

HEALTH SYSTEMS RESEARCH

Does it make a difference?

The Joint Project
on Health Systems Research for Eastern and
Southern Africa

Joint HSR Project
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Dr Corlien M. Varkevisser, Manager Joint HSR Project 1987-1991
Dr Yvo Nuyens, HSR and Development Programme Manager, WHO/HQ
Dr Gordon Stott, Consultant to the HSR Programme, WHO/HQ

Second edition (1992):

Contributions and revision by:

Mr Leon A. Bijlmakers, Associate Professional Officer,
Joint HSR Project 1989-1992

Dr Gabriel M.P. Mwaluko, Manager, Joint HSR Project since 1992.

Third edition (1995):

Contributions and revision by:

Mrs. Amanda le Grand, Professional Officer,
Joint HSR Project 1992-1995

Prof. Gabriel M.P. Mwaluko, Manager, Joint HSR project since 1992.

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HEALTH SYSTEMS RESEARCH - DOES IT MAKE A DIFFERENCE?

PREFACE TO THE THIRD EDITION

This is the third version of Health Systems Research: Does it make a difference?. It comes five years after the first version was published. By now, we should be able to answer the question whether Health Systems Research (HSR) makes a difference or not.

The Joint Project on Health Systems Research for the Eastern and Southern African Region has been active in promoting HSR for almost ten years. The great enthusiasm for the Joint HSR Project is stronger than ever, as may be shown by the following observations: The number of countries in the Southern Africa Region involved in HSR has increased over the years from 5 to 14 core countries, with the number of new, associate and observer countries increasing all the time. In addition, another six countries from outside the region have expressed interest in HSR and participated in some HSR activities.

All countries participating have established either an Unit or a Focal Point for HSR in the Ministry of Health. Apart from Ministries of Health, also universities and NGOs who expressed the wish to be involved and trained in HSR have been assisted. Three universities now have a focal point for HSR, and several meetings and training workshops have been held for NGOs in different countries. A hundred research projects have been developed and completed during HSR training workshops. All research projects resulted in recommendations for improving the health care services. Two internal evaluations revealed that about half of the recommendations have indeed been implemented.

These observations show that the spirit for HSR is there. Three external evaluations have all been very positive and recommended extension of the project. While the second phase comes to an end in December 1995, a proposal has been made for the Third phase of the project, covering the period 1996-2000. The enthusiasm of all different stake holders in HSR remains high, and we are positive that HSR will be further consolidated before the end of the century.

In the Third phase, the executing agency of the HSR Project will be WHO/AFRO, which has committed itself to develop HSR into a regional HSR programme. The target is to get all the member countries benefitting from the HSR experience as a problem solving, action oriented and timely health research system for development.

*Dr. E. Samba
Regional Director AFRO*

FOREWORD

The title of this publication has been derived from a letter from Dr J.M. Last¹ published in 1977 in the New England Journal of Medicine entitled 'Health services research - does it make a difference?'. Based on an extensive review of articles over the period 1950-1969, Last concluded that "...with trivial and mostly unimportant exceptions, health services research had no impact on medical or social policy".

Much has changed since Last wrote his provocative letter. Health and health services have come to be seen in a much broader social, cultural and economic context, the interrelated parts of which are today considered as constituting the health system. The question may now be rephrased - Health systems research: does it make a difference?

Health systems research is an approach which aims to improve the health of the people by making optimal use of research. It aims to provide relevant information to health managers and policy makers at all levels to assist them in adequate decision making. The concept of Health Systems Research (HSR) has been developed particularly to address the problem of poor utilisation of research results.

Over the past few years, there is growing recognition that health systems research is a useful tool to empower policy makers in informed decision making. World-wide, many initiatives were undertaken to strengthen HSR: the Commission of Health Research for Development; Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, the GTZ MCH/FP Network for Health Systems Research in Southern Africa, and the Joint WHO/RTI/DGIS Project on Health Systems Research for the Southern African Region - which is described in this booklet, have all supported Health Systems Research.

The Joint Project started in 1987 with 10 countries. Currently 14 countries in the Southern African region are formally participating, while several other countries have been involved as observers in HSR activities. By carrying out health systems research on topics of recognized national importance, the Project contributed to the process of getting policy-makers directly involved in setting research priorities and using research findings. Early 1992 the Joint Project entered its second phase of operation for another four years. In its nine years of existence, all Ministries of Health involved in the HSR Project established a Unit or focal point for HSR. With a growing awareness of the usefulness of HSR, the demand for HSR has been increasing. New countries are joining the Project, while the need for continued training and sensitisation in HSR in the core countries continues.

In the third phase, the Joint HSR Project will, among other priority issues, address the role of HSR for Health Sector Reforms. Emphasis will also be on decentralisation and sustainability of HSR.

The purpose of this publication is to bring the concept and the approaches of HSR used by the Joint Project to the attention of health policy-makers, administrators and researchers at national and international level. It is hoped that this publication will:

The purpose of this publication is to bring the concept and the approaches of HSR used by the Joint Project to the attention of health policy-makers, administrators and researchers at national and international level. It is hoped that this publication will:

- provoke discussion and thinking on HSR;
- stimulate new approaches and initiatives in this field; and
- expand or develop comparable programmes in other parts of the world.

Health Systems Research not only has the potential to influence health policies, but it is increasingly being regarded as an essential component in the formulation and implementation of such a policy and in the overall social-economic development.

1. INTRODUCTION

1.1 The focus of Health Systems Research (HSR)

Although there have been great advances in health science and technology over recent decades, the health conditions of many millions of people, particularly in the developing world, remain highly unsatisfactory and a cause for deep concern. One of the reasons, apart from scarcity of resources, is that health delivery systems in most countries have been unable to absorb these technologies and to bring them within the reach of the majority of the population.

The crux of the problem and the challenge for the future lie in the adaptation of the knowledge and technologies already available so as to make them more relevant, appropriate and applicable to the needs of the community and the health care system into which they are to be integrated.

The selection, adaptation and utilization of health technologies and the contribution they make to the physical, mental and social well-being of the population constitute the field of Health Systems Research. HSR is thus concerned with the identification of needs as much as with the finding of solutions. In all of this the community has an important role to play.

The potential benefits of Health Systems Research, both in costs and outcomes, are widely recognized and most countries have initiated in recent years some Health Systems Research and development activities. However, various country reviews have shown that geographical coverage and progress in quantity, quality and impact have, to date, been limited.

Health Systems Research (HSR) is ultimately concerned with improving the health of the target population, by enhancing the efficiency and effectiveness of the health system as an integral part of the overall process of socio-economic development. Stated simply, Health Systems Research aims to help solve practical problems, target resources on high-priority areas, improve the efficiency and effectiveness of health policies and programmes, and reduce the cost of health care.

Box 1: Characteristics of Health Systems Research

HSR is:
• <u>problem and action oriented</u> , studies specific problems to find feasible, practical and affordable solutions;
• <u>participatory</u> , requiring active and continuous collaboration between those who identify the problems to be studied and who are the main potential users of the research results (the health systems managers) and those who search for the facts and suggest alternative solutions (the researchers);
• <u>multisectoral</u> , deriving its inputs from various social and economic sectors;
• <u>multidisciplinary</u> , requiring contributions from a wide variety of disciplines best obtained through a team approach (which in itself presents technical and managerial challenges); and
• <u>replicability of methodologies used</u> , which can be applied to similar problems in different countries.

While HSR methodologies can be applied to similar problems in different settings, the findings and solutions to these similar problems are unlikely to be the same, due to differences in cultural, social, economic and political realities. This last fact is one of the strong arguments in support of the need for a national core of Health Systems Research, with external technical support whenever needed.

1.2 Policy basis for HSR

The mandate to develop Health Systems Research programmes in specific countries and in WHO in general, stems from various resolutions formulated during the last few years by the World Health Assembly, the Executive Board, Regional Committees, and Global and Regional Advisory Committees on Health Research.

The WHO Health Systems Research and Development Programme contains a range of activities aimed at fostering national and international action to promote awareness of the value of HSR. It hopes to achieve this aim by strengthening national capabilities for HSR and by supporting HSR projects, the results of which can be applied to improve the performance and efficiency of national health systems in the future.

In 1986, WHO convened a Health Systems Research Advisory Group which endorsed these main approaches and recommended their adoption and implementation in all six WHO regions.³ In 1987, WHO formulated the Global Medium Term programme on HSR for the period 1990-1995. This 5 year programme set the target that by 1995, 70% of countries would be carrying out HSR as part of their managerial process for health development, and would be using the findings in policy making and in the development, organisation and functioning of the health system.⁴

1.3 Health Systems Research in the African Region

In the early 1980s, a number of institutions in the African region were selected to lend support to Health Systems Research, and several national, sub-regional and regional courses and workshops were organized to enhance this effort.

A WHO Study Group on Health Systems Research (Brazzaville, February 1985) recommended that the network of national Health Systems Research centres should be extended, that the institutions should develop training in research methodology, and that steps should be taken to guide decision-makers and inform them of the potentialities of HSR.

Later, at a meeting in Lusaka, September 1985⁵, the Regional Director of WHO/AFRO was requested to:

- È continue collaborating with Member States in development and strengthening of national mechanisms for identification and periodic review of national research priorities relevant to health for all strategies;
- È promote health-related research on social, economic and behavioural determinants of health and their interaction; and
- È support national health research councils or similar bodies as an essential element in the formulation of national research policies.

2. THE JOINT WHO/DGIS/RTI PROJECT ON HEALTH SYSTEMS RESEARCH

2.1 Origin

In the course of a policy meeting, early 1985, it became clear that the Netherlands Ministry of Development Co-operation (DGIS), WHO and the Royal Tropical Institute shared a common concern over the state of primary health care implementation in Africa. Convinced of the valuable contribution that properly organized Health Systems Research could make to improve the situation, the three organisations pooled resources and initiated the Joint WHO/RTI/DGIS Project on HSR for the Southern African Region. The Southern African region was considered the most appropriate setting for a joint initiative of this nature as the political climate in this region was favourable towards HSR.

To ensure that the Joint Project would fully reflect country needs and priorities, a meeting was held in May 1986 in Harare, Zimbabwe, with representatives from Botswana, Malawi, Mauritius, Tanzania and Zimbabwe. These five countries had expressed their interest in participating in a joint project and had some experience in this field. These representatives participated in the development of the project proposal for the first phase of the Joint HSR Project.

Before the end of Phase I of Project (1987 - 1991) twelve countries were actively participating and in the Phase II, fourteen countries are core participants while a number of new, associate and observer countries continue to enquire on the Joint Project activities with the aim of participating.

2.2 Objectives

The mission of the Joint HSR Project is

È to promote health in the countries of the eastern and southern African region through a more appropriate organization and effective operation of comprehensive primary health care activities, by integrating Health Systems Research in the decision-making process at all levels.

The following were the objectives of the first two phases of the Joint HSR Project:

1. Strengthen structures and mechanisms to promote Health Systems Research in the countries of the Southern African region.
2. Increase the capacity of health and health-related staff as well as of researchers to develop and implement Health Systems Research.
3. Provide technical and financial support for the development and implementation of Health Systems Research proposals.
4. Promote the utilization of Health Systems Research results at all decision-making levels.
5. Facilitate the mutual exchange of expertise and experience in Health Systems Research between the countries of the eastern and Southern African region and also, if possible and requested, other countries.

Short-term objectives:

6. to form a critical mass of trained and experienced researchers in the countries, capable of developing and implementing Health Systems Research;
7. to prepare and implement research proposals on critical issues pertaining to the reorientation of national health systems towards health for all, in response to priority needs as defined by countries; and
8. to increase the utilization of the results of these research projects in the decision-making process at all levels.

Medium-term objectives:

9. to strengthen institutional resources in Health Systems Research in the countries concerned;
10. to increase the credibility and capability of national professionals and institutions in this field; and
11. to develop intra-country and intercountry institutional networks.

2.3 Target groups and approach

During the first and second phase, the Joint Project served 14 countries of the Eastern and Southern African region, contained in the then WHO Sub-region III: Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Sao Tome and Principe, Seychelles, Swaziland, Tanzania, Zambia and Zimbabwe. In the same period, also several countries from outside the sub region participated in some HSR activities: Cameroon, Ghana, Guinea Bissau, Kenya, Uganda, and South Africa. In the third phase, Comoros, Kenya, Uganda, South Africa and Zanzibar will formally take part in the activities of the Joint HSR project, while Guinea Bissau will join the Lusophone countries.

To attain the Joint Project's objectives, raising awareness, interest and commitment to Health Systems Research of policy-makers and senior managers is crucial. Equally important is the active involvement of health workers and the participation of community members in the different phases of the research process. Also non-governmental organisations and university staff have to be involved in HSR.

A flexible and pragmatic approach to project implementation was proposed, placing special emphasis on:

- *institutional development* to ensure the sustainability of Health Systems Research;
- *training* to strengthen national capacities in this area; and
- *research* to improve the basis for informed decision-making in health at all levels, starting from the community up to the national level.

2.4 The first phase

The Joint Project on HSR became operational in March 1987 and was originally planned for a period of four years. The total budget was US\$ 2,860,000, of which DGIS contributed the major share of US\$ 2,600,000, while WHO/HQ and WHO/AFRO contributed US\$ 200,000 and US\$ 60,000 respectively.

The WHO Country Office in Harare, Zimbabwe (formerly named WHO Sub-Regional Office III) became the basis of operation for the Joint Project. The Royal Tropical Institute provided a Project Manager for the entire first phase, which was extended to four years and nine months. DGIS sponsored three Associate Professional Officers (APOs), appointed by WHO for periods of two to three years each, to support the Joint Project. Additional technical support was made available through the Royal Tropical Institute and WHO/HQ on request.

All parties supporting the Project (WHO/HQ, WHO/AFRO, WHO subregional Office, DGIS and RTI) were represented in a Project Steering Committee, that met either once or twice yearly to advise the Project Manager on policy issues.

Two external and one internal evaluation confirmed that the Joint Project fulfilled essential needs. It appeared to have noticeable effects in terms of:

- increased awareness of the utility of HSR at all levels of health systems;
- increased research and management skills among participants, facilitators and organisers of HSR training courses; and
- implementation of problem-solving measures recommended by the research projects that resulted from such courses.

Some progress had also been made with the establishment and/or strengthening of local structures and mechanisms to support HSR: all Ministries of Health involved in the Joint Project had a Health Research Unit, or at least a Focal Point for HSR, and in most countries some manpower and funds had either been set aside by the Ministry of Health or obtained from multi- or bilateral agencies to help the unit function.

2.5 The second phase

The same sources that were so positive about the first phase of the Joint Project also strongly pleaded for its continuation, since they recognized that the achievements were at different stages in the participating countries.

Therefore, a project proposal was prepared for the second phase, in which the same parties were involved - WHO/HQ, WHO/AFRO, DGIS and RTI. The second phase extended from January 1992 to December 1995, with a total budget of US\$3,000 000. DGIS made again the largest contribution of US\$2,925,000, while WHO/HQ and WHO/AFRO contributed US\$25,000 and US\$50,000 respectively.

A new Project Manager, recruited from the sub-region, was again provided by the Royal Tropical Institute. He was over the period of four years supported by three WHO Associate Professional Officers, one from the Netherlands and two from the sub-region, all sponsored by DGIS.

A Technical Advisory Committee was created in Phase Two to assist the Project Manager with operational issues and to make recommendations to the Steering Committee. See figure 1 for the organogramme. The Project Management provides the secretariat to the Technical Advisory Committee, which meets once yearly.

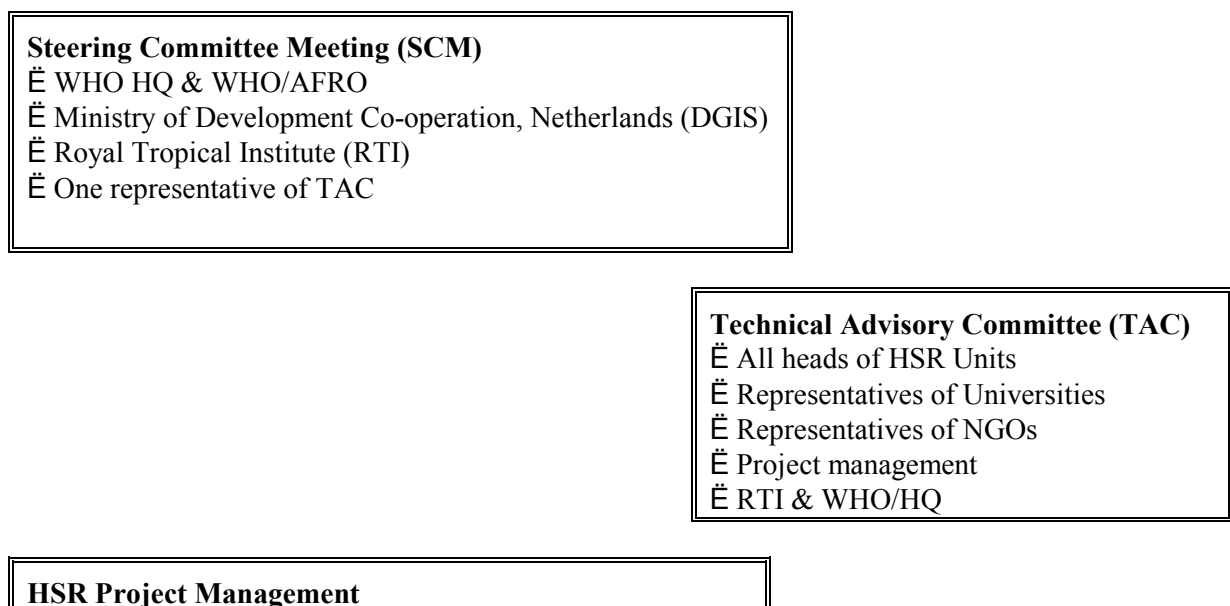
The Steering Committee which was established in the first phase continued to advise the Project Manager on policy issues. In addition to representatives of the original parties also a representative of

Technical Advisory Committee (TAC), elected annually by the TAC, took part in the Steering Committee Meeting. Terms of References for the Steering Committee and the Technical Advisory Committee can be obtained from the Project Manager.

The objectives of the first phase, as enumerated above remained valid for the second phase. In addition, the following guidelines were developed:

- Guidelines for HSR 2nd phase:**
- continued support for HSR promoting structures at national and provincial levels;
 - continued support for HSR training courses, including implementation of research projects, at provincial and district levels;
 - making available funds for the implementation of small problem solving research projects, as well as for policy supporting and evaluating research;
 - increased support for inter-country HSR activities;
 - support of multi-centre research projects on topics of common interest and policy issues;
 - initiation of HSR activities in Universities and other countries in the southern African region who have shown interest in HSR;
 - increased transparency of the activities of the Joint Project within and outside the region through publications and advocacy.

Figure 1: Organisational Structure of Joint HSR Project, 1987-1995



• Project manager • 2 APOs • WHO Harare office with technical support provided by the Royal Tropical Institute (RTI)
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2.6 The third phase

During the second phase, two external and one internal evaluation took place, and all recommended a continuation of the HSR Project into a third phase. While the project had made extensive progress in terms of awareness building, capacity building and institutionalising HSR, it was felt that another few years would be required to make the project sustainable. Therefore, two major changes were proposed for the Third phase: decentralisation and multi-donor support. The HSR project should acquire larger local ownership than before by expanding to the Steering Committee Meeting of the HSR Project (see figure 2 for the proposed new organogramme). Decentralisation was also sought by shifting the responsibility for execution of the project from WHO/HQ to the Regional Office of WHO (AFRO). Multi donor support would decrease dependence on one major donor.

A formulation meeting was held in March 1995, to which all parties concerned were invited (WHO/HQ, WHO/AFRO, RTI, and Project management), as well as 4 country representatives, including someone from the universities. In addition, COHRED was invited because of its long experience in HSR and IDRC requested to participate because it had shown interest to start a similar project targeted at Francophone countries in West-Africa.

The formulation meeting resulted in a draft project proposal, which was sent to all countries for their comments and approval. After approval of the proposal by all participating countries during the World Health Assembly (WHA) in Geneva, in May 1995, the draft proposal was further revised and finalised by WHO/AFRO, and submitted to donors. The new proposal has again been circulated to all country representatives, for transparency and any comments. Three resource mobilisation meetings were planned. The first was held in Harare in August 1995 to sensitise local representatives of donor agencies, the second was held in The Netherlands in October 1995, while the third was held in November 1995 in Arusha, Tanzania.

For the Third phase, the objectives have been reformulated as follows:

Mission of HSR for 1996-2000:

to promote health in the countries of the Eastern and Southern African region through improved performance of the health care system, based on the principles of equity, participation and quality, through integration of Health Systems Research in the decision and policy making process at all levels.

Specific Objectives

1. Support countries to develop a National Health Research Policy
2. Support countries to develop strategic and annual plans for HSR

3. Promote the establishment of appropriate and operational structures and mechanisms for coordinating HSR
4. Encourage countries to allocate adequate resources to implement HSR plans
5. Assist countries to integrate HSR in curricula of relevant training institutions
6. Provide technical support to implement and evaluate HSR projects, on both policy and operational issues
7. Promote incorporation of HSR in national health programmes
8. Support utilisation of research results in the decision making process
9. Provide financial and technical support to create and maintain data banks on HSR
10. Support effective technical co-operation among participating countries and other partners in HSR

In the Third phase the organisational structure changes as follows: the Steering Committee will be enlarged, to involve, for each country either the Minister of Health or Permanent/Principal Secretary or the Chief Medical Officer. As such, all countries will be represented at the highest possible level. The TAC will continue as before.

The total budget for the Third phase is made up of approximately US\$6,600,000.

3. STRATEGIES FOR IMPLEMENTING HSR ACTIVITIES

In the Joint HSR Project, a number of strategies were used to advocate HSR:

- Intercountry meetings
- Country Support visits
- National Consultative Meetings
- Training
- Strengthening structures and mechanisms
- Networking
- Technical and financial support to countries
- Resource mobilisation

Each of these strategies will be discussed in the sections below.

3.1 Intercountry workshops on HSR

From the beginning of the Joint Project, it has been a matter of principle to secure the full involvement of policy makers, health managers and researchers of the countries in the sub-region. The first activity of the Project was, therefore, the organization of an intercountry workshop on HSR (July 1989 in Harare, Zimbabwe) to exchange experiences, define local needs and resources, and to specify the possible role of the Joint Project in supporting Health Systems Research efforts in the sub-region.

Representatives of 10 countries (Botswana, Lesotho, Malawi, Mauritius, Mozambique, Seychelles, Swaziland, Tanzania, Zambia and Zimbabwe) attended the workshop. They made inventories of HSR achievements, constraints and needs in their respective countries, including:

- Ë main activities carried out in the field of HSR thus far;
- Ë structures and potential for HSR in the country;
- Ë HSR priorities; and
- Ë specific needs for strengthening HSR activities.

From the discussions of the country presentations it was apparent that some HSR activities had been carried out in all the countries. The nature and extent of these research activities, however, varied with each country's state of socio-economic and health system development. Problems and constraints that were identified varied between countries. A summary is presented in box 2.

Box 2. Problems and constraints in HSR

- Ë Resources were not adequate in certain countries, especially in terms of manpower. There was a lack of trained manpower at the periphery and a high attrition rate of the few trained personnel available. Training facilities were also inadequate.
- Ë There was insufficient documentation on research projects and their results were, therefore, not available for utilisation by decision-makers.
- Ë The non-involvement of decision-makers in the planning and formulation of research activities meant that research results were not used for management and planning for health development.
- Ë There was no coordinating body to set research priorities, develop a research data bank and monitor the utilization of research results.
- Ë There was no sub-regional information system network for the exchange of information and relevant technical literature.
- Ë The funding of research, especially in universities, was not coordinated with, or geared to support the information needs of health systems development.
- Ë The process by which research priorities were established in most countries did not take sufficient account of managerial and developmental needs and the problems at the front line of health care delivery

The concept of HSR in the southern African context was extensively discussed and its multisectoral setting emphasized. Against the background of the various country papers, tentative action plans for each participating country were prepared by the country representatives. All this contributed to a very positive start of the Joint Project.

Although action plans and priority areas for intervention differed between the various participating countries, all delegates agreed on three main areas for concentrated effort:

- Ë strengthening of local structures to promote HSR;
- Ë strengthening of local capabilities to conduct HSR; and
- Ë enhancing internal and intercountry communication with respect to HSR.

The workshop recommended that the tentative plans⁶ be implemented by the respective Ministries of

Health, with support from the Joint Project. A number of recommendations were also made on how the Project could promote the systematic exchange of experiences between countries and provide support for the implementation of the various national plans of action.

3.2 Country support visits

After the First Inter-country Workshop, the next step for the Joint Project was to follow-up the country action plans through country support visits. Such visits permitted elaboration on the country's needs and resources for HSR, and in-depth planning for further activities with support from the Project. During those first country visits, most of the Ministries of Health designated one of their officials to maintain regular contact with the Project and to ensure that the planned activities would be carried out.

Further steps following these country support visits depend on the stage of development of HSR in the respective countries and on their priorities:

Some countries first want to concentrate on *consensus building* through consultative meetings with health policy-makers, managers and researchers, to create a suitable climate for the promotion of HSR.

Others immediately opt for *development of skills* by training workshops, to build a pool of appropriate research and managerial skills in the country.

All countries stress the need for *consolidation* by means of creating or strengthening organizational structures and mechanisms to sustain the use of HSR as a management tool.

Experience in several countries suggests that these are three overlapping phases in national capacity building. Each phase may need periodic renewal until its objectives are achieved.

3.3 Consensus building

A national consultative meeting may last one or two days and is held to sensitize, build consensus and develop action plans. Participants (20-40) usually include senior policy-makers, health managers, researchers and lecturers/teachers with decision-making power in institutions that wish to work together to prepare a national programme. The exact form and agenda of a consultative meeting varies depending upon the HSR mechanisms already in place within the country, the types of participants who attend and give presentations, and national policies and circumstances.

Box 3: Objectives of National Consultative Meetings

- | | |
|---|---|
| • | sensitize policy-makers, health managers and researchers to the value of HSR in planning, management, and evaluation; |
| • | identify HSR needs to support policy and programme development and assist in solving operational problems; |
| • | review current HSR activities and co-ordination mechanisms at the national level, and problems or deficiencies in the use of HSR as a policy development and management tool; |
| • | identify potential mechanisms to promote and coordinate HSR within the Ministry of Health |

and between the Ministry and other organizations so as to provide relevant and timely information for decision-making; and

- prepare a plan of action for developing more appropriate structures for coordinating and supporting HSR at the national and, possibly, provincial/regional levels.

An exemplary type of programme that works best in consultative meetings is given in box 4.

Box 4: Exemplary programme for Consultative meeting

- a presentation on the concepts, scope and potential of HSR presented by the Joint Project with examples from other countries experiences, with case studies which illustrate how it has been used in the country being visited presented by a researcher/manager showing how research has led to support of programme and/or policy development and solve health management problems;
- an exercise in which participants identify research needs to support policy and programme development and to solve operational problems within the health system;
- a presentation by a representative of the Ministry of Health and a regional/provincial medical officer, summarizing some priority needs for HSR;
- presentations which review current HSR activities and co-ordination mechanisms at the national level, and problems or deficiencies in the use of HSR as a policy development and management tool;
- working sessions in which participants identify potential mechanisms to promote and coordinate HSR within the Ministry of Health and between the ministry and research institutions so as to provide relevant and timely information for decision-making; and
- working and plenary sessions in which a plan of action is agreed upon for developing more appropriate structures for coordinating and supporting HSR at the national and, possibly, provincial/regional level.

3.4 Development of skills

a) training materials

It was realized from the start that training in HSR skills would have to be done through locally available facilitators. Identification of suitable persons (in Universities, Research/Training Institutes or Ministries of Health) was therefore one of the major objectives of an initial country support visit. Some training materials on research methodology were already available but they needed modification. It was decided to revise them with the help of a multidisciplinary group of researchers from countries in the Southern African region. In February 1988, the Joint Project organized a workshop in Harare to develop training modules with 10 experienced researchers from Botswana, Lesotho, Malawi, Seychelles and Zimbabwe. Starting from training material developed in the early 1980's⁷ the team drafted a HSR Training Course⁸, strengthening the learning-by-doing orientation of the original material and carefully adjusting the methodology to HSR requirements. The course, as developed in

early 1988, divides training into three consecutive stages:

1. A first introductory workshop of 18 days in which the HSR approach is presented and groups of participants are guided step-by-step in preparing detailed research proposals on a priority problem in their own working situation;
2. A second stage consisting of a field work period of about six months, during which the various research projects are actually carried out by the respective groups of participants under the active guidance of local facilitators; and
3. Finally, a third stage, consisting of a workshop of two weeks, in which data gathered are analysed and interpreted, the findings are reported, and recommendations are made to help solve the problem investigated.

A fourth stage should be added, in which recommendations resulting from the research results are implemented, mainly by the researchers:

HSR Methodology Training Cycle

Stage 1 Proposal Development	Stage 2 Field work	Stage 3 Data analysis & Report writing	Stage 4 Implementation of recommendations
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The working hypothesis was that this approach would ensure, as far as possible, that the research would have a practical orientation, that it would be implemented, and that its results would be used. The courses are organized by Ministries of Health, with technical and financial support from the Joint Project. The training materials were further revised on the basis of the experiences gained in these training courses. They were also discussed in a technical working group convened by WHO and International Development Research Centre, Ottawa, Canada (IDRC) and subsequently they were published in 1991 and reprinted in 1992.⁹

**Health Systems Research Training Series
Volume 2.
Designing and Conducting HSR Projects
Part I. Protocol Development and Fieldwork
Part II: Data analysis and report writing
Varkevisser, Pathmanathan and Brownlee.
IDRC/WHO, Ottawa, 1992**

In the Third phase, it is planned to revise the training manuals again in order to better address community needs, and to suit more cost-effective training approaches. The revision will again be a collaborative effort of different organisations concerned with HSR, and involving a multidisciplinary team.

b) Facilitators

To further strengthen the pool of facilitators which can help conducting HSR training courses, as well as provide assistance to health workers who want to do their own research, the HSR Unit of the Ministry of Health in Zimbabwe, based in the Blair Research Institute, took up the idea of organizing a Training of Trainers (ToT) Workshop. The Joint Project staff welcomed this initiative, and in a joint effort in mid-1990 a set of training materials were developed for a one-week workshop.

The workshop covered three areas: educational methods, research methodology and management of HSR training courses. The research methodology part of the workshop was covered by a number of presentations on key issues in the training modules used in regular HSR Training Courses, each followed by a group work session during which participants criticized existing research proposals and made improvements, where necessary. This approach appeared quite successful, as the learning-by-doing element was preserved despite the fact that the actual implementation of the research proposals was not part of the training.

When evaluating the Training of Trainers workshop, it was decided, however, that in future workshops the aspects of data analysis and report writing should be covered more extensively. The duration of further ToT courses has therefore been extended to 12 days.

3.5 Strengthening national structures and mechanisms

For HSR to become fully established as an essential feature of the health-care scene, it must be brought within the ambit of research policy-making bodies and executive agencies able to take care of co-ordination, promotion, training, technical support, and dissemination of research results.

How such structures and mechanisms should look, has to be determined by the respective Ministries of Health, in consultation with health policy-makers, managers and researchers. When the Joint Project started in 1987, some experience already existed in the countries of the sub-region and the following elements were identified that could form part of national structures to support HSR:

- Focal points for HSR
- Health (Systems) Research units
- Health (Systems) Research Advisory Committees
- Technical Working Groups or Task Forces.

The Joint Project, in its original design, did not plan to provide funds or external expertise in support of the development of national structures for HSR. It rather has provided indirect support, for example by assisting in the drafting of long-term action plans and the identification of possible donors; by sponsoring fellowships to enhance the capacity of research units, and by supporting requests to other donors for temporary external expertise; and by providing technical and financial support for training courses and research proposals developed by research units (research proposals to a maximum of US\$ 20,000 each).

Each of the above mentioned structures are discussed below.

a) Focal Points

In order to be able to plan and implement HSR, it is essential that there is at least one person in the Ministry of Health who takes responsibility to co-ordinate needs and resources in health research, either part-time or full-time. Such a focal point will be responsible to formulate and focus research needs, and to ensure that research results reach their appropriate destination. He/she will be a central point where institutions volunteering to participate in health research can direct themselves to.

The most essential functions of an HSR focal point are listed in box 5.

Box 5: Functions of Focal Point for HSR

• make an inventory of research needs in the ministry and in the
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	field;
Ë	promote HSR, linking with research institutions such as the Faculty of Medicine, Sociology, Economics, the Institute for Development Studies; National Institutes of Medical Research and others.
Ë	collect research results and promote their utilization; and
Ë	promote training of health staff in HSR.

Focal points could be situated anywhere in the Ministry of Health but, in practice, it is usually the Planning Department or the Department of Epidemiology that takes this coordinating role, or a Research Institute such as the National Institute for Public Health, if it forms part of the Ministry. In some countries so little connection exists between research and training institutions relevant for HSR that it may be advisable to have a focal point for the co-ordination of training and implementation of HSR in the University as well.

b) Health (Systems) Research Units (HSR Units)

Ministries of Health that can afford it, may establish HSR units, with personnel available on a full-time basis. Various disciplines are preferably represented among the staff of a Health (Systems) Research Unit, for example, public health/epidemiology and medical sociology/health economics. As a unit has more manpower than a focal point, it can expand its functions, as presented in box 6.

Box 6: Functions of HSR Unit

Ë	assist in setting priorities according to research needs in the Ministry of Health and in the field;
Ë	delegate research to suitable institutions and follow up progress and results;
Ë	assist in the development of research proposals (by professionals as well as other health staff);
Ë	organize HSR training courses;
Ë	serve as a documentation centre for HSR;
Ë	disseminate relevant research results to health decision-makers in the ministry of Health, related ministries, and in the field; and
Ë	carry out HSR (for example, for policy preparation or evaluation, or for evaluation of certain health programmes or parts of programmes).

c) Health (Systems) Research Advisory Committees

Health (Systems) Research Advisory Committees bring together health decision-makers and health researchers to coordinate HSR efforts on a national scale. Such a Committee should, ideally, have members drawn from the main groups that are concerned with HSR: i.e. private research institutes,

universities, Ministry of Health, representatives of health managers at provincial/regional level, other health-related ministries, WHO, UNICEF and major donor agencies supporting health programmes.

A high-level representative of the Ministry of Health should preferably head the Committee to ensure that the research needs of the health system are communicated to research institutions, and that the findings of HSR will be applied. The Committee advises the Minister of Health.

Box 7: Functions of Health Research Advisory Committee

- Ë develop health research policy; develop strategies and draws long-term and annual plans for health research including HSR
- Ë set priorities for research, taking needs and resources into account;
- Ë pool local research resources, identify resources, and solicit the necessary additional resources to carry out the desired research;
- Ë evaluate the relevance and quality of proposed research projects;
- Ë monitor the progress of research projects; and
- Ë discuss the implications of research results for decision-making and ensure that such results are considered for implementation.

The Focal Point for HSR or the Head of the Health Research Unit should do the preparatory work for the meetings of the Committee and act as secretary. The Committee meets according to need but rarely more than three to four times a year.

d) Technical Working Groups or Task Forces

The Health (Systems) Research Advisory Committee may delegate the technical planning, monitoring and/or implementation of specific research projects or groups of projects to small task forces, formed on an *ad hoc* basis, ensuring that all relevant research disciplines to cover the topic are included. These working groups meet more often than the Committee, for example once or twice a month, depending on the stage of the research and progress made.

3.6 International networking

During the First Intercountry Workshop, suggestions were made on how to promote international networking of HSR expertise and experience. Further discussions with local experts during country support visits were instrumental in translating the suggestions into the following actions:

- Ë the publication of a newsletter for the sub-region;
- Ë the collective drafting of the training modules, which proved an extremely instructive experience for all concerned;
- Ë the standard practice that when the Ministry of Health in a country organises an activ-

ity such as a consultative meeting or a training workshop, it invites observers from neighbouring countries that intend to organize similar activities in the near future;

- the establishment of a small library of selected textbooks and journals on HSR in the WHO country office in Harare, and the distribution of the most important publications as "packages" to all national HSR units/focal points;
- establishing links with national and international institutions that are willing to do literature searches and photocopy articles for research projects carried out in the sub-region. The Joint Project also facilitates contacts between researchers who are developing similar research proposals.
- the organization of intercountry workshops on HSR on a regular basis (every two years).

3.8 Technical and Financial Support

Technical and financial support was given to countries either through support of HSR methodology training courses, Training of Trainers courses or support of individually elaborated HSR proposals within a set budget ceiling. During Phase I support was mainly on an individual country basis, while in Phase II support was mostly given at inter-country level.

The Joint Project has also provided technical support to participating countries to develop long-term plans for HSR.

3.9 Resource Mobilisation

Resource mobilisation for HSR has taken place for different activities and at different levels. Several individual countries participating in the HSR Project have managed to obtain funds for specific activities, such as HSR training courses and research projects. Some of the donors/ technical organisations which supported individual country HSR activities were DANIDA, GTZ, SIDA-SAREC, UNICEF, USAID, EC to name a few.

Several countries have developed a Long Term Plan for HSR, among others Botswana, Namibia, Mozambique, Zimbabwe, Zambia and Tanzania, but so far only Botswana and Zimbabwe have received funding for its long term HSR programme (from Norway for Botswana and from DGIS, the Netherlands for Zimbabwe). It is likely that the HSR proposal of Mozambique will also be funded by DGIS.

There has also been collaboration with partner organisations involved in HSR. GTZ funded a country visit on HSR to Cameroon, COHRED co-funded a country visit to Equatorial Guinea, and IDRC/COHRED and the Joint HSR project jointly organised and funded a country visit to four countries in West-Africa, which could be a pre-cursor for a West African Joint Project.

With the new efforts in 1995 to mobilise more donors for the Joint Project, hopefully more HSR long-term plans will be funded.

3.10 Overall approach

The various strategies described above that are used by the Joint HSR Project to develop and implement HSR, allow for a pragmatic and flexible response to country needs. Countries can join in HSR

activities when they feel they are ready for it, as there is always some activity going on in the sub-region in which they can participate.

If HSR in a specific country loses momentum - for example due to turnover of staff or organizational changes within the Ministry of Health - there are opportunities to catch up at a later stage. The mutual exchange of experiences is the main driving force of the Project.

4. ACHIEVEMENTS AND CONSTRAINTS

Since its inception in 1987, the Joint Project has attempted to support all countries of the Eastern and Southern African region that expressed the wish to strengthen HSR, applying various strategies in close collaboration.

4.1 Sensitisation

Sensitisation of HSR was among others enhanced by the organisation of intercountry meetings and by making country support visits. Intercountry meetings, which were held every two year, proved very useful as they enabled participating countries to share experiences with each other, and to sensitise new policy makers, health planners and health managers on the potential use of HSR. More details on intercountry meetings are provided in section 4.8 on networking.

All the English-speaking countries that participated in the first intercountry workshop were visited by the first Project Manager in the years 1987 and 1988.

In 1989, visits were made to Mozambique and Angola, and in 1991 Namibia was visited, one year after it gained its independence. Some countries required a second visit to re-enforce the HSR unit. This was done in 1992 and 1993 to Zambia, Tanzania, Malawi and Namibia.

The first visit to a French speaking country, Madagascar, was made in 1993. No country visits were done in 1994 due to many other activities. In 1995 Tanzania was revisited again at the request of the Permanent Secretary of Tanzania.

In 1995, a number of country visits were made outside the subregion, to Cameroon, Equatorial Guinea, Kenya and four countries in West-Africa: Benin, Burkina Faso, Mali and Guinea Conakry. The visit to Cameroon was funded by GTZ, the one to Equatorial Guinea was co-funded by COHRED and the visits to West-African countries were co-financed by IDRC, COHRED and the Joint HSR project. The latter visit took place as IDRC aims to initiate a similar project on HSR in West Africa.

4.2 Consensus building

In Zimbabwe, Swaziland, Tanzania and Zambia, consultative meetings were held in the course of 1988-1989. Between 1992-1995 consultative meetings were held in Namibia, Madagascar and Cameroon.

These meetings invariably revealed that local HSR resources and achievements were greater than expected, but it also became evident that:

- health decision-makers were often unaware of the research that had been done, let alone of the results;

- researchers were unaware of specific research needs within the health system and followed their own interests;
- within the health system no mechanisms existed to co-ordinate research needs, and to cater for research needs expressed at provincial or district level; and
- hardly any mechanisms existed for co-operation between, and even within, different research institutions.

As consultative meetings bring together health policy-makers and managers at national and provincial levels, and researchers from different disciplines, they provide an excellent opportunity to discuss these communication problems, their causes, and measures which should be taken to improve the situation. In all the countries concerned, concrete proposals were made and endorsed immediately or soon afterwards. The proposals dealt with: the location of a focal point for HSR within the Ministry of Health; the composition of interdisciplinary advisory committees on HSR; and the planning of training courses to strengthen local capabilities for HSR.

The immediate results of the National Consultative meetings show that HSR is considered of high value and that countries are committed to strengthen HSR.

4.3 Development of skills

Development of skills involves two components: training materials and facilitators.

a) Training Materials

As presented under section 3.3, training materials were developed with a group of local researchers in 1988. A set of 20 modules on 'proposal development and fieldwork' were pre-tested in training workshops of the Joint HSR Project before they were printed.⁸ The content was kept under review and modified in the light of experience and the comments of course facilitators and participants. Input was also obtained from trainers at the Public Health Institute in Malaysia, who had developed similar modules.

A second set of 10 modules on analysis of data and report writing were developed a year later by a small group of researchers from Malaysia, Zambia and Zimbabwe, who had experience in conducting HSR training courses. These modules too were used in training workshops and reviewed several times, before they were ready to print. The entire package was finally discussed in an IDRC/WHO technical working group, before it was published in 1991⁸.

All national HSR units in the Southern African region have been supplied with copies of these training modules, which are widely used in training courses as well as at universities. They are also suitable for individuals who would like to embark on their own research projects. The popularity of the training modules has resulted in their translation from English into French, Spanish, Portuguese and Arabic and the ever-increasing demand has made the Joint Project to request from IDRC permission to print their own copies. Permission was obtained and diskettes containing the training modules have been sent to all HSR Units in November 1995.

b) Facilitators

Most of the researchers who were involved in the development of training modules in 1988 have also acted as facilitators in training courses, mostly in their own countries. In order to prepare more peo-

ple for a future role as facilitators in HSR training courses, potential facilitators were invited to attend training workshops as observers. In this way, however, few facilitators can be trained.

To conduct an HSR training course, a minimum of four facilitators is required apart from the course organiser, who should also be acquainted with training/teaching, research, and the HSR training course in particular. A team of facilitators should preferably encompass different disciplines, with at least one public health physician and one social scientist with public health experience. In reality, facilitators come from a wide range of disciplines, including epidemiology, biology, dentistry, nutrition, economics, education and (bio)-statistics, but all have experience in public health.

There are several constraints in maintaining and expanding the pool of facilitators. Firstly, it is under constant pressure because all local and external institutions in need of research manpower compete for the same, highly skilled people. Secondly, due to the poor economic situation in many sub-Saharan countries staff of the Ministry of Health and Universities turned to apply for better paid jobs in private or international sectors. This braindrain affects all government sectors, and as HSR facilitators are drawn from the Ministry of Health and universities, the HSR Project has also been severely affected. The only remedy is to ensure that training of new facilitators keeps pace with or, preferably, surpasses the inevitable drop-out.

Selecting new facilitators from among the best participants of a previous training course is only possible if they have previously been exposed to the theory and practice of research, which is not always the case. To further strengthen the pool of facilitators, the Joint Project organised over the years five 12-day Training of Trainers Workshops, in which most of the countries from the sub-region participated, including Namibia and Madagascar, countries which joined the project only recently. Zimbabwe has even organised a second Training of Trainers Course.

The materials that are used for the Training of Trainers course now cover four areas: educational methods, research methodology, data analysis and report writing, and HSR course management. They are available from the Joint Project, but it should be noted that they are **different from Volume 5** of the IDRC/WHO HSR Training Series, which puts more emphasis on educational methods, and less on research methodology, data analysis and report writing.

Another effective way of obtaining a critical mass of experienced researchers who can support others in doing HSR is to encourage medical and social science faculties of universities to incorporate HSR methodology in the curricula for their students, so that the pool from which potential facilitators can be selected is strengthened on a permanent basis. Initiatives to strengthen HSR at the universities of Tanzania, Zambia and Zimbabwe started in 1992 (see chapter 5).

4.4 Research projects

Since the start of the Joint HSR Project, 23 HSR training courses, each including a research proposal development workshop, a field work period, and a workshop on data analysis and reporting writing, have been completed with technical and financial support of the HSR Project. Summaries of the HSR reports have been published by the Joint HSR project (see list of publications in annex 5).

Number of teams per country who attended HSR training courses, 1988-1995

Country	1988	1989	1990	1991	1992	1993	1994	1995	Total teams
Angola							2		2
Botswana		(4)				1	(4)		10
Lesotho			1		3	1			5
Madagascar							3		3
Malawi	4	4					1		9
Mauritius	1	4				1	1		6
Mozambique			4				1		5
Namibia					1	3	1	4	9
Seychelles	3				4		1		8
South Africa*							1		(25)*
Swaziland			2				1		3
Tanzania		4	4			2	1+1 (4)		16
Zambia*			4		4	2 (5)	1 (5)		21+?
Zimbabwe		4	5	5		3	1+1 (4)	(5)	24=?
Cameroon			1				2		3
Guinea Bissau							1		1
Ghana			1+1						2
Kenya						1			1
Total									

* The figures presented in () are funded from extra project sources. Some question marks are added, as the exact figures for those countries are not available, but known to be much higher, as many HSR training activities have taken place with extra project funding.

a) Training courses as part of the HSR Project

HSR Project training courses usually involve four teams of four to six participants. Each team develops and implements its own research project. The teams usually come from provincial or district level, often strengthened by one or two participants from national level or from a university or research institute.

Each team usually consists of people with different professional backgrounds: medical doctors, midwives, nurses, administrators, public health inspectors, nutritionists, social scientists. Participants may also come from health-related sectors such as education, agriculture or social welfare.

Annex 2 provides an overview of all the training courses and the titles of 104 completed research projects.

The topics can be grouped into five broad categories according to WHO classification. For each cate-

gory some examples are given.

A. Maternal and Child Health/ Family Planning and Nutrition

- . Maternal mortality (Malawi, Tanzania, Zambia, Namibia)
- . Neonatal, perinatal or infant mortality (Malawi, Mauritius, Tanzania)
- . Utilisation of child spacing services (Malawi)
- . Malnutrition (Tanzania, Zambia)

B. Disease control

- . Late reporting/defaulting of Tuberculosis patients (Lesotho, Zimbabwe)
- . Malaria (Malawi, Zambia)
- . Oral health (Malawi, Tanzania)

C. Primary Health Care, Water and Sanitation

- . Drug Provision and Use (Malawi, Zambia, Ghana and Mauritius)
- . Functioning of Primary Health Care (Cameroon, Ghana, Tanzania and Zambia)
- . Coverage and use of sanitation (Zimbabwe, Tanzania, Zambia)

D. AIDS/Sexually Transmitted Diseases

- . Condom use (Botswana, Tanzania)
- . IEC (Lesotho)
- . Knowledge, Attitude, Practice (KAP) (Malawi, Zimbabwe)
- . Incidence of gonorrhoea (Seychelles)

E. Management and Quality of Health Care Services

- . Staff attrition (Lesotho, Seychelles, Zimbabwe)
- . Patient congestions (Seychelles, Mauritius, Tanzania)
- . Collection of PHC data (Zambia)
- . Referral procedures (Kenya, Mauritius)
- . Perceived quality of care (Zimbabwe)

More and more examples are now available of countries which find their own financial resources and run the courses themselves (e.g. Botswana, Malawi, South Africa, Tanzania, Zambia, Zimbabwe). The Joint Project is asked either for training materials, facilitators or technical comments on quality of work done.

b) Training courses in HSR outside the HSR project

Zambia is currently in the process of health sector reforms and has embarked on a large training programme for all districts in HSR methodology in order to prepare them for the new tasks ahead once the decentralisation of health services, a part of Health Sector Reforms, is a fact. Zambia has also received bilateral funds from the Netherlands for HSR training to support the implementation of two PHC programmes in Western and Northern Province. As such, a large number of district level and provincial level health staff have been trained in HSR.

Zimbabwe has also obtained bilateral funds for HSR (again from the Netherlands) and has been organising several training workshops in HSR following the standard HSR approach.

South Africa has been involved in training in HSR methodology since 1992, when the Public Health Programme started its short courses in public health at the University Western Cape. The Medical Research Council of Cape Town ran a two week course in HSR methodology, including the whole training cycle: protocol development, field work, data analysis and report writing. In total about 600 health staff, academic staff and NGOs have been training in HSR methodology. An evaluation of the

HSR course run by the Medical Research Council revealed that despite its short duration, the approach has been quite successful and very well appreciated by the participants¹⁰.

4.5 Utilisation of research results

The extent to which recommendations that resulted from the studies have been implemented varies from research topic to research topic. The two main factors that were found to influence success, were: selection of a research topic that ultimately led to recommendations that could be implemented by the research team members themselves in their day-to-day work, involvement of policy-makers and support from the national health research unit in the finalization of reports and dissemination of results.

The Joint Project staff continues to monitor and promote the dissemination and utilization of research results and the implementation of recommendations. One of the strategies used to increase the involvement of policy-makers in HSR is to urge participants in training courses to select and discuss their research topics with health managers and policy makers prior to the course, so that they can be approved by local health authorities. Also, relevant authorities are usually invited to come and discuss the results and recommendations at the end of the data analysis workshop, before the reports are finalized. Some countries have institutionalised the organisation of a one-day symposia annually (Malawi, Zimbabwe, Zambia) to discuss research results with policy-makers and other researchers.

During the second phase, the Joint HSR project planned to organise a series of workshops to assess implementation of the recommendations of some HSR projects which addressed a similar topic. The first workshop took place in August 1994, addressing four studies on maternal mortality which were developed out during HSR training courses. The meeting revealed that much more had been done with the results and recommendations of the studies than was known to the project management. A second workshop was held in August 1995 on four studies on the provision and use of drugs. Reports of these workshops are available from the Joint Project Management.

4.6 Support to specific HSR projects

a. Support for individual research projects

The Joint Project has a budget line for financial support for HSR projects initiated by individuals or institutions in the Southern African region, to a maximum of US\$ 20,000 per project. However, practice has shown that proposals submitted usually need a considerable technical input to improve the research methodology before funding can be considered. So far, the Joint HSR Project staff has given technical advice for some 50 research proposals. About 20 proposals were funded by the Joint Project, whereas some other studies were channelled to other funding agencies. The small number of submitted research proposals that qualify for funding has led the Project staff to believe that the present emphasis on training is still justified.

b. Documentary Support

The Joint Project in the WHO Sub-regional Office in Harare has a small library with a selection of handbooks on all the disciplines relevant to HSR, as well as some scientific journals. Packages of 20 of the most important handbooks have been provided to all national health research units and Focal Points in the sub-region. Over the years, this basic package has been extended with new publications relevant for HSR.

For literature searches in support of specific research topics, the Joint Project has limited facilities. It has access to WHODOC, the computerized database of all documents, publications and articles released by the World Health Organization since 1986. Requests for more thorough literature searches can be passed on to the Medical Library in Zimbabwe, WHO/AFRO or WHO/HQ, who can access various bibliographies and have better facilities.

4.7 Development and strengthening of national structures and mechanisms

The development of adequate structures and mechanisms at national level is a sine qua non for the institutionalization of HSR. Establishing and developing these structures and mechanisms is a long-term process with many interfering factors (economic constraints, braindrain, reorganizations within Ministries of Health) which are often beyond control of the Ministries concerned and certainly beyond the control of the Joint Project.

The first steps followed by the HSR project for strengthening HSR have been described in chapter 3: country visits, consultative meetings, and establishment of HSR focal points/units, strengthening of Advisory Committees, technical/ financial support, and resource mobilisation.

a) Structures

The current situation of structures and mechanisms for HSR in the subregion is summarised in Table 2. Most countries have now an HSR focal point of HSR unit in the Ministry of Health, and about ten countries have developed a Long Term Plan for HSR. Support structures, such as National Research Councils or Research Advisory Committees are not yet present or functioning in all countries. In some countries Research Councils, originally created to assess proposals for research, are becoming more and more important as bodies that set priorities, initiate and co-ordinate research and promote the utilization of research findings. However, unfamiliarity of health policy-makers, managers and researchers with the practical, problem-oriented, non-biomedical approach of HSR on the one hand, and insufficient representation of lower cadres of health services and non-medical personnel in the health research committees and councils on the other hand, are some of the constraints at national levels that hamper the institutionalisation of HSR.

As Health Research Committees and Councils mature, it is expected that there is a future role to play for ad-hoc, multidisciplinary task forces for HSR. Such task forces, can be assigned specific research tasks in order to facilitate decision-making in particular at national (policy) level. Some countries have experience with this type of mechanism.

b) Long term plans for HSR

Once an HSR unit is established, HSR can be consolidated by development of a long term plan for HSR. Ministries of Health are assisted, at their request, in the development of three to five-year action plans for HSR. A country action plan contains fairly detailed descriptions of past achievements, actual versus desired situation, prevailing constraints, objectives, specific proposed activities and the input required from the country itself and from external agencies to implement the plan so as to achieve the objectives.

Each year, during the annual Technical Advisory Committee meeting, countries are enabled to discuss their experiences in HSR, problems and strategies in promoting HSR are shared, and information is exchanged in the development of Action Plans for HSR. Starting 1996, the Project will refocus the approach in such a way that the National Health Policy of a country will become the starting point. Through it, support will be provided for development of National Health Research Policies and

Strategies plus plans to achieve such policies. A few (Namibia, Zimbabwe) countries have started on this course already. The emergence of Health Sector Reforms calls for an examination of the role of HSR in generating supporting information for policy-makers.

Countries are encouraged to submit their HSR action plans to donor agencies for funding. If required, the Joint Project or the HSR and Development Programme at WHO Headquarters may endorse requests for assistance, or help to identify and approach suitable donor agencies.

c) Human resources

WHO can appoint Associate Professional Officers (APOs) for two or three years, to assist Health Research Units which are lacking manpower from specific scientific disciplines that are locally not easily available (for example, social science or health economics). The APO Programme has been designed to expose young academicians to the practice of development work, which requires that the incumbents receive guidance in the performance of their duties and that a reasonable infrastructure is in place. The Joint Project can be instrumental to endorse requests from Ministries of Health, seek approval from AFRO and request WHO Headquarters to identify donor agencies who are willing to sponsor and recruit APOs.

So far, APOs have been posted in Mauritius (1988-91), Tanzania (1988-89, and 1991-1994), Zimbabwe (1994 onwards) Mozambique (1995-onwards) and at the WHO Country Office in Harare (from 1987 onwards).

d) Fellowships

Incidentally, the Joint Project provides fellowships for specialized training of new members of Health Research Units (for example, one- to three-months fellowships in epidemiology, or health economics). Applications for fellowships, however, are usually referred to other agencies (for example, International Health Policy Programme or Rockefeller Foundation).

4.8 International networking

a. Intercountry Workshops on HSR

The most intensive and rewarding form of networking have been the Intercountry Workshops on HSR, which are held every two years. The first one, in July 1987 in Harare, was decisive for the operations of the Joint Project in its first two years (see section 3.1). The Second, Third and Fourth Intercountry Workshops on HSR were held in June 1989 in Harare, in April 1991 in Maseru, Lesotho, and in November 1993 in Malawi, respectively.^{10,11,12}

The Second Intercountry Workshop drew participants from 12 countries of the sub-region, among whom were the Heads of national Health Research units, as well as representatives from a few other countries who had shown interest in HSR (Cameroon, Ghana and Kenya). Experiences with HSR over the preceding two years with respect to three main issues were reported and discussed under:

- È institutional strengthening,
- È training, and
- È actual research, and implementation of research results.

All country delegations developed and presented draft plans for HSR activities for the next two years

in their respective countries.

The Third Intercountry Workshop was attended by delegations from 12 countries of the sub-region, and representatives from agencies who are involved in programmes related to HSR. The continuation of the Joint Project, after expiry of the first phase at the end of 1991, was an important point on the agenda. The unanimous opinion was that the Joint Project should be extended with a second phase of four years. Recent developments in national structures and mechanisms were discussed, as well as the methodologies, results and recommendations of a number of studies developed in training courses. As in the two previous intercountry workshops, the last two days of the workshop were reserved for the drafting of country action plans, which later in 1991 formed the basis for the development of a proposal for Phase II of the Joint Project.

The Fourth Intercountry Workshop was attended by some 75 participants, including many high-level policy makers from the subregion. The meeting focused on six areas in HSR: application of research results, capacity building, involvement of Universities, decentralisation, involvement of NGOs, and partnership at country level between external agencies and national HSR partners. The meeting concluded with 12 recommendations on ways of intensifying HSR in future plus a strong recommendation for continuation of the Joint Project. Similar to the preceding Intercountry meeting, all countries represented drafted or updated their plan of action for HSR. These plans were further discussed and elaborated during the TAC and the Management Course for HSR managers which took place after the Fourth ICM.

b. Institutional Networking

With the assistance and involvement of WHO Headquarters, institutional networking between the Joint Project and other organizations supporting HSR has become increasingly important.

IDRC

IDRC has been strongly involved, together with the Malaysian Institute of Public Health and some international experts in the development of the HSR Training Series for various target groups. The HSR training series has been published by IDRC and WHO. IDRC initiated and co-funded a Joint WHO/IDRC/COHRED mission on HSR to West-Africa, with the intention to start a similar HSR Project for Francophone countries in the near future.

COHRED

Collaborative activities have been developed with the Task Force on Health Research for Development, which promotes Essential National Health Research (ENHR) in a number of countries, some of which are in the Southern African region. The Task Force was established in 1990 for an initial period of two years to implement recommendations contained in the report of the International Commission on Health Research for Development (COHRED).² In the Third phase specific areas for collaboration between the HSR Project and COHRED have been spelled out, particularly priority setting in health research at national level.

GTZ supported Network for HSR in Southern Africa

The Joint Project closely co-operates with a GTZ supported project for HSR in the area of maternal and child health and family planning (MCH/FP). Started in 1989 and based in the Ministry of Health in Zimbabwe, the MCH/FP HSR Project supports research activities in 14 countries in the Southern African region. The HSR newsletter is a joint effort of the GTZ supported Project and the HSR Project. Starting in 1996, the mandate of this project will include Health Sector Reforms.

Commonwealth Regional Health Community Secretariat (CRHCS)

The Commonwealth Regional Health Community Secretariat in Arusha, Tanzania, supports training and research in the area of Reproductive Health in various countries in Eastern, Central and Southern Africa. Initial discussions have started to embark on a joint enterprise to revise and adapt the HSR training materials, with particular emphasis on adding a component of computer training in the manuals.

Social Science and Medicine in Africa Network (SOMA-NET)

SOMA-NET, based in Nairobi, focuses on bringing together health and social scientists to work on areas of common interest in health.

The Joint Project has participated (1994) in HSR training courses organised by SOMA-NET.

Other Examples of Networks

Links also exist with UNICEF, IHPP, SIDA/SAREC, International Clinical Epidemiology Network (INCLIN), UPP (University Partnership Project) and the Commission of the European Communities. Representatives of the above mentioned organizations have attended one or more HSR Intercountry Workshops or related activities.

Close co-operation between these various institutions and programmes, especially in planning of activities and using already existing national structures and mechanisms for Health (Systems) Research, is of utmost importance. Where possible, special efforts are to be made by the responsible officers of these institutions and programmes to avoid unnecessary duplication of activities and the creation of parallel structures in the countries concerned, as in the long run this would counteract the development of HSR in the sub-region. Such collaboration has been formalised between GTZ MCH/FP Project, CRHCS and the Joint HSR Project. It has been agreed that the programme co-ordinators will be invited to each others meetings where relevant. The GTZ MCH/FP co-ordinator technically and financially supports the HSR Newsletter.

Co-funding of and joint participation in specific activities are some other ways in which collaboration is realised.

c. Newsletter

One of the established forms of international networking is the publication by the Joint Project of the HSR Newsletter.¹³ This newsletter gives an account of Project activities, country activities and general developments in the field of HSR in the sub-region. The coverage of the Newsletter has doubled over the past few years, and also includes many subscribers from outside the subregion.

4.9 HSR Publications

In order to promote the HSR Project, and the results of the studies developed in HSR training workshops a number of publications and promotion materials have been developed.

a. Update 1992 in French

Since Madagascar became actively involved in the HSR project, Cameroon requested support from the HSR Project to strengthen HSR in the country, and also other French speaking countries showed interest in HSR, it was decided to translate the Update 1992 in French.

b. Promotion materials on Joint HSR Project

In order to promote the HSR Project more widely, various promotion materials have been developed: a yearly calendar, with the annual plan of activities; leaflets on the HSR Project in English and French; and a poster showing the main objectives, strategies and activities of the HSR Project.

c. Summaries of HSR studies

A monograph has been made of summaries of studies that were developed during HSR training courses between 1988-1993. In total 67 summaries are included (out of about 100 studies completed), subdivided into 5 categories: MCH/FP, disease control, PHC/Water and Sanitation, AIDS, and Health Management Issues. Each summary contains information on the methodology used, major results, and recommendations of the study. A second edition is planned for 1996.

d. Series: HSR - It can make a difference

Some of the studies completed as part of HSR training courses supported by the Joint Project pertain to similar problems. For example, to date, there have been numerous studies on utilization of delivery care, four on tuberculosis control services, four on maternal mortality, four on the functioning of primary health care activities at village level, and four studies related to provision and use of drugs.

The topics mentioned above are apparently so common a problem, that future researchers are likely to address these issues again in a different context. In order to make the results of the completed studies in this field available, and to assist future researchers in developing their data collection tools, it has been decided to make thematic publications including an exemplary research protocol.

The series is entitled "HSR - It can make a difference". Each volume will comprise of four parts: an exemplary research proposal on a priority problem, including data collection tools; a summary of the methodology used in a number of studies on that problem carried out in different countries; the summarised results of those studies; and finally, the recommendations made in each of those studies, and reports on the extent to which these recommendations have been implemented.

The first topics covered in the series are on provision and use of drugs, maternal mortality, defaulting from out-patient treatment among tuberculosis patients, inadequate functioning of village health posts, and poor sanitation. Volume 1-4 have been published, other volumes are expected to come out during 1996.

It is believed that these publications will be helpful to those who would like to undertake studies in similar fields. A list of publications is provided in annex 1.

5. NEW FOCUS IN HSR PROJECT DURING SECOND PHASE

5.1 HSR University Initiative

Universities have a crucial role to play in HSR. They harbour the concentrated expertise in all disciplines relevant for HSR, and have the potential to provide the next generation with the attitudes and skills necessary to conduct HSR.

The collaboration with various universities in the Southern African region has recently been intensi-

fied, in line with recommendations of the Third Intercountry Workshop and the Joint Project's Steering Committee.

From the perspective of the Joint Project, the need for intensified co-operation with the universities was apparent:

Ě **Sustainability/inclusion of HSR in curricula**

As the Joint Project had to strive for sustainability once it had been proven that it was possible and rewarding for health staff to carry out problem-solving research in the field, it was only logical to proceed to training institutions and identify how HSR could be included in the curricula of these institutions.

Ě **Need for critical mass of trainers in HSR**

Health managers from the district and provincial levels might be good researchers but lack the skills and especially the time to guide inexperienced health workers into developing HSR projects. Universities and other research institutions which have teaching and research as regular tasks, could assist in enlarging the critical mass of facilitators for HSR training among these institutions.

Ě **Need for policy-related research**

In the first two phases, few studies in support of policy development or evaluation were developed. In order to satisfy the need for such research at policy level, co-operation of professional researchers from universities and research institutions is indispensable. This was another reason for the Joint Project to search for ways to involve the universities more thoroughly in HSR.

Ě **Need for inter-disciplinary approach**

Much sensitisation still needs to be done on the benefits of an interdisciplinary approach to health management problems, and on the necessity to analyse these problems with all parties concerned, including health managers, health staff and the community.

In the second phase of the Project, a concerted effort was therefore made to promote HSR at three universities: in Tanzania, Zambia and Zimbabwe.

The HSR University Initiative aims at sensitising Medical as well as Social Sciences and other relevant departments for HSR, in order to include the HSR philosophy and methodology as a regular component in the curriculum of these faculties, in teaching as well as in fieldwork.

At each university a Focal Person interested in HSR was identified, who collected an interdisciplinary core group around him or her to assist in the development of HSR activities.

In 1992, during an inter-university meeting of the three core groups, which included the heads of Ministry of Health HSR Units, these activities were to a certain extent harmonised. They included:

(a) **HSR Inventory**

The compilation of annotated bibliography of major HSR-related research undertaken over the preceding five years at different departments and faculties, in order to visualise what others were doing and facilitate inter-disciplinary co-operation.

(b) **Inter-disciplinary research projects**

The development and implementation of inter-disciplinary research protocols focused on priority topics of the Ministry of Health in the different countries. The list of topics are included in the annex listing all research projects developed in HSR training courses.

(c) **Inclusion of HSR in curricula**

Identification of possibilities for the inclusion of HSR training in the curriculum, for combined, inter-disciplinary teaching and for combined fieldwork of students.

The HSR University Initiative appears to generate genuine enthusiasm among university staff, not because it brings something completely new but because it capitalises on existing expertise and experience and stimulates more effective, creative use of available resources with a minimum of extra input.

It is noteworthy that, though various departments and health-related training institutions have introduced HSR in their curricula, efforts to join forces in teaching, student field attachments and research are still rare or non-existent, even with respect to problems that clearly require an inter-disciplinary approach (e.g. the triangle of poverty, malnutrition and ill health). Vertical structures, which in combination with scarce resources create a spirit of competition rather than co-operation between academic departments, let alone between different faculties, form a stumbling block to such co-operation. Moreover, physical barriers hamper communication, in particular between medical faculties and the main campus with faculties of Arts and Social Science, Business Management and others which in all three participating universities are miles apart.

It is not an easy task for HSR core groups to swim against the stream, despite their enthusiasm. Core group members and HSR focal points are self-selected persons with a broad interest, and usually already overburdened with many competing duties. It is highly unlikely that universities will soon follow the example of Ministries of Health, which recognized HSR as one of their tasks for which they reserved at least some manpower, office space and logistical support.

A major task of the core group would be to maintain contacts with the Ministry of Health, with health staff and community members about their needs for research. Thus far, lines of communication between health managers and researchers have been very weak in most countries. When from both sides co-ordination takes place, chances of success seem bigger.

In the Third phase, the HSR University Initiative will receive extra attention and funds, with the overall objective to introduce and strengthen the teaching of concepts and methods of HSR at Universities, in order to enhance their involvement in health (policy) research issues, identified by the Ministry of Health.

5.2 HSR and Non Governmental Organisations (NGOs)

In many countries, non governmental organisations (NGOs) play an important role in health care provision, in some countries even up 80% of the rural populations is served by mission hospitals. Several NGOs are also involved in health research.

It was therefore decided to involve NGOs in HSR activities, starting with sensitisation meetings for NGOs. A first exploratory meeting was held in Swaziland in 1993, involving NGOs from eight different countries. This meeting revealed much enthusiasm among NGOs for HSR, and resulted in a number of recommendations for future NGO involvement in HSR. A second sensitisation meeting

was held in Zimbabwe in 1994, involving 3 countries only, but a larger number of NGOs per country. Representatives of NGOs have been invited to annual TAC meetings and intercountry meetings. In 1994, a training course in HSR methodology has been organised for NGOs from 5 countries in the subregion. In future, however, HSR activities for NGOs should be integrated with the activities of the Ministry of Health, in order to avoid parallel structures.

6. EVALUATIONS OF THE JOINT HSR PROJECT

A number of evaluations of the HSR project has taken place over the first and second phase:

- 1989: external evaluation, covering 3 countries
- 1991: external evaluation, covering 2 countries
- 1991: written evaluation, covering all countries
- 1993: peer (internal) review, covering 10 countries
- 1994: external evaluation, covering 3 countries

The internal evaluations focused mostly on the utilisation of research results, and awareness of HSR among policy makers and health planners.

For instance, the 1991 written evaluation was addressed to participants of training courses. It showed that of 32 projects involved, 14 were considered successful in terms of recommendations implemented and 10 were reasonably successful.

The peer review, conducted by HSR focal points/trainers from the subregion, included 20 studies. Of the 156 recommendations resulting from those studies, 69 had been fully implemented and 42 partially. Non implementation of recommendations was mainly due to lack of funds.

Two examples:

- A study on malaria in Botswana recommended to make available impregnated bed nets. Talks were held with communities involved with the study to convince them of the use of such bed nets and nets were provided.
- The high incidence of gonorrhoea in Seychelles was reason to conduct a study on its causes. Recommendations on early check up, promotion of condoms, enhancing awareness of STD/AIDS, training of nurses in STD counselling were all taken up. The number of gonorrhoea cases dropped remarkably after implementation of the recommendations from a high of 958 to 92 cases within a period of four years!

These findings are promising, and indicate that HSR comes out clearly successful towards its objectives of action oriented research.

In terms of awareness of HSR at different levels, the peer review revealed that most policy levels are well aware of HSR. Some examples of policy formulation influenced by results of HSR studies were: policies on health reforms, health care management, introduction of user fees and cost recovery.

The external evaluations were all generally positive about the strategies and achievements of the HSR project, and advised continuation of the project for further consolidation of its achievements. The last external evaluation, in June 1994, confirmed that generally Ministries of Health recognise the importance of HSR. One of the recommendations was to allow a stronger role for universities and other institutions of higher learning, since education and research is their key mandate. Another important recommendation was to explore possibilities for more cost-effective training, as the current training model is not likely to be sustainable. These recommendations have, among others, been accommo-

dated in the proposal for the Third phase of the HSR project.

7. CHALLENGE FOR THE FUTURE

National Health Policies throughout the African region are firmly geared towards Primary Health Care (PHC). Evaluations of the impact of this strategy, however, have shown that its effects upon the health status of communities have been limited, notwithstanding the substantial resources invested. One important reason for the failures that have occurred is that many interventions were based on impressions, intuition or on socio-political considerations, rather than on accurate facts and figures obtained through sound research. HSR has thus become an indispensable tool for successful PHC implementation.

Socio-economic developments in the Southern African region, as in so many other parts of the world, urgently demand measures to economise on service delivery costs, not only in the field of health but also in other sectors.

As far as the (relatively very costly) health and health-related services are concerned, the Joint Project provides a methodology to achieve that objective:

- Ë it is action-oriented;
- Ë it identifies and analyses felt problems with respect to the operation of health systems, and recommends practical solutions;
- Ë it taps new sources of knowledge and experience (field workers, communities, patients, etc.) and involves them in finding solutions;
- Ë it addresses inefficiencies in existing health and health-related systems rather than aiming at the establishment of new services; and
- Ë its pragmatic - yet reliable - approach focuses on the adaptation of operational practices within such systems to actual circumstances and to limited national resources.

It does not restrict itself to research (methodology development, data gathering and presentation) only. By encompassing at the same time the training of trainers and researchers, network building at national and intercountry levels, and strengthening channels of communication between fact-finders, policy-makers and managers, the Joint Project tries to avoid important shortcomings of some earlier initiatives.

It bridges the existing gap between research and policy-making by:

- Ë involving policy-makers and managers in the establishment of research agendas;
- Ë demystifying research and transforming it into a tool for management;
- Ë helping to focus attention on practical problems; and
- Ë promoting the creation of permanent structures to smoothen the research process and to feed policy-makers with research findings and recommendations to help solve the problems investigated.

The Joint Project's planning and implementation has, so far, been very flexible. The comprehensive

programme of activities has time and again been adjusted to the actual and varying needs and opportunities of the countries concerned. The Joint Project is coming towards the end of its second phase and much has already been achieved:

- Ë there is a greatly increased awareness of and interest in HSR at all levels of the health system;
- Ë health managers are becoming more actively involved in the research process, from problem identification to application of results;
- Ë within the university setting, researchers are realizing that they have an important contribution to make to the solution of priority health problems;
- Ë a multidisciplinary approach is being used and considerable experience of team-work has been acquired; and
- Ë institutional networking, at national, regional and international levels, is becoming a regular feature of HSR.

Two main challenges now have to be faced, namely:

- how to ensure sustainability: that the present momentum is maintained in the Eastern and Southern African region; and
- how to ensure transferability: that the acquired experience is made available to other countries and regions.

Sustainability

Building and maintaining an effective HSR process requires countries to give high priority to the development of an adequate infrastructure and appropriate institutional arrangements. These would bring increasing national self-reliance and would permit the gradual transition from direct international support to a mutually beneficial technical collaboration.

It seems reasonable to expect the countries in the Eastern and Southern African region to establish firm foundations for HSR, with the following essential elements:

- Ë A Health Research Unit within each Ministry of Health, with adequate budgetary provision, suitable staffing, with comprehensive terms of reference, and reporting directly to a high decision-making level. This has been achieved in all core countries.
- Ë Suitable co-ordinating mechanisms bringing together representatives of the Ministry of Health, other Ministries, Universities, Research Institutions and Non-Governmental Organizations, and involving the different levels of the health system (for example: health research advisory committees, technical working groups, task forces). This remains an area which needs further strengthening in most of the countries.
- Ë Incorporation of HSR activities as an integral part of major health programmes (for example: maternal and child health, communicable disease prevention and control, AIDS). This has been achieved to some extent in a few countries (Zimbabwe, Zambia) UNICEF has made it an official policy recently to allocate a percentage of each health programme budget for health research.
- Ë Making the necessary institutional arrangements for capacity building and skills development, including the preparation of trainers, the training of health service managers and academic research staff, the development of appropriate training materials, and the provision of technical

support. Several countries now run their own courses, but except for South Africa no country runs training courses on a regular basis. Further efforts to institutionalise training are still required.

- Ë Inclusion of appropriate coverage of HSR in curricula for training of doctors, nurses and other health workers. This will be a major activity in the Third phase of the HSR Project.
- Ë Mobilisation of resources to facilitate implementation of long -and short- term HSR plans developed as a result of National Health Policies and National Health Research Policies. More support is required for the individual countries in this respect, as few countries have been able to obtain funds for their long term plans for HSR.

All of this implies creating a supportive climate for HSR by ensuring adequate financial support, establishing a suitable career structure for key personnel, providing incentives and rewards, and encouraging networking. Some countries have recorded great achievements, others still have a long way to go. Continued support from the international community will be needed to further support HSR. This may take several forms:

- Ë making Associate Professional Officers or other temporary experts to assist available in the developmental phases of capacity building and institutional strengthening;
- Ë providing financial support to complement national investments for long-term development of HSR infrastructures, possibly on a decreasing scale to allow countries to gradually absorb the full costs; and
- Ë assuring the availability of technical support in training, research and development by facilitating collaboration between countries and institutions with similar interests, experience or expertise.

Transferability

The Joint Project has acquired some valuable experience and expertise in the field of HSR which is already being made available to other countries and regions.

Four complementary strategies will continue to be used by the Project on a broad basis:

- Ë documenting the methodologies and approaches developed and making them widely available to a variety of users, such as national and provincial/regional authorities, university departments, international agencies and non-governmental organizations;
- Ë involving other countries, who have shown interest, in specific activities of the Joint Project;
- Ë encouraging other international health research programmes to use and build on the methodology and approaches developed; and
- Ë supporting international networking through technical co-operation, meetings, workshops, training courses, country visits and fellowships.

The implementation of these strategies provides both an opportunity and a challenge to the international community.

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ANNEX 1:

Publications on HSR

Ë Health systems Research - Does it make a difference?
Joint Project on Health Systems Research, 1990. (Eng)
Second edition 1992 (English & French)
Third edition 1995

Ë Health Systems Research - It can make a difference

The following publication are at various levels of preparation: Planned; on-going; completed

Group 1 (completed):

Ë Volume 1:Availability, provision and use of drugs, completed 1994.

Ë Volume 2:Factors associated with maternal mortality, completed 1994.

Ë Volume 4: Functioning of Primary Health Care at Village Level, completed 1995.

Ë Summaries of Health Systems Research Studies 1987-1993: Joint HSR Project, Harare, Zimbabwe, completed 1994.

Ë Reports of Working Group on Maternal Mortality: What can be done - 1993/1994

Ë Report of Working Group on Availability, Provision and Use of Drugs: What can be done - 1996/1997

Ë Update 1995 - HEALTH SYSTEMS RESEARCH: Does it make a difference? The Joint Health Systems Research for Eastern and Southern Africa

Group 2 (Planned):

Ë Volume 3:Factors contributing to underutilisation of out-patient services among tuberculosis patients, in preparation, on-going.

Ë Volume 5:Low coverage and use of pit latrines in rural communities, in preparation, planned.

Ë Volume 6:Factors associated with the incidence of Sexually Transmitted Diseases, including HIV/AIDS, in preparation, on-going.

Ë Volume 7:Suicides and Para-suicides, on-going.

FURTHER INFORMATION

Further information on any aspect of the Joint HSR Project or copies of reports and documents related to it may be obtained by contacting one of the following:

Prof Gabriel M.P. Mwaluko

Manager, Joint HSR Project
WHO Country Office
P.O. Box CY 348
Harare
Zimbabwe
e-mail: mwaluko@healthnet.zw

Dr. L.G. Sambo,
Responsible Officer, HSR
WHO/AFRO
PO Box 6
Brazzaville
Congo

Dr Andrei Issakov
Acting Responsible Officer
Health Systems Research
and Development
World Health Organization
CH - 1211 Geneva 27
Switzerland

Prof. Corlien M. Varkevisser
Primary Health Care Programme
Royal Tropical Institute
Mauritskade 63
1092 AD Amsterdam
The Netherlands

Those who are interested in receiving details of any of the research projects listed in Annex 1 should write to the responsible officer for Health Research in the country concerned (see names and addresses in Annex 3).

ANNEX 2:

HSR training courses and completed research projects

1. MALAWI (April 1988 - October 1988)
Organizer: Professor P.R. Khonje, Chief Research Officer, Ministry of Health
 - a. A study of factors contributing to low utilization of child-spacing services in the Northern Region of Malawi with emphasis on male participation.
Principal investigator: Dr J. Masanjika
 - b. Oral health knowledge, attitudes, practices and oral health status in Mchinji District.
Principal investigator: Dr W. Mukiwa
 - c. A study of factors that influence nursing care at Queen Elizabeth Central Hospital, Blantyre.
Principal investigator: Dr F. Sungani
 - d. Factors contributing to high neonatal mortality rate in Lilongwe District.
Principal investigator: Dr W. Chiomba

2. SEYCHELLES (May 1988 - November 1988)
Organizer: Dr A. Kitua, Epidemiologist, Ministry of Health & Social Services
 - a. Study of factors influencing the low recruitment of student nurses in Seychelles.
Principal investigator: Mrs M. Servina
 - b. Study of factors contributing to a high attrition rate in the nursing profession in Seychelles.
Principal investigator: Mrs E. Savy
 - c. Study of factors leading to the incidence of gonorrhoea in Seychelles.
Principal investigator: Dr P. Vidot
 - d. Study on factors influencing low compliance to diet of diabetic patients referred to Dietetic Clinics in Mauritius.
Principal investigator: Ms U. Haw Tai Wah

3. ZIMBABWE (January 1989 - July 1989)
Organizer: Dr Shiva Muragasampillay, Epidemiologist, Ministry of Health
 - a. Study of reasons for defaulting from out-patient treatment among tuberculosis patients in Masvingo Province.
Principal investigator: Mr D. Proudfoot
 - b. A study on the maintenance of district council clinics in Midlands Province.
Principal investigator: Dr D. Dhlakama
 - c. An investigation into the reasons for the failure of the Beitbridge sanitation project to reach its target.
Principal investigator: Mrs S. Mutambirwa

- d. Investigation into factors affecting staffing levels of health institutions in Matabeleland North Province.
Principal investigator: Mrs I. Moyo
4. TANZANIA(March 1989 - March 1990)
Organizer: Dr S. Ndeki, Director, CEDHA, Arusha
- a. Protein Energy Malnutrition in Sengerema District - Prevalence and risk factors.
Principal investigator: Dr P. Mtey
 - b. A study on high perinatal mortality in Shinyanga Urban and Rural district, Tanzania.
Principal investigator: Dr N. Katole
 - c. Utilization of maternal services in Musoma District.
Principal investigator: Dr E. Massesa
 - d. Associated factors hindering supervision to rural health units in Same District.
Principal investigator: Dr R. Momburi
5. MAURITIUS (September 1989 - April 1990)
Organizer: Dr O. Awotar, Director National Programmes of Research and Training, Mauritius Institute of Health
- a. An evaluation of the supply, distribution and utilization of antibiotics, anti-diabetic and anti-hypertensive drugs at primary health care level in Mauritius in order to optimize their use.
Principal investigator: Mr S. Ramphul
 - b. A study of referral procedures from district to regional hospitals in Mauritius.
Principal investigator: Mr M. Abdoolakhan
 - c. A study of factors contributing to high infant mortality in the district of Black River.
Principal investigator: Dr S. Auckloo
 - d. A study of factors influencing the use of treatment services of health centres in Mauritius.
Principal investigator: Dr H. Hung Yeung San
6. MALAWI II (November 1989 - September 1990)
Organizer: Professor P.R. Khonje, Chief Research Officer, Ministry of Health
- a. A study of knowledge, attitudes and practices of school teenagers in Mzimba District about HIV infection/AIDS.
Principal investigator: Mr B. Tembo
 - b. Service related factors contributing to maternal death in health facilities in Malawi - a prospective study.
Principal investigator: Mrs A. Phoya

- c. Factors contributing to shortage of essential drugs in health centres of the Southern Region.
Principal investigator: Mr G. Vinkhumbo
 - d. Malaria management in the Central Region of Malawi - a community based study.
Principal investigator: Mr J. Nkhoma
7. SWAZILAND (February 1990 - August 1990)
Organizer: Mr M. Hlophe, Health Planner/Health Research Coordinator, Ministry of Health
- a. Knowledge, attitudes and practices of primary school children, parents and teachers on schistosomiasis in Mayiwane Nkundla, Hhohho Region, Swaziland.
Principal investigator: Ms S. Mthupha
 - b. Study of factors contributing to high defaulting rate among tuberculosis patients in Swaziland.
Principal investigator: Dr C. Mabuza
 - c. Study of the factors contributing to late reporting and late diagnosis among pulmonary TB patients in Lesotho.
Principal investigator: Ms E. Mosala
 - d. Appropriateness of community-based drug outlets for dispensing essential drugs in the Dangbe West District of Ghana.
Principal investigator: Dr E. Amuah
 - e. Study of factors contributing to the under-utilization of community health posts in the South-West Province of Cameroon.
Principal investigator: Dr E. Ngapana
8. ZAMBIA (May 1990 - January 1991)
Organizer: Dr R. Chimba, CDD/ARI/HSR Manager, Ministry of Health
- a. A study of factors influencing the low number of ordinary and ventilated improved pit latrines constructed in Kabwe Rural District, Central Province, Zambia.
Principal investigator: Mr D. Phiri
 - b. Primary Health Care Posts in Siavonga Sub-district: "Why are some functioning and others not?"
Principal investigator: Mr M. Chamvu
 - c. Factors contributing to the high rate of malnutrition in the age group of 6 to 23 months in Mwinilunga District of North-Western Province.
Principal investigator: Dr K. Habanyama
 - d. Low utilization of trained traditional birth attendants for deliveries in rural Lusaka Province.
Principal investigator: Dr V. Nyirenda
9. ZIMBABWE II (May 1990 - November 1990)

Organizer: Dr S.K. Chandiwana, Director, Blair Research Institute

- a. Reasons for low utilization of delivery services in Guruve District, Mashonaland Central Province.
Principal investigator: Ms C.S. Zvavamwe
- b. Underutilization of growth monitoring services at health facilities in Seke and Marondera Districts, Mashonaland East Province.
Principal investigator: Mr G. Marimbe
- c. Pattern of workshop attendance by health workers of Mashonaland West Province.
Principal investigator: Mrs R. Mhango
- d. Utilization of data in planning and management of health services in Buhera District, Manicaland Province.
Principal investigator: Ms A. Chideme
- e. Evaluation of the CARD sanitation programme in Gutu District.
Principal investigator: Mr S. Mharakurwa

10. MOZAMBIQUE (September 1990 - May 1991)

Organizer: Dr A.R. Noormahomed, National Director of Planning, Ministry of Health

- a. Study of factors contributing to low fee collection in the Central Hospital of Nampula.
Principal investigator : Dr A. Ndeve
- b. Causes of reduction of coverage of deliveries at the peripheral maternities of the city of Maputo
Principal investigator: Dr J. Leopoldo da Costa
- c. Mortality in children less than two years of age in three provincial capitals (Nampula, Tete and Inhambane)
Principal investigator: Mr J.G. Tembe
- d. Main causes of low coverage of Expanded Programme of Immunization in the city of Beira.
Principal investigator: Mr R. Guilande

11. TANZANIA II (October 1990 - August 1991)

Organizers: Mr P. Ilomo and Mr M. Mapunda, HSR Unit, Planning Department, Ministry of Health

- a. Factors influencing high maternal deaths in Songea District, Ruvuma Region.
Principal investigator: Dr P. Raphael
- b. A study on factors associated with low coverage of pit latrines in Sumbawanga District, Rukwa Region.
Principal investigator: Mr C. Shayo
- c. Factors contributing to low condom use in relation to Aids control programme among adults in Mbozi District, Mbeya Region.

Principal investigator: Dr Y. Hemed

- d. A study on poor performance of village health committees in relation to PHC activities in Iringa Rural District.
Principal investigator: Dr M. Mwakajila
- e. A study on factors influencing the performance of village health committees in enhancing community involvement in health activities in Ejisu District, Ghana.
Principal investigator: Dr G. Amofah

12. ZIMBABWE III (May 1991 - February 1992)

Organizer: Dr S.K. Chandiwana, Director, Blair Research Institute

- a. Reasons which contribute to delay in serving outpatients at United Bulawayo Hospitals.
Principal investigator: Mr L. Zindove
- b. Reasons which contribute to delay in serving outpatients at Harare Central Hospital.
Principal investigator: Mr J.J. Munodawafa
- c. An investigation of factors leading to the increase in number of TB cases in Chitungwiza.
Principal investigator: Mrs E.E. Tsopotsa
- d. Factors leading to non-functioning of medical equipment in relation to provision of health care at Parirenyatwa Group of Hospitals.
Principal investigator: Mr A.F. Zingoni
- e. Factors that contribute to the community's low perception of health services provided at Mpilo Central Hospital.
Principal investigator: Mr M. Nkomo

13. ZAMBIA II (July 1992 - January 1993)

Organizer : Dr Roy Chimba, Head HSR Unit, Ministry of Health

- a. A study of factors contributing to patient congestion at chest clinics in Lusaka and Kabwe Districts, Zambia
Principal Investigator : Dr Roland Msiska
- b. A study of factors contributing to patient congestion at Kitwe Central Hospital, Copperbelt Province, Zambia
Principal Investigator : Mrs H. E. Ngulube
- c. A study of factors contributing to high morbidity due to malaria in under fives in Mbala District, Northern Province, Zambia.
Principal Investigator : Mr J. Mwamba
- d. A study of factors contributing to maternal mortality in Mongu District, Western Province, Zambia
Principal Investigator : Mr K.N. Kufuna

14. LESOTHO (August 1992 - May 1993)
Organizer : Ms Lucy Makoae, Head, HSR Unit, Ministry of Health
- a. A study of high attrition among Nurses of the Ministry of Health in Lesotho
Principal Investigator : Mrs C. Seipobi
 - b. A study of factors contributing to limited effects of information, education and communication (IEC) strategies on AIDS in changing people's sexual behaviour in Lesotho
Principal Investigator : Mrs E.M. Majalle
 - c. A study on inadequate coverage and level of integrated MCH/FP services in health facilities in Lesotho
Principal Investigator : Dr A. J. K. Shayo
 - d. A study on factors associated with maternal deaths in the North West Health Region of Namibia
Principal Investigator : Ms S.N. Ipinge
15. NAMIBIA July 1993-April 1994
Organiser: Ms Maazuu Zauana, Head HSR Unit, Ministry of Health
- a. Factors contributing to the high rate Acute Respiratory Infections and Mortality among the under fives in Rundu district North East regional, Namibia
Principal Investigator: N J Amadhila
 - b. Factors contributing to the increase in STD cases in Gobabis district, South region, Namibia
Principal Investigator: T M Sixolo
 - c. Factors contributing to malnutrition in Khorixas district Central region, Namibia
Principal Investigator: B Amuenje
 - d. A study to determine factors contributing to high acute respiratory infections prevalence, and mortality among under fives in Gaborone, Botswana, 1994
Principal Investigator: V S Chakalisa
16. SEYCHELLES July 1993 - May 1994
Organiser: Mr Jude Padayachy, Head, HSR Unit, Ministry of Health
- a. Factors associated with low back pain in the working population in Seychelles
Principal Investigator: Patricia Palmyre
 - b. A study on factors contributing to poor referral of obstetric emergencies from Primary Health Facilities to H.S.A. Hospitals in the Southern Districts of Lesotho
 - c. A study of factors contributing to long waiting time for patients attending the medical out-patient department of Dr A G Jeetoo hospital in Mauritius
 - d. Factors influencing prioritisation of district health needs in Kenya

Principal Investigator: Dr Ruth M Kariuki

17. TANZANIA-UNIVERSITY September 1992
Organiser: Dr Festus Kalokola, HSR Focal Point, Muhimbili Medical School, Dar es Salaam
 - a. A study of the factors influencing integration of health programmes at the district level in Tanzania
Principal Investigator: Dr T K Kabalimu
 - b. A study on factors contributing to poor functioning of the referral system in the delivery of health services in Tanzania
Principal Investigator: Dr I Semali

18. ZAMBIA-UNIVERSITY September 1993
Dr S Mbewe, HSR Focal Point, University of Zambia
 - a. Decentralisation of Health Services
Principal Investigator: Dr T.J. Ngulube
 - b. Quality Assurance of Health Care Delivery
Principal Investigator: Dr A M Ngwengwe

19. ZIMBABWE- UNIVERSITY October 1993
Organiser: Dr Jane Mutambirwa, HSR Focal Point, University of Zimbabwe
 - a. Community-Based Home for AIDS patients
Principal Investigator: Dr G. Woelk
 - b. Cost and Quality of Care for HIV/AIDS patients in hospitals in Zimbabwe
Principal Investigator: Dr I Chitsike
 - c. The impact of confidentiality in counselling on the quality of care provided to AIDS patients by the family
Principal Investigator: Dr Rose J Ndlovu

20. MOZAMBIQUE March 1994 - March 1995
Organiser: Dr Rui Vaz Gama, HSR Focal Point, Director National Institute of Public Health, Ministry of Health, Maputo
 - a. Satisfacao dos utentes em relacao aos cuidados recebidos nos centros de saude da cidade de Maputo
Principal Investigator: Benedita Fernandes, LIC. EDUC.
 - b. Sobrecarga de utilizacao do Banco de urgencia de pediatria do hospital Josina Machel em Luanda
Principal Investigator: Jorge Lima D ESP. MED. INTERNA.
 - c. Utilizacao de recursos em cuidados de saude infantil nos centros de saude de Luanda
Principal Investigator: Josenando T. MD, MPH, ESP, Instituto Nac. de Souda Publica

- d. Causas da desistencia dos agentes de saude de base nas actividades sanitarias da regioao de oio, Republica da Guine-Bissau
Principal Investigator: Roberto Armando Ferreira Cacheu MURS
21. ZIMBABWE-NGOs August 1994 -
Organiser: Dr Moses Mbeba, Course Director, c/o Department of Community Health, University of Dar es Salaam, Tanzania
- a. A study to investigate factors associated with home-based care for AIDS patients in Mashonaland West
- b. A study to investigate the effect of implementing free health services for children under six years and pregnant women, on the quality of health care in South Africa
- c. A study to investigate the factors associated with high incidence of suicide in the Northern Region of Namibia
- d. A study on high prevalence of diarrhoea in under fives in Masasi District, Mtwara region, Tanzania
- e. A study on high prevalence of malnutrition among the under five (5) year old children in Monze District, Southern Province, Zambia
22. MADAGASCAR October 1994 - July 1995
Organiser: Dr Razafindralambo Yvon, Head of Planning, Evaluation and Programme Monitoring, Ministry of Health
- a. Etude des facteurs influant sur la mise en place de la dJcentralisation au niveau des services de santJ de district a Madagascar
Principal Investigator: Dr Rigobert Rafiringason
- b. Une Jtude des facteurs contribuant B la faible participation communautaire au programme nutritionnel de Tanadiky (district de Manakara), Madagascar
Principal Investigator: Dr Paul Georges Rakoroarisoa
- c. Etude des facteurs associJs B la faible acceptabilitJ du recouvrement des cofrts dans un district sanitaire de Madagascar
Principal Investigator: Gaston Eddie
- d. La Co-gestion en Question? Etude des facteurs qui influent sur la participation communautaire B la co-gestion des pharmacies communautaires dans la province du Sud Ouest du Cameroun.
Principal Investigator: Dr. Peter Fonkwo
- e. Etude des diffJrences dans le systPme de recouvrement des cofrts entre les institutions sanitaires publiques et privJes non lucratives dans la province de l'Adamaona, Cameroun
Principal Investigator: Dr. Mbam Mbam
23. ZIMBABWE - ECSACON May 1994 - June 1995

Organiser: Dr Rose Ndlovu, Department of Nursing Science, University of Zimbabwe

- a. Factors influencing quality of bedside nursing care at Muhimbili Medical Center in Tanzania
Principal Investigator: Mrs Chugulu Juliet P
 - b. Factors affecting the quality of nursing care at the 4 Central Hospitals in Zimbabwe
Principal Investigator: Miss Mugweni Evangelista
 - c. Factors that affect performance of nurses/midwives in maternity units of midwifery training hospitals in Malawi
Principal Investigator: Mrs Simbota Miriam
 - d. A study on factors contributing to inadequate community based nursing care in Mauritius
Principal Investigator: Mr Kurreeman Bhye C
 - e. Factors influencing nurses performance in basic nursing care in Mbabane Government and Raleigh Fitkin Memorial Hospitals in Swaziland
Principal Investigator: Dr Zwane Isabel Thembi
24. BOTSWANA August 1994 - June 1995 (Extra Joint Project funding)
Organiser: Mr Pilate Khulumani, Head HSR Unit, Ministry of Health
- a. A study on contributing factors towards teenage pregnancy in Mahalapye/Serowe/Palapye sub-districts, Botswana
Principal Investigator: Mrs K L Machacha
 - b. A study on an analysis of the extent of home delivery, the associated complications and factors contributing to home delivery - Okavango Sub-District, Botswana
Principal Investigator: Mr Robinson Masole
 - c. A study to assess the quality of child welfare services at facility level by health care providers in Kweneng and Bobirwa District, Botswana
Principal Investigator: Mrs Tilly Ngulube
 - d. A study on decline in duration of breast feeding in Kgatleng and South East Districts, Botswana.
Principal Investigator: Mrs Rachel Mosinyi
25. ZIMBABWE November 1993 - June 1994 (Extra Joint Project funding)
Organiser: Dr Wijarajah, Matebeleland North, PMD, Hwange, Zimbabwe
- a. A study to provide baseline data for a home-based care programme and to recommend strategies which meet the needs of people i.e. HIV and care givers
Principal Investigator: Ormah Ethel Dube, District Nursing Officer, Umzinguane District
 - b. A study to determine the prevalence and reasons of traditional smoking among under five children in Gwanda district
Principal Investigator: Egleah S Mabuzane, DNO, Gwanda

- c. A study on traditional practice and customs which have adverse effect on pregnancy and child birth
Elida Khani, DNO, Nkayi District
 - d. A study on investigation into the treatment seeking behaviour of STD patients in Hwange district, in areas with high STDs, Zimbabwe
Principal Investigator: Musa M Mono, Hwange
26. ZIMBABWE June 1995 - February 1996 (Extra Joint Project funding)
Organiser: Ms Busi Nyathi, Blair Research Institute
- a. A study to determine factors that contribute to low EPI coverage in Mutasa district as from 1992,
Principal Investigator: B. Shumba, Community Nurse, Mutasa District
 - b. A study of factors leading to high attendances of un-referred patients at Mutare Provincial Hospitals, out-patients department,
Principal Investigator: Dr C Dhege, GMO, Mutare Hospital
 - c. Factors affecting collection and utilisation of health information in Chivi district
Principal Investigator: Mr F Mhlanga, Health Services Administrator, Masvingo
 - d. Factors influencing poor management of mild Acute Respiratory Infection both at home and at health institutions in Zaka district
Principal Investigator: Mr R R Ndlovu, Administrator, Ngomahuru Hospital
 - e. A study to determine factors influencing the outcome of labour of referred women at Masvingo General Hospital
Principal Investigator: E Marimbiri, Clinical Instructor, Masvingo Hospital

ANNEX 3:

Responsible officers for HSR per country

ANGOLA	Dr Josenando Theophile Director National Institute of Public Health (INSP) Rua Amilcar Cabral Luanda
BOTSWANA	Mr Pilate Khulumani Principal Research Officer Ministry of Health Private Bag 0038 Gaborone
LESOTHO	Ms Lucy Makoae Research Coordinator Ministry of Health P.O. Box 514 Maseru
MALAWI	Dr. Lester Chitsulo Chief Research Officer Ministry of Health P.O. Box 30377 Lilongwe 3
MAURITIUS	Dr. Mohith Executive Director Mauritius Institute of Health Pamplemousses
MOZAMBIQUE	Dr Rui Gama Vaz Director National Institute of Health Ministry of Health C.P. 264 Maputo
NAMIBIA	Ms. Maazuu Zauana Ministry of Health and Social Services P. Bag 13198 Windhoek 900
SEYCHELLES	Mr. Joachim Didon Ministry of Health P.O. Box 52 Victoria
SOUTH AFRICA	Dr. L. Makubalo Director Epidemiology and Health Systems Research Department of Health P O Box X 828

Pretoria 0001

SWAZILAND Mr. Amos Zwane
Ministry of Health
P.O. Box 5
Mbabane

TANZANIA Dr Lawrence Munyetti
Head HSR Unit, Department of Planning
Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam

Dr. Festus Kalokola
HSR Focal Point University
MUCHS
P.O. Box 65001
Dar es Salaam

Dr Simon Haule
Christian Medical Board of Tanzania
P O Box 9433
Dar es Salaam

ZAMBIA Dr Benson H. Himonga
HSR Manager, Ministry of Health
P.O. Box 30205
Lusaka

Dr M.A. Banda
Church Medical Association of Zambia
P O Box 34511
Ben Bella Road
Lusaka

Dr. S. Mbewe
HSR Focal point University of Zambia
Dept. of Education
University of Zambia
P.O. Box 50110
Lusaka

ZIMBABWE Dr Steven K. Chandiwana, Director
Ms. Busi Nyati/ C. Hongoro
HSR unit, Blair Research Institute
P.O. Box 8105, Causeway
Harare

Dr. Jane Mutambirwa
Medical School
University of Zimbabwe
P.O. Box A 178
Avondale, Harare

Mr Nyenya/ Mr. A. Musiiwa
Zimbabwe Association of Church-Related Hospitals
P O Box 1556
Harare

ANNEX 4: List of relevant events

Intercountry Workshops:

First Intercountry Workshop: July 1987 in Harare, Zimbabwe

Second Intercountry Workshop: June 1989 in Harare, Zimbabwe

Third Intercountry Workshop: April 1991 in Maseru, Lesotho

Fourth Intercountry Workshop: November 1993 in Lilongwe, Malawi

Fifth Intercountry Workshop: November 1993 in Arusha, Tanzania on health sector reforms

Evaluations:

External mid-term evaluation of the Joint HSR Project:
by Dr W. Zevenbergen and Dr E. Kaptue in February 1989

External end-term evaluation of the Joint HSR Project:
by Dr G. Mwaluko and Dr P. Chimimba in February 1991

Internal evaluation of training courses and research projects:
by Joint HSR Project staff (C. Varkevisser, M. Mbeba and L. Bijlmakers) in January-March 1991

Internal evaluation (Peer Evaluation) of 10 countries in the Joint HSR Project:
by HSR Project staff (G. Mwaluko, M. Mbeba and A. le Grand and key persons from 10 countries, June 1993

External evaluation of the Joint HSR Project:
by Dr. Vic Neufeld, Dr. Winny Mpanju-Shumbusho and Dr. Jane Doherty

Steering Committee Meetings:

10 July 1987 in Harare, Zimbabwe
14 March 1988 in Harare, Zimbabwe
9 December 1988 in Amsterdam, The Netherlands
30 June 1989 in Harare, Zimbabwe
14 December 1989 in Amsterdam, The Netherlands
20 December 1990 in The Hague, The Netherlands
26 April 1991 in Maseru, Lesotho
22 August 1991 in The Hague, The Netherlands
8 April 1992 in Harare, Zimbabwe
11 December 1992 in The Hague, The Netherlands
December 1993 in the Hague, The Netherlands
30 September 1994 in The Hague, The Netherlands
19 November 1995, Arusha, Tanzania

Technical Advisory Committee Meetings:

First TAC: November 1992 in Harare, Zimbabwe.

Second TAC: November 1993 in Lilongwe, Malawi
Third TAC: November 1994 in Livingstone, Zambia
Fourth TAC: November 1995 in Arusha, Tanzania

ANNEX 5:

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Dr. Rui Gama Vaz
Director
National Institute of Health
C.P. 264
Maputo
Mozambique