

## Chapter 3

# Authentic Partnership

### Introduction to Partnership Development

**Frank Anderson:** We have with us Raymond de Vries, a sociologist from the University of Michigan, in the Medical School Department of Ethics. He is what could be called an embedded sociologist. Although he is embedded, we can see him at the desk. Sociologists are observers, and they observed processes and they observe people interacting, and Ray has been observing the Ghana–Michigan partnership for quite some time as well. Ray has been thinking about what that means and what issues come up. He can say it very well, so I would like to introduce Ray de Vries, our embedded sociologist, to give us an overview of this partnership idea that will be embedded in the work that we do this week.

**Ray de Vries:** Thanks, Frank. I, like everyone else, am excited to be here today. To me, this is almost unbelievable – the number of people with a number of interests that have come together behind a single project. Of course as Frank said, we have a lot of content work to do while we are here over the next three days, but content without paying attention to process is not going to succeed.

I was going to say not likely to succeed, but if the process breaks down, then all this beautiful content, all the curricula, and all of the things we are doing back at our home institutions cannot succeed. We are going to spend a whole session after the coffee break talking about partnership, but Frank has asked me to give a brief introduction into the value and the need to focus on partnerships.

I want to start by using this quote which comes from a colleague of ours in Ghana, who was very involved in the project in Ghana (but he is not with us today) and is somebody that you might know; Professor Peter Donkor. Professor Donkor said,

“The surest way to achieve an enduring and successful collaboration is by ensuring that while you pursue your interests, you also look after the interests of the other partner.”

I think that there is a great deal of wisdom here and I kind of want to do a little sermon about this. I want to unpack the wisdom in that brief statement from Professor Donkor.

He starts by saying, “The surest way to achieve an enduring and successful collaboration...” What's so exciting about us being here is that we have the shared goal of creating the structures we need to improve maternal health in a sustainable way. That is what we all want to do. But, we will not reach our goal without an enduring collaboration. And that's key. I've heard several of the speakers this morning in their welcoming use the word ‘sustainable’. And I think that's on everyone's mind. Sustainable collaborations just don't happen because we have a good idea; they take us thinking about the ways we are working together. This is why we put the session on collaboration and the worksheet on collaboration at the very beginning our time together. The collaboration comes first - not later. You have to structure the way you're going to work together to pursue the great ideas that you have.

The second part of the statement is,

“...while you pursue your interest, you also look after the interest of the other partner.”

To look after the interests of the other partner you have to know the interest of the other partner. And that might seem obvious and simple, but, again, listening to some of the speakers in the

introduction, there was talk about, "Let's pay attention to local conditions."

Folks might be coming here with great ideas but unless you know what your partner wants and you know the situation into which those ideas need to be introduced, you will not succeed. You have to know the interest of your partner. Knowing the interest of your partner requires two things, I think. Respect – each partner in the collaboration needs to have respect for each other, has to understand that I have something to learn from you, and you have something to learn from me. This attention to the other is really critical for sustainable collaborations.

The second part of this is reflection and this is part of what – I'm not so sure I like being called an embedded sociologist, it seems kind of strange – the one thing that I can offer and the one thing that my discipline offers is it helps people to think about and see what they're doing with new eyes. So I think constantly throughout this process you have to reflect on: "What are my interests?", "What are my partner's interests?", "Am I listening to my partner?", and, "How can we help we make these two things work together?"

Another point about the statement – pursuing the interest and looking after the interest of the other – is that knowing the interest of your other partner requires effective communication. You have to find ways where you're really talking to each other and really listening to each other. And effective communication starts with attention to detail. In the worksheet we are going to give you, we actually ask for a lot of detail. It's not just, "Oh yeah, we agree to communicate." But you have to face the problems that are going to happen because typically they'll be from two different cultures. And I don't just mean the culture between a country outside of Africa and a country inside of Africa.

Part of the collaboration is universities working with ministries of health and ministries of education, and those organizations have different cultures. So you have to be attentive to how you will communicate and what you will hear when the other person says something. So, in sum, this is Professor Donkor's statement again, "The surest way to achieve an enduring and successful collaboration is by ensuring that while you pursue your interest, you also look after the interest of the other partner."

A last thought before going to break and also a little assignment for you. We have to avoid the upside down Golden Rule. We all know the traditional Golden Rule, "Do unto others as you would have them do unto you." It's part of the value system of most every religion in the world. This example comes from Christianity.

What's the upside down Golden Rule? (And we heard about this today.) Here's a king saying, "Remember the golden rule." The people say, "What's that?" And someone answers, "Whoever has the gold makes the rules." That is another way of thinking about the Golden Rule. In observing collaborations between high-income countries and middle-and-low-income countries, I find that this is one of the problems of collaboration. And I'll have some more to say about this in our next session, but we have to keep this in mind when they collaborate. Respect and reflection require understanding the Golden Rule in this way.

I'll leave you with this and a few questions you can work together with your partners, maybe over coffee - it's not always true that when I succeed, you succeed. And this is what I mean about being reflective and thinking about your relationships. 'If I'm coming from the University of Michigan, and I come to Ghana, and I run a project, I'm going to succeed if I can take what I have learned in Ghana and bring it back to United States and publish a few papers. It doesn't matter to me what happens in Ghana. My success is really not necessarily connected to your success.' And I'm sure, it can be flipped the other way. But of course, I'm speaking from my perspective from someone coming from a high-income country.

You have to pay attention to this. It is sensitive; maybe we don't want to talk about it, but enduring collaborations require attention to this detail. So one thing that I am going to encourage you to do over the break is to find the members of your partnership -and again, that means cross-country and inter-country and also in-country partnerships - and talk about how you will handle the unavoidable imbalances that are going to occur in a collaboration. And how will you move beyond the abstract of, "Hey, we respect each other," to the details of the things that you will do? The actual, practical things that you will do to make sure that you are respecting each other, listening to each other, and communicating well. So we have more work ahead.

Understanding how we're going to work together, I think, is probably the most important part of what we are doing here. We do need infrastructure, we do need the curriculum – we need those sorts of things – but the process is critical. So thanks for your attention.

**Kwabena Danso:** Well, I think we have come a little far this morning. We are going to break for 15 - 30 minutes. And of course, during that time, we can have some snacks in 'cocoa break'. In Ghana we say 'cocoa break' because we produce cocoa. Coffee will be there, but I think that we want cocoa break to be generic for all the others: coffee, tea, what you have. So if you hear 'cocoa break', it is also for 'coffee break'. So we will take a break and come back in thirty minutes. It is down there, in the main foyer of the college. Please come back here in the next thirty minutes. Thank you.

## **Partnership Development Process**

### **Speakers:**

Ray de Vries, University of Michigan – Moderator

Frank Anderson, University of Michigan

Kwabena Danso, KNUST

Samuel Obed, Korle Bu Teaching Hospital

General Discussion

**Ray de Vries:** Welcome back. Frank has asked me to moderate this session, which will go into much more detail than where we left off before the coffee break about creating a successful and enduring collaboration. We will hear first from Frank about the charter process that was used in the relationship between University of Michigan and Ghana. I'm going to then add a few words about what we learned in that charter process. And then we will hear a couple more examples coming from the Ghana side about collaborations, what is effective and what is not effective. So we are going to begin with Frank.

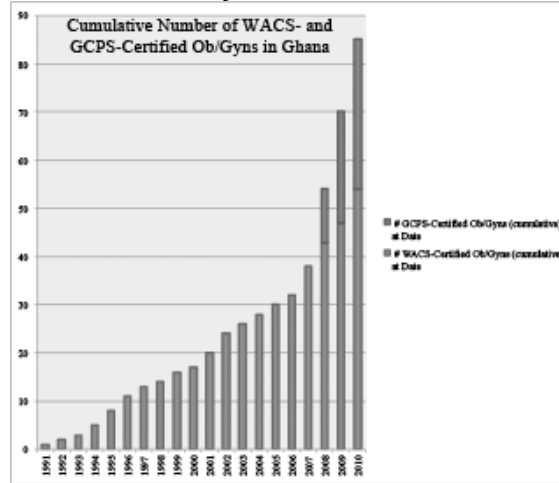
## **Overview of the Elmina Charter Project**

**Frank Anderson** Thanks. And then we will have time for you guys to talk about your own partnerships as well. I heard a lot of comments during the break about how people enjoyed Ray's discussion. I did as well. Being very technical, we can be lost in all of the details of the technical stuff, so this part of adding on this reflective piece is important, and I would like to give you an example, a concrete example, of how this is expressed. Sometimes you talk about these things loftily, but how do we actually make it happen? In your folder, you have the charter for collaboration that we created during a Gates-funded project. I'd like to tell you a little bit about how that came about.

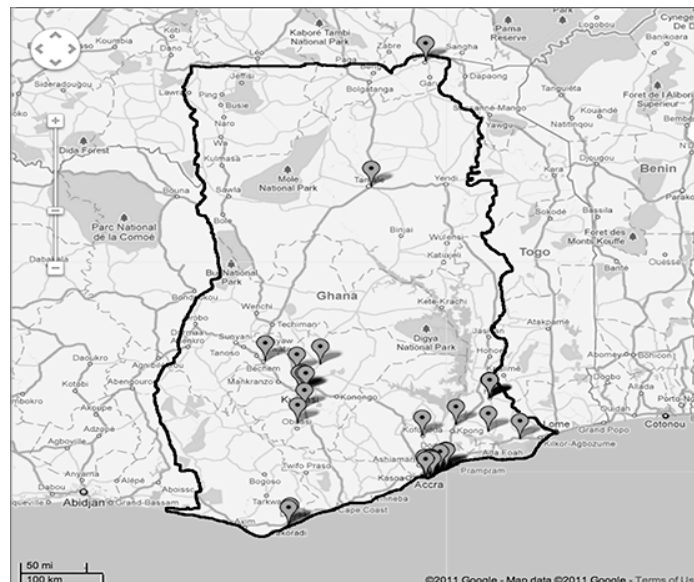
Our Charter group met in Elmina on February 1, 2009. Michigan had had this history of working with Ghana, as you know, with Tom Elkins, Tim Johnson, Jack Sciarra, JR Marty, JB Wilson, ACOG, Royal College of Obstetrics and Gynecology, and many others. The funding was during the 1990's and when that funding ended, the University of Michigan continued to work with the

University of Ghana, hosting residents and medical students, which turned into our medical students going to Ghana, which turned into the President of our University going to Ghana and visiting the Vice Provost of two universities, which turned into engineering students going to do engineering projects, which turned into the emergency medicine department working with the Ghana College to start an emergency medicine residency, and on, and on, and on. It stemmed from this OBGYN partnership, but expanded to the entire university. We had an opportunity from the Gates grant to use this example of training OBGYNs retention and leverage that experience with other parts of the University and other partnerships, and that's why I think it is so valuable to have these academic partnerships.

You've heard about the numbers of Ghanaian residents, but I just wanted to show you a graph that I made for recent publication in the American Journal of Public Health.



You can see how in 1991, one OBGYN had completed the program and by the end of 2011 there were 85. The green is the West African College of Surgeons, which you have heard about. That is a five-year certification program, where the graduates go to Nigeria to take an exam. When Ghana created the Ghana College, you could see that they were able to certify people in three years and started to pick those numbers up. Now we are at 140. I don't have the distribution, but you can only imagine the slope as it continues to grow, especially knowing that now they have 50 residents in the program.



Here is a distribution map. Many of my public health colleagues will say, “Well, yes, you train physicians, and they stay in the cities and go into private practice, etc. etc.” Well, I think that in 10 more years this map is also going to look very different.

Obviously, cities and very urban areas are going to get filled. Ghana has two new medical schools and David Kobila is starting an OBGYN department in Tamale, Ghana in the northern part of the country. But it is a process and it is going to take a while. It has already taken 15 years; this is not one of these five-year development projects. We have got to take a long view.

So this is what is happening in Ghana right now. That kind of gave us this leverage with the university, where the Bill and Melinda Gates Foundation was interested in capacity building projects. That was before the economy crashed, though. What is interesting is that we had a learning grant to strengthen training and deployment of human resources and health in Ghana.

### **Charter for collaboration**

We had four major objectives: to look at, assess, and develop research infrastructure at the medical schools; to look at the resources and capacity to improve education and training in all areas of health; to work with the ministry to look at data for policy decision-making; and to look at the distribution of health workers and match health workers with clinical needs.

These were all in line with the Ghana Human Resources for Health priorities. We also had an objective during the proposal process to develop a Charter for Collaboration, so we wanted to think how we were going to work together and what would that look like. We wanted to identify and document principles for collaboration between Michigan and the Ghana partners that can guide the interactions. We felt like the critical milestone for that objective was the approval of the document, this *Charter*, addressing the principles of communication, compensation, research, and educational collaboration. It was not a memorandum of understanding; it was a broader agreement document. We felt like past programs were developed fairly vertically – priorities set by the donors, limited timelines, capacity building might be limited or short-lived, and sustainability may not be ensured – and I know you are all experienced with those types of projects.

Most collaborative projects are initiated by the north; are mono-disciplinary or partly interdisciplinary; might have disagreements concerning the remuneration; and the collaborative research is complex or a poorly understood process with lots of possibilities, but with lots of logistical problems as well.

We did this Charter process to open the dialogue among partners to ensure that the Ghanaian priorities had been identified, that the policies and procedures under the collaboration were considered, and that we consciously talked about mechanisms of communication. We developed overarching principles and we used those to guide the implementation of a pilot projects and proposal development in the learning grant process.

It identifies our priorities, our assumptions, the risks, relevant policies and procedures, reviewing of the typical consulting model and trying to change that into a capacity-building and partnership model. And then looking at previous collaborations to see what worked, what didn't work, what were the recommendations, and what were the alternatives.

During that Elmina Process, we had a one-week conference. We had a facilitated process of 10 hours for the Charter. We discussed sessions on past stories of partnerships that worked, we talked about gender, and we talked about cultural issues. These conversations were frequently very intense and sometimes difficult, but at the end there was positive feedback so we could all clear through the

historical issues and the financial issues, sort of put those aside so that we could move on with the work that needs to be done. We had a way then in this Charter that served as our kind of Charter agreement, our Charter principles. That allowed us to work together.

There are different sections in the Charter. One section is called 'We recognize that'. What are the assumptions, what are the givens, how has the history of past projects informed the present, and what is the current situation of faculty structures, of Ministry of Health structures, hospitals, public health facilities? Then there is this idea of consciousness, that we need to do these things, consciousness like what are the priorities of each institution? In our case it was education, data for decision making and research, how to communicate, and where is it going.

We also have a section called 'Guiding Principles' and we used a whole collaborative process to re-brainstorm all the principles that we thought were important. We boiled them down to the ten principles that are on your Charter for Collaboration. We considered this Charter document kind of a contemporary model for collaboration. It would be a living document that would include these processes for commitment, faculty involvement, progression, communication, and faculty support – all of these things are out in the open. The emphasis on the charter document differentiates a partnership that relies solely on the technical interventions. It really means that we have something more than just a technical intervention.

The process for the Charter document as the background of the process created a platform for technical interventions, so this makes the work applicable across campuses and across disciplines. It just wasn't about our project; these principles are cross-disciplinary. Consciously addressing the ramifications of the inherent and overlooked inequities is the first step in creating the authentic collaborative international team that begins to capitalize on diversity and movement to this new era of partnership based on the new paradigm for planning projects in an ever increasingly interconnected world. Not all sites are equal; they can still be one-sided, but there's much to be learned to determine the best practice. But it is inconsistent with these one-sided, vertical implementation projects because it is harder to do. But it has a much bigger impact, not just for your own project, but for your university as well. That was our concrete process for how we came up with the Charter. Now I'll turn the microphone back over to Ray.

### **Good and Bad Partnerships**

**Ray de Vries:** Thanks, Frank. Let me say that if I'm a good moderator, we will end the session at about noon and that will leave us a half an hour to have a discussion here, because we know that a lot of you are involved in partnerships and we're speaking out of our experience with partnerships that we have done together. We're hoping that the things that we bring to your mind might bring to mind successes and problems that you have had in your own partnerships. So when we are done, I really do want to engage us in conversation about partnerships – things that make them work, things that make them difficult.

I want to build now on what we ended with in the last session on making partnerships work and giving you some more concrete examples. I think you are going to hear from me and my colleagues as well, that there are certain key issues that come up again, and again, and again. Those of the key issues that we encourage you to think about with the worksheets – Frank's favorite thing is worksheets – we have given you. You might take a look at the Charter – it's in the folder you were given right after the program – and also near the back is the worksheet for development of partnerships. If it is useful to you, you might make some notes there. I do want to say one thing which is kind of difficult for me to say based on what I talked about the last session. We are arguing for the fact that each party has to respect the other, but of course this is coming from me and I'm coming from North America. There's kind of a paradox here and I just want you to appreciate that

even though I am saying that this has to be an equal partnership, I am the one who is saying it. I am hoping that the next time we meet, that I have a partner here from Ghana who is talking with me. We do have some colleagues here who will talk about it, but I just want to acknowledge that paradox before we begin.

So what I want to do is to show you some examples of things that make partnerships work and things that hinder good partnerships. And, really the title of this part should be, “Making Partnerships Takes Work.” It's not just work. We can all get excited about the platitudes but at some point we really have to dig in and think about how we are going to make this work. And clearly my message has been that, ‘good intentions are not enough’. I prowled the Internet for a good illustration of, ‘good intentions are not enough’ and I think that this is an exquisite example: a dog who is trained to retrieve, but you really have to think about what you are retrieving.

So as I have emphasized before, good intentions are not going to be enough to get us where we want to go. And I think the main message here is - I want to borrow a Dutch word – I used to work in the Netherlands. The Dutch have a word that we don't have in English. We could make one up, but it's *bespreekbaarheid*, and it really would translate to “speak-able.” The point of a good collaboration is that everything has to be made *bespreekbaarheid*, or speak-able. It has to be put on the table. We have to recognize that we share the same goal, but we have to be honest that we all have our own individual goals as well. If we don't make that speakable at the outset, we are going to run into trouble.

Secondly, we have different cultural understandings of what collaboration is, of what success is, of what it means when you do not answer an email within 60 minutes or two hours. Work cultures are quite different. And in working with the collaboration earlier in Michigan, we have certain expectations of our colleagues that absolutely are culturally given and do not apply to other educational systems.

We also have to acknowledge that history shapes our relationship with one another. The history of the relationship - between high-income countries and low-income countries, between the global north and the global south - shapes what we expect from each other and how we approach each other. If we do not make that *bespreekbaarheid*, if we do not make that speakable, our collaboration is going to be in trouble.

I want to give you some examples that come from Professor Donkor, a Ghanaian. He spoke to us when we last met five years ago about specific examples of things that went wrong in collaborations. I think the point here is to have you see what went wrong and think about how you will address that in your own partnerships. So, for example, here's one: a vitamin A supplementation trial done between KNUST and a European University, which I won't name. The object was to do capacity building, but interestingly enough, KNUST - the Ghanaian institution - was not involved in hiring the key appointments. The advisory board had just token representation from the African partner. There were no staff from that institution on the research site and all the leftovers from the investment went back to the European country. Professor Donkor pointed out that his institution felt used and, of course, then they lost interest and, as a result of miscommunication and unequal partnership, this project did not work. It just collapsed.

The second example is capacity building to train PhDs - not obstetrician gynecologists. Here the relationship is between KNUST and a North American university. Again, they had this common goal that they all shared equally but they did not start with agreed-upon concepts. The way they screen candidates to be trained for a PhD – Ghanaians who were going to be trained in this North American country – was done poorly and in the end there was no guaranteed placement of these people, where they would go to get their training. In the end four candidates were trained, but none

of them came back to work at KNUST, which was one of the original goals, at least in the mind of the people were the African partner for this project. And, of course, the department's interests were not being addressed. They didn't agree on processes from the outset. And again, you might say it was successful – four PhDs were created – but they didn't come back to the institution as KNUST had hoped.

Another project trying to create a collaborative center for research, which was a collaboration between Ghana and a European country. And again, a shared goal, but when the management structure was set up, it was set up in a way that it was skewed in the favor of the European partner. Right? Because we know better. That's the idea. At some point there are some good intentions involved, like 'Hey, we know how to do this. We will set up a management structure that works fine in our country.' But none of that respect and reflection goes on. The director of the project was selected by the European country, an agreement was set up that could not be altered, and, okay, there is token representation from KNUST on the advisory board.

Professor Donkor went on to point out some of the reasons for failure and from the flipside, what you have to do to avoid failure. And, a lot of these are in the Charter; if you look at the Charter, you'll see that we address these.

- institutional involvement
- poor leadership or the wrong leadership
- poor management structure and chain of command
- not having a work plan
- loss of interest and the priority kind of drops away
- unequal interest in collaboration

Again, it is back to that point I made earlier that my success isn't necessarily your success. I might succeed, you might succeed, and it doesn't relate to me. So it's really important that you focus on that mutuality in the relationship.

Some more reasons for failure are inadequate resources, inadequate compensation, unfair sharing of the spoils of the process, not being transparent with each other, having goals and ideas that you don't share with your partner, feeling exploited, having crazy unrealistic expectations and, again, the inequality in partnerships. We can say, "Let's have respect for each other," but you actually have to get down to the fact that when we author papers, how are we going to decide who is the first author, who is senior author, who gets to be an author on a paper? It's not enough to just say that I respect you and then work it out on the fly when you are trying to decide who is an author. Communication becomes important.

Misunderstanding goals and processes, changing rules in midstream, and dealing with differences in local laws and regulations – as Professor Donkor pointed out - these differences in Ghanaian law and how you had to procure things and how you had to record expenditures, and how you had to create contracts can all contribute to misunderstandings.

The flipside to this are the lessons learned:

- You need to have high-level institutional involvement. The institution you're working in has to be behind you and see this as a good project and want to be involved in the project.
- Fair and representative management structures are important.
- A detailed and agreed-upon work plan.
- Adequate compensation. Here again, an example from our collaboration with Ghana; we have different ways of working in Michigan than in Ghana. In Michigan, if we get funding from a



granting agency, faculty members can use it to pay for part of our effort. So 20% of our time, or one day a week, can be used from this grant. We discovered though, for our Ghanaian partners, we might give them 20% of their effort, but they couldn't stop at the other 100%, so now they are working 120%. That's the kind of communication that you need to have. How realistic is it, where will the compensation go, what will it free you to do, what will you not be free to do?

- Frequent meetings to iron out emerging problems
- Keep communication lines open
- That lesson about all partners' interests being addressed
- This is important, and we heard this from the Gates Foundation. You have to have a metric for evaluating a project, its success, also the success of the collaboration

Another important thing about enduring collaborations is that you have to structure it in a way that it outlives everyone in this room. It can't be based on one charismatic person like Frank Anderson, because some day Frank is going to retire (believe it or not!) and Professor Danso is already retired. It has to have a structure that can be picked up by the next generation.

The benefits of good partnerships are communication, respect with different voices, commitment to the project, and a context for collaboration that is contagious – your partners are excited about this. These things I am showing you are things that we learned when we interviewed people who participated in the Ghana-Michigan collaboration. One of our metrics for evaluation was interviewing people after we were well into the collaboration. We asked people to talk about, how is the health of the collaboration, how has the Charter made this collaboration different from other collaborations? These are the kinds of things we heard that were different when a Charter preceded the work that was done. An interesting thing about the first bullet point is that we heard from people in Ghana and also in Michigan that not only was communication between the countries improved, but that communication *within* the country was improved. The people in Michigan from different departments that never talk to each other, as a result of the Charter, were talking to each other. We heard from Ghanaians that people at Universities had a really difficult time getting into the Ministry and talking to the ministers. After the Charter, that communication improved, which was one of the most interesting and unanticipated aspects of our work together. We thought it was all about our inter-country collaborations, but it actually improved within-country collaborations as well.

And you see that in this quote. This is a quote from one of the participants from Ghana. “From those of us coming from Ghana, there is greater collaboration amongst ourselves.”

To be honest, problems remain. I am sounding a little Pollyann-ish up here. If you have a good charter, you're set to go 25 years from now and still be working well. But we also heard of a few problems in our conversations with participants. There is still concern from Ghana that we are working hard to collaborate but still the processes is being directed out of Michigan and not here in Ghana. There are infrastructure problems like different cultural understandings of what the appropriate response time is for an email. The five-hour time zone difference made arranging phone calls very difficult. Regarding the infrastructure problems - you saw the slight about Internet access. Those things are created problems that you need to anticipate and address. Different hierarchies within the two universities like who is the key player in Ghana compared to who is the key player in Michigan, and that wasn't always sorted out equally.

The charter helps, but I want to be honest about the fact that these things remain. This comes from Peter Donkor and I think that this will be helpful when you're developing your partnership plans as we ask you to do in the worksheet: There has to be institutional ownership of the collaboration and a thorough understanding of the expectations of all partners. You must do what you need to do to

ensure that everyone is a winner; my success might not be your success, but if I am successful, then I want you to be successful in the ways you need to be in your own university, your own country, your own ministry.

Peter Donkor says that you have to make this *bespreekbaar*, or *speakable*. What is in it for me and my institution? And then you have to be transparent about that. And here is that quote again from Donkor, “The surest way to achieve an enduring and successful collaboration, is by ensuring that while you pursue your interests, you also look after the interests of the other partner.”

Thanks for your attention. I hope that this has stimulated some thinking on your part and that we can have a good conversation before we break for lunch and you go start working on your own partnership plans. In effect, what we are asking you to do is to have your own Charter process for your own collaboration. We took several days to work this out and we learned a lot. We hope that what we learned can help you do this more efficiently and in a more streamlined way. So, thank you.

**Kwabena Danso:** Thank you. A lot has been said in terms of partnerships and the ethics of it. What I'm going to look at is not to repeat what has been said already, but to give specific examples of how some of the principles and guidelines have been applied - essentially to make the point that partnership in all the sense must be bilateral and should not be one-way traffic. So it is important that at the initiation of the partnership that there is a clear understanding of the objectives as to what needs to be worked on, what needs to be achieved, what is going to be the input on both sides, because, as the name implies, partnership will mean that at least two universities trying to collaborate and work towards a common agenda, each to fulfill an objective. The two objectives might not be the same for each, but it would be a fulfillment of some objective as they pursue a common goal.

In the case of our partnership - and I will take Kumasi as an example - it started as you've been told with the training of postgraduates for building capacity in maternal health to address maternal mortality and morbidity, and, of course, neonatal mortality and morbidity as well. Initially it was at the level of student and faculty exchanges. Now, as time has gone, we have moved into the stage of growth where student exchanges have been expanded and moved beyond OBGYN.

For now, we have medical students who go to the University of Michigan for their elective observations and junior specialists and junior faculty also go to the University of Michigan. On the other side, we have students from the University of Michigan coming from completely different disciplines, like biomedical engineering, who come to Kumasi to work together with the Department of OBGYN, to look at the workings of the department so as to be able to devise and build new tools to solve problems. For instance, one specific example was trying to devise a new vacuum tube that can be used to address and delay second stage due to poor maternal effort. Then also students from University of Michigan Minority Health International Research Team (MHIRT) have come to Kumasi and even moved beyond Kumasi to go to places like Mampong and other places. So it has not just been a one-way affair.

Looking at the growth of partnerships, which must be objective for every partnership, we also have had partnership established in other disciplines. In internal medicine for instance, we are looking at a partnership for the unit of cardiology where implants – cardiac implants, pacemaker implants – will be available. Skills and facilities will also be available in Kumasi. Now, in oncology for instance, we have been able to set up a team where we can videoconference on the two sides of the globe to show that both sides are having their needs or their objectives fulfilled.

The other aspect that I would want to add is the levels of engagement. I think that when are talking about partnership it must involve all. Or it must grow to involve all aspects of an institution, so that it is not only doctors that are involved, but the other supporting institutions or supporting units of

institutions must also be involved. In that respect, for instance, we have had partnership exchanges for ultra sonography as one area that we are developing and in fact, as I speak now, in the university in Kumasi we have an undergraduate program in ultra sonography, which has been built out of this collaboration.

So I will end here and say that for partnerships based on all that has been said, we need to be clear in our mind at the onset of what we want to achieve as a common rule and what each player of the partnership wants to achieve. There should be an understanding that if I achieve my objective then I help the partner also to achieve his or her objective.

The second thing that I would like to conclude is that we should look at the partnership not as a static concept. We must nurture it; we must let it grow so that eventually it infiltrates other aspects of our life. Maybe we can take an example, if you permit me, from the oldest partnership that we know - which is the partnership of marriage – in whatever form that it is. It is supposed to grow and continue to grow until death do us part. Thank you.

**Samuel Obed:** Hello. It is still morning. What I am going to tell you is not about partnership; what I am going to tell is an experience of someone who has gone through the system to create the *Elmina Declaration of Partnership* between the University of Michigan and Ghana. Whatever I am going to say this morning is solely my responsibility and I owe no interest to anybody.

The outline will be an introduction, some partnership processes that we have gone through, and most important, the challenges that we faced as we evolved the Elmina declaration and how it has been sustained. We are told that the 1970s and 1980s were a period of hardship within this country. There were no obstetric facilities functioning in the country. There were only a few OBGYN specialists in the country and, because of their low salaries, they were very demoralized. If you look at Ghana, there were no OBGYN specialists practicing beyond Kumasi and Kumasi is just about a third of the way from Accra up north. As a result, there was very high maternal morbidity and mortality.

We were also told that in the 1970s, the physician population ratio was 1:12,900. By 1985, it worsened to 1:22,900, and we were not making progress at all in the country. We were also told that between the 1960s and 1980s, out of the thirty doctors who qualified in the UK and have been sponsored by the Ghana government, only three returned home.

Now we were also told that in 1987 there was a meeting in London that drew representatives from medical schools in Ghana, Ministry of Health, the West African College of Surgeons, the Royal College, and the American College. This meeting was sponsored by the Carnegie Corporation of New York. We were also told that there was an agreement at this meeting, and the agreement was to develop a full local resident training program.

The objective given to this was that they were to ensure that maternal morbidity and mortality ratios were rapidly reduced. It was to improve on the infrastructure of the health delivery system in the country. It was also to recruit Ghanaian specialists abroad. Ghanaians who have qualified were enticed to come home and teach people like me to qualify. The sum total of this was that there should be an increased total number of obstetrician gynecologists in the country. The support, as we were told earlier this morning, came from the Carnegie Corporation of New York, the American College, the Royal College, and the Ministry of Health, Ghana. The program was inaugurated in Accra in 1989, and I was one of the four people from Accra who was enrolled in the program at that time.

Now what were the initial challenges? There were two existing groups of residents at that time: those who were already in the program and didn't know when they would finish, and those of us who were

freshly recruited. People were looking forward to going out to support other family members, but not necessarily to earn medical degrees for themselves. And the condition in the country was such that they cannot just stay in this country, work, and feed themselves and their family and cater to their future. There was also mistrust between those who are creating this idea and the old residents. Some of us who were new were confused as to which direction we should take. Unfortunately, some of the old residents left and some of the new ones also left. But I believe that they will regret leaving.

What made the program stabilized? By and by, economics of the country improved. And after some agitations, the government accepted that the doctors in the country should be given an extra allowance - the popular ADHA - which in that time was about two to three times their basic pay. That helped a lot. But most important were the resources that were churned out by the candidates who took the exams. We were considered to be the most successful department among those taking the exams in West Africa, Kumasi, and Accra.

As a result of this program for the University of Ghana, we now have a deputy provost of the College of Health Sciences, we have produced a dean of the School of Public Health, and we have a vice-dean of Post-Graduate Studies at the College of Health Sciences at the University of Ghana.

The past and current heads of departments at the University of Ghana OBGYN are from this program. The past Chairman of the West-African College of Surgeons Faculty of OBGYN is from this program. The past secretary and current secretary are all from this program. And also the current secretary of the Ghana College of Physicians and Surgeons OBGYN faculty is also from this program. In Kumasi we also produced the acting provost. If I had not been aged, I would have been the provost. But because Ghanaians retire after 60 years, that was impossible.

We have also had a dean of Medical Sciences in Kumasi, and the past three and current heads of the OBGYN Department who are all from this program. Kumasi has also produced a minister of state in Ghana. In the interim, there has been two other medical schools added to the existing ones in the country: Tamale and Cape Coast. The faculty members in these OBGYN departments are all products of this program.

Now the second level of challenge. At the beginning we were promised that there would be sub-specialization. This is very bad; there was no written document on this. So when people started to come out from this program, there was agitation for sub-specialization and Ghana was not equipped to take on that journey. However, this problem has been resolved by the formation of the Ghana College of Physicians and Surgeons. And currently in our program we have subspecialties in Reproductive Health and Family Planning, Urogynecology, and Gynoncology. There are plans to set up units for Maternal and Fetal Medicine, Reproductive Endocrinology, and minimally-invasive surgery.

What are the current challenges? The Carnegie funding dried up long ago and the Ghana government is not able to keep up with the support of postgraduate training in this country. There is some sort of discontentment coming up now because of funding issues. Because of the same funding issues, equipment has broken down and is not easily replaced.

At this stage, let me mention Professor Tim Johnson. I believe he is a Ghanaian, only he was born somewhere else. He has been a conduit between the Ghana programs and whatever is happening outside of Ghana. Through his instrumentality, we were able to bring the president of the University of Michigan on a visit. As a result of that, we have the *Elmina Declaration of Partnership*, which, as Professor Danso explained, has gone beyond the scope of OBGYN. All of the universities in the country, the Ghana Health Service, and the Ministry of Health are now with the University of Michigan as a key partner.

We know about the scope of the Charter so I won't go into detail with that. I think I will end here, do some discussion, and take some responses from you. Thank you.

**Raymond de Vries:** Thank you, Professor Obed. I failed to introduce Professor Obed. He is the head of the Department of Obstetrics and Gynecology at the Korle Bu Teaching Hospital. Some of you knew that, some of you didn't, so thank you again, Professor Obed, for your comments.

As I said at the outset, we know that many of you have been engaged in collaborations for quite some time. We would like to take the remaining 25 minutes before we break for lunch to hear from you on your reactions on what you heard today. As you've noticed this is mostly focused around our experience in the relationship between Ghana and the University of Michigan, so we would like to hear comments about that, but also things that you have learned in your collaborations. So we have this time to open up and hear from you, and I think I will be the one moving this microphone around. So, comments, reactions, experiences?

I do have to say that I like the metaphor that Professor Danso used of collaborations as a marriage. Because those of us who are married know how difficult it is to keep that collaboration going, but also to see it grow through the years. So please, comments.

**Washington Hill:** I'm Washington Hill from the HRH group in Rwanda. I think that one of the things that I've heard and one of the things that I tell people about how things are going in Rwanda (besides the cold) is that we – Dr. Stephen please stand up; he's my twin – have a model in HRH for twins. I actually have a twin; you don't know him. This is not my biological twin, but in the HRH program we have a twin. We work very closely with that twin. It has changed over the years in the program. But we work very closely.

What I have heard here and would like to share with you is that it is a two-way street. We learn from our twin because we come into a country with all of these ideas, but we learn that ... Stephen is very nice in saying, "That won't work." And then he learns from me, so that it is a two-way street: we teach them and they teach us, and that is the kind of collaboration that we want. The goal is reduction of maternal mortality and with my wife the goal is to prevent stress. We get very upset when we have a maternal death or when we have a baby who is committed to a nursery with a temperature of 100.5, but then we have to step back and ask how we can collaboratively work to make that not happen. So that is something I would like to share.

**Ray de Vries:** Can I ask you to put a little more meat on those bones of having a twin? The concept is interesting but is there anything else you can tell us on what makes it work? Now, you have twinning. I know I have some colleagues in the Netherlands who have twins in programs in Africa, but is it something specific about twinning that you think makes it work?

**Pauline Hill:** Hi, I'm Pauline Hill and I am part of the HRH program as well. For me, I also have a twin, which means every meeting I go to, he is there. We collaborate on what we are going to present, what problems he sees as are going to need to be corrected in the nursery, then my twin and I go to the twins in labor and delivery and ask how we can work together. It is not about me, it's about how I can encourage them to work and to collaborate. It's just like a family. I have a lot more twins than I ever thought I would have.

**Diana Wolfe:** Hi, my name is Diana Wolfe, and I was the first HRH OBGYN in Butare. Butare is south and is a little bit of a smaller institution. One comment I can make about training is that the twins we dealt with were junior faculty and they needed to be sensitized by their senior faculty, like Dr. Rulisa, to know what the concept is of twinning. And that meant working together to do rounds,

to do morning reports, to commence journal clubs, to commence simulations, and many activities that my colleague, Dr. Washington, is doing and expanding. That is what I wanted to say about twinning.

**Kwabena Danso:** I think that there is something that we need to take into consideration. Depending on the objective, there will be different players that will be playing. For instance, if you take OBGYN training. It is important to involve the Ministry Of Health, universities in our country, and the Ministry Of Education. It is important that we do recognize the role of the Ministry of Health concerning Liberia and Ghana.

In Ghana, for instance, postgraduate training is also under the Ministry of Education as well, the universities come under the Ministry of Education. But the health aspect also falls under the Ministry of Health. So you see the local irregularities. This should not blind us. It is the principle we are using to work.

**Ray de Vries:** That was really critical, these different levels of engagement.

**Rachel Nardos:** I am originally from Ethiopia. I grew up in Ethiopia, but I had my postgraduate education and medical school in the USA. So now I pretty much navigate both worlds and that actually has pretty much opened my eyes to some of the nuances of partnership and collaboration. I cannot overemphasize how important it is to, when you are trying to form this kind of partnership, work with people who really understand the culture of the place where you're trying to work. If you have the opportunity to work with people who know both systems and are able to navigate and bridge those gaps, it makes a huge difference. The reason why I am saying this is because I often times will go to meetings and places where my Ethiopian partners are presenting their case and I will be going there with my US partners, and what I hear and what I get from the body language and the cultural norms is completely different from what my American partners do. I can pick up a lot of things that other people are not able to. It is just fascinating to me how much those things go towards building trust and long-term sustainable relationships. I really would like to encourage this group that if you have access to people who really understand the culture and have strong Western educational backgrounds as well, to use them as part of your bridge. Thank you.

**Yvonne Butler:** Hi. I am Yvonne Butler with the Baylor College of Medicine, working in Liberia. I just wanted to piggyback on what my colleague, Rachel, said. I was also born in Liberia and raised in the US, trained in the US, and now I've been working in Liberia for 18 months. It does make a big difference. I actually had a completely different comment, but I wanted to echo your thoughts and say that you actually hear a difference. But you not only hear a difference, you have a unique ear. You hear as not only your native country representative, but you also hear differently as an American representative (if you are affiliated with an American institution) but both sides may not hear the same thing you hear. So it is actually a third ear that may not necessarily reflect what either of your colleagues hear. And I think that is the important thing. Liberians are finding ourselves really trying to implement this postgraduate program. One thing that has been focused on is the idea of decreasing the brain drain. There are different concepts on how we would do that, but one concept is why not try to reintegrate Liberians who have left to return. But it is really important to know that as we do that, we may hear something completely different.

My second actual comment was related to collaboration. In the case of Liberia there is not one international collaboration but multiples in not only academic institutions but also a variety of NGOs and other international organizations. I have a question - what is the process of integrating all of those various bodies with their own agendas into creating a successful institution? I'll be interested to know if the University of Michigan has had a similar experience and how they handled that.

**Ray de Vries:** Frank, can you speak to that? Here is the comment. ‘How do you manage when several different people with the same goal in the one country and several collaborations exist in the same country?’

**Frank Anderson:** Well, in terms of the obstetrics and gynecology training, there are other people that have come in and have provided inputs. I think there are different types of partnership. I think there are inputs that can be integrated in the larger program. But then there is usually a primary partnership. We have worked with Ghana, but we can work with other countries as well, and there has been some staying power in the initiative that we have. What are we funded on? So, we have maintained that relationship. I find that students get funding to do projects, other people get funding, faculty from Ghana get funded to come to our school, so your definition of partnership isn’t just necessarily what you find in an activity. Do you know what I mean? I think the transparency and the respect that is built in the long term of academic partnering happens whether or not there is funding.

**Rashwan Hamid:** I like your presentation on partnership and collaboration, because I think it is one of the very difficult issues to achieve in many countries, especially when you have so many universities. In some countries things have been achieved in the formation of postgraduate medical boards; this brings all the universities together. When you count all the stakeholders together with the Ministry of Health, there is a body and a high-ranking board, which has access to the presidents and others. And so it deals with the situations regarding equipment and deployment at a higher level and it makes whoever comes easier. So there are countries now who have these postgraduate medical boards and they are working well.

**Ray de Vries:** Just as a quick follow up on this whole conversation – the embedded sociological comment – I know in anthropology sometimes there is a sense that, “I am an anthropologist and I am going to this part of the world; I own this part of the world. I don’t want any other anthropologists coming to my corner of the world and doing research on my people.” I think your comments bring up that we come from the West to collaborate but we are not the only people coming to collaborate with you. So you have this plethora of people to collaborate. I do sense, from my limited time here, competition between, “this is mine here, what is this other university coming to do?” If we don’t acknowledge that then we also are set up for problems which we have to be upfront about -this idea of one level for them. Point everyone to the same goal. Other comments?

**Jeff Wilkinson:** Jeff Wilkinson from Malawi. Taking your hierarchal relationships a step further, imagine Byamagisha, Rulisa, and Mbaye are going next week to have a meeting with the Secretary of Health and Human Services in the US, and the labeling of partnership will be Makerere – US relations. It seems a bit odd and we don’t necessarily think that, but that is exactly what is happening in the reversal when we are saying the UNC – Malawi relationship, the Baylor – Malawi relationship, the Indiana – Kenya... I think you are getting my point. So I think that our partners will see that it is a useful thing to think of as you think of partnerships.

I’ve seen this a lot in the fistula world, where you have high-powered people talking to high-powered people and they start making rules for the relatively low-powered people without the discussion that is necessary to make that work. Being cognizant of these hierarchical dynamics and how our partners might feel about those and then avoiding those – Grace might tell you that in the fistula thing there were some issues and that we are making lemonade out of lemons right now.

**Ray de Vries:** I think that the idea Professor Danso brought up about one-world engagement is really important and should be emphasized here. See, the collaborations are kind of a middle-level but currently we need to pay attention to the people above us.

**Doreen Ramogola-Masire:** Hi, my name is Doreen and I am an obstetrician gynecologist from Botswana, trained in the United Kingdom and South Africa and working with an American institution. Often times I am asked, “Whose side am I on”, by the Ministry of Health in my own country and by the university that I collaborate with. So these are some of the things and I always say that I am on the right side of helping patients. One of the things that I heard about the training in Ghana is that it creates the way that we would like to go with the idea of management. I think the idea of just training the members in terms of technical skills and thinking that they will ultimately lead, as my colleague just said, to maternal mortality reduction is not quite the case.

I come from a country that is relatively well off and we have a very new medical school. We do not have OBGYN residency training yet and what we find is that we have two major problems: problems of leadership and problems of systems. So you can have the best technically trained people but they come into a system where really the leadership is at the board level, the government level, the hospital level, and the Ministry level is not there. The systems are all in place. You have money but there is no oxytocin. So there are two things, and if we do not pay attention to those as we create our training program, we are really going to struggle in maternal mortality. And I am using my country as an example.

**Irwin Merkatz:** Well, first of all I'd like to thank Frank for a number of points, but I'd like to thank him for the transparency of the discussion that has allowed me to gain insight to myself. I think that's one thing I want to talk about in our collaboration and in our partnerships.

I am responsible for a very large academic department, which is well represented here by several faculty members, but I come from a community known as the Bronx, NY, which is known as working-class, immigrant population and not affluent. When we send people away, they say that we have enough problems right here in the Bronx, why are we worried about Rwanda or Ghana? The answer is we have to bring back to the Bronx what we have learned here in terms of partnerships. And I promise that I will.

In the same time, when I have several dozen faculty here, it means that somebody in the Bronx is covering their work while they are here, so the rest of the academic department is a partner to those who are getting their names in the paper or those who are in the meetings. So I want to thank the general department for allowing Diana, Sierra, or Alex to be here. So, those are the forgotten partners that really need to be brought into the open. Thank you.

**Audience member:** I think we have discussed a lot of things, but we haven't mentioned the fact that we are referring to the Ghana program but haven't mentioned those who have actually made the Ghana program work. And that is the doctors who are here that spent countless hours training the physicians. I think that each collaboration in the long term, those that are on the ground and those that are actually doing the teaching, need to be commended for what they have done and without them this could not have been achieved.

**Kwabena Danso:** I want to react to a comment from this side talking about leadership being key to getting things right. That is very true, and in fact, it is a part of this collaboration to also realize that when the leadership of maternal health has been properly trained and put in place, we will see a lot of changes going on. We have a paper that has been published in one of the journals proving that when you have posted an obstetrician at a district hospital, for instance, you start seeing calls for, “Hey, let's have the oxytocin be replaced,” or, “I need an ultrasound; I need that; I need that; I need that.” So the essential thing is that in whatever system we are hoping to put in place, we need people operate the system.

As far as maternal health is concerned, it is the OBGYNs and their cohort that move that agenda



forward. So it is important that we look at this training. It is important to make that leadership presence felt. That is what this collaboration is about.

**Yirgu Gebrehiwat:** In hearing the thoughts on this discussion, I was wondering what our main point is. Is it training more than 1000 obstetricians at the end of the decade?

The second point that I was thinking about is what kind of obstetrician we train. Do we want to train a super technician who started with all procedures, or do we want an obstetrician who has some attributes of a leader, some attributes of a teacher, and some attributes of a researcher who is capable of raising issues in (inaudible). So I think we need to think about the attributes of the obstetrician gynecologists we train.

The third point is that we know that something has to happen to achieve a different level of development. We have heard we are raising the high standards. So what are we going to do when it comes to strengthening the system, creating the necessary academic people who will train and maintain the system.

And the last point is that I wonder what the place is for regional associations of these countries. Because at the end of the training we going to be wider group of professionals and their countries. This program has to be positively received by the respected societies of this country.

I think we need to work towards something - not bilaterally with one US university and another US university as a partner - but to some sort of final collaboration between university professional associations. And then the government can work to bring the Ministry of Education or the Ministry of Health (or both) to the meeting so they can be involved in the process. The last week is a story of the success that we have heard from the University of Michigan and Ghana as a one-to-one collaboration. Now we are talking about many universities. It will take a number of university arrangements and collaborations and a number of foreign institutions. So we have now some mechanism of organized relationships. Because unless there is an academic association of the relationship, I can possibly see an occasion where you are going to compete. I mean this is a reality - some of the relationships may work and some of the relationships may not work, so at the end of the day we need to find a mechanism of looking into what is happening and push up those relationships that have fallen behind, so nobody in those single relationships is working within a vacuum. Thank you.

**Male African Participant:** Thank you and many things are addressed by Professor Yirgu, so I only have one question which is that we have many partnerships in the pipeline for the program we are starting. So, do we really think that having multiple partnerships will affect the success of this partnership? Thank you.

**Ray de Vries:** Yes, that remains an important question. I don't think it necessarily should alter, but I think the possibility is there if we think about it. But other people may have thoughts greater than mine.

**John Mulbah:** My name is John Mulbah and I am an obstetrician from Liberia. I've sat here listening to the comments and also the concern coming from some of us. It is important that when we come here, for us to understand partnership and collaboration. If we take the country of Liberia, we are in desperate need of help, so we may collaborate with many parties. The partnerships will understand that they have to collaborate to achieve a common goal.

Because as I stand here, I am also a fistula surgeon, I manage the national fistula project in my country. I am getting help from Johnson and Johnson, I am getting help from Zonta International,

and they are all partners. Fistula is the example that I am giving you now. I know that fistula cases are associated with lots of stigmatization. Johnson and Johnson is interested in training and Zonta is also interested in training. You will not get a patient at that hospital to operate if you have not mobilized the patient or sensitized the community. You have to understand that we have collaborated to achieve the common goal. This is very important for us to do and especially for people who are coming to the help of other people. Because many universities are using faculty to train our residents. We came to Ghana, we went to Michigan, we went to Baylor University, we went to Boston University, and we went everywhere to achieve our goal. But the help will be coordinated. We will be transparent; we will coordinate the help.

**Ray de Vries:** Thank you for your comment. I should go to the back of the room. I have been favoring the front of the room. We will start here and then go to the back.

**Joseph Ngonzi:** Thank you, my name is Joseph Ngonzi and I am the Chair of Obstetrics and Gynecology in Uganda for Mbarara University. I just have two questions and then one comment. Listening about the partnership between Michigan and Ghana, we seem to find it successful. I pose to you these two questions: how did you manage to steer through the political environment and how did you manage to make a political will on your side? Because without local political involvement, then efforts can never be sustainable.

Number two is in a couple of different countries there is a sort of a ban on recruitment because of so many reasons; one of them is lack of resources to be able to recruit and retain some of these highly specialized physicians. How did you manage to be able to retain over 90% of the physicians that you were able to train? Because that is very important.

It is not easy to object to offers outside of our country, especially if they come with better pay. A case in mind is myself. I received so many offers to go where I am able to earn ten times what I am earning in my country. But I look at the future and I say, 'If I go, what will happen?' Many have gone, so let me stay and be able to erect the pillars, but hopefully the future will be able to judge me right.

My comment that I want to give lastly is that we are learning from failed partnerships at my university. There are some partners that came in and they were not very transparent, and at the end of the story, they were churning out papers, and interestingly, none of us were part of publication. And so when some partners came, we still listen and we say that we do not want to collaborate. But along the way we discovered, well, we need to change our mindset and be able to discuss a dialogue on equal terms.

And I'll just give one example of a partnership. They came and they said that one of our challenges is senior mentorship and residency training and service delivery and research training. 'How best can you be able to partner with us and achieve our goals as we help you to achieve your massive goals with us?' They have been able to support some residents by paying their tuition and by giving them a small stipend and this has been very successful. So my comment lastly is for the African institutions. Yes, there is a challenge to try and bargain on equal terms, but there are many factors that seem to dictate who gets the biggest share. Nevertheless - for our American partners - it is very important for you to know that most of these institutions are young and upcoming, and as you come in, it is important that you help raise the capacity of these small institutions to sustain whatever program they are carrying. Thank you.

**Ray de Vries:** We are running a little late so I propose one more question, and if somebody from the Ghana-Michigan collaboration wants to briefly answer those two questions then we will move on. Does someone want to speak to those questions on how we engage politics between UM and

Ghana? Professor Danso? And then we are ready for lunch.

**Kwabena Danso:** Well, the involvement of the government is paramount from the beginning. The agency of government that needs to help is the Ministry of Health. So we realize what is now the Ministry of Health was well represented from the beginning. The second thing is how do you retain? There are a lot of things that you have to put in place to make the partnership or the products of the partnership be successful. One thousand new OBGYNs is over and above what we would have achieved if we went at the same level. That is what we are talking about and the system in order to accommodate them.

There is panel discussion on the government to overview that. But in the Ghana example, concurrently there was a movement in the working conditions of doctors, where an additional remuneration was added - the ADHA; I think that was mentioned in the presentation. The government must be brought on board right from the beginning. That will be the job of the local parties. That is why in this assembly we have invited representatives from the Ministry of Health and also invited people from the Ministry of Education. That is the answer: you cannot just train and train for training sake. You are training to be used by a system. The confidence of the system is – in this case Ministry of Health – is very important, so let's bring them on board from the beginning. Thank you.

**Ray de Vries:** And that is the perfect opportunity to take this moment and ask the folks who are here from the Ministries of Health and Ministries of Education to please stand. I think we have done a really fine job of working on it. Anyone from a Ministry of Health or Ministry of Education please stand so you can be recognized. [Applause]. They will be a critical part of this whole process.

**Frank Anderson:** Okay, wow. What a morning we have had already. Thank you so much for your efforts and thoughts. I am just going to check with Madeline, but lunch will be from 12:30 to 1:30 and then we will have another plenary session about infrastructure and program design. We will be back in this room at 1:30.

**Kwabena Danso:** Good Morning! Welcome to the second day. Yesterday, we had the first session and I believe at the end of the day, the enthusiasm, the determination, and the commitment was obviously very high. The night also hopefully you rested well so we are refreshed to come and continue this day. We will begin by looking at a recap of what we did yesterday and then move on to what we have to do today. Essentially I am sure we are now in tune with the workings that we have in our representations and then break into the country partnerships and the worksheets. I'll have Frank take us through the recap and then take it from there.

### Meeting Recap

**Frank Anderson:** Ray, our embedded sociologist, is going to make some comments in a minute. I wanted to just ... for myself and from everything that I have heard, and I get to hear from all of you guys, which is great because I can see people's eyes lighting up, and people getting this idea, moving their partnerships along, and building the relationships. The partnership session yesterday morning seemed to be especially touchy for a lot of people because it opened up some conversations for us that we don't usually have.

I wanted to thank Ray for coming here and opening up that type of communication, that line of communication because I think it had a nice effect on our small group work. The second part of our day was hearing the country stories and I was amazed to hear the variety of stories, to hear number one that so many countries are moving in this direction. I think 10 years ago, a conversation about training obstetricians and gynecologists or specialists in general was on the very low level. Now what I'm hearing is that all of the countries that are represented here are moving in the direction of having

expert capacity in their country to deal with maternal care. And so it is happening and 20 years from now we won't be doing this.

We're at this time now to figure out how to make that happen for African countries to implement what they want and what we can do is not just American universities but other organizations, funders in a way that the support can be harmonized and collectively offer to you. Finally, you got to get with your small groups. Some were one-country groups just meeting your Ministry of Health partner. Other groups had several partners in the same country. So there is a lot of good discussion going on, a lot of issues being looked at and a lot of transparency and a lot of progression and tremendous feedback. We had a nice dinner last night which was lovely and here we are again today.

We asked Ray gives a comment yesterday as a recap on the country stories but we kind of ran out of time. So great, I'd like you to come up to the microphone and give us your impressions and then I'd like to get your impressions as a group.

### **Thoughts and Impressions**

**Ray de Vries:** Thanks, Frank. Frank had asked me to more or less pay attention to the country stories and make some observations about what I saw. Essentially I have four areas of things that I would like to talk about very briefly. This will be very brief. The first is transparency. The second is mutuality - back and forth. The third is levels of engagement. And then the fourth thing is models of cares.

So in terms of transparency, I am thinking across all the stories we heard yesterday and it was clear that in every story, transparency was very important. That is being open with each other about what you're up to, the nature of the partnership, and with whom your partnering. In particular what I found interesting in light of some comments both in the sessions and what I heard outside of the sessions is these partnerships are not exclusive. We had the metaphor marriage the other day but maybe the better metaphor for partnerships is polygamous. It is not as if once you are engaged with one partner that excludes other partnerships.

I was impressed with the collectivism of some of the countries' working partnerships - that is where they went to find resources, where they got engaged both within the country and outside the country, but I think that the underlying message about transparency is that we need to be transparent about that. We need not to be jealous when somebody says, "Well, I am partnering with this other person." As I was saying yesterday, no one owns these efforts; this isn't my country or my part of the country. That came through in many of the stories.

The other thing under transparency that I was impressed with is the idea of leveraging partnerships. I thought that was very interesting that you may have a partnership with someone that you can leverage to generate new partnerships or to change people's mind in your own country because the nature of the relationship gives you some kind of credibility that you can translate into more resources for yourself and more resources for the ultimate goal of improving maternal health.

In terms of mutuality, this might be a little bit more sensitive, but in listening to some of those stories, I was concerned about were these partnership really mutual. Are we really willing to learn from each other or is unidirectional? That one partner has something to teach and that the other partner only has something to learn. I get a sense from that, and listening to these stories, and sometimes that felt like the case in certain countries, that it was a one-way relationship. I've used example before in Rome, so those of you who were in Rome will remember this.

I work in the field of ethics, and I'm concerned about the fact that we in North America and Europe

think that our models of ethics can be directly applied to countries outside of North America and Europe. So we travel to Africa, we travel to Central America, and we say, "We have a model of ethical reasoning that you need to adapt when you do clinical trials and when you do clinical work." Most ethicists never listen to the way that ethics get done in these other countries.

So, we come in with our American idea of the best way to make a decision is each individual must decide, never keeping our ears open to say, "There's something about relationships and community that should inform ethics decision-making." So we tend to hear only one side of the story, and we think that our model is the only model that should work. After all, it started back with the Greeks, it was developed during the Reformation, and now we have these modern philosophers, never saying that there are other ways of doing moral reasoning that we in North America can learn from.

So that is an example of sometimes I heard this lack of mutuality. Somebody talked about what I could call 'Structured Inequality'. That is, when residents come from outside of Europe or North America, they are not allowed to touch patients. But we in North America can send our medical students to Africa and they can immediately begin giving care. I think we need to pay attention to that type of structured inequality.

What this calls for is something that I mentioned in my talk about being reflective. And I heard that coming up also in the topics that you actually have to stop for a minute think about what is going on here. Am I really respecting my partner? Am I honoring my partner? So, that is mutuality. Another thing is levels of engagement - I think Professor Danso brought this up - which is the need for engagement on all levels. I saw that in most of the country stories that the collaboration kind of sits in this middle level but you need to engage people above you in the institution and in your country and the people were actually doing the work below you. The partnership is here, but it has to engage other players, especially players who have the power to make the partnership work. So I was quite impressed that Liberia (and there are other countries here, too) but we got to hear from Liberia yesterday that someone from the Ministry of Health was here, which shows that kind of clear engagement at that level.

Two more things, models of partnership. We heard several different models of partnering and I think that is why we are here. You have to be open to learn from each other and use different models of partnering, but I would caution us when we're being reflective about our models to say, "We want to provide training, but we also want to develop infrastructure. To what extent do our models generate well-trained obstetricians, or 1000+ obstetricians, but also how do they shape infrastructure that will continue this training beyond the life of the partnership?" When scrutinizing our model, I think that should be foremost.

And my final takeaway message is that it seems that probably the ultimate things that is important for partnerships is trust. In talking to some people yesterday, the question was raised - which I think is reasonable - isn't it dangerous to over scrutinize our partnerships? If you start thinking about fifteen ways in which partnerships should work, won't it lead to people saying, "Yeah I am kind of unhappy about that." I think we have to avoid that side as well, of being too cautious and too sensitive. Ultimately what we want our partnerships to generate, which is why we need transparency, why we need mutuality, is trust. That I can trust you and you have my interests in mind, and when you are pursuing your interests, you won't ignore my interests. Those are just a few of the things that I noticed yesterday. Thank you.

**Frank Anderson:** I know you have all read this book, but if you missed Ray's talk, it's on page 77. He has reflections on global partnerships and if you'd like to read more on Ray de Vries, it is available.

Our intention as we are recording all of these talks is that we will make transcripts and you will be able to have this in print as well at some point. But at this point, I would like to get some comments from the audience about your reactions yesterday, especially to your small group work, but also your reactions to perhaps the country stories and partnerships.

**Kwabena Danso:** So I will pass the microphone around. Show by hand and I'll give the microphone to you to give some comments. I'll also look around if I see that your body language is indicating that you have something to say, I'll give it to you. Yes, Yirgu.

**Yirgu Gebrehiwat:** Yesterday was quite a productive day in the sense that it created an opportunity for networking and created an opportunity for exploring what is happening in terms of postgraduate training in our respective countries. We have also seen the challenges and also realized that countries are in different phases of implementing a reasonable postgraduate training program. From the Ethiopian perspective, in the afternoon it has given us an opportunity to explore the best ways of pushing this agenda of having more obstetricians in the country. One of the issues that we reached a consensus on is establishing a consortium of universities, with four or five US universities collaborating with around four or five Ethiopian universities. We know that the need is huge.

We have currently thirteen medical schools in the country which have started undergraduate training and also would like to proceed to postgraduate training. If we use these resources only within four or five universities, I think it is probably a misuse of whatever opportunities that we have. One of the things that we decided upon is to have a consortium so that all institutions of higher learning in the country could be beneficiaries. We have explored the challenges of really going out of the main focus areas and into the other facilities or other institutions. But this is a work in progress and we will see which mechanism would be best to suit us.

The second issue that we have reached a consensus on is how we can centralize all the efforts into one institution, like an Ethiopian hosting institution that can track whoever is coming, what program they would like to run, etc. So that whoever comes in from the US not only benefits one institution but could also potentially benefit other institutions which may be ready for that particular kind of subject matter or that particular kind of patient care. So all in all it was quite productive. Maybe on the downside is that we are not keeping time. Maybe it is the heat or the humidity, the sessions were a bit long. Today, I hope that we will have more structured decisions and also some opportunities to go around Ghana and see the city of Accra. Thank you.

**Kwabena Danso:** Thank you. I am happy that you brought up the issue of time keeping. Today I think we will remind speakers that we will have to keep time. Any other comments?

**Jean Anderson:** Hello, I am Jean Anderson from Johns Hopkins, and I am extremely happy to be here. We have a fledgling partnership with Sierra Leone. I think we proceeded past the blastocyst stage yesterday and are a full-fledged embryo. I think that what has been so wonderful is the opportunity not only to meet our partner, Dr. Phillip Koroma, who is the chair of the department of OBGYN in Sierra Leone, but to then interact with those of you who already have partnerships in other stages of development nearby in the region, like Liberia and Cameroon, and to really learn from and be able to troubleshoot some of the issues. We talked a lot about how to start a partnership and how decisions would be made.

One of the things that I would be interested in hearing from others, hopefully in the course of today or tomorrow, is how you do that in your different partnerships. We talked about starting a board with some relevant stakeholders on both sides, including the Ministry of Health and the Ministry of Education representatives, midwifery representatives, and really heavily weighted towards Sierra Leone partners. Anyway, I just wanted to say that so far this is a terrific conference. I think what we are learning from all of you is just amazing. So thank you.

**Lee Learman:** Good morning, I am Lee Learman from Indiana University and we are in partnership with Kenya. Just to report briefly some very exciting news from the Ministry of Health of Kenya, from Dr. Mueke at our breakout session yesterday. We learned about a very recent strategic plan for Kenya which will require one OBGYN specialist at each of the primary care hospitals that may be planned throughout the country which will require the numbers of OBGYN specialists in Kenya to grow by about 500 individuals in order to appropriately staff those hospitals. This is all from Dr. Mueke, and I must add very quickly that this is all in the planning stages, nothing has been approved and there are no newspaper articles to be written at this point. But there is also a private-public partnership that is being established to help fund all of these training positions and the major challenge that we discussed at our table was, "Once they are trained, will they stay?" And how to be sure that this major governmental effort to more than double the number of specialists in the country yields the ability to retain the vast majority of those trainees. So any advice that you all can share with us will be appreciated. Thanks!

**Kwabena Danso:** Thank you. I've just been reminded that there are some people who were not here yesterday and have joined us today, so I would like to introduce them. We have the Commissioner of Education from Uganda, so please introduce yourself.

**Robert Odok-Oceng:** Good morning, everyone, I'm happy to be with you here. My name is Robert Odok-Oceng and I am Commissioner of Higher Education and Training. My work is policy formulation, monitoring and evaluation at the university level, and I also tend to advice on technical nature concerning universities that govern Uganda. I am very happy to be with you, because I think this is my first time to join you. When I learned that it was about the welfare of our mothers, I knew you were on the right track. Because in Africa, those who agree to our agenda, would agree with me that women are vital to the maintenance of the economy of Africa. Most of the time when you drive outside the city, you find that they are the one in the gardens with children at the back tilling land. Now imagine that women is sick or she has a miscarriage or that the child has died. What does that mean for production? It means that production will recede or will come down and you know Africa is still developing part of the world and we need all human resources for its development. I'm not saying that women in Africa will be working, because I am a man myself, but I'm saying that I am just telling you the truth of what is on the ground. Therefore what you are trying to do will help our mothers to live a healthy life and therefore will make them very productive.

My concern is what we have just raised. How will we retain those we are training, and how do we reach the real mothers? Most of our mothers in the urban centers in Africa already are doing well because they meet these services. But those who are really in need are in the rural setting. In the case of Uganda, medical doctors do not want to go to the villages and even nurses with degrees do not want to go the villages. It is really the midwives, the nurses with certificates or sometimes diplomas, and clinical officers who are the ones who maintain the health of people in the rural areas. I think this conference should also think about retention and how to change attitudes.

Teaching is about three things: it is about the transmission of knowledge, transmission of skills, and imparting the right attitude. I think we are doing well in knowledge and skills, but because we are not doing well with attitude, most of our people do not see the need to do exactly what they went for. Because when you are a doctor, you are not supposed to be in town to treat those who are healthy. You are supposed to be where the sick are. Today most of our morbidity and mortality is in the rural setting because of the economic background we are facing. I think this conference and future ones should look at that seriously. Otherwise, we shall do a great thing here but the morbidity and mortality of our mothers and their children will continue and African will remain to be backwards.

**Stephen Rulisa:** Thank you. I just wanted to share my experience on partnership. Having heard about different programs, I think the program we have here in our country is a bit different from the other models. We had a similar problem before where we had a US or European institution partnering with our institution. What happened is that when a donor comes with funding and comes to the program, the results that we get are the ones dictated by the donor and not the ones that we want. That's what we have been getting all the time.

Eventually, we figured out wishes from our national program accounting for what we want. And then the next step was to be to find a partner who would be willing to partner with us but we wanted to make sure that before that we know where we are going and the other person is taking you where you want to go. That was a problem. Before people would say, "No you don't want to go there, you want to go here." Then you follow.

We lived with that and it hasn't taken us very far, so eventually we found the program in which we know where we want to go and we have a partner who can accompany us on where we are going. That is where the HRH program was born. The Ghanaian program that was formulated. Then we had our objective where we want to go. And then we are looking for partnerships, who would be willing to accompany us on where we wanted to go. Then we are planning on putting together a basket fund whereby which all the donors who are working in our center put together all the funds. Now the government will formulate what we say, that if you want to partner with us this is where we want to go. So please put together all of the funds and then we will tell you where to invest in.

Now, that accountability. The donor also wants to know where their funds go, which of their funds. And then they had to check where their funds go. So that is where it came and then they had put together a consortium of US universities who we are willing to partner with. We don't see them as Yale, Duke, or Harvard; we see them as a group of partners who are partnering with us on the objective that we know.

It becomes difficult if you start managing one university that is driving here and another one that is driving there, you don't achieve a common objective, especially when you are working on the training program for the whole country. You can't work if one institution works with one institution and another university has its own institution. It's a common objective, there is one main consortium from the US, and there is one objective and one that has only end result, which I think is the best model, other than micromanaging things.

Yes, of course you have to micromanage a few egos here and there, but you know you have one objective and are driving towards one common goal. I think that is better than having several institutions who are working with several other institutions in the country. The objective won't be quantified at the end of the day if you come in a country and ask how many US universities? Ten. What are the objectives? Different. It becomes difficult for other countries to quantify the output. I like this forum because we want to work as a consortium. That you can quantify results, but I think the outcome will be better if the partnership is really works, as de Vries says. I like that. I usually enjoy hearing de Vries' presentations. So I just wanted to share our experience of the HRH program, which was spun out of such collaborations that where there before. I think the results are much better than what we had before. Thank you very much.

**Frank Anderson:** Thank you very much Stephen. That model is definitely something that needs to be considered, but it's a different model than what we are talking about. I think there is also some harmonization of that model which we can continue to talk about.