Focus on the District Health System
Dr Yogan Pillay Deputy Director General National Dept. of Health writes in the latest update in DHS News...

There are many exciting things happening around the district health system (DHS) and primary health care that should be shared widely, hence the need to revive the DHS News! The most exciting news is that there is significant political commitment from the Minister and Deputy Minister to strengthen primary health and the district health system.

The district health system is the institutional vehicle for the delivery of primary health care services. The DHS is also important in that it should by definition ensure that the primary health care approach is adopted as written in the Alma Ata Declaration of 1978 and as reaffirmed at all primary health care conferences, globally, regionally and nationally since then! So what’s new?

Dr Yogan Pillay
There is increasing acknowledgement internationally that health system strengthening is the only way to ensure that health services reach those most in need of services. Whilst this may be a ‘no brainer’ there has been less emphasis on health systems since the focus on HIV, TB and malaria. However, all development partners as well as bilateral and multilateral organizations have now begun to acknowledge the importance of health systems. It is clear that without a strong health system, vertical programmes, as the HIV and AIDS programme has been to date, cannot succeed and be sustained. This is also true in the face of a growing realization that chronic diseases, including AIDS, require a health system that will not only prevent these diseases but also provide care and support throughout the lives of individuals with chronic diseases.
PhD title: Aid coordination in Burundi: challenges and lessons learnt

It is a year already since my proposal was accepted by Higher Degrees at UWC. The following is an update on what I have been doing on my PhD since then.

First of all, let me explain the context in which this work is embedded. I have been involved in teaching, researching, clinical mentoring and program management in Burundi since 2005, through a French governmental program for HIV. From that very “vertical position”, I moved towards a systems approach, when I started to wonder about the exact effects of our HIV program on the rest of the system, especially as I could see inequalities between the care of HIV and non-HIV patients and the selective capacity-building for health professionals involved in HIV activities.

I began looking at the health system-wide effects of global funding such as GFATM. However, as I thought more specifically of Burundi as a post-conflict country, my focus narrowed down to coordination of aid in the health sector. Indeed, Burundi, after the end of the war, was flooded by foreign aid, because of lack of local resources to rebuild the country. The significant volume of foreign aid from multiple origins, combined with the lack of leadership at national level was overwhelming for the health system. I also wondered whether externally led conflict resolution did not induce a vacuum of power, with significant impact on the leadership and the vision that one country has on its own future.

The aim of my PhD is to explore how Burundi’s ability to coordinate has evolved during the last 10 years (2002 to 2011), using the example of HRH policy. Given that HRH is a pillar of the health system, which has been severely affected by the war, I am assessing the aid coordination pattern and its evolution - from a power analysis angle - using the case of HRH policies.

Data collection was undertaken in 2 steps, at multiple levels and using different tools. The first part was in 2009 over 5 months. Qualitative data were collected using semi-structured interviews, from key stakeholders in aid agencies, government institutions at central-level, provincial level and facilities managers and key-informants as well as NGO managers in 3 provinces. I ended up with about 70 interviews, around one hundred questionnaires and dozens of documents to analyze. The second part was undertaken in 2011 over 3 months, from March to May. It consisted of a similar but simplified process and sampling.

The data collection was both challenging and pleasant. Challenging in the first place because Burundi is a country where amenities such as power and internet supply are not always good or easily available. Sometimes I stayed overnight in places without electricity or water. But I experienced the real conditions of health professionals working in that area and of the local inhabitants. Supervising research assistants in another country was also not an easy process. Skype is a wonderful tool! In another sense, however, it was also easy because one of the official languages in Burundi is French, my mother tongue, and I was also already very familiar with the entire country context, making it much easier for access to people, including for elite interviews.

Another challenge was to recruit and train research assistants. I recruited psychologists, who are graduating in sizeable numbers but who unfortunately do not find employment positions. They were good in interviewing people and building trust. An extremely challenging effort for me was negotiating their salaries. One is tempted to pay them very well to offset the prevalent poverty and the uncertainty of their employment status, but I was told by local people that this would compromise future contracts. So I had to follow local rules and sometimes felt that it was too little. And indeed, the assistants complained at the beginning, comparing the salary scale I was offering to those of UN agencies…..which I could not afford anyway. Yet in this I found myself in the company local employers who also complain about this practice. This is a reminder of the negative effects one can induce with good intentions!

The third challenge I faced with regard to my data collection was that I could not easily find individuals who were used to transcribing directly from audio material. The general practice is to transcribe manually onto paper and then to the computer. Transcribers therefore wanted to be paid twice the price I was offering……besides being more costly it was also funny!

I am starting now with the analysis and writing-up. It is a whole new learning process since my background is very quantitative, but I am sure once I am done, it will be worth the effort!
SOPH has been awarded a grant by the City of Cape Town to conduct a workload assessment. The study will be conducted over a year by Dr Gavin Reagon

Background
A formula for the calculation of the workload of clinical staff was developed several years ago based on the type of services provided at the health facilities of the City of Cape Town and the time taken to provide those services. The formula utilised city-wide average service times, for a mix of all services provided in the City Health facilities, to calculate adjustment factors which could then be used to weight the particular mix of services provided at each facility. Data on the number of patients attended to and the mix of services provided to those patients are collected monthly via the routine monthly report (RMR). Therefore the adjustment factors are applied to the routine monthly data in order to quite accurately calculate the workload at each facility on a monthly basis. With the passage of time the types of services as well as the mix of staff providing those services has changed considerably. Hence the validity of the current formula and the accuracy of its application are questionable and continuing to use the formula without updating it might result in miscalculations of workload for some facilities.

Primary Aim
To develop and apply a formula for measuring clinical workload based on average service time, case-mix and routine monthly data.

Primary Objectives
- Assess the current mix of services provided by City Health facilities
- Assess the categories of staff providing the current mix of services
- Determine the average service time used to provide each service type within the overall case-mix
- Determine the percentage time spent by each staff member on directly attending to patients during a workday
- Develop an adjustment factor for each type of service provided, stratified by staff category
- Modify the existing workload calculation used to weight the number of clients seen by case-mix and service time
- Validate the new workload calculation by comparing and contrasting it against the percentage time spent on patients
- Modify the PREHMS database to allow it to utilise the formula to routinely calculate and provide a report on the monthly clinical workload for each category of staff in each facility

Research Design
- This will be done in 2 stages
  - First the types of service provided by facilities and the categories of staff providing each service will be assessed via a questionnaire completed by all facility managers.
  - Then a modified waiting time survey will be conducted to determine the service time for each type of service provide by each category of staff at a random sample of facilities.

Added Benefit
Since a waiting time survey will be utilised to measure the average service time per type of service, a by-product is that the waiting time will also be measured. This means that the change in waiting times since the last waiting time survey (done in 2007) will become available. It is then useful to determine what actions have been taken to reduce waiting times and assess their effectiveness in reducing waiting times.

Secondary Aim
To assess what activities have been implemented to reduce waiting times and determine their level of effectiveness.

Secondary Objectives
- Assess what activities have been implemented to reduce waiting times
- Assess the current waiting times at a random sample of facilities
- Determine which activities were successful in reducing waiting times

Sample
A random sample of clinics stratified by size will be selected. Since there are very few combined clinics and community health centres managed by City Health, all of them will be selected. One day which is representative of an average day will be selected. All patients who arrive at the facilities selected into the facility sample on that day will be included in the patient sample.

Data Collection
Questionnaires will be provided to all facility managers asking them to list the services provided at their facilities, the categories of staff who provide each of those services and the manner in which the services are provided. The same questionnaire will have a section which asks all facility managers to list the activities which they have implemented to reduce waiting times at their facilities.
and the approximate date at which those activities were implemented.

Facilities included in the sample will be visited by information officers to confirm the services they provide and obtain more details on the manner in which the services are provided by each category of staff, as well as the range of time used to provide each of the services. To achieve this they will briefly interview all staff members present at the facility for 5 to 10 minutes. If no staff members from a category of staff are present on the day then they will return to interview those staff when they are present.

Waiting time survey time–tracking tools will be developed by modifying the previously used tools as required to accommodate any new or changed activities. The modified time–tracking tools will be piloted. The waiting time survey will then be run on the predetermined day.

**Analysis**

- The following analysis will be done:
  - Calculate the total numbers of patients seen (headcount) and compare it to the average numbers seen per day, as listed in the routine monthly data.
  - Calculate the numbers of patients seen for each type of service and compare it to the average numbers seen for that service per day, as listed in the routine monthly data.
  - Calculate the average actual service time for each type of service
  - Compare the average actual service time to the average normative service time
  - Calculate an adjustment factor for each type of service stratified by category of staff providing the service
  - Test the adjustment factors by comparing the clinical workload derived from it with clinical workload measured by the percentage time spent on patients (which is derived from the waiting time survey).
  - Determine the current waiting times
  - Compare the current waiting times to the 2007 waiting times to assess the effectiveness of interventions used to decrease waiting times
  - Determine if the causes of high waiting times have changed since 2007

**Major Activities**

- Prepare and pilot questionnaires for facility managers
- Collect data from facility managers via questionnaires
- Workshop results from questionnaires with sub–district managers, programme managers and a sample of facility managers
- Visit sampled facilities to assess the services which they provide
- Prepare and pilot time tracking tools
- Training of staff and volunteers to run the Waiting Time Surveys
- Run the Waiting Time surveys
- Enter and analyse data from surveys
- Compare survey results with previous survey
- Develop workload calculation
- Apply workload calculation and validate it against survey workload measurement
- Programme PREHMIS database to allow it to automatically utilise workload formula to produce monthly workload reports
- Workshop workload formula with sub–district managers, programme managers and a sample of facility managers
- Finalise workload calculation and apply it to routine monthly data
- Finalise PREHMIS database programming to allow automatic monthly workload calculation and reporting
- Develop a manual to allow staff to easily conduct waiting times surveys which allows both the updating of the Workload Formula when required and the assessment of the reduction in waiting times

**Outputs**

- Workload Formula which can be used to routinely assess clinical workload in tandem with routine monthly data.
- Modified PREHMIS database which routinely calculates and provides a Workload Report for each category of staff per facility
- Updated waiting times assessment
- Description of all activities which resulted in a decrease in waiting times
- A manual which details how to update the workload formula
- A manual which details how to run iterative waiting time surveys

**City Health Staff Involvement**

- Manager from City Health to spearhead the project
- Sub–district managers, programme managers and facility managers will be required to participate in pre and post survey workshops
- Facility managers will be expected to coordinate the waiting time surveys at their facilities (if their facility is selected into the sample)
- Information officers to administer and capture questionnaires on types of health services provided and interventions implemented to reduce waiting times
- Information officers to train community volunteers and run the waiting time surveys
- Information officers to enter, clean and analyse waiting times data
- Information manager to oversee the waiting times survey and assist with the development and application of the Workload Formula

**Other Staff Requirements**

- UWC staff to advise on and assist with the Waiting Time Surveys, the development of the Workload formula and the production of manuals
- UWC staff to conduct the update programming to the waiting time database to allow the modified waiting time survey to output the data required for the workload formula
- UWC staff to train information officers to run the waiting time surveys, enter data, clean data and analyse data
- Staff to programme PREHMIS to routinely calculate and produce a workload report
- Community volunteers to assist with the waiting time surveys
The Flagship course was organised through the Southern African Regional Programme on Access to Medicines and Diagnostics (SARPAM) with support from the UK Department for International Development (DFID), the Southern African Development Community (SADC) and the African Development Bank (ADB). SARPAM is a 4 year project to support the implementation of the SADC Pharmaceutical Business Plan which was approved in 2007 and aims to improve the access to quality affordable essential medicines in the region, and to assist regional pharmaceutical collaboration by SADC member states. To this end, SARPAM works with stakeholders in 14 SADC member states including governments, civil society, regional institutions, international agencies and the private sector.

Course Faculty

In 2010, SARPAM conducted a situation analysis of the pharmaceutical sectors in the regions, which informed a 3 year plan for regional harmonisation. The plan includes pooled procurement of selected pharmaceuticals and the standardisation of regulations around medicine registration with a view to improving access to quality and affordable medicines for the prevention and treatment of diseases that are of public health concern in the region. The implementation of this design was launched through the Flagship Course on Pharmaceutical Policy Reform.

Seventy participants in total, comprised of 14 country teams with 5 senior representatives from the public pharmaceutical sector, civil society and private pharmaceutical sector participated in this course. A panel discussion at the University of the Western Cape was scheduled into the programme to facilitate further dialogue around the plans for regional pharmaceutical reform. One of the highlights of the course was the official opening by the Director-General Health for South Africa, Ms Malebona Precious Matsoso (a pharmacist and UWC alumni). Ms Matsoso has been involved in medicine regulation and has been a member of various advisory panels locally and internationally, mainly tasked with improving access to medicines.

About the Course

The goals for the course were twofold, viz, to build capacity within the region and to sensitize member states about the strategies outlined in the SADC pharmaceutical business plan. Developed by the World Bank Institute and Harvard School of Public Health, the Flagship course has been used successfully in global,
regional and national courses on health sector reform in more than 40 countries. The course was taught by Prof. Michael Reich and Prof. Marc Roberts of Harvard School of Public Health and co-ordinated by Dr. Wilbert Bannenberg. Various academics and researchers from SADC based universities provided support to the Harvard faculty as country facilitators. Among the facilitators was a group from the UWC Schools of Public Health and Pharmacy and this team comprised of Hazel Bradley and the Access to Medicines in Africa and South Asia (AMASA) research team (Dr Kim Ward, Bvudzai Magadzire and Carolle Kinyua).

The pharmaceutical Flagship course material has been used in other global courses held in Washington in 2009 and 2010, and in Jordan in January 2010 for seven countries involved in the Medicines Transparency Alliance (MeTA). For the SADC course, the course material was supplemented by extra information on SADC policies and the potential of regional collaboration to improve the pharmaceutical sector. Overall, the pharmaceutical Flagship course is based on the view that pharmaceutical sector reform cannot be solved in ‘one right way’. Therefore, international experience in combination with local knowledge and priorities is helpful in developing and implementing effective and defensible policies. In addition to considering relatively technical issues like improving supply chain performance, fighting corruption and “leakage”, and improving purchasing practices, the course focused on broader contextual concerns involving both the politics and ethics of priority setting decisions. Thus, skills in political analysis and strategy were part of the curriculum, as well as issues like the relationship of price to demand and the potential role of health insurance schemes in facilitating more effective accesses to medicines.
The course utilised multiple methods including plenary overview presentations, small group discussions and the case-based approach. Based on real pharmaceutical policy examples the cases helped course participants develop their skills by exploring how they would deal with various challenging situations. The course also used a textbook and cases co-authored by Marc J. Roberts and Michael R. Reich, *Pharmaceutical Reform: A Guide to Improving Performance and Equity*. This book is currently being published and it will be made available electronically on the World Bank site free of charge.

At the end of the five-day course, participants had been exposed to a practical approach for analysing pharmaceutical systems performance, and for designing and implementing effective reform initiatives. In addition, the course equipped participants with practical knowledge of how to diagnose problems and use various interventions (involving changes in financing, payment, organization, regulation, and persuasion) to improve pharmaceutical system performance. Participants were encouraged to apply these to their own national situations, taking into account the regional collaboration initiatives currently under discussion. By the end of the workshop, each country presented a poster which showed a problem that the group had identified and the proposed interventions.

**Panel Discussion at the School of Public Health, UWC**
On Tuesday, the 12th of July the UWC Schools of Public Health and Pharmacy hosted a panel discussion: *Pharmaceutical reform in Southern Africa- international perspectives and national implications*. The panel discussion was held at the School of Public Health and Flagship course participants and facilitators were bused to UWC where they were joined by staff from the Schools of Public Health and Pharmacy and pharmacists and other health professionals from the health services, academic institutions, NGOs and professional organizations. This was an opportunity for professionals from Cape Town, SADC countries and the School of Public Health, Harvard University to engage in an important topic of mutual interest.

After a brief welcome by Prof. David Sanders (Emeritus Professor of the School of Public Health), Joseph Mthetwa, Senior Programme Officer for Health and Pharmaceuticals at the SADC Secretariat, gave an overview of the *SADC Protocol on Health* and the *SADC Pharmaceutical Business Plan*. This was followed by a presentation by Prof. Michael Reich of Harvard School of Public Health on the key concepts of the *Flagship Course on Pharmaceutical Reform* and how it could be used to improve pharmaceutical reform and performance of the pharmaceutical sector. Dr Kim Ward then gave a presentation on the research aims of the *AMASA Project* which is a joint project between the Schools of Public Health and Pharmacy at UWC and looks into issues of access to medicines in South Africa. Dr Kim Ward, Prof. Michael Reich and Joseph Mthetwa were joined on the panel by Dr Chiedza Maponga (School of Pharmacy, University of Zimbabwe) and Celestine Kumire (SARPAM Project Manager) and Prof. Sanders chaired a lively discussion on issues ranging from the impact of pharmaceutical regulations to research opportunities and challenges, on access to medicines. Prof. Marc Roberts of Harvard School of Public Health summarized the discussion and Prof. Sarel Malan (Director of the School of Pharmacy) closed the event.

**Future Plans**
The panel discussion created significant interest in the Flagship course and the local facilitators are exploring the possibility of future initiatives for South Africa and the region as a whole.

More information about the Flagship course and SARPAM is available on SARPAM website - [www.sarpam.net](http://www.sarpam.net)

*Profs. Nadine Butler and Sarel Malan of the School of Pharmacy in conversation with Gary Black of the Pharmaceutical Society of South Africa and Lizette Turner*
Winter School 2011

In total we had 317 delegates who attended the Winter School over the 3 week duration. This year however, our Winter School offering was reduced because many participants cancelled due to lack of funding support from their institutions. Initially we had 20 courses advertised for the Winter School but due to the cancellations only 17 courses were presented.

The following courses were presented at the 2011 Winter School:

1. Current Thinking & Practice in Health Promotion
2. Computerised District Health Information Systems: an Intermediate course
4. Understanding and Analysing Health Policy
5. Using Health Information for Effective Management: an Intermediate Course
6. Health Management
7. Health Promoting Settings: A Partnership Approach to Health Promotion
8. Computerised District Health Information Systems: an Advanced course
9. Monitoring and Evaluation of Primary Health Care Programmes: Programme I (2 weeks)
10. Qualitative Research Methods
11. Epidemiology and Control of HIV/AIDS, Tuberculosis and Malaria in the Era of Antiretrovirals
12. Community Participation in Health
13. Health Promoting Schools: Putting Vision into Practice
15. Globalisation and Health: Key Aspects for Policy Makers, Managers & Practitioners
16. Quantitative Research Methods
17. Alcohol Problems: Developing Multi-Faceted Programmes for Communities Living with Alcohol

Some comments from students from evaluations received:

❖ “Very well organised and facilitated. Staff were always helpful and approachable”
❖ “Overall I found the courses very informative and exciting – even challenging at times. Will definitely motivate for our CLO’s to attend”

In general participants found the Winter School very well organised, informative and structured to meet their expectations. The organisation of the Winter School is the culmination of a collaborative partnership between the lecturers and support staff to ensure the efficient and successful offering to all delegates. I especially would like to thank the support staff who put in a lot of hard work and dedication to ensure that the organization of the Winter We look forward to Winter School 2012, which should be even better and more successful!

Lillian Parsons is working with Nikki Schaay and Prof. David Sanders in the SOPH until December. She is an intern with Human Rights Internet -- an NGO funded through the Canadian International Development Agency. Lillian has her undergraduate degree in History and Political Science from the University of Toronto and Masters of International Public Health from the University of Sydney. Prior to touching down in Cape Town, Lillian was working in Vancouver as a policy analyst for provincial patient satisfaction, and has worked on various other health related projects from global investment in R&D for neglected diseases to patency rates in hemodialysis patients. She is incredibly excited to be back working in the global health realm, and after too many months of the dark rainy skies of Vancouver, is happy to be in a place where sun seems to be the norm!
Voices from the Global Project
Revitalizing Health for All
Led by Prof. Ron Labonte, Prof. David Sanders and Ms Nikki Schaay

Background
The Revitalizing Health for All: Towards Comprehensive Primary Health Care (RHFA) project began in 2007 as an innovative health research project with approximately 50 collaborators in nearly 20 countries in Africa, Asia, Latin America, Europe, North America and Australasia. The project will be completed in 2011.

The overall goal of the RHFA project, in collaboration with the PHM, is to enhance the capacities of researchers and research-users to generate and use new CPHC research knowledge for policy and program change in specific country contexts.

The three broad objectives of the project were to:
- compile the existing evidence base on CPHC globally and develop a sound and defensible framework for analyzing past and future evidence;
- facilitate a unique ‘research-in-action’ capacity building program that partners early career researchers, mentors and health practitioners, managers and policy makers to undertake new studies of comprehensive PHC in selected countries; and
- explore what approaches, methods and tools are most useful in advancing an understanding of, and action on, comprehensive PHC implementation.

An important component of the RHFA project from the outset has been to improve ‘research-to-action’ by closing the gaps and reducing the challenges that often arise between the researcher and the research user in health systems research. To this end, the project has developed an innovative ‘research-to-action’ model of a research team comprised of:
- an early-career researcher (typically located within an academic institution);
- a research-user (a government official who is typically responsible for managing some aspect of the country’s primary health care policies or programs); and
- a mentor (a senior researcher with experience in research on comprehensive PHC, health systems and development).

Throughout the course of the RHFA project, each of the 20 research triads (located in Africa, Asia, Latin America and those working with Indigenous/Aboriginal peoples in Canada, Australia and New Zealand) have been working collaboratively to (a) design and implement a

The theoretical foundation of the project: the comprehensive primary health care approach

First expressed in the Alma-Ata Declaration on Primary Health Care in 1978 the PHC approach – both as a political philosophy of health as well as an implementation strategy, is directed at meeting the health care needs of communities (including vulnerable and marginalized people) whilst also addressing the social conditions threatening their health.

In the context of increasing inequities in both wealth and health and the challenges faced by many countries in reaching the Millennium Development Goals, the 30th anniversary of the Alma Ata Declaration in 2008 brought with it a renewed interest and activity in the PHC approach.

An interest in returning to the values and principles of the PHC approach, and particularly its approach to the social determinants of health and inequality, is not only evidenced in such recent publications as the 2008 World Health Report “Primary Health Care: Now More than Ever”1, but is being discussed at a global level as a potential strategy to manage what Dr Chan, WHO’s Director-General, has described as “the ‘double crisis’ of devastating disease and overwhelmingly failing health systems in many low-income countries”. As Dr Chan noted at the most recent World Health Assembly: “Countries with solid health infrastructures and efficient mechanisms for reaching vulnerable populations will be in the best position to cope”1 with the current threats to health security.

Universal access to PHC was not, she suggested, to be considered another health programme, but rather a ‘way of doing health’, something that is core to a comprehensive national health system, and thus as a basis for health system revitalization.

1 The project has a designated website in which more information on some activities can be found: http://www.globalhealthequity.ca/projects/proj_revitalizing/index.shtml.
comprehensive PHC research project and (b) collectively begin to plan how the results (both in terms of outcome and process) be used to inform the development and/or implementation of positive changes in health policy and/or practice in (at least) the local context in which the research studies were conducted.

Obviously, the vision of the RHFA project is that the lessons learnt and recommendations made through the 20 research projects do not remain – or be applied – within the research sites alone. By using the KTE (knowledge, translation & exchange) process, the project will support the teams in advocating to ‘get their message across’ and so begin to link research to action in health systems. One of the ways the project will seek to do this is through use of the Canadian IDRC’s outcome mapping process\(^2\) to:

- identify boundary partners (ie. individuals, groups or organizations with whom the triads work with or interact directly with and with whom they would like to influence),
- identifying the action the teams want these partners (like health policy makers and health service programme managers) to take with respect to the findings of their research, and
- develop appropriate strategies, including progress markers, to work with these boundary partners in order to achieve the desired outcome. These strategies are likely to include providing input and facilitating dialogue at Health Ministry meetings, PHM events (or, in the case of Ethiopia and the DRC specifically, equivalents such as fora), and local events which bring together the health services (both public and NGO), community representatives, research institutes and international or donor agencies.


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**Voices**

1. **From South Africa**

   Dear Ron, David, Corrine and Nikki

   Working in a triad was phenomenal. I really feel that the arrangement is a revolutionary innovation and hope that it will be replicated in many research initiatives in the future. Working with a mentor and a research-user made for rich and stimulating input while the research-user added a practical dimension. We as researchers /academics have now forged a long-term relationship with Salamina, a representative from government and it has elicited plans for future interactions. I hope that these interactions will create opportunities for others in government (in South Africa) to learn about the value of research for informing policy. As a researcher who was early in the field, the triad gave me the space to grow in leaps and bounds. It gave me the space to take a lead in the content direction of the research. It gave me the space to make fundamental decisions regarding the research process and most importantly, the triad showed confidence in me to present our work to the rest of the world. The skills that I have gained from all these opportunities have been amazingly empowering and have enhanced my
desire to add value to the field of research and to be part of a community that wants to change the ills of the world...

The findings from all the country projects have generated a wealth of knowledge that I think we can all draw from and augment and therefore paves the way for opportunities for further collaborations amongst all of us. And who knew that we were all part of such an awesomely diverse team until we all met in Ottawa?! The amazing success stories from many of the projects is enough to give the rest of us the courage to surge on with our own efforts to make success stories in our respective countries. I felt very blessed to meet the colourful array of fellow colleagues. I really wish to maintain the connections that we have made...

Lastly, thank you for this opportunity to have been part of a great team of individuals from so many corners of the world. I honestly hope we will cross paths soon in the future.

Kind regards
Nonhlanhla
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2. From Australia

Dear Friends

There is much to reflect on with our Teasdale Corti project. I learned a lot from working with Sara and Dr. Heidari on the Iranian project – especially about the work Iran has done in relation to CPHC – it is impressive and an aspect of Iran that does not appear in the international coverage. It was lovely to work with Sara and see her growing confidence in writing and analysis over the course of the project.

I also valued the opportunity to work with the Indigenous projects at the start of their training and learn more about the cultures and practices that are so important to the heart and spirit of Indigenous life in the early 21st century – it was a privilege to see that ways in which Indigenous peoples from Australia, Canada and Aotearoa connected and related over the course of the project.

It was also a privilege to be part of the initial African training and then to see how well each project had gone and to hear about your results at the final meeting. I stand in complete awe of the work of the DR Congo team to be able to undertake such careful work despite the terrible conditions of war and its impact that you live with on an everyday basis.

The final meeting was a great event and the week went well because of the different perspectives, approaches and values we brought to the week and the projects. I’m sorry that more policy people didn’t come to our meeting on Thursday and hear about the project and its impressive work.

Ron, David Corinne and Nikki led the project very competently and were a great leadership team for us all.

I hope we can keep this network of CPHC researchers in touch (perhaps through the People’s Health Movement) – perhaps we should plan to meet again during the 3rd People’s Health Assembly in Cape Town in July 2012. Meanwhile go well in completing your research and writing it up and thanks for the opportunity to get to know some of you for the first time and to come to know others in more depth.

With very best wishes
Fran Baum
fran.baum@flinders.edu.au

3. From Iran

My journey in Teasdale-Corti project started with an under-developed research idea in mind. It was almost four years ago when I was thinking of how to develop this idea, and who will be assisting me. I could see a long road ahead of me, narrow and dark.

The first light of hope shone when I replied to the call of interest, tried to pull ideas together and shape a research proposal. A good start...as I needed help indeed. I shared my idea with my mentor Fran Baum whose enthusiasm, encouragement, and support gave me more energy to step forward.

Along the way, I’ve found more hands in mine. We are different in nationality, in culture, in language, and in skin colour but we’ve had one thing in common: being passionate about what we are doing and about health, equity and justice. A mixed group of young people in the early stages of their learning and experience collaborating together and gaining long term research experiences.

The energy and passion of people who led the project have been inspiring. There is still a lot to be learnt from them!
My journey has opened a new door for me to make a stronger contribution to people’s health, to equity and to social justice, the things that we all dream of. I now have a broader network of friends, stronger capacity and greater confidence to continue research and expand my intellectual boundaries.

Sara Javanparast  
Email: sara.javanparast@flinders.edu.au

4. From Uruguay  
Ron, David, Corinne and Nikki,

I can say that I am full of gratitude to all of you and to the participants in this project, for the opportunity you gave me to know you and to experience this global research effort all around the world to produce evidence and generate practice in order to enhance the claim for health and justice.

The situations of different societies and cultures have the same determinants, but there are countries and people that are worse than others. Coming to know this through the particular cases studies that were made visible through this research, once again presents the urgency for solidarity and compromise.

I especially want to thank David Sanders for his contribution. It opened my eyes and heart to the health situation in Africa. I also came to understand that each location or country needs particular strategies, something I realized in discussion with the team of Colombia, a country at war. All the persons I met in El Salvador gave me a new perception about life founded on respect and collective effort

My own team in Uruguay has also been a lovely challenge, one full of learning and support to grow in research capacity but also growth in humanity and friendship.

To all my gratitude, I thank you all, deeply.  
Ingrid Gabrielzyk  
ingrid.gabrielzyk@gmail.com

5. From the Democratic Republic of the Congo  
Dear Ron, Corinne, David and Nikki,

As a research user – a total pragmatist and definitely not an academic – this has been a fascinating learning experience for me. I have always been a user of anecdotal information in project proposals and reports; I now see its place in a rigorous framework of a research protocol to bring data to life and communicate the living reality of some pretty graphs and tedious tables that are produced by quantitative methods. I love these mixed methods.

I have learned a lot about academic rigour and I henceforth eschew my sloppy methods of using project monitoring data to draw conclusions: I am a reformed character.

The biggest gain for me is to find the place of our programs in a theoretical framework of CPHC. We developed our Safe Motherhood program by trial and error. It was delightful and encouraging over the three years to learn more and more how what we developed pragmatically totally supports the theory, and we might have got there faster if we had started from a theoretical starting line; but we feel we have been freer to develop and adapt to the context by not being put into any theoretic box.

I am excited to have discovered a new methodology to explore further our Safe Motherhood program: the measurement of social capital, its importance in a post conflict situation, how we develop it. Other interesting themes would be: how we can build further onto the foundation of SM, towards health insurance for under fives health. I would also love to track prospectively the impact of the program on the social determinants of health over the long term.

Thank you so much for your accompaniment over these three years. It has been a wonderful experience. I have met a group of amazing committed people who are changing their world.

With best wishes.  
Lyn Lusi  
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