalf of LOGIC [14]. This work of SOGOC has been catalytic in incorporating MDRs as a component of Cameroon’s Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2013.

SOGOB piloted MDR in three facilities at three different levels of the health system. They actively engaged with other partners involved in similar approaches, and contributed to the now nationally agreed MDR guidelines and training curriculum. Together with its partners, the ministry of health is now rolling this curriculum out to every health facility in the country. SOGOB has the specific responsibility to train the trainers and mentor teams that have recently introduced MDR in their facilities. SOGOB was instrumental in organizing the first review of the roll-out process in 2013.

3. Conclusion

The FIGO LOGIC Initiative has demonstrated that external support of national professional associations of obstetrics and gynecology, over a relatively short period of time, can significantly enhance their internal organizational capacity. From this base, the organizations developed effective working relationships with the appropriate departments and groups within the ministry of health within their countries, developed functioning networks, and enhanced their reputations at national and international levels. The associations are now better equipped to enhance maternity care within their countries and have begun to do this on international levels. The associations are now better equipped to enhance maternity care within their countries, developed functioning networks, and enhanced their reputations at national and international levels. The associations are now better equipped to enhance maternity care within their countries and have begun to do this on international levels.

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Conflict of interest

The author has no conflicts of interest.

References