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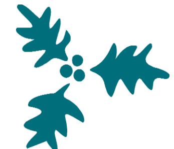
COHRED

Research into Action

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

Happy New Year  Bonne Année

# The Next Step: An Interim Assessment of ENHR and COHRED

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AT ITS MEETING IN NOVEMBER 1995, the COHRED Board recommended that an interim evaluation of both ENHR and COHRED should be carried out by an external evaluation team. The objectives of the evaluation were further elaborated at the Board's meeting in June 1996. They can be summarised as follows: • to assess the effectiveness of the ENHR strategy; • to assess COHRED's effectiveness in promoting ENHR at country, regional and global levels; • in addressing the first two objectives, to elicit the views of a wide range of stakeholders at the country, regional and global levels.

As recommended by the COHRED Board, the evaluation team considers this report to be an **interim** assessment, its primary intention being to facilitate future strategic planning.

The evaluation team began its work on 28 June 1996, immediately after the special meeting of the Board. It reviewed many relevant documents and interviewed

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key informants, including donors and organisations as well as leaders of research networks. It also undertook site visits to seven countries: the Philippines, Nepal, Mozambique, Kenya, South Africa, Nicaragua, Jamaica, Trinidad/Tobago and Barbados. A member of the evaluation team was able to attend regional ENHR networking meetings in Asia (Manila in July) and Africa (Kampala in October).

The team found virtually universal agreement that ENHR remains a strong and timely idea which has attracted researchers and policy-makers in many developing countries. While there are high expectations that the concept can be realised in practice, it is generally recognised that this is a relatively early stage in the development of what is a complex process. Nevertheless, most donors and key leaders in the international health field are expecting that by now there should be four or five "success stories," while a few more should be added to this list in the next three years.

*The team believes that this expectation has been fulfilled — there are several country examples where significant progress is evident and where a good start has been made on creating a sustainable ENHR system.*

**The evaluation team proposes four recommendations** that represent a "next step" for COHRED and its many partners.

### PRODUCT: TRAINING IN "ENHR TECHNOLOGY"

The ENHR process represents an approach to the design, production and use of research that is distinctive; this is COHRED's niche, its "added value" product. Furthermore, most of its components have a strong "science" and experience base, much of it to be found within the research networks that have indicated their intention to contribute to ENHR. The challenge is to make this available knowledge and experience accessible to, and used by, all those involved in the ENHR process. Examples of these component competences include: political mapping; advocacy skills; strategies for community participation; the methodology of priority setting; donor coordination and fund solicitation; and networking skills.

*The team recommends a special initiative to capture the available expertise regarding these competences, prepare strategies and materials ("toolkits"), and provide training to country ENHR groups.*

### PARTNERSHIPS: PURPOSE-SPECIFIC COALITION BUILDING

At the heart of the ENHR process, in the work to date, are three partner groups: researchers, policy-makers and community representatives — each of which shares the goal of having health research used to improve the health and quality of life of the people. Ideally, it is a partnership of equals, where each respects the others' points of view. In some countries, depending on the specific objectives, other partners should be added. These may include donors, non-governmental organisations (NGOs) and elements of the private sector. Creating these purpose-specific coalitions and sustaining them so that they function in a dynamic and effective fashion represent complex challenges; however, the relevant expertise is becoming available in several countries.

*The team recommends the creation of regional "ENHR mentoring teams", to assist countries with coalition-building, particularly in the early stages of the ENHR process when political mapping is most important. Where possible, these mentoring teams*

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*should include representatives of the three core partners — researchers, policy-makers and community groups. In some situations, a donor representative could be added.*

The principles of purpose-specific coalition-building, with mutual respect among partners, also apply at the global level. COHRED and the various country ENHR groups have important contributions to make to the global health research agenda. In particular, COHRED's relationships with the World Health Organization (WHO) and the World Bank should be strengthened since it is critically important to link the national and global health research processes; these two components are not only complementary but also interdependent.

*The team recommends establishing a task force to explore specific ways in which national and global research initiatives can be linked. The task force should be initiated by COHRED and should include representatives of WHO and the World Bank, with a view to developing exemplary collaborative projects at a country level.*

## PEOPLE: COMPREHENSIVE RESEARCH CAPACITY STRENGTHENING

For ENHR to be successful, all the people involved must be adequately prepared. Research training cannot be restricted just to researchers. Other partner groups must receive training in selected components of the research process, including policy-makers and community and NGO representatives. Donors too can be learners as regards certain aspects of the ENHR process, as this will make their contribution more relevant and effective.

*The team recommends that the scope of research training be broadened beyond the usual researcher community; COHRED should identify countries where there may already exist experience with a broader scope of research training, the aim being to strengthen and disseminate this experience.*

In many countries, the potentially available research capacity to contribute to the ENHR agenda is not actually being tapped. There are many reasons for what might be called "internal brain drain". This complex situation is not well understood, and solutions are not readily available.

*The team recommends that COHRED initiate one or more country case studies focused on this issue. These studies would not only be analytic and descriptive, but would proactively propose and implement solutions to ensure that potentially available research expertise is indeed contributing to the ENHR process.*

ENHR represents a paradigm shift regarding the production and use of research, and thus calls for a long-term commitment of vision and resources. It will be particularly important to prepare the next generation of health leadership to join the ENHR enterprise.

*The team recommends that COHRED facilitate special initiatives with appropriate networks and institutions so as to introduce ENHR concepts and skills to the curricula which prepare future health professionals. These initiatives should feature opportunities for students to participate directly in all aspects of the ENHR plan.*

## PERFORMANCE: A STRONGER COHRED

As the international community becomes increasingly aware of the existence of the ENHR initiative, COHRED can shift its energies and resources from promotion and advocacy activities to more in-depth analyses of aspects of the ENHR process, and to actions which will effectively link national and global research. Adjustments along these lines can be made at each level of the COHRED mechanism: the Council, the Board, the Secretariat and the regional networks.

*The team recommends that the COHRED Board become more "problem-oriented" in the way it functions. This could be achieved by forming small short-term task force groups to deal with specific relevant issues. The COHRED Board could also be made more efficient either by creating a small executive committee where each member has a specific responsibility or by reducing its size.*

*The team recommends that the COHRED Secretariat be strengthened to increase its capacity for specific analytic projects. This could be done either by adding a professional officer to the Geneva-based unit, or by engaging regionally-based professionals on a part-time basis.*

The evaluation team believes that these recommendations and considerations, taken together, represent a strategic "next step" for COHRED and the various ENHR country-based initiatives, and will enable them to build strongly on the excellent base that has already been established. The challenge is to ensure that the ENHR process achieves its original intention, which was well described in the Commission report as being to *"... 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 toward the fundamental goal of equity in health."*

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# *COHRED Board takes up the challenges of interim assess-ment*

Having reviewed, with members of the Evaluation Team, the findings and recommendations of the Interim Assessment, and strongly encouraged both by the Team's reporting of universal agreement that Essential National Health Research remains a strong and timely idea and by the significant progress made by several countries in creating a sustainable ENHR process, the Board took the following decisions : ▼ to maintain the present structure of COHRED while (**1**) involving more strongly COHRED constituents and related stakeholders, (**2**) enhancing the regional networks' capacities for monitoring and mentoring ENHR country developments, and (**3**) increasing the Secretariat's critical mass in order to achieve a better balance between promotional activities and analytical work; ▼ to start a process of capturing available expertise and experience in the seven key elements of the ENHR strategy—methodology of priority setting, facilitating community participation, political mapping, donor coordination, etc; of identifying possible resources to address these competences; and of preparing strategies and materials for distributing and using this ENHR technology; ▼ to launch an initiative to define markers of success that move beyond the current, almost exclusively activities-oriented indicators, so as to include qualitative and more rigorously quantitative measures of success, and thus to demonstrate that health research is indeed "an essential link to equity in development;" ▼ to critically review experiences with purpose-specific coalition building—both at country level and globally—in order to explore ways of linking national and global research agendas, and of assessing the potentials of a cooperative initiative for mobilising country-level resources for essential national health research.

The responsibility for putting these decisions into effect and for examining other recommendations made by the Evaluation Team was assigned to a number of **Special Task Forces** which the Board set up for this purpose. These Task Forces are to call upon the expertise of Board Members, Constituents and other ENHR partners, and will report back to the COHRED Board within a short and rigorous time-frame.

# Health Research in Nepal

## The Reality

What is the status of health and health research in Nepal? How is it formulated, conducted and used? To start with, the bitter truth about Nepal is that there is disjunction at all levels of health management. There is disjunction, even mismatch: between reality and policy development; between policy and strategy development; between strategy and programme development; between programme and its implementation, and between implementation and evaluation.

The other side of the scenario is equally depressing. Most of the research documents end up in waste-baskets without having ever been reviewed or used. A sad fate for all this research! But the real value of most research outcomes is so low that this could be called the most appropriate fate. At least, it frees the serious users from undertaking a futile exercise. Most research is biased or so designed to find justification for preconceived ideas or already determined actions rather than presenting informed or appropriate choices.

In spite of loud talk about political commitment to improve or modernise health management, and in spite of the enforcement of a "New Health Policy", Nepal's health care services continue to be in a shambles. Indeed, Nepal's health care system could very well be regarded as a case study of failure.

## Vacuum in Health-care System

The health care network that exists in developing countries like Nepal largely ignores, or is incapable of meeting, the health needs of the people, especially those who are deprived, displaced, marginalised and vulnerable. In some countries of this Region, as much as 85 per cent of the population do not have access to a modern health care system, which is adopted as the system of choice by most of the governments of these countries. (The figure was cited for Nepal by the Hon. Prime Minister Serbahadur Deuba in his inaugural speech at the seminar on "Medical Education," Kathmandu, 13–16 September, 1995). Even so, most of the modern health facilities are more or less exclusively devoted to the interests of the five to ten per cent of the elite or upper class. As disenchantment with the existing traditional care among the population in these countries grows, an unprecedentedly high demand is being placed on so-called modern health care. High expectations or demand coupled with poor or no opportunity create a state of *vacuum*, generating a viscious circle of spiralling cost of care, lopsided health care development, mediocre services, dangerous or harmful or unnecessary or useless prescriptions or practices, quackery, and the flight of health professionals.

## The Contradictions

Poor health coverage is complicated by ever-rising demands and a craving for relief rather than prevention or proper management. Other problems—like unsafe water and waste management, insufficient food and nutrition, growing indoor and outdoor pollution, child marriage and early marriage, sex discrimination or subjugation, child labour, girl trafficking, decreasing land productivity, lack of work and opportunity, further aggravate the problems.

It is satisfying to note more and more political commitment pledged by the governments of developing countries to PHC (Primary Health Care) as a means of closing the gaps in health care delivery. However, those in power deliberately tend to provide technological solutions to all problems. To reap the concentrated benefits for themselves, they advocate too many centres of excellence and implants of vertical edifices. They use all systems of communication to make the people addicted to glorified and mystifying technocentric approaches by managing information so as to cut short their power to reason and analyse. No information is ever provided on the extent of resources they guzzle in their development and maintenance, how these structures get the scarce resources diverted from most needy sectors, and how they tend to fall off after the external resource is withdrawn or curtailed.

Even PHC itself is subjected to too many manipulations. In most developing countries the PHC programmes are in a mess and are stressed by too many unpredictable and uncertain or *ad hoc* decisions from the top. The prescriptive attitude from the top devotes too little attention to the real needs of the people and to local conditions. Community participation tends to be limited to *compliance* or, at the most, *"cost-sharing by the community"*. Politicians, government bureaucrats and executives not only pay lip service to PHC but also whisk off the cream in the name of the same. Many mushrooming NGOs too are controlled by the same group of people and are equally good at hijacking the benefits intended for the people. Therefore, the argument that private organisations, foundations or the trusts would do better is irresponsible or mere escapism.

Despite heavy priority for extended immunisation, Nepal is at present confronted by occasional epidemics of measles, confirmed cases of poliomyelitis and neonatal tetanus. Informed decision is marred due to the poor quality of the data, which are sometimes cooked-up or grossly

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## Country Update Nepal ... *continued from page 5*

deficient. Manpower and infrastructure development programmes in many developing countries are often inconsistent with their stated policy and objectives.

## The Way Out

Time is ticking away. If something is not discovered or done to solve the problem, the vacuum in the health service could result in a disaster that would not spare the interests even of the elite or dominant class. Now is the time to have a shift of international and regional support and political commitment of the national governments away from the immoral, top-down approach that currently dominates health to a holistic one that deals with and adjusts to the entire set of conditions that shapes people's health and people's lives, including their surroundings. It is not an easy task. But these are our problems. We have to discover ways and means to solve them.

Health policy and services research is to be geared up with a new direction to formulate strategy that can be called both appropriate and country-specific. The research needs to facilitate informed decisions of the politicians and other decision-makers, including the people themselves, so that they are able to take health beyond medical care or the existing care system to holistic care, that is: appropriate and feasible, people- and development-oriented, participatory and pro-active, integrated with all aspects of human life, problem-oriented or need-based, quantitatively and qualitatively adequate and at the same time affordable, accessible in a way that can be called equitable and justifiable, able to monitor and tackle existing and emerging problems, transparent and comprehensive to the providers as well as the people or the target groups, responsible enough to provide an informed choice or decision for the client, and to respect them and their potentiality to assert their health, accountable for any side-effects or problems resulting from the implementation of the policy or programmes, and incorporated with in-built evaluation and feedback mechanisms for self-correction and optimisation.

### The Challenges

How to make governments, institutions, NGOs, health professionals and even the people invest more, in terms of physical and intellectual resources, in health research?
How to streamline research priority so that research is need-based and problem-oriented?
How to generate information so that an appraisal could readily be made at any point of time with adequate, reliable and usable information for rational and appropriate policy decision and strategy development?
How to develop systems so that more and more people are influenced to work as a team involving multi-disciplinary and multi-institutional people for policy and strategy development?
How to enable research to help the informed and rational decision-making of: People, Government, Health-related agencies, and Health professionals including grass-roots workers?
How to avoid useless, duplicated and even harmful research?
How to avoid biases in research ? Conversely, how are new ideas or new ways of thinking and behaving generated to the benefit of systems and services development?
How to improve or develop institutional and individual capacity to develop, implement and utilise research independently?
Emphasis should be given for the development of : appropriate health policy and strategy; infrastructure and institutional capacity for research promotion and development; a guidance and counseling system that is serviceable; training of young scientists on research methodology, management and review techniques, and data management and data safety.
How to minimise donor-driven or donor-oriented research?
How to avoid or minimise the existing gap in research resources or technology between developing and developed countries?
How to enable institutions, laboratories and councils in developing countries to do research into the problems of developing countries? Why should the developed countries continue to be custodians of knowledge and technology for developing countries?
How to make the professionals interested in generating or developing quality and pragmatic research programmes ?
How to develop mechanisms or a regulatory system to prevent unethical or harmful research in Nepal? How to oblige researchers to follow NHRC ethical guidelines?
How to oblige professionals to integrate the research with their service and continued education or competency development ?
How to coordinate research activities all over Nepal ?
How to develop a network and data linkage system for dissemination of information within and outside the countries of the region for research promotion, development and utilisation?

## Some Challenges for the Nepal Health Research Council (NHRC)

The Nepal Health Research Council (NHRC) is a statutory body coordinating and authorising all the research in health in Nepal. It has made good progress in its infrastructure development and activities. However, it still has a long way to go to achieve its objectives and to become effective in solving problems related to health care delivery in Nepal. Like many research organisations in other countries maybe, the NHRC is facing a whole series of challenges (see box), the answers to which are obviously hanging in the air. It is essential to find them.❑

***The above article is based on the paper entitled "Status of Health Services Research in Nepal," presented by Professor Mathura P. Shrestha, Chairman, Nepal Health Research Council, at the* Regional Workshop on Research Management for Essential National Health Research, *held in Kanchanaburi, Thailand, in December 1995.***

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# News From ENHR Partners

**COHRED, like ENHR (Essential National Health Research), is all-embracing, inclusive, participatory. The ENHR principles it advocates can be used by all the groups that make up the world of health research and are already being used by many — to whatever extent, in whatever form and under whatever name. Acting as a forum for communication between the various ENHR partners seems to follow logically as one of COHRED's roles. This column is meant to contribute to that role.**

The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH is an executing agency, wholly owned by the Government of the Federal Republic of Germany. It is commissioned and funded predominantly by the German Government to contribute to the planning and implementation of technical cooperation projects carried out in collaboration with organisations in partner countries.

## The GTZ Approach

The concept is based on the principles of sustainability and self-responsibility of the national partner organisations and takes into account the following strategic guidelines:

- adaptation to the local context
- multisectoral commitment
- participation of all target groups
- self-help orientation
- decentralisation of decision-making.

Currently, more than 115 health projects are being carried out in about 77 developing countries. The current annual value of GTZ assisted projects in the field of health, nutrition and population amounts to DM 120 million. More than 100 internationally recruited field staff members, including personnel from developing countries, are seconded to these projects. In recruiting specialists for projects, GTZ can tap a large pool of experts with extensive experience in developing countries. The activities of GTZ, Division of Health, Nutrition and Population (Head: Dr R. Korte), focus on three areas of intervention: Essential Health Services (EHS); Disease Control; Reproductive Health. EHS activities target, among other fields, the public health services, where GTZ is giving active support to the Essential National Health Research (ENHR) initiative, assisting developing countries in setting their own priorities in health research and carrying out related projects.

For example, as a follow-up to the "Network of Networks" Meeting in Zimbabwe, in January 1996, GTZ—in collaboration with 18 networks and institutions—is establishing a mailing list for the different networks active in Health Research for Development in the Eastern and Southern African Region. This list, which is being hosted and administered by HealthNet/SatelLife, is expected to improve collaboration between the networks and to serve as a forum for announcing conferences, training courses and other events. It will also offer the possibility of storing (and retrieving by E-mail) research proposals, research results and other documents at (from) the central computer. Last but not least, this mailing list, which is open to everybody who wants to subscribe, is hoped to avoid duplications and to save the scarce resources available.

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## Does Applied Research Matter?

***This update draws on an article by John G. Haaga and Rushikesh M. Maru* on the ten-year experience of the Maternal and Child Health—Family Planning (MCH–FP) Extension Project in Bangladesh (1983–93). The article assesses how, and under what circumstances, research-based advice and results of pilot projects contribute to change in large-scale public programmes.***

Relatively uncommon as models go, the (MCH–FP) Extension Project (the Project) is a programme of applied research supported with long-term international aid funding and carried out at an international institution located in the aid-receiving country. The implicit model is a unidirectional sequence of research leading to advice leading to action: Problem identification ➪ Small-scale tests of proposed solutions ➪ Decision ➪ Large-scale implementation.

However, this simple sequence is rarely followed in practice. The Project was originally devised as part of a government programme to test country-wide programme innovations delivered to the Matlab** Maternal and MCH–FP Project of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) by a non-governmental organisation (NGO) and to produce recommendations for implementation nation-wide. The main client for its research (the Family Planning Directorate of the Ministry of Health and Family Welfare [MOHFW]), the main funder (the Bangladesh mission of the United States Agency for International Development [USAID]), and the implementing agencies (ICDDR,B, supported by the Population Council and the University of Michigan) remained constant for ten years. On the other hand, the paths connecting research, advice, decisions, and implementation changed over time as the service-delivery problems that were the subject of research and the policy environment varied and problems in implementation were encountered.

Salient features of the Project design include: 1 - field offices used as "policy laboratories"; 2 - collaboration with government officers at both central and field levels; 3 - demographic surveillance and periodic surveys at project sites, and, increasingly, ***qualitative*** research; and 4 - a focus on implementation issues.

In recent years, much of the Project's work has dealt with: ways of organising the outreach services of paramedics; ways to train and motivate supervisors, and ways to use available management information systems data for local-level planning and decision-making.

In their communications with policymakers, the Project proceeded from the premise that continuity, institutionalisation of operations research rather than conducting a series of discrete projects, has the advantage of building avenues of communication over time. Research results often reach top managers and policy-makers not so much in the written report or even the executive summary or briefing but in the form of speech-writing, staff work for aid negotiations, and participation by researchers in committees and commissions. Effective communication with policymakers is often mediated by others. For example, several Bangladeshi NGO leaders and researchers serve regularly on advisory and oversight committees for the government and have influence on decisions without having a place in the hierarchy. Ensuring that such people know about research results, and soliciting their views on the research agenda, is often a more effective tactic than communicating with transient and preoccupied officials.

Independent research institutions, when they are trusted, can help the reflective manager by creating an alternative channel that bypasses the intervening layers of officialdom. The Project found that one of the most effective methods of communication was researchers' joint visits to project sites with high-ranking officials from the government or from the donor agencies. The immediacy and clarity about things learned on field visits seemed to influence not only foreign aid officials but also the Bangladeshi officials whose day-to-day responsibilities and experiences are removed from village or slum life.

The following example of the Project's work "Recruitment and Training of New Field Workers" illustrates the kind of problems encountered and the policy outcome.

> "The ideas that have an impact are those with instructions attached for the users."

An early intervention was the provision of counterpart training from Matlab community health workers for their government colleagues in project sites, but the initial performance gains dissipated after outside support was withdrawn.

The Project attempted to improve the quality of the worker-client interaction through in-service training, with some success. However, a greater density of workers would have been required to provide increased coverage. Now, a basic problem for the family planning and health programmes in Bangladesh has been the immobility of women. They are

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## Does Applied Research Matter? ... *continued from page 8*

unwilling, or are forbidden, to travel far, or often, or for purposes that are socially unacceptable. This situation is changing, albeit slowly. Women have not used fixed-site clinics adequately. In the 1970s, several NGO programmes had shown that community-based distribution by itinerant female workers could succeed.

Under the first two Bangladesh plans, female Family Welfare Assistants (FWAs) were hired and trained. By the mid-1980s, 12,000 FWAs were deployed, roughly three per 20,000– 30,000 population. Research in Project areas showed that women who lived far from the FWA's residence were less likely to use contraceptives than were the FWA's neighbours. Other factors, including distance to the fixed-site clinics and some workers characteristics, mattered little. This research, and the NGO examples, supported the conclusion that the employment of a greater density of workers would pay off, and that recruitment of workers specifically from the areas to be served was crucial, because workers would not commute far. The government decided to expand greatly the number of FWAs (from 13,000 to 26,000, later scaled back to 23,500), and a consortium of donors agreed to fund the new positions.

During 1986–89, much of the Project's technical assistance to the government focused on helping plan and implement recruitment and training of FWAs, and on ensuring the integrity of the hiring process, for a nation-wide expansion of the work force.

What was unusual in this case was that the Project staff were involved in the actual recruiting of FWAs, although the staff had advised against sudden expansion (previously, recruitment on too large a scale had allowed serious abuses and swamped the training system). Project staff were posted to help division and district officials as each district in sequence recruited more workers. Their task was to make sure that the rules about publicising the openings were followed and that the women hired met the job criteria. The Project was responsible to the Director of Administration in the Family Planning Directorate for a special reporting system to monitor the nation-wide progress of the recruitment. Project staff served on boards investigating allegations of irregularities.

The recruitment of the FWAs proved successful generally, in that the great majority of the women recruited exist, met the criteria, were trained, and are now on the job. The period in the late 1980s and early 1990s, when these additional FWAs began work, coincided approximately with an increase in contraceptive use. Much of the increase was accounted for by use of oral contraceptives, and most of the users reported the government as their source of supply.

**Did applied research matter then?** In fact, it was in the case described above that the Project's research had perhaps the greatest effect on decision-making in that it resulted in an expansion of the work force of female field workers. Research on patterns of contraceptive use, experience in both the government and NGO services with female community-based distribution workers, and research and observation showing that female workers could be effective in rural Bangladesh, all contributed to the willingness of the government to expand this cadre and of donors to pay for it. Expansion in itself did not require any serious change in the organisation's culture or threaten existing power relations. But the willingness of the MOHFW leadership to change the methods of recruitment did require a serious commitment to change. Project research, feedback from the field, and technical assistance improved the way the decision was implemented. Implementation is the easier if the policy advice is consonant with existing power relations, while policy advice that disrupts long-standing relationships is liable to remain mere declaration. Also, what is needed from research is not originality so much as clarity and applicability. The ideas that have an impact are those with instructions attached for the users.

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* John G. Haaga was Project Director, MCH-FP Extension Project, ICDDR, Bangladesh, from 1991 to 1993. Rushikesh M. Maru was an Associate of The Population Council, Dhaka, Bangladesh, at the time the article on which this item is based was written.

** Matlab is the major field research station of the International Centre for Diarrhoeal Disease Research, Bangladesh.

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## GTZ ... *continued from page 7*

Suggested **topics for discussion** include: Advocacy for health research and development; priority setting; capacity building; resource mobilisation; evaluation; dissemination of results; utilisation of research results, and networking.

To subscribe to the mailing list, send an electronic mail message to 'majordomo', the software programme that handles all the messaging for AFRO-NETS: majordomo@usa.healthnet.org

Type the following commands only in the text of your message (leave the 'Subject' line empty):

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***For further details and enquiries, contact***: Dieter Neuvians, MD, Health Systems Research, Southern African Region, P.O. Box 2406, Harare, Zimbabwe; Tel 263-4-733 696 • Fax 263-4-733 695 • E-mail: neuvians@harare.iafrica.com

# UPCOMING EVENTS

## MEETINGS & CONFERENCES

### JUNE 2–6, 1997

**IV Latin American Congress on the Social Sciences and Medicine.** First Announcement

*Location:* Cuernavaca, Mexico

*Contact:* For further details and application forms, write to: Dr Mario N. Bronfman, Instituto Nacional de Salud Pública, Av. Universidad No. 655, col. Sta. Ma. Ahuacatitlán, Cuernavaca, Morelos; Mexico 62508; Tel 52-73-11 11 40 • Fax 52-73-11 11 56 • E-mail: bronfman@servidor.unam.mx

*Description:* The themes of the Congress include: Social Sciences and Medicine at the End of the 20th Century: Balances and Perspectives (Plenary); Health Systems Reform and its Problems: Financing, Privatisation, Coverage, Decentralisation and Equity; Inequality and Health: New Evidences of Class, Gender, and Ethnicity; Organisation, Management and Evaluation of Health Services. The registration fee is US$100.

### OCTOBER 12—16, 1997

**8th International Congress of the World Federation of Public Health Associations.**

*Hosted by:* The Tanzania Public Health Association

*Location:* Arusha International Conference Centre, Arusha, Tanzania

*Contact:* Professor W.L. Kilama, Director General, National Institute for Medical Research ( NIMR ), ENHR Task Force Secretariat, P.O. Box 9653, Dar-es-Salaam, Tanzania; Tel 255-51-307 70 • Fax 255-51-306 60 • E-mail: Wkilama@costech.gn.apc.org

*Description:* The Congress theme **Health in Transition: Opportunities and Challenges** was dictated by the realisation that there are today many changes affecting human health—either positively or adversely. The Congress Programme is expected to build around the following subthemes: epidemiological transition; new, emerging and re-emerging infections; demographic, environmental, and social and economic transition; health sector reform; nutrition; technical cooperation; gender issues; ethics; family health; capacity building; accidents, disasters and wars; health research in transition.

The Congress deliberations would constitute substantial inputs in the ongoing exercise on Renewing Health for All.

## COURSES

**Management Methods for International Health**
*Dates:* February 6–May 2, 1997
*Location:* Boston University School of Public Health, Center for International Health

*Contact:* A brochure about the programme describing its content, faculty and fees is available from the Center for International Health, 53 Bay State Road, Boston MA 02215-2101 USA. Tel 617-353 4524 • Fax 617-353 6330 • E-mail: cih@bu.edu
*Description:* The format of this programme combines case studies, group discussion, problem-solving exercises and lectures. Intended for all health personnel who have, or expect to have, managerial or supervisory responsibilities, this course addresses the practical application of management principles in the public and private health sectors of developing countries.

**Research & Evaluation for Program Development**

*Dates:* 9 April–21 May, 1997
*Location:* CICHS/University of Connecticut Health Center
*Contact:* University of Connecticut Health Center, 263 Farmington Avenue, Farmington CT 06030-6330 USA. Tel (860) 679 1570 • Fax (860) 679 1581 • E-mail: fosterbey@nso1.uchc.edu
*Description:* Designed for national and regional directors and administrators, coordinators of special programmes (e.g. family planning, infectious disease control), data managers, and researchers in ministries, universities, and non-governmental organisations, the course is directed toward the development of skills necessary for systematic and ongoing data-gathering and analysis, leading to effective programmatic evaluation and policy and operations-related research. The course uses an applied research and evaluation methodology tested cross-nationally in developing countries.

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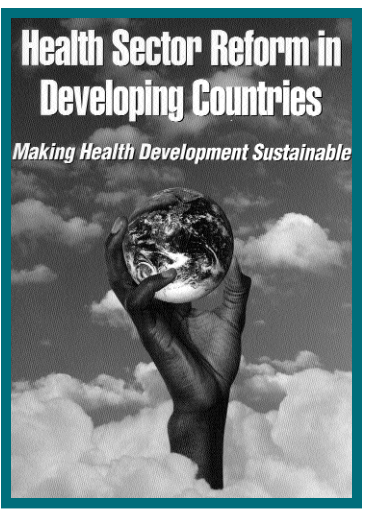
**Training Package: Training Course for Health Committees and Health Staff**
United Nations Children's Fund, UNICEF
Consisting of 19 modules which can be used separately or together, this training package has been developed for the following purposes: to build capacity of health committee members and health staff to interact with each other and work with communities; to provide community members and health staffs with the necessary skills to make informed decisions on the best use of available resources; to improve the management of resources at health unit level, i.e. management of staff, drugs, equipment, finance, time.

***For more information, contact:*** Dr Kasa Pangu, Senior Advisor, Health Section, TA-24A, UNICEF, 3 UN Plaza, New York, NY 10017, USA. Tel 212-824 6339 • Fax 212-824 6462 • E-mail: kpangu@unicef.org

# PUBLICATIONS

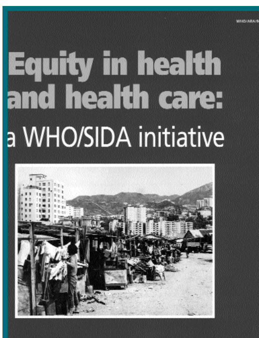
TOWARDS A HEALTHY SOCIETY: CASE STUDIES IN HEALTH SOCIAL SCIENCE PARTNERSHIPS IN ASIA-PACIFIC REGION. Eds. Kalinga Tudor Silva and Pilar Ramos-Jimenez. Social Development Research Center, De La Salle University Press and Asia Pacific Network (APNET) of the International Forum for Social Sciences in Health. 1996. 135 pages. ISBN 197-555-123-8.
This book presents some examples of cases of partnership experience in health social science in Hong Kong, India, the Philippines, Sri Lanka and Thailand. The case writers in the areas of teaching, research, advocacy, and health service delivery raised obstacles and rewards obtained from partnerships with various sectors as well as issues crucial for effective collaboration in the Asia and Pacific context.



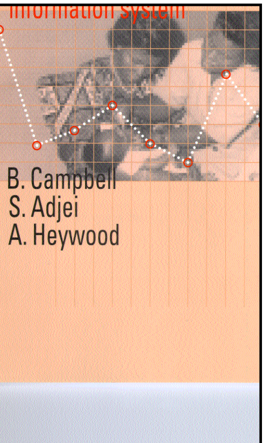

HEALTH SECTOR REFORM IN DEVELOPING COUNTRIES. *Making Health Development Sustainable*. Peter Berman, editor. Published in the *Harvard Series On Population and International Health*, Department of Population and International Health, Harvard School of Public Health, Boston, Massachusetts, 1995. 418 pages. Harvard University Press, ISBN: 0-674-38525-X.
This volume collects seventeen papers contributed by distinguished international health professionals to the DDM (Data for Decision Making) conference *Health Sector Reform in Developing Countries: Issues for the 1990s*, held in Durham, New Hampshire, in September 1993.
At the focus of these papers is a formidable challenge which faces wealthy economies and developing nations alike. This challenge is to provide health care that meets the needs of a nation, satisfies the demands of many different groups in the population, and adapts flexibly to the rapidly changing capabilities of modern medicine, but which does not pose an impossible financial burden on families and the national economy and which is both sufficient for today and sustainable to meet the uncertainties of the future.
The collection is organised into three sections. The first section sets out the theories and concepts underpinning reform efforts. The second provides a description and analysis of a variety of recent experiences in vastly different parts of the world, while the final section deals with practical concerns of moving from theory to action.
The book provides valuable insights and information to both generalists and specialists interested in how health care will look in the world of the 21st century.

THE CURAÇAO HEALTH STUDY. **Methodology and main results.** J.F. Alberts, et al. Published by Northern Centre for Health Care Research, Groningen, The Netherlands. In Curaçao: the Foundation for Promotion of Research & International Cooperation in Healthcare ISOG 2000. 1996. 119 pages.

ISBN 90-72156-36-7.
The Curaçao Health Study is the first large-scale health interview survey in the Caribbean region. This book presents the main results of the study. It discusses the population's health status, use of health services, and satisfaction with health care. Attention is focused on the identification of high-risk groups in need of specific policy interventions and health promotion programmes.




**Equity in health and health care: a WHO/SIDA initiative**. A non-formal publication of the World Health Organization (Doc. WHO/ARA/96.1), Geneva, Switzerland, 1996. 51 pages. Available on request from: Division of Analysis, Research and Assessment. World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.
This document describes the above initiative which aims at placing equity in health and health care higher on the public policy agenda and to evaluate and promulgate promising practical approaches to achieving equity in health development.




**From data to decision making in health**. The evolution of a health management information system. B. Campbell, S. Adjei, A. Heywood. Royal Tropical Institute – Amsterdam, The Netherlands. 1996. 96 pages. ISBN 90-6832-096-3. Price approx. US$18. The book can be ordered from: Royal Tropical Institute (KIT), Publication Dept, Mauritskade 63, 1092 AD Amsterdam, The Netherlands. Tel 31-20-568 82 72 • Fax 31-20-568 82 86.
The book summarises four years of practical experience in Ghana in transforming the existing masses of underutilised data still being collected by peripheral health workers into a meaningful decentralised information system apt to guide decision-making by the same health workers. It will be of practical relevance to most district or regional-provincial health officers and senior level health planners and policy-makers throughout the developing world. Students of public health, nursing or medicine, local NGOs and international institutions and/or donor agencies should also find the document most useful.