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Setting priorities for safe motherhood programme evaluation: A participatory process in three developing countries

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Abstract

A participatory approach to priority setting in programme evaluation may help improve the allocation and more efficient use of scarce resources especially in low-income countries. Research agendas that are the result of collaboration between researchers, programme managers, policy makers and other stakeholders have the potential to ensure rigorous studies are conducted on matters of local priority, based on local, expert knowledge.

This paper describes a process involving key stakeholders to elicit and prioritise evaluation needs for safe motherhood in three developing countries. A series of reiterative consultations with safe motherhood stakeholders from each country was conducted over a period of 36 months. In each country, the consultation process consisted of a series of participatory workshops; firstly, stakeholder's views on evaluation were elicited with parallel descriptive work on the contexts. Secondly, priorities for evaluation were identified from stakeholders; thirdly, the evaluation-priorities were refined; and finally, the evaluation research questions, reflecting the identified priorities, were agreed and finalised. Three evaluation-questions were identified in each country, and one selected, on which a full scale evaluation was undertaken.

While there is a great deal written about the importance of transparent and participatory priority setting in evaluation; few examples of how such processes could be implemented exist, particularly for maternal health programmes. Our experience demonstrates that the investment in a participatory priority-setting effort is high but the process undertaken resulted in both globally and contextually-relevant priorities for evaluation. This experience provides useful lessons for public health practitioners committed to bridging the research–policy interface.

Keywords: Programme evaluation; Safe motherhood; Participatory priority setting

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1. Introduction

Evidence based decision making and participatory priority setting are well established concepts in public health [1–3] not least in developing countries, where resources are scarce and programmes may be highly dependent on international donor inputs [4] and global opinion [5]. It is especially important in resource constrained settings to set contextually-relevant priorities for research, funding and programming [6]. Recognizing stakeholder needs and setting priorities is a key component of evaluating health interventions [7] and safe motherhood strategies [5]. While priority setting and evaluation used to be the remit of those with power and influence, it is now recognised that participation of stakeholders is key to this process [2,5,8,9]. Participation of stakeholders is particularly important to facilitate the process of getting contextually-relevant research into policy and practice and increasing a culture of evidence based decision making [8,9]. Despite general awareness of the importance of getting research into policy and practice, documentation of the process of how this might be done is difficult to find [1,6,10].

As part of an international safe motherhood research initiative we worked collaboratively with stakeholders in developing countries to identify effective and cost-effective safe motherhood strategies. We use "we" in this paper to reflect the perspectives of the authors, who comprised researchers from three developing countries where research was being planned; as well as researchers from a developed country research institution responsible for co-ordinating the study. The individuals were all involved in the research planned, and played a role in the process being described in this paper.

This paper reports our experiences and lessons learnt in implementing a participatory process of setting a research and evaluation agenda. Its main thrust is on country focused priority setting for safe motherhood programme evaluation, which is related to the 5th Millennium goal of improving maternal health. The process was embarked upon early in the life of the research initiative in an effort to be inclusive in identifying the priorities for conducting evaluation studies. The aim was to empower national stakeholders in developing countries to have greater ownership of the evaluation findings, to be more openly accountable and transparent in conducting the evaluation, and through this participation, improve the uptake of evaluation findings into decision making processes for future policy and programming in the country.

Working in a participatory manner with stakeholders is recommended in order to demonstrate good practice in collaborative research settings [9]. These recommendations address issues of participation to establish trust and ensure research that addresses local priorities; the need for developing countries to set their own research priorities and conduct their own research. The recommendations also posed questions about how priority setting might be put into practice. This paper describes a process to address a need for documentation of the practice of priority setting in research, which is otherwise hardly discussed in the wider literature. We acknowledge that the concept of participation can mean many different things and may also be partial or incomplete. The "participation" referred to in this paper was influenced by the Nuffield Council's recommendations described above [9] and describes processes by which the views of key stakeholders were integrated into the priority setting exercise. The principles of participation are reflected in the consultation and workshops used in our approach to identifying priorities. The concept of participation is also reflected in the desire to increase openness, and critique in developing policy [11], and by creating an environment of mutual learning through discussion. We use the concept of participation not to claim that we have consulted all possible stakeholder views, but that we have at least attempted to include a wide range of groups, mostly working at policy and programme level, which have interest in achieving the fifth millennium goal. The various perspectives allowed us to combine nationally-relevant evaluation priorities and needs with matters of global significance such as measuring reductions in maternal mortality and coverage of skilled attendance at delivery.

2. Methods

2.1. Context

Our research involved three developing countries: Burkina Faso, Ghana and Indonesia. As well as high rates of maternal mortality, the three countries provided settings with a range of poverty levels, literacy rates and life expectancy at birth [12]. Indonesia,

for example, provided a context where disparities in maternal mortality between the rich and the poor are particularly striking, the rate being up to four times more among the poorest compared to the richest groups of the population [13]. While the risk of maternal death in developing countries could be as high as 1 in 64, the comparable risk for developed countries is as low as 1 in 8000, revealing one of the greatest health inequities between the developing and developed world [14].

2.2. The participatory process to identify evaluation questions

To identify priorities for safe motherhood programme evaluation in the three countries, we held a series of workshops and consultations with stakeholders over a 3 year period (Fig. 1). For our purposes, "safe motherhood stakeholders" included representatives from the Ministry of Health and its partners, international donor organisations, national and international non-governmental organisations and the research and training community. Efforts were also made to represent all safe motherhood programmes and projects in each country. Existing programmes and projects were listed with the assistance of maternal public health departments, for example, Reproductive and Child Health in the ministries of health and through local researchers. In addition, the snowball approach was used to identify others involved in maternal public health activities. The process was therefore to a large extent deemed to have included the main bodies involved in this field of work.

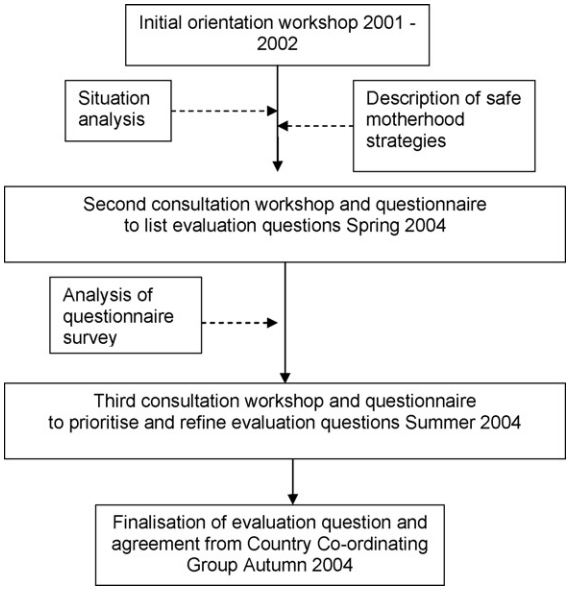

Fig. 1. Summary of key steps in participatory process.

As far as was feasible, we tried to ensure that the different organisations were representing different types of organisations—those involved mainly in policy or influencing policy, organisations involved in implementing programmes and other organisation or individuals which provided the services affected by changes in programmes. The organisations involved in

Table 1
Grouping of participants according to background and affiliation

	Indonesia	Ghana	Burkina Faso
Grouping by background			
Programme	20 (44%)	7 (46%)	6 (29%)
Policy	9 (20%)	4 (26%)	6 (29%)
Service	6 (13%)	4 (26%)	6 (29%)
Other	10 (22%)		3 (13%)
Total	45	15	21
Grouping by affiliation			
Central	13 (29%)	7 (46%)	6 (29%)
Donor	5 (11%)		
Regional	8 (18%)		6 (29%)
District	5 (11%)	3 (20%)	
NGO	9 (20%)	5 (33%)	6 (29%)
Other	10 (22%)		3 (13%)
Total	45	15	21

implementing programmes ranged from those which were working closely with the government at central level to others which were working closely with urban and in rural communities. Table 1 provides a grouping of the representation from the different organisations. Representation from each of the different types of organisations listed above was identified. In most cases, the individuals involved were the head of that organisation in country, or a selected deputy. Individuals were provided with a small fee for their time, and travel expenses as the only "incentive". The expected roles of the stakeholders were clearly identified in the invitation letters, which explained the need for consultation in order to reach an agreed priority list for evaluation studies. Each stakeholder officially represented the aims and mandate of their organisation, but it was also apparent that they sometimes represented their own interests. However, many of the participants were well known for their commitment and years of dedication to working to prevent maternal deaths in their countries.

While the process of priority setting was participatory, the final decision about which of the priority questions to evaluate was ultimately governed by opportunity and feasibility for evaluation in the country. Qualitative and quantitative methods were employed in the processes of consultation and subsequent elicitation of the evaluation questions; the steps and methods are described in the following sections.

2.3. Initial consultation

The participatory process began in 2001 with an initial orientation workshop, hosted by the Ministries of Health in each of the three countries. The first consultation had two objectives; to orient key safe motherhood stakeholders in the countries on the goals and purpose of the research initiative, and to elicit each country's key evaluation priorities. Following initial consultations, sensitisation, and discussions, a smaller subgroup of interested parties was formed to ensure that the research was congruent with the initiative as well as with the needs of the policy environment and health system in each country. This local group was named the Country Co-ordinating Group (CCG) and was chaired by a senior Ministry of Health official. The CCG provided a main link allowing research to be disseminated and utilised by decision makers and programme implementers. The group met routinely twice a year, with extra sessions throughout the process described in this paper for updates on progress and to provide feedback on the findings.

All three countries already had national safe motherhood programmes in place, however, the programmes were not always evenly distributed within the country. It was sometimes difficult to identify projects and their geographical areas. It was also not easy to decide on the starting point for the proposed research. To address this, a situation analysis was conducted to describe the particular context of each country. The situation analysis drew upon data already available from needs assessments, routine health information and surveys obtained from central, regional and district government offices as well other safe motherhood stakeholders. In addition, a systematic description of the existing safe motherhood programmes in each country was generated primarily as a means of matching evaluation needs with feasible opportunities [15].

2.4. Outputs of the first consultation

Endorsement and interest of the Ministries of Health to collaborate with the research initiative to conduct safe motherhood programme evaluation research

- An initial list of "evaluation questions" per country, considered as priorities.
- A systematic description of all existing safe motherhood programmes in each country.
- A descriptive situation analysis of each country context.

2.5. The second consultation

The second consultation was held between April and June 2004. This consultation identified priority evaluation questions by way of workshops and questionnaires. Participants completed an anonymous questionnaire at the start of the workshop to elicit their preferences for safe motherhood programmes. During the workshop, participants were asked to discuss and list three significant evaluation questions of importance to each country. These activities were intended to focus participants and stimulate active participation during the workshops. Results of the questionnaire and group discussions were presented and synthesised during the plenary session. Group discussions followed to explore

and discuss important evaluation questions. Duplicate questions resulting from group discussions and workshop questionnaires were eliminated and similar questions collapsed into one, resulting in a list of more synthesised and coherent questions. At the end of the workshop participants and the wider stakeholder groups were given a second questionnaire to complete and return. The questionnaires aimed to encourage more thinking about the emerging evaluation questions and important characteristics of safe motherhood programmes.

The workshops were conducted in a staggered fashion, starting in Indonesia. Important lessons about the process were used to inform subsequent workshops in Burkina Faso and Ghana. As a result, the process of conducting this second formal consultation was not exactly the same in each country. For example, in Indonesia, initial questions identified were used in group discussions in an attempt to engage participants. This approach was found to prevent participants from thinking beyond the already identified questions and therefore was not repeated in Ghana and Burkina Faso.

2.6. Outputs of the second consultation

- A list of important characteristics of safe motherhood programmes.
- A list of priority evaluation questions.
- A second anonymous questionnaire (post-workshop) eliciting preferences for the priority questions and characteristics of a safe motherhood programmes generated during the workshop.

Once workshops had been conducted in all three countries, analysis of post-workshop questionnaires ensued in preparation for the next step in the consultation.

2.6.1. Analysis of post-workshop questionnaire data

The analysis plan was developed by a statistician and given to lead researchers in the countries to perform analyses. Results were then sent for quality check back to the statistician and another researcher who supervised the analysis. There was open communication during the analysis between the statistician and researchers in the countries about the analytical process.

The questionnaires elicited information about characteristics of respondents (position, seniority, and affiliation), asked respondents to rank and rate characteristics of safe motherhood programmes and priority questions for evaluation to indicate their preferences. The analysis of questionnaires included four components:

- A description and grouping of respondents (Table 1) to describe the characteristics of the group and to determine whether different types of respondents had different preferences.
- Preference scores for each safe motherhood programme characteristic and evaluation question from rating questions. From ranking the questions, we generated frequencies of 1st, 2nd and 3rd placements for each characteristic and evaluation question and a score that combined the 1st, 2nd and 3rd rankings.
- A sensitivity analysis assessed the consistency of preference scores for each characteristic or question by adjusting the means and medians of the rating data and altering the relative weights attached to the 1st, 2nd and 3rd rankings.
- Finally, the programme characteristics and priority evaluation questions for which respondents exhibited consistent preferences for were compared to assess whether they were consistent.

When analysis of questionnaire data had been completed, the final series of workshops were organised in the countries to look more closely at the three prioritised evaluation questions before assessing which question to take up for a full-scale evaluation. Results of the analysis are presented in the results section. The following section describes the proceedings of the final workshops where the questions were refined.

2.7. The third consultation

The third and last consultation was held between May and September 2004. The workshops were held in one country at a time with a slightly smaller subset of stakeholders who had been involved throughout the process. This workshop was conducted using principles of a focus group discussion, with a topic guide (Box 1), moderator and scribe. The main objective of the consultation was to use results of post-workshop questionnaires distributed during the last consultation

Box 1: Refining the evaluation questions and developing common understanding: except from topic guide for Indonesia.

Identified evaluation question: what is the most effective and cost-effective strategy for improving the competence of the Bidan di Desa (village midwife)?

Take each question and find out more about specific parts of it. Start with open questions, but may need to move to specific questions.

"Effective and cost-effective": what is meant by these words? (Be prepared to indicate what we think they could mean)? What are the expectations of the policy makers regarding the type of findings? More specifically, find out if Health outcome is desired. What are the indicators of "success" by which they wish to judge a strategy? Are these HEALTH outcomes?

If not outcome, what sort of measures expected/needed?

If outcome measurement is desired, what type? (Maternal? Perinatal? Mortality? Morbidity? All cause, or direct causes, or both? Include abortion consequences or not? Directed towards delivery only or throughout pregnancy?) Are other outcomes of interest, e.g. child survival?

What are the reasons for the choices made?

Use the checklist for the "building blocks of economic evaluation" as a flipchart exercise if necessary. It provides a clear idea of what sort of economic evaluation is favoured by the participants (see also "cost-effectiveness" background paper).

"Strategy"—elicit ideas about the strategies participants have in mind. Examples might be training (Type? In-service/pre-service, experiential/theoretical, etc.), provision of equipment, improving motivation, etc.

"Competence"—what is meant by competence? What measures/indices might be used?

Comparisons—explore the expectations of participants regarding the comparisons that an evaluation may require. For example, is the intention to compare different strategies? (training versus addressing motivation) or different means of training?

Quantifying the "effect"—what size of effect is expected. Is there a certain degree of difference between comparisons of, e.g. strategies being looked for?

to come to a consensus on the three most important evaluation questions. Another objective was to improve common understanding of the meaning of the prioritised evaluation questions; a process we called refinement. Before the main session began, findings from the post-workshop questionnaire were presented which were then taken up by the groups to discuss and refine. The main outputs of this final workshop were three refined, agreed priority evaluation questions for each country. These questions were finally presented to each Country Co-ordinating Group before agreement was reached to proceed with the evaluation of highest priority. As agreed at the beginning of the partnership, this decision depended on opportunities for evaluation afforded by the country and feasibility of the evaluation.

3. Results

The ultimate aim of the process was to identify priority questions for evaluation, however, results of the

Table 2
Preferences for safe motherhood programme characteristics

Country	Most important characteristic	Second most important characteristic	Third most important characteristic
Burkina Faso	Meeting national policy priorities	Generating some reduction in maternal mortality	Generating important reduction in maternal morbidity
Ghana	Meets policy priorities	Seeking primarily to improve the provision and quality of services	Has a sustainable financing base
Indonesia	Having a sustainable financing base	Improving the provision and quality of services	Generating large reductions in maternal morbidity

priority setting exercise are manifold; including the process itself, development of lasting collaborations and capacity strengthening for all involved in the process. We present below results of the post-workshop questionnaire, which determined the questions to be taken up for full-scale evaluations.

3.1. Grouping of respondents

Country stakeholder participants included those who attended workshops and those who completed the questionnaires but did not necessarily attend the workshops. Response rate up to the time of analysis varied across the countries from 47 to 90%. Respondent groups were broadly similar across the countries, with the majority of respondents working with programmes within governments or donor agencies followed by policy-makers as shown in Table 1.

3.2. Preferences for important characteristics of safe motherhood interventions

A summary of preferences for three most important characteristics of safe motherhood interventions for the three countries is shown in Table 2. In Burkina Faso and Ghana, meeting national priorities were of high importance, while this was not noted in Indonesia. Unsurprisingly, reducing maternal mortality and improving maternity care services also featured as important priorities. The country preferences for important characteristics of safe motherhood interventions were not altered by adjustments of rating scores, or weighting of ranking data.

3.3. Preferences for evaluation questions

A similar process to that outlined above for analysis of preferences for important characteristics of safe

Table 3
Preferences for evaluation questions

Country	Most important question	Second most important question	Third most important question
Burkina Faso	What is the most cost effective strategy to ensure skilled attendance at delivery in different contexts	What is the effectiveness and cost effectiveness of community based interventions in reducing maternal mortality?	What is the most cost effective system that keeps health care providers motivated and accountable for their actions?
Ghana	In the poorest regions of Ghana, what is the added value in terms of cost-effectiveness of free delivery care in increasing uptake and reducing institutional maternal and perinatal mortality?	What are the quality assurance mechanisms needed to reduce maternal mortality by 10% over the next 5 years?	What is the cost-effectiveness to government of an exemption for delivery care policy based on reimbursement by insurance schemes compared to District Assembly reimbursement in reducing maternal deaths owing to intra and postpartum haemorrhage, and increasing uptake of delivery care?
Indonesia	What is the most effective and cost-effective strategy to sustain the Bidan di Desa (village midwife) programme?	What is the most effective and cost effective strategy for improving the competence of midwives?	What is the most effective and cost effective referral strategy for reducing maternal mortality?

motherhood programmes was followed to analyse questionnaire data for preferred evaluation questions. The three most important priority questions for each country are presented in Table 3. The most important evaluation question in all three countries reflected a common interest in cost-effectiveness. The three countries however differed considerably in terms of the safe motherhood strategy to be evaluated. As shown in Table 3, in Burkina Faso, the three top priority questions related to two main areas; community interventions aiming to increase demand for utilisation of maternity services and the provision of skilled delivery care, within which the health professional's motivation featured. In Ghana, the selected priority questions relate less to specific safe motherhood strategies, and were closer to considerations of the health system as a whole, especially in terms of financing and fee-exemption mechanisms. The Indonesian questions were specific to two areas; professional midwives and referral, reflecting aspects of the Indonesian national village midwife programme. The country preferences for important evaluation questions were also not altered by adjustments of rating scores, or weighting of ranking data.

4. Discussion

Our interpretation of this process of priority setting for research and evaluation pertains firstly, to the findings relating to priorities in safe motherhood, and secondly, to lessons learnt from the process of the reiterative consultation. Taking the priorities identified in each country, we note that the preferences for safe motherhood programme characteristics are mostly shared across all three countries. Four main preferences were identified; safe motherhood programmes are expected to meet national policy priorities, reduce maternal mortality and/or morbidity, improve services and be financially sustainable. None of these are surprising findings, and are likely to be common preferences in many other types of health programmes. Indeed, given the experience of many of the researchers in this area of work, the preferences were similar to what would have been our own expectations and preference. By comparing between the results presented in Tables 2 and 3, it can be seen that preferences for programme characteristics are reflected in the value placed on effectiveness and cost effectiveness in the evaluation questions. Effectiveness was commonly conceived as health outcome measures such as mortality and morbidity. Given the global emphasis placed on the millennium development target of a 75% reduction in maternal mortality by 2015, and the difficulties in measuring this target, the importance thus placed on health outcomes is to be expected.

The desire for information on cost-effectiveness is likely to be a consequence of financial considerations in settings where resources are clearly limited. It may be possible that the importance of cost effectiveness in many of the priority questions was influenced by the aims of the initiative, as described in the Introduction. However, our interactions especially with policy makers in these countries, suggest that it is this area of work which they find most appealing in the initiative. The preferred programme characteristic of "improving services" was reflected in only one question on quality assurance in Ghana. This question implied a desire to identify how to improve maternity services, rather than asking what the effects and the costs of a strategy might be.

Most of the priority evaluation questions could be matched successfully to current national policies. In Burkina Faso, skilled attendance at delivery is the main strategic objective of the 2004–2008 national safe motherhood strategy, resulting in two priority questions relating to skilled attendance and the motivation of the providers. In Ghana, the implementation of a policy of universal fee exemption for delivery care was first discussed in 2002 and then implemented in four regions of the country by September 2003. The policy has, since April 2005, extended to the remaining six regions. An evaluation of this strategy would clearly be useful to assess a national policy where implementation has been rapidly scaled up. In Indonesia, there has been a sustained investment in the Village Midwife (Bidan di Desa) Programme over the last 15 years, which aims to provide every village in the country with a dedicated midwife. This is reflected in the interest to evaluate midwife competence and referral mechanisms, and may also have influenced the importance of financial sustainability as a preferred characteristic of safe motherhood programmes. Again, none of these topic choices were a surprise, nor were they contrary to the researchers' interests, as it is likely that the influence of global agendas for action in safe

motherhood permeate to national and country level policies and programmes [16].

Turning to the lessons learnt from the participatory consultative process, we must first reflect on the time required to come to conclusion on the final priority evaluations. The longest time was spent on initial consultation and sensitisation, building of relationships and conducting country situation analysis. Through this process, a mutual perceived need was developed for sufficient evidence upon which to base decisions. We also reviewed as many existing safe motherhood programmes in our focus countries as possible, informing us as to real opportunities for evaluation. We included a variety of stakeholders, instead of consulting only with one or two key decision makers, and conducted a robust and transparent analysis of stakeholder views. It is acknowledged however that groups reflecting service-users (e.g. women's advocacy or civil society groups) were not prominent in our stakeholders groups. Some representation of communities and civil societies may indeed have been included particularly as non-government organisations which worked in the community were involved in the process. However, we realise that participation may have been incomplete because of lack of direct consultation with women and community stakeholders. This was not planned as part of this process for three reasons. Firstly, our main objective was to identify what to evaluate in terms of the value of safe motherhood programmes. The evaluations were only planned post hoc, i.e. after the programmes had already been implemented. One might question whether it is appropriate to consult community stakeholders regarding their priorities for evaluation in such post hoc situations, when in fact they might not have ever been consulted in the development of the programme itself, and if so, perhaps only partially. The importance of consultation with community level stakeholders in developing programme strategies are of course well recognised, however, it is probably true that the degree of consultation varies especially with the scale of the programme. Secondly, as an international research initiative with the achievement of high level international development goals as its key focus, the research project is somewhat constrained in working at community level as it needed to target large, national level programmes which had large scale national impact. Finally, there are feasibility and resource constraints. Had the consultation been done to include community members, the time and costs involved in doing this at a national scale would have been too large. It is unlikely that the inclusion of even one or two "community representatives" (for example a chief of a large African tribe) could guarantee that the voice of the community be heard. For these reasons, we felt that we had to settle for community representation in the form of particularly non-governmental organisations working at community level.

A further time-consuming process was the need to hold a series of workshops in each country phased across countries to allow lessons to be shared between countries, rather than holding one single event per country or even attempting to bring all countries to a round table discussion. We could not, however, have otherwise arrived at an in-depth understanding of the perspective, views and preferences of the stakeholder participants at the workshops. Our topic guide (Box 1) illustrates some of these issues; we found that the concept of cost-effectiveness is understood differently by individuals, and that "health outcomes" were not always ultimate outcomes such as mortality. The concept of a "strategy" also varied from relatively simple interventions (such as a training programme) to very complex sets of interventions (such as referral). The time between 2002 and 2004 was also used to develop evaluation methods and data collection and survey tools which the initiative used in the final full-scale evaluations. These methods and tools have also been developed in order that they can be applied in future evaluations.

It may have been possible to conduct the reiterative series of consultations more time-efficiently. At a practical level, it is usually easier to organise a meeting of high ranking officials for shorter, rather than longer periods of time. Also, by conducting shorter duration workshops, the participants were generally more alert and interested. Finally, we found that information requirements were identified at each workshop, and the intervals between workshops allowed time for the collection and presentation of important information such as the situation analysis, and the description of safe motherhood programmes. One possible consequence of the long time frame was that country priorities were likely to change. However, in comparing the priorities articulated in 2004 compared to 2002, we found that the fundamental concepts and priorities were similar, and particulars of the evaluation question were the main

variable. For example, in Ghana, the earliest consultations asked the initiative to evaluate the effects of health system strengthening initiatives, and these were refined to specific financing and fee-exemption mechanisms. In Burkina Faso, skilled attendance was consistently identified as a priority over the consultation period.

We encountered little lack of consensus in the process. During the workshops, although a wide range of opinions were expressed, the process we adopted, designed for the wide range, seemed to result in little dissatisfaction. One advantage of the written questionnaire to supplement the findings from the discussions conducted at the workshops was to elicit views from those less willing to speak out during the meetings. Bringing together a range of opinions was most explicit in the final synthesis workshop, where the results after ranking and sensitivity analysis were presented. In all three countries, the three priority questions were not contested, although in the case of Burkina Faso the final decision was convoluted as some of the questions initially chosen were dismissed only to be chosen again. As noted above, it is possible that consensus was reached because, while many stakeholder groups were involved in the process, there may have been representation only from "mainstream" groups, rather than from groups such as community representatives or women's lobby advocates [17].

The evaluation questions identified are complex and will be costly to research. For this reason, there was only the possibility of selecting one, out of the three priority questions identified. This final decision about which question to evaluate was less participatory, and rather more based on the initiative researchers decisions around feasibility issues, a point which was made clear from the outset. The single priority evaluation for each country was presented to each Country Co-ordinating Group for final approval, and no disagreements were experienced. In part, this was a result of the views, preferences, expertise and opinion of the local safe motherhood stakeholders being an integral part of the evaluation questions from the outset.

After such a significant investment in time, how can we assess the success of this consultative process? We did not explicitly investigate stakeholders perspectives about their involvement as part of the research process described in this paper although this may be warranted as a separate exercise. However, stakeholders' continued participation, support and interest in the research process and results may indicate their positive attitude towards being part of the process. Informal commendations about the research process were received from many participants on several occasions. The research studies conducted through this process have recently been completed, and are just beginning to enter the stage of dissemination. The full effects of the process described will have been of value if we find high levels of interest in the evaluation findings, acceptance of the methods and findings used in the evaluations, and in the long term, uptake of these findings into policy and programme implementation.

5. Conclusion

The exercise fulfilled its objectives of involving stakeholders in a research priority-setting process and achieved our goal of identifying local priorities and opportunities for large-scale and rigorous safe motherhood programme evaluation. We have documented the strengths and limitations of the process, particularly the significant investment required to build relationships, describe and understand contexts and communicate in terms that local stakeholders could identify with. We conclude that the evaluations undertaken are contextually relevant and reflect local expert knowledge and national priorities for safe motherhood in all the three countries. The ownership which was fostered between the local stakeholders and the consultative process will help to ensure that the results of the evaluations are taken up into policy and practice. The evaluations were completed in the three countries at the end of 2006.

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