

The African Midwives Research Network

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and Social Development**

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Sida Evaluation 07/16

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Executive Summary

Background

The Africa Midwives Research Network was initiated in 1993 and has been supported by Sida since its origin. Since 1997 there have been three project phases, the last of which covered the five years from 2002 to 2007. During this period Sida supported AMRN directly and also financed a technical collaboration between the Karolinska Institute and AMRN. The budget for these two contracts was SEK 14 million.

The Evaluation

Sida is committed to continue its support to AMRN provided the government makes funds available for this purpose. This evaluation has been commissioned to analyse the results achieved to date, assess the network and provide recommendations on future activities. The evaluation builds on analysis of documentation, a survey to members, and site visits to three countries; Tanzania, Uganda and Zambia. The evaluation has been carried out between April and June 2007.

Coverage

AMRN is sometimes said to extend to 32 countries, but in fact there is regular and sustained communication and collaboration between the seven core member countries of Eritrea, Kenya, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe. Nurses and midwives from other countries have sometimes taken part in conferences, joint research programs, or in training activities.

Organisation

AMRN is a loosely organised network. It is based on volunteer work and it has organised biennial conferences regularly and with an increasing number of participants (200 at the last conference in 2005) over a ten-year period. In Zambia some 80 persons have received training in research methods, evidence based practice, information technology and scientific writing. Achievements vary between the seven countries, but taken together the total number of midwives who have received training can be estimated to some five to six hundred. AMRN maintains a website and aims also to keep in contact with members through newsletters, (the website is maintained at a minimal level and the production of newsletters has been discontinued in recent years).

National and Regional Levels

There is a Constitution that sets the framework of cooperation in AMRN. This serves the purpose of the regional organisation, but it does not address what the national level organisations should look like nor how they should be governed. There is a considerable variety and the organisation would be more transparent and accountable if it was clear to members at national level what it means to be a member and what they can expect from their membership.

Conferences

The biennial conferences are important events that draw a lot of attention. They have had interesting programs for five days and they fill a vacuum where midwives in the region had no similar arena for professional exchanges in the past. The conferences are much appreciated by participants and there is a

need to continue this activity. There is also a need to develop its format to ensure that it is as efficient and effective as possible.

Workshops

AMRN has two forms of training activities; at regional and at national level. It is useful to develop courses through regional cooperation, but it becomes expensive and less effective to run programs regionally. Most programs have been conducted at national levels after being developed regionally, and that should be the focus in the future as well. The national programs cover research method, evidence based practice, information technology and scientific writing. There is a logical progression between subjects, but the evaluation found that the level of theoretical input was at times very high considering the level of at least some of the students. It is also important that when training is to develop in phases, the next steps occur in rapid succession. Otherwise the impetus gets lost and students have to start anew or lose their motivation.

Impact

There has been a considerable impact as a result of the AMRN activities. The evaluation team saw significant changes in practice at wards and clinics in all three countries visited. The impact has been created through changes at many levels; in the rules and regulations for work coming out of the Ministries of Health that guide practice, through changes in curriculum at nursing colleges and midwifery schools, and through sharing of knowledge from evidence based practice, such as that disseminated through the training programs and the biennial conferences. Change happens because of several interconnected causal factors, some coming out of AMRN and others that have other origins (such as WHO, UNICEF and other international or national organisations).

Sustainability

The evaluation builds on the assumption that Sida will continue supporting AMRN several years into the future. This raises the question of sustainability. There is no doubt that the impact, embodied in the changes in practice that the evaluation has documented, is sustainable. These changes have led to safer, more effective, at times cheaper services to mothers at delivery. There is no reason to suspect that these changes will be reversed. AMRN as a network is also sustainable, the persons presently members can and will keep in contact. But the activities of the network, the biennial conferences, the training workshops, are not sustainable without donor funds (from Sida or somewhere else). It is not likely that they could cover costs commercially nor that governments in the region would allocate funds.

Recommendations

The evaluation concludes with recommendations on how the network and its activities can be further strengthened. There are some aspects of organisation that need to be developed, communication between members should increase, and there are some strategic options for network design. The activities should be consolidated; those midwives who have attended conferences and workshops need to continue evidence based practice and there are many more who ought to get access to the insights, the knowledge and experience contained in AMRN.

List of abbreviations used in the report

AIDS	Acquired Immune Deficiency Syndrome
ALARM	Advanced Labour and Risk Management
AMRN	African Midwives Research Network
DFID	Department for International Development (UK)
FCI	Family Care International
FGM	Female Genital Mutilation
FIGO	International Federation of Gynaecologists and Obstetricians
GNP	Gross National Product
HIV	Human Immune Deficiency Virus
HR	Human resources
HRH	Human resources in health
ICM	International Confederation of Midwives
KI	Karolinska Institutet
LSS	Life saving skills
MDG	Millennium Development Goal
MFAS	Ministry for Foreign Affairs, Sweden
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGO	Non governmental organisation
PhD	Doctor of Philosophy
PPH	Postpartum haemorrhage
SCF	Save the Children Fund
SEK	Swedish crowns (6.8 SEK = 1 USD)
Sida	Swedish International Development Agency
SMI	Safe Motherhood Initiative
SR	Sveriges Riksdag, the Swedish Parliament, Stockholm
TAMA	Tanzania Midwives Association
THET	Tropical Health Education Trust
TOR	Terms of reference

UK	United Kingdom
UN	United Nations
UNANM	Uganda National Association for Nurses and Midwives
UNICEF	United Nations Children's Fund
USD	U.S. Dollars
UTH	University Teaching Hospital
WHO	World Health Organization
WRA	White Ribbon Alliance

1. Introduction

Background to the Project

The Africa Midwives Research Network (AMRN) was created with an overall purpose to improve the quality of midwifery care in Africa as well as to strengthen and empower the African midwives in their professional performance. The starting point can be traced back to a Regional Reproductive Health Workshop in 1993 that was attended by midwives from Tanzania, Zimbabwe, Zambia, Mozambique and Sweden.

At first the collaboration was loosely organised as capacity building for research on reproductive health, but in recent years the network organisation has become more formalised. A system of biennial conferences has been set in place, and other joint activities, such as regional seminars, a joint secretariat, and other mechanisms for institutional collaboration have been created. There is a governance system with a board elected every second year on a rotating basis between the collaborating countries. The country where the chairperson and the treasurer are posted is the hosting country for the two-year period.

The work by the board and secretariat is done on a voluntary basis, but there is an ongoing project with Sida that finances concrete activities of AMRN. There are also other funding agencies that support network activities. The present (2002–2007) phase of AMRN is a continuation of a Sida support that has been going on since the origin of the network (1995–1997) including a project period of three years (1999–2001). The support to AMRN has existed parallel to other activities in institutional collaboration and research capacity building that Sida has financed in several of the participating countries.

AMRN aims to serve as a base for sharing information, strategies and solutions based on scientific evidence for provision of good midwifery care. AMRN also aims at improving the status of the midwife through research, and thus to enhance the dialogue between professional groups. These activities are meant to contribute to the overarching goal to reduce maternal mortality and morbidity. The specific project objective is to further develop AMRN for the identification, development, national and international exchange, and dissemination of research results in existing and ongoing programs. While the activities are directed at professionals, in particular nurses and midwives in reproductive health care, the final aim is to meet the needs of people, such as adolescents, women during pregnancy and delivery and their newborn babies, couples in need of contraceptives or counselling.

The stakeholders in the research network designed the present project in a workshop in 2002. Sida is supporting the activities at a regional level as well as activities at country level during the period 2002–2007. The budget for the project activities is SEK 10 888 800. On top of that, Sida also finances an institutional collaboration between the Karolinska Institute (KI) and AMRN during the same period with a total amount of SEK 2 601 500. The total amount of financial support from Sida to AMRN related activities thus amount to slightly less than 14 million SEK during the five-year period.

Purpose of the Evaluation

Sida intended to carry out an independent, external evaluation of the AMRN activities in the beginning of 2005, i.e. a mid-term evaluation slightly more than halfway through the project. However, it was perceived that too short a time had elapsed for any sustainable results to be seen and therefore the evaluation was postponed to early 2007. The present evaluation is expected to be formative and to identify strengths and weaknesses in the network. The evaluation is designed to give recommendations to AMRN on how to develop activities, as well as to Sida on how continued support can best be put to use. The terms of reference emphasise that Sida expects to continue the support to AMRN provided the government makes funds available for this purpose. The terms of reference are enclosed as annex 1.

Evaluation Methods

The two of us who have been commissioned as external evaluators have different backgrounds for the task. Gaynor Maclean is a midwife by profession and has pursued an academic career with research on reproductive health. She has a long record of teaching and has worked as an international consultant. Kim Forss has a background as an economist and is specialised on evaluation research. He works out of his company Andante – tools for thinking AB. Both have spent a number of years living and working in Africa and Asia.

The main source of data in the evaluation comes from visits to three of the countries participating in the network. The terms of reference mention 32 countries taking part in the network, but there is a core of seven countries that are active in the network from which we selected three to visit. These were Tanzania, Zambia and Uganda. We could equally well have visited any of the others; Mozambique, Zimbabwe, Kenya or Eritrea. But as the secretariat of AMRN is in Zambia it seemed important to interview the Chairperson and others in management there, and as the Secretariat had been in Tanzania during the first six years, we thought that interviews with the persons who had been associated with AMRN there would be useful.

Each country visit lasted for a week, and during that week we met the AMRN focal points and members, interviewed participants in training programs and discussed the impact of training, viewed changes in practice at clinics, held talks with officials of ministries of health on nursing and midwifery services, spoke to NGOs about reproductive health issues, and visited nursing and midwifery colleges and universities with programs in these subjects. A program of visits and list of interviews is enclosed in annex 2.

The meetings covered various subjects and the terms of reference show that there was much to seek information on. We developed open but structured interview guidelines for the main categories of informants. These are enclosed in annex 3. It would be important to assess the extent and impact of AMRN in other countries too. It is to be expected that it has achieved most in the countries where the organisation has had its home and where the most active participants live and work. We developed a survey that we sent out to 80 respondents in the other 29 countries, but unfortunately the response rate was low (11%). The questions are enclosed in annex 4, but we cannot make anything but sporadic use of the few responses. Nevertheless we do refer to the responses occasionally, so it is useful to know that the respondents were members since 7–8 years back (with one exception, who was not a member at all and had never heard of AMRN – how that person ended up on a list of AMRN members may be another story). The respondents had substantial training as midwives and nurses and had long clinical experiences. Many were in teaching positions. With one exception, they came from the seven “core” countries of AMRN.

Apart from country visits and interviews there, and the survey, we have studied documents of the project such as plans, progress reports, teaching material, internal evaluations. A list of documents consulted is seen in the references at the end of the report. We have had interviews at Sida and at the Karolinska Institute.

The evaluation pursues four themes of inquiry. First we discuss the relevance of the AMRN and its activities. This leads to an analysis of issues concerning human resources in the health services and whether AMRN can contribute to better career opportunities for midwives in the region. We also discuss rights based approaches to development and analyse whether AMRN could do more to work in advocacy from a rights based perspective.

Second we undertake an organisational analysis of the network as such. Does it have the best organisational properties? Is it possible, or desirable, to think differently around the structures and processes of network cooperation? Should the task be to expand the network further or does it need to be consolidated? Can the governance systems be improved?

Third, we analyse the activities that AMRN has undertaken to date. Are they in line with the overall task and purpose? Are they efficiently implemented? Is it possible to suggest improvements? What were the roles of other organisations such as KI and Sida? What will their roles be in the future?

Fourth, and most important, the evaluation turns to the impact of AMRN activities. It is well known that the overall purpose is not met, maternal mortality and morbidity appears to be on the increase in all the member countries. However, these trends are caused by other and more fundamental social and economic changes in the region. Whether AMRN has an impact or not must be analysed at a more detailed and specific level, and that is done through the follow up to training and research that was organised during the years of collaboration.

Each of these four themes is the subject of a chapter in this report, and the whole study concludes with recommendations for the future in Chapter 6.

2. Context and Relevance

Trends and Issues in Sexual and Reproductive Health in Africa

Worldwide, more than half a million mothers and 2 million newborn babies die each year (WHO 2003a, SCF 2007). It has been acknowledged that amongst the major public health indicators, maternal and child mortality demonstrate by far the highest differential between poor and rich countries (WHO 1989, UNICEF 2003). Almost half of the total maternal deaths each year occur in sub-Saharan Africa where the lifetime risk of a woman dying from pregnancy related causes is estimated at 1 in 16 by comparison with an overall average of 1 in 2800 in 'developed' parts of the world and 1 in 29,800 in Sweden (WHO 2003a).

A woman in sub-Saharan Africa is almost 100 times more likely to lose her child in the first five years by comparison with a woman in the industrialised world, with nine out of ten women in the region likely to lose a child during her lifetime. In a recent ranking of the wellbeing of mothers and children in 140 countries Sweden, Iceland and Norway top the list with nine out of the ten of the lowest ranking countries being in sub-Saharan Africa. The ten bottom ranked countries in this 2007 Mothers' Index portray a reverse image of the top ten, rating low on all the indicators and reporting that conditions for mothers and children are devastating.

The indicators include the fact that two-thirds of births are not attended by a skilled attendant, a high lifetime risk of dying from pregnancy related causes and high incidences of child malnutrition and mortality. In these countries there is inequity in respect of primary education for girls, on average less than five years formal education for women and women earn only half what men do for equivalent work (SCF 2007). It has been well documented that the incidence of maternal death and by inference that of maternal morbidity as well as perinatal mortality is highest amongst women who are poor and illiterate and where gender inequality exists (WHO 1998, Macdonagh 2005, Maclean 2005).

The sexual and reproductive health situation in Africa is further complicated by the prevalence of HIV/AIDS and malaria, low acceptance and use of contraception, high incidences of unsafe abortion especially amongst adolescents and harmful traditional practices (Abu-Raddad et al 2006, Barreto T et al 1992). Sub-Saharan Africa has just over 10% of the world's population, but 63% of all HIV infections are to be found in the region (UNAIDS/WHO 2006). In spite of a call for access to affordable and voluntary testing and screening for HIV and protection of the rights of infected individuals, none

of these priorities have been translated into laws, and most policies fail to account for the costs of such measures (CRP 2003). Critical links between HIV and maternal mortality have been confirmed in the region (DFID 2005). It has been established that HIV and malaria combine to adversely affect pregnant women and their babies as the mechanism by which women normally protect themselves against malaria is counteracted in HIV positive women (Kain et al 2007). Deaths in early pregnancy are under-reported in most countries particularly where there are high levels of unsafe abortion (Bareto et al 1992). Harmful practices include female genital mutilation (FGM) with an estimated 3 million girls being subjected to the procedure each year in sub-Saharan Africa and the Middle East (UNICEF 2005). Amongst traditional practices, administration of herbs in an attempt to accelerate labour frequently results in further complications including ruptured uterus and obstetric fistulae (WHO 2006a).



To the left; Private midwife with teenage girls she is enabling to acquire literacy skills, to the right a midwife with a couple she was counselling in antenatal clinic (both pictures Kampala)

Skilled Attendance in Connection with Pregnancy and Delivery

Since the launch of the Safe Motherhood Initiative (SMI) two decades ago, reducing maternal mortality has become a focus for international attention (SMI 1987). Skilled attendance during childbirth has emerged as a critical issue in recent years in attempting to achieve the Millennium Development Goals (UN 2000). In addition to the presence of a skilled attendant at birth, it has long been established that the maternal mortality ratio (MMR) decreases also when other reproductive health indicators are favourable. For example, where women live in urban rather than rural areas, when the female literacy rate is high, the total fertility rate is low, the per capita Gross National Product (GNP) is high and the uptake of tetanus toxoid immunization is high (WHO 1998). Hence, the provision of skilled attendance for every woman as a human right needs to be placed within the context of reducing poverty and promoting gender equity. This becomes very relevant in the current political climate.

Whereas almost all births are attended by a skilled health worker in the industrialized world, this falls to 58% in less developed countries and to 34% in those described as least developed (WHO 2006b, UNICEF 2007a). Sub-Saharan Africa, as well as many parts of South Asia, largely falls into the latter category UNICEF (2007b) reports that data on skilled attendance at delivery are only available for 74% of live births in the developing world and that delivery care has improved in all regions with the exception of Sub-Saharan Africa and parts of South Asia. The question of what constitutes 'skilled' in the context of skilled attendance was a topic generating much debate at the outset of the initiative (Maclean 2000). Whereas specific skills were identified and clarified by both WHO and the International Confederation of Midwives (ICM) (ICM 2002), the issue of keeping up to date and utilising

evidence based practice has become an area of increasing concern in recent years. A resolution of the World Health Assembly has called for the enhancement of nursing and midwifery services, based on sound scientific and clinical evidence. Initial work by WHO identified ‘a significant divide between developed and developing countries in terms of research capacity, evidence gathering and the methods applied in critical appraisal and use of evidence for practice’ (WHO 2003b). It is within this context that the work of AMRN becomes particularly relevant in progressing towards achieving the MDGs in Africa.

It has been emphasized that there is a need not only for the availability of a skilled attendant but that s/he must be able to work within an enabling environment (FCI 2002, WHO 2004). This includes addressing issues of supplies and equipment, functioning systems for referral of women with complications and supportive supervision as well as effective programs of education. The intervention calls for government policy commitment linked to equity (FCI 2002, Rizzuto & Rashid 2002, Lule et al 2005, Macdonagh 2005). Not least amongst these issues lies the complex and challenging question of human resources.

Human Resource in the Health Services

Whilst there are numerous matters that contribute to an enabling environment the issue of human resource (HR) in the health services underpins the concern of whether or not a skilled attendant may be able to function effectively. It has been stressed that focusing on increasing the production of skilled attendants is unlikely to be successful without also improving the broader human resource management systems that impact on the recruitment, development, deployment and motivation as well as the retention of health workers. It is further claimed that efforts to ensure a skilled attendant at every birth underscores the need for changes in human resource management and it is very evident that numerous health systems, particularly in countries with high MMRs, demonstrate ‘an overall lack of qualified staff, inequitable distribution of providers, high levels of absenteeism, and increasing attrition of skilled workers due to the impact of HIV/AIDS and regional/international migration’ (Macdonagh 2005).

Political commitment has been identified as an integral part of improving the human resource in respect of providing sufficient numbers of skilled attendants to meet the national need (Crump 2003). One of the approaches that has been taken by Family Care International is to take a government’s stated policy commitments in respect of maternal health and calculate how many skilled attendants are needed nationally to meet that target. The gaps are frequently found to be huge and can prove intimidating for governments but can also help them to face up to the commitments already made, that may well be encompassed in national plans and statements. This highlights the need to start training and retaining appropriate numbers to meet the stated goal (cited in: Macdonagh 2005)

Chen et al (2004) point out that appropriate workforce strategies can generate enormous efficiency gains but that successful strategies must be country-based and country-led. They should focus on the front lines in communities and need to be backed by appropriate international reinforcement. Vujicic et al (2004) point towards other important factors that impinge on the HR issue beyond the undeniable matter of poor remuneration; and these include professional fulfilment and career advancement opportunities. Living and working conditions including safety, transport and housing are also deemed important.

Rights Based Approaches to Reproductive Health

It has been well established that not only is there an enormous disparity between MMRs in the developed by comparison with developing countries but that further disparities exist between the different socio-economic groups within countries (Kunst & Houweling 2001, Braveman, et al 2001, Murray

2001, Hawkins et al 2005). It is reported that there is a significant increase in the risk of women dying due to pregnancy related causes in the presence of increasing poverty and further that gender analysis has revealed ways in which 'power imbalances enforced through culturally sanctioned ideas' can have deeply damaging effects on women's health (Hawkins et al 2005). Cook et al (2005) identify five basic kinds of human rights that highlight issues relevant to MMR. These encompass rights relating to:

- Life, survival, security and sexuality
- Reproductive self determination and free right to maternity
- Health and the benefits of scientific progress
- Non-discrimination and due respect for difference
- Information, education and decision making

It has been stressed that the human rights declarations underlying the UN system and adopted as law by virtually every country in the world lay out a vision for the rearrangements of power that are necessary for change and should therefore inspire strategies for meeting the MDGs. Three interlocking concepts: health systems, health equity, and human rights form the central themes developed by the Task Force in considering the goals, targets and indicators for child health and maternal health in this context (Freedman et al 2003). It is claimed that part of a larger struggle toward social justice can be observed in efforts being made to narrow disparities in health between the differing social groups (Peter & Evans 2001).

Over a decade ago, Magowe (1995) used a framework featuring human rights to promote the concept of Safe Motherhood. She emphasized the need to reduce discrimination in order to reduce maternal mortality. Magowe argued that human rights could be used to support actions at local, regional and national government levels. The advance of Safe Motherhood through human rights was advocated during the Safe Motherhood Technical Consultation in Sri Lanka in 1997. Transformation of thought that might result in political action was urged: 'The re-characterization of maternal mortality from a health disadvantage to a social injustice places governments under a legal obligation to remedy the injustice.' (Cook 1997) She maintained that in order to advance Safe Motherhood in this way, countries need to be seen to be violating international treaties, but maybe more importantly 'their own constitutions and values by neglecting to address the preventable causes of maternal death'.

It has been proposed that existing national constitutions as well as international human rights treaties offer opportunities that are underutilized to advance the causes of Safe Motherhood including the Convention on the Elimination of all forms of Discrimination Against Women (The Women's Convention), the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the African Charter on Human and People's Rights (WHO World Health Day 1998).

The Swedish government is committed to the principle of human rights in the context of her international policy on sexual and reproductive health and rights (MFAS 2006). Respect for human rights, democracy, good governance and equity between women and men are amongst the central components designed to permeate the country's new policy for global development (SR 2005). There is hardly any doubt that the subject matter of what AMRN does is closely related to the social, economic and cultural rights of human beings. However, even if the work of AMRN is connected to issues that are rights, it is not obvious that the cooperation in AMRN takes a rights-based approach to them. There seems to be no one "correct" understanding of a rights based approach (Lutrell et al 2005). International NGOs and UN agencies have adopted a variety of definitions.



To the left, student midwives interviewed (UTH Lusaka); to the right, a new family group including the father who had been present for the birth of his baby (Entebbe)

A common denominator seems to be the objective of ensuring the realization of people's rights as laid down in the Universal Declaration of Human Rights and other human rights instruments. By referring to such documents international NGOs add a new dimension to what they are doing. As such a rights based approach is not a political position – it is more a shared and universal framework – one that governments have recognized and one that civil society groups have contributed to developing, e.g. anti-apartheid campaigns or women rights movements.

There is an important distinction used in rights based approaches between “duty holders” – those who have the obligation to ensure that human rights are respected, protected and fulfilled, and “rights holders” – those that legitimately can claim rights and entitlements. Accordingly, NGOs have two main tasks: (a) to enhance the capacity of poor and marginalized people to become aware of and claim their rights, and (b) to assist local and central governments to deliver on their obligation. International NGOs with a rights based approach seem to prefer the first task, but the UN definition highlights the need to also build the capacity of duty bearers as well as rights holders.

There are those who claim that the most important role of civil society is to make people aware of their rights. Civil society organisations should hold people accountable – monitor and report from the grassroots on the use and abuse of power and allocation of government resources. Civil society organisations should not be involved in any service delivery – filling gaps in Government capacity, but build accountability from below focusing on networking, lobbying, monitoring, organizational development, etc. Others argue that the role of civil society depends on the context. In poor developing countries with legitimate governments, civil society organisations should not only help people claim their rights, but also assist governments to fulfil their rights – because governments may not be unwilling only unable to do so. They are poor and lack the resources to do what a Government should do. If you want to make a difference, NGOs should work with the government and not in parallel or contrary to government plans.

In line with AMRN's main emphasis in preparing midwives to undertake research and implement evidence based practice, AMRN's activities enable “duty holders” to deliver services, but the network does not principally work to mobilise people to claim their rights in this field nor does it visibly work politically to ascertain that women's rights to safe motherhood are respected and that adequate resources are devoted to this. Some rights based organization actually exclude the possibility of being involved in service delivery – a rights based NGO should only claim rights from the duty holders. That is not the position taken by AMRN. Furthermore one could argue that to be engaged in services can be seen as a way to mobilize target groups and making authorities more responsible. However, we have not seen AMRN take such a position either. In conclusion, AMRN can be seen as rights-based because it works

within a field where the international community has codified economic, social and cultural rights. AMRN's activities has focused on "duty holders" to deliver services, but it should be possible to use the network to discuss various experiences of working with "rights holders" as well.

Box 2.1 A rights-based approach to reduce child mortality in Uganda

Two economists (Svensson and Björkman) followed a project where people in a Ugandan village were informed on their rights to health services and they were assisted to organise themselves to claim services from the local health clinic. Corruption and inefficiency were reduced when clients could give voice to their complaints and demand quality service. When the clinic became more responsive, people started using it more, and they also got more trust in the services. When the study was followed up one year later the child mortality in the village had been reduced by 33% by comparison with the neighbouring villages, and the average weight of children had increased. (Forskning och Framsteg, no 4, 2007)

Conclusion in Respect of AMRN's Relevance

In the context of achieving the MDGs, the Task Force on Maternal and Child Health identified numerous issues that are most likely to require attention in countries experiencing high mortalities. These include human resources; leadership at the national and sub-national levels; human rights/transparency/accountability; financing; management at the district level and in health facilities; evidence based practice and building up and supporting the capacity of citizens to effectively address these issues in their own countries (Freedman et al 2003). The AMRN-Sida tactic embracing an arena approach for development (Johansson & Christensson cited in TOR 2007) is in a strategic position to directly address many of these issues and to influence some of the others. The significance of the 'core group', comprising persons in leading positions who have the mandate to make quick decisions has been instrumental in moving the work forward in respect of midwives both undertaking research and implementing evidence based changes in practice. AMRN has also been instrumental in facilitating the professional fulfilment and career advancement opportunities identified as pertinent by Vujcic et al (2004) and cited earlier.

There is evidence of impact with considerable transformation taking place within the countries studied (See chapter 5). Implementation of change in practice can be a protracted and sometimes ineffective exercise. A study in South Africa (Theron 1997) reports the outcome of the implementation of an in-service training program for health workers in peripheral areas. Although this was a distance learning approach the study concluded that even though midwives who had completed the program demonstrated an improved level of knowledge, no alteration in their practice was detected. Various explanations are offered for this stalemate that has occurred following diverse educational approaches, amongst them the suggestion that the midwives who completed the course may not have been able to alter the management protocols, nor possess the skills to negotiate for introduction of change. As a result a sombre warning has been mooted from the African continent that 'The widely held assumption that improved knowledge results in improved care may not be true' (le Roux et al 1998). In utilising the arena approach cited above, together with the AMRN programs in communication skills and information technology the AMRN core group have been well placed to overcome some of these barriers to introducing changes in practice.

The work of AMRN having been initiated in 1993 (TOR 2007) could therefore be described as visionary. It preceded the current emphasis by WHO on the importance of building research capacity and evidence based practice in the field of maternal and newborn health (WHO 2003b, WHO 2003c, WHO 2003d). However, there are further factors that continue to hinder improvement in care; and these hinge upon issues of human resources, health care systems and supplies and equipment. These will persist in contributing or detracting from the enabling environment that is an obligatory background to the effective functioning of a skilled attendant (FCI 2002). The fact that AMRN national

leaders are in senior positions and are increasingly consulted at a national, regional and international level to advise on and contribute to strategies and policies on these and other critical issues is both timely and crucial.

3. The Network Approach

The Meaning of a Network

AMRN has the word network in its name and title and in this section we will explore what kind of a network it is and what kind of a network it could develop to be. The very word “network” implies some form of a structure. It suggests that we are looking at a system composed of different parts – and that these parts are related to each other. The elements of network theory are simple. The elementary units are nodes (for example persons, organisations, regions, and countries) that are related to each other via links (for example friendship, transfer of funds, joint purposes). Together, links and nodes form structures that are networks. The premise that organisations are networks of recurring relationships applies to organisations at any level of analysis (Noriah and Eccles 1992).

So, what kind of a network is AMRN and how can one better understand AMRN as an organisation with the help of network analysis? A network can usually be depicted in the form of a graph. Figure 1 below presents two examples of network structures, and it readily gives rise to definition of at least three structural properties; (1) the size of the network, (2) the configuration of relationships and (3) their connectedness (these are illustrated in figures 2 and 3).

Network Size

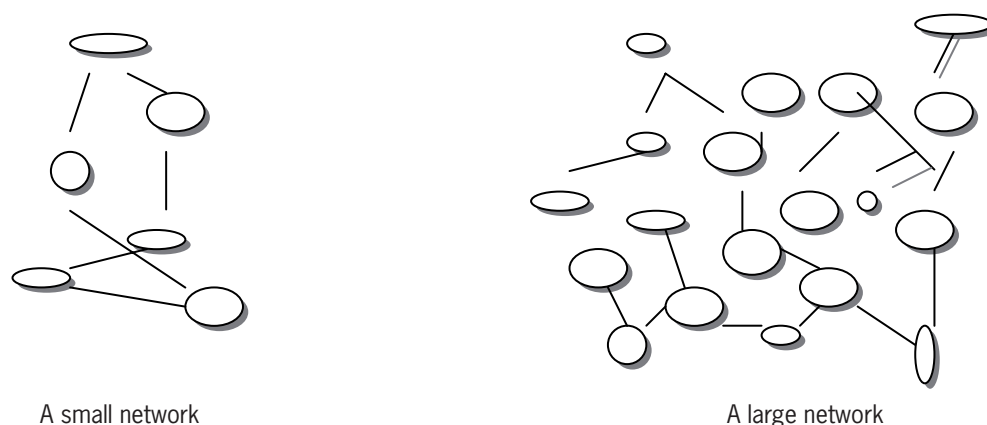
The size of a network is often given. In an investigation of network properties in aid, Forss (1988; 1990) found that the number of actors could vary from some ten and up to hundreds of actors. The networks that had most actors were those that were preliminary forms of sector wide programs, such as Swedish aid to the agricultural sector in Zambia, or to the small industry sector in Tanzania. At a first glance AMRN seems to be a large network. As the terms of reference and other descriptions indicate, it is “African” in scope and that implies coverage of the whole continent. Some presentations say that it is a network extending to 32 countries. However, in the course of the evaluation we found that it is a relatively small network. There are regular contacts between the seven core member countries of Eritrea, Kenya, Uganda, Tanzania, Zambia, Mozambique and Zimbabwe. If we look at countries as members of the network, it is these seven that make up the network.

But AMRN does not necessarily count membership by countries. It could be possible to look at institutions or even individuals as the relevant parts of the network. In each of the seven countries there are a handful of persons who are quite active in AMRN, and then there are others who are paying members. AMRN in Zambia counted some 80 members and there were about equally many in Tanzania. If there are equally many members in each of these seven countries the network could be said to have some 5–600 members. In both Tanzania and Zambia members are expected to pay a nominal membership fee, but it seems that people would still be members even if they haven’t paid the fee. In Uganda midwives automatically become AMRN members by virtue of their membership of the Uganda National Association for Nurses and Midwives.

There are no clear obligations or rights associated with membership, for example in respect of voting at the annual meeting. Hence AMRN (at national levels) is a rather informal organisation, where those

who want to engage themselves for the purposes of the organisation can do so and can take part in the activities. There is of course no problem with that, but in the long run it could make the organisation vulnerable to the commitment and loyalties of some few people. The annual meetings of AMRN (in Tanzania and Zambia) occur in connection with the annual meetings of either the Tanzania Midwives Association (TAMA) or the Zambia Nurses Association. Our interviews with chairpersons indicate that there was not any formal counting of members, of who paid or not and whether that meant one could vote for functions in the organisations or be eligible. However, the Constitution of AMRN does not say anything about governance at the national level and hence the persons who have been active at the regional level have designed their own means of how to develop the organisation at the national level.

Figure 3.1 Illustration of different size of networks



What about the other African countries (apart from the core of seven countries)? People and organisations from other countries have attended conferences, presented research proposals, or even taken part in training activities. There have been more frequent contacts with countries such as Swaziland, Malawi, Namibia and Ethiopia. But they are not part of the network to the extent that they have formalised relations or take part in governance, or have access to network resources provided, for example, by Sida. If these countries were to be considered part of AMRN then we have a network of some 12 to 15 member countries.

Yet other countries have taken part and possibly benefited from activities. AMRN had a research project financed by the Rockefeller Foundation and through that midwives/researchers from other countries attended the biennial conference and shared in research work in other ways. There were participants from some French speaking countries in West Africa, and from Gambia, Ghana and Nigeria. There were also partners from Egypt and Sudan. The size of the AMRN as a network organisation is thus hard to determine; formally speaking it is no more than seven countries and it is only these that take part in governance and who have some frequency in the interaction and where there is a sense of rights as well as responsibilities in relation to the organisation. But depending on how we look at it, one could speak of a larger network¹. The responses to our questionnaire show a strong support for extending the network to many other African countries, including those that are French speaking (75% agree that the network should include French speaking countries). However, at the same time 67% strongly agree that the network needs to be consolidated. Both might be desirable and indeed possible, but that depends on the amount of money available. With limited resources it is necessary to choose.

In conclusion we found that AMRN has an appropriate size; it has a core of seven member countries and within each of these countries it is quite open to participation. Other countries can take part in

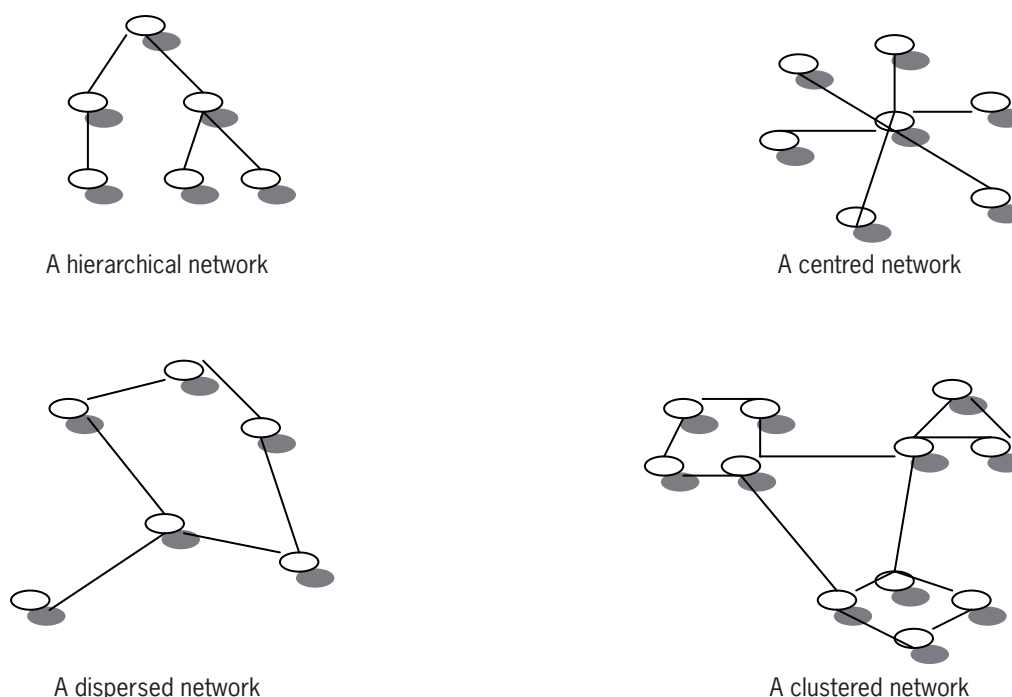
¹ There is no centrally held registry of members. When the evaluation asked for a list of members we got the mail addresses of the chairpersons in the seven core countries, and then a list of participants in training events and attendants at the biannual conferences. This reflects the informal character of the network and it is not necessarily critical.

conferences and selected activities, hence AMRN has “open boundaries” although formally speaking other countries are not yet full members. There is no doubt that it could expand, there seems to be an interest in the activities from many other countries. However that would mean that the relatively informal character of the network would change, and in the short run that would entail costs. We think it is better to consolidate the present network structure and to develop activities in these seven countries.

How the Network is Kept Together

The configuration of the network is the second design variable. There are four possible network configurations. We have called them hierarchical, centralised, dispersed and clustered respectively (figure 3.2). There is no reason to consider any one superior to the others a priori. Utility and effectiveness would depend on the nature of the task that the network should accomplish and which actors are found at different levels. AMRN appears to be more like a dispersed network than any of the other organisational structures.

Figure 3.2 Illustration of four network configurations



At its origin, in the first years of operation, it was probably more like a centred network, as much of the initiative and visions seems to have come from the Secretariat in Tanzania. The other countries related more to Tanzania than to each other, and the links between them seems to have passed through Tanzania. When the Secretariat shifted to Zambia at the end of 2005, there was a temporary shift in the level of activities. That is in itself not surprising and would be expected when difficult and time-consuming activities are handed over with no extra resources added. AMRN has not become a clustered network; we have not found any indications that there are groups with more intense communications with each other than with the rest of the network. If, for example, there were more Portuguese or French speaking countries present such groups could easily form. This is a strong argument to keep AMRN primarily for countries where English is spoken frequently. There is a high cost associated with translation in workshops and conferences, and that money could be better spent either directly on training, research, or service delivery. If AMRN is to expand more and if it was to become African, it is very likely that the configuration of the network would have to change and that the Constitution would have to change accordingly.

During the evaluation we visited Tanzania, Zambia and Uganda, and we have also looked at various documents. We don't find any evidence that some countries would be absent from discussions. Eritrea and Mozambique would otherwise be the countries that are different from the other five, who all share English and a tradition of relating to the UK for professional development, training, curriculum development and so on since colonial times. It is of credit to the network that these two countries have found a natural and equal role in AMRN. We think it is important that AMRN retains the characteristics of a dispersed network. The members in the seven different countries should communicate freely with each other and share ideas, research findings, and develop training according to the needs and opportunities. A dispersed network is more effective and it would keep the channels of communication open. There is sufficient diversity between these seven countries for them to contribute to each other's development and to generate interesting experiences for each other.

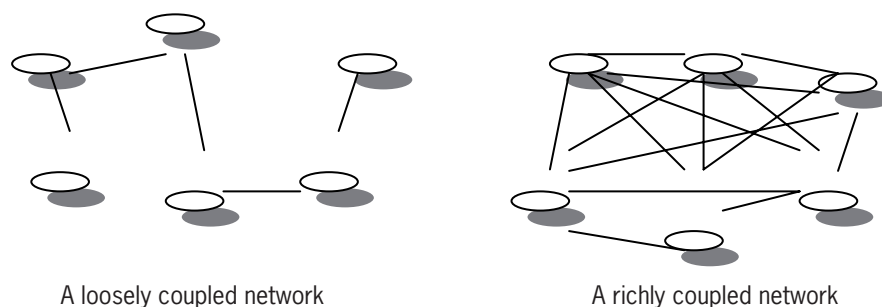
Contacts in the Network

The third structural feature relates to the number of links among the actors in the network. There is a visual presentation of the differences between a loosely coupled and a richly coupled network in figure 3.3. Several authors have claimed that richly coupled networks may have strong advantages in coordinating behaviour and thus in responding to emerging opportunities or threats (Porter, 1990; Piore, 1992; Perrow, 1986). But there are also other viewpoints. Granovetter's (1973) theory of weak ties in sociological network theory casts an important light on the nature of co-operation. This theory explains how a social system organised by a greater number of acquaintances (weak ties) rather than close friends (strong ties) will exhibit greater aggregate innovativeness, cohesiveness and adaptability.

The questionnaire indicates that contacts between network members (apart from the persons that are most active in the executive board) are limited. 75% of the respondents say they do not cooperate with AMRN institutions in other countries, they do not receive newsletters and they do not visit the AMRN website regularly. No more than 25% say they are in regular correspondence with other AMRN members; they do not meet frequently outside AMRN activities, and less than 50% meet other AMRN members in their countries. However, in interpreting these results it is necessary to remember that the number of respondents is very low and may not be typical at all. On the other hand, those that did respond say that problems with internet access, power cuts, work situation, mean that they cannot maintain contacts in the network as much as they would like to, and that is likely to be a general problem.

AMRN must be considered a relatively loosely coupled network. There is not a great deal of communication between the network partners. Newsletters are few and far between. The website is not interactive and it is rarely updated. Many of the processes that could keep a network together, such as these, are not really visible on AMRN. Instead there are three processes that keep the network together; the Executive Board meetings, the Biennial Conferences, and the Regional Training programs.

Figure 3.3 Illustration of loosely coupled and richly coupled network designs



The Executive Board meetings are relatively few, for obvious logistic reasons, and as far as we have seen there is no communication to other members about the board procedures or results. As the work that goes into keeping AMRN together as a network is to a large extent voluntary and occurs outside of the persons' regular employment, it follows that there is a clear limit to what one could expect in terms of intensity of communication and engagement. It is, in fact, quite remarkable that the network has been sustained at a high level of activity. The question is if it would be better to create salaried positions and thus to make sure that someone has the task of keeping the network alive and to keep members up to date on developments.

The internal evaluation of AMRN in Tanzania suggested that the post of a coordinator for activities in that country should be created. The equivalent evaluation in Uganda recommends the recruitment, training and retention of project experts. There is hardly any doubt that such posts could be useful at both the level of individual countries and to the network as a whole. The disadvantage is that it presupposes finances. The network has been able to do a number of things within the present organisational structure and the network resources have been used for activities that are directly useful to midwives. It is better to have activities than to have organisational structures and as long as AMRN continues to be useful to members without having permanent institutions, so much the better.

The AMRN offices in Uganda, Zambia and Tanzania are all different. In Tanzania the office is immediately outside the Muhimbili hospital gates. It is a central location, but as it is usually not staffed, midwives who pass by cannot easily get access to the computers or to the library. It is useful for the elected members in Tanzania to have some joint space, but it comes at a high price. Office furniture, copying machines and computers all hold a high standard, but as the office is closed most of the time the equipment cannot be used to its full potential. The secretariat in Zambia looks different as it is adjacent to the offices of some of the persons working in the regional secretariat or for AMRN in Zambia. It is well equipped and maintained too, and it seems that it is more accessible than the office in Tanzania. In Uganda office space for AMRN has been allocated at the Uganda National Association for Nurses & Midwives in Entebbe, this has the advantage of providing easy access to the officers of the former organization who sometimes assist AMRN with transport and other facilities, but is far from the main Mulago hospital in Kampala, another office base is currently under consideration for use of members working there. The computer at the Entebbe office is in good condition and has recently been updated but sometimes midwives face difficulties in accessing the internet from the site.

AMRN's Constitution

The Constitution is a document of 12 pages and it specifies most of what a constitution should specify. Most important, it sets the aim, the objectives and the functions of the network. The first function that is mentioned is "to mobilise for membership within the African region". The discussion above has touched upon the size of the network and how its parts relate to each other.

We have not seen that AMRN does much active work to mobilise members throughout the region. The Conference invitation is disseminated and people are welcome to the conference from all over the region. But it does not seem that there is any active drive to recruit members. We have argued that a smaller network may be more useful. It is definitely more sustainable. If the network was to grow, it needs to become more formalised and it may also require full time personnel in the Secretariat. In the short term, that is, in the next five to ten years, we think resources put into AMRN are better used for training and research, and advocacy, than for a broader regional representation at meetings. We would suggest that the network functions are modified accordingly in the Constitution (page iii, section 5.1).

It is not quite clear where membership is vested. The Constitution says that "full membership shall be open to all professional midwifery interest groups within National Associations" (page iv, article 6.1). In practice, people appear to be members in individual capacity, and there is no sense of institutional

representation. We did not see any institutional ownership of AMRN in either Tanzania or Zambia. It is not quite clear what the “National Association” is either, but we take that to be a professional association of nurses and/or midwives. That may need to be made clearer in the Constitution.

The AMRN members that were interviewed in Tanzania and Zambia usually saw themselves as members of AMRN in that particular country. (The membership fee in Zambia was almost ten times as high as that in Tanzania). As there were annual meetings of AMRN in Tanzania and Zambia, it does seem appropriate to think of it as national chapters of a regional organisation. But the Constitution does not say anything about organisation and governance at national level. It would be useful to set out how AMRN should be organised at national levels and how national representatives could take part in decisions at the regional level. The present Constitution vests membership in “midwifery interest groups”, and there could thus in theory be many from one country and few from other countries. A clear hierarchical structure that defines AMRN’s organisation at national and regional level could both consolidate the present network and make it easier to expand to a few other countries if there is a desire to do so. The national chapters of AMRN could be open to individual and institutional members and the members should be registered. Members could vote at annual meetings, and the elected chairpersons and other functions should be accountable to members. The leaders of the national organisations could represent their national members at the regional level. The details of these arrangements need to be worked out and adopted by AMRN.

The Constitution says that the Secretariat (headquarters) should be in any member country and shall be determined from time to time. The Secretariat was in Tanzania from 1999 up to 2005 and has since been in Zambia. It is an important principle that all members should be called upon to take this responsibility. It is also prudent not to shift the Secretariat too often as the costs for doing so are high. It was time to shift the Secretariat from Tanzania in 2005, and it is very useful to have all the key functions of the Executive Committee in one country. There is no need to change the Constitution on this point; it is flexible and the decisions appear to have been appropriate and on time.

The Constitution is not easily accessible and it appears to have been updated, though it is not quite sure how and when. The Constitution should be presented on the webpage and should also be a document that is frequently consulted and in use.

4. Network Activities

In this chapter we turn to the activities of the AMRN. These are straightforward; the network has been focused on the delivery of some few specific services in training and exchange of research findings and evidence based practice. This sort of relative simplicity of the design and focus on some few activities is often found to lead to good results in regional programs of development cooperation². Regional programs otherwise have a tendency to get overly complex and to aim for many levels of objectives, while at the same time often having limited resources. AMRN has not had that problem. In the following we review each of the four activities of the program and we also discuss the contribution of KI and the role that KI has played in the development of AMRN.

² See for example the World Bank, (2007) *The Development Potential of Regional Programs – Evaluation of Multi-Country Development Programs*; World Bank, (2007) *Global Evaluations Sourcebook – Sourcebook for Evaluating Global and Regional Partnership Programs*; Forss and Lundström (2004) *Evaluation of EPOPA, the Export promotion of Organic Products from Africa*. Commissioned by Sida.

Biennial Conferences

The Biennial Scientific Conferences constitute the flagship activity of AMRN. They are the most visible activities and the ones that are most widely attended. Taken together they have been a great success; they have been implemented according to schedule every second year and within budgets throughout the lifetime of AMRN. They have had relevant themes that are in line with the rights-based approach to midwifery and the conferences have had a focus on reaching poor people with services and addressing poverty issues. Table 4.1 presents the five Biennial Conferences that have been held to date and the sixth scheduled for November this year.

Table 4.1 AMRN Biennial Conferences

Date and venue	Conference theme	Participants	Cost (USD)
1997, Zimbabwe			
1999, Zambia			
2001, Tanzania	Evidence based Reproductive Health care: A key to the development of all nations	336	
2003, Mozambique	Enhancing Clients' Rights and Quality of Care in Reproductive and Sexual Health	100	48.000
2005, Uganda	Enhancing Quality of reproductive Health Care in the Advent of the Millennium Development Goals	200	48.000
2007, Kenya	Strengthening research capacity among nurses and midwives: challenges in utilizing evidence based cost effective interventions in promoting maternal and child health.		

Source: Progress reports from the project and audited accounts.

Once the conferences have been held it seems obvious that these events should happen. In fact, it is quite remarkable that plans such as these that were set in 1996/97 are actually implemented on time and within budgets, and with an increasing number of participants. The fact that they have been implemented according to intents, based on voluntary labour and very small amounts of money, is in itself a major achievement.

It was difficult to assess what participants thought of the conferences. There were no separate evaluations asking whether the arrangements met expectation, whether the participants learnt from the papers presented, whether the schedule of events at the conferences could be improved, or any of the other standard evaluation questions that conference organisers usually ask participants about. The responses to our questionnaire do not suggest that the conferences should have been done differently. When we raised the subject during our interviews in Tanzania, Zambia and Uganda, the respondents generally were very pleased with the conferences.

When we look at the conference program of the 5th Biennial Conference in Uganda, we note that during the four days of the conference there is only one event at a time; either a presentation or a workshop. All sessions occur in plenary, with all attendants present at the same time. To take an example, between 11.00 and 12.40 on the second conference day there were 7 presentations of some 20 minutes each, followed by 35 minutes of discussion. That sort of schedule is not really conducive for effective professional exchanges; the first paper presented would be forgotten by the time discussions were held, and anyway to discuss seven papers in 35 minutes easily becomes superficial. It would have been far better to have parallel meetings and thus to allow more time, and smaller groups for focused discussions.

It is difficult to choose keynote speakers for conferences. It may be difficult to get persons with busy schedules, such as ministers or other politically important people. It should of course also be speakers who can set the tone for the conferences. AMRN appears to have had good keynote speakers most of

the time, but there was one mistake when the First lady of the Republic of Uganda addressed the 2005 conference. It is important to gather an understanding of the kind of messages keynote speakers will deliver, so that they do not become counterproductive for the purposes of the conference. This would be particularly important when political figureheads are invited to speak at the conferences.

This example shows that AMRN needs to reflect more critically on the conduct of the Biennial Conferences and to evaluate them carefully with the help of the participants, either through interviews or questionnaires. There is a need to develop the format of the conferences and to learn on how to improve them and create a higher impact, even if the participants generally have been very content with their experiences.

Regional Workshops

AMRN has since its beginning conducted regional training programs/courses for midwives. The aim was to develop courses and conduct them with participants from a number of countries. By having several nationalities present AMRN would achieve its objective of disseminating experiences between countries in the region, and midwives would develop professionally by engaging with colleagues from other countries. Once the courses have been developed at regional level, it was expected that they be implemented on a national basis so that more midwives could attend. It is, after all, quite expensive to bring participants from seven (or more) countries together for the training and the question is if the expected benefits merit the increased cost of the regional event. AMRN has conducted two different regional training programs; in research methodology and in scientific writing and communication skills. The titles of some programs have changed over the years, but the content follow those mentioned above, and the difference between the training events is clear.

As with the Biennial Conferences, the participants were clearly very content with the regional programs. Looking at the course in research methodology, this is conducted in four phases each hosted by a different member country. Phase one focuses on identifying a research question and/or statement and developing a research proposal. Phase two teaches appropriate methods of data collection. Phase three incorporates methods of qualitative and quantitative data analysis. Phase four helps midwives to write up and disseminate findings from their research. There is a logical progression from one subject to the other and the overall course design appears suitable.

In meeting persons who have taken part in the course, there are some questions that need to be addressed. It can take a very long time from the first meeting in the course to the follow-up. Some of the persons we spoke to had had an introduction to research methodology in 2001 and had then developed a research proposal. In 2007 the research was still not started and there were only results from a pilot phase to show. The ideas generated were not put to use, and the follow up from the course to research practice appears to be weak. Also, the time lag between the different events in the program appears to be too long. In other cases, the AMRN training in research methodology was in itself fine, but as the persons that attended later commenced on Ph.D. programs they had to attend research training again.

The content of the research methodology course is quite advanced and more or less follow what could be expected at a Ph.D. level introduction to methodology. There are components on research design, sampling methods, statistical techniques as well as qualitative data gathering and analysis, etc.

The contents are certainly appropriate for training in the research process. However, some of the participants did not appear to have the background required for such a sophisticated program. In some interviews we followed up the research proposal of the persons interviewed, and it seemed that even very basic questions around population size, sample size, sampling methods, were not fully understood. There were no grades or any other summary of the training programs and hence we cannot say how many that actually mastered the subjects, or reached the objectives, of the training.

The regional programs are expensive compared to national workshops. The costs of bringing people together from Eritrea, Uganda, Kenya, Zambia, Zimbabwe and Mozambique are substantial. Airline tickets, hotels and per diem add to the budget, and there might be additional costs for translation. While the regional dimension as such is important, we would think that the overall interests of exchanges of experience between the AMRN member countries are best taken care of through the Biennial Conferences. The cost-effectiveness of regional training would be very low compared to what can be achieved through national training programs. In the past the regional programs were used to introduce subjects, but in the future we would suggest that subjects are introduced in the national context instead. The workshops can be more quickly developed and it is more likely that the training will have an impact on practice when more people are trained. They can then support each other and work together for research or to make sure that research findings are put to use. Even though regional cooperation is worthwhile, some of AMRN's arenas are more suitable for action at the national level.

National Workshops

The national workshops have followed the content of the regional programs, and in some cases subjects have been introduced directly at national level. The types of training are similar to that at the regional level; (1) research methodology, (2) evidence based practice, (3) information technology, and (4) scientific writing/communication. Table 4.2 presents an overview of the national workshops that have been conducted during the period of 2002–2007.

Let us look closer at the case of Zambia. The research methodology course was introduced in 2000 when the first part was conducted. This was followed up with a second program in 2002, which is shown in table 4.2. Since then the course has not been conducted again. The demand would be there and it is only a minor share of the 3.000 midwives in the country that received the training. If a program such as this is introduced, it should be continued and the aim should be to introduce training programs that can be run regularly. The training in evidence-based practice is an example of how training should be introduced and developed, starting at a low level with fewer participants and then being repeated and expanded.

In Zambia, the sum total is 117 training opportunities. However, some of the participants have progressed from one training event to the other so it is not a total of 117 different persons being trained. Taking account of that some persons have participated in more than one training event; the total number of persons trained is closer to around 80 or 85. Table 4.2 presents data from all the seven countries, and it would seem as around 1.500 persons have been trained altogether and that is a considerable achievement. There are differences between countries that we have not been able to explain, but the table shows that efforts vary over time but it is an impressive training effort overall.

Table 4.2 Training programs at national level (year, number of persons trained)

	Eritrea	Kenya	Mozambique	Tanzania	Uganda	Zambia	Zimbabwe
Scientific method						2002 (10)	
Evidence based practice	2002 (20)	2004 (24)	2002 (22)	2005 (16)	2000 (25)	2002 (13)	2001 (18)
	2002 (32)	2005 (30)	2003 (22)	2006 (29)	2001 (17)	2004 (14)	2005 (256)
	2005 (52)	2006 (25)	2004 (21)		2002 (25)	2005 (19)	
			2005 (22)		2004 (27)	2006 (21)	
			2006 (17)		2005 (19)		
					2006 (21)		
					2006 (26)		

	Eritrea	Kenya	Mozambique	Tanzania	Uganda	Zambia	Zimbabwe
Scientific writing and communication skills	2003 (50)	2004 (20)	2003 (20)	2005 (15)	2003 (25)	2004 (19)	2003 (16)
	2004 (150)		2006 (30)		2005 (26)	2005 (17)	2003 (16)
Information technology	2006 (50)	2003 (20)	2003 (20)	2003 (16)	2003 (24)	2004 (14)	2003 (12) 2003 (13)

Source: AMRN Progress Reports

In Tanzania the participants in the national events came from different parts of the country. There was a conscious intent to make sure that midwives serving in remote areas such as Kigoma, Mbeya, Mwanza and other distant towns also got an opportunity to be trained. A similar approach has been used in Uganda with midwives from private practice and institutions and mission hospitals as well as government facilities included. In both Mozambique, Kenya and Zimbabwe there were training events in different parts of the country, which is another way to make sure that midwives on “hardship postings” also get access to training. As the training opportunities are also meant to serve as an incentive, it is important that serious efforts are made to get a large share of personnel from rural areas and from locations that are more difficult to work in.

In the case of Zambia, the training has for the most part been conducted by the persons who are also elected to the management of AMRN in the national office (which also is the regional Secretariat at present). On some occasions there have been other resource persons, for example to run the information technology workshop. The capacity to initiate and run the programs professionally is obviously there. The programs have been run professionally and the participants express that they learnt much from the occasion.

A few of the programs were evaluated at the end of the training, but such evaluations are not the rule. We have not looked closely at the content of the national workshops, but they – like all training programs – can and should be assessed and further developed. There is always room for improvement. It would also be useful if the biennial conferences could have sections where the experiences from national training workshops could be compared.

One of the problems in the training programs that progress in steps, over several years, is that people disappear. Out of the group of 12 that started training in Zambia in 2000, no more than 3 or 4 remain. According to interviews, some of the former participants were deceased, some had left the profession and some had moved to other countries. Those in the last group could of course still benefit from the training, though more for the benefit of their clients in their new countries of residence than for people in Zambia.

Journal Clubs

The purpose of journal clubs is to enhance midwives critical appraisal skills by engaging in reading research findings, discussing and evaluating the research and strategies to apply the findings in practice. In that, the journal clubs form a practical and logical extension of the workshops in evidence-based practice, as these are also meant to teach practitioners the skills in reading scientific reports, and the ability to tell whether the findings are applicable in the conditions under which they work.

The journal clubs make literature available and offer a place where midwives can access and read research publications. It should be possible to do so in the AMRN offices and at times also in the wards where midwives work. In Zambia, Uganda and Tanzania the local offices could offer such amenities in theory, but in practice it is more difficult. First, the AMRN offices are not always open, and they tend to be closed after working hours, when other midwives would be most likely to visit them. However, most of the midwives we talked to generally expressed some doubts about the prospects of reading after work:

“Working hours are long and often the work is very hard, we are few people in the ward and sometimes it is overcrowded with women to deliver. There are all kinds of short-ages. At home we have families waiting, children and husbands. It is difficult to get time to go and read scientific reports even if we would like to....”

This part of the program is probably not very effective, but on the other hand it does not cost that much money. The shortage of relevant professional journals however poses a serious stumbling block at present. It may serve a purpose as a vision of how things ought to be, what professionals should be encouraged to, and – in the event that someone does have the time – that the possibility to take part of the research frontier is there.

Website and Newsletters

Communication is an essential part of a network and for that the website as well as frequent and substantive newsletters are important. AMRN should be credited for setting up a website early and for maintaining funds to keep and update the service.

Newsletters are also important and should be produced regularly. A quarterly Newsletter is said to be produced by AMRN (in the program documents and at the website). The first issue was produced in Sweden and the second one was done in Lusaka, Zambia. The third issue was produced in Dar-es-Salaam, Tanzania. The third issue was distributed in the 3rd Biennial conference that took place in 2001. It was then expected that Uganda would continue with the production of the Newsletter, but no newsletters have been produced since 2001. There is not much more to be said than that this must obviously be rectified. Many members are connected to the Internet and an electronic newsletter, published on the website and distributed over the net, is a necessary complement to the other activities.

The website is not always open and it took several weeks before the evaluation team could read the website. It was apparently closed for maintenance, or there were other problems with the server, or there were other problems with the company hosting the site. The website has the most essential information but it needs to be developed and managed more actively. Some of the shortcomings with the present site are:

- It does not show when it was last updated
- Events occurring in 2003 are still mentioned as “upcoming”
- Under the heading of “Information from member countries” there is no further information
- There is no information on how the network is set up, how people are elected etc.
- It should be possible to download key documents, for example the AMRN constitution, project documents, workshop plans, programs of past biennial conferences, research papers, etc.
- The webpage could be interactive, asking for feedback, encouraging communication to secretariat, national focal points, etc.

The costs for hosting the website appear rather high at USD.1.000 per year and that does not include the work involved in developing the material on the site (it is only the hosting of the site and technical support). We would suggest that the communication strategy of AMRN is developed further and that the funds allocated for newsletter production, website development, maintenance and hosting are reconsidered. There is a good start, but these aspects of AMRN have not received much attention during the past five years. They are important and need to be further developed.

Technical Support and the Role of KI

The AMRN is a capacity building project run by African midwives for the benefit of other African midwives and the institutions they work in. Sida and Karolinska Institutet (KI) played an important role when the network was initiated and in the past the advice from KI has played an important role. During the present phase of the project, 2002–2007, there has been one contract between Sida and AMRN that set out the objective and activities of AMRN as such, and another contract between Sida and KI that provides for advice and training support from KI to AMRN. The contract between Sida and KI stipulates that KI should collaborate with AMRN as set out in the contract between Sida and AMRN.

During the past 5 years the most important role of KI has been to assist with the research training, in particular developing the Ph.D. studies of AMRN members. This is not quite part of the AMRN program, but it is a very important activity if AMRN is to be sustainable in the long run. Within the framework of the contract of advisory services, the resource persons at KI attend the Executive Committee meetings and give advice on the development of the network. Another important advisory service was the support to the development of training programs, as mentioned above the workshops done at national levels are developed through regional cooperation. The KI can also advise on the workshops and provide inputs at the national level if requested to do so.

The support provided by KI has been greatly appreciated by all the representatives of the AMRN that we interviewed. There seems to have been an atmosphere of good collegial and professional collaboration. The persons involved have known each other for many years, and professional exchanges over as much as 15 years make for strong ties of friendship and loyalty. This continuity has been very helpful and has made for cost effective technical support to AMRN.

Providing technical support for institutional development is a difficult process. There are many traps that the partners in cooperation may fall in. In particular, it is common that the advisers assume more prominent roles than suggested by the word advice, and hence that “ownership” rests with them rather than with the elected representatives from the participating countries. We saw no evidence of that here. On the contrary, as we met with the former as well as present Chairpersons, we could verify that ownership is and has been fully in the hands of these elected officeholders.

We have not seen any “exit strategy” as such of the KI, but as the activities of the KI are well defined and limited in scope, this may not be necessary either. It does not seem as if the AMRN is dependent on future institutional support from KI. Whereas this might be helpful, in the way that professional exchanges always are, we think the present staff and management are in a good position to develop the network based on their own skills and capacities. AMRN may not be sustainable financially, but in terms of human resources it is.

Allocation of Funds

When the present project was prepared, the partners met in Stockholm and developed the project plan with the help of a logical framework. This sets out the strategies and relates the different activities to them. There is also a clear indication of how the funds are to be used for the different activities. The audited accounts show that AMRN and KI adhered to the plans without any major deviation. There are no audited accounts for 2006 or 2007 yet, but from what we have seen of the previous years, there were no major changes.

That means that out of the USD 1.349 million, USD 553.000 was used for regional activities and USD 535.000 for national level activities. USD 261.000 was used for advice, support and other services from KI. The overall balance seems appropriate, but in the long run it would be desirable to see more funds

allocated directly and used at national levels. The function of the regional activities has been to initiate national activities, and when that has been completed, most of the expenditures could be expected at that level.

Considering the major expense categories; (1) biennial conferences, (2) regional programs, (3) national workshops, (4) website, newsletters and other joint AMRN activities, it would seem that the first and the last are the components that need to be developed and maintained at regional level at present, while the national workshops can be expanded and intensified at that level.

5. Impact of AMRN Activities

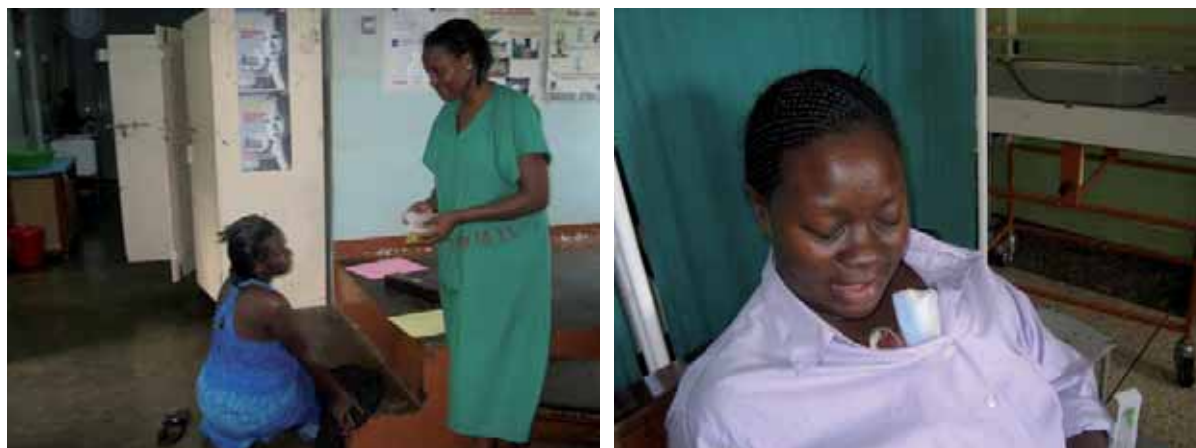
The issue of impact can be considered from numerous angles in that AMRN activities have impacted individuals, professional groups, families, communities and organizations within member countries, within the region and beyond. Examples of such impact are provided below and are drawn from data collection in the countries we visited. The ultimate aim of AMRN is that provision of quality midwifery care and improving the status of the midwife through research will ultimately reduce maternal mortality and morbidity (TOR 2007). However evidence of the latter is known to be difficult to acquire in the short term and presents particular problems in most developing countries where registration systems may be inadequate, reporting unreliable and misclassification endemic (Pathmanathan et al 2003, WHO 2004, Nanda et al 2005).

The impact of AMRN activities has inevitably been subject to both enabling and limiting factors. Impact has been enabled by such events as workshops and conferences as well as participation of the focal people in each country in a variety of national, regional and international activities. The commitment of the focal people in the countries we visited is truly enabling to AMRN and can only be described as outstanding, without such commitment it would be difficult to see how AMRN would have any impact at all. However, there are also limiting factors and many of these hinge on a paucity of professional journals and other means of regularly updating midwifery practice and the almost non-existence of dissemination of research findings undertaken by AMRN members. The limited access to some of the computers and to the internet at the times when midwives are available also restricts activities and therefore limits impact. The relatively small proportion of midwives who have been able to avail themselves of the benefits of AMRN activities and educational programs also means that impact on practice will inevitably be slow when countries are viewed in their entirety as opposed to considering specific areas where AMRN is active. Whereas in places where AMRN midwives are working there is clear evidence of changes in practice that are beneficial in promoting the wellbeing of mothers and babies as illustrated below.

Evidence of Impact

There is evidence of impact on the knowledge, practice skills and attitudes of the midwives in the three countries visited. The programs and activities of AMRN have undoubtedly made a considerable contribution to widening and deepening the body of midwifery knowledge which has impacted practice evidenced in changing the management and care provided during pregnancy and labour. Recognising that around 15% of women will experience obstetric complications that cannot necessarily be identified by antenatal risk assessment midwives in Tanzania, Zambia and Uganda utilise a focused antenatal care approach (Lindmark & Cattingius 1991, WHO 2003c) rather than the traditional routine visits. This has had the effect of rationalising approaches to antenatal care making it more manageable. In busy maternity departments in Uganda, midwives working in antenatal clinics select twenty women

each and concentrate their time and skills in providing care and education for one group at a time. This has proved more satisfying for the women as well as the midwives. In the same area, husbands are encouraged to come with their wives to antenatal and child health clinics and as an incentive couples are given priority over unaccompanied women in being seen more promptly.



To the left, mother encouraged to be mobile & adopt position of her choice in labour – at birth centre providing midwife led care (Kampala); to the right, mother providing 'kangaroo care' for low birth weight baby (Kampala)

Couples interviewed in an antenatal clinic in Uganda expressed satisfaction with the new approach and there were a number of men present at the time of our visit who were convinced of the advantages of accompanying their partners.

Other changes in practice evident in all three countries include avoidance of routine procedures such as pubic shaving and enemas and episiotomy for primigravidae. Women are encouraged to take nourishment and to be mobile during the first stage of labour and in a number of areas adopt the position of their choice for delivery though the latter is dependant on how manageable the individual midwife finds this. Social support during labour (Maimbolwa 2004) seems to vary in the individual countries as well as between the different facilities that we visited. In some labour wards fathers are encouraged to be present for the birth if the couple so wish, but in others they are encouraged to be with their wives whilst they are mobile during the first stage of labour only. Reasons for not allowing social support even during the first stage of labour include the problems of space, privacy and a concern that relatives bring in herbal remedies to accelerate labour. The latter can result in causing or increasing the risk of complications such as obstructed labour and ruptured uterus. These issues were reported in both Zambia and Uganda. Although no figures were available, midwives in the countries visited reported a lower incidence of postpartum haemorrhage (PPH) since the introduction of active management of labour, stating 'we rarely see PPH now'. Active management however was compromised in the extremely busy central maternity department in Lower Mulago in Kampala due to the limited numbers of midwives available to attend the large number of deliveries.

Being aware of the evidence that the majority of maternal deaths occur postnatally (Koenig et al 1988, Kwast 1989), midwives in Entebbe, Uganda now follow up mothers for 6 days following delivery. The women are encouraged to attend the clinic daily for checks this time during. There is currently no tracing of those who fail to return but possibilities of mobilising retired midwives within communities to take care of this are currently under consideration. A number of retired midwives have returned to help alleviate the serious staffing shortage in the teaching hospital in Lusaka, though they have not usually been able to benefit from updating and education in evidence based practice. In Upper Mulago, Kampala a midwife-led unit has been established to provide care for women in normal labour. There is considerable indication of evidence based practice in all the areas of care provided in this unit.

The quality of the midwifery services can often best be judged by the impact on the uptake of care as communities increase their demand for high quality services (JHPIEGO 2003). There is still a higher uptake of antenatal care than delivery care in many of the areas visited and reasons for this were discussed in both Zambia and Uganda. These relate sometimes to preference for delivering with the familiar figure of the traditional birth attendant at home, at a facility nearer home or offer no choice of leaving the immediate vicinity due to lack of transport when needed especially during the night. In many situations there could be room for further collaboration with the neighbouring communities to seek ways of continuing to enhance the quality of care and access to it, thus further increasing the uptake of care. Studies undertaken by AMRN members include examining women's satisfaction with care, men's attitudes towards antenatal care and the choice of place of delivery (Mwebaza & Nakirijja 2001, Jose & Deolinda 2005, Muchina & Muiva 2005). Wider dissemination of these findings and a greater commitment to partnership with the community to address the issues already identified through AMRN midwives' own research could lead to further impact through continuing to improve the quality of care that has become available through evidence based practice.

Quality of care is also influenced greatly not only by the skills of the health professional but by the environment in which care is provided (See Chapter 2). Lack of supplies including gloves and essential drugs and critical staff shortages were evident in the three countries studied. The main teaching hospital in Lusaka experienced a complete lack of water for two days during our visit which not only detracted from the quality of care but posed real threats to the health and safety of both patients and staff. This kind of situation which is by no means exceptional in the region coupled with a lack of gloves and other protective clothing detract from progress otherwise made and must be a matter of urgency for governments in countries struggling with the HIV/AIDS pandemic. The use of iron and vitamin supplements to treat iron deficiency anaemia is a relatively simple remedy. However, anaemic pregnant women identified by midwives could not be treated in poor communities in Uganda where medicine stocks at the health facility ran out and women were too poor to buy the necessary supplement. Since anaemia predisposes to numerous complications including premature labour, infection and haemorrhage, the lack of this essential supply undermines the efforts of well informed health professionals and continues to put women and their babies at risk to the major complications which can result in maternal and neonatal death or disease.

Structures through which Impact is Created

In all three countries visited, AMRN has succeeded in impacting numerous and important structures that are essential in order to facilitate meaningful and sustainable changes in practice. These include:

- Statutory Bodies responsible for regulating nursing and midwifery: General Nursing and Midwifery Councils
- Professional Associations for Nurses and Midwives, including the Private Midwives Association in Uganda
- Professional Associations for Obstetricians nationally and internationally through International Federation of Gynaecologists and Obstetricians (FIGO)
- Universities and training schools for nurses and midwives and for preparation of those who teach within these professions
- NGOs including collaboration with for example the White Ribbon Alliance; Save the Mothers Organization
- Ministries of Health (MOH)

The close association of AMRN with the statutory bodies has considerable significance since this has enabled revision of the basic midwifery curricula in these countries to include emphasis on evidence based practice. This is reflected in the assessments required for registration that originate from the Statutory Bodies. Therefore the focus of teaching and learning is making a major shift from factual recall to appreciating the importance of research and considering available evidence for practice. Although some teachers had received preparation and updating for this curriculum change, some have not and this lack needs to be addressed so that students can be taught with confidence to develop skills in critically evaluating relevant research and also to be able to undertake small scale projects themselves. This should enable them to qualify with a critical and analytical approach to professional responsibilities, as evidenced amongst many of the midwives who have completed the AMRN programs. Incorporating research methodology in the Bachelor of Nursing program is building the capacity of future nurse and midwife teachers and managers. Where this teaching is being undertaken by AMRN midwives there is an obvious commitment to promoting safe motherhood and extending evidence based care in all areas of practice, teaching and management. This was very evident for example at the Christian University in Uganda where students of various nursing and midwifery backgrounds had really caught the vision and commitment to promote safe motherhood. Thus the fact that the AMRN focal people in the countries visited hold key positions in universities and hospitals ensures considerable impact through these structures which shape the future of education and practice.

Professional Associations within Tanzania, Uganda and Zambia have offered a natural and useful place for AMRN within the countries' nursing and midwifery professions. There is linkage with the International Confederation of Nursing (ICN) through these associations, but not inevitably with the International Confederation of Midwives (ICM). The Private Association of Midwives in Uganda however is in membership with the latter and so is the Tanzania Midwives Association (TAMA). Membership of ICM is advantageous to midwives, facilitating dissemination of specialised information and sharing experiences worldwide. It is also a pre-requisite for formal linkage with FIGO; otherwise such a connection is unofficial and may also be unsustainable. Midwives within the Associations need to clarify their identity as midwives in order to affiliate with ICM. There is a reluctance to totally separate the identity of nurses and midwives in Uganda and Zambia (though not in Tanzania) because of their professional interdependence and the goodwill experienced between these groups and this can only be encouraged. Possibly ways of satisfying the criteria for ICM membership should be explored by AMRN members within associations whilst maintaining cohesion with the nursing profession within their national situations.

In the countries visited the AMRN focal people are acknowledged as experts in the field by other professionals and to a varying degree by their own Ministries. For example, the MOH in Zambia requested AMRN to be present in a major forthcoming debate on the human resources in health (HRH) issue. In Uganda, during this evaluation, it was requested by the MOH that AMRN become part of a larger initiative being undertaken in collaboration with the Tropical Health Education Trust (THET) of the UK. AMRN members are also represented through their experienced personnel at an international level. With a number of years of experience of the AMRN Secretariat in Tanzania, representation of the region at such organizations as WHO, Geneva by a Tanzanian member is considered very valuable by and on behalf of other countries in the network. AMRN Uganda is active in Save the Mothers Organization through the Ugandan Association of Obstetricians and Gynaecologists and FIGO. In Tanzania and Uganda, AMRN midwives are also active in the White Ribbon Alliance (WRA) and in Zambia WRA benefits from a strong link with midwives through the Zambian General Nursing Council.

Further involvement of AMRN members with the MOH in each country would be beneficial in contributing to policy making and strengthening health systems to provide enabling environments where midwives may work and continue to influence the quality of care. Nanda et al (2005) advise that

‘evidence-based advocacy using available data can enhance political commitment and is important for fostering an enabling policy environment that promotes maternal health’. Strengthening this link could therefore only be advantageous in considering sustainability of AMRN activities and in so doing providing acceptable, accessible and appropriate care for an increasing number of women and families in these countries.

Sustainability

It is evident that financial sustainability of AMRN in the absence of Sida funding is not a realistic possibility at this stage. However, in the countries visited links had been established and funds procured from other organizations including the Rockefeller Foundation and the Irish Development Agency. Professional sustainability in respect of undertaking research and implementing evidence based practice is evident in the three countries and in our opinion should be a measure of success in respect of sustainability at this time. The lack of writing and publication of research findings amongst AMRN members limits the effectiveness of research undertaken nationally and in the region and therefore threatens sustainability. There seems generally to be a lack of confidence in writing skills amongst AMRN members, limited awareness of the process and little evidence of commitment to attempt to tackle the realm of published literature, though the need is definitely perceived by focal people in each country.

AMRN members have enabled changes in practice to be reflected in protocols and practice guidelines where they work or have influence. This has the effect of sustaining the recommended changes and extending evidence based practice beyond the immediate practice of those who have attended AMRN workshops. AMRN programs have been extended to midwives working in government, private and mission hospitals, health facilities and private practice, so that the chances of sustaining practice changes have been optimised across the various sectors of the societies. These are considerable achievements that need to be put on record as historically introducing fundamental changes in midwifery practice has not been easy to accomplish in any part of the world without experiencing conflicting pressures and having to confront accepted dogma with soundly placed scientific theory (Houston 1986, Houston & Weatherston 1986, Bastos et al 2007).

However, we found that midwives who have implemented change due to the decisions made by others who have attended workshops did not inevitably understand why their practice has changed. It is apparent that second hand acquisition to practice change is likely not to offer as secure a prospect for future sustainability and continued improvement through critical and analytical thinking which is evidently not passed on. Therefore, more midwives need to have the opportunity to participate in evidence based workshops, so that changes in practice may not only be sustained but sustained with understanding and carry the potential for dynamic professionalism sensitive to and dedicated to keeping abreast with modern scientific advances. The suggestion in Uganda that evidence based workshops could be incorporated into life saving skills programs is therefore credible and a proposed merging of the ALARM (Advanced Labour and Risk Management) module with the evidence based module is worthy of consideration. This would continue to assist in updating existing practising midwives who have not had the advantage of a research approach during their basic nursing or midwifery programs.

There was evidence that midwives who have completed the research methodology course had adopted critical and analytical thinking in their practice. Although a quantitative study was not undertaken, nor would it be a reasonable approach in the situation, a few examples will serve to illustrate the impact of AMRN activities in the context. A midwife in Zambia explained how she now approaches her work with enquiry asking ‘Why is this happening?’ ‘What can we do about it?’ She explained that ‘critical and analytical thinking is helping me in my daily work’ and stressed the importance of acting on what is learned with this approach in order to improve care, for example, why so many women continue to deliver outside of the health facility.

A midwife in private practice in Uganda has established numerous activities to address issues that underlie maternal and newborn mortality. Aware that MMR is higher amongst the illiterate and poor, the midwife arranges for girls who cannot avail themselves of formal education to attend literacy classes after they have finished working. She is also exploring income generating initiatives in collaboration with local co-operative officers to assist women's development amongst the poor.

In utilising the arena approach to development cited earlier there is emphasis on maintaining a balance between learning and output in order to promote sustainability. The remarkable ability and commitment of the AMRN core group evident in the three countries visited illustrate the considerable learning that has taken place amongst these midwives where credible output has been demonstrated. It is clear that the successes can be attributed to numerous factors, namely the education of these midwives, their experience of working in the network and learning from each other, their personal commitment and their professional positions within the national set up that enables them to function effectively. In order to sustain the changes already in place and continue to move forward, there is a need for preparation of future leaders in the field who can provide continued inspiration and skilled guidance in the coming years. It is apparent that such leaders will need the evidence-based advocacy skills urged by Nanda et al (2005) in using all the available national, regional and international data to enhance political commitment and foster an enabling policy environment that will ultimately contribute to reducing maternal and neonatal mortality and morbidity.

Effectiveness

The effectiveness of AMRN embraces the quality of care provided which is being markedly influenced through evidence based midwifery practice in the countries studied. Additionally, effectiveness can be considered in the light of the professional standing and recognition of the AMRN leaders apparent at national and international levels. As indicated above, effectiveness in the quality of care provided has been limited by a lack of resources in the working environment both human and fiscal implicating health care systems and supplies. AMRN members are emerging into the international arena as educated, accomplished and confident professionals, their effectiveness in contributing to safe motherhood and skilled attendance being limited not only by their working environments but also by the lack of dissemination of the valuable research carried out by members in the region.

Whereas effectiveness refers to whether objectives of the project are achieved or not, it is another question whether resources are used efficiently or not. On the whole, the outcomes of the AMRN project are accomplished at a low cost as most of the key factors (personal time) are volunteered. Hence the project amounts to some 10 million SEK that are used to very good effect. The question is whether they could be used even more efficiently. In some ways it is possible to suggest that would be the case. The major changes in that case would be:

- Focus activities on the seven core member countries, trying to reach and involve other countries involve high costs and uncertain benefits.
- Focus on activities where there is a response. At times the funds have been used to maintain contacts (for example with Eritrea). When a country does not itself maintain contact, the other members might find better ways of utilising the resources than at a high cost maintaining liaisons that have no long run potential if there is not a reciprocal interest.
- Move quickly from regional to national training programs, as the regional program have very high costs compared to the national training.
- Increase the number of participants in the national training programs and encourage participation from remote areas. Workshops should be able to take in some 20 to 25 persons each time.

- Reduce the time between training events; follow-up training should occur within a year, as the momentum is lost otherwise.

The above examples point to more cost effective use of funds. There are also some examples of less cost effective expenditures in the past. In March seven internal evaluations were initiated at a total budget of USD 3,000 per country, meaning a total of USD 21,000. We do not quite understand why that decision was taken although AMRN members have since commented on it being a useful experience to undertake a 'self assessment' the timing was, in our opinion, inappropriate and therefore cannot be justified in the context of cost effectiveness.

The synergy-effectiveness of a regional network as opposed to national networks is a moot point in the context of cost effectiveness. Whilst respondents in the countries visited told us of advantages of exchange at the biennial scientific conferences and of having representation of the region at an international level, there are practical problems in the overall administration of the funds in the current situation. Firstly, there is a heavy burden of responsibility and administration on those working at the Secretariat level and secondly there is both delay and an added cost incurred in transferring funds from Sweden currently to Zambia and thence to the individual participating countries. In our considered opinion, there would be advantages in retaining some aspects of the regional network, such as the biennial conferences and possibly specific initial workshops, but to channelling funds directly to AMRN chapters within the member countries. This would allow countries to plan and execute the actions they perceive as priorities without needing to rely on administrative activities elsewhere. It needs to be remembered that all these activities are currently undertaken on a voluntary basis in addition to the considerable responsibilities borne by the AMRN members in their daily jobs. Whilst there are enormous advantages of such personnel being strategically placed within the health and education systems, their effectiveness could be further enhanced by some administrative support at the national levels, even on a part time basis.

Lessons Learnt

In considering the effectiveness of AMRN, numerous lessons have been learned. These will offer valuable discussion points in considering the way forward to ensure and expand the effectiveness of AMRN in the future, particularly in respect of achieving the Millennium Development Goals:

- Selection of people within each country who form the core group according to the 'arena approach' model has proved critical in that they are in leading positions in the institutions and are well placed to influence change.
- The commitment of AMRN members within the countries visited contributes greatly to the success of the network.
- The research methodology programs have enabled some midwives to undertake personal research, progress to study for higher degrees and experience promotion within their own countries.
- Given the present structure of the research methodology program it cannot be assumed that dissemination of findings will ensue. There is very little publication of research findings from the network, published papers mainly emanating from doctoral theses of very few AMRN members.
- Writing scientific papers is a skill that has not been acquired across the network and therefore dissemination of findings that would be useful to share is inhibited.
- Implementation of evidence based midwifery practice is apparent as a direct result of the evidence based workshops in the countries studied. Changes in practice have been introduced to other midwives but these midwives are not necessarily aware of the reasons underpinning the changes.

- Keeping abreast with current evidence is proving more problematic in the absence of a supply of professional journals and other means of communication and regular updating. This is more difficult in some areas due to limited access to computers and the internet.
- As in ‘the skilled attendance during childbirth’ initiative, it is apparent that evidence based midwifery practice requires an enabling environment and this is not available in the majority of government institutions visited. Addressing these major issues within the health care system is a long term venture to which AMRN midwives are making some valuable contributions, further expertise in using ‘evidence based advocacy skills’ (Nanda et al 2005) could enhance their contributions and move the work forward.
- In the countries visited, AMRN members are increasingly recognised for their midwifery expertise and research capabilities and are invited by obstetricians and others to contribute to important activities in safe motherhood.
- The AMRN biennial scientific conferences are meeting points for professionals from across the world as well as in the region and offer opportunities to further build capacity within the midwifery profession.
- Administering funds on a regional level is proving to be demanding administratively on the volunteers involved, prone to cause delay in individual country activities and not cost effective due to bank charges in more than one country.

6. Conclusions and Recommendations

The major achievements of AMRN can be summed up clearly; a network has been created and it has shown a remarkable resilience and continuity over the past 15 years. The work of AMRN is highly relevant and in line with key issues of the Millennium Development Goals. The work of AMRN represents the kind of activities that should be supported according to Sida’s policy on sexual and reproductive health, gender and equity. It has a high relevance in the light of the overall aim of poverty reduction in Swedish development cooperation.

AMRN builds on the work of midwife volunteers who combine their regular employment as researchers, teachers, administrators, government employees with the duties associated with being AMRN members. It is important to bear this in mind; many other projects and programs financed in development cooperation have fully employed staff. It is interesting to note that the continuity of persons in AMRN that builds on volunteer contributions appears to be higher than in many projects that offer regular employment. It is also important to have in mind the relatively small amounts of money being used. Even though SEK 14 million is a large sum, it is comparatively small as a development project. This sum is supposed to cover activities in at least seven countries and over a period of five years. Against this background of relevance and effectiveness, the evaluation has focused on what AMRN is, what it does, and what impact it has, and we provide recommendations in each of these areas.

Organisational Issues

AMRN is a relatively small network and it is loosely connected. The boundaries of the network are open and there are many reasons to increase its size from the present seven core countries. However, the interaction and governance between national and regional levels is not clearly defined. There is a difference between countries concerning what it means to be an AMRN member, who is a member and what rights and obligations follow with membership. The network is kept together through communica-

tion, but both newsletters and websites have weaknesses that were pointed out above. Our recommendations to AMRN for the next three years would be:

- Establish a working group during the upcoming biennial conference in Nairobi to review the Constitution and to set up guidelines for governance at national levels, define what membership means and where it resides, and build the regional governance based on national chapters. The working group could have a task to suggest proposals to the AMRN meeting of 2009.
- Develop a registry of members with updated addresses and in particular e-mail addresses. Create mailing lists and set targets for communication with members. Allocating a small sum from the budget to acquire the assistance of part time administrative assistants at the national levels could assist progress with this and with other administrative duties.
- Take up the idea of producing a newsletter and do so, but with limited ambitions. It need not be a full journal or a very comprehensive text. It should be sufficient with key messages between members, and there are ample experiences of research and practice happening in the region for a newsletter to be produced twice a year.
- Review and develop the website, and seek cheaper and more effective service providers to host the webpage.
- Concerning the number of countries where AMRN is active; we would suggest that the network keeps its present size and develop the format for national membership before new countries are added. AMRN can still disseminate information to midwives' organisations in other countries and can also welcome people to its events, in particular to the biennial conferences. Before growing and expanding, it needs to consolidate the present organisation.
- Since administering funds on a regional level is proving to be demanding administratively on the volunteers involved, prone to cause delay in individual country activities and not cost effective due to bank charges in more than one country, channelling some of the funds directly to AMRN chapters within the member countries could be advantageous.

Activities

AMRN has been wisely focused on some few and well defined activities; the biennial conferences that have been held regularly for ten years with an increasing number of participants; the development of training programs at a regional level and sometimes conducted with regional participation, the national level training programs and workshops, and finally the communication activities; website, newsletters, and the management of the network itself through meetings of the Executives. All four activities are necessary ingredients in the AMRN cooperation and should be continued.

- The biennial scientific conferences are the most prominent part of AMRN and they should be given emphasis. They hold a large potential to reach many objectives through disseminating research findings, encouraging research collaboration, and to serve as advocacy platforms for the profession.
- There should be an evaluation carried out on completion of each biennial scientific conference to assist organisers in critically reflecting and continually improving on the conduct of the conference and creating a higher impact.
- During the conferences it would seem effective educationally and professionally to have parallel meetings and thus to allow more time, and smaller groups for focused discussions.
- There should be an increased focus on national rather than regional workshops and each one should be evaluated by participants and facilitators.

- It would seem beneficial that the biennial conferences have sections where the experiences from national training workshops could be shared and compared.
- Some means of enabling midwives to keep up date with evidence based practice are essential. Initiating or recommencing journal clubs or research discussion groups with a similar objective should be considered in order to facilitate this. There is a need to explore ways of accessing professional journals and ways of extending access for practising midwives to computers and to the internet for this purpose.
- There is a lack of dissemination of research undertaken by AMRN members. Initially this will require further scientific writing workshops and devising a system of supporting and guiding AMRN members seeking to publish their work. This support and mentoring may need to be acquired from outside the network initially and should extend until there are a sufficient number of published authors within the network to pass on their skills to others.
- In order to further promote evidence based practice, consider the possibility of combining some evidence based practice workshops with existing life saving skills programs (LSS/ALARM).
- Since midwifery teachers are key people in promoting the long term emphasis on midwifery as an evidence based profession with midwife researchers becoming increasingly available across the region, it is important to provide further sessions to update all such teachers in research methods and evidence based practice and determine ways to encourage them to constantly update their own practice and approaches to education.

Are there any activities that could be added? As mentioned above, even though the theme of the biennial conference in Mozambique was the rights-based approach to reproductive health, we have not seen any work on the “demand side” (compare with Box 2.1, page 14) during this evaluation. It should be possible to encourage such approaches among groups of midwives who have an interest, to monitor and compare experiences between countries, and possibly encourage replication on a larger scale if evidence shows that the approach works.

AMRN has focused on research, training and evidence based practice. It has not been actively engaged in advocacy, such work has been the role of other professional associations (such as TAMA in Tanzania). There is of course an overlap between such organisations and AMRN. Though there is a case to engage in advocacy in the long run, we would still recommend AMRN to keep its focus on the issues, subjects and the activities, where it has been working in the past and where it has a proven track record of achievements.

The institutional collaboration between AMRN and Karolinska Institutet has been effective. AMRN can be sustained without technical support but it does need a budget and there is no chance that governments in the region will provide funds. We suggest that the collaboration between AMRN and KI be continued, but it may not be necessary to design this as a separate project such as has been the case during the past five years. Within the overall budget support from Sida to AMRN, it should be possible for AMRN to call for services from KI when and if that is needed and it could for example be helpful to:

- Explore ways with KI of obtaining accreditation within the national and international university systems for AMRN programs successfully completed. This would ensure that the qualifications are not only appropriately recognised but carry some currency within the academic world which would contribute to higher education and therefore professional advancement of the individuals concerned. Associating published papers and effective dissemination of research with credit acquisition could provide an added incentive to achieve this goal.

Impact

The question of impact has been addressed against a background of causal analysis. Attribution is always difficult in development cooperation, and there is a long chain of events that may lead from an intervention such as AMRN activities and onwards to the final target, of increased reproductive health and safe motherhood. Even though the overall trends in this field appear to be negative, there is no doubt that AMRN has had a positive impact. A number of evidence based changes have been introduced in practice, and there have been related changes in curriculum and in regulation that make the changes sustainable. However, the AMRN activities have been some of many contributing factors where other initiatives also had a role to play. It is important to recognize that important changes usually occur through complex interaction between many initiatives and there has to be an enabling environment. Efforts to achieve such an environment in the clinical situation are constantly and severely challenged in most areas where AMRN midwives work as acknowledged above, and midwives need to be at the forefront of national initiatives to address such issues, therefore we suggest that;

· Acknowledging the varying degree of impact that AMRN members are already making at Ministry level, ways of further assisting midwives to be pro-active in advocating and achieving the enabling environment – critical to the effective functioning of skilled attendants able to provide evidence based care – should be explored. This may require more specialised knowledge and skills for example in ‘evidence-based advocacy’ (Nanda et al 2005) in order to address major issues including strengthening health systems and actively contributing to policy making. Sida and KI may be well placed to offer assistance in achieving this if requested.

As AMRN has achieved an impact in the past, there is good reason to expect that it can do so in the future as well. The evaluation cannot add anything on this but to encourage AMRN members to keep working as they have done in the past, to work at different levels within administration and through training to increase evidence based practice in the health care systems of member countries.

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Annex 1. Terms of Reference

An Evaluation of African Midwives Research Network (AMRN), a Capacity Development of Midwives Project and an Institutional Collaboration between AMRN and Karolinska Institute, Division of Reproductive and Perinatal Health Care

1. Background

Midwives from Tanzania, Zimbabwe, Zambia, Mozambique and Sweden initiated the African Midwives Research Network (AMRN) in Tanzania in 1992 at a SAREC (Department for Research Cooperation at Sida) sponsored Regional Reproductive Health Workshop. The Board of the AMRN is elected every second year on a rotating basis between the collaboration countries. The country where the chairperson and the treasurer are posted is the hosting country for the 2 year period.

The ongoing project phase of AMRN is a continuation of a Sida support that has been going on since the formalization of the Network (1995–1997) including a 1st project period of 3 years (1999–2001). The present project document has been elaborated jointly by the most concerned stakeholders of the project, by the focal points of the Network and collaborating partners at KI, at a LFA meeting in January 2002. At the entrance of the present phase of the project, the Network covered 32 countries in Sub-Saharan Africa. AMRN aims to serve as a base for sharing information, strategies and solutions based on scientific evidence for provision of quality midwifery care in the area of reproductive health within the region. AMRN also aims at improving the status of the midwife through research. These goals ultimately will help in reducing maternal mortality and morbidity.

The *project purpose* is:

To further develop AMRN for the identification, development, national and international exchange, and dissemination of research results in existing and ongoing programs.

The *target group* of the AMRN is:

The beneficiaries of the work of AMRN is the reproductive health care sector and the people it serves such as adolescents, women during pregnancy and delivery and their newborn babies, couples in need of contraceptive or STD counselling.

The *overall objective* of the network is:

To improve the quality of midwifery care in Africa

Strengthen and empower the African midwives in their professional performance.

Sub-objectives are:

- i) Improved midwifery practice through research in order to provide quality midwifery care for reproductive health.
- ii) Further enhanced research knowledge and skills among midwives in the Region through dissemination of existing knowledge and training.
- iii) Identify and conduct research in midwifery practice as well as in reproductive health.
- iv) Enhanced exchange of ideas and knowledge in midwifery research through an AMRN Newsletter, meetings and conferences.
- v) Smoother running of Network activities through improved and regular communication
- vi) Improved co-ordination and collaboration with other professional groups working in the area of reproductive health

- vii) Recruitment of new members to the Network.
- viii) Sida is supporting the AMRN Regional Programme and activities at country level during the period 2002–2007 with a total amount of SEK 10 888 800. The Network includes the institutional collaboration with Karolinska Institute (KI) which also is supported by Sida during the same period 2002–2007 with a total amount of SEK 2 601 500.

Project activities:

On financial support from Sida, AMRN country representatives and Karolinska Institute collaborators met in February 2002 to go through a LFA workshop to identify and define the needs and problems of the Network. The main problem identified was insufficient communication among Network members.

The workshop came up with three different strategies to meet the problem: AMRN network capacity strategy, research capacity building strategy and evidence-based midwifery practice strategy.

During a further meeting between AMRN Chairperson and KI collaborators in May 2002 in Stockholm, it was agreed that a fourth strategy (A) of Institutional Collaboration Networking be included (Concept Memo in Annex 1).

A. Institutional Collaboration Networking Strategy

During the previous support from Sida, AMRN has worked in collaboration with Swedish midwives but there was no strategy and activities specifically specified.

To enhance collaboration activities, it was agreed during the meeting between AMRN Chairperson and KI collaborators that a *Core Group* chaired by the AMRN Chairperson be formed consisting of the following members:

AMRN Chairperson

AMRN Vice Chairperson

AMRN Secretary

AMRN Treasurer

Two representatives from KI

One representative from ECSAOGS

One representative from ECSACON

Inclusion of representatives from ECSAOGS and ECSACON is to enable AMRN to collaborate with other professional organizations in the region that have similar goals.

This working model named “Networking Institutional Collaboration: a arena approach for Development” is elaborated by KI in their 10 year collaboration with the nursing schools in Zambia (enclosed annex 1).

B. AMRN Network Capacity Strategy

In addition to inadequate communication skills among midwives, there are also problems related to infrastructure. Also, poor communication and inadequate marketing of Network objectives and activities result into inadequate coverage of AMRN activities in other countries. Problems of late arrival of funding and delayed response to correspondence were also identified. Improving AMRN capacity to network will improve the possibility of national, inter-country, regional and international exchange, which will have impact on the quality of midwifery services.

C. Research Capacity Building Strategy

Although some midwives have attended the Research Methodology course during the last three-year support from Sida, the number is very small. Many midwives do not get a chance to attend continuing education courses. For those who participate in research, midwives are usually involved as data collectors or research assistants, and this mainly results from midwives lack of knowledge and skills in the research process. This lack of knowledge and skills could be increased by midwifery curricula that do not put emphasis on research methodology. Training midwives in research methodology will increase their skills so that they become engaged in collaborative multidisciplinary research. This will help in building a critical mass of midwifery researchers who will spread their research findings for implementation into practice. Research training will also increase the number of publications by midwives, which at the moment is very low in the region.

D. Evidence-based Midwifery Practice Strategy

The coverage of the evidence-based workshops during the previous financial support from Sida was limited and thus its impact on midwives' knowledge of its importance was limited on how to develop implementation of research findings inadequate. Last payment was made in December 2006 for activities to be implemented during the first six months of 2007.

2. Purpose and Scope of the Evaluation

Originally, Sida intended to carry out an independent, external evaluation in the beginning of 2005, i.e. a mid-term evaluation. However, it was perceived that too short time for the project had past for having a midterm evaluation 2004–2005 and therefore the evaluation has been post-poned to begin during spring 2007. The evaluation is planned to be both backward-looking as forward-looking and to identify both strengths and shortcomings in the network functioning and its development and to give recommendations for an eventual future Sida-support on how future development co-operation in the best way could contribute to develop forms for a future programme approach. Sida is in principal positive to continue the support to AMRN. The findings and recommendations of this evaluation are to be used for the owner of the project as one input of their planned project proposal, as well as for Sida in its decision how to continue its support.

3. The Assignment (issues to be covered in the evaluation)

The evaluation should finally give recommendations on how to strengthen the Network.

To assess whether the networking collaboration has carried out the planned activities and has *achieved the results* planned in accordance with the stated objectives in the project document and annual plans.

Assess the value of the *institutional collaboration/partnership* between AMRN and KI, advantages and disadvantages.

Assess the value of the *working model* applied in the project functioning “Networking institutional collaboration – an Arena Approach” (elaborated by KI in another project in Zambia), advantages and disadvantages.

Give examples of and analyse *processes/ways of working that has functioned* and lessons learnt from these from what are experienced or documented, especially as regards *sustainability*, the network's survival after Sida support is finalized. For example, how has AMRN succeeded in contacting other organisations for collaboration and in receiving financial support from other sources than Sida.

Assess to what extent that the project has succeeded in *reaching poor women and their families*.

Assess to what extent that the project has contributed to any changes towards *gender equality*, for example raised the status of midwives or included fathers in preventive maternal health /presence during deliveries.

Assess to what extent and in what concrete situations a *rights-based approach* is applied by the Network.

Assess how the *role of Sida* perceived by the Network and if there is a desire for a closer engagement with Sida.

Assess how the Network could become more *results-based and results-orientated* and discuss its relative *cost-effectiveness*.

Assess the experienced and documented *synergy-effects* and Regional added values/benefits of being a regional network as viewed from individual countries' perspective.

Assess the *financial and administrative capacity* of the network and how well it corresponds to the Sida rules and regulations.

Assess how the *continued support* to AMRN including KI should be formalized and directed.

4. Methodology, Evaluation Team and Time Schedule

Sida will draft a TOR for the evaluation which will be sent to the key-stakeholders of the project (AMRN & KI repr) and the evaluators for comments before finalized. As soon as the ToR is processed in as a final drafting form and contracts signed, Sida will invite the two evaluators for a meeting to discuss and agree upon the content of the evaluation and the final ToR. Interviews will be carried out at concerned Sida AMRN programme responsible person/s. Relevant documents will be sent electronically to the evaluators, enclosed please find list of necessary background material. Interviews of key-actors of AMRN and KI and field-visits at working-places of midwives will be carried out by the evaluators in 3 countries (Zambia, Uganda, Tanzania). Both evaluators will visit one country together; one evaluator will visit one country each by her/himself. A questionnaire study directed to all 32 country networking partners will be distributed and collected by e-mail and analyzed by the evaluators. The evaluation team will consist of 2 evaluators representing the following competences: The evaluation period will be around 12 May–18 June, during 5 weeks by each consultant.

5. Reporting

Reporting of conclusions and main findings of the evaluation in each of the 3 recipient countries before departing from these countries. A Seminar will be arranged by Sida in September where the evaluators will present the evaluation as part of the overall evaluation assignment.

The evaluation report shall be written in English and should not exceed 20 pages, excluding annexes. Format and outline of the report shall begin with an Executive Summary and include conclusions and recommendations. The draft report shall be submitted to Sida electronically and in 2 hardcopies (air-/surface mailed or delivered) no later than 2007-06-17. Within 2 weeks after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 5 hardcopies, latest on 2007-08-30. The evaluation report must be presented in a way that enables publication without further editing. Subject to decision by Sida, the report will be published in the series *Sida Evaluations*.

The evaluation assignment includes the completion of Sida Evaluations Data Work Sheet (Annex 2), including an *Evaluation Abstract* (final section, G) as defined and required by DAC. The completed Data Worksheet shall be submitted to Sida along with the final version of the report. Failing a completed Data Worksheet, the report cannot be processed.

Annex 2. List of Persons Met

Interviews in Tanzania

Mr. Tumaini Nyamhanga, AMRN Focal Point, Tanzania
Mrs. Agness Mtawa, AMRN Secretariat, Tanzania
Mr. January Karungula, Director of Nursing Services, Muhimbili National Hospital
Mrs. Angelina Sepeku, Manager of Maternity Services, MHN
Dr. Kohi, Dean, School of Nursing
Mrs. Stella Mpanda, Former Chairperson of AMRN
Mrs. Feddy Mwanga, Chairperson of Tanzania Midwives Association, TAMA
Dr. Angela Ramadani, PMTCT Coordinator, Ministry of Health
Gustaf Moyo, Registrar of Nurses and Midwives Council, Ministry of Health
Mr. Clavery Mpandana – The Director of Nursing, Ministry of Health
Mrs. L. Mfalila, Reproductive Health Unit, Muhimbili, and Chairperson, White Ribbon Alliance
Dr. Oscar Nkatilo, Clinical Services Manager, Umati, IPPF.
Ms. Annie Mganga (Acting Head of Midwifery School)

Interviews with four former participants in Evidence-based Practice Workshops and Scientific Methods Course:

Amina Omar

Amina Mwakuluzo

Cecilia Masawe

Susan Ndambala

Focus group interview with 20 students at midwifery school

Visits to three maternity wards at Muhimbili National Hospital.

Interviews in Uganda

AMRN Officers Uganda Chapter

Ms Enid Mwebaza (President AMRN Uganda)

Ms Nkayarwa Jolly (Treasurer AMRN Uganda)

Ministry of Health, Kampala

Dr Jackson Amone (Assistant Commissioner, Integrated Curative)

Uganda National Association for Nurses & Midwives

Mrs Janet D. Obuni (President UNANM)

Mr S. Kamukama, (Administrator UNANM)

Entebbe Hospital

Ms Regina Wagonda (Assistant Matron)

Ms Josephine Drazu (Nursing Officer)

Mulago Hospital

Dr. C. Biryabarema (Head of Department Obstetrics & Gynaecology)
Dr Nakato (Consultant Neonatologist)
Ms Nassuma Edith (Senior Principal Nursing Officer)
Ms Kitibwa Kabenge Sarah (Senior Midwifery Officer)
Ms Dhugira Hellen (Nursing & Midwifery Manager)
Ms Byenkya Rosemary (Nursing & Midwifery Manager)
Ms Akongo Chwa (Nursing & Midwifery Manager)
Ms Florance Aziga (In charge Labour Ward)
Sister Rose Nakayiza (Sub/In charge Labour Ward)
Ms Margaret Kiguba (Senior Nursing Officer Special Care Baby Unit)
Ms Tibifumaira Goreti (Senior Nursing Officer in Charge Special Care Baby Unit)
Ms Acakara Marie Antoinetter (Private Maternity Ward)
Ms Bertha Birungi (Nursing Officer Antenatal & Gynaecological Clinic)
Ms Harriet Kabogoza (Nursing Officer Antenatal & Gynaecological Clinic)
Ms Prossy Naggujja SSekeimpi (Gynaecological theatre)
Ms Nabacwa Oliver Norah (Nursing Officer Renal Unit)

School of Nursing & Midwifery, Mulago

Mrs Kabanga M Nargaret (Principal)
Ms Bulwa Milly (Midwifery Tutor)
Ms Lillian Ochama (Health Tutor)
Ms Veronica K. Ddumba (Health Tutor)
Mrs Matron Mary (Warden)
Large group of student midwives

Kampala Christian University

Ms Jemima Mutabaazi (Course Tutor)
Discussions with 35 BSN students

Mengo Hospital

Ms Mary Joy Muwonge (Matron I/C)

Rubaga Hospital

Sr Imelda M. Nakitto (Principal Nursing Officer)
Mrs Sekyondwa Margaret (Deputy Principal Nursing Officer)
Mrs Otima Helen (Deputy Principal Nursing Officer)

Nsambya St Francis Hospital

Sr Nakkazi Sarah (Midwife in Charge Labour Ward)
Sr Namukwaya (Midwife in Charge Postnatal Ward)
Sr Muzaale Anne (Midwife in Charge Surgical Ward)
Sr Asio Alice (Midwife in Antenatal Clinic)

Mosoke Clinic, Ntinda

Ms Imelda Christine Musoke (Private midwife)

Ms Florence Irau (Co-operative Officer)

Ms Magdalen Alum (Assistant Co-operative Officer)

Interviews in Zambia

AMRN Secretariat

Dr Margaret Maimbolwa (Chairperson)

Ms Mwinga Tolosi (Secretary)

Ms Alice Hazemba (Treasurer)

AMRN Facilitator

Kwaleleyela Concepta

General Nursing Council

Ms Dorcas (Standards & Compliance Manager)

Zambia Nurses Association

Ms Jennipher Munsaka

Maternity Department, University Teaching Hospital, Lusaka

Pumulo Kabalanyana (Midwife, labour ward)

University of Lusaka

Mrs Getrude Kakonkanya (Acting Principal Tutor Midwifery School)

Mrs Mercy Mbewe (internal evaluator for AMRN country program)

Chainama College of Health Sciences & Maternity Ward

Mr Eddie Mbewe

Chelstone clinic

Mrs Phiri Elizabeth

St John's Private Hospital, senior midwifery & management staff:

Ms Raymunda Kabota

Ms Zelesy Mutinta

Ms Apred Banda

Interviews with four former participants in Evidence-based Practice Workshops and Scientific Methods Course:

Mrs Catharine Simbeye

Mrs Esther Simwanza

Ms Emeldah Kabwe

Mr Mondwi Hosea (Kitwe)

Focus group interview with 9 student midwives at the midwifery school

Interviews in Sweden

Gunilla Essner, Sida/DESO

Kyllike Christensen, Karolinska Institutet

Annex 3. Survey to Network Members

The questionnaire was designed in the survey instrument “SurveyMonkey” and distributed via e-mail.
This is a list of questions only.

1. What is your name?
2. What is your present post?
3. What are your basic midwifery qualifications?
4. How long was your basic midwifery training?
 - None
 - Less than 6 months
 - 6–12 months, or longer
5. How much experience have you had in midwifery practice?
 - None
 - Less than one year
 - Between 1 and 5 years
 - More than 5 years.
6. Since when have you been a member of AMRN?
7. How did you first hear about AMRN?
 - Through a training program, if so what kind of training
 - Heard about it at other nursing/midwifery conferences
 - Information from a colleague
 - Found information on the internet/in journals
 - Other, please explain
8. What AMRN activities have you taken part in?
 - Training in research methodology?
 - Evidence-based practice workshop?
 - Scientific writing workshop?
 - Training in communication skills?
 - Attending bi-annual conference in 2005
 - Attending bi-annual conference in 2003
 - Attending bi-annual conference in 2001
9. Do you receive the AMRN newsletter? Yes No Sometimes
10. Are there any AMRN activities taking place in your country? Yes No Please describe
11. How many others in the midwifery profession take part in the network from your country?
12. Do you regularly meet with other AMRN members from your country?
13. Is there any collaboration between institutions in your country in respect of the AMRN? Which ones?
14. Have you any suggestions on how the AMRN activities in your country could be strengthened?
15. Which institutions in other countries do you cooperate with as part of the AMRN network?

16. What kind of joint activities do you have with them? joint research projects
 organise workshops and conferences
 joint collaboration to speak to politicians/administration
 about problems
 exchanges of experiences
17. Do you regularly access the website of AMRN?
18. Do you have any special problems communicating with others in the network?
19. What do you think would help in this situation?
20. Are you in regular correspondence with other AMRN members in the region? Which ones?
21. Do you also meet other AMRN members outside the AMRN activities above?
22. Please note the extent to which you agree or disagree with the following statements:
- ☐ The midwifery profession has a high status in the society where I live
 - ☐ People respect the work that I do as a midwife
 - ☐ It has more status to be a midwife now than ten years ago
 - ☐ My participation in the network has helped me develop professionally
 - ☐ The AMRN is my most important source of learning
 - ☐ The AMRN provides me with support from colleagues in other countries
 - ☐ Through AMRN I have been able to pick up experiences from other countries in the region that can be useful in my country
 - ☐ There has been major changes in midwifery practice based on research (if agree, examples)
 - ☐ The AMRN helps motivate us to work with poor people and their families (if agree, examples)
 - ☐ Through AMRN we get ideas, examples and tools to work with gender and equity
 - ☐ It is important that communication in the network is intensified
 - ☐ The network should be extended to French speaking countries
 - ☐ It is important that the network is consolidated before taking in new countries
 - ☐ The webpage and the internet exchanges are very useful to keep up to date with the network activities
 - ☐ The most important contribution has been to learn about research
 - ☐ It is still difficult to translate research findings into practice if yes, what could the network do to help
 - ☐ The AMRN has helped us with publicity and campaign to raise awareness about midwifery and her important role in reducing maternal mortality and morbidity. Comments, suggestions.....

Annex 4. Interview Guidelines

AMRN Secretariat, Country Focal Points

- The role of secretariat/focal points, is it formalised? Time and resources?
- Support from KI, extent and value of advice, issues not covered
- Network decisions, who take them, how are they prepared,
- Financial resources, sustainability, sources of income, research funding
- Organising the conferences; who does the work, what kind of advise and support
- The research function in 10 years time?
- Understanding the rights-based approach. What is it, what does the network do?
- Function as Secretary, Treasurer – training, support?
- Membership in the network, what is it, what does it entail?
- How can the network grow?
- Work to raise the status of the profession?
- Any influences on curriculum in midwifery training
- Influence obstetricians in how they work in practice+
- Any other useful activities?
- Evidence based workshops, what do they cover, is the curriculum adequate?
- Ability to critically assess research, what is most important against background of practice?
- Experience of changing practice? Examples
- Obstacles to change?

Students in Nursing College

- Awareness of research influencing practice?
- Access to journals
- Midwifery textbooks
- Essays expected to write?
- Exposure to clinical experience
- Experience of complicated cases?
- Confidence in detecting abnormal cases?
- What do you plan to do after training is completed?

- Why do you want to become a midwife?
- Aware of safe motherhood initiatives?

Dean, Managers and/or Teachers in Nursing College

- Introduction to the curriculum
- Teaching methods
- Teacher qualifications
- Clinical training
- Supervision of students
- Teachers training and development
- Assessment; final exam, formative assessment, what do these consist of?
- Extent of training in research methodology
- Availability of scientific journals
- Student exposure to scientific reading
- In all above respects – changes in recent years?
- AMRN influence?
- Status of applications, student performance

Other Stakeholders (Ministry of Health, Professional Associations, Multilateral Agencies)

- What do you see as the major issues/problems around reproductive health
- What are the reasons behind increases maternal mortality and morbidity
- What should be the priority activities to reverse these changes?
- Which are the most important organisations working in these fields?
- How do you see the midwifery profession developing?
- What could be done to strengthen their performance?
- Do their services reach poor people – how could they work to reach poor people?
- How do you interact with AMRN, what do you do together

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