EVALUATION OF REGIONAL WORKSHOPS AND FOLLOW UP ACTIVITIES TO STRENGTHEN THE ROLE OF HEALTH CARE PROFESSIONAL ASSOCIATIONS IN ACHIEVING MDGs 4 AND 5

Evaluation conducted by
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List of acronyms and selected abbreviations used in this report

AFSOG  Afghan Society of Obstetricians and Gynaecologists
AMA   Afghan Midwifery Association
CHS   Community Health Sciences
CSAPs  Country specific action plans
DRC   Democratic Republic of Congo
EPS   Ethiopian Paediatric Society
ERC   Ethical Review Committee
FIGO  International Federation of Gynaecology and Obstetrics
FMOH  Federal Ministry of Health
GPs   General practitioners
HCPAs Health-care professional associations
MDGs  Millennium Development Goals
MOH   Ministry of Health
MOU   Memorandum of understanding
NGO   Nongovernmental organization
ORS   Oral rehydration solutions
PMNCH Partnership for Maternal, Newborn & Child Health
RBM   Results-based management
RMNCH Reproductive, maternal, newborn and child health
SOGC  Society of Obstetricians and Gynaecologists of Canada
TAMA  Tanzania Midwives Association
UNICEF United Nations Children’s Fund
US$   United States dollar
WHO   World Health Organization

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EXECUTIVE SUMMARY

Introduction

Many low- and middle-income countries are not on track to reach the public health targets set out in the Millennium Development Goals (MDGs). Research has indicated that health-care professional associations (HCPAs) can greatly contribute to the achievement of MDGs 4 and 5. However, these associations are weak and uncoordinated. Therefore, in line with the HCPA Joint Statement, the Partnership for Maternal, Newborn & Child Health (PMNCH) organized three regional workshops in response to: (1) the growing recognition of the potential role of HCPAs in addressing the human resource crisis; (2) a commitment by international HCPAs to collaborate on strengthening national HCPAs and increase their ability to engage in advocacy activities; and (3) a need to increase involvement of HCPAs in planning and implementing programmes and polices related to reproductive, maternal, newborn and child health (RMNCH).

The three workshops were held in November 2007 (Blantyre, Malawi), March 2008 (Ouagadougou, Burkina Faso) and November 2008 (Dhaka, Bangladesh). They brought together representatives from national HCPAs involved in RMNCH service delivery (pharmacy, nursing, midwifery, obstetrics and gynaecology and paediatric associations), public-sector representatives and other key stakeholders. Their aim was to enhance the role of HCPAs in achieving MDGs 4 and 5.

PMNCH structured the workshops around five key growth areas: (1) advocacy; (2) human resource; (3) organizational strengthening; (4) service quality improvement; and (5) RMNCH planning. The 17 participating countries were: Afghanistan, Bangladesh, Burkina Faso, the Democratic Republic of Congo (DRC), Ethiopia, Haiti, India, Malawi, Mali, Myanmar, Nepal, Niger, Nigeria, Pakistan, Senegal, Tanzania and Uganda.

This report assesses the regional workshops at three levels: (1) the achievement of the overall workshop objective, which was to increase the capacity of national HCPAs to contribute to the development of national RMNCH policies and programmes; (2) interactions between and among HCPAs, ministries of health (MOH) and development partners; and (3) the implementation of country specific action plans (CSAPs) defined during the workshops.

It is to be noted that points (2) and (3) move towards the achievement of the overall workshop objective. The report also focuses on the factors facilitating and inhibiting implementation of the original workshop objectives, and makes suitable recommendations.
Methods

The evaluation team used both quantitative (web survey to all participants) and qualitative research techniques (desk reviews of available documents and sample key informant interviews). 195 participants attended the three workshops – 58 in Blantyre, 59 in Ouagadougou and 66 in Dhaka. There were a further six participants from PMNCH and six representing the advisory board to the PMNCH. The latter were salient senior representatives from international HCPAs involved in direct coordination, organization and follow-up of regional workshops along with PMNCH. It should be noted that the evaluation was hampered by difficult communications (poor internet access and telephone connectivity) and lack of baseline information on national HCPAs.

Themes and recommendations

Recommendations are discussed under seven themes, which evolved by converging evidence from all three data sources (triangulation of data).

1. PMNCH support

   PMNCH support was mentioned in all three data sources as a main source of encouragement to move forward in the implementation of CSAPs.

   Recommendation: PMNCH should consider where it can most usefully support future workshop participants in implementing their actions plans.

2. HCPAs, MOH and United Nations agencies: individual roles and need for coordination

   Several respondents noted the need for a more integrated and coordinated approach to enhancing HCPAs’ capacity to implement CSAPs and contribute to RMNCH. This applied at all levels, from health ministries and international agencies down to individual HCPAs.

   Recommendation: PMNCH and HCPAs should develop a joint strategy for more effective coordination in future. The focus should be on areas they can influence directly.

3. Financial constraints

   Survey participants from Bangladesh, Myanmar, Burkina Faso, Mali, Niger and DRC all pointed out lack of funding as a major impediment towards taking CSAPs forward. Interviewees from the advisory board, DRC and Haiti mentioned financial constraints as a major barrier to the accomplishment of targets laid out in the CSAPs.

   Recommendation: PMNCH should consider earmarked funds for follow-up activities, a funding assessment checklist for each CSAP, and the potential of additional funding sources.
4. **Ownership of the process: delegation of a full-time focal person to provide leadership**

   The survey respondents from *Uganda and Bangladesh* mentioned lack of personal involvement and failure of focal persons as major factors impeding implementation of CSAPs. Other feedback supported the view that ownership of the process and dedicated human resource are essential for post-workshop follow-up.

   **Recommendation:** PMNCH should consider the appointment of a focal person for each country during the pre-workshop planning phase, avoiding senior people who may be too busy to do the job properly.

5. **Communication strategy**

   Lack of clear lines of communication between PMNCH, development partners and HCPAs was referred to as a weakness of CSAP implementation by interviewees from the advisory board, *Burkina Faso* and *Bangladesh*.

   **Recommendation:** PMNCH should ensure that appropriate communication methods are used for each country, and that post-workshop communications are well-coordinated and integrated across stakeholders.

6. **Regular supervision and monitoring**

   A survey respondent from *Mali*, interviewees from the advisory board and nine out of 13 interviewees from the Dhaka workshop all said that regular supervision and monitoring were needed.

   **Recommendation:** PMNCH should consider adopting a results-based management (RBM) approach for future workshops.

7. **Realistic action plans**

   Nine interviewees (four from the advisory board, four from *Pakistan* and one from *DRC*) said that workshop objectives could not be implemented unless CSAPs were realistic.

   **Recommendation:** PMNCH should look closely at how CSAPs are framed during workshops, and ensure that lessons learned are carried forward to future workshops.

8. **Proposed conceptual framework**

   Without strong and sustained follow-up by PMNCH, and a clear sense of ownership and commitment by HCPAs, it seems possible that the current workshop model will continue to under deliver.

   **Recommendation:** A new conceptual framework (Figure 1) could serve as a useful reference when planning similar activities in future. It integrates most of the recommendations made in this report, linking the original idea of regional workshops with the final desirable impact.
**Limitations of this Evaluation**

Our evaluation was hampered by poor internet access and telephone connectivity and a lack of baseline information on national HCPAs. Also, a proper analysis of impact requires a comparison group. The absence of control HCPAs and an adequate sample size impaired assessment. The only source of the “before status” of RMNCH initiatives was anecdotes from interviews (with the element of recall bias) and desk reviews. These offered little for baseline comparison.

Although the desk reviews provide mixed evidence, most interview participants did not link their country’s post-workshop activities with the PMNCH workshop. Almost all interview respondents mentioned that an evaluation conducted after a lapse of time (about 24 months) was not feasible and evoked a recall bias.

Moreover, legal and contract-issuing procedures took time, which delayed the start of the evaluation. Direct face-to-face communication with the workshop participants was not possible and it was realized rather late that there would be a poor response to web surveys and phone connections. Aga Khan University does not have readily available direct international telephone connection points, so initially the evaluation team had to use mobile phones to schedule interviews with the workshop participants. Further challenges were posed by time differences across zones and the need to hire a French-speaking consultant to conduct some interviews.

**Conclusions**

This evaluation suggests there may be limitations to the current workshop format as a tool for enhancing the capacity of HCPAs to contribute to RMNCH plans. On the positive side, the workshops generated goodwill, raised awareness of key issues and led to increased interaction between HCPAs. On the negative side, most countries (88%) were unsuccessful in fully implementing their CSAPs and achieving the three key workshop objectives, while post-workshop activities were bedevilled by a range of difficulties.

In future, the challenge for PMNCH is to ensure that workshops are more successful in meeting all their objectives – and especially that of increasing the capacity of HCPAs to contribute to the development of national RMNCH policies and programmes. The proposed conceptual framework in this report outlines an approach that might achieve greater impact, and ultimately lead to better health outcomes for women and children.

Based on this report, we feel secure in saying that these sorts of workshops can be used in the future for increasing interactions among the HCPAs. In fact the regional approach is better in the light of given country level constraints provided that the elements of our proposed conceptual framework are taken into account. Finally, we
found that country level advocacy was good in Burkina Faso and Niger (+++ on our scale) and helped in achieving the CSAPs. Therefore in our opinion workshops can encourage country level advocacy if MOH is involved as a major stakeholder during the implementation phase.
1. Introduction

This assessment centres on a key theme in RMNCH – the significant potential of HCPAs to accelerate progress towards MDGs 4 and 5. To a large extent, they do this individually through their own efforts, often in difficult and resource-constrained circumstances. However, they can potentially achieve much more by collaborating closely across disciplines and with their international and regional counterparts. In particular, by adopting a joint agenda for advocacy, they will be able to exert more influence over the development of national RMNCH policies and programmes. By influencing policy, they can help improve health outcomes for millions of women and children.

The World Health Organization (WHO) 2006 World Health Report and other sources recognize the role of collaboration between different elements of the health workforce in strengthening health systems.\(^1\) HCPAs are key partners in this process.\(^2\) However, many low- and middle-income countries have weak and uncoordinated HCPAs and are set to miss the MDGs’ public health targets, including those relating to MDGs 4 and 5.\(^3\)

To tackle this problem, international HCPAs are gradually taking on a leadership role, in partnerships and individually, to ensure their associations become more heavily involved in RMNCH efforts.\(^4\) HCPAs can be effective in several important areas, including advocacy, community mobilization, evidence gathering and the development and implementation of national RMNCH plans and policies. Awareness raising and team building are also key roles.

The three regional workshops that are the subject of this report were organized by PMNCH to assist HCPAs in these areas. The overall objective was to help them increase their capacity to contribute to the development of national RMNCH policies and programmes – with the ultimate aim of achieving MDGs 4 and 5 in each participating country.

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Background to the regional workshops: the HCPA Joint Statement

In January 2007, a group of international HCPAs issued a Joint Statement with PMNCH, committing themselves to the Partnership’s vision and goals. This outlined:

- The growing recognition of the potential role of HCPAs in addressing the human resource crisis.
- A commitment by international HCPAs to collaborate on strengthening national HCPAs and to increase their ability to engage in advocacy activities.
- A need to improve the planning and implementation of RMNCH programmes and policies.

To follow up on this statement, the PMNCH secretariat developed a series of workshops with the theme: “the role of HCPAs in reaching MDGs 4 and 5”.

Regional workshops for HCPAs

The workshops were held in:

- Blantyre, Malawi (November 2007).
- Ouagadougou, Burkina Faso (March 2008).
- Dhaka, Bangladesh (November 2008).

They brought together representatives from national HCPAs involved in RMNCH service delivery (pharmacy, nursing, midwifery, obstetrics and gynaecology and paediatric associations), public-sector representatives and other key stakeholders. The 17 countries participating were: Afghanistan, Bangladesh, Burkina Faso, DRC, Ethiopia, Haiti, India, Malawi, Mali, Myanmar, Nepal, Niger, Nigeria, Pakistan, Senegal, Tanzania and Uganda.

A total of 195 people attended the three workshops, of whom 183 represented HCPAs (58 at Blantyre, 59 at Ouagadougou and 66 at Dhaka). There were also six PMNCH participants and six people who represented the PMNCH advisory board – all of whom were senior personnel involved in direct coordination of the workshops with PMNCH.

The workshops were structured around five key growth areas (Table 1):

1. Advocacy (helping HCPAs become good advocates for RMNCH).

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2. **Human resource** (helping HCPAs better define and implement their organizational needs so as to ensure functionality of associations and improved capacity to fulfil their functions).

3. **Organizational strengthening** (helping HCPAs get better at advocacy, human resource, quality improvement and RMNCH planning, and establishing better partnering between associations and with the public sector).

4. **Service quality improvement** (training, continuing education, monitoring/supervision, standards of care, regulation and accreditation issues).

5. **RMNCH planning** (helping HCPAs work together and with the public sector to ensure comprehensive and integrated plans).

**Structure and objectives**

PMNCH invited each country to nominate the two or three key growth areas that were most relevant to its efforts to improve RMNCH (Table 1). It structured the workshops to enable HCPA representatives to discuss best practices and the challenges they faced in implementing the five growth areas. People from different professions and countries were encouraged to exchange information, both with each other and with public-sector and regional representatives.

The desired outcomes were:

- 1-2 year action plans to be implemented collaboratively by all HCPAs.
- Cross-professional HCPA collaboration in countries.
- Increased regional dialogue among HCPAs in the region.
- Improved collaboration between HCPAs and the public sector.

More information about the context of the workshop, and their structure and objectives, is given in appendices 1-4.
2. Evaluating the regional workshops

2.1 Background

In mid-2010, PMNCH asked the Department of Community Health Sciences (CHS) at Aga Khan University, Pakistan, to assess the workshops against three objectives:

1. The overall objective (to increase the capacity of national HCPAs to contribute to the development of national RMNCH policies and programmes).
2. Interaction between HCPAs, health ministries and development partners at national and regional levels.
3. Implementation of the action plans agreed during each workshop.

Points 2 and 3 lead towards the achievement of the overall objective.

PMNCH also asked the Department of CHS to identify and analyse the factors facilitating, and inhibiting, achievement of these objectives and to make recommendations for the future.

2.2 Methodology

We used quantitative and qualitative research techniques to assess the workshops. The quantitative element was a web-based questionnaire that asked participants about the key growth areas their HCPA had chosen. The qualitative component was a desk review of documents (see appendix 12, 13 and 14) and interviews with participants. Response to the questionnaires was limited (see Box 1 and appendix 6), so we agreed with PMNCH to approach all respondents for interviews, giving the qualitative component greater weight than the quantitative.

A more detailed explanation of the methodology adopted, and limitations of the evaluation, is given in appendix 3 and 4.
3. Results

3.1 Overall findings

Summary of overall objectives achieved

- Most (88%) of the HCPAs that participated achieved at least some of the objectives set at the regional workshops.
- Nine (53%) implemented elements of the CSAPs defined during the regional workshops.
- Of these, two (11.7%) also contributed towards national RMNCH plans.

Overall impact of workshops

The evidence available from the various sources used in this evaluation (questionnaires, interviews, desk review of documents) is limited, due to the difficulties described in appendix 4. However, it is possible to give a rough indication of the impact of the PMNCH workshops in each participating country. In Table 1 below, countries are assigned a rating on a sliding scale, based on accomplishment. The detailed sections on each workshop later in this report summarize the findings on which these rankings are based.

Key growth areas

Table 1 also indicates the key growth areas selected by each country at each of the three workshops. It shows that organizational strengthening was the most popular choice across all three workshops, selected by 13 countries (five at both Blantyre and Ouagadougou, and three at Dhaka). This appears to indicate that HCPAs recognized effective organization as a key factor in the successful implementation of CSAPs and the overall workshop objectives. The organizational failings noted later in this report, and their impact on implementation, bear this out. Advocacy (five at Dhaka, four at Ouagadougou and one at Blantyre) and quality improvement (five at Ouagadougou, three at Blantyre and two at Dhaka) were the second most popular choices. Overall, human resource (two at Dhaka and one at Ouagadougou) and RMNCH planning (one at Ouagadougou and one at Blantyre) received relatively little emphasis.

There is no obvious correlation between the key growth areas chosen by any country and that country’s eventual success, or lack of success, in achieving the workshop objectives. As discussed below, success would appear to have depended on unrelated factors, such as the availability of resources, political will and the proximity of HCPA offices to each other and to those of the MOH and development partners.
<table>
<thead>
<tr>
<th>S. No.</th>
<th>COUNTRY and level of objectives achieved</th>
<th>WORKSHOP 1 – BLANTYRE, MALAWI - NOVEMBER 2007</th>
<th>AREAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ETHIOPIA</td>
<td></td>
<td>Advocacy</td>
</tr>
<tr>
<td>2.</td>
<td>TANZANIA</td>
<td></td>
<td>+ + +</td>
</tr>
<tr>
<td>3.</td>
<td>UGANDA</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>4.</td>
<td>NIGERIA</td>
<td></td>
<td>---</td>
</tr>
<tr>
<td>5.</td>
<td>MALAWI</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S. No.</th>
<th>COUNTRY and level of objectives achieved</th>
<th>WORKSHOP 2 – OUAGADOUGOU, BURKINA FASO - MARCH 2008</th>
<th>AREAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>BURKINA FASO</td>
<td></td>
<td>Advocacy</td>
</tr>
<tr>
<td>7.</td>
<td>MALI</td>
<td></td>
<td>+ + +</td>
</tr>
<tr>
<td>8.</td>
<td>NIGER</td>
<td></td>
<td>+ + +</td>
</tr>
<tr>
<td>9.</td>
<td>DRC</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>10.</td>
<td>SENEGAL</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>11.</td>
<td>HAITI</td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S. No.</th>
<th>COUNTRY and level of objectives achieved</th>
<th>WORKSHOP 3 – DHAKA, BANGLADESH - NOVEMBER 2008</th>
<th>AREAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>AFGHANISTAN</td>
<td></td>
<td>Advocacy</td>
</tr>
<tr>
<td>13.</td>
<td>BANGLADESH</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>14.</td>
<td>INDIA</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>15.</td>
<td>MYANMAR</td>
<td></td>
<td>+ +</td>
</tr>
<tr>
<td>16.</td>
<td>NEPAL</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>17.</td>
<td>PAKISTAN</td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>
There were interactions between and among HCPAs, MOH and development partners.

There was implementation of CSAPs defined during the regional workshops.

HCPAs demonstrated capacity to contribute towards national RMNCH plans.

Increased interaction and implementation of CSAPs

Fifteen countries (88%) reported increased interactions between HCPAs and between HCPAs and MOH and development partners. Nine of these (53%) implemented elements of their workshop CSAPs.

Contributing to national RMNCH plans

In two countries – Burkina Faso and Niger – HCPAs met the principal workshop objective of contributing to national RMNCH plans. Feedback from participants suggests this was largely due to strong MOH involvement during the workshop, and in the post-workshop follow up activities. The respondents from Burkina Faso and Niger said that a network of HCPAs contributed to the revision and implementation of national RMNCH and drug policies.

Documents from Burkina Faso suggest that the PMNCH regional workshop created momentum towards achieving MDGs 4 and 5. The MOH and Directorate of Family Health continue to be closely involved with HCPAs in post-workshop activities.

Documents from Niger show strong evidence of activities such as consensus building, creation of an HCPA network, and organization of training sessions, open days and workshops. It was also reported that the Society of Obstetricians and Gynaecologists of Canada (SOGC) disbursed funds to countries participating in the Ouagadougou workshop.

Common factors

An analysis of the data identified some common factors that either facilitated or inhibited implementation of the workshop objectives in all participating countries. These are summarized in Table 2 below:
Table 2: Common factors facilitating or inhibiting achievement of overall workshop objective in all participating countries

<table>
<thead>
<tr>
<th>Facilitating factors</th>
<th>Inhibiting factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enthusiastic participation</td>
<td>Funding constraints</td>
</tr>
<tr>
<td>Wide representation from international and regional organizations/agencies</td>
<td>Overcommitted focal persons with lack of time</td>
</tr>
<tr>
<td>Workshop acting as catalyst to promote professional bonding</td>
<td>Lack of administrative support</td>
</tr>
<tr>
<td>Workshop bringing different HCPAs together</td>
<td>Weak HCPAs</td>
</tr>
<tr>
<td>Workshop acting as a platform for networking</td>
<td>Lack of clear roles and responsibilities at all levels (PMNCH, United Nations agencies, HCPAs and MOH)</td>
</tr>
<tr>
<td>Reinforcement of the need to strengthen health systems</td>
<td>Over-ambitious CSAPs</td>
</tr>
</tbody>
</table>

3.2 Blantyre workshop – November 2007

Summary of objectives achieved

- Three out of five countries (60%) achieved interaction between and among HCPAs.
- Two out of five (40%) implemented CSAPs agreed during the workshop.
- All five countries focused on organizational strengthening. Three also focused on quality improvement, while Nigeria focused on advocacy and Uganda on RMNCH planning.

No countries achieved **Objective 1** (to improve HCPA capacity).

**Objective 2: Interactions between and among HCPAs**

Following the workshop, participating HCPAs reported a better understanding of the challenges of organizational strengthening. In 2008, they developed strategies and started implementing changes for an improved organization.

In Tanzania, HCPAs representing obstetrician-gynaecologists and midwives facilitated post-workshop training. This covered the active management of the third
stage of labour and the use of misoprostol for preventing postpartum haemorrhage. The MOH subsequently registered the use of misoprostol. This seems to be a result of improved communication between HCPAs after sharing office space (see below), and shows how simple steps to improve professional interaction can have the potential to influence RMNCH policy advances.

It was learnt from review of reports that in Nigeria the midwives rejoined International Confederation of Midwives (ICM) and were represented in the Council at Glasgow in June 2008. However, there is strong need to strengthen collaboration amongst the HCPAs in Nigeria.

Participants from Tanzania, Uganda, and Nigeria said the workshop encouraged HCPAs to work jointly on human resource issues. In Uganda, government and private-practice midwives interacted more after the workshop, and may now merge their operations.

In 2008, the Tanzania Midwives Association (TAMA) convened two meetings for revision of policies and protocols as part of strategic advocacy efforts. The president of TAMA expressed interest in sharing an office building with associations that had no permanent office space. Now, TAMA and the Association of Gynaecologists and Obstetricians of Tanzania operate in one building, substantially strengthening their collaboration in areas such as training, advocacy and requests for funding.

In Ethiopia, HCPA representatives organized a post-workshop meeting with funding from PMNCH. The Ethiopian Paediatric Society (EPS) also organized a post-workshop meeting of HCPAs in Ethiopia to discuss quality improvement and organizational strengthening.

Objective 3: Implementing CSAPs agreed during the workshop

While funding is a major barrier to the ability of HCPAs to advance RMNCH policy priorities, the success of countries like Ethiopia to secure support for their initiatives helps capacity building, increased professional interaction and implementation of CSAPs.

In Ethiopia, the EPS worked with the Federal Ministry of Health (FMOH), PMNCH, the United Nations Children’s Fund (UNICEF) and WHO to seek financial support for infrastructure strengthening.

In Tanzania, HCPAs planned and implemented post-workshop activities on quality improvement, advocacy, continuing education, monitoring and supervision. Organizational strengthening was selected as the only priority area in the CSAP.

In Nigeria, the progress was hampered by the distance between HCPA offices, the failure to establish an HCPA forum and the difficulty of communicating with the head of the Child Health Division, who was rarely available. Weak collaboration between
HCPAs before the Blantyre workshop also contributed to the low level of joint work after the workshop.

**Post-Blantyre challenges**

Despite progress in the areas described, our review of CSAPs and other documents from the Blantyre workshop suggests that post-workshop follow-up and implementation of CSAPs by HCPAs has been patchy.

This resulted from factors such as inadequate funding, lack of time and lack of ownership by HCPAs, which were highlighted by participants from Tanzania, Uganda, and Nigeria as constraints to progress. A typical comment was: “efforts for joint activities are being done but still the crisis is huge”.

In Nigeria, a further constraint was the fact that most of the leaders of the HCPAs were not based in Abuja where the FMOH and United Nations agency offices are located. This made communication between these entities difficult and was further complicated by the fact that the head of the Child Health Division of the FMOH, who was responsible for a lot of activities, remained very busy.

The respondent for Ethiopia pointed out that the change of officers in the organizations was a major barrier in the implementation of the proposed CSAP. The limitations of the workshop format were mentioned by one respondent: “[the] workshop tried to provide too much information in a very short time and the facilitator was overworked”. However, almost all respondents said the workshop was well organized and resulted in some organizational strengthening of HCPAs.

**Summary of post-Blantyre challenges**

1. Inadequate follow-up on workshops.
2. Incomplete implementation of CSAPs.
3. Lack of funding.
4. Lack of time and ownership of actions.
5. Changes in HCPA personnel.

**Recommendations**

- **Challenges 1 and 2**: PMNCH and HCPAs should ensure sustained, coordinated follow-up of CSAPs. The need for follow-up and effective post-workshop communications should be emphasized during workshops. CSAPs should be ambitious but realistic.
- **Challenge 3**: where possible, PMNCH should identify funding constraints in advance and ensure that CSAPs are realistic and tailored to take them into
account. When additional funding is available, PMNCH should advise HCPAs how to access it.

- **Challenge 4**: HCPAs and PMNCH should take care to appoint appropriate focal persons for the coordination of post-workshop activities. This will ensure ownership of CSAPs and avoid the appointment of people who are too senior or time-constrained to provide effective leadership.

- **Challenge 5**: PMNCH and focal persons should communicate frequently and regularly, using the most appropriate and convenient communication channels. This will ensure that PMNCH is made aware at an early date if a focal person has to step down suddenly, and will expedite the appointment of an appropriate replacement.

### 3.3 Ouagadougou workshop – March 2008

**Summary of objectives achieved**

- All six countries (100%) achieved interactions between and among HCPAs.
- Four out of six (66%) implemented CSAPs agreed during the workshop.
- Two out of six (33%) improved HCPA capacity.

**Objective 1: Improved HCPA capacity**

By achieving this objective, *Burkina Faso* and *Niger* were the most successful of the 17 countries that participated in the three regional workshops. Desk reviews suggested that each country’s MOH was closely involved in the workshop and in follow-up activities, which may have contributed to their success in improving HCPA capacity. Respondents mentioned that a network of HCPAs contributed to the revision and implementation of national RMNCH and drug policies.

There is a concentration of HCPA, MOH and development-partner resources in Ouagadougou, the capital of *Burkina Faso*, including the Directorate of Family Health. This was a major factor in the success of post-workshop capacity building. In addition, several of the HCPAs have strong management structures and sound pre-existing collaborative links.

Documents from *Niger* show strong evidence of activities such as consensus building, creation of a national HCPA network (May 2009), and organization of training sessions, open days and workshops. It was also reported that PMNCH disbursed funds through SOGC to countries participating in the Ouagadougou workshop for start-up activities.
Objective 2: Interactions between and among HCPAs

The formation of formal HCPA networks in Burkina Faso, Mali, DRC and Niger and organization of restitution workshops were the main activities after the PMNCH workshop, along with awareness campaigns and training of health professionals.

Niger

In Niger, more effective interaction between HCPAs appears to have been established soon after the workshop. In September 2008, six HCPAs created momentum for establishing a national network. They set up a temporary office at the revival of the international conference on primary health care and African health-care systems in Niger, where they formulated an action plan for creating the network and deciding its future activities. A national network of HCPAs was established in May 2009. Since then, members of the network have communicated regularly by email, organized meetings, workshops and exchange visits and issued joint reports from a temporary office.

Civil society organizations were invited to an open day at the MOH in November 2008. They discussed the roles of nongovernmental organizations (NGOs) and HCPAs and their concerns about the functioning of health systems. Other meetings were subsequently held to consolidate and expand the network of HCPAs, and to discuss the need for a permanent secretariat. A key task was to identify qualifying organizations and establish requirements for membership of the network.

The HCPA network has organized training and open days to improve RMNCH advocacy and increase awareness among policy-makers. It contributed to the 2011-2015 National Health Development Plan, and generated more than US$10 000 for national RMNCH programmes.

Members of the network have been trained to strengthen technical capacity and quality assurance. This included a two-day workshop in Niamey in June 2011, which was funded by PMNCH. It was attended by over 30 representatives of HCPAs, NGOs and other organizations, with the aim of strengthening their contribution to RMNCH. The HCPA network conducted a survey in June 2009 to identify and categorize HCPAs in Niger, and subsequently established a list of relevant organizations. Increased collaboration between HCPAs in Niger strengthened the partnership between HCPAs and the MOH and other national-level stakeholders.

A progress report was published by the HCPA network in February 2010. It describes the activities summarized above, includes an action plan and confirms that the PMNCH regional workshop was the starting point for awareness building among HCPAs.
**DRC**

The PMNCH workshop generated fresh impetus for HCPA interaction and cooperation in **DRC**. The HCPAs formed an online network and produced an action plan and a programme of activities, which included advocacy through conferences, workshops, the media and other channels.

The Congo Society of Paediatrics contributed to the creation of a national protocol for quality-improvement measures. These included neonatal resuscitation training for nurses and midwives and training on awareness and prevention of childhood diseases by vaccines. A 15-day RMNCH awareness campaign focused on nurses, teachers, district sanitary inspectors and others working in RMNCH.

The National Association of Nurses of Congo organized an awareness day focused on the role and objectives of HCPAs, and to generate recommendations for improving RMNCH. Participants included gynaecologists, midwives, nurses, paediatricians and pharmacists.

In response to a request from PMNCH in February 2009 for follow-up activities, paediatricians become more involved in neonatal screening of sickle cell disease, training, seminars and networking. As a result, an article was published in the *Journal of Clinical Pathology*: “Neonatal screening for sickle cell anemia in the Democratic Republic of Congo: experience from a pioneer project on 31,204 newborns”.

**Burkina Faso**

Research revealed good signs of HCPA cooperation and interaction. After the regional workshop, a network of HCPAs was created in **Burkina Faso**. This contributed to the revision and implementation of national RMNCH policy and worked on several RMNCH-related quality improvement and assurance initiatives. There are now 20 functional teams working for quality improvement in the country.

The HCPA network regularly interacts with national stakeholders at meetings and workshops. A cooperation agreement was reportedly signed with the MOH.

**Senegal**

HCPAs planned a meeting to develop a consultation framework and to stage a version of the Ouagadougou workshop at national level. The Association of Midwives organized events focused on capacity building for reproductive health. The nursing and midwifery associations collaborated to complete their joint advocacy and awareness actions.
Objective 3: Implementing CSAPs agreed during the workshop.

**Niger**

There is good evidence of HCPAs working to implement workshop CSAPs in *Niger*. *Niger* shows progress in consensus building for the categorization of HCPAs, establishment of HCPAs network, and organization of various training sessions and workshops to implement CSAPs.

**Mali**

The HCPA network in *Mali* is cooperating with a range of national stakeholders, including the MOH, to advance RMNCH. Key activities include cervical and breast cancer screening campaigns, approval for the prescription of oxytocin by matrons to prevent postpartum haemorrhage and creation of a protocol to manage newborns.

The Malian Society of Gynaecology and Obstetrics was involved in establishing a national quality assurance network in *Mali* after the PMNCH workshop, and has been active in the provision of training for gynaecologists and paediatricians.

**DRC**

There is evidence that HCPAs in *DRC* have been implementing their CSAP by promoting safe-motherhood practices, developing the training curriculum for midwives, and improving data collection.

The Children, Seeds of the Future Association – Congo planned a one-month project in September 2008 to identify and educate skilled birth attendants, other health professionals and administrative officials to further the ends of RMNCH.

**Burkina Faso**

Documents show that the workshop CSAP is well developed in *Burkina Faso*. Leaders of the main HCPAs met immediately after the workshop to finalize the CSAP, which was later sent to PMNCH and other partners. A series of joint meetings in June, October, 2008 and January 2009 reviewed the status of planned activities, and an office of the HCPA network was established in October 2008.

In March 2009, Ouagadougou hosted an open panel entitled: “Universal access to reproductive health by 2015: Myth or reality”. It was attended by the First Lady of Burkina Faso, the Minister of Health and representatives of WHO and other international organizations.

In May 2009, a national workshop on the role of HCPAs in achieving MDGs 4 and 5 replicated the PMNCH workshop. It was attended by the wife of Prime Minister and presented national policy for reducing maternal, neonatal and infant mortality.
In November 2009, a reproductive-health consultant assessed progress against the CSAPs. The resulting report highlighted key factors that contributed to progress:

- The workshop took place in Ouagadougou, the capital of Burkina Faso.
- Burkina Faso is a small country, with all the HCPA leaders, MOH and the development partner offices based in Ouagadougou.
- Three out of the five HCPAs already had a functional secretariat before the workshop.
- Some kind of collaboration already existed between HCPAs before the workshop. For example, the societies of obstetrics-gynaecology and paediatrics organized a joint congress in 2006.

**Cooperation between Burkina Faso and Mali**

After the PMNCH workshop, participants from **Burkina Faso** and **Mali** met twice, in Ouagadougou and Bamako, Mali. The Ouagadougou meeting in May 2008 resulted in a joint declaration to advance RMNCH by establishing a sub-regional association of nurses in the francophone Economic Community of West African States. A five-member committee was formed to coordinate activities during the set-up period. However, implementation was delayed due to lack of funding.

**Funds for CSAP from PMNCH**

PMNCH allocated US$ 3000 per country to enable the International Federation of Gynaecology and Obstetrics (FIGO) to check the progress of CSAP implementation in the six francophone African states. FIGO was also asked to organize a meeting of the countries to analyse the factors affecting their progress, and to revise their CSAPs if necessary. However it is not clear whether FIGO was successful. Nevertheless the advisory board interviews verified that in **DRC** funds were disbursed by SOGC, and a PMNCH-funded evaluation was conducted in **Burkina Faso** and **Nigeria** in 2009.

**Post-Ouagadougou challenges**

Although this was in some respects the most successful of the three workshops, with two countries achieving the overall objective, participating countries reported significant post-workshop challenges.

**Niger challenges**

Lack of funding was reported as the major barrier in carrying out planned activities in **Niger**. Other barriers included insufficient human resource, materials, equipment and logistics, lack of secretarial support staff, irregular attendance of some officers and inadequate financial resources.
Mali challenges

Financial constraints and lack of motivation were the main barriers after the PMNCH workshop. Common barriers included:

- Poor funding and challenging logistics.
- Variable levels of commitment and limited capacity.
- Weak organization and management.
- Lack of timely follow up for implementation of CSAPs.
- Lack of an appropriate office space.
- Weak network and communication (phone connectivity and access to the internet hindered this evaluation, especially in Senegal, Mali and Niger).
- Lack of technical and financial support and unavailability of stakeholders.
- Lack of an updated contact list of workshop participants.
- No periodic meetings were organized amongst associations to assure follow up of activities after the PMNCH workshop.

Burkina Faso challenges

Absence of political will was the most notable challenge faced by the network of HCPAs in making effective contributions towards human resource development in Burkina Faso.

- The country has no accrediting body to endorse RMNCH programmes or regulatory body responsible for HCPA quality assurance.
- There is no functional head office for HCPA activities. Despite a good communication network, several activities from the CSAP did not happen due to lack of funding, logistic barriers and a lack of technical and institutional support from the partners.

Senegal challenges

Key barriers to implementation included funding constraints, overcommitted staff with lack of administrative support, weak HCPAs (especially those of nurses and midwives), lack of clear roles and responsibilities and over-ambitious CSAPs. A progress report on the CSAP lists barriers to organizational strengthening, quality improvement and advocacy. These were:

- Unavailability of some officials.
- Time constraints.
- Lack of logistic coordination.
- Difficulties in accessing multilateral partners and aligning the agendas of stakeholders.

A recommendation of the progress report was to ensure proper dissemination of the CSAP to medical bodies, local authorities and all relevant stakeholders.

**DRC challenges**

In organizational terms, the absence of any HCPA regulatory body for quality assurance has been a barrier to CSAP implementation. In the purely physical sphere, geographical distances within DRC posed a major challenge, because HCPAs lacked the human, material and financial resources to overcome them. Other barriers include:

- Non-conducive policies at national level and absence of political will.
- Logistical challenges and lack of funding.
- Weaknesses in the area of advocacy.
- Lack of office space.
- Lack of supplies in clinics.
- Stakeholders who are unavailable.

**Summary of post-Ouagadougou challenges**

1. Lack of funding and financial resources.
2. Insufficient resources, human and material.
3. Weak follow-up, organization and communication.
4. Absence of political will and contact with FMOH.
5. Inadequate dissemination of the CSAP to all relevant stakeholders.

**Recommendations**

- **Challenges 1 and 2**: additional funding should ideally be made available to help HCPAs create the stable organizational platform needed to increase RMNCH capacity (especially given the issues of poor role definition and lack of leadership identified in Senegal).

- **Challenge 3**: PMNCH and HCPAs should ensure sustained, coordinated follow-up of CSAPs. HCPAs involved at Ouagadougou specifically asked for support to mobilize resources and improve interactions with WHO country offices and the MOH. They also recommended that PMNCH should periodically monitor the indicators defined in the CSAPs. The need for follow-up and effective post-
workshop communications should be emphasized during workshops. CSAPs should be ambitious but realistic.

- **Challenge 4**: PMNCH and HCPAs should attempt to apply the lessons learned from Burkina Faso and Niger – the only countries to increase HCPA capacity to contribute to RMNCH plans. These countries demonstrate the benefits of sustained commitment by the MOH, and of concentrating HCPA resources in one place (ideally in a shared office). These factors help to create a conducive environment for high-valuation interactions with relevant RMNCH stakeholders.

- **Challenge 5**: as recommended by the Senegal progress report, PMNCH should support HCPAs in their efforts to disseminate CSAPs to medical bodies, local authorities and all relevant stakeholders, nationally and regionally. This should generate “buy-in” and goodwill towards implementation of the CSAPs.

### 3.4 Dhaka workshop – November 2008

**Summary of objectives achieved**

- All six countries (100%) achieved interactions between and among HCPAs.
- Three out of six (50%) implemented CSAPs agreed during the workshop.

No countries achieved **Objective 1** (to improve HCPA capacity).

**Objective 2: Interactions between and among HCPAs**

Most of the participating HCPAs had a functional secretariat and were already interacting with each other prior to the workshop.

**Pakistan**

After the workshop, the Pakistan Medical Association followed up by hosting an ad hoc meeting, and several other RMNCH-related meetings were held. UNICEF funded an in-country meeting involving government representatives and HCPAs, which resulted in a memorandum of understanding (MOU) endorsing the CSAP. The CSAP has also been presented to the speaker of the national assembly, to the MOH and at national HCPA conferences.

The Association of Mothers and Newborns – Pakistan secured support to implement the CSAP in selected districts (Badin and Khairpur of Sindh province) where baseline data on RMNCH is available. In April 2009, a three-day workshop on maternal and perinatal health care was held by the Society of Obstetricians and Gynaecologists of Pakistan (under the aegis of the Asia-Oceania Federation of Obstetrics and Gynaecology). One-third of the 40 participants were midwives, and one whole day
was devoted to their training. HCPAs also provided a variety of other RMNCH-related training for health-care professionals. RMNCH-related information based on the Pakistan Demographic and Health Survey 2006-07 was disseminated in 10 private medical colleges in Sindh, supported by the TACMIL Project (Technical Assistance for Capacity Building in Midwifery, Information and Logistics) and other partners.

**India**

The *India* respondent said HCPAs had developed a document to raise continuous quality improvement standards in collaboration with the MOH, Public Health Foundation of India and UNICEF. A consortium was formed to work on newborn care initiatives.

The manuscript and MOU submitted to PMNCH from *India* show that the participating associations are working to formalize the HCPA network. Most associations in the network have approved an MOU reaffirming their commitment to MDGs 4 and 5 and are using the CSAP as their organizing platform. Other post-workshop activities include the launch of an advocacy campaign by the Society of Midwives in India and the White Ribbon Alliance (India). This aims to promote greater political commitment to promoting safe motherhood. The pharmacy association has taken the lead in establishing a working group within the International Pharmaceutical Federation to write a reference paper on the role of pharmacists in RMNCH. The Federation of Obstetric and Gynaecological Societies of India delivered a presentation in March 2010 at the annual convention of the International Paediatric Association entitled: “The importance of pharmacists in MNCH towards achieving the health-related MDGs”.

**Myanmar**

The *Myanmar* respondent suggested social marketing as a potential source of income generation, and as a means of reducing reliance on donors. It is not clear whether Myanmar used this approach in generating more than US$10 000 funding for RMNCH programmes.

A key aim was to develop and implement a national protocol on quality improvement measures and to hold national meetings for consensus building and dissemination. The respondent also said the Myanmar Medical Association had been working on the areas of service quality improvement, human resource development and organizational strengthening for RMNCH prior to the workshop, and that these activities continued afterwards.

**Afghanistan**

The workshop was the first opportunity for paediatricians, obstetricians, pharmacists, midwives, nurses and representatives of the MOH of *Afghanistan* to convene and work together. The workshop CSAP is now serving as a collaborative platform for a formal HCPA network.
HCPAs and private practitioners held meetings after the PMNCH workshop to discuss the introduction of low-osmolarity oral rehydration solutions (ORS) and zinc supplementation for children (see below).

Post-workshop activities included:

- The building of an HCPA network, which started just after the PMNCH workshop. HCPAs met in November 2008 and agreed to have a general secretariat. The network was established by February 2009.

- Enhanced training opportunities in emergency obstetric and neonatal care offered by the Afghan Society of Obstetricians and Gynaecologists (AFSOG).

- Advocacy work by the Afghan Midwifery Association (AMA) to promote the use of a partograph and active management of the third stage of labour.

The Afghan Paediatric Association trained 280 doctors (both established and recent graduates) in the use of zinc and low-osmolarity ORS in 2009. AFSOG organized its second and AMA its third, congress inviting about 400 gynaecologists and more than 400 midwives respectively. Safe Motherhood Day was also celebrated with assistance from the Ministry of Public Health and HCPAs.

Objective 3: Implementing CSAPs agreed during the workshop

CSAPs were implemented in Afghanistan, Myanmar and India. It should be noted that the training of physicians in Afghanistan was carried out in a fluid security situation.

**Afghanistan**

The network of paediatricians, pharmacists and nurses promoted use of zinc and low-osmolarity ORS as part of their CSAP. The interviewees from Afghanistan endorsed that the network of paediatricians, pharmacists and nurses subsequently promoted these measures. Two workshops were conducted in December 2008 to train private practitioners and pharmacists. For new medical graduates being hired by the Ministry of Public Health, a two-day workshop on the management of sick children and zinc and low-osmolarity ORS was planned for May 2010.

**Myanmar**

The paediatric and obstetrics-gynaecology societies initiated a project to strengthen the quality of reproductive health services offered by general practitioners (GPs). This included training in family planning, antenatal care, postnatal care and related areas. Activities to train another 480 GPs are underway and the medical association is providing training to GPs on emergency obstetric and neonatal care. The paediatric and obstetrics-gynaecology societies of the Myanmar Medical Association are committed to strengthening the health-care system in the private sector, thus helping the public sector in achieving MDGs 4 and 5.
India

To carry forward the CSAP developed at the PMNCH workshop, the participating HCPAs put in place five MOUs, and wrote to the MOH to request formal links with the Government of India’s RMNCH programme for the MDGs. The CSAP has been endorsed by the Indian Academy of Paediatrics.

The HCPAs planned three RMNCH workshops for 2009-2010, which were expected to bring different HCPAs together. In November 2009, the National Neonatology Forum of India developed a concept plan for the creation of a newborn-health consortium in India.

Post-Dhaka challenges

HCPA participants were often senior professionals, who had limited time after the workshop to follow up on its conclusions and liaise with other HCPAs. This hindered progress in some countries.

India challenges

- Funding constraints, non-availability of a designated focal person, lack of ownership (time constraints, lack of remuneration), absence of strong PMNCH support for resource mobilization and vested political interests (each new government implementing its own agenda).
- Two interviewees did not see a connection between the CSAP and the post-workshop activities summarized above, and believed these would have occurred anyway.

Afghanistan challenges

- Lack of commitment and coordination, and safety and security issues.
- Respondents suggested that better coordination with PMNCH would help to overcome some of these barriers.

Myanmar challenges

- Lack of funding and unavailability of stakeholders.
- A respondent suggested that greater self-reliance – generating income by social marketing instead of relying on donors – would help to overcome these bottlenecks.
**Bangladesh challenges**

- Funding short-falls, lack of resources, logistical barriers and lack of institutional and personal involvement in the core group.
- Respondents said that a change of government resulted in key personnel leaving their posts. Therefore, several initiatives, particularly those related to community-based skilled birth attendants, were affected.

**Nepal challenges**

- Time constraints, no heterogeneous group, a lack of initiative and a lack of responsibility on behalf of the coordinator of the Nepal team.
- An email from the president of the Nepal Pharmaceutical Association said: “After returning back to Nepal from Dhaka workshop, we never met again since we were all from different walks of life and went back to our own jobs. [We] never got together again as no one took such initiative”.

NB: the apparent lack of meaningful collaborative activity in Nepal is unique to this workshop, and may be worth investigating further.

**Organizational lessons learned**

Based on lessons learned from the Dhaka workshop, Jennifer H Requejo of PMNCH produced “Regional collaborations as a way forward for RMNCH: the South Asian health care professional workshop”. This was published in the *Journal of Health Population Nutrition* in 2010.

One of the 16 interviewees from the Dhaka workshop mentioned that the venue of the workshop was changed rather abruptly from Pakistan to Bangladesh for security reasons. Another said his nomination to attend came at the last moment. Both of these comments may imply the need for better planning and coordination.

The experience of Dhaka helped with planning for the fourth PMNCH regional workshop in Jordan in December 2010 (which is outside the scope of this report), where greater emphasis was placed on follow-up activities. A simple questionnaire was introduced to measure changes in funding patterns, the level of coordination and relationships with other stakeholders, and to identify barriers to, and opportunities for, greater involvement in national-level RMNCH planning.

**Summary of post-Dhaka challenges**

1. Lack of funding and need for greater self reliance.
2. Need for good communication and strong PMNCH post-workshop support.
3. Vested political interests and changes of government.
5. Lack of collaboration and unavailability of stakeholders.

Recommendations

- **Challenge 1**: the respondent from *Myanmar* referred in passing to the possibility of raising funds through social marketing. While it is unclear what this would involve, or whether Myanmar used the approach in generating more than US$10,000 in RMNCH funding, the idea should be investigated as a potential source of additional funding in other contexts.

- **Challenge 2**: there was an apparent disconnect between the CSAP and the post-workshop actions in *Pakistan*. This should be investigated to identify areas where there is potential for miscommunication and misunderstanding in future. The very dynamic security situation in Pakistan should be taken into account.

- **Challenge 3**: where feasible and appropriate, PMNCH and HCPAs should attempt to apply the lessons learned from *Burkina Faso* and *Niger* (see Ouagadougou recommendations above).

- **Challenge 4**: closer monitoring and coordination of post-workshop activities by PMNCH might be effective in helping HCPAs overcome some of the problems created by a dynamic security situation. This was highlighted in feedback from *Afghanistan*.

- **Challenge 5**: PMNCH and HCPAs should collaborate to ensure that workshop representation and post-workshop participation are as inclusive as possible. The positive benefits of this were seen in Dhaka, where pharmacists and anaesthesiologists were included in the workshop. In *Afghanistan*, HCPAs encouraged collaboration between all the professionals involved in the RMNCH continuum of care, to ensure the widest-possible buy-in to the CSAP.
4. Discussion and General Recommendations

4.1 PMNCH support

PMNCH support was mentioned in all three data sources as a main source of encouragement to move forward in the implementation of CSAPs. Survey respondents from Afghanistan and India and interviewees from Bangladesh, India, Burkina Faso, Mali and the advisory board all pointed out the need for PMNCH to improve planning processes, regular monitoring and coordination with local HCPAs. Based on their experiences around the three regional workshops, participants highlighted areas where PMNCH could make improvements, such as:

- Coordination of HCPA activities (Afghanistan).
- Communication with WHO country offices to facilitate HCPA accreditation (India).
- Planning, monitoring and follow-up (advisory board members).
- Post-workshop interaction between PMNCH and country HCPAs (Mali).
- Support in organizing subsequent meetings (India).
- Technical and financial support from PMNCH and MOH (Afghanistan).
- Continual encouragement of HCPAs (Bangladesh).
- Nominating another focal person for the initiative (Pakistan).

The desk review showed that emails were sent from the HCPA network in Niger to PMNCH, requesting feedback about planned conferences and the procurement of office space. The reply from PMNCH was considerably delayed.

Recommendation

PMNCH should analyse the feedback from Blantyre, Ouagadougou and Dhaka and decide where it can most usefully support future workshop participants in implementing their actions plans. It should focus its efforts in those areas.

4.2 HCPAs, MOH and United Nations agencies: individual roles and need for coordination

Survey respondents from DRC and Mali pointed out that unavailability of MOH and development partners was one of the main barriers in the implementation of activities related to service quality improvement. Interviewees from the advisory board recommended that the HCPAs, NGOs, development partners and MOH of each country should work together in an integrated manner. Interview respondents from Afghanistan, Bangladesh, Nepal and Pakistan also strongly recommended that the
role of local government and development partners should be enhanced and channelized.

Areas highlighted for improvement included:

- Greater political will within government to work with HCPAs (DRC and Nepal).
- More commitment and availability of stakeholders to help HCPAs implement planned activities in the area of service-quality improvement (Mali).
- Integrated working between HCPAs, NGOs, development partners, donors, civil society and MOH (Bangladesh and advisory board).
- Clearer roles and responsibilities for PMNCH and HCPAs (advisory board).
- Closer working between HCPAs and health ministries (advisory board).
- More support from MOH in implementing CSAPs (Afghanistan).
- Technical assistance from development partners and help with fundraising (Bangladesh and Pakistan).

Recommendation

PMNCH and HCPAs should review these factors and develop a joint strategy for more effective coordination in future. The focus should be on areas they can influence directly, such as clearer roles and responsibilities, availability of stakeholders and technical assistance from development partners.

4.3 Financial constraints

Respondents from Bangladesh, Myanmar, Burkina Faso, Mali, Niger and DRC all pointed to lack of funding as a major impediment to implementing CSAPs, as did many members of the advisory board. One advisory board member said that resources should be earmarked for post-workshop start-up activities.

All six interviewees from the Ouagadougou workshop said HCPAs could not be expected to accomplish the targets in the CSAPs without financial support. The respondent from DRC highlighted lack of finance as a barrier to staging a restitution meeting. The interviewee from Haiti said: “HCPAs are aware of the power they can have, but to use this power they need means”.

Eight of 13 interviewees from the Dhaka workshop felt strongly that, without financial resources, it was futile to expect CSAPs to be accomplished. A participant from Bangladesh said that HCPAs had anticipated financial support from PMNCH and development partners. A Pakistan participant said: “funding should be earmarked by each activity. A proper funding can minimize the lag period between planning and action”.
Recommendation

PMNCH should look at the feasibility of earmarking funds for follow-up activities after future workshops, and a funding assessment checklist could be part of each CSAP. It should also explore the possibility of additional funding sources, such as the social-marketing idea mentioned by the respondent from Myanmar.

4.4 Ownership of the process: delegation of a full-time focal person to provide leadership

Respondents from Uganda and Bangladesh highlighted the need for a focal person within a country’s HCPA network. They felt this would ensure “ownership” of the CSAP and follow-up activities. The lack of a focal person was seen as an obstacle to implementation.

This was reflected in interviews with members of the advisory board. Five out of eight interviewees suggested that, without a specific contact person and ownership of the process, effective coordination of post-workshop plans was not possible.

Clarification of roles is another area that should be strengthened. A recurring theme in feedback was uncertainty over who was responsible for implementing actions from the workshops. For example, one advisory board member remarked that lack of role clarification was significant at all levels. It was mentioned that: “FIGO handed over responsibilities to the line staff which did not work”; presumably because there were no clear lines of communication. The same respondent elaborated: “frequent changes of office bearers leads to disruption in communication”.

Other comments highlighted:

- Lack of a focal person prevented an immediate follow-up meeting (DRC).
- HCPA members are mostly volunteers, so a salaried focal person is needed (Burkina Faso).
- Non-availability of a focal person was a major drawback (India and Pakistan).
- Key people who attended the workshop were later ousted from their jobs or retired, preventing continuity and CSAP implementation (Bangladesh).
- Designated focal persons were busy senior people (Pakistan).
- Assignment and roles of focal persons were ambiguous (Pakistan).

Recommendation

PMNCH should consider the appointment of a focal person for each country during the pre-workshop planning phase. This would help to ensure that an appropriate
person is appointed, and is able to attend the workshop in person – possibly in lieu of a more senior person who is less suited to the role of post-workshop coordination and leadership.

4.5 Communication strategy

Feedback from respondents highlighted that communication should always be fit for purpose, and should result from an integrated communication strategy among all stakeholders. For example, a respondent from Bangladesh said: “we don’t have a culture of responding to emails”. Similarly, an advisory board member said that weak lines of communication with the francophone African countries, such as Burkina Faso, resulted from irregular access to emails and the fact that email is not widely used. In some cases, computers are unavailable. If these obstacles had been understood in advance, and incorporated into a coherent plan, different forms of communication could have been used for these countries.

Seven out of 13 interviewees from the Dhaka workshop pointed out the need for an effective communication strategy. Another respondent from Bangladesh said: “there is lack of coordination between government, all HCPAs and donor agencies”. This points to the need for an integrated communication strategy among all the stakeholders: PMNCH, the International Confederation of Midwives, the International Paediatric Association, FIGO, development partners, donors, health ministries and local HCPAs.

**Recommendation**

PMNCH should ensure that pre-workshop planning includes an investigation of the most appropriate communication methods for each country, which should then be used post-workshop. Efforts should be made to coordinate communications with those of other stakeholders.

4.6 Regular supervision and monitoring

Feedback from respondents points to the need for closer and more frequent supervision and monitoring of post-workshop activities. The advisory board respondents were generally agreed on the need for quarterly follow-up meetings at country level, periodic progress reports and regular monitoring by PMNCH.

This was reflected in the feedback from workshop participants. Nine out of 13 interviewees from the Dhaka workshop agreed with the need for regular supervision and monitoring. One respondent from India said: “proper follow up is needed, otherwise workshops are only show case activities”. An interviewee from Bangladesh
“regular crisp evaluations should be planned”. A respondent from Pakistan said: “can someone ask HCPAs at regular intervals as to what is happening?”

**Recommendation**

PMNCH should consider adopting a results-based management (RBM) approach in future, which would ensure a more structured approach to achieving the desired outcomes. RBM is an approach for ensuring that the processes, products and services of participating organizations contribute to the achievement of clearly stated results.

RBM can also be used to develop a common operating “log frame”, which is a tool for indentifying and organizing the main elements in a project. If the log frame is properly implemented, RBM can become a useful approach for organizing workshops and post-workshop activities.

**4.7 Realistic action plans**

Care should be taken to ensure that CSAPs are realistic and achievable within reasonable timeframes. During the interviews, four advisory board members said the current CSAPs were over-ambitious. One described them as: “more or less a wish list”. This view was reflected in participant feedback. An interviewee from DRC said: “country specific plans should be feasible”.

Four interviewees from Pakistan commented on the CSAPs. One said: “[we] need clearly defined goals and targets with specified timelines, otherwise people disappear into their own enclaves after coming back from the workshop”. However, another said that over-ambitious CSAPs had been set “because people felt that we should at least aim for higher standards so that in the end at least some goals are achieved”.

**Recommendation**

PMNCH should look closely at how CSAPs are framed during workshops. Their objectives should be ambitious but realistic, given the known constraints in each country. Lessons learned from previous workshops should be carried forward so that future participants can clearly see the obstacles that other countries have faced in implementing over-ambitious CSAPs.

**4.8 Proposed conceptual framework**

Without strong and sustained follow-up by PMNCH, and a clear sense of ownership and commitment by HCPAs, it seems possible that the current model will continue to under deliver.
Recommendation

The proposed conceptual framework (Figure 1) could serve as a useful reference when planning similar activities in future. It integrates most of the recommendations made in this report, linking the original idea of regional workshops with the final desirable impact.

Figure 1: Proposed conceptual framework – way forward
5. Limitations of this Evaluation

Our evaluation was hampered by poor internet access and telephone connectivity and a lack of baseline information on national HCPAs. Also, a proper analysis of impact requires a comparison group. The absence of control HCPAs and an adequate sample size impaired assessment. The only source of the “before status” of RMNCH initiatives was anecdotes from interviews (with the element of recall bias) and desk reviews. These offered little for baseline comparison.

Although the desk reviews provide mixed evidence, most interview participants did not link their country’s post-workshop activities with the PMNCH workshop. Almost all interview respondents mentioned that an evaluation conducted after a lapse of time (about 24 months) was not feasible and evoked a recall bias.

Moreover, legal and contract-issuing procedures took time, which delayed the start of the evaluation. Direct face-to-face communication with the workshop participants was not possible and it was realized rather late that there would be a poor response to web surveys and phone connections. Aga Khan University does not have readily available direct international telephone connection points, so initially the evaluation team had to use mobile phones to schedule interviews with the workshop participants. Further challenges were posed by time differences across zones and the need to hire a French-speaking consultant to conduct some interviews.
6. Conclusion

This evaluation suggests there may be limitations to the current workshop format as a tool for enhancing the capacity of HCPAs to contribute to RMNCH plans. On the positive side, the workshops generated a lot of goodwill, raised awareness of key issues and led to increased interaction between HCPAs – and to a lesser extent with MOH and development partners. In two countries, Burkina Faso and Niger, they provided fresh momentum in circumstances that were already favourable, and contributed to a measurable increase in HCPA capacity.

On the negative side, most countries (88%) were unsuccessful in fully implementing their CSAPs and achieving the three key workshop objectives. Post-workshop activities were bedevilled by a range of difficulties. Those mentioned most frequently by respondents were inadequate support from PMNCH, lack of funding, poor coordination and communication, and lack of leadership and political will.

In future, the challenge for PMNCH is to ensure that workshops are more successful in meeting all their objectives – and especially that of increasing the capacity of HCPAs to contribute to the development of national RMNCH policies and programmes. The proposed conceptual framework in this report outlines an approach that could achieve greater impact, and ultimately lead to better health outcomes for women and children.

Based on this report, we feel secure in saying that these sorts of workshops can be used in the future for increasing interactions among the HCPAs. In fact the regional approach is better in the light of given country level constraints provided that the elements of our proposed conceptual framework are taken into account. Finally, we found that country level advocacy was good in Burkina Faso and Niger (+++ on our scale) and helped in achieving the CSAPs. Therefore in our opinion workshops can encourage country level advocacy if MOH is involved as a major stakeholder during the implementation phase.
**EVALUATION OBJECTIVE**
Assessment of regional workshops and follow up activities to strengthen the role of HCPAs in 17 countries in achieving MDGs 4 and 5

**Evaluation framework**

- **Multiple Sources of Evidence**
  - **Quantitative**
  - **Web survey**
  - **5 areas**
- **Qualitative**
  - **Desk Review**
  - **Interviews**

**Converging lines of inquiry**

**Chain of evidence**

HCPA regional workshops assessed at 3 levels: objectives, interactions and action plans

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**Figure 2: Convergence of information through data triangulation**
7. List of Appendices

1. Context of the three regional workshops
2. Ethical approval
3. Evaluation methodology
4. Limitations of this evaluation
5. Evaluation project team
6. List of Participants – Blantyre workshop
7. List of Participants – Ouagadougou workshop
8. List of Participants – Dhaka workshop
9. List of Advisory Board members
10. Generic and country specific questionnaires
11. Interview guide
12. Summary of interviews with members of the PMNCH advisory board
13. Summary of interviews with participants of the Ouagadougou workshop
14. Summary of interviews with participants of the Dhaka Workshop
15. List of documents analysed for desk review of Blantyre Workshop
16. List of documents analysed for desk review of Ouagadougou Workshop
17. List of documents analysed for desk review of Dhaka Workshop