Chapter 6

Deployment of OBGYNs and Working with Ministries, Communities and Other Healthcare Partners

Speakers:
Gloria Asare, Ebenezer Appiah – Denkyira; Ghana Health Service, Ghana
Yvonne Bultler; Liberia, Ethiopian Society of OBGYNs
Yirgu Gebrehiwot; Ethiopian Society of OB-GYN; Africa Federation of OBGYN & Ethiopian Society of OBGYN, Ethiopia
Myron Aldrink, Medical Teams International

Frank Anderson: Hello! Our next discussion will start in just a minute, we are running a little bit late. I have a few announcements. Number one, I wanted to show you the brand new, hot off the press, Comprehensive Reproductive Health Family Planning book, produced by the faculty at the Komfo Anokye Teaching Hospital.

Kwabena Danso: It is the whole entire Ghana program.

Frank Anderson: This is third in a sequel of books produced by the faculty. The first one is comprehensive obstetrics in the tropics. The next was comprehensive gynecology in the tropics. And the third was comprehensive reproductive health and family planning in the tropics. A mature faculty is also producing textbooks. And these will be actually used. They are available at the registration desk. How much are the books?

Kwabena Danso: $50

Kwabena Danso: Thank you, Frank. We are going to have our next panel, and it is on deployment of OBGYNs and working with ministry, working with communities and other healthcare partners, and faculty development. For the speakers, we have Gloria Asare and Ebenezer Appiah – Denkyira, who is the Director General of the Ghana Health Service. His Deputy is Gloria Asara, so both the Director General and the Deputy are here. Can we see you before we begin? Then we have Stephen Kennedy, Bernice Dahn, and John Mulbah, Liberia. Are they around? Good. And we are also privileged to have the President of AFCOG, Yirgu Gebrehiwot. Can we see you? Good. So our panel is set. We will give the floor to them. Gloria, are you ready? Ok.

Ghana Health Service Presentation

Gloria Asare, Ebenezer Appiah: Thank you very much. Thank you, this is the Ghana flag welcoming you to Ghana. The outline: we will talk about a bit of introduction and background and then go into the training and deployment and working with different partners, challenges, and some actions we have taken to address them, and the way forward and conclusions.

Maternal and child health has been a priority of Ghana and we are looking at the attainment of the MDGs as a priority. Part of program of WIC, there is a whole objective of maternal, newborn, child, and adolescent health, family planning, and improvement of equity. Those are some of our sector objectives. Maternal mortality was declared a national disaster in 2008. We have had a lot of consultative meetings, which targeted OBGYNs and midwives. We have had a good training program for OBGYNs in Ghana, as you are aware. I think yesterday we spoke about them. The Carnegie people have been working with the West African College and now the Ghana College. We

have very good retention and high levels of training. We are working with the Ministry. The Ghana Health Service is an agency of the Ministry of Health. We are responsible for the public health services and we work in partnership with all stakeholders, like the teaching hospitals, mission, and the quasi-government hospitals, which are like the MINES, and the Military and Police Hospitals, with some NGOs, civil society organizations, and development partners. We do that to implement the health sector policies and strategies. The Ministry of Health agencies include the teaching hospitals and regulatory bodies such as the Medical and Dental Council and the Nursing and Midwifery Council. The Ministry of Health again provides the policy and the strategy direction for the health sector.

In the Ministry of Health, we have a human resources division, which is responsible for pre-service training and professional postgraduate training with the Ministry of Education. When it comes to the postgraduate training of doctors, it is with the Ghana College of Physicians and Surgeons. The Ministry of Health has also supported the training of OBGYNs in the past. There is a lot of support from the government and now it is left to the Ministry of Health budget. Now we have less money so there is a lot of rationing sort of going on. So the Ministry of Health actually supports the training of the endangered disciplines. They put money down for the endangered disciplines like psychiatry, lab medicine, etc. The agencies like the Ghana the Health Service and the teaching hospitals support their residents and those who do not have support, support themselves.

When the training is over, the ministry constitutes a committee that distributes the graduates among the agencies, like the teaching hospitals, the Ghana Health Service, the Christian Health Association of Ghana and Mission Hospitals. We all have quotas, and the quotas change. When they are given to us, the Ghana Health Service posts our specialists. The teaching hospitals deal with their own specialists and we post our specialist and other staff to the regions and the districts. In Ghana we have 10 regions and 216 districts. Under the districts we have sub-districts, which our communities. Those who want to go to the quasi-government facilities do so by resigning from the Ghana Health Sector or they go on secondment.

Yesterday, I picked some slides from Frank's presentation so maybe you can take them from memory. He had a slide showing the cumulative number of trained OBGYN specialists in Ghana, from when we were using just the West African College to 2008 when the Ghana College graduates also came on board. The numbers just keep increasing. There is also a map of Ghana showing where most of the obstetricians can be found. They are concentrated in the greater Accra and the Ashanti regions where we had two major teaching hospitals and also in the Tamale teaching hospital in Tamale there is a concentration coming up. And then we have some in some other regions like the Eastern region, the Western region, and other places.

I have a slide here on the number and ratio of selected health workers currently working in facilities per 200,000 population. This was taken from the National Emergency Obstetric and Newborn Care Assessment in 2010. We had a national one where we went to all facilities make at least five deliveries in a month. We did an assessment, and we saw the obstetricians and gynecologists in Ghana in those facilities, which was almost all facilities that deal with deliveries. We have 279 obstetrician gynecologists in total. What we think we need is at least 459; that is what the service providers in the managers said they needed. So, we have got a gap there. That gap represents two obstetricians per 200,000 population, and we want to have at least four obstetricians per 200,000 population. The distribution of OBGYNs by facility type facility type is also in the report.

This is what I just spoke about, that we did an assessment. I've circled the OBGYNs. You can see that there are not too many if you look at other service providers that we have. That is a number, and that is the ratio, which is showing that we still have a gap. They are distributed in the facilities. About 11% are in the teaching hospitals, 9% are in the regional hospitals, and 80% are in the district

or other hospitals, and these include private facilities. Forty percent are in the government facilities. Eight percent are in the religious or mission hospitals and 52% are in the private, for-profit sector.

The northern region does not even have one OBGYN in the Ghana Health Service. There are few obstetricians in the teaching hospital, but this graph does not include the teaching hospitals. So in total there are 55, and even the one in the upper West has gone to school. There is no obstetrician in the upper West region as we speak. Depending on the size of the hospital, we are supposed to have one to four in the smallest district hospitals and between four and six, and six and seven in the bigger district hospitals. In the regional hospitals we expect to have five to fourteen obstetricians in the hospital. We're still working on our staffing norms; this is a draft from the Ghana Health Service.

So we had been talking about communities. The Ghana Health Service exists primarily to ensure the health of Ghanaians and provide quality healthcare to all people living in Ghana. So everybody here, we are concerned about you. It is not only Ghanaians. So we have a cardinal goal to bridge all geographical barriers as much as possible. Things that prevent people from but accessing health services when needed. We have what you call the Community-Based Health Planning and Services Strategy (CHPS), and in this we are expanding this throughout the country. We place a community health officer or a community health nurse – a few of them have midwifery skills – in the community to do house-to-house visits and to provide services to the community and link them to the facilities. CHPS is bringing services to the doorsteps and also ensuring that the communities play their role and that we plan with them and they own their own health and contribute to this. Maternal, newborn, and child health, and family planning are all major parts of the CHPS operations.

We partner with the district assemblies. This has increased community participation and has increased in the CHPS zones. There is continuous production and availability of community health officers and nurses. We have zoned the country and we are improving what we call functional CHPS.

CHPS can be based in a compound that is very remote. You just have to put a compound in and the person will live there. We don't have to wait for compounds. Even in the urban areas we deploy people to the communities. So that is what we call functional CHPS. If you look here, this is a general doctor-population ratio of all doctors. It has been 1: 11,929 in 2009, and then it improved in 2011, and then went a little worse again in 2012. But when you look at CHPS, we are increasing in functional CHPS. Between 2011 and 2012 we increased the functional CHPS by 551.

We work with other healthcare partners. The OBGYNs, midwives, pediatricians need to work closely together with anesthetists and everybody else. We see that the work of anesthetists is also very important and the physicians. Teamwork should be at all places. It takes a lot of good teamwork to actually save lives. The Ghana Health Service works with Mission hospitals, quasi-government hospitals, and private providers, even though we don't do too much for the private providers because of some lack of funding. We need to do better - all of us.

We also work with professional bodies. We have something called Evidence for Action, which is an advocacy movement for MDG 5. We just last year launched Maternal and Newborn Health Professional Society, which includes the Society of Obstetricians and Gynecologists in Ghana, the Pediatric Society, and Midwifery Associations and this is being spearheaded by the School of Public Health.

We also have traditional and faith-based health providers that we have to sometimes contend with because they do things sometimes very differently from us. Some of our major challenges are that we have inadequate numbers and in inequitable distribution of staff. The factors for that are both within and outside of the control of the health sector. Not all of it is within our control.

The specialists are concentrated in the teaching hospitals and we have inadequate medical officers and general practitioners who otherwise would bridge in the gap. We have inadequate support for family planning, reproductive health, and community work among some of our obstetricians. There is inadequate multi-sectoral engagement in health. The measures we have taken to address them is this training and retention.

We are very happy that the trained OBGYNs have stayed in the country and are contributing a lot. We need policies and innovative strategies to attract service providers to the underserved areas and address some of the non-health factors by working with the district assemblies in others. We need to improve the quota of specialists to the Ghana Health Service, and we are working with the Ministry on that. To strengthen the collaboration with the teaching hospitals, we are doing a lot of that under the MDG acceleration framework. To improve private sector participation in multi-sectoral response and strengthen engagement with professional associations.

Some doctors have persistently refused to post to the relatively poor and low resource regions of Ghana. But we see that although the doctor to population ratio for the Ashanti and greater Accra regions look to be good, about 50% of those are in teaching hospitals. We need more consideration and commitment to explore sustainable strategies to improve doctors and midwives.

Our way forward is to strengthen and foster the involvement of OBGYNs and pediatricians in service delivery. We say that they should have select areas and own them, so they have to zone the areas where they are working – the communities and the districts – and work with them. So that the society and the communities we need to fill their presence in support. The MGD 5 acceleration framework is doing that with the teaching hospitals. We want to build capacity and support referral and referring facilities and also towards decentralizing training. We need a lot of mentoring, coaching, and improved monitoring and supervision.

Other goals are to strengthen teamwork and task sharing, strengthen and implement e-health, develop feasible policies for staff distribution, and disseminate the best practices. We do not intend to leave the private sector behind. We need to find ways to work with them. In conclusion, this is a good strategy, to have the 1000+ OBGYNs and their deployment is very important and should be linked to the communities. There should be support for innovation and other aspects in this program. The Ghana Health Service is happy to partner and to make this a success and have a real impact in Ghana and the other countries. We thank you for your attention.

Kwabena Danso: Thank you. We will follow the next presentation from Dr. Mulbah and his team. With permission, the Director General has then told me that he has been called by Chief Director of the Ministry of Health, so we will give him the opportunity to make his comments and then his deputy will still be with us.

Ebenezer Appiah – Denkyira: Thank you very much. I'm sorry for leaving you midstream. But the presentation is real. In Ghana we are making sure that obstetricians, apart from the institutions that they are in, will mentor other additional districts because they cast shadows downwards. It is important for them to create a real effect of excellence where they are, then invite the institutions around them, who will refer to them, and coach them in what they're supposed to be doing. We expect them to also go down there and train and coach with the maternal, therefore it is clinical or conduct research assessment. That would be the job of the obstetrician. They are also responsible to ensure everyone has the lowest level they give us, added to the messages that we give to the general public.

We are trying to ensure that every pregnant woman in Ghana and baby born is followed up and

linked to the next level of care. At the highest point is the obstetrician. We will challenge obstetricians to ensure that there should be district-wide zero maternal mortality. And I'll give them all the necessary support to be able to do that. This program is very important to us, and we will be following it with keen interest. Thank you very much.

Kwabena Danso: Thank you and with this I think we will say goodbye to the Director General. And now, Dr. Mulbah.

Liberia Team Presentation on Deployment and Capacity Building

Yvonne Butler: Hopefully, I am a prettier version of Dr. Mulbah. I am Yvonne Butler, and I am one of the assistant professors in the Baylor College of Medicine, Global Women's Health Program. I will be speaking on behalf of our team here, Dr. Stephen Kennedy and Dr. John Mulbah, and of course in the back, our esteemed Deputy Minister, Dr. Bernice Dahn. Before we start there is a silent partner who is sitting who I would really like to acknowledge. Dr. Susan Raine is the head of our Global Women's Health department and she actually supports me and allows me to be full-time faculty in Liberia. And my former Fellowship Director, Dr. Ben Chi, who was really great as a mentor and pushing me to explore whatever it is that I wanted to do in global health.

So we have three main objectives. I'm not going to take too much time on the context and guiding principles. You've heard a lot about this already. I'll try to focus most of this presentation on a roadmap for deployment and capacity building. I always like to start with the context and the reality is that women are dying to give life across sub-Saharan Africa. This was a picture taken in Liberia in 2006 by a Pulitzer Prize contestant. You all know about the Civil War and you know that there were lives lost, people internally and externally displaced, the country's infrastructure destroyed, and for our purposes here, the gains in maternal health prior to the Civil War were all reversed. So as you can see, Liberia's maternal mortality ratio trend in 1986 prior to the war was about 260 per 100,000 live births. There still needed to be major improvements, but we were heading there. At the height of the Civil War, the maternal mortality ratio had increased to 1900 per 100,000 live births. It currently stands – 2010 was the last date I have from the World Health Organization – at 770 per 100,000 live births. Now there have been some gains in improving this, but the reality of it is that we have a long way to go.

Liberia has the 8th highest maternal mortality ratio in the world and the 17th highest infant mortality ratio in the world. I'm not going to go over this again, but this is just a notation that the Liberian Demographic Health Survey, the last published one in 2007, placed the MMR at actually 994 per 100,000 live births. When you look at why the MMR is so high you find that there are a lot of different reasons. There are not enough skilled providers (this is again old data from 2007) but only 46% of Liberian mothers received any kind of assistance during their childbirth, and this is any kind of skilled provider assistance, not necessarily an OBGYN, but could be a midwife or trained professional in obstetric care.

What is interesting is that if you look at the residential distribution of Liberia, the vast majority of the population actually lives in a capital city. So you would think that access to health would be much easier and more available. Regarding our physician workforce capacity, the reality of it is that Liberia needs a lot of physicians. The Ministry of Health And Social Welfare estimates that we need 893 additional residents to cover the current unmet need of Liberia.

So now given that context let me just focus on a bit on what our current guiding principles are. Our healthcare system is structured in a decentralized fashion, so at the most local level you have community health workers, followed by community clinics. Community clinics refer up to health centers, and the health centers you have a variety of trained cadres: physician assistants and nurses.

Health centers refer up to county hospitals, and county hospitals currently refer up to the national referral hospital in Liberia, which is currently the John F. Kennedy Medical Center. Our OBGYN educational structure first occurs at the University of Liberia, A.M Dogliotti School of Medicine. Licensing occurs through the Liberian Medical and Dental Council. And, of course, now we have the newly established Liberia College of Physicians and Surgeons, where our postgraduate program currently resides.

Again, this is already been reviewed so there is no need to go over it, but just to mention that the Ministry of Health has really been instrumental in making sure that this program was formed, created, and has funding. There are a variety of established licensing and professional agencies in addition to the Council, which provides your licensing. There is the West African College of Physicians and Surgeons, Liberia Chapter, which is now playing a key role in CME and continued faculty support, as well as the A.M. Dogliotti College of Medicine, which provides continued assistance especially during our first year.

Now on to why we are here, our deployment and capacity building. This is a really important quote from one of our current residents who was asked whether or not he could possibly see himself leaving the country once he was trained in Liberia and practicing in perhaps more lucrative places like Ghana or Nigeria. His response was, "When the bullets and bombs were raging night and day, we chose to stay. So why would I leave now? I plan to one day take on your role, so we can continue this process." I think that is really powerful and tells you that we are really on to something here.

The postgraduate program recently started in October 2013. There are four specialties, OBGYN, pediatrics, surgery, and internal medicine. There are four to five residents per specialty. Our curriculum is based on a Harmonized Ghana and WAHO model. Our residents, which for the OBGYN department we have five, will rotate amongst seven hospitals. There is a reliance on a variety of both local, sub-regional, and foreign professionals. There's funding from the World Bank, the Liberian Government, and WAHO. We are currently looking at other sources of funding, and of course there is an additional pathway for our residents to become certified with the West African College of Surgeons.

There are multiple regional and international partners. In addition to the West African Health Organization (WAHO) and our Ghana College of Physicians and Surgeons here, there is a West African College of Physicians and Surgeons, there are a variety of academic institutions, and there are also opportunities to expand and establish partnerships. The current chair Dr. Mulbah has done an awesome job in mobilizing his current resources. He heads the fistula program that provides a pathway for our residents to gain fistula surgery training. He also loves the University of Michigan, I have to put that there. He did come in with a maize and blue tie. I'm just saying.

What are we doing regarding faculty involvement? One of the interesting things that happened is that once we started this program, there was a reinvigorating concept regarding mandatory CME. Previously physicians were licensed, and their license would be renewed, but there really was not a structured step that states that they need to have a certain number of credit hours as a professional to maintain you license. So this is hopefully currently on the way. There are of course many research opportunities locally, sub-regionally, and internationally. There is faculty consultation. There are many times as a junior faculty when I may have an ultrasound or even a surgical pathology specimen that'll take a picture and send it over to Susan and say, "Please send it out and let me know what you all think." It is amazing, right? We, of course, get our patients consent, but it is really a way of having this electronic consultation. This also happens on the local level, where our private partners are now calling and saying, "Hey, I heard you guys have an OBGYN here. We have this question and we would usually handle it this way, but what do you think?"

Interestingly, one of our midwives recently said to me, "Doc, it seems like you guys are now all into these postgraduate things. What about us? What are you going to do about us?" This is exciting because it really means that people are buying into this idea that you have to have this academic stimulating environment, we are not just practicing to be practicing but it is actually based on sound evidence-based medicine.

There is a supportive faculty development through a number of avenues. The West African health organization supports exchanges for faculty development and there is also opportunities for international exchanges with various academic institutions abroad. There are plans for additional faculty support from various academic partners as well. So now rather than any one saying, "You know I heard about Liberia and I really want to help, let's fly down there and do something for two weeks," now there is a process where you have to contact the postgraduate program as a visiting faculty. There is now this process that is streamlines so you actually get good continued support and not necessarily the run-of-the-mill, mission, type of support.

Our community development is also growing and the postgraduate program was built on this rotational structure that allows communities to access medical services based on evidence-based medicine. So what does that mean? It means that our residents are deployed into our more rural sites, they will then start to institute the concept of protocol and evidence-based care, rather than just practicing as they previously did. Other areas are also gaining access to additional training support, including maternal mortality awareness, emergency obstetric training, as well as implementation of various protocols.

That's it. Again, thank you and I'll give the microphone to Dr. Kennedy to see if he has any words.

Stephen Kennedy: Actually there is nothing else to say, but we do appreciate the time you took to listen to our presentation. We just wanted you to know that the Liberian program just started officially about 3-4 months ago. There is a lot of potential and we also are open to secondary partnerships and expansion, as she communicated. The ultimate goal is to strengthen the health system and also train and deploy manpower to meet the needs of the population of the country. Thank you.

Kwabena Danso: Thank you and I would congratulate you for taking the first step to start. A journey of a thousand miles, they say, starts with one step. So congratulations. So now we have Yirgu to talk to us.

Ethiopian Society of OB-GYN

Yirgu Gebrehiwot: Good afternoon. I am going to make a presentation based on the perspective of the Ethiopian Society of Obstetricians and Gynecologists, and what is really happening in Ethiopia. Postgraduate training in Ethiopia started about thirty-two years ago. Currently we have seven medical colleges or institutions that are conducting postgraduate training in obstetrics and gynecology at one or the other labor. The Ethiopian Society of Obstetricians and Gynecologists was established twenty-two years ago. There is a ten-year difference between the first postgraduate training in the country and the establishment of the Ethiopian society. Much of the impetus to establish a society came following the 1987 meeting on safe motherhood in Nairobi Kenya, when the famous statement, "Where is 'M' in MCH," was really articulated. The maternal health has been really been a missing element in maternal and child health. The whole purpose of establishing the society, which by then was around 70 or obstetricians, was to address the huge unmet need in terms of maternal health and the very high maternal mortality that was prevailing at the time. The mission and the vision stated was that ESOG or the Ethiopian Society would be collaborating with all

stakeholders relevant in the country in order to address the huge maternal mortality.

Currently the Society has one central office and has got seven chapters throughout the country. ESOG is partnering with a number of institutions, but the lead institutions are as follows: the first one is the Federal Ministry of Health, we are collaborating with the H4 Group, the UNFPA, the WHO, UNICEF, the World Bank, we are also doing CDC and other international NGOs. The other partners are the FIGO; we are collaborating with the University of Michigan, with Emory University, and also with the German Society of Obstetricians and Gynecologists. We have been quite active in the area of maternal health on a number of pointers, but because the area under discussion is what we are doing with the Ministry and with communities as a professional association, I'll try to cite some important examples.

Nationally, I would say that ESOG is a very important partner of the Federal Ministry of Health. As you know, or might know, we have a health sector development program. Which is a twenty-year plan with a cycle of five years, now we are into the fourth cycle of the Health Sector Development Program, which will address HSDP 4. The emphasis of HSDP 4 is to improve maternal and newborn health status in the country. Fortunately, Ethiopia achieved earlier MDG 4 and has made quite substantial progress with MDG 6, particularly controlling malaria, tuberculosis, and also HIV, with a rate of 2.1%. However, there is quite a challenge when it comes to MDG 5. The rate of change is about 4.9; the rate of decline is about 4.9% per annum, but this pace of change has to be accelerated, because to be on track to achieve the MDG 5, we will have to reduce maternal death by 5.5% per annum. There is a change, but the change is not enough and we have to really work hard.

ESOG in this perspective is a member of the National Task Force on Reproductive Health. It has been either elite or has collaborated with still developing policies, guidelines, and training manuals. To mention a few, we have developed material on comprehensive abortion care, we have developed a policy guideline on family planning, we have training material on basic emergency obstetric care, and we have a national guideline, which was essentially developed and owned by the Federal Ministry of Health own Gender Based Violence, just to mention a few contributions we have made to the national agenda.

We have also created a forum for dialogue on important issues and we have been quite instrumental in rolling out evidence-based intervention. To cite an example, back in 2010, we were instrumental in rolling out magnesium sulfate uptake in 107 public hospitals around the country. Before 2010, preeclampsia is worth being managed with diazepam, but we know the evidence was out there that magnesium sulfate was quite superior in terms of reducing morbidity and mortality and from preeclampsia.

In relation to working with communities, we have done a number of activities. We have more than 10 projects with more than 10 million Ethiopian investment on it. Just to give you some highlights, we are currently working on a PMTCT program, and in that, the current program is a PMTCT option B+. We have over 60 facilities, particularly these are private facilities throughout the country where more than 120,000 women per annum are getting screened, know their status when they are HIV-positive, and are linked to appropriate care with retroviral treatment and follow-up care for their newborns. We have also collaborating with the Federal Ministry of Health to improve access to comprehensive obstetric emergency care. Nationally, we have close to 300 obstetricians throughout, but we know that this is not enough for the whole country. In this venture, what we did was we did send young obstetricians who have graduated for six months to about 22 hospitals in hard-to-reach areas to stay there for six months, train in the first three months, mentor in the second three months, so that GPs and health officers are having the necessary life-saving skills to provide emergency obstetric care. By doing this we are able to train about 47 physicians and health officers to be able to provide life-saving procedures and more than 20,000 women so far have benefited by accessing

operative services. Otherwise these women would have either been transferred elsewhere or have severed morbidities and mortalities because of a lack of access to essential interventions.

We have three model clinics, which are now currently reduced to two. We hope to increase those model clinics to about five. These are model clinics on gender-based violence, and particularly catering to the need of women who are surviving sexual assault. These are highly specialized clinics that offer comprehensive medical care, psychiatric care, and provide necessary legal evidences so that victims can pursue proper legal course.

Regarding postpartum hemorrhage, which is a very important killer disease in our part of the world, we have worked on a manual for health extension workers. As you might have heard from yesterday's presentation by Senait, we are close to 38,000 health extension workers who are catering to the need of the community. The lowest level of the health system is a health extension worker and there are two female health workers catering to a population of about 5,000. So in that relation, we have developed a training manual for the health extension workers on how to use misoprostol in case of home deliveries and what to do in case a woman is going to encounter a postpartum hemorrhage until she is transferred to the next facility. That training manual is translated in three languages and is distributed throughout the region.

We are also working on family planning and have recently completed what is known as a Logic Project in Leadership in Obstetrics for Impacting Change. With this project we have introduced for the first time, maternal disease audits into the country where nine hospitals and forty-five centers were involved in a process of quality assessment and quality improvement by looking at maternal disease and near misses in their respective facilities.

We are working with a number of health professional associations. ESOG has established a consortium of professional associations involving public health associations, nurse associations, midwife and medical doctor associations, and anesthesiologists and anesthetist associations. Essentially what we do is sit, discuss, and make sure that there is no competition between these associations. In anyway possible we try to complement each other in activities. This is gone through quite a process of building trust, building confidence, and also creating a mechanism of transparency so that none of these organizations are in any way in some sort of conflict or competition.

In conclusion, I would say that the society of professionals in the society of obstetricians and gynecologists have become one of the leads partner organizations, with a proven track record in terms of improving maternal health in the country. I thank you.

Kwabena Danso: Thank you. We have a fourth presentation for this session before we move on straight to the next one. It is by the Medical International Team, Myron Aldrink.

Medical Teams International

Myron Aldrink: Thank you. My name Myron Aldrink with Medical Teams International. I just have two quick questions to answer. We are an NGO – we were probably the only NGO here, or at least on of the few here – so the first question is why are we at the meeting? And the second question is how can we support you in what you are doing?

We are honored to be here for three reasons. One is that Medical Teams International is a non-governmental organization that focuses on maternal health and also on trauma. By trauma we mean something like EMS, which is ambulances, how to transport people to the hospital, so that combination of maternal health and EMS trauma. The second reason is that we are also associated with the Medical Surgical Skills Institute at Korle Bu Teaching Hospital here in Accra. As you

probably know, the medical and surgical skills is designed to do continued medical education training to surgeons, doctors, nurses, and other medical professionals. This is in conjunction with Johnson & Johnson and other support.

The reason why that is important is because the MSSI is focusing on maternal health in the future. And the third reason is that we are honored to be working with the University of Michigan, with Frank and Vanessa on a research study having to do with task shifting across Africa. This is research that we are doing and we know that it is a sensitive subject to find out what countries are open to this, what facilities, and how we can do this. That is why we are here.
The second question is how we can possibly help where you are all doing. As Irwin mentioned this morning, there is sort of a triangle of healthcare where you have community health, regional districts, and in the tertiary and teaching hospitals. NGOs are primarily at the community level, but we realize that one of the key issues are the district and regional hospitals especially in maternal health. Our focus in the future will be on addressing the needs of the regional districts, whether it is the training, providing equipment or supplies for the facilities, and also the infrastructure – trauma care, the support and moving all of that.

Again, we are honored to be here, and we applaud you for what you are doing. As an NGO, how can we help support you as this all develops, especially in the regional district office? Thank you and if you have any questions, please see me afterwards.

Kwabena Danso: Thank you. At this juncture, we will move straight into the next panel discussion. That is on research, monitoring, evaluation, and quality/assessment.