Promotion of Institutional Links in Health in the Commonwealth

Commonwealth Secretariat

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by Margaret Thomas

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FOREWORD

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This year, at the beginning of the final decade in which we commit ourselves to reach the goal of Health for All by the Year 2000, the Steering Group is meeting to consider the progress of the Commonwealth Health Development Programme. There is, at this time, a renewed emphasis on the importance of human resource development as a key strategy in improving the working of health services. Develoment is seen as not simply furthering a series of isolated donor projects in particular enclaves but improving the functioning of the whole health system. In particular, Ministries of Health are directing efforts to enhance the skills of all who work in health.

Human resource development can be assisted by the twinning or linking of institutions in developing countries with similar but more mature organizations in other parts of the world. It has proved an effective way "to transfer know-how, train staff and build up management capabilities" [Cooper 1984].

Given the slow growth of development assistance budgets and the hard choices that have to be made in relation to health investments, institutional collaboration schemes offer low-cost mechanisms to help improve the functioning of the parts of the national health system, in particular allowing staff to acquire a "self-sustaining confidence about local and international sources of specialized knowledge and technology" [King 1986].

The Commonwealth is uniquely placed to help in two ways. First, there is the interweaving between the member states of "cultures, politics, literatures, sociologies and social technologies" [King 1986] and the common use of the English language. Second, and perhaps more important at the present time, when many LDCs and particularly those in Africa are sliding into a deepening crisis of poverty and hunger, the World Bank has reinforced the need for tenets of conduct that the Commonwealth has long upheld: "a determination to respect the rule of law and vigorous protection of the freedom of the press and human rights". Human potential, says the Bank, must be given absolute priority through

better health, education, infrastructures and communications and also through better and more equitable government. Better health depends critically on a well functioning health system manned by able staff with "efficient training and supervision".[World Bank 1989].

It is within this framework that the future dimensions, financing and potential of institutional links will be examined by the Steering Group. From the discussions it is hoped that a working plan for action can be drawn up.

1. The Concept of Institutional Linking or Twinning

Linking or twinning can be defined as a special professional relationship of co-operation between two health institutions. Frequently one is in a developed country and the second in a developing country [North-South link]. Other but rarer linkages have been established between two or more developing country institutions [South-South link]. A link arrangement can be formal or informal but it must be both free and independent and able to cut across geographical and political boundaries.

The arrangement should be used to promote specific objectives. It should represent the desire of the institutions involved to share research, learning and teaching experiences, to enhance management and organizational capability, to exchange ideas and to co-operate in the solution of common problems. A twinning demands useful and well-maintained contacts, good communication and a continuous exchange of information and people. There should be scope to involve people of different age-groups and different professional skills, and a worthwhile link will provide opportunities for a continuous process of learning. Known and successful links have been established between universities, medical schools, nursing colleges, district health authorities and libraries. One ambitious scheme links two countries, Wales and Lesotho, and has involved the twinning of schools, colleges, the Young Farmers Unions and, shortly, District Health Authorities.

Twinning, if successful, may develop into tripleting and still further into regional or international net-working. The aim of a network is not to subordinate institutions into a common pattern, rather to increase the ability of each to respond to the particular problems and opportunities it faces.

2. The Context for Linking Arrangements

Any programme of collaboration between institutions in different countries has to take account of the changing international, national and institutional environment in which it has to function.

2.1 The Commonwealth framework

The 49 countries of the Commonwealth are at different stages of economic development and have different systems of government. They have differently organized systems of health care delivery, and cultural and educational traditions. The systems of government and administration, and the relationships between institutions and the state vary widely, and both these, and the institutions themselves, are evolving rapidly. There are great differences, for example, in the way training programmes are organised and in the emphasis given to post-graduate education and research as opposed to primary health care development. Further diversity can be found in funding systems, in the adequacy of funding and in the language of academic dialogue. An open and pragmatic approach is needed to cope with such a varied set of countries, institutions and circumstances and to draw on the rich resources and experiences that are available.

2.2 Donor Assistance

Most links depend on funding from aid agencies. Agencies are increasingly selective in the activities that they will support and in defining the length of time that financial support will be available. They also ask for the measurement of the effectiveness of a link to be planned for and discussed from the commencement. Frequently they seek proof that a link will lead to a practical contribution to a country's economic development - a wider objective than, say, an increase in the number of teaching schedules or research activities. Attention tends to be focused on scientific and technological subjects as opposed to the social and cultural aspects of the development process. Increasingly, also, Northern donors expect commercial benefit to flow directly or indirectly from aid programmes. For example a link arrangement may lead to an increase in the number of foreign students attending a particular university in the North, raising its fee

income and enhancing its research capability. This means that from the beginning potential link arrangements are carefully documented, and costs and benefits systematically appraised.

2.3 The Impoverished Learning and Operational Environment of many Developing Country Institutions

Many institutions in Less-Developed Countries (LDCs) operate in a difficult and impoverished learning and working environment. There are severe domestic financial constraints on all activities and a critical shortage of foreign exchange to further involvement internationally. For those who are involved in the daily operation of health institutions certain common factors can be identified:

- a strong sense of isolation, of being apart from much of the creative and intellectual thought and recent research that is being undertaken and published. Lack of money has left training institutions, district health authorities, even the Ministry of Health, without access to new books, journals, video films, computers and data bases. Many operate without reliable photo-copiers or telephone and postal system.

- a single operator in a national field. Many LDCs have, with difficulty and sacrifice, established one medical college, one college offering courses in health administration, one specialist hospital or treatment centre for the treatment of cancer or AIDS. This results in a lack of specialized networks able to advance research, produce and circulate articles or journals, or initiate team projects.

- promotion of North-South rather than other directional links. Where financial help is available from donors it usually assists staff to travel to Europe or North America rather than to other countries of Africa or other provinces of India. South-South links, regional networks, publications and meetings remain weak activities.

The LDC institutions find themselves isolated from the information-based culture of the Developed Countries [DCs] and remote from the specialized networks, journals, conferences and research and consultancy documents that are the vehicles of that culture.

2.4 Financial Constraints on DC Health Institutions and in the Health Sector generally.

Many DC institutions, particularly those in higher education and the health sector in general, have been subject to financial constraint by DC governments in recent years. The growth of social sector expenditure, the share of national resources consumed by the health and education sectors and the effectiveness and efficiency of expenditure have become matters of vital concern for Governments of most DCs. Governments have looked for restraint in public expenditure growth and the reduction of government deficits. Privatisation, decentralization, charging students and patients, attention to effectiveness and efficiency have all been key strategies in this new approach. This has had an effect on the climate for scholarship and research which can be illustrated with 3 examples:

- Less public subsidy has meant substantially higher fees being charged to students from LDCs. In many institutions this has led to a drop in the number of overseas students attending courses, with all its ramifications.

- The ratio of students to teachers has been increased involving a heavier teaching load and less time for staff to undertake other activities.

- The freezing of public funds has meant curtailment of activities, even closure of entire departments of universities. Commercial sponsorship has frequently been sought as replacement funding with emphasis on research linked to immediate commercial and national uses.

In this difficult environment the putting in place of academic links and other forms of international co-operation will be scrutinized on a cost-benefit basis as closely as investment of resources and time in other activities. This problem emerged earlier in the USA than in Europe. [Family Health Care Inc. 1979].

2.5 Need for expertise in strengthening health systems for a Primary Health Care approach.

2.5.1 Many LDCs are finding difficulty in pursuing a Health for All by the Year 2000 strategy and in reorganizing Ministries of Health to actively promote Primary Health Care (PHC). The concept of PHC encompasses not only the provision of a wide range of services for health promotion, disease prevention and treatment of common ailments (with referral of patients as necessary) but also basic principles of equity. It stresses community participation and collaboration between sectors in active pursuit of a healthy population and healthy living conditions.

Ministries of Health are failing to serve as the directing and co-ordinating authorities for the PHC approach. The reasons have been identified by a WHO Expert Committee [WHO 1988] as:

- an inadequate or inappropriate range of responsibilities.
- an isolated role in the national health system.
- excessively centralized responsibilities.
- poor management and weak leadership.
- inadequate links with other sectors.
- limited involvement with the community.
- lack of financial resources.

The Expert Committee went on to list seven strategies for overcoming these weaknesses and the relevant technical, political and cultural factors to bring about change. In the Recommendations made by the Committee the importance of the exchange of information and experience both of a technical and factual nature was stressed.

2.5.2 One Network that already exists to promote the change of curricula in medical schools to a PHC community-oriented approach, and to assist institutions in

countries that have decided to introduce innovations in the training of health personnel, is the Network of Community-Oriented Educational Institutions for Health Sciences. The Network is based at the University of Limburg, Maastricht, The Netherlands. It has financial backing from WHO. [see Appendix 6]. Many Commonwealth institutions already belong to the Network. Links and collaborative approaches have a great deal to offer in solving the problems that Ministries have to face.

2.6 The Challenge

This, then, is the changed and still changing background of the 1990s. It has to be taken into account in the planning of new links or the strengthening of existing ones. The challenge is to create conditions in which scholars and administrators in health from the different countries of the Commonwealth can work together in useful and productive ways.

3. The Objectives of Linking

A Link must have a defined purpose and objective. It can, in itself, be the main element of a relationship or it may be a single element in a project that involves several and varied activities.

It would be wrong to regard one single visit or a number of unco-ordinated visits as a link arrangement. A link is a planned integrated activity that aims to foster exchanges of staff and co-operation on a long term basis of perhaps five or more years. It should bring benefits to both partners in knowledge and understanding. It should aim to meet the wider social and economic requirements of society in general.

The benefit of links should not flow in one direction alone; a mutual interest and benefit are prerequisites for success. "Links are delicate mechanisms and depend on continuing mutual confidence and regard between members of staff concerned". [British Council 1987]. "Extreme care must be exercised" in choosing the right partner. [Willoughby 1985]. "The potential for conflict is great" [Baker et al 1989 [1]]. The main areas where links have proved themselves valuable are:

- institutional, organizational and administrative development.
- staff development, particularly mid-career staff.
- management training.
- improvement of technical expertise.
- course and curriculum development, and training techniques.
- technology transfer (which should be appropriate to the country).
- collaboration in research.
- community matters, particularly in relation to PHC development.

4. Starting a Link

Links can start in a variety of ways, for example:

- o personal contact leading to a shared interest or enthusiasm which is developed through a link.
- o the desire to draw on the experience of another institution or organisation for development of a new activity, a new training course or some administrative or technical skills.
- o the need for access to laboratory or field work facilities which requires linkage with another institution.
- o as a result of a "top-down" approach, an initiative may come from a government or aid agency as a way of meeting a specific need included in an aid package, e.g. establishing base-line data about a population before planning an immunisation programme.
- o through a desire to extend or formalize an existing informal arrangement.

Frequently an individual or an institution which initiates the link will already know, perhaps, through a period of study abroad, or research articles, where useful collaboration can be arranged. On other occasions help might be sought through an aid agency or an organisation like the Commonwealth Secretariat in the identification of a suitable partner.

Links are likely to be long-standing and successful only when a real advantage to both parties is evident and where there is a genuine shared interest. Thorough and frank preliminary discussions between possible partners is essential as to how a link is seen as developing over time.

If a link seems feasible then a link agreement should be produced. This should state clearly the objectives of the link, and the time scale, the various activities of the link, the cost of the activities year by year, and in total, and the benefits seen from the link. Willoughby has pointed out that institution building for mid-career training will very often require a time

horizon of perhaps ten years rather than the normal three or five years of the usual project cycle. (Willoughby 1985).

Each partner should nominate a co-ordinator with a major responsibility for overseeing the activities of the link. It is important to remain conscious of the "enormous time investment required to maintain the momentum of a project while seeking financial support and planning the future" [Baker et al 1989 [2]].

5. Characteristics of Good Linking Arrangements

From a number of evaluation studies it is possible to note that adherence to certain guiding principles will work to ensure the success of link arrangements.

5.1.1 The DC institution should:

i) be a training, educational, research or administrative institution with experience of and responsibility for managing a permanent staff, and its own physical facilities.

ii) have an appropriate and well qualified and experienced staff.

iii) be a recognized authority in its field.

iv) have significant experience of developing countries.

v) have its head take an active and personal interest and support the principles of the collaboration.

vi) have the facilities and expertise to provide a training of trainers input.

vii) have major interests and knowledge and expertise which coincide with those required by the LDC institution.

viii) have the capacity to work out in detail the logistics and language requirements for each visit to a LDC and particularly the release of competent staff.

ix) look for a good match of academic/research/ administrative interests and a good balance of academic level research/administrative/ capability.

x) be competent in problem diagnostic and consulting skills and be able to price its services accurately when these are requested. If not it should associate itself with a consulting firm possessing these skills.

5.1.2 The LDC institution should:

i) identify and develop teams to specialize in the topics which are the subject of the link.

ii) ensure that activities planned are of real use to the country and not too sophisticated for the current level of experience.

iii) provide and maintain adequate equipment, service, transport and facilities for the sustaining of joint activities.

iv) identify and specify individual members of staff and charge them with responsibility for each teaching/research/administrative task involved in the collaborative programme, stating the dates on which they assume responsibility.

v) design and properly maintain staff/student/ research records for follow up and evaluation purposes.

vi) liaise closely and regularly [reporting quarterly or half-yearly and on an agreed report basis] with sponsoring donor agencies.

vii) make plans, specifying details and arrangements for continuing activities, particularly courses at the conclusion of the formal link arrangements.

viii) in the case of a multi-campus institution, ensure that the most appropriate and conveniently reached campus is used for meetings/training courses etc.

ix) create a special short course unit to stimulate, manage and integrate the institution's short course/seminar/lecture series programme.

x) ensure that LDC staff receive adequate advance information about link preparations.

xi) ensure that counterparts selected are eligible to be appointed to full-time appointments, and have good prospects of becoming full-time members of staff.

xii) ensure that in the case of training courses, those trained have the opportunity to teach others wherever possible.

xiii) have its head take an active and personal interest and support the principles of the collaboration.

5.1.3 Together the DC and LDC institutions should:

i) determine the content of the training/research/ teaching/administration link.

ii) design evaluation procedures and specify indicators by which effectiveness can be determined.

iii) determine the nature of the teaching material/ research etc to be developed (preferably in the LDC to ensure local relevance), also the language to be used, allocate the component tasks of such development and agree and adhere to a timetable for preparing and completing materials.

iv) agree and adhere to a timetable specifying individual responsibilities and the details of the way the DC institution and staff are to decrease their input, particularly to course design, curriculum formulation, teaching, management procedures etc and the LDC institution to increase its participation.

v) secure the involvement and support of relevant professional and advisory bodies in co-ordination and in determining training needs and mounting short training courses.

vi) investigate and encourage the support and involvement of the private sector in designing and financing link arrangements.

5.1.4 The Donor Government/Donor should:

i) ensure that the objectives of the collaborative link are clearly stated and carefully adhered to.

ii) separately specify the sums in the total aid financing which are to be devoted to the major components of the link, e.g. courses (design,

mounting, management and evaluation) and preparation of teaching materials (including translation if necessary).

iii) ensure full documentation on costs and seek to establish speedy administrative procedures for the transfer of funds, particularly for the purchase of equipment; ensure also that office in charge of funds agree procedures for approving, implementing and monitoring programmes and that this information is kept to be made available to official evaluators.

5.1.5 The LDC Government should:

i) ensure that LDC participants stayed linked to the collaborative activities for a significant period of time, and if replaced, that the substitutes are staff of an appropriate level and capability.

ii) ensure that if the collaboration involves training, that participants arrive promptly and stay the whole duration of the course.

iii) ensure that relevant ministries/agencies are made aware of the link activities, and what evaluators will be looking for after the link has finished.

5.2 Problem Areas

Several problems were repeatedly mentioned and highlighted in evaluation documents:

- Language: sufficiency of funds for crash courses, translation of documents (particularly for training courses) and employment of competent interpreters.
- DC Staff Release: frequently difficult for DC staff to be released for longish periods. Temporarily employed staff sent to LDCs were often unsatisfactory.
- Solo Travel and Accommodation: often found difficult by both DC and LDC staff alike.

- Transferability of qualifications: difficulties experienced by LDC students in meeting entry requirements of DC institutions; LDC staff unable to practise in a DC institution (eg as midwife) because of professional requirements for practice.

- Foreign Exchange: LDC shortage of convertible currency making activities lop-sided, e.g. far more visits by DC staff to LDC than vice-versa.

- Mutuality of interest: a LDC institution may require linkages with a number of other DC centres that have relevant experience in particular fields. There should be no attempt to restrict or monopolize access. Each individual link needs its own agreement, costing, monitoring and evaluation procedures. This was emphasized many times.

- Research and teaching: a fresh emphasis needs to be put on "normality" or "ordinariness", on routine matters and topics, alongside work of a developmental character. There should be opportunities for LDCs to research in DCs or in other LDCs.

- Synthesis of past and on-going research in LDCs is urgently required. The U.N. Agencies are seen to have an important role in remedying this situation.

6. Costs of Linking

6.1 Link arrangements are financially and organisationally attractive to donor agencies, since projects are frequently small-scale and not costly. Two aspects in particular are worth noting.

6.1.1 o Delegation of decision-making
Arrangements can allow for a whole series of small-scale decisions and transactions to be delegated to the two linked institutions. Because of their very nature, involving parties in DCs and LDCs, arrangements and transactions are slow and time-consuming to deal with. "The myriad of small funding decisions" [King 1986] are best transferred to the link partners. This usually proves an appropriate low-cost and long-term management solution.

6.1.2 o Investment Protection
Link schemes can be convincingly portrayed as "informal methods of investment protection" [King 1986]. If a donor has invested several million pounds in a new teaching hospital in a capital city, a large associated sum of money will have been provided for intensive training overseas and for consultancy services for technical assistance on-site. A further fairly small amount of money can ensure perhaps ten years of further valuable interaction with teaching hospitals overseas. Project funds can be designated for short-term training courses, exchange of staff, provision of books and journals and purchase of equipment. Other funds could be specially earmarked to transfer expertise to a "triplet" institution in a neighbouring LDC.

6.2 Information on the cost of links is scanty and where information is available little of it relates to health linkages.

6.2.1 Financial Costs

Link schemes are generally small-scale in financial terms. The British Council has advised that many of its university link programmes operate over a three or five year period on a budget of £10,000 per annum or less. This figure does not reflect many hidden

economic costs such as free accommodation, free food and free transport provided for visiting staff by the host institution. The Academic Links with China Scheme has operated in a tightly constrained framework of finance (up to £3,000 per annum) and duration (up to 3 years). "Much has been achieved on such modest funding" (British Council 1987). The link between Herefordshire Health Authority, U.K., and the Muheza District, Tanga Province, N.E. Tanzania, has cost about £6,000 p.a. This has been financed by the Commonwealth Foundation [£4,000 p.a.] and the Lennox-Boyd Memorial Trust [£2,000 p.a.]. The Herefordshire Health Authority has provided free accommodation for the Tanzanian visitors and accounting and administrative help. There have been some small donations from drug companies [Wood and Hills 1988].

6.2.2 The experience of the European Commission, also, is that links are small scale financial programmes. An evaluation of linkages in several sectors, mostly non-health, financed from the Lome I and II agreements for the ACP states and from the first and second Financial Protocols for the MSE States showed 20 linkages in 5 ACP/MSE countries with allocated funds of between 20 - 25 million Ecus [£14.5 - £18 million] overall. The allocation for each linkage ranged from 150,000 to 2.5 million Ecus [approx £100,000 - £1.8 million]. These included supplies of equipment in many instances and the cost of shipment.

Table 1 - Range of Costs of Twenty Link Schemes financed by the EEC [DG VIII].

Allocation (million Ecu)	Number of Linkages
0.1 - 0.6	9
0.6 - 1.2	5
1.2 - 1.8	1
1.8 - 2.4	3
2.4 - 3.0	2

[£1 = 1.3525 Ecu]
April 1990 Exchange Rate

Source: Commission of the European Communities [DG VIII] Evaluation of Inter-Institutional Co-operation. Synthesis Report 1988.

The EEC evaluation states that the size and growth of the programme, its financial cost and its distribution over ACP/MSE countries had been generated more by the universities that were involved rather than by active internal EEC planning, i.e. the EEC had responded to requests rather than initiated them.

6.2.3 A further comparison can be made with the University Co-operation programme financed by the Government of the Netherlands. The programme has operated since 1969 and has moved from an unstructured approach to one where objectives, conditions and criteria are explicitly stated. The allocation per project has varied from Dutch florins 0.5 million to 3.0 million [approximately £160,000 - £1m] the amount depending in

part on the length of the period of implementation. Dutch support is now limited to around 15 linkages overall.

6.2.4 Evaluation documents show that costs could be further pared if training courses that are part of a link arrangement are run in a LDC rather than DC. One evaluation showed that cost per participant in a training scheme held in London was approximately 3.5 times that in Indonesia [Lowcock and Watson 1988]. While there were some advantages in U.K. training [the participants felt that they gained a great deal from exposure to European culture and way of life] the evaluators felt these were insufficient grounds to justify the substantial extra cost.

6.2.5 Marginal Costing

Most link schemes appear to be of fairly modest cost because linkages between universities or research institutions are regarded as additional activities for established faculties or administrative authorities, i.e. they can be costed without reference to capital or running costs of an institution, or staff overheads such as pensions, sickness and holiday payments. If universities moved to place their link activities onto a consultancy basis, charging for premises and staff time on a full cost basis, the totals would be very different.

The very smallness of the budgets involved may present problems for some donor agencies which are used to handling large scale projects. This can result in a low degree of interest in link funding proposals and should be anticipated by the institutions involved. Well thought out procedures for handling money, and accounting for it, that are included in a project proposal can enhance its chances of acceptance.

7. Link Evaluation Procedures

7.1 Evaluation has always been an essential procedure in the management and planning of donor assistance. It is more critical today as aid agencies find their budgets not being increased in line with inflation and governments demanding more accountability.

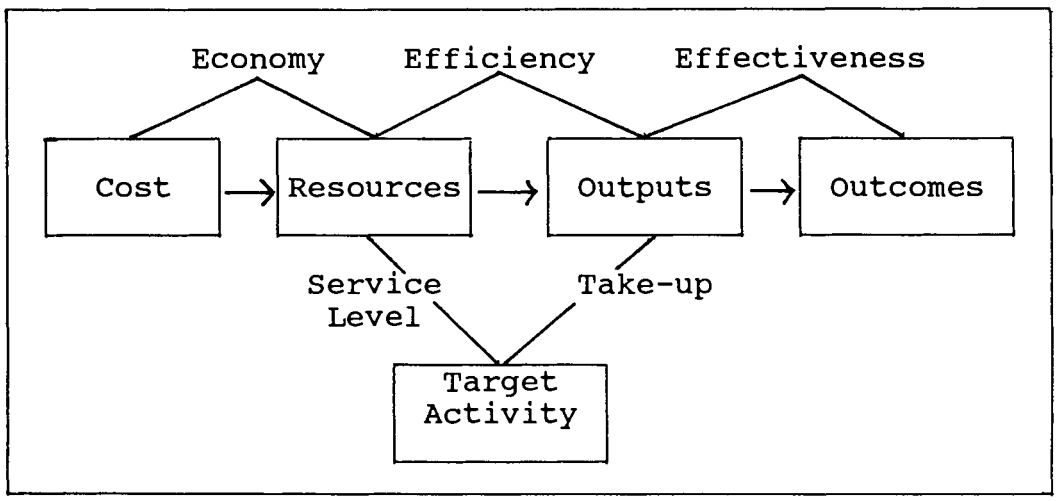
It is often hard to measure the performance of link arrangements, especially in terms of quality and effectiveness, but it is wrong to overstate the difficulties. There is need to be clear from the outset what the link was intended to achieve, and what distinguishes a good link from a poor one [see Section 5]. Quality and effectiveness can be monitored in various ways, for example by tracing those who participated in link training arrangements. What positions do they hold five or ten years later? Have they trained other staff or produced training manuals?

The key step is to decide what are the important indicators that really need to be monitored and to eliminate unnecessary data collection. Second, link directors must assign clear responsibilities: who is responsible for each activity; who will monitor performance; what must be reported on a regular or an exceptional basis. Third, indications of performance should always be accompanied by a yardstick that indicates whether results are good or bad. Finally, there is need for clear and simple reporting.

There must be a commitment by both link partners to the evaluation process. Performance has to be evaluated objectively and there must be freedom to admit when things could be improved and the corrective action needed.

7.2 Measuring Performance

Fig. 1: Measuring Performance at Four Levels



Most activities of links can be measured in four dimensions:

i) The Cost.
ii) The Resources Provided.
iii) The Outputs.
iv) The Outcomes.

Performance indicators can be developed based on the ratios between them, in particular:

- Economy measures - the cost of acquiring resources such as staff, premises or computers.

- Efficiency measures - the cost of a training course in U.K. compared with one in Tanzania, or the drop out rate in U.K. as compared with a course in Tanzania.

- Effectiveness measures - the final outcome - e.g. the number of course alumni that have been promoted since training, number of training courses run by alumni, publications produced by alumni.

The most obvious difficulty in link arrangements is how to measure the outcome or effectiveness of the link.

Fig. 2 Measuring Performance in a Link Training Scheme

	Quantifiable	Not Readily Quantifiable
Resources ↓	Costs of Staff Premises Equipment	
Services Provided ↓	o Lecturers o Support staff o Curriculum o No. of students o No. of classes or courses o Research facilities	o Mastery of new experimental techniques o Quality of teaching o Content & adequacy of curriculum o Facilities o Extra-curricular activities
Output ↓	o Alumni o Journal articles/ books	o Special needs e.g. language o Background factors, e.g. cultural problem of communication with supervisors. o Commercial contacts for DC
Outcome	o Attendance rates o Exam results o Placing of alumni on leaving o Placing of alumni after 5/10 years o Training course material o Promotion of further LDC student placement in DC institutions	o Promotion on return o Management changes instituted by alumni o Books, articles etc. produced by alumni o Non-work achievements o Commercial development beneficial to both LDC/DC

Identifying Key Performance Indications

Deciding which performance indicators should be regularly monitored in a link is a matter of judgement and depends to some extent on the donor, the institutions involved, the time period and the circumstances in the LDC.

- Some issues may be critical to one donor, not to another, e.g. participation by women in link training schemes.

- Some LDCs may attach more importance to particular issues e.g. decentralisation of health services and their administration.

- Some indicators, e.g. drop out rate of trainees may be an important local management issue but may be such a small percentage as not to warrant inclusion in a regular reporting procedure.

- some indicators may be worth monitoring at less frequent intervals than others, e.g. publications, journal articles may be reviewed at perhaps 2 year intervals, while others may be reviewed more frequently e.g. number of training courses, number of students attending.

In choosing the critical indicators it is often useful to make a distinction between operational performance that needs to be monitored at regular intervals and underlying performance (for example quality and effectiveness) that may be just as critical but which it is not sensible to debate every month, even if information were available.

Setting Targets or Yardsticks

There is little point in reporting performance indicators without some kind of target or yardstick that indicates whether the figures are good or bad. There are two possible approaches: setting targets, or using comparisons such as last year's figures or averages from other linkages. As links tend to be "one-off" activities the course is usually to set realistic targets related to the unique link activities.

7.3 Producing Reports

A required stage in the link process is the design and production of the required report. The questions that need to be asked are:

i) Who is the report for, and for what area are the persons responsible?

ii) What decisions do they have to take or genuinely need to monitor, in the sense that they might intervene if the result were unsatisfactory?

iii) How frequently do these decisions need to be taken?

The report should then contain the minimum information needed to satisfy these requirements. The exclusion of less critical items from regular reports does not mean that they are not monitored or reported. Any exceptional item could be included on an open page which would be specially reserved for any unprecedented or unusual event.

The most important aspects are economy and brevity. Brevity means eliminating statistics that are of marginal value and devising the most economical means to display indicators that need to be included. Other obvious points are:

- the avoidance of over-crowding on the page.
- the use of clear headings.
- the employment of graphs to illustrate trends and variations.
- the highlighting of key figures.
- the inclusion of text commentary alongside relevant figures for readers who dislike statistics or graphs.

8.0 The Way Ahead: Recommendations for Action

8.1 One way of taking forward the active promotion of institutional links would be to establish a special programme [maybe named LINKS] perhaps within the Health Programme of the Secretariat or attached to one of the major donor countries of the Commonwealth. Alternatively a Commonwealth University or other group or institution might be interested in taking on the responsibility with appropriate financial backing. Money could be sought from WHO, UNDP, the EEC and the Secretariat itself. The programme LINKS could be established as a project with a time-framework and evaluated after an agreed period of time to find out if this was the best framework in which to continue this particular work. The Health Programme of the Secretariat could be given an overall evaluative responsibility.

Full time staff could be appointed including a project co-ordinator, a professional information officer and a secretary. LINKS could develop a system of working relations with individual institutions and with organisations that have already been active in promoting regional or international co-operation and working towards the adoption of a Primary Health Care approach. The collection of information about the activities of other organisations should enable overlapping and competition to be avoided and complementary and joint activities to be promoted.

LINKS could offer regular services to institutions within the Commonwealth; for example:

- a bulletin on ideas for co-operation, institutional profiles, offers and demands for links.
- guidance as to membership of other Networks and Associations.
- technical guidance on priority topics of interest to institutions generally.
- ad hoc papers and technical notes.
- technical and financial support to specific co-operative action involving groups of institutions participating in a project.

Initially such services could be free. After a period of time it might be possible to ask registered institutions to co-finance LINKS through membership fees.

8.2 A possible action programme for LINKS could relate to four areas, if not more:

1. Institution Building and Development.

2. Programme Development.

3. Staff Development.

4. New, effective approaches to learning, teaching, consultancy and research.

8.2[1] **Institution Building and Development**

- to encourage all countries to nominate a focal point for enquiries about possible linkage.

- to circulate INRES-SOUTH Data Base requirements to all LDC institutions to encourage registration of all health institutions in "South" Commonwealth countries with the Data Base [see Appendix 7].

- to prepare a comprehensive information service on demand for and offers of linkages, and the expertise available in institutions, also ongoing major research and sabbatical leave arrangements. LINKS could consider the computerisation of this information.

- to foster a sustained programme of linking through active promotion, participation of staff in conferences, arrangement of liaison meetings utilizing regional and inter-regional organizations.

- to support the creation of networks of institutions in areas where they do not exist.

- to consider an enhanced role for the Commonwealth country institutions that belong to the Network of Community-Oriented Educational Institutions for Health Science. [see Appendix 6].

- to publicize case studies of successful past linkages and what they have achieved.

- o to set up an information base on existing donor resources and to serve as catalyst in mobilizing resources.

8.2[2] **Programme Development**

Possible actions would include:

- o to publish innovations in curricula and activities (particularly related to a PHC approach) and to consider the setting up of a computerised information source.

- o to foster exchange of experience in priority areas e.g. through forming interest groups in relation to particular topics.

- o to publish working documents on the experience of institutions in critical areas such as informatics, management of new technologies, environmental hazards in relation to health, etc.

- o to facilitate setting up of clearing houses of materials in relation to particular topics in regions where they do not exist.

8.2[3] **Staff Development**

- o to identify institutions able and willing to provide assistance in specific staff development and training programmes.

- o to identify sources of funding and to develop a programme of fellowships for studies in health and scientific matters, and management and administration of health services based on a PHC approach.

- o to publish a manual on staff training and development in new areas such as individual development plans, standards of performance, institutional policies particularly in relation to PHC.

8.2[4] **New and Effective Approaches to Learning, Teaching, Consultancy and Research.**

- o to document existing research in LDC on the topics selected.
- o to document and disseminate innovative approaches.
- o to promote and identify ways to support the participation of member institutions in innovative programmes.
- o to initiate an identification study on new approaches at inter-regional level and in South-South linkages.
- o to prepare notes for a Bulletin which describes effective approaches.

The approach would be based on action-learning and action-research, modular programmes that reduce the cost of course development, self-learning and action planning, computer assisted training. A special emphasis should be given to mid-career training.

-- THE END --

APPENDICES

APPENDICES

Nominated Focal Points in Commonwealth Countries for Linking Arrangements 1989

BOTSWANA

Mrs Kegalale Gasennelwe
Acting Under-Secretary, Manpower
Ministry of Health
Private Bag 0038
Gaborone
Botswana

INDIA

Shri. R.K. Ahooja
Joint Secretary
Ministry of Health and
Family Welfare
Nirwan Bhavan
New Delhi 11
India

JAMAICA

Chief Medical Officer
Ministry of Health
Kingston
Jamaica
West Indies

ZAMBIA

Dr. L. Chiwele
Deputy Director of Medical Services
Ministry of Health
P O Box 30205
Lusaka
Zambia

A Model Proposal for Funding a Programme of Institutional Collaboration in the Health Sector

Please submit 4 copies
in English

1. **Submission Date** _____

2. **Title of Programme**

_____

_____

3. **Principal Proposer**

Name _____

Department: _____

Organisation/Institution: _____

Address: _____

City: _____ Country: _____

Telephone: _____ Telex: _____ Telefax: _____

Type of Organisation:

|__| University |__| Public Body

|__| Educational Institute |__| Non-Govt. Organisation

Employees in Organization:

Total No: _____

No. of employees attached to this application: _____

4. Name of proposer responsible for the proposal, address, telephone, telex and fax numbers (if different from above)

_____

_____

_____

5. **Associated Link Partner:**

This information must be supplied for each link partner associated with the principal proposer. [Please photocopy this page to ensure information is given for each partner.]

Department: _____

Organisation/Institution: _____

Address: _____

City: _____ Country: _____

Telephone: _____ Telex: _____ Telefax: _____

Name of principal proposer Title or Appointment

_____ _____

Is Financial Assistance requested by the Associated Link Partner?

|__| Yes |__| No

Type of Organisation

|__| University |__| Public Body

|__| Educational Institute |__| Non-Govt. Organisation

Employees in Organization:

Total No: _____

No. of employees attached to this application: _____

6. Present state of the art in proposed area, or state of knowledge in field of collaboration.

7. Aim of the proposed link and benefits expected. Please state these separately and give as much detail as possible, e.g. granting of degrees, curriculum development, fellowship programmes, new training programmes, research, publications, journal articles, books, preparation of information service on expertise in particular areas, development of local culture-appropriate approaches to health management problems, etc.

8. Detailed description of the activities proposed, including an allocation of tasks between partners, and a timetable (over period not exceeding 60 months).

9. (i) Duration of the proposed collaboration (not more than 60 months from date of conclusion of the contract).

(ii) Commencement date proposed.

[N.B. The proposed date for the commencement of the link should, in general, be set at a minimum of six months after the date of despatch of the proposal.

No responsibility can be accepted for any costs incurred before the formal commencement date specified in the contract of assistance, if one is concluded.]

10. Has this or a similar proposal been submitted to any other donor agency? (Specify agency, date of submission and result.)

11. List of any recent publications by link leaders, their colleagues and partners in the proposed link.

12. Are there any other link arrangements or prior commitments such as co-operation agreements with other institutions which could affect this proposal, or any other commitment or interest which could affect the availability of information or the functioning of the link?

13. **Breakdown of Costs**

Please complete separately for each institution which is requesting financial support. [Photo-copy this section as necessary]

Type of link contract requested:

☐ Full Cost contract

☐ Marginal Cost Contract [Mainly for Universities, Medical Colleges, Training Institutes etc.]

Marginal Costs are the additional costs (staff, travelling expenses etc.) that are incurred during the operation of the link.

Currency Used: £ (or US$ if preferred)

COST ESTIMATE

	YR 1	YR 2	YR 3	YR 4	YR 5	TOTAL
Labour costs						
Travel and Subsistence						
Equipment						
Other Expenditure (separate major items) 1. 2. 3. Other						
Overheads						
Total						

Amount requested from donor agency _____ £/US$ (Please delete accordingly)

Percentage of total cost _____%

Other sources of funds _____

Please use your columns as appropriate (e.g. three year link - exclude years 4 and 5).

14. **ONLY FOR MARGINAL COST CONTRACTS**
Personnel allocated to Link Proposal

a) Personnel to be supported by donor - Scientist - Administrative Staff - Secretarial Staff etc. - Other (specify)	Number	Man-years for duration of link
b) Personnel charged to other sources. - Scientist - Administrative Staff - Secretarial Staff etc. - Other (specify)	Number	Man-years for duration of link

15. Any other information to justify Request for Funding.

16. **Summary of Principal Proposer's and Link Partner's Costs**

Name of Principal Proposer and Partners	Country	Total Cost		Share	
		Currency £ or US$	Amount	Amount requested from donor	% of total cost

Value of Local Currency against £ or US$ _____

Date of above valuation _____

I, the undersigned signify that all the information given in this document is true and accurate.

Signed at
PLACE_____ DATE _____

Signatures of Chief Proposer, and Administration Officer responsible for the proposal.

A Model Draft Link Memorandum

1. LINK TITLE

Link Partners' names and subject.

2. AGREEMENT

A link, leading to co-operation between [A.....] and [B.....] is agreed for an initial period of (C) years with effect from (D). The general framework set out below indicates how the co-operating partners will endeavour to develop their association; the inputs represent a defined programme, but circumstances may well suggest variations as the co-operation develops. Support from appropriate prospective donors is available. Some ..... US$ out of total budget of .....US$ is promised by [E].

3. WIDER OBJECTIVES

The wider objectives of the link are as follows:

[Here should be stated the impact outside the link partners on national, economic and social development.]

eg development of a national cadre of high-level specialists qualified in (subject) and capable of contributing specialist skills to the implementation of national policy in (subject).

4. IMMEDIATE OBJECTIVES

In order to achieve the wider objectives the following immediate objectives have been set:

[Here should be stated the impact within the institutions]

eg provision of well-trained graduates and postgraduates through development of a fully-trained cadre of local staff

use of action-oriented research to produce local teaching materials for the institution, and to create a role for the Department as a centre for solution of practical problems.

5. OUTPUTS

[Here should be stated the results to be achieved in terms of measurable outputs]

eg o the strengthening of (subject) nationally, with enhanced high-level staffing of public sector, parastatal and private sector institutions.

o the production of publications.

o the existence of a new course curriculum.

6. SCHEDULE OF ACTIVITIES

[Here should be given a schedule of activities over the life of the link agreement arranged by financial year. Where possible a bar chart showing activity should be produced. The schedule should give an order of priority for each activity. It is desirable to separate out inputs of long term training, book provision and major pieces of equipment from short visits, small equipment purchases, lecturing assignments, etc].

7. MONITORING AND EVALUATION

[Here it should be stated that an annual report will be submitted at the end of each financial year giving a summary of the aims and objectives of the link and how each one has been met. The report should identify problems, assess achievements and identify possible programme changes to be made in the light of the previous year's link activity. It should also account for expenditure incurred].

At the end of a link agreement, outside evaluation frequently takes place.

A useful model Contract and Letters of Agreement are given in Cooper 1984.

Donor Agencies in the Commonwealth, the European Economic Community and the United Nations

Most official aid agencies will accept applications to fund institutional links. A linkage will frequently be put in place as part of a larger project and tied to the objectives of that project. The normal period of support is about five years. Agencies will examine an application closely to find out if it can be sustained after project funding ceases.

A comprehensive survey of Commonwealth bilateral and multilateral programmes of assistance in the health sector has already been published by the Commonwealth Secretariat. This is the 2-Volume Report "Development Co-operation for Health in Commonwealth Countries": An Inventory of Donor Sources of Aid to Health July 1986. A brief summary follows of donor assistance that might be available to finance linking schemes.

I Commonwealth

Commonwealth Bilateral Assistance

Australia, Canada, New Zealand and the United Kingdom are the principal Commonwealth donors. In addition some Commonwealth LDCs engage in small co-operative programmes with Commonwealth partners.

In the case of the United Kingdom, British assistance to links is funded by the Overseas Development Administration (ODA) with the British Council usually acting as ODA's agent. Assistance to a link arrangement is normally provided as part of a bigger project.

Commonwealth Multilateral Assistance

Commonwealth Fund for Technical Co-operation

The multilateral resources available for health through Commonwealth channels are small. The overall budget of CFTC is approximately £25m per year and this covers 5 programmes. Two programmes, Fellowships and Training, and The Technical Assistance Group [TAG] would be able to provide resources for activities that might usefully precede a firm link being put into place. Fellowships and Training Programme provide long and short duration training opportunities and study visits mainly in Commonwealth LDCs. The Technical Assistance Group provides experts on long and short term

assignments to carry out defined terms of reference in many areas, including health. The provision of assistance in each sector depends on a formal government request being submitted.

The Commonwealth Foundation

The Foundation is an international organisation of the Commonwealth countries established to develop and strengthen professional co-operation within the Commonwealth. The Foundation's income, derived largely from contributions of member governments, is £1.54 million. It supports activities, amongst others, that relate to rural development, social welfare and the handicapped. It has helped sponsor the link between Herefordshire Area Health Authority, U.K. and the Muheza District, N.E. Tanzania [Wood and Hills 1988].

Health Programme of the Commonwealth Secretariat

The Commonwealth Secretariat's Health Programme serves as a catalyst and an intermediary as well as a secretariat for the exchange of information and experience. It disposes of no funds of its own though it can tap small amounts of CFTC funds for developmental and training activities. The Health Programme would not be able to finance a link, per se.

Relevant Addresses

Australian Development Assistance Bureau (ADAB)
P.O Box 887
Canberra City 2601
Australia
Telephone: (062) 495733
Telex No: 62631
Facsimile No: (062) 487521

Canadian International Development Agency (CIDA)
Place du Centre
2000 Promenade du Portage
Hull, Quebec
Canada
KIA OG4
Telephone: (613) 997 5456
Telex No:

New Zealand Aid Programme
Ministry of Foreign Affairs
Private Bag
Wellington,
New Zealand
Telephone:
Telex No: 3441

U.K. Overseas Development Administration
Eland House
Stag Place
London SW1E 5DH
U.K.
Telephone: 01-273 3000
Telex No: 263907/8
Telegraphic Address: Overseas - Ministrant, London
Inland - Ministrant, London Telex

The British Council
10 Spring Gardens
London SW1A 2BN
U.K.
Telephone: 01-930 8466
Telex: 895 2201 BRICON G

The British Council has offices in most Commonealth countries. Addresses are obtainable from the British Council or from the Annual Report and Accounts 1988/89 [British Council 1989].

[The Commonwealth Fund for Technical Co-operation]
[The Commonwealth Foundation]
[The Health Programme of the Commonwealth Secretariat]
are all based at:

The Commonwealth Secretariat
Marlborough House
London SW1Y 5HY
Telephone: 01-839 3411
Telex: 27678
Fax: 01-930 0827
Cables: COMSECGEN LONDON SW1

Commonwealth Regional Health Community for East, Central
and Southern Africa
P.O. Box 1009
Arusha
Tanzania
Telephone: 2961 Arusha
Telex:
Cable No: REGHEALTH ARUSHA TANZANIA

Eleven countries make up the Health Community. Most activities aim to improve operational infrastructure of health systems in member states. There is also a special focus on curriculum development. The Community has a small budget only.

The Caribbean Community and Common Market (CARICOM)
P.O. Box 10827
Bank of Guyana Building
Georgetown, Guyana
Telephone: 69281-9
Telex: 2263 CARISEC GY

Thirteen countries in the area belong to CARICOM. Health is a principal area of interest and current activities cover, in particular, the development of health management systems. The operational budget is small.

II. The European Economic Community

Application for the funding of a link may also be made to the Commission of the European Communities (EEC), Brussels. The EEC actively promotes and finances economic and social development in a large number of developing countries. Directorates General VIII (Development) and I (External Relations) are responsible for administering the assistance programme. In addition, DG XII (Science and Technology for Development) has a sub-programme, Medicine, Health and Nutrition in Tropical and sub-Tropical Areas. This is a science based programme aimed at bringing together European research institutes and institutes in developing countries. It encourages small, well-focussed projects on a wide spectrum of scientific topics [Commission of the European Communities 1989].

The agreements under which the EEC supports the developing countries are entitled the Lome Conventions. The Fourth Lome Convention was agreed and signed in Brussels in December 1989 [ACP-EEC Council of the European Communities, Brussels 1990]. The original Lome 1 agreement signed with 46 countries in 1975 has been extended to cover agreements with 53 African, Caribbean and Pacific countries (the ACP States). Many Commonwealth countries are party to the Lome 4 Agreement. The two major concerns of the EEC at the present time are food security and rural development with particular reference to the promotion of self-reliance and sustainable development.

Projects that provide assistance under these two heads are given priority. The Articles of the Lome 4 agreement that are relevant to institutional linking arrangements are found in Title XI Cultural and Social Co-operation (ACP-EEC 1990), Pg. 103. They are Article 151 Education and Training, Article 152 Scientific and Technical Co-operation, Article 154 Health and Nutrition and Article 159 Regional Co-operation. There is specific reference in these Articles to "associations, twinning, exchanges and transfers of information and technology."

The policy of the EEC is that a developing country which has signed the Lome Conventions must define its own priorities in health (as in other sectors) and submit proposals for funding of projects that fit in with the country's indicative programme. The proposals are passed to the EEC delegate in the ACP country. The addresses of the Delegations are given in "The Courier", a magazine which is published jointly by the ACP and EEC every 2 months. The Delegations have the responsibility for forwarding funding proposals to the relevant Directorate in Brussels.

Relevant Addresses

[Directorate-General for Science & Technology XII]
[Directorate-General for Development VIII]
[Directorate-General for External Relations I]
Commission of the European Communities
Rue de la Loi, 200
B-1049 Brussels
Belgium
Telephone: 235.11.11
Telex: COMEU B 21877
Cable: COMEUR Brussels

III U.N. Agencies including WHO

The UN Agencies have provided financial assistance for link arrangements for many years. In a recent draft report, the UN has emphasized the fundamental underlying relationship between human resource development and social and economic development [Martohadinegoro and Williams 1989]. The Report gathered together information from various agencies of the UN System as to the amount spent on "developing knowledge, training and improving skills". All

of the following agencies had expenditure in the health sector, but the Report does not give a breakdown for sectors or for expenditure on link arrangements by the agencies.

UNDP

Out of a total of US$4,062 million budgeted over 1980-87, about US$453 millions (11%) were allocated for training purposes. What is identified in the report is the need for a more co-ordinated effect to strengthen LDC national and regional training institutions instead of using those in developed countries.

UN Department of Technical Co-operation for Development (DTCD)

Over 3,000 awards are granted annually for the pursuit of academic and professional studies. About 50% of the awards are for university studies and 50% are for practical training. There is emphasis in the practical training programme on developing water resources and also in furthering integrated rural development.

UN Population Fund

Around US$138 million was spent over 1980-85 and about one-third of this sum was spent on human resource development: fellowships, seminars and equipment.

UN Regional Commissions

All are involved in significant expenditure on human resource development. The Economic and Social Commission for Asia and the Pacific (ESCAP) is the first of the Commissions to initiate a regional plan for the region's 3 billion people. It has stated that human resource development should be addressed through comprehensive planning, not haphazardly with each agency and each sector acting separately.

UNESCO

Virtually all the activities undertaken at UNESCO are aimed at human resource development. Over 1980-88 some $105.5 million was made available for training, averaging about 14% of total project expenditure. Over 1986-7 UNESCO provided a total of 4,216 individual fellowships, study grants and travel grants. A small amount only of this sum related to health and to link arrangements.

WHO

The World Health Organisation's human resource development activities are mainly the responsibility of the Division of Health Manpower Development [from 1990 this will be known as Development of Human Resources for Health]. Over 1980-87 expenditure from WHO's Regular Budget totalled $320 million (about 17% of the WHO Regular Budget for that period). Other extra-budgetary expenditure over 1980-87 amounted to a further $155 million, bringing the total to $475 million. Within Regular Budget activities the largest item of expenditure is on fellowships (62%). In 1986-87 HMD Programme distributed some 7,000 fellowships and provided travel and subsistence allowances for almost 6,000 participants to attend educational meetings or WHO courses. Again, no separate breakdown was available to show support for link arrangements.

The UN Report concludes that the contribution of the UN System to human resource development is substantial and member states are the principal beneficiaries. Two major problems are recognised:

i) The high wastage rate of trained manpower after completion of training, particularly after return to a LDC.

ii) The problems encountered in placing fellows and trainees in institutions of higher education in the 'North' because of stringent entry qualification rules.

Three recommendations emerge from the report:

[1] Establishment of an inter-agency "focal point" [this could be UNDP] which would monitor and assess co-ordination and implementation of human resource programmes by member states and UN agencies. This is felt to be urgent.

[2] Human resource development activities should be more oriented to human fulfilment at grass roots level.

[3] Invitation to member states to consider Human Resource Development as a permanent agenda item in the meetings of the Ad-Hoc Committee of the Fourth International Development Strategy.

These recommendations are to be discussed further at a UN meeting on this report in 1990.

They have major implications for the development of the Commonwealth's own LINKS programme [if this were agreed]. There would be a necessity to:

i) put in place a Commonwealth Secretariat/UNDP Link so that Commonwealth LINKS and UN Links are developed along the same lines.

ii) encourage the focus of LINKS to a primary health care oriented approach to foster "grass roots" development in line with UN thinking and in accord with WHO's Health for All policy.

iii) decide how the Commonwealth LINKS programme would proceed, to avoid overlap and duplication with UN/Member State programmes.

Relevant Addresses:

UNDP
One United Nations Plaza
New York, N.Y. 10017
U.S.A.

Tel. (212) 906 + extension
(212) 906 5302 [Mary Hanley - Information Officer]
Telex 236286
Fax. (212) 750 9315

UNDP has a special TCDC programme to encourage South-South links.

Proposals for funding should be addressed to:

Surinder M.S. Chadha
Special Unit for Technical Co-operation among
Developing Countries
304 East 45th Street
Room FF-1204
New York, New York 10017

UNFPA
220 East 42nd Street
New York, N.Y. 10017
U.S. A.

Tel. (212) 850 + extension
(212) 850 5841 [Mr. Joyoti Singh - Information Officer]
Telex 236286
Fax. (212) 557 6416

UNICEF
Headquarters
United Nations
New York, N.Y. 10017
U.S.A.

Tel. (212) 415 8000
Telex 239521
Fax. (212) 754 4416

WHO
Avenue Appia
1211 Geneva 27
Switzerland

Tel. (022) 791 21 11
Telex 27821
Fax. (022) 791 07 46

Names and Addresses of Existing Professional and other Associations in Health in the Commonwealth

It would be possible for an enquiry for a link partner to be directed to one of the Commonwealth Professional Associations. The following associations could be approached:

Association of Commonwealth Universities
36 Gordon Square
London WC1H OPF

Telephone: 01 387 8572

Commonwealth Medical Association
BMA House
Tavistock Square
London WC1H 9JP U.K.
Telephone: 01-387 4499

Commonwealth Association for Mental Handicap
and Developmental Disabilities
c/o National Institute of Mental Health and Neurosciences
P.O. Box 2900
Bangalore 560 029
India

Commonwealth Nurses Federation
Commonwealth House
18 Northumberland Avenue
London WC2N 5BJ U.K.
Telephone: 01-930 1863

Commonwealth Pharmaceutical Association
Pharmaceutical Society of Great Britain
1 Lambeth High Street
London SE1 7JN U.K.
Telephone: 01-735 9141

Royal Commonwealth Society for the Blind
Commonwealth House
Haywards Heath
West Sussex RH16 3AZ U.K.
Telephone: 0444 412424

Commonwealth Society for the Deaf
105 Gower Street
London WC1E 6AH U.K.
Telephone: 01-631 5311

Special mention should be made of:

World Federation for Medical Education
17 Teviot Place
Edinburgh
Scotland, U.K.
Telephone: 031-226 3125

The World Federation aims at global reform in the education of doctors. A World Conference on this theme was held at Edinburgh in 1988. The Report of the Conference sets out an International Collaborative Programme for Reorientation of Medical Education. [World Federation for Medical Education 1988].

NETWORK OF COMMUNITY-ORIENTED EDUCATIONAL INSTITUTIONS FOR HEALTH SCIENCES

University of Limburg, P O Box 616
6200 MD Maastricht, The Netherlands

List of Members in Commonwealth Countries as at November 1989

	Commonwealth	All Countries
Full members :	13	44
Associate members :	22	71
Corresponding members :	10	27

Network Telephone Numbers

Tel. 043-888.888/888.303/888.313

Telex: 56880 fgrlnl

Telefax: 43-437266

FULL MEMBER INSTITUTIONS

1. University of Newcastle
   Faculty of Medicine
   Rankin Drive
   Newcastle N.S.W. 2308
   AUSTRALIA (WP)

   Repr. 1: Dr. John Hamilton

2. McMaster University
   Faculty of Health Sciences
   1200 Main Street West
   Hamilton, Ontario L8N 3Z5
   CANADA (AM)

   Repr. 1: Dr. Stuart M. MacLeod, Dean

3. University of Sherbrooke
   Faculty of Medicine
   3001, 12th Avenue, Fleurimont
   Sherbrooke, Quebeck, J1H 5N4
   CANADA (AM)

   Repr. 1: Dr. M.A. Bureau, Dean

4. University of Science and Technology
   School of Medical Sciences
   University Post Office
   Kumasi
   GHANA (AF)

   Repr. 1: Dr. J.O. Martey, Dean

5. Christian Medical School
   Bagayam
   Vellore - 632 002, Tamil Nadu
   INDIA (AS)

   Repr. 1: Dr. M. Booshanam Vasanthakumar, Principal

6. University Sains Malaysia
School of Medical Sciences
Penang, Minden 11800
MALAYSIA (WP)

Repr. 1: Dr. A.M.M. Roslani, Dean

7. Ogun State University
College of Health Sciences
P.M.B. 2001
Sagamu, Ogun State
NIGERIA (AF)

Repr. 1: Prof. O.O. Ajayi, Provost

8. Obafemi Awolowo University
Faculty of Health Sciences
Ile-Ife
NIGERIA (AF)

Repr. 1: Dr. W.O. Odesanmi

9. University of Ilorin
Faculty of Health Sciences
PMB 1515
Ilorin
NIGERIA (AF)

Repr. 1: Dr. O. Ogunbode, Dean

10. Bayero University Kano
Faculty of Medicine
P.M.B. 3011
Kano
NIGERIA (AF)

Repr. 1: Dr. O.K. Alausa, Dean (Coordinator)

11. The Aga Khan University
Faculty of Health Sciences
Stadium Road, P.O. Box 3500
Karachi 74800
PAKISTAN (EM)

Repr. 1: Dr. David D. Ulmer, Dean

12. Makerere University
Faculty of Medicine
P.O. Box 7072
Kampala
UGANDA (AF)

Repr. 1: Dr. Raphael Owor, Dean

13. University of Zambia
School of Medicine
P.O. Box 50110
Lusaka
ZAMBIA (AF)

Repr. 1: Prof. Kopano Mukelabai, Dean

ASSOCIATE MEMBER INSTITUTIONS

1. University of Western Australia
Department of General Practice
328 Stirling Highway
Claremont, WA 6010, Perth
AUSTRALIA (WP)

Repr. 1: Dr. Douglas MacAdam, Head

2. University of New South Wales
School of Medical Education
P.O. Box 1
Kensington, New South Wales
Sydney 2033
AUSTRALIA (WP)

Repr. 1: Dr. K.R. Cox, Head

3. University of Chittagong
Institute of Applied Health Sciences
63 Central Road, Dhanmondi R.A.
Dhaka - 1205
BANGLADESH (AS)

Repr. 1: Dr. Nurul Islam, Coordinator

4. University of Guyana
Faculty of Health Sciences
Turkeyen Campus, Box 841
Georgetown
GUYANA (AM)

Repr. 1: Dr. Oswald Simon, Dean

5. Christian Medical School
Ludhiana 141008, Punjab
INDIA (AS)

Repr. 1: Dr. A. Zachariah, Dean

6. Dayanand Medical College
Post Box No. 265, Civil Lines
Ludhiana 141001 (Punjab)
INDIA (AS)

Repr. 1: Dr. Livtar Singh Chawla, Head Dept. Med.

7. St. John's Medical College
Bangalore - 560 034
INDIA (AS)

Repr. 1: Dr. A.F.A. Mascarenhas, Principal

8. Medical Council of India
Dr. B.C. Roy Foundation
Medical Education Centre
Kotla Road, Temple Lane
New Delhi - 11002
INDIA (AS)

Repr. 1: Dr. P.S. Jain, Secretary

9. Miraj Medical Centre
Medcol Project, Wanless Hospital
Miraj. 416 410 Dist: Sangli
Maharashtra
INDIA (AS)

Repr. 1: Dr. P. Zachariah, Coordinator

10. Pravara Medical Trust
Pravara Rural Hospital & Medical College
Loni - 413 736, Shrirampur Taluka
Ahmednagar District, Maharashtra
INDIA (AS)

Repr. 1: Shri Ashok Patil, Joint Man. Trustee

11. University of the West Indies
Faculty of Medicine
Mona, Kingston 7
JAMAICA (AM)

Repr. 1: Dr. Samuel R. Wray, Dean

12. AMREF Training Centre
Wilson Airport, P.O. Box 30125
Nairobi
KENYA (AF)

Repr. 1: Dr. Sem Singh Bhachu, Course Coordinator

13. Moi University
Faculty of Health Sciences
P.O. Box 3900
Eldoret
KENYA (AF)

Repr. 1: Prof. Haroun N.K. arap Mengech

14. University of Malawi
Medical School Project
P.O. Box 5576
Limbe
MALAWI (AF)

Repr. 1: Dr. John D. Chiphangwi, Project Coord

15. Universiti Kebangsaan Malaysia (UKM)
Faculty of Medicine
Jalan Raja Muda
50300 Kuala Lumpur
MALAYSIA (WP)

Repr. 1: Dr. Sharifah Hapsah Shahabudin, Assoc.Prof

16. University of Maiduguri
Dept. of Comm. Med.
College of Medical Sciences
Unimaid, P.M.B. 1069
Maiduguri, Borno State
NIGERIA (AF)

Repr. 1: Dr. Michael K.O. Padonu, Head

17. Baqai Medical College/Baqai Foundation
III-B, 1/7, Nazimabad
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A Note on the Aims of the Network of Community-Oriented Educational Institutions for Health Sciences.

General Aim

The general aim of the Network is to provide mutual support to member institutions who wish to adapt their curricula to the health needs of the communities which they serve.

Main Objectives

There are 5 primary objectives:

- Assisting institutions in countries that have decided to introduce innovations in the training of health personnel with the ultimate goal to improve health care and to contribute to the achievement of "Health for All".

- Development of techniques, approaches, methods and tools appropriate to a community-oriented curriculum, e.g. problem-based learning.

- Strengthening of faculty competence related to community-based education.

- Promoting population concepts in the health services system and the curriculum.

- Strengthening of membership institutions in their implementation of community-oriented learning and appropriate instructional methods.

Membership

Over 1979 - 1989 the membership has grown to a total of 37 full members and 60 associate member institutions.

Clearing House

The Secretariat has established at Maastricht a large information retrieval bank containing almost every item that has been written about community-oriented education since 1980.

Annals

The Annals of Community-Oriented Education are published each year.

Network Institutions

There is an African Chapter and a Latin American Chapter and special organisations for the Eastern Mediterranean Region, the European Region and for the 8 Thai Medical Schools. More information is available from Mrs. Ine Kuppen, Secretary of the Network.

The Work of INRES-SOUTH Data Base
Health Institutions in Commonwealth Countries registered with INRES-SOUTH

The Work of the INRES-SOUTH Data Base

INRES-SOUTH is an Information Referral Service. It is housed in the Special Unit for TCDC in the Office of the Administrator of UNDP at New York. It maintains a computerized database on training programmes and expertise capabilities of institutions in developing countries only. If one institution wishes to collaborate with another, INRES-SOUTH can identify an institution.

What the INRES-SOUTH Data Base contains

INRES-SOUTH currently contains the equivalent of some 30,000 pages of information in English, French and Spanish. In July 1988 INRES-SOUTH became operational on computer. The composition of the data base was as follows:

Region	No. of Developing countries	No. of institutions registered
Africa (excl N. Africa)	29	400
Asia & Pacific (excl W. Asia)	24	1,180
Arab States	14	343
Europe (developing countries)	11	325
Latin America and Caribbean	29	1,011
	107	3,264

By the end of 1989 it is hoped that 5,000 institutions will have registered.

The institutions are mainly, but not limited to, universities, government organizations, research centres, consulting firms and non-profit organisations.

The Information on each Institution

INRES-SOUTH maintains basic information on each institution such as address and annual budget; whether it is a government organisation, a NGO or in the private sector; its purpose and main activities; research and testing equipment and computer hardware/software configuration; technical staff; information services; and the affiliations, associations, or joint ventures in which it participates.

For each training programme there is a description of the programme, basic elements of the curriculum, starting date, duration and application deadline, degrees or certificates awarded, language requirements, required educational and professional qualifications, and financial cost to participants.

For each expertise capability there is information on the projects the institution has implemented, with the level of the contracts, name of the sponsor and the country or countries in which they were implemented.

All printouts carry the date that the information was entered. All institutions were requested in March and April 1987 to update their information. Information is coded in accordance with the 9,000 terms of the UNBIS Thesaurus.

Registration Procedure

An INRES-SOUTH Information Request form can be obtained from the local UNDP field office. Languages used should be English, French or Spanish. The forms can be returned to UNDP or sent direct to:

INRES-SOUTH
Special Unit for TCDC
United Nations Development Programme
One United Nations Plaza, FF-1200
New York, N.Y. 10017
U.S.A.
Telephone: (212) 906 5141
906 5140
Cable: UNDEVPRO NEW YORK attention INRES
Telex: 125980 attention INRES

UNDP Finance

To encourage South-South projects (TCDC projects) structured on the INRES-SOUTH data base, the Special Unit for TCDC of UNDP will provide financial assistance to projects that are submitted and approved.

"Co-operation South"

UNDP publishes a magazine entitled "Co-operation South" three times a year in English, French, Spanish and Arabic. There is a special information column on INRES-SOUTH.

Example

An example is attached of information relating to the Faculty of Medicine, College of Health Sciences, University of Nairobi, Kenya.

Health Institutions in Commonwealth Countries registered with INRES-SOUTH (1989)

Country	No. of Health Institutions
Bangladesh	1
Barbados	1
Cyprus	1
Guyana	1
India	5
Jamaica	1
Kenya	1
Malaysia	4
Sri Lanka	1
Trinidad & Tobago	2
Zimbabwe	1
Total	19

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Consultancy of Margaret Thomas

1989

1. To consider the responses to requests for information on twinning arrangements for human resource development between institutions in Commonwealth countries.

2. To examine successful and unsuccessful projects and consider the reasons for the outcome.

3. To investigate in detail, if appropriate, any particularly valuable examples which could serve as models for future arrangements.

4. To prepare a report on the above for the CHDP Steering Grup;

   a) setting out critical comments on the present situation.
   b) making suggestions for arrangements which should be developed further or for which support might be sought with benefit.
   c) considering those influences or procedures which may lead to success or failure.
   d) making recommendations to the steering group on how to proceed with the development of this part of the programme.

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