Overview

The Population Leadership Program at the University of Washington convened its third annual conference in Addis Ababa, Ethiopia, from July 26 through July 30, 2004. The conference was held at the International Livestock Research Institute, on the eastern edge of the city. In total, 24 PLP Fellows spanning all five cohorts attended, along with eight staff and faculty from the University of Washington (See Appendix A for a full list of participants). The Nonprofit Technology Leadership Program (NTLP) held its conference contiguous with the PLP meeting, beginning of the final Friday. All told, 15 countries were represented during the weeklong discussions.

Agenda

The conference covered five days with a moderated session each day, as shown on the week’s schedule on the following page. The five sessions covered a broad range of topics and learning opportunities, with an overall aim of increasing knowledge and skills and developing concrete plans for post program collaborations among Fellows. Each session included a handful of PLP fellow presentations, and many used small group break out sessions. In addition, Fellows and PLP staff held many planned and unplanned small-group discussions that served to deepen analytical thinking and solidify action plans.

Along with the workshop sessions, the week included an opening reception, professional site visits, a guest speaker, and a variety of tourist activities.

The opening reception was held at the Addis Ababa Hilton and boasted over 160 in attendance, thanks in part to the efforts of the Ethiopian Fellows who acted as conference coordinators, and the invitations extended to alumni and staff of other Packard and Gates-funded population who were in Addis at that time, including Visionary Leadership Program, International Family Planning Leadership Program, and others.

Site visits included trips to the Addis offices and clinic of the Family Guidance Association of Ethiopia and the Fistula Hospital of Addis Ababa.
The first day of the conference attendees were treated to a luncheon presentation by Professor Yamane Birehane, a Professor of Epidemiology and a rising star of RH community in Ethiopia. He discussed a variety of RH issues facing contemporary Ethiopia.

**Action Items**

The general discussion of post program initiatives revealed a convergence of interests among various Fellows around four topics: Maternal Mortality, Adolescent Health, Policy Advocacy, and Human Resource Challenges. Small groups formed around the first three topics and met at length during the conference; the final group will initiate work this fall.

**Maternal Mortality**

Fellows from Sub-Saharan Africa produced a concept paper (see Appendix C) that proposes a multi-phase project on maternal mortality. With a focus on Cameroon, Ghana, Liberia, Nigeria, Sudan, and Zambia, the timeline involves four distinct phases over two years: analysis of literature, field-based analysis of maternal mortality intervention, development of a cross-country report, and dissemination of results and policy dialogue.

**Adolescent Health**

The Adolescent Health group spanned Africa, Central America, and South Asia. The minutes (see Appendix D) outline a multi-year set of activities that include: expansion of TeenSmart in participant countries; skill transfer on training young service providers; creation of a PLP manual for international distribution of ASRH ideas and initiatives; and launching a PLP ASRH email newsgroup.

**Policy Advocacy**

The Policy Advocacy session was comprised of Fellows from South Asia and the Horn of Africa. Their conversation focused on the role of post-program support for leveraging effective policy changes in Fellow’s respective countries. The conversation started with an identification of post-program support on both an individual and an organizational level. Participants agreed that international forums and workshops provide excellent learning environments and networking opportunities, so they stressed that post-program initiatives should promote and support these opportunities. Secondly, they encourage the PLP to consider a pan-cohort conference to further strengthen ties and efforts. Finally, they proposed that the PLP maintain a “skill set” repository and that they encourage Fellow-to-Fellow travel to expose new ways of managing and solving shared policy issues.
Human Resource Challenges

Steve Gloyd laid plans in Addis to spearhead an effort to address issues Fellows face across the board in Human Resources (brain drain, for example). Steve has plans to initiate the dialogue this fall.

Conclusion

The true test of all the above-mentioned proposals will be the follow through and commitment critical to their success. Efforts between the PLP fellows and the Post Program Faculty and Staff at the University of Washington must now dovetail to provide timely information, resources, and reports to further the initiatives from concept papers to reality.
Appendix A: PLP Summer Conference Attendees

Population Leadership Fellows

Dr. Olapeju Oreofe Adenusi | NIGERIA | Department of Community Development & Population
Ms. Tigist Alemu | ETHIOPIA | Consortium of Reproductive Health Associations (CORHA)
Mr. Fekadu Chala Dabi | ETHIOPIA | Family Guidance Association of Ethiopia
Dr. Bernice Nukunu Tamakloe Dahn | LIBERIA | United Nations Population Fund
Dr. Abhijit Das | INDIA | Sahayog Society for Participatory Rural Development
Ms. Sara Musa El Saed | SUDAN | Freelance Consultant
Dr. Adesegun Olayiwola Fatusi | NIGERIA | Obafemi Awolowo University
Dr. Ermias Getaneh | ETHIOPIA | Ministry of Health
Dr. Woldemedhin Haile | ETHIOPIA | ActionAid Ethiopia
Dr. Moawia Elsadig Hummeida | SUDAN | University of Kordafan School of Medicine
Dr. Gelila Kidane | ETHIOPIA | Ministry of Health
Dr. Hassan Mohtashami | IRAN | U.N. Population Fund
Ms. Edith Rona Mukisa | UGANDA | Naguru Teenage Information & Health Center
Dr. Adeh Sylvester Nsoh | CAMEROON | Ministry of Health
Mr. Oscar Noel Ocho | TRINIDAD & TOBAGO | Ministry of Health
Dr. Anthony Adofo Ofosu | GHANA | Ministry of Health
Dr. Bolanle Oluemisile Oyeledun | NIGERIA | Johns Hopkins University, Center for Communication Programs
Ms. Mana Kumari Rai | NEPAL | Tribhuvan University
Ms. Ruth Largaespada Rodríguez | NICARAGUA | Teensmart International Representative
Ms. Maria Luisa Sánchez Fuentes | MEXICO | The Information Group on Reproductive Choice (GIRE)
Dr. Christine Kaseba Sata | ZAMBIA | University Teaching Hospital Board of Management
Ms. Ena Singh | INDIA | U.N. Population Fund
Mr. Sisay Worku | ETHIOPIA | National Office of Population
Dr. Raana Zahid | PAKISTAN | World Population Foundation

Population Leadership Faculty and Staff

Julie Beschta | POPULATION LEADERSHIP SEMINAR TEACHING ASSISTANT
Anita Verna Crofts | INTERNATIONAL RESEARCH & EDUCATION COORDINATOR
Heather D'Agnes | GRADUATE ASSISTANT
J. Patrick Dobel | EVANS SCHOOL OF PUBLIC AFFAIRS
Diana Fletschner | EVALUATION COORDINATOR
Stephen Gloyd | DIRECTOR
Aaron Katz | POST PROGRAM INITIATIVE COORDINATOR
Robert Plotnick | CHAIR
SAVING MOTHERS’ LIVES ACROSS SUB-SAHARAN AFRICA:
WHAT REALLY WORKS?
CROSS-COUNTRY ANALYSIS OF MATERNAL MORTALITY REDUCTION
INTERVENTIONS

CONCEPT PAPER

Background
According to the most recent estimates developed by the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), and United Nations Population Fund (UNFPA), approximately 529,000 maternal deaths occurred in 2001, with more than 99 percent occurring in developing countries1. The lifetime risk of maternal death is highest in sub-Saharan Africa, with as many as 1 in 16 women facing risk of death from maternal causes compared to 1 in 94 in Asia, 1 in 160 in Latin America and the Caribbean, and 1 in 2,800 for developed countries.

Recognizing the need to urgently address the current undesirable maternal mortality situation, the global community has endorsed the reduction of maternal mortality as one of the eight Millennium Development Goals (MDGs), with the target of reducing maternal mortality ratio by three-quarters between 1990 and 2015. In the MDG framework, two indicators have been specified for monitoring progress towards the maternal health goal namely, the maternal mortality ratio and the proportion of deliveries with a skilled health care provider.

The MDG goal of maternal mortality reduction is most unlikely to be realized in many of the countries of sub-Saharan Africa, except a significant turn of event in maternal mortality intervention in Africa occurs. Experience of the Safe Motherhood programmed has so far shown that it is not sufficient for commitments to be made or for programmers to be conceived and even contentiously implemented, rather programmers need to be evidence-based to produce desired

results. On the other hand, there are clear-cut evidences in literature that maternal mortality reduction could be accomplished within a relatively short time. The drastic reduction in maternal mortality in Indonesia and Sri-Lanka in the 1990s, for example, prove the feasibility of maternal mortality reduction. The association between access to skilled attendant at delivery and maternal mortality reduction has also been clearly established.

While maternal mortality reduction efforts are not exactly lacking in sub-Saharan Africa, the question of their impacts is one that has not been critically examined. The questions as to why these interventions may have worked or failed to work in different contexts in sub-Saharan Africa (SSA) have not been addressed in any concrete way. Cross-country analysis of maternal mortality reduction interventions that could have shed more lights on this question, for example, is lacking in the literature. On the other hand, while a few examples of successful project in maternal mortality reduction intervention in sub-Saharan Africa have been reported in literature, many of these have not benefited from critical independent evaluation and lessons from them have not been widely applied. On the other hand, the success of most of these interventions beyond the immediate “pilot project” have not been established and factors affecting their sustainability have also not been examined.

As part of the leadership commitment to address the high maternal mortality situation in very meaningful way, the current project is being proposed by the a team of Population Leadership Fellows of the University of Washington from sub-Saharan Africa countries – Cameroon, Ghana, Liberia, Nigeria, Sudan, and Zambia – to address some of the gaps mentioned above through a cross-country analysis of experiences. The Fellows’ countries all have high MMR. Nigeria, for example, has the second highest number of maternal deaths in the world with approximately 37,000 maternal deaths annually and a maternal mortality ratio (MMR) of 800 maternal deaths per 100,000 live births. Ghana, which has one of the lowest maternal mortality statistics in West Africa, has a MMR of 540 maternal deaths per 100,000 live births. The MMR of following countries also exemplify the challenging maternal mortality situation in sub-Saharan Africa: Sudan – 590 maternal deaths per 100,000 live births; Cameroon – 730 maternal deaths per 100,000 live births; Zambia – 750 maternal deaths per 100,000 live births; and, Ethiopia – 850 maternal deaths per 100,000 live births.
The cross-country analysis that would be undertaken in the context of this project would result in a publication that would form the basis for dissemination at an international and national levels as well as policy dialogue in SSA countries. Thus, the project would be filling a great vacuum in the maternal mortality reduction knowledge-intervention-policy spectrum and provide key lessons and evidence-based platforms for future program interventions and policy actions. It will also provide a basis for follow-up actions by the PLP Fellows themselves and other actors in their country to develop maternal mortality interventions. On the whole, this project holds the potential to contribute in concrete ways to improving the health of women and their families in sub-Saharan Africa (and probably other developing countries) and to accelerating progress towards the achievement of the MDG goals in the sub-continent.

**Project Structure**

Countries where this project would be implemented are Cameroon, Ghana, Liberia, Nigeria, Sudan, and Zambia. The project would be implemented by the PLP Fellows in partnership with University of Washington Faculties and relevant stakeholders within each country/project site. Expert resources from other national and other international sources will also be involved as deemed necessary.

The multi-country project will have a secretariat and a Project Coordinator, who will be one of the PLP Fellows. The secretariat will be coordinate central planning activities, serve as a clearinghouse for information and cross-country linkages, as well as linkage with external resources. The secretariat will have a full-time Program Assistant for the duration of the project. Each country that would be involved in the initiative will have a Country Principal Investigator (CPI) who will be a PLP Fellow from the country in question. One of the faculties of University of Washington (UW), with expertise in international health and experience in sub-Saharan Africa, will serve as Chief Technical Advisor (CTA) to the project. The CTA will facilitate the linkage of the project with other technical resources from UW as well as other international sources/networks, and coordinate their contribution. Three Technical Advisors (TAs), who will be experienced experts in the fields of reproductive health epidemiology, health sociology, and medical statistics/evaluation studies, will be selected from UW and/or other sources to provide
assistance to the project centrally as well as nationally. Interns from UW will have opportunity to be involved in this project at various times.

The Country Principal Investigators will have a multi-disciplinary country team that will include an obstetrician & gynecologist (or experienced midwife), social scientist, and community health practitioners.

A Project Steering Committee (PSC) will be established to coordinate central activities and ensure uniformity in methodology. The PSC will consist of the CIPs, the Project Coordinator, the CTA and other TAs, and selected stakeholders from the scientific and development communities.

**Project Activities**

The project would be implemented in phases, over a two-year period.

**Phase 1: Critical analysis of the literature**

An extensive and critical analysis of literature regarding maternal mortality interventions and outcome in both developed and developing countries will be undertaken. For this purpose, we will cover various kinds of literature, including articles published in peer-review journals, evaluation reports from international agencies, materials from websites of agencies, and other grey literature.

A library and citation service will be engaged to assist with some of the preliminary search for relevant documents, and for obtaining such documents for use of the project. CIP will also use country sources to obtain other relevant documents, particularly reports of in-country program activities, monitoring and evaluation reports, and policy documents.

At the first stage, the analysis of documents would enable us to get a bird-eye view and up-to-date information on maternal mortality intervention issues, activities and useful/relevant indicators, which would be useful in the designing of instruments and other relevant materials. The analysis will also enable us to comprehensively identify success stories and promising interventions that could be more critically analyzed at the next stage.
The PSC, using the result of the analysis, would also draw up a list of criteria for identifying the projects that would be visited for critical evaluation, develop central instruments to be used for in-country analysis of projects, and format/guidelines for report writing.

This phase will cover a 6-month period.

**Phase 2: Field-based analysis of maternal mortality intervention**

Based on the outcomes of phase 1 activities, the CIP and the country team would identify interventions to be critically evaluated through field visit. To start with, the CTA and the secretariat will organize a 1-week “methodology workshop” that would involve all members of the PSC, with the aim of ensuring that each CIP develop appropriate skills in the guidance of the project implementation and masters the involved methodologies. The workshop will also involve field-based exercises to ensure skills-acquisition and also serve as opportunity to pre-test the instruments.

Based on the lessons learnt from the field experience final instruments would be developed and also a project implementation guide. The CIPs would consequently organize an orientation for their country team at the beginning of the country-based exercise.

Reports of the exercises would be developed under the leadership of the CIP, according to the uniformly developed instruments, and forwarded to the secretariat. The secretariat – through the use of the services of the CTA, the TA, Project Coordinator and other expert resources – will review the reports and give feedback to each country team to use in finalizing the reports.

This period will last 6 months.

**Phase 3: Development of cross-country report**

The secretariat will hold a 1-week “reporting and writing workshop”, which will involve all the PSC members. An extra member of each of the country team would also be involved in the workshop. The output of the workshop will be a draft report. Each country team would further review the draft report and forward comments to the secretariat.
The forwarded comments will be used in reviewing and finalizing the reports: independent scientific and literary/editorial experts will also be engaged in finalizing the reports. The final form of the report would subsequently be printed for distribution, using the services of established publishing companies.

**Phase 4: Dissemination of Results and Policy Dialogue**

A dissemination seminar would be organized at international level, involving all the participating countries. Follow-up national level dissemination will also be organized for local actors, and follow-up policy dialogues would be undertaken to get policy and program actors at the national and local levels to use the results in their activities. Each country team will also be explore the opportunity of dialogue with funding agencies within their countries to use the report of the project in designing interventions within their geographical areas. The result of the projects will also be widely disseminated through publication in peer review journals at local and international levels.

**Appendix D: Adolescent Post Program Activities Action Item Plan**

**POST PLP PROGRAMME ATIVITIES ADOLESCENT**

**PARTICIPANTS**

- Raana Zahid – World Population Foundation (WPF) Pakistan
- Ruth Largaespada – TeenSmart International – Nicaragua
- Oscar Noel Ocho – Ministry of Health – Trinidad and Tobago
- Luisa Sanchez Fuentes _ GIRE – Mexico
- Edith Mukisa – Naguru Teenage Information and Health Center – Uganda
- Anthony Ofosu – Ghana Health Service – Ghana
- Sylvester Adeh – Ministry of Health – Cameroon
- Adesegun Fatusi – Obafemi Awolowo University, Ile-Ife Nigeria
- Mana Rai – Tribhuvan University Institute of Medicine - Nepal

**Expectations:**

- Sharing of expertise for capacity building to facilitate the delivery of ASRH services
- Learn more about TeenSmart and how it can be adapted for Pakistan, Ghana, Trinidad and Tobago
Learn about other experiences that are related to adolescents that are available in other countries that could be adapted to Nicaragua

Receive resources to facilitate capacity building to work with adolescents

Exchange visits to successful ASRH services

Develop center for SRH information for adolescents

**Contributions that are available amongst Fellows:**

- Raana – Organization’s experience in working with NGO partners
  - IEC materials - Manuals, videos, posters, etc that have been developed
- Ruth – Share experience and findings from evaluation of TeenSmart
  - Provide training as to the operation of the project
- Oscar – Share experience of community collaboration for implementation of ASRH
  - Share experience with working with schools
- Anthony – Share experience with working with out of school youth
- Sylvester – Intergenerational communication
- Edith – Share best practice experience with ASRH services
- Luisa –
- Mana – Share research findings with fellows and others
- Segun – Result of the baseline of the “Community Partnership in Adolescent Health” (COMPAD) Project, Ile-Ife, Nigeria
  - subsequent project implementation materials

**Activities:**

- Training program in Mexico to implement TeenSmart program in Fellows countries
- Exchange visit to facilitate training of service providers in Trinidad & Tobago and Nicaragua by Edith
- Develop a PLP manual and program for ASRH internationally
- Create PLP adolescent email service
<table>
<thead>
<tr>
<th>Activity</th>
<th>Tasks</th>
<th>Output</th>
<th>Means of verification</th>
<th>Outcomes</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conduct TeenSmart training program in Mexico</td>
<td>1. Complete final evaluation of program</td>
<td>X number of NGO trained</td>
<td>Report from the training program</td>
<td>TeenSmart project adapted and implemented in X number of countries</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Develop proposal for PLP</td>
<td>X number of country representatives trained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Access funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Implement the training program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Adapt and replicate project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Exchange visit to Trinidad and Nicaragua</td>
<td>1. Develop proposals</td>
<td>X number of service providers trained in ASRH friendly services</td>
<td>Reports from training program</td>
<td>X number of ASRH services implemented</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Access funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Develop training program by Consultant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Implement training program for service providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Implement ASRH friendly services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Develop a PLP manual and</td>
<td>1. Review current training manuals for service</td>
<td>First draft of the manual completed</td>
<td>Complete d manual</td>
<td>Manual is pre-tested in all Adolescent PLP</td>
<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>program for ASRH</td>
<td>providers in ASRH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identify gaps in content</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Develop a PLP manual for service providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Pretest manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Revise manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>countries</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Create PLP adolescent email</th>
<th>1. Identify Fellows interested in ASRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Seek support from NTLP/Fellows</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Listserve created</th>
<th>Listserve Fellows utilize the listserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>