Workshop on health care professional associations (HCPAs) and their role in achieving MDGs 4 & 5

November 2007
Blantyre, Malawi
Meeting report
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<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
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<tr>
<td>FMoH</td>
<td>Federal Ministry of Health</td>
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<td>HCP</td>
<td>Health care professional</td>
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<td>HCPA</td>
<td>Health care professionals association</td>
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<td>ICM</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MNCH</td>
<td>Maternal, newborn and child health</td>
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<td>SNL</td>
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Introduction

Maternal, newborn and child health (MNCH) is continuously threatened by poverty, weak health systems and lack of both material and human resources in many developing countries. Efforts to combat these problems to date have been segmented, focusing either on the mother, the newborn or the child. The mandate of The Partnership for Maternal, Newborn and Child Health (PMNCH) includes efforts to harmonize the work to achieve MDGs 4 and 5 at country, regional and global levels. In its attempts to increase collaboration and line of sight action, The Partnership for Maternal Newborn and Child Health has identified Health Care Professional Associations (HCPAs) as a key target group with which to work to improve the health status of mothers, newborns and children.

In August 2006, key representatives from international HCPAs and The Partnership met in Geneva to discuss ways to strengthen the role of HCPs at country level. Discussions centered on the need to strengthen the participation and role of HCPA's in MNCH policy and programme development. Participants of this meeting issued a Joint Statement to guide HCPs in their efforts to advance maternal, newborn and child health (Annex 1-Joint Statement).

Ways of maximizing HCPA contribution to the advancement of MNCH were further discussed during the first Partnership Forum held in Dar es Salaam, Tanzania, in April 2007. The importance of intra HCPA collaboration and cross constituency partnering was repeatedly demonstrated.

In this context, The Partnership secretariat, with guidance from the HCP Workshop Advisory Group¹, decided to develop a series of workshops to increase the contribution of HCPA's to MNCH. Four workshops were planned: two in Africa (one in the Anglophone and one in the Francophone regions), one in Asia and one in South America. The Partnership chose Malawi as the host country for the first workshop with participants from Ethiopia, Tanzania, Uganda, Nigeria and Malawi. This first workshop is to serve as a base model for subsequent ones.

This report outlines the planning process, presents a summary of the key proceedings and session recommendations, the outputs, perceived successes and challenges as well as suggestions to be taken into consideration during the development and implementation of the following workshops.

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¹ Members are representatives of The Partnership Board: the International Pediatric Association, the International Federation of Obstetrics and Gynaecologists, and the International Confederation of Midwives

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### Millennium Development Goal Four
**Target 1:**
Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

### Millennium Development Goal Five
**Target 1:**
Reduce by three quarters the maternal mortality ratio

**Target 2:**
Achieve universal access to reproductive health
Planning the Workshop

The planning process for the Malawi HCPA workshop began with a meeting in Geneva held from 4-10 July 2007. This meeting included the Malawi-based workshop coordinator, The Partnership secretariat team and external consultants, AED Consultants, Berengere de Negri and Suzanne Prysor Jones. The meeting identified a skeleton theme and objectives, a draft Agenda and set up an E-Forum to share information and strategize. Several notes, guidelines, templates and tables were developed to be sent to the different speakers or key panellists who were intervening during the workshop.

AED’s Berengere de Negri and Lennie Kamwendo were identified as co-facilitators of the workshop. The following is a report written by both, with input and finalization from organizer Kadi Toure of the Partnership secretariat. Co-facilitators’ terms of reference are presented in Annex 2.

Theme and Objectives

Numerous consultative telephone conferences and email exchanges with the HCP advisory group, consultants and The Secretariat staff produced the final conference theme and objective:

**Theme:** the Role of HCPs in reaching MDGs 4 and 5.

**Objective:** to increase the contribution of HCP Associations to national MNCH plans by strengthening their participation in policy and program development and increasing the alignment of activities to the national targets regarding the achievement of MDGs 4 and 5.

The attainment of this overall objective was contingent upon the realization of five separate specific objectives:
Five specific objectives:

1. Strengthen the role of HCP associations as *advocates* for MNCH and in *policy dialogue*;
   
   *Being an effective player in dealing with legislative barrier; improving drug use policies; advocating for MNCH funding, quality improvement measures)*

2. Explore HCP associations role in promoting *one country MNCH plan*;
   
   *Working together as good partners with the public sector to make this effective)*

3. Develop the role of HCP associations in *quality improvement*;
   
   *(Training; continuing education; monitoring / supervising standards of care; regulation and accreditation issues)*

4. Increase HCPA joint activities to address the human resources crisis with respect to MNCH;
   
   *(Advocacy for and development of new cadres; task analyses; revision of job descriptions)*

5. Strengthen *organizational aspects* of HCP associations to enable them to develop more fully their roles in the areas mentioned in objectives One to Four, and establish better partnering between associations and the public sector.

   *(Strengthening leadership, defining vision-plans-responsibilities, effective partnering with the public sector, harnessing energies of members, keeping HCPAs involved in key issues affecting MNCH)*

These five specific objectives became the areas of focus for the different workshop sessions and were translated into topics for presentations, panel discussions, and group work (Annex 3 Agenda).

**Output**

A key consideration in the planning of the meeting was the question: *How do we ensure that this meeting goes beyond a meeting to action?*

Follow-up action was identified to be as important as the exchange of information. As such, it was important to find a mechanism to ensure that "lessons learned" be adopted by the HCPs present and extend to the MNCH partners at country level. The organizing committee therefore identified the creation of a one- to two-year action plan as a key output of the conference.

The goal of the action plan would be to enhance the participation and role of HCP Associations in the five focus areas:

- Advocacy and MNCH policy dialogue;
- Supporting the one country MNCH plan;
- Improving the quality of MNCH care;
- Working together to address the human resources crisis;
- Strengthening the organizational aspects of HCP associations.

To ensure realistic targets action plan, guidelines were developed which asked participants to identify a restricted number of focus areas and activities, fill out rigorous templates requiring timelines and identifying responsibilities and potential support from international and regional associations and organizations. For further details on the organization and logistics of the conference, see Part Two: Planning the Conference.
The Workshop

The Opening Ceremony

The workshop proceedings began on Sunday, 11 November 2007 with participant registration, opening speeches and Malawian cultural entertainment. The welcome speeches from the Director of PMNCH, Dr. Songane and the Principal Secretary in the Ministry of Health (Malawi), Mr. Kan’gombe, set the scene for HCPs to examine their roles in saving the lives of women, newborns and children. Speakers asked the participants to focus on the similarities between the participating countries in terms of health problems affecting mothers and children and use those as a platform for collaboration during the workshop.

Day One

The Speeches

Dr Francisco Songane, Director of PMNCH presented the current situation regarding the attainment of MDGs 4 & 5 on a global scale and on a regional scale. Dr Songane listed gaps and areas of necessary intervention. Dr Songane emphasized the fact that health care professionals are key in making a difference and stated that this workshop should provide the needed impetus for change, noting that:

- there has been very little, and in some countries, no tangible progress in reducing maternal and neonatal mortality rates;
- coverage of the known MNHC effective interventions is low;
- there are inequities in the provision of MNCH services;
- existing resources could be used better and fragmentation still prevails;
- additional funds are needed, and;
- there is a crisis in human resources.(Annex 4 - Presentations).

The Director of Reproductive Health in Malawi, Dr Chisale Mhango, highlighted the government's MNCH policy in Malawi. Dr Mhango noted that there was no One MNCH Plan, but that its development is supported by current health reforms (Annex 4 - Presentations). He also noted that the health sector is funded through a Sector Wide Approach (SWAp) which will run from 2004 – 2010. The SWAp focuses on six pillars as follows:

- human resources;
- pharmaceutical supplies
- essential basic equipment;
- facility development;
- service delivery, and;
- policy and system development.

The Ministry has proposed to transfer child health services to the Reproductive Health Unit to facilitate One Plan for Maternal Newborn and Child Health and IMCI.

Malawi’s Minister of Health, Honorable Marjorie Ngaunje delivered the welcome address. Her own poignant and challenging experiences with some HCPs in Malawi served to provide insight into some of the problems which need to be addressed in order for mothers and babies to be saved. (Annex 4 - Presentations)
Presentations and panel discussions on the five focus areas followed this opening session.

Advocacy and MNCH policy dialogue

The presentation on advocacy by a participant from Malawi shared the efforts of a Midwives’ Association in advocating for the mobilization of material resources, noting that government can not fully provide all the necessary resources for the health sector. The presentation highlighted two issues:

1) the lack of trust of midwives in their association, and
2) the lack of collaboration among HCPs. (Annex 4 - Presentations)

The discussion pointed to a need to review the legal status and mandate of HCPAs, and the need to collaborate with governments as partners to achieve MDGs 4 and 5 as well as the need to encourage exchange visits and productive ideas between countries. It also highlighted the diverse activities that HCPAs undertake:

a) dialogue with government at quarterly intervals;
b) ensuring of standards of care;
c) the establishment of new programs that are aimed at providing appropriate care to vulnerable groups such as youth;
d) strengthening the public and private sectors to maximize results.

The recommendations outlined were that HCPA’s advocate for:

- a strong voice to be heard from professional associations;
- standards of care be agreed by governments;
- community involvement, participation and empowerment;
- resource mobilization for both private and government health facilities from government and corporate sectors;
- advocacy to children and youths be conducted through the school curricula.

Supporting one MNCH Plan

The One MNCH Plan presentation illustrated the case of Nigeria where such a plan and integrates services, including focused antenatal care, intrapartum care, emergency obstetric and newborn care, postnatal care, newborn care, feeding infants and young children. (Annex 4-Presentations)

The challenges included the bureaucratic structure of the government, the ability to access funding, incorporating vertical programs such as HIV and malaria and dwindling human resources. The presentation also stated that HCPA collaboration is a necessity for supporting a One Plan. The importance of follow up monitoring and evaluation was also highlighted.

Discussions centered on the issues that affect support provided by HCPAs to the one MNCH plan. It was agreed that HCPAs should focus on the following points:

- ensuring the existence of One Plan for MNCH;
- continuing medical education for staff in MNCH hospitals;
- appropriate funding and distribution;
- partnering with Ministry of Health, donor agencies and NGOs;
- collaboration and sharing of experience;
- private/public partnership;
- appreciating efforts of health care workers;
- emphasizing a change of attitude among health care workers and leaders;
- meeting patients’ expectations;
- partnering with: Federal Ministries of Health (FMoH), State and Local Government Authorities (LGAs) in developing and implementing ‘One Plan’;
Day Two

HCPAs and Quality Improvement

A Ugandan participant presented on how HCPAs can contribute to quality improvement. The presentation focused on the provision of community perspectives of MNCH care, in particular of the need for HCPs to view the community especially mothers, as partners rather than clients, in the attempt to improve the quality of care. Partnership was identified as a key element of long-term, sustainable quality improvement in regards to the ministries and the media in particular. The presenter also stated that HCPAs should partner actively with colleges of medicine, nursing and midwifery to develop curriculum, train cadres, do research, promote evidence-based practice and develop standards for education and practice.

The session on quality improvement also provided an opportunity for the Senior Research and Policy Adviser for the Saving Newborn Lives (SNL) programme as well as the Newborn Health Program Manager at Save the Children, Malawi, to share their thoughts on the role of HCPs in saving newborn lives and Kangaroo Mother Care (KMC).

The presentation outlined global progress on MDG 4 in comparison to that of Africa. It also related neonatal mortality burden with physician density in countries, highlighting the link between the two. The presentation provided information about scaling up effective interventions, pointing to the difference between the theoretical and real applications of integrated packages in the continuum of care. Finally the presentation listed some of the ways in which HCPs could help minimize neonatal mortality through providing technical support for national planning for public health policy, auditing deaths and quality of care and advocating and promoting accountability among others. The presentation also covered the ingredients for quality care which include the three “Ss”: staff, sites and supplies.

The last presentation covered the collaboration for scaling-up Kangaroo Mother Care (KMC) in Malawi. It listed the advantages of KMC which include the provision of warmth to the baby, frequency of breastfeeding as well as early discharge from hospital. The presentation outlined the need for KMC in Malawi and detailed the role played by HCPs as champions in setting it up.

The need for government leadership and community support was also highlighted as were the achievements of the KMC programmes, especially in terms of policy and training and implementation. In Malawi, KMC is now a government policy and has been incorporated into the Road Map for Accelerating the Reduction of Maternal and Newborn Mortality and Morbidity, with 6 referral sites implementing KMC and plans under way to scale up the use of KMC in all hospitals in the country. (Annex 4-Presentations)

The panel discussed the need to examine gaps in service delivery and determine the goals for child mortality, maternal and perinatal audits. The primary recommended was that the HCPA role centre on mobilizing material resources necessary for quality MNCH care. Other recommendations included:

- forming perinatal fora to discuss perinatal issues;
- providing regular feedback and focus on monitoring and evaluation.

- providing community perspectives of care;
  - viewing community as partners as opposed to clients,
  - soliciting perspectives of mothers about quality care;
- partnering with the Ministry of Health to ensure that quality improvement policies and programs are included in MoH work plans;
- working together to foster a horizontal integration of quality improvement in the continuum of care;
- actively partnering with schools in curriculum development and training of cadres;
- promoting operational research, evidence-based practice and standards and guidelines.
HCPAs and the Human resources crisis

The ACCESS Community Interventions Specialist presented on the program’s collaboration with the HCPs. The presenter reviewed ACCESS initiatives which include: prevention of postpartum haemorrhage, newborn survival (including KMC), malaria in pregnancy, pre-service education and the Safe Birth Africa Initiative.

The presentation then highlighted ACCESS’ work with the Association of Ethiopian Nurses and Midwives to improve skills, 1 resolve the human resource crisis as well as collaborate with the Ethiopian Society of Gynaecologists to strengthen emergency obstetric and neonatal care. (Annex 4-Presentations)

The ensuing panel discussion identified the following as necessary action points for HCPAs:

1. take the lead in solving the health workers crisis through education, advocating for higher wages for health workers, working to help change attitudes, offer technical assistance in their management and help to secure resources for training;
2. promote continuing education for HCPAs by advocating for post graduate education;
3. work to improve working environment in the health sector by advocating for and improving work environments (infrastructure and protective gear) and funding and remuneration for workers;
4. support HCPA members by encouraging innovation and speaking in a united voice for members and the community.

Group Work Session 1

During this session participants were divided into country groups and asked to identify priority areas of intervention out of the five focus areas that would serve as the basis for their action plan. The choice of these areas was to be based on the critical need for reform and ability to impact on other areas. Here, participants tended to go beyond the mandate and identify activities.

Associations, Unions and Councils

A presentation was made to clarify the differences between of associations, unions and councils, their distinct responsibilities, boundaries and interactions.

Day Three

Organizational Strengthening of HCPAs

The presentation focused on the strategy to strengthen the Society of Gynaecology and Obstetrics of Nigeria (SOGON). The presentation described the activities undertaken which included: active membership drives; regular meetings and conferences; collaboration; the use of advocacy; the development of leadership: standing committees, ad hoc committees and partnership with the public sector. It also outlined challenges faced by SOGON which included: funding challenges; the increased participation of women professionals; the lack of administrative staff and voluntary membership.

The panel discussion allowed HCPAs to share their successes and challenges. Common strands included: commitment to quality care provision; striving for continued professional development through in-service training and conferences; working with the media and affiliation to international organizations such as the International Federation of Gynaecologists and Obstetricians (FIGO), the
International Confederation of Midwives (ICM), and International Paediatric Association (IPA). Almost all the HCPAs collaborate with NGOs, development partners and governments.

Challenges included: registration and accreditation of some HCPAs as legal entities; bureaucratic government processes; moving from the hospital to community interventions; HCPA membership; lack of publications and inadequate communication at country level between HCPAs as well as with the Ministries of Health.

The panel discussion also highlighted the following:

- each HCPAs has strengths and weaknesses, but all of them need strengthening in some aspects;
- lack of infrastructure is a major setback for all HCPAs and should be seen as a priority;
- communication among HCPAs is essential within the country, regionally and internationally;
- communication with other constituencies at country level is crucial.

The panel also made recommendations to The Partnership as follows. The Partnership should:

- help with procurement of infrastructure by/for HCPAs;
- facilitate communication between HCPAs at country, regional and international levels;
- facilitate communication between HCPAs and members of other constituencies;
- feedback to The Partnership Board about HCPAs issues.

Group Work Sessions 2 and 3

Participants were divided into country groups to develop their action plans, incorporating immediate action steps, responsible parties as well as individual responsibilities. This session included interventions from international and regional organizations. Action plans were sharpened. Participants seemed satisfied with the level of support and with the outputs.

Day Four

Country Action Plan Presentations

During this half day session, participants were asked to share their action plans (Annex 4 - Summary of country action plans).

Blantyre Declaration of Commitment to MDGs 4 and 5

A declaration to reiterate the commitment of the participating HCPs to playing their part in achieving MDGs 4 and 5 was revised by the group and signed (Annex 6 - Blantyre Declaration).

The "Parking Lot"

The parking lot was used by various participants. Some international organizations such as ICM, UNICEF used it to indicate the kind of support that HCPs can reasonably expect from them. Some issues which were raised but unanswered during the were also parked.

These included:

- the notion of competency based HCPA training and its necessary link to skills and knowledge development as essential to the provision of MNC health care was discussed and parked;
ICM described their twinning project which seeks to strengthen weak Associations through exchange visits or electronic communication with strong Associations;
a debate on training of Ethiopian health extension workers (HEWs) also took place.

The International and Regional Associations and Agencies Panel

This panel provided some representatives of international and regional associations and agencies (International Confederation of Midwives, international Pediatric Associations, Council of International Neonatal Nurses and UNICEF) with the opportunity to share their areas of intervention and describe the support that they have available. (Annex 7- Summary of International/Regional Association/Agency Intervention)

How PMNCH can help in achieving action plan targets

During this session a presentation was made which outlined the support that The Partnership is able to provide to the HCPAs in order to facilitate the achievement of the goals outlined in the action plans. These areas of potential intervention consisted of technical support, especially in regards to the identification of sources for funding and in proposal writing; advocacy (lobbying on behalf of HCPAs) and facilitating communication among HCPAs and between HCPAs and members of other constituencies among others. The presentation also underlined the need for follow up and reporting on action plans. Partnership expectations of meeting participants included:

- quarterly reports;
- development of in-country follow up mechanism;
- creation of country management teams, continued networking among HCPAs within and among countries and “walking the talk” – translating the action plans into reality (Annex 4 - Presentations).

Closing remarks

In the workshop closing remarks, Lennie Kamwendo, workshop co-facilitator, reminded participants that they had come as individuals but also representing differing HCPs and nationals of various countries. However, they should return to their countries as collaborative teams, working together towards the common goal of reaching MDGs 4 and 5. The workshop provided a rare opportunity for them to reflect on their past roles as HCPs, discuss key issues in MNCH, socialize and form new networks.

They were left with a modified quote from the “Women Deliver” conference: “If you want to go fast, go alone, if you want to go far, go together, for our mothers, newborns and children, let us go fast and far.”
Conclusion

The following were the identified successes of the workshop:

- **a good participation** regarding the number of participants, the quality of participants, representatives from the Ministry of Health and international organizations, and leadership of The Partnership; strong engagement by the participants;
- **the sharing of information** was considered excellent, through presentations, panel discussions, exhibitions and networking/social opportunities;
- numerous pledges of technical assistance;
- annual work plans were developed by country teams;
- the articulation of achievable goals and activities, and identification of personal responsibility to achieve the goals resulted in strong commitment and satisfaction.

Recommendations included:

- The development of a common definition of the terminology, especially that used to classify discussion areas.
- A greater focus on organizational strengthening with discussions built around the following questions:
  - How are you organized?
  - What are your roles, functions?
  - What is the association vision?
  - What needs to be done immediately?
  - What is the legal status and issues of the association?
  - What are its structure, resources and principal activities?
  - What are the members’ role?
    - Who are your members? How many are they?
    - What do you expect from the members?
    - What do they expect from you (association)?
    - What are your strengths and weaknesses, challenges?
  - What expectations are there from the members, regarding dues etc?
  - What help do you need?
    - data base; communication; infrastructure; collaboration; funding.
- Greater focus for the topic of quality improvement, namely on the following:
  - establishment of standards and guidelines;
  - lobbying the government for standards of care;
  - development of training curriculum;
  - audits of association strengths and weaknesses and of clinical practice.
- Greater consideration for the issue of follow up.
Part Two: Planning the Conference

Logistics and Format

Numerous consultations led to the identification of the workshop format. It was esteemed that in order to achieve the overall objective of this workshop, information about problems and challenges faced by HCPAs would have to be enumerated and analyzed. It was also determined that reachable solutions could only be identified by those who would be responsible for implementing them and following them up. These observations indicated a strong need for a highly interactive workshop with a focus on HCP assessment of problem areas, challenges and potential solutions.

Presentations of success stories or examples

The format of the workshop was devised in such a way as to provide opportunities for participating countries to share a success story pertaining to the role played by the HCPAs in the success as well as highlighting best practices or lessons learned. Each focus area provided a representative with the opportunity to present the achievements of its country pertaining to that specific area. This strategy provided for substance for discussion by the panels and also allowed for cross-fertilization of ideas (Annex 8 - Guide notes).

Panels and plenary on each of the objectives

A Panel discussion (with 4 panelists consisting of representatives from different professional Associations, Agencies and/or organizations) followed each presentation. Panel chairs and their panelists were introduced to each other before the meeting and asked to share areas that they wished to cover during their time on the podium. Question and answer sessions followed each panel and recommendations on the focus area in question were recorded (Annex 8 - Guide notes).

Country group work

Country group work followed presentations and panel discussions and consisted in identifying focus areas of interventions for the HCPAs in the various countries and the development of action plans for those focus areas that would result in increased HCPA contribution of MNCH planning. Country groups consisted of the HCPAs and public sector representatives from a given country. Representatives of international associations and agencies floated between the different country groups and facilitated some of the discussions. Country group work was divided into three sessions which were the key fora for the development of action plans: The first two sessions focused on selecting 2 or 3 of the 5 growth areas for HCPAs associations. Groups were asked to:

- articulate a vision for each objective selected
- identify current obstacles to reaching the vision
- select 3-5 priority actions that country teams agree to pursue in the next 1–2 years: linking identified actions to their country’s current MNCH plans;
- develop and implementation plan for the actions (who, when, how); plan should indicate how associations can work together in the implementation of the actions.

During the third working group session, country teams were to outline the support that they need from regional and/or international bodies to facilitate the implementation of the identified activities (Annex 9 - Country Group work template).
Information display sessions

Participants were asked to bring information about their organizations and/or activities related the HCPA and/or MNCH. During the evening of the second workshop day, participants put up and manned information booths. This provided the workshop attendees to learn about the different activities that are undertaken in the various countries and provided a time for sharing of ideas and best practices. This also provided the opportunity for those members that did not make a formal presentation to share their experiences.

The Parking Lot

The Parking Lot consisted of four flipcharts, posted in the corners of the room where participants could write issues or questions that they wanted answered but could/would not raise during the session. During the course of the workshop time was set aside so that the issues raised in the Parking Lot could be addressed.

The visit to the Kangaroo Mother Care (KMC) Unit at Queen Elizabeth Central Hospital

As an extracurricular activity some members of the group were taken to the KMC unit at Queen Elizabeth Central Hospital. They reported on their visit to the entire group, stating that the initiative in and of itself should be considered a positive example to be replicated in other countries. However they did note inadequate staffing and lack of entertainment for ward patients.

Identifying Workshop Participants and Presenters

Five countries were identified for this workshop. The series of workshop which is to include an Anglophone, a Francophone, an Asian based and a Latin America based workshop began with the Anglophone. Countries were chosen based on the language, MNCH indicators, presence of HCPAs at country level and variability of experiences in the focus areas for a greater cross learning.

Based on the expected outputs of the meeting, the organizing body decided that it was capital to have a representative from each of the HCPA associations groups (i.e. paediatrician, obstetrician/gynaecologist, nurse, midwife and pharmacist). There was a stated preference for HCPAs that are members of the following international organizations: International Confederation of Midwives, International Council of Nurses, International Federation of Gynaecology & Obstetrics, International Paediatric Association, International Pharmaceutical Federation and the Council of International Neonatal Nurses. Presence of national HCPAs who are members of the aforementioned international HCPAs would have allowed not only for inter-national HCPA cooperation but would have had the advantage of adding the national-regional-international HCPA collaboration dimension to the discussions.

Criteria for the HCPA representatives are as follows:

- be involved in public health;
- so as to be in a position to provide inputs on how to better align HCPA actions with national programmes;

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2 The original idea consisted in having two representatives from each of these associations, one senior and one junior, but numbers were reduced due to budget constraints.

3 Pharmacists were very difficult to find and invite; only one pharmacist came to this workshop.
• attest to having time enough before and after the workshop to prepare and follow up on issues and actions;
• be willing to either make a presentation during the course of the workshop or participate in panel discussions;
• be able to effect change in their own working environment, at community and national level to improve outcomes for mothers, newborns and children;
• be able to implement education and training programmes for their colleagues;
• be of different levels of experience.

In addition country delegations were to include one high level public health official. This person was to preferably be a member of the Ministry and have the following qualifications:

• have major responsibility for maternal, newborn and child health in the country;
• be a senior decision-maker, who interacts with the professional associations and with national planning processes as part of his/her daily work;
• be in a position to follow up on actions identified during the workshop.

In addition members from international and regional organizations and agencies were invited (Annex 10 - Participants list) as resources and presenters.

The process of identifying and communicating with participants was extremely challenging partly because of weak or non-existent networks as well as poor communication between international-regional-national level HCPs, HCPs in different countries and among HCPs within the same country. International level HCPAs were asked to identify their country level members. Once this information was available to the organizing team proceeded to contact the presidents of the national chapters of the HCPAs in order to identify participants.

Because of the difficulty in obtaining responses from participants, the organizing team used diverse sources of information often asking for the same contacts to be made by the Ministry of Health, UN country offices, regional bodies and so forth. This way of proceeding in many instances facilitated access to some participants. A total of 56 participants were able to attend. Additions were made to the participants as some interested parties requested that they allowed to attend. In the case of this workshop, their addition was a positive one, however one should take heed as inviting observers adds to the number of participants thereby reducing the number of opportunities that the original participants have of speaking, increasing the number of constituencies and possibly broadening discussion, which can be both positive and negative.

Evaluation of the workshop by the participants

A daily evaluation was conducted during the workshop, involving, each day, two volunteers among the participants. Every day, the participants were asked to fill a short evaluation form, in an anonymous way. The form had two sentences that needed to be completed by participants. (1) Today, what I liked most was…. (2) Tomorrow, I wish….

Daily evaluations allowed the co-facilitators and meeting organizers were able to judge (a) if participants were “on track”, (b) what could be changed, adapted based participants’ needs.

Overall, participants expressed their desire “to continue as is”. This was repeated each day. They particularly liked the panel discussions and country group work, which we did in the afternoon of day two. They particularly liked the dynamism of the group and requested more time for comments from the floor. Each morning, the two volunteers presented the overall results, which were followed by additional comments by the participants if necessary.
A final, more elaborate and structured evaluation (Annex 11- Final Evaluation form) was conducted on the last day of the workshop. There too, the participants rated the different workshop elements very highly. On a scale of 5 (5= like very much; 1= not at all), about 65% of all ratings (based on 14 questions) were marked 5, displaying great satisfaction. Almost 30% of entries were rated with a high score of 4 and the rest, (~7%), 3. Only one person rated a 2 in the entire evaluation form.

![Evaluation rated by Participants](image)

The great majority enjoyed discussions, questions and answers between the participants, panellists and facilitators. Approximately 75% found that the workshop met its objectives and provided an opportunity for exchange and contact development among same country participants. They also valued the development of their action plan and the facilitator’s role in helping them to stay realistic.

Additional open ended questions were asked in the evaluation (Q 14-Q18).

- Responding to the question regarding logistics and arrangements (Q 14), participants expressed their high satisfaction with the hotel and food arrangements, and the support given by the organizers and co-facilitators. The main complaint was the administration of per diems in USD travel checks. Participants were charged high commissions for their transactions at the bank.
- In regards to the question related to what participants found most valuable in the workshop (Q 15), participants agreed that the panel discussions, question and answer sessions and country group work were the most appreciated approaches.
- When asked what not so useful during the workshop (Q 16), the majority of the participants said that everything was important. One person mentioned that the information display session was not so interesting, but s/he added that it was more due to its organization.
- This comment leads to the next question (Q 17) which asked how the workshop could be ameliorated. Several suggestions were given, such as having a 5-day workshop instead of 3 and half; have clearer and more focused objectives; and changing the sitting arrangements in the room.
- Finally, the website idea (Q 18) was very well accepted and desired by almost all the participants. Annex 12 -Evaluation Results provides more detail about specific results and comments collected during the evaluation.

**Workshop logistics**

The meeting was held at the Protea Ryalls Hotel in Blantyre. Participants were lodged at the meeting venue, which facilitated after workshop group work, and dining together. The hotel had all of the necessary amenities and hospitable staff.

The entire workshop was conducted in one very large meeting room. During the country group work sessions, countries were assigned different tables. This allowed the facilitator and international and regional representatives to walk freely and listen to the different discussions without having to leave the room. It also allowed the participants from different countries to share among each other as movement was not restricted. It is however necessary in this case for the style of activity to change frequently to avoid a dip in participant interest and attention.

Coffee and tea breaks and lunch were held outside. This provided a needed change in scenery which kept spirits up. The information display sessions were set up in a lounge area which consisted yet again in another change of scenery that kept interest alive.
Organization of the meeting was split between The Secretariat, the local facilitator and the local WHO office. Lack of regular discussions resulted in a few complications:

- The hotel received different information from different sources, thereby resulting in an issue with the number of rooms reserved and with the length of meeting room reservations.
- Per diems for the participants were paid out of Geneva in the form of USD travellers checks and were transported to Malawi. This resulted in participants being subjected to high fees and exchange rates.
- An allotment was made to the Malawi office covering only hotel costs. This raised issues as there was no flexibility in use of funds on the ground. Requests for payment for unforeseen expenses such as transportation for the Minister of Health and other emergencies had to be routed through Geneva. This arrangement was inefficient.

Recommendations included:

- having a specific administrative focal point in the country office responsible for handling all of the in country issues;
- allotting a fixed percentage of the budget to cover all in country costs + contingencies
- having weekly update meetings;
- having only one interlocutor for external service providers (so as not to give different instructions);
- identifying speakers earlier;
- improving communication between the workshop Coordinators and participating HCPs/HCPA;
- avoiding the issuance of per diems in travellers checks;
- organizing site visits;
- asking each invited country to prepare and come with a country assessment, including a snapshot of the country, a profile of the HCPs and their numbers in the country;
- providing details of the structure of PMNCH, its constituencies, board members and modus operandi;
- providing details of the international and regional associations at the workshop, including their actions and contact details;
- ensuring government presence from each country at the workshop;
- considering representation from the community/care receivers can be powerful agents to change attitudes.