

COHRED



Research into Action

The Newsletter of the Council on Health Research for Development (COHRED)

EQUITY — An Afterthought ?

'The global economic recession of the 1980s, along with structural adjustment programmes in developing countries and cost containment pressures in industrialized nations, has resulted in reduced social spending in many countries.

Countries are finding it difficult to implement equitable policies and often feel caught between considerations of equity and of short-term efficiency. There is insufficient consensus on the most practical means of measuring or reducing social gaps in health and health care under current conditions of resource constraints.

Because of these problems, concerns about equity must be more explicit and more public.'
(Equity in health and health care: a WHO/SIDA initiative, WHO, Geneva, 1996, p. 2)

WHILE the gap between the haves and the have-nots gapes ever wider throughout the world, in the domain of health some efforts at least are being made to ensure 'fair shares for all.' What do we mean by equity in health? Essentially, it means that people's needs, rather than their social privileges, guide the distribution of opportunities for well-being. This principle lies at the heart of a global initiative launched last year by the World Health Organization (WHO) and the Swedish International Development Cooperation Agency (Sida), whose goal is 'to promote and support practical policies and action to reduce avoidable social gaps in health and health care.'

The initiative, as described in the WHO publication *Equity in health and health care*, is conceived within

the broader drive for 'health for all' that WHO has spearheaded over the past two decades, but it is based on a critical reappraisal of needs and strategies in the

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light of the economic, social and political conditions prevailing throughout the world as we approach the year 2000. It also responds to concerns shared by other organisations and specialised agencies of the United Nations system, in particular UNDP and UNICEF.

In virtually every society in the world, social privilege is reflected by differences in social and economic status, gender, geographical location, ethnic and religious differences and age. In pursuing equity in health and in health care, the new initiative is trying to reduce avoidable gaps in health status and health services between groups which — for one reason or another — live at different levels of social privilege. It follows as night follows day that health research has a key role to play in this endeavour.

Goals of the initiative

The specific objectives of the WHO initiative are:

- to make the reduction of social gaps in health and health care a higher priority on the agendas for policy and action of national and international organisations, recognising the pressures created by current economic, social and political trends;
- in selected countries, to support the targeted research and ongoing monitoring activities that are needed to develop and evaluate effective and efficient policies to reduce social gaps in health and health care. The activities in selected countries should develop models and technical instruments that other countries may adapt

to their own conditions;

- to promote and support an international exchange of experiences likely to be effective and efficient in reducing social gaps in health and health care.

Wide disparities

Striking differences in health between richer and poorer nations have long been recorded. A child born in a developing country of Africa, Asia or Latin America is roughly ten times more likely to die before reaching the age of five than a child born in Europe or North America. Comparable gaps exist within countries; the life expectancy at birth of the most disadvantaged segment of the population in Mexico

for non-white men in South Africa were double those of men of European background in the same country. The US Medicaid programme was designed to ensure health care for disadvantaged children (and their mothers), while Medicare ensures health care for the elderly regardless of income. Not only is Medicare far better funded than Medicaid, but more than two-thirds of Medicaid funds go to care for the elderly and for disabled adults.

All these gaps are widening and worsening in most countries of the world. To give only one example: political changes in Russia (and throughout Eastern Europe) have had profound health consequences and invariably the least-advantaged social groups are experiencing the greatest impact. Men's average life expectancy in Russia has fallen from 62 to 59 years since 1992 and is still falling. Overall, the mortality rate in Russia has risen by 20% — an increase with no precedent in modern times.

Opportunities for well-being

WHO's *Equity in health and health care* emphasises that 'Equity means fairness. It means that people's needs, rather than social privileges, guide the distribution of opportunities for well-being. In virtually every society in the world, differences in socio-economic status, gender, geographical location, ethnic or religious group and age reflect differences in social privilege that heavily influence opportunities for health and well-being.'

There may be substantial disagreement about what constitutes a 'minimum' level in health and health care. In some contexts, it might refer to

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“Equity means fairness. It means that people's needs, rather than social privileges, guide the distribution of opportunities for well-being.”

is 20 years less than that of the most affluent segment. Although only 39% of the population of Côte d'Ivoire live in cities, the cities receive at least 80% of the public health expenditure.

Then there are the gender, ethnic and age-group gaps. A study in India showed that girl children aged between one and 23 months were almost twice as likely to die by the age of two as were boy children; it concluded that the most likely explanation was the different behaviour of families towards boy and girl children — rather than any biological differences. In 1990, the death rates

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very good standards; in others, 'minimum' standards might only ensure that nobody starves to death when food is available nearby, or bleeds to death for lack of timely emergency care after an accident. Each society must achieve a sufficient level of consensus about what equity means for that society to take effective action to reduce inequities.

In the special context of health, pursuing equity means trying to reduce unfair and unnecessary social gaps in health and health care while working efficiently to achieve the greatest improvement for all. It requires a political commitment to push for the achievement of the highest possible standard of health that can be shared by all. It should not mean trying to lower those who were previously privileged to the least common denominator. In a pertinent passage headed 'Equity in sharing progress, not an equal distribution of poverty,' WHO's publication observes: 'People's material expectations are fed by global communications that now permit disadvantaged rural and urban families in India or Brazil

“ Pursuing equity... requires a political commitment to push for the achievement of the highest possible standard of health that can be shared by all. ”

to know about the lifestyles enjoyed by wealthy families in India or Brazil or by both wealthy and less well-off families in France, Sweden or the United States.'

What is the role of research?

Already in 1990 a report of the Commission on Health Research for Development was actually entitled: 'Health Research: Essential Link to Equity in Development.' The report underlined that, for the world's most vulnerable people, 'the benefits of

research offer a potential for change that has largely gone untapped.' And it went on: 'We have found a gross mismatch between the burden of illness, which is overwhelmingly in the Third World, and investment in health research, which is overwhelmingly focused on the health problems of the industrialised countries.' The Commission concluded that research 'will strengthen the ability — and the resolve — of developing countries to meet the needs of the most disadvantaged and, reinforced by international scientific and financial resources, to accelerate progress towards the fundamental goal of equity in health.'

The Commission underlined that research is essential for advancing health and development, and suggested four reasons. Firstly, research is essential for guiding action, since action without the right tools and information can be ineffective and wasteful of resources. Secondly, it has a crucial potential for developing the new tools that increasingly constitute a veritable armamentarium of weapons in the war against disease. Thirdly, health research provides the basis for effective planning and the wise use of scarce resources. Finally, research fosters a scientific, problem-solving culture; without research, a society's capacity to address problems, old and new, is diminished.

ENHR — a step towards equity in health

In 1995, the Board of COHRED approved the Plan of Work and Budget for 1993–1997, and expressly included identifying priorities for health research that would meet one of the broad objectives of essential national health research (ENHR) — 'to achieve equity in health and development; all partners in health (health researchers, health care providers, policy-makers and the public at large) must participate in defining priorities for health research.' No longer could it be argued that equity had been somewhat undervalued in the efforts to encourage ENHR at the country level. Indeed in the July-September 1995 issue of *Research into Action*, Dr Julio Frenk, Executive Vice-President of the Mexican Health Foundation, wrote that a research agenda must be an integral part of every initiative to reform and renew health systems. He added pointedly: 'What is essential about ENHR is its commitment to goals like equity, quality and efficiency, which are precisely the same ones that the reform movement promotes.'

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Global Health Equity Initiative

In September 1995, a workshop at Harvard looked at policy to address inequity in health. A five-day follow-up meeting in February 1996, in Bellagio, Italy, elaborated the concept of a 'global health equity initiative.'

*This Initiative is planning country-level perspectives on health equity, particularly from developing countries. Interest has been expressed thus far from **Bangladesh, Brazil, China, Ethiopia, Ghana, Italy, Kenya, Mexico, Russia, South Africa, Sweden, Uganda, UK, the USA and Viet Nam.***

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targets regarding revision of a comprehensive and quality health service. Managers at every level are expected to routinely direct their efforts to implement these policies and make decisions to meet their own goals and

Systems vs. Information

Use of information for decision making at the level where the information is generated is a critical element. An MIS is most likely to succeed when those who are expected to use it are involved in designing it and putting it into practice. This can build in commitment to the system, and helps to ensure that the service providers and managers know not only what they are doing but also how to make use of the resulting information. Such a system also stimulates the use of information for self-assessment and peer review.

In many countries, health care data are not yet used in these ways but are merely collected to fill in forms that are passed along to higher levels of the system; it is not especially helpful at the level where it is collected. Some significant differences between these two types of systems are illustrated in the Figure.

A recent publication from the Tropical Institute in Amsterdam (see *Research into Action* 7, 1996) provides an overview of three years of experience with the Management Information System in Ghana. Between 1991 and 1994 an integrated system was designed. Instruments were developed, training was undertaken in MIS use and the system was evaluated in one of the three regions concerned.

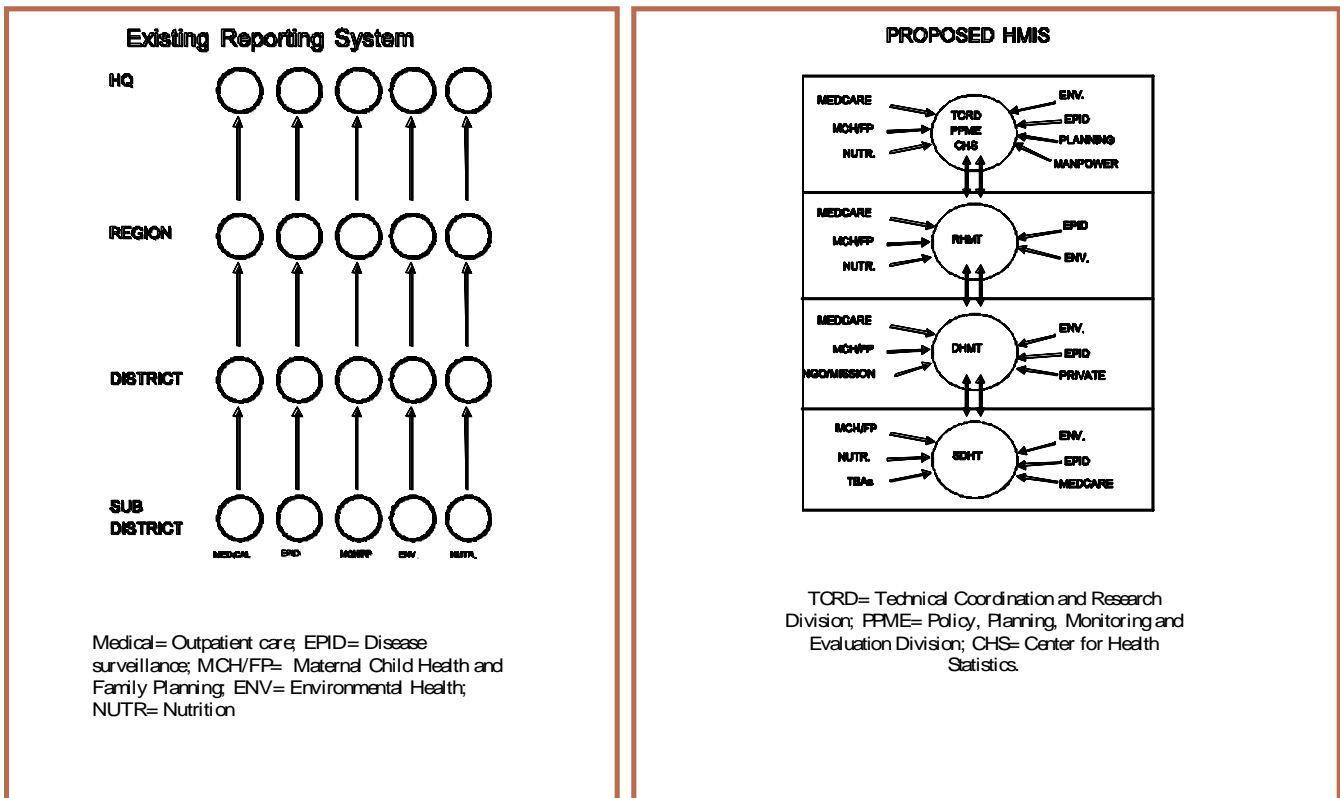
What is a Health Management Information System?

Routine health service data are collected or aggregated at every level of the health care system, but are they used as a resource, leading to improvements in health care? If the right data are collected, converted into information and put to work in making decisions, the answer can be yes. Information can provide a firm basis for management, because it can indicate what is really happening within the system — who is being served, whether targets are realistic and whether they are being met in the specified period of time. An MIS is therefore a way of ensuring that the health care data collected can be transformed into information that can be used to improve the overall effectiveness of the health care system. An MIS can make it possible to monitor trends in programme performance over time. Health facility staff can see whether they

MIS IN GHANA: A CASE STUDY

are getting results, and at higher management levels it becomes feasible to identify health facilities, districts and regions in need of support and supervision. Information can be used to make better decisions about the use of scarce resources, and to improve the coverage and continuity of health care services. *'From Data to Decision Making in Health: The evolution of a health management information system'* presents a case study of the transition from reporting to MIS in three of ten regions in Ghana, and underlines many of the MIS issues being confronted in other developing countries. Ghana proves to be an excellent MIS case study because the Ministry of Health has placed special emphasis on developing national guidelines for policy, goals

Comparison of a reporting system to a management information system at the National, Regional, District and Sub-district levels



Instead of merely collecting data and passing them along in a report, an MIS moves in a circle. Data collection leads to self-assessment and decision-making. This is followed in turn by a report, but the process does not stop there. The information is fed back into the system, where it can lead to changes in the collection of data. So while the focus of a reporting system is on data **collection**, the MIS focuses on the **use** of data. Making the transition from a reporting system to an MIS is a difficult process. In a health reporting system, an enormous amount of time may be spent filling in forms, and yet decisions are often made on the basis of political pressures or 'intuition.' Little use may be made of quantitative data; people may not even recognise how much information is available, much less see how it can be put to use. In addition, there are incentives to maintain the status quo, while the transparency encouraged by an MIS may be threatening. However, once an MIS is in place, it can be a means to improve both the effectiveness of health care and the satisfaction of those involved.

Objectives of the Integrated MIS The overall objective of the evolving health MIS in Ghana, as in any other setting, was to facilitate decisions at all levels that would improve the quality and coverage of health care services. More specifically, the MIS was designed:

- to improve the ability of health service providers, managers and policy-makers to **assess** both individual and institutional performance with respect to coverage of the catchment area, the quality of the services provided and the effectiveness of different strategies;
- to **compare** performance over time, and to compare their own situation to that of other facilities, districts or regions, as well as to local or national targets;
- to **identify** health facilities, districts and regions in need of support and supervision; and
- to **monitor** trends in coverage, quality and effectiveness — which can guide policy development, planning and budgeting.

Four tools were developed to aggregate indicators and to enable self-assessment.

They also allowed feedback to lower levels and reporting to higher levels,

as shown in the Table (right).

Each of these four self-assessment and reporting tools converted raw data into indicators, which were then used to

chart line graphs and cumulative coverage graphs, making it possible to compare performance and changes over time or against local or national targets. Such comparisons could be used directly in making more informed decisions, and in planning actions that make more effective use of resources.

System Review and Evaluation The initial achievements of this effort, as monitored by a baseline and follow-up survey, suggested marked improvements. Staff at all levels had clearer knowledge of goals, objectives and targets as these pertain to health facilities and district catchment areas. When teams carried out self-assessment of their own overall performance, instead of having performance assessed only by technical units from 'above', there was an improved sense of teamwork and greater integration. Further, MIS training and support were found to complement other management-strengthening exercises, in particular at the regional and district levels. The mechanism for self-assessment of health service coverage has been adopted nationwide in Ghana as a framework for the first Ministry of Health annual report to be drawn up in many years. Although the initial focus has been on health services coverage, the lessons learned are being applied to develop a more comprehensive MIS, which will include human resource development, transport, drug supplies and financial resources. During the development of MIS in Ghana, certain stumbling blocks appeared, suggesting a number of issues and lessons that may arise for any organisation that is considering an MIS. Among these critical questions are:

- How much emphasis should be placed on a participatory approach to MIS design?
- Can the MIS be kept simple, in the face of growing needs for information?
- How does training in use of forms differ from training in use of information?
- What happens to the old reporting systems?
- Where does MIS belong in the organisational structure?
- Can a link be established between MIS and resource allocation?
- How are supervision and feedback related to MIS?
- Are routinely collected data sufficient?
- Can MIS really expand the coverage or improve the quality of PHC?
- Does the transparency stimulated by an effective MIS act as a source of conflict or does it lead to improved performance?
- Does the existence of MIS always produce improved decisions?

Most of these questions do not have short or simple answers. What is important is to examine the related issues in the context of the country where further development or design of an MIS is under way. The authors hope that

Self-Assessment Tools and Frequency of Use by Level

Self Assessment Tools	Number of Indicators	Frequency of Self-Assessment, Peer Review, Feedback and Reporting			
		Sub-district Health Facility or Hospital	District Health Management Team	Regional Health Management Team	Central Level
Tool 1: PHC: Coverage Assessment	19	monthly	quarterly	half-yearly	annually
Tool 2 PHC: Continuity	16	half-yearly	half-yearly	half-yearly	annually
Tool 3 Out-Patient Disease Surveillance	5 selected	half-yearly	half-yearly	half-yearly	annually
Tool 4 Hospital Admissions, Deaths and Case Fatality	5 selected	half-yearly	half-yearly	half-yearly	annually

many of the related considerations discussed in 'From Data to Decision Making in Health' will help those involved in developing an MIS to avoid unnecessary pitfalls and to take advantage of the lessons learned in Ghana. □

This Report was written for Research into Action by Bruce B. Campbell, Royal Tropical Institute (KIT), Amsterdam, The Netherlands. Campbell now works in Nepal, seconded to UNFPA by KIT, as Chief Technical Advisor to the Family Health Division of the Ministry of Health. Using lessons learned in Ghana, he is making similar efforts to develop and introduce an integrated health management system throughout the Kingdom of Nepal.



Manila Task Force on Research Priority Setting

Many developing countries have attempted to set national priorities for research, in response to the 1990 recommendations of the Commission on Health Research for Development. On 13–15 February 1997, representatives with ‘on the ground’ experience in national research agenda setting as well as those with international health perspectives, converged at the University of the Philippines Manila to discuss these experiences and the use of the ENHR strategy for research priority-setting.

Professor Charas Suwanwela, Chair of the COHRED Board, welcomed the 13 participants to the workshop, emphasising their pivotal role in synthesising the lessons learned from the countries’ experiences in priority-setting. Dr Mary Ann Lansang, Chair of the recently created Task Force on ENHR Competencies, said that the workshop was one of several initiatives that were developed in response to the interim evaluation of COHRED last year. As a starting point for the ensuing discussions, Dr Yvo Nuyens, COHRED Coordinator, presented a review and analysis of country experiences on research priority setting.

A framework for research priority-setting was proposed that had, as its underlying principle, the ‘demand side’ of health and development, and equity in partnerships and in development as its goal. The participants discussed the elements involved in this dynamic, inclusive and interactive process of priority-setting. While reiterating the value of systematic and scientific assessments of health status, health systems, and health research systems, the participants also gave equal importance to systematic and scientific analyses of user demands, felt needs and values.

Guidelines were further developed in the following areas:

- understanding and engaging different stakeholders;
- strategies for promoting broad-based participation, dialogue and consensus;
- information needs for priority-setting;
- selection of criteria for priority-setting; and
- enhancing

What lessons have we learned?

the interface between national and global health research priorities. The group identified specific needs for advancing the process of research priority-setting: the presence of a balanced and committed core group that would articulate, monitor and periodically evaluate the processes and outcomes of priority-setting; strengthening the methodological capacities of countries in areas such as data gathering and analysis, consensus-building, and research problem-specification.

In response to these concerns, the participants agreed to collaborate in the preparation of publications that would assist countries in implementing the ENHR strategy for priority setting. For example, a handbook could serve as a guide to the different steps of priority-setting, as culled from the successes and failures of previous efforts in different countries. The first of these publications is expected to be released by June 1997.

Other participants in the workshop were: Mr Romeo Arca, Jr. (Philippine NGO Council for Population Health & Welfare, and workshop rapporteur), Dr Peter Figueroa (Ministry of Health, Jamaica), Dr Lennart Freij (Swedish International Development Cooperation Agency), Professor Vic Neufeld (McMaster University, Canada), Dr David Okello (Makerere University, Uganda), Ms Remedios Paulino (ENHR Programme, Dept. of Health, Philippines), Professor Corazon Raymundo (*Tuklas Pangkalusugan* Foundation, Inc., Philippines), Professor Chitr Sitthi-Amorn (Chulalongkorn University, Thailand), Dr Tessa Tan-Torres (University of the Philippines Manila), and Dr Steve Tollman (University of the Witwatersrand, South Africa). □

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Country Update GHANA Cont'd

Daily Graphic, Accra, Wednesday, February 26, 1997, pp. 1, 3

‘Professor Francis Nkrumah, Director of the Noguchi Memorial Institute of Medical Research, has called for more health research into areas that still pose a challenge to health care delivery in the country.

‘Professor Nkrumah said this at the opening of a three-day workshop on “Strengthening research in support of changes in the health sector” being held in Accra.

‘The workshop is being organised by the Health Research Unit of the Ministry of Health together with the Council on Health Research for Development of Geneva and the Advisory Council for Scientific Research for Development in The Netherlands.

‘It is being attended by over 90 researchers from the health sector, universities, non-governmental organisations and public organisations.

‘Dr Yvo Nuyens of the Council on Health Research for Development urged the researchers to let their research agenda reflect the needs of the country.’

NEWS FROM ENHR PARTNERS

TECHNOLOGY ASSESSMENT

SPECIAL INTEREST GROUP
ON DEVELOPING COUNTRIES
SPIG / DC

The Special Interest Group on Developing Countries (SPIG/DC) was established last June during the 12th Annual Session of the International Society of Technology Assessment in Health Care (ISTAHC), held in San Francisco, California, USA. For nearly two decades, there have been discussions at international meetings and organisations about introducing health technology assessment (HTA) into countries in the developing world. As early as 1981 the technology issues confronting developing countries were raised at separate meetings held in Copenhagen and in Brasilia, from which emerged recommendations for the establishment of a regional centre for HTA and for a 'health technology assessment system to be created at the national level.'

From the very beginnings of ISTAHC in 1984, the importance of introducing evaluative mechanisms into developing countries emerged as a perennial item for discussion, but the lack of adequate funds and access to appropriate channels in those countries precluded any real progress. On several occasions, individuals from developing countries were invited to attend ISTAHC annual sessions at the Society's expense and occasionally, ISTAHC members participated in seminars or served as consultants in developing countries. In any case, such activities seemed to have had no impact of consequence.

Following several meetings organised by WHO which emphasised health technology transfer to developing countries, the Forty-third World Health Assembly in May 1990 called upon WHO to work 'with the global and regional Advisory Committees on Health Research, to assess new and emerging areas of science and technology.' This increasing interest by WHO in health technology assessment led to the transfer of the Appropriate Health Care Technology programme from the WHO Regional Office for Europe to WHO, Geneva, and its renaming as the Programme on Technology Development, Assessment and Transfer (TEC). One of the aims of this programme was to assist developing countries to establish HTA mechanisms.

This important development was followed by two WHO meetings, organised by Gordon Stott, one sponsored by the Eastern Mediterranean Regional Office in 1993 and another by the WHO Collaborating Center in Copenhagen in 1994. The first focused on (1) promoting HTA and establishing at 'regional and country levels effective mechanisms for health technology assessment and quality assurance;' (2) exploring

opportunities for cooperation with other international organisations or national agencies in these fields; (3) urging WHO, Geneva, to organise a working group in a partnership to include other organisations such as ISTAHC and INCLIN, and (4) recommending that WHO Regional Offices establish HTA training and orientation pro-

grammes.

The second WHO-sponsored meeting, in Copenhagen in 1994, pursued, among others, these purposes: (1) to review needs, opportunities and priorities for technology assessment to improve health care in developing countries; (2) to consider the roles that the various

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organisations involved could play; (3) to identify suitable institutions in developing countries where training in technology assessment and its application in improving health care might be given; and (4) to prepare general guidelines for orientation seminars for national policy- and decision-makers; training courses for other categories of health personnel. These two WHO meetings, while serving a valuable purpose in producing excellent and concise reports as well as providing opportunities for participants to establish important contacts, did not lead to further action. However, they may have raised the level of interest in HTA at WHO, Geneva, and helped to reinforce the interest of some members of ISTAHC in working with developing countries.

During the 11th Annual Meeting of ISTAHC in Stockholm, in June 1995, it was agreed that a survey to consider possible approaches for working with developing countries to introduce HTA into their health care systems should be undertaken in industrialised and developing countries and in those in economic transition. The key questions asked for opinions on whether the initiative was needed and on the elements to be included in the initiative. The responses were all strongly supportive, and many included specific suggestions and offers to collaborate.

Improving Health Care Quality

At the next ISTAHC Annual Session held last June in San Francisco, another meeting brought together some 50 people representing 16 different countries (11 of them developing countries), who concluded that a Special Interest Group on Developing Countries (SPIG/DC) within ISTAHC would serve a valuable purpose in focusing attention on the health technology problems of the majority of the world's population. It would also help to create a consensus of opinion on what needs to be done and how to go about it. Specifically, this SPIG/DC could develop the means of working with and assisting developing countries by promoting the appropriate use of HTA to improve the quality of health care and the allocation of resources. While each nation would be urged to create its own HTA capability, an important objective was to promote regional interest and collaboration.

The author was elected to serve as overall Coordinator and to help to catalyse the initiative and to foster coordination among regions. The following were chosen or were subsequently appointed to serve as **Regional Coordinators**: Dr Somsak **Chuncharas** of Thailand for the Southeast Asia Region; Dr Santiago **Lastiri** of Mexico for the Latin American Region; Dr Tessa **Tan-Torres** of the Philippines for the Western Pacific Region (Dr Tan-Torres is also the liaison officer to the ISTAHC Board of Directors); Peter **Heimann** of South Africa and

Yunkap **Kwankam** of Cameroon for Africa; and Dr Alicia **Granados** of Spain for the Mediterranean. An Associate Coordinator for Eastern Europe is soon to be identified.

Asian meeting on health technology assessment

The first meeting of the SPIG/DC-Asia was held during December 2-4, 1996 in Kuala Lumpur by arrangement with the Ministry of Health of Malaysia and with financial assistance from COHRED to meet local costs. The 15 participants came from seven countries — Hong Kong, Indonesia, Malaysia, the Philippines, South Korea, Singapore and Thailand, while Dr David Banta from the Netherlands served as the resource person for the meeting. The objectives were to serve as a forum for discussions on issues related to health technology assessment and use in developing countries, and to explore possible means for further collaboration in this field among the member countries. It soon became clear that many countries in the region deal with health technology assessment mainly to provide information to users and decision-makers, not just for academic interest. There is therefore a clear need for mutual information supports among the countries, and the participants agreed that they can learn a lot from one another. The studies made so far have had varying degrees of impact on the policy-makers, who often need to react to the issues in a relatively short time, based on available and far from perfect data. Some participants expressed concerns about the validity of studies conducted in these countries and proposed training as a way to increase the quality of technology assessment studies. There was also a need to raise public awareness about health technology assessment and use. The Group agreed to meet again next year.

The proposed activities of SPIG/DC include: • Initiation of an analysis of the presence of and potential for HTA in selected developing countries; • production of a document on HTA from the perspective of developing countries; • production of publications and learning materials on HTA, including the adaptation of published assessment reports to national needs (needs-based HTA); • convening orientation seminars, training courses and workshops on HTA; • promoting HTA with the aim of having it institutionalised in either the public or private sector (e.g. Ministries of Health or academic centres); • making HTA part of relevant loan applications to the World Bank and other international organisations; and • establishing collaborative relationships with other institutions working in related fields.

Finally, the establishment of SPIG/DC provides an opportunity for interaction and collaboration with **COHRED** and **ENHR** activities. **SPIG/DC** and **ENHR** are activities with the same ultimate goal of improving the health of people in developing countries. HTA, as employed by the SPIG/DC, is a 'tool' just as ENHR is a critical tool for equitable health and development. As with ENHR, HTA is also a research activity, the results of which are meant to provide policy-makers with a basis for rational decision-making. □

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Youth-friendly health services

Last December, Abidjan, Côte d'Ivoire, hosted the 4th Congress of the Society of African Gynaecologists and Obstetricians (SAGO), which brought together some 350 gynaecologists from French-speaking African countries.

The Congress was preceded by a three-day workshop aimed at developing a protocol on research to evaluate and improve reproductive health services for adolescents, and to discuss the strategy for utilising the research results. In advance of the workshop, information about existing services for adolescents, government directives, research interest and capacity, government interest in using research findings and the possibilities of raising funds for a new research project had been collected (by questionnaire) from each of the six participating countries — Benin, Cameroon, Côte d'Ivoire, Guinea, Madagascar and Senegal. The countries had been selected on the basis of the answers received to the questionnaire, as representative of places where the project would seem to have the greatest potential for being successful. The proposed new research will include a baseline study to define the profile of adolescent users of health services and the preferred quality of the services offered. Based on the survey results, each country will examine ways of increasing information to adolescents or making the existing services more youth-friendly. The steps taken will be evaluated by a second survey. The workshop's multidisciplinary teams (comprising representatives of youth groups, ministries of health, service providers and research groups or centres) tentatively selected for each country the most needed interventions, research methods and study zones, as well as the staffing of the research team. In addition, they outlined a timetable, identified initial training needs and funding sources, and prepared budget estimates. The youth representatives made a point of affirming their active commitment to all phases of the research project. □

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Atelier Pré-Congrès de SAGO RESOLUTION

Vu l'ampleur que revêt les problèmes de santé en général et ceux de santé reproductive des adolescents en particulier,

Vu l'impact des recherches effectuées ultérieurement,

Vu la pertinence et la nécessité de l'implication des jeunes dans les projets de recherche sur la santé en général et la santé reproductive des adolescents en particulier,

Considérant notre engagement et notre détermination en tant qu'agent de changement pour un développement durable,

Nous, Représentants jeunes à l'atelier d'Abidjan, réunis ce Jeudi 5 Décembre 1996, ..., en marge des activités de l'atelier de développement d'un protocole de recherche sur les services de santé reproductive des adolescents,

Réaffirmons notre disponibilité à œuvrer pour l'amélioration des services de santé reproductive des adolescents, en prenant une part active dans les différentes phases du projet en cours d'élaboration;

Souhaitons une intégration effective des jeunes dans le projet, notamment par une prise en charge financière de ces derniers comme volontaires sur une ligne budgétaire spécifique;

Exhortons les pouvoirs publics, les organismes internationaux, les ONG à ne ménager aucun effort pour soutenir la promotion de la santé et du développement des adolescents.

Décidons de mettre en place un Réseau de jeunes pour la santé des adolescents en Afrique francophone au Sud du Sahara.

Equity ... continued from page 3

Information for action

Useful facts and figures already exist in most countries, indeed government ministries often have a wealth of data, but these are frequently not examined. Emphasising the need both for research and for ongoing monitoring, the WHO/SIDA initiative explains that data on health and health care must be broken down according to social groups, in order to make valid comparisons and assess how gaps change over time. The old familiar indicators of health status and health care can be used, but at least a few other criteria should be assessed, and the gaps in absolute levels must be measured. After all, the goal of information is to support better policies; this won't happen unless the policy implications of facts and figures are thoroughly discussed and evaluated.

Equity in health and health care points out that information is not enough. The message has got to be aired, in order to mobilise public attention and achieve the public consensus that is vital to ensure political will. That in turn calls for strategic thinking about political obstacles. And achieving equity requires real changes in resource allocations; all too many countries spend a disproportionate share of their health budgets on hospital and tertiary-level care, while relatively little public health money goes to proven cost-effective measures such as maternal and child health and improved sanitation.

The WHO/SIDA initiative builds on the work towards health for all carried out by WHO and its many partners over the past decades. Previous efforts by WHO in Western Europe and other regions have provided a sound foundation, and equity in health projects are now under way in countries in Africa and Asia. COHRED welcomes and applauds this initiative, and hopes to play its own part in fostering and encouraging continuing efforts in the whole field of health research for development. It is no longer sufficient to pay casual lip-service to the goal of equity in health and health care; it is high time to transform research into action. □

This article was written for Research into Action by John H. Bland in consultation with Yvo Nuyens, Ph.D. It is based on the WHO publication 'Equity in health and health care: a WHO/SIDA initiative.'

Contact: Drs E. Tarimo & P. Braveman, ARA, World Health Organization, Geneva, Switzerland. Fax 41-22-791 07 46.

UPCOMING EVENTS

MEETINGS & CONFERENCES

MAY 25 – 28, 1997

13th International Meeting of the International Society of Technology Assessment in Health Care (ISTAHC)

Location: Hotel Rey Juan Carlos I, Barcelona, Catalonia - Spain

Contact: Congress Secretariat, PACIFICO, S.A., E. Granados, 44, 08008 Barcelona, Spain. Phone 343-454 54 00 • Fax 343-451 74 38

Description: The plenary sessions will build around these themes: Does technology assessment contribute to health policy? Is technology assessment sophisticated enough to provide answers that can be useful to clinical practitioners? The integration of stakeholders in the health technology assessment process. — The panel discussions are expected to evolve around such topics as: health technology assessment in developing countries; biotechnology in health care: socio-economic issues; the place of outcomes research in health technology assessment.

The official language of the Conference is English. The Conference has full accessibility for people with mobility problems.

JULY 20 – 24, 1997

3rd International Conference — Social Science and Medicine Africa Network (SOMA-Net)

Location: Harare, Zimbabwe

Contact: Dr Anne Pertet, Coordinator, SOMA-Net, P.O. Box 20811, Nairobi, Kenya. Phone 254-2-560 569 • Fax 254-2-567 577 • E-mail: somanet@ken.healthnet.org

Description: The main theme of the Conference is: Africa Health in the 21st Century: Social Science and Health Approaches. Sub-themes include: African health policy sector reform; Community participation for sustainable health and development; enhancing capacity in social science and health.

OCTOBER 5 — 8 & OCTOBER 8 — 12, 1997

2nd International Conference Scientific Basis of Health Services

5th Annual Cochrane Colloquium

First Announcement.

Both events will be held at the Amsterdam RAI Congress Centre.

For more information, contact Bureau PAOG Amsterdam, Tafelbergweg 25, NL-1105 BC Amsterdam, The Netherlands. Phone +31-20-566 4801 • Fax +31-20-696 3228 • E-mail: c.walta.PAOG@inter.nl.net

COURSES

The Amsterdam's Master's in Medical Anthropology

Dates: Academic year 1997–1998

Location: Universiteit van Amsterdam, The Netherlands

Contact: Universiteit van Amsterdam, Faculty of Social Sciences, Medical Anthropology Unit, Attn Dr Ria Reis, AMMA Program Manager, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, The Netherlands. Phone 31-20-525 2670/2621 • Fax 31-20-525 3010 • E-mail: amma@pscw.uva.nl; homepage: <http://www.uva.nl>

Description: This programme is for students from both Southern and Northern countries, for social scientists work-

ing in multidisciplinary research projects in the field of health and health care, and for physicians and other professionals of health care. Students will be taught to set up and conduct high-quality medical anthropological research and to write excellent research reports.

Applicants are expected to have a Master's degree in any of the Social Sciences or the field of medicine, public health, pharmacology, or a paramedical science. Full-time tuition is Dfl. 18,500.

15th annual Health Care in Developing Countries Programme

Dates: May 31 – August 27, 1997

Location: Boston University School of Public Health

Contact: Health Care in Developing Countries, Center for International Health, 53 Bay State Road, Boston, MA 02215-2101 USA. Phone 617-353 4524 • Fax 617-353 6330 • E-mail: cih@bu.edu

Deadline for applications is April 14, 1997. Per-week tuition \$600.-

Suited to clinicians, managers, planners and other professionals, this intensive twelve-week course provides a comprehensive overview of issues faced in the planning and delivery of health-care services in resource-constrained environments. The course provides 33 per cent of the credits required for a Master of Public Health (MPH) degree at Boston University.

A brochure about the programme is available from the address indicated above.

The **Swiss Tropical Institute (STI)** offers the following **Advanced Module courses:**

— **Medical Practice in Developing Countries with Limited Resources**, Ifakara, Tanzania, June 9–29, 1997.

— **Accidents due to Venomous and Poisonous Animals**, STI, Basel, Switzerland, June 2–5, 1997

— **Certificate Course — The Basics of Travellers' Health**, March 18–21, 1997

For further information and registration, contact: Swiss Tropical Institute (STI), Course Secretariat, P.O. Box, CH-4002 Basel, Switzerland. Phone 41 (0) 61-284 82 80 • Fax 41 (0) 61 284 81 06 •

E-mail: sticourses@ubaclu.unibas.ch

WORLD WIDE WEB PAGES VIA E-MAIL

AFRO-NETS' moderator Dr Dieter Neuvians has this good piece of news for those of our colleagues with E-mail connection only:

HealthNet/SateLife has established a free 'GetWeb MailBot' service, which means anyone with an E-mail programme can download documents from the World Wide Web by sending a message to **getweb@usa.healthnet.org**

Leave the 'Subject' line empty. Type the following text in the body of your message:

```
get <URL>
end
```

Replace <URL> [Uniform Resource Locator] by the desired WWW address. To retrieve AFRO-NETS' home page, for example, you would write

```
To: getweb@usa.healthnet.org
Subject: <leave blank>
```

```
get http://www.healthnet.org/afronets/index.html
end
```

You will receive via E-mail a plain text (ASCII) copy of the home page.

PUBLICATIONS

Please note, COHRED cannot supply the publications reviewed on this page. Please write to the relevant address.

The Global Burden of Disease.SUMMARY. Edited by Christopher J.L. Murray and Alan D. Lopez. 1996. 43 pages. ISBN 0-9655466-0-8

This study represents a new and substantial contribution to the knowledge about global and regional disease and injury patterns and how they are likely to change, and also about the probable effects of major risk factors for human survival. The Study, which began in 1992, includes the use of a new method of calculating disease burden known as the disability adjusted life year (DALY) which combines data on disability and premature death.

UK/Europe/Africa/India/Middle East contact: Harvard University Press, c/o Wiley & Sons Ltd. Southern Cross Trading Estate, 1 Oldlands Way, Bognor Regis, W. Sussex PP22 9SA, UK. Phone 00-44-1243-779777 • Fax 00-44-1243-820250 • E-mail: customer@wiley.co.uk • Web order form: <http://www.hup.harvard.edu>

Operational research projects in DAP: An annotated inventory. Action Programme of Essential Drugs, World Health Organization. Document WHO/DAP/96.3 (English only). 1996. 88 pages.

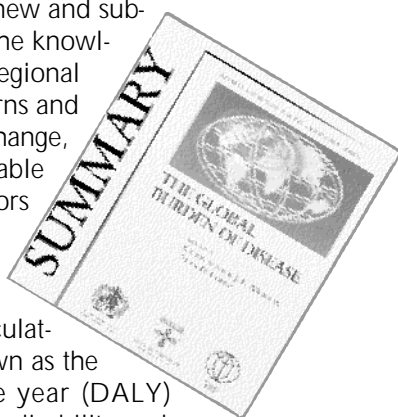
This document is part of a series reporting on the activities and results of the Action Programme's operational research. The inventory, which is based on information stored in a computerised database, contains detailed information on 70 research projects. The database can also be used to search for or extract information on particular countries, technical areas or types of research. The inventory will be useful to researchers planning or implementing similar types of research who wish to gain a more comprehensive understanding of particular research issues or country-specific situations.

Available from: Action Programme on Essential Drugs, CH-1211 Geneva 27, Switzerland. Fax (41-22) 791 07 46.

Health Research in Faculties of Medicine in Addis Ababa, Dar es Salaam and Maputo. Report from a seminar held in Arusha, Tanzania, 21–24 May 1995. M. Mugambi, J. Mtabaji, A. Swai (Eds). Conference Reports 1996:1, Sida. Published by Swedish International Development Cooperation Agency (Sida). November 1996. 42 pages. ISSN 1401-0569, ISBN 915867429-2

The Report highlights the discussions during the seminar and includes the country reports presented at the seminar. The Report is hoped to provide guidance with regard to future directions of cooperation for Sida (SAREC) as well as for other donors.

Available from: Sida, S-105 25 Stockholm, Sweden. Phone 46(0)8-698 50 00 • Fax 46(0)8-20 88 64



Newsletters published by the South African Medical Research Council (MRC)

MRC News — Official newsletter of the MRC, published four times a year.

AIDS Bulletin — This quarterly publication aims at HIV/AIDS researchers, policy-makers, community health workers, counsellors and AIDS activists.

Urbanisation and Health Newsletter — Quarterly newsletter published by the Urbanisation and Health Research Programme, which is part of the WHO Collaborating Centre for Urban Health.

Contact addresses:

Medical Research Council, P.O. Box 19070, Tygerberg 7505, South Africa

MRC News: Leverne Gething or Adri Labuschagne, Corporate Communication Division.

Phone 27-21-938 0293/0341 • Fax 27-21-938 0395 • E-mail: lgething@eagle.mrc.ac.za, or: labusch@eagle.mrc.ac.za

AIDS Bulletin: Michelle Galloway, Corporate Communication Division.

Phone 27-21-938 0205 • Fax 27-21-938 0395 • E-mail: mgallow@eagle.mrc.ac.za

Urbanisation and Health Newsletter: Pam Cerff or Michelle Galloway, Medical Research Council.

Phone 27-21-938 0444/0205 • Fax 27-21-938 0342 • E-mail: pcerff@eagle.mrc.ac.za, or: mgallow@eagle.mrc.ac.za

COHRED

COUNCIL ON
HEALTH RESEARCH
FOR DEVELOPMENT

This newsletter of the Council on Health Research for Development is published four times a year.

Printed on recycled paper, **RESEARCH INTO ACTION** is issued complimentary upon request.

Editor in Chief: Yvo Nuyens, Ph.D.

**Editing, desk-top composition
and layout:** Hannelore Polanka, M.A.

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Tel (41 22) 979 95 58 • Fax +(41 22) 979 90 15 • E-mail: cohred@pingnet.ch

COHRED, the Council on Health Research for Development, is a non-governmental organisation. It was established in March 1993, and is located in the European Office of the United Nations Development Programme in Geneva, Switzerland.



The Council consists of member countries, agencies, organisations and an

18-member board, the majority of whom are from developing countries.

Its objectives are to promote the concept of Essential National Health Research (ENHR), which aims to assist countries in identifying their health and research priorities as well as strengthening their research capacities, and encourages multi-disciplinary and multi-sectoral collaboration to ensure that health policies and decisions on important health issues respond to the actual needs of the public and will translate into health gains for the population at large.

In addition, COHRED brokers national financial and other support for countries if requested to do so.