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INT'L Health Policy

INT'L HEALTH POLICY PROGRAM

(Pew Memorial Trust)

THE WORLD BANK INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

file Pew

March 21, 1985

TO: Mr. Lowell Doud, LEGVP

FROM: David Hodgkinson, PHNDR

SUBJECT: Proposed Pew Memorial Trust Program in International Health

1. Per our conversation, please find attached a copy of Dr. Measham's memo of January 2 concerning the referenced program.

2. As I mentioned on the telephone, Ms. Becky Rimel of the Pew Trust will be visiting the Bank on Thursday, March 28 to discuss how we might structure a cooperative venture with Pew concerning international health policy. I hope that you will be able to join us in meeting with Ms. Rimel to review the legal aspects of establishing a relationship between Pew and the Bank.

3. Thank you again for assisting us in this matter.

Attachment

cc: Mr. North, Dr. Measham (PHNDR); Ms. Birdsall, Mr. de Ferranti (PHNPR)

TDH:cmk

Discussion Draft
31 March 1986

INTERNATIONAL HEALTH POLICY PROGRAM

Toward a Program Approach

This note is an elaboration of themes presented in an October 1985 paper entitled "Improving Health When Resources are Limited." That paper, prepared for discussion in developing countries, presented several illustrative topics of potential interest and suggested three broad elements of an approach to the support of effective work on them. The elements suggested were the development of skills, the strengthening of institutions, and the encouragement of closer cooperation between policy makers and analysts.

The preliminary ideas presented here represent an effort to begin translating these three general themes or principles into a concrete plan of operation. The ideas have three sources:

— The views of policy makers, policy analysts, and external assistance agency representatives consulted during exploratory visits to ten countries in Asia and sub-Saharan Africa.

— The contributions of members of the International Health Policy Program's Advisory Committee, and others in the World Bank and the World Health Organization.

— The experience of earlier institutional development programs in the developing world, especially the institutional strengthening effort of the WHO/World Bank/UNDP Tropical Disease Research Program; the Milbank Memorial Fund's Faculty Fellowship Program for community health in the Americas; and the Agricultural Development Council's support for agricultural economics in Asia.

It is hoped that the guidelines suggested are flexible enough to be relevant for the very different situations of the African and Asian countries visited. How relevant the suggestions are for Latin America remains to be determined: one reason for presenting them at this point is to provide a basis for discussions with people knowledgeable about that area.

The International Health Policy Program is an Initiative of the Pew Memorial Trust in Cooperation with the World Bank and the World Health Organization.

At the heart of the proposed strategy would lie a network of what might be called "health policy analysis groups" or "health policy development groups." Each group would consist of three to four people; the membership of each would include both policy makers and policy analysts. The International Health Policy Program would provide support for the development and work of the groups, and for the establishment and strengthening of relationships among them.

Composition

Each health policy analysis or development group would consist of three, occasionally four types of people:

— One or two policy analysts. These would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in quasi-governmental or independent research and training institutions like institutes of development studies, university economics or sociology departments, schools of public health, or management institutes; but some might come from the planning units of health ministries or the health/social service divisions of planning ministries, in situations where significant work is undertaken intra-ministerially.

The policy analyst would be the group's principal worker. Each would devote some 25-50% of his or her time to program activities.

In Asia, the typical analyst would be the recent recipient of a doctoral degree in a field like economics, epidemiology, one of the behavioral sciences, or management; in some cases, he or she would have a master's degree and be planning or working toward a doctorate. In Africa, the analysts would more frequently be doctoral candidates; in some cases,

they might be candidates for a master's degree judged capable of doctoral-level work at some point in the future.

— A senior research adviser. This would normally be the analyst's or analysts' superior: say, a faculty dean or department chairman in a university; the director of an independent or quasi-governmental development institute; or the director of policy and research in a government ministry.

The research adviser would provide overall senior-level guidance and support to the analyst(s). Among other things, the senior adviser's involvement would be designed to promote an institutional sense of responsibility for the successful execution of program activities: to ensure, for example, that each analyst is able to spend the full amount of time envisioned on program work; and that any grant funds flowing through the institution are smoothly administered. The research adviser, while not devoting more than a small portion of her or his time to the program, would be expected to meet regularly with other members of the group; to be available at other times as needed by the analyst(s), and to participate in any orientation programs and in the periodic participants' meetings described below.

In Asia, the senior research adviser would frequently be an analyst with extensive health policy experience; in some cases, he or she would be a leading authority in the field. Sometimes in Asia and more frequently in Africa, the senior research adviser, while equally distinguished, would usually have less health policy experience. He or she might, for example, be a general development or agricultural economist directing a development research institute; or a physician with a clinical research background

heading a medical research organization. (As indicated below, supplemental external research advice for the policy analyst(s) would be provided in those cases where the research adviser is not a health policy specialist.)

— A senior policy adviser. This would usually be a responsible official from a governmental organization concerned with health, such as health or planning ministry. He or she might, for example, be the director of policy in a health ministry or the director of the health/social welfare division of a planning ministry. He or she would have extensive field and policy experience but would not necessarily have an analytical background. Upon occasion, the policy adviser might be a leading official in an important non-governmental health service organization through whose activities the results of program-supported analyses might be applied. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analyst's or analysts' superior; and where feasible and/or desirable, there would be a research adviser from some local outside institution.)

The policy adviser would have two functions. The first would be to ensure that the analyses performed are relevant to and useful for policy decisions faced by the adviser's agency. The second would be to see that the findings of program-supported work are disseminated within the agency. The policy adviser would be expected to devote approximately the same limited amount of time to program activities as the research adviser.

— An IHPP program associate. In two or three cases, the work of the policy analyst(s) would be supplemented by that of an IHPP program associate. Each associate would be located in a region with several program-supported health policy development groups. The associate would be

assigned to one of the participating institutions (probably although not necessarily a research institution) and would be appointed jointly by that institution and the IHPP. Each program associate would be a person with advanced methodological skills and with administrative capacities, knowledgeable about high-quality work of relevance being done elsewhere. The associate would preferably but not necessarily be from another developing country. He or she would be expected to spend approximately 50% of his or her time participating in the research and teaching activities of the groups with which he or she is most directly associated. The other 50% of the work would be administrative: providing staff assistance to the typically overcommitted program directors within the region, the organization of the conferences and other "networking" activities to be described below, and generally seeing that things keep moving; and to undertake exploratory visits to people, institutions, and countries within the region not covered during the program's initial year.

Objectives and Work Program

The activities of each health policy development group would center around a set of empirical studies or analyses of policy issues of importance to the senior policy adviser's agency and of interest to the group members.

Each study within the set would be discrete and limited in duration, normally occupying a year or less of an analyst's time. The overall set of studies would last over a period of three to five years.

In some circumstances, the studies might be executed within the context of a larger programs supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP health policy development group.

The issues addressed by the IHPP-supported studies would lie within a range defined by the IHPP Advisory Committee. This range would be based on the list of illustrative topics presented in the IHPP October 1985 discussion note, as modified on the basis of the suggestions of developing country policy makers and analysts consulted during the exploratory visits.

The study program would be directed toward the achievement of three objectives. The first objective would be the production of analytical studies of practical value for decisions made by the agency of the senior policy adviser's agency. The second objective would be the development of promising junior analysts. Their IHPP-supported experience would be designed to qualify them to conduct independent research and to contribute on an ongoing basis to policy discussions concerning the issues about which they had gained expertise. The third objective would be the development of relationships between the policy makers and analysts associated with the program, and others in their respective institutions, to facilitate continued cooperative work as discussed below.

Links among Groups

The health policy development groups just described would constitute the program's basic units or modules. The evolution of larger structures would be encouraged through support for the development of links among groups.

One way of doing this could be through support for two or more groups with complementary interests in the same city or country. One might

imagine, for example, epidemiologists in a medical faculty working on one topic in relationship with a ministry of health; and economists from a faculty of social sciences working with a planning ministry on another topic. Upon occasion, there might be overlapping membership among groups: a director of policy and research of a health ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties.

In such situations, the participating groups would be encouraged to meet for regular informal discussions of their work, perhaps over lunch and dinner. Among other things, such discussions could be designed to stimulate participants' suggestions for further work: other topics in need of investigation, for example, and other people who might be invited to investigate them.

In some cities and countries, the number of skilled and interested people would be sufficient to support only one group. When this is the case, regular inter-country meetings would be arranged to encourage the emergence of regional networks for the purpose of mutual reinforcement among otherwise isolated efforts.

The effort to establish links among groups would also include regular (perhaps annual) meetings of analysts, research advisers, and policy advisers associated with the program. In addition to program participants, such meetings might be attended by similar people from other institutions within which groups might be formed in the future; and by outside authorities on the topics under discussion. The meeting site could rotate among participating groups, with the host group(s) being responsible for program and other meeting arrangements.

Support Provided

The support provided would be of two types. The first would be for the work of the individual groups. The second would be for the many networking and similar activities described above, designed to foster relationships among groups.

The kinds of support provided would vary from situation to situation. Typically, the assistance made available for a group might include:

— Local research and seminar costs. Among other things, this would cover the cost of field investigations, of secretarial assistance, of publishing and otherwise disseminating research findings. Funds might also be made available for the portion of an analyst's time spent on program work.

— Consultancies and participation in local research/seminars by outside specialists. Such participation would be arranged where the group's senior research advisers are not specialists in the issues to be studied, and/or where their other responsibilities prevent them from providing adequate professional support to junior analysts. A continuity in outside participation would be sought wherever possible, perhaps through the development of collaborative relationships between a group and an individual or institution from outside the country concerned.

— Short-term orientation and/or training programs for group members. The nature of these would vary greatly. Examples might include a study tour for group members to other developing countries where issues of interest to the group have been effectively analyzed or handled; participation by the senior advisers in short-term courses covering relevant material outside their range of expertise (for instance, an introductory

program in health economics for a policy adviser whose background is primarily clinical or in epidemiology/public health for a research adviser who is an agricultural economist); attendance by group members at international meetings on the issues with which they are dealing.

-- Longer-term overseas internship, training, or data analysis/writeup opportunities for the analyst(s). Where the analyst(s) concerned do not have the necessary advanced qualifications at the outset of the program, provision of support to provide such qualifications would be seen as a legitimate item for support. Normally, any formal overseas training would be undertaken only after the analyst had completed at least one initial field study, developed and executed in cooperation with outside expert assistance if required; and any field research undertaken in connection with an overseas degree course would be done in the analyst's home country. Overseas post-doctoral fellowships or data analysis opportunities of up to a year or so could also be considered for an analyst during the second or subsequent year of Program activities. To the extent possible, any overseas experience would take place in an institution with which the developing country group had established an ongoing collaborative relationship with respect to Program activities.

-- Equipment and supplies (but not buildings).

Five-year support of the types described would probably be required if the full potential for development of the junior analysts is to be achieved, especially in Africa. But three-year initial grants would probably be workable in most places and perhaps desirable as a way of weeding out any obviously non-performing groups without having to wait the full five years and of providing an early point at which to increase support for groups

doing particularly well. To encourage the production of tangible findings within twelve to eighteen months of the program's initiation, the initial participants' meeting would be held at that time.

The volume of support provided for each group would have to be worked out on a case-by-case basis. The experience of institutional development efforts in other fields suggests that somewhere on the order of $150-175,000 over three years or $225-250,000 over five years might be a reasonable maximum for a group with one policy analyst. A group with two analysts might qualify for up to 40-50% more support. The costs of any IHPP program associates and of the networking activities described above would be additional.

Selection Procedure

Health policy development groups would be selected for participation in the program through a modified competition. Invitations to apply and application guidelines (which would include an indication of the maximum amount available) would be sent to a moderate number of promising institutions. Applications from other institutions would not be encouraged, but any institution learning of the competition and wishing to apply would be permitted to do so.

Institutions to receive invitations to apply would be identified through:

-- Exploratory visits. The visits thus far made have led to the identification of some 40-50 institutions or individuals of adequate promise to receive invitations, in anticipation that one-third to one-half this number of applications worthy of serious consideration would be received.

-- Recommendations from knowledgeable specialists in other

organizations. In particular, World Bank and World Health Organization staff members would be informed of the program guidelines and application procedures, and invited to suggest institutions and individuals worthy of consideration. Of particular interest would be cases where IHPP support to a health policy development group could complement and enhance the effectiveness of programs assisted by the Bank and WHO.

-- Recommendations from developed country research and training institutions. Developed country research and training institutions which approaching the IHPP for support would be told that the IHPP's purpose is to strengthen developing rather than developed country organizations. At the same time, the better ones would be encouraged to suggest developing country individuals and organizations they think might wish to cooperate with them. The suggestions would be discussed with others knowledgeable about the country concerned; and suggestions found worthy of serious consideration would be followed up by the issuance of invitations to apply to the developing country organizations or individuals in question. (Any such invitations would leave the choice of a developed country cooperating institution up to the developing country applicant.)

The applications submitted would be preliminary and brief, no more than two or three pages each. Each application would be submitted by a responsible official of the institution employing the analyst(s). It would indicate in general terms the types of issues to be analyzed and suggest two or three illustrative studies to be carried out. It would provide the names of the senior research adviser (often the person signing the submission) and the analyst(s), and the name of the policy organization which would cooperate in the work envisioned. It would be supplemented by material

which should be already available or require little additional effort to prepare: a current prospectus and/or recent annual report from the institution, curricula vitae of the proposed research adviser and analyst(s), and copies of the analyst's or analysts' best or most relevant work.

Also provided would be a letter from an appropriate high-level official of the cooperating policy agency. The letter would confirm that the topics proposed had been selected in consultation with the agency, that the agency would participate in the work, and that it would anticipate using the results in formulating its policies. The letter would also indicate the name of the person from the agency who would serve as the group's senior policy adviser.

This material would be reviewed by an IHPP technical committee. Each group would be assessed both in terms of its own promise and in terms of the potential for developing cooperative relationships with other groups. The groups whose applications were thought most promising in these two respects would be selected for site visits by senior, experienced professionals. Such visits, which would involve intensive discussions over a period of up to several days, would be made only to sites where support is considered likely. The principal purpose of the visits would be to formulate detailed work and development programs in consultation with the group members and others. Once developed, the programs would be referred back to the technical committee for final review and approval.

The Longer Term

If the program is successful, a significant proportion of the junior analysts supported should within five years have established professional

reputations that would make them attractive candidates for continued support from local authorities or other donors. This would almost certainly be the case should the demand of external agencies for short-term health policy studies remain as strong as it presently is.

Also, it is to be hoped and anticipated that some groups would perform well enough to justify a significant expansion in their activities, with increased support from the IHPP or other sources. As noted earlier, a review of progress after three years or so would start a process of channelling an increasing proportion of available funds to those groups doing the best work. A continuation of this process through subsequent reviews would facilitate progress toward a longer-term objective of creating a few sizeable health policy development centers of excellence.

file: Pew
(or Gwatkin?)

IMPROVING HEALTH WHEN RESOURCES ARE LIMITED

Toward a Program of Support for Health Policy Analysis and Formulation in Developing Countries

A Discussion Note

concerning

An Exploration
initiated by the Pew Memorial Trust in cooperation with
the World Bank and the World Health Organization

October 1985

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult global and local economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy makers have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization have begun working together to address such issues. In addition to their continuing efforts to provide additional resources, they are cooperating in an exploration of ways to support the attempts of developing country policy makers to find more effective ways of using the resources available.

The exploration is to feature visits with developing country policy makers and analysts to solicit their advice about program directions. The purpose of this note is to describe briefly the issues and the approach currently under consideration, in order to invite comments and suggestions.

The Issues

Within the overall theme of effective resource use, a set of more specific issues is to be selected as a basis for further program development. The selection is to be guided by the priorities of the countries concerned. Preliminary discussions undertaken in preparation for exploratory visits in countries where interest is thought likely to exist

have suggested six illustrative areas as being among those for possible attention:

-- The Allocation of Health Program Resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the cost and effectiveness of the different approaches currently in use, and experimentation with new and potentially more cost-effective approaches.

-- The Financing of Health Programs. The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services, and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

-- The Contribution of Non-Governmental and Private Health Services. In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

-- Health Implications of Policies outside the Health Sector. Activities outside the health sector -- nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others -- have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

-- Health Consequences of Individual Behavior. How individuals behave -- whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support -- is as important for their health as is the availability of medical services. A recognition of this has led to an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

-- Adoption of Effective Health Policies. If potentially effective health policies are to do any good, they must be adopted and acted upon as well as formulated. Getting them acted upon, especially when action involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies

has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

The Approach

For each of the issues selected, the ultimate objective of the program is to facilitate the formulation and implementation of more effective policies. Since the lead in this will have to be taken by policy makers and analysts in the countries concerned, the program's intermediate objective is to assist in strengthening developing country capacity for effective action with respect to these issues. As with the selection of subjects, the approach to be taken to the strengthening of capacities will be established with reference to country-specific needs and interests identified during the exploration. Preliminary conversations with knowledgeable observers have suggested that three broad areas are likely to command attention in most settings:

-- Skill Development. Any successful effort to deal with the issues selected will require the development and application of skills in especially short supply in most developing countries. These include skills related to the generation and analysis of relevant information, and to the use of this information for the formulation and implementation of effective policies. In the health sciences, an epidemiological outlook is likely to be particularly relevant for this. Of potentially equal value would be the involvement of social and management scientists -- economists, operations researchers, behavioral scientists, and others -- who have hitherto participated much less actively in the formulation of policies concerning health than concerning other areas of development. Also required will be increased skills in information handling on the part of those directly involved in policy decisions.

-- Institutional Strengthening. If such skills are to be effectively applied, considerable attention will have to be paid to the development of institutional settings for this purpose. In many cases, it is likely to be possible to build upon existing institutions and to strengthen linkages among them. This will require incentives for analysts from other disciplines to devote themselves to health, to collaborate and to gain a sense of fulfillment for engaging in policy work. For policy makers, ways will have to be devised for freeing them at least temporarily from the

pressures of day-to-day decision-making so that they can devote the reflection required for solutions to major policy problems. Mechanisms for encouraging more frequent, regular, and meaningful interactions between policy makers and researchers will have to be established.

-- Cooperation between Policy Makers and Analysts. The establishment of such mechanisms will be particularly important because the development and implementation of more effective health policies will require much closer relationships between policy makers and analysts than have traditionally been the rule. At present, policy makers are unaccustomed to using research findings to support policy formulation, and analysts are not oriented toward shaping their products to fit the needs of policy makers. As a result, policies are too often formulated on limited and even inaccurate data, and policy makers are unsupported in either making or evaluating those policies. Closer cooperation will be required if this situation is to be changed.

The Exploration

The exploration's discussions with developing country policy makers and analysts are to take place between the fall of 1985 and the spring of 1986. Upon their conclusion, a set of recommendations concerning program directions and financial support is to be prepared and submitted to the Pew Memorial Trust for its consideration. For financial and administrative reasons, it is anticipated that support for no more than a limited number of sites will be recommended during the program's initial phase.

The exploration is being guided by an Advisory Committee, chaired by John R. Evans, which includes representatives of the World Bank and the World Health Organization. The Program's Director is Davidson R. Gwatkin.

The Pew Memorial Trust is the principal source of financial support for the exploration. The World Health Organization and the World Bank are providing active professional and logistical support; office facilities have been made available by the World Bank.

Comments and suggestions are encouraged and may be addressed to

Davidson R. Gwatkin, International Health Policy Program, N-561 1818 H Street NW, Washington, DC 20433, USA; telephone (202) 676-9453, cables: PHN INTBAFRAD Washington DC.

July 22, 1985

To : John Kevany

John,

How much money is she talking about? If more than a small amount ($5,000) there is no easy way for us to support, as we do not have a staff member who could sponsor it as a proposal to REPAC, except perhaps Tony. However, Tony might wish to find other means of support; if only, for example, to commission a background paper, and I would then pitch in.

The other possibility is Pew Trust money, so I am passing it also to Dave Gwatkin.

Nancy Birdsall

cc: A. Measham
D. Gwatkin

Pew Memorial

Cornell University
DIVISION OF NUTRITIONAL SCIENCES
Savage Hall
Ithaca, New York 14853-6301

A DIVISION OF THE NEW YORK STATE COLLEGES OF HUMAN ECOLOGY AND AGRICULTURE AND LIFE SCIENCES
Statutory Colleges of the State University of New York

June 28, 1985

Dr. John Kevany
World Bank
Department of Population, Health and Nutrition
Room N-363
1818 H Street, N.W.
Washington, D.C. 20433

Dear Dr. Kevany:

First of all, let me thank you for taking the time to see me and to discuss our mutual research interests. The lunch also was most appreciated!

As we agreed, I have enclosed a copy of a brief research proposal to develop improved tools for the assessment of maternal nutritional status. I have not included any references but am quite prepared to do so when the time comes. As you know, I welcome any and all comments that you have to offer, particularly about what the World Bank would and would not find to be of interest.

I am very pleased that you are interested in this subject and look forward to hearing you reaction to this draft document.

Sincerely yours,

Kathy Rasmussen

Kathleen M. Rasmussen, ScD
Assistant Professor

kmr

Encl.

xc: J.-P. Habicht

DRAFT

ASSESSMENT OF NUTRITIONAL STATUS AMONG PREGNANT AND LACTATING WOMEN: A PROPOSAL FOR THE DEVELOPMENT OF NEW METHODS

Kathleen M. Rasmussen and Jean-Pierre Habicht

The ability to assess maternal nutritional status accurately is essential for scientists, policy makers and program planners. Scientists want to study the determinants of maternal nutritional status and to relate maternal nutritional status to its biological consequences. The consequences of interest include size at birth, lactational performance, and the growth, health, and survival of infants. Policy makers and program planners need to know if and to what extent nutritional as well as health and socioeconomic interventions affect maternal nutritional status. An excellent example of this latter case is the growing evidence for an interaction between maternal nutritional status and the length of the period of post partum infecundability: breastfeeding women who are beneficiaries of food distribution programs may be in particularly high need of family planning assistance.

The importance of accurate assessment of maternal nutritional status is graphically illustrated by the failure of recent supplementation studies to demonstate the expected improvements in birth size and lactational performance. These results indicate that either nutritional supplementation does not act in the manner anticipated or that methods presently in use are inadequate for selecting women who are likely to benefit from such programs. These are important alternative hypotheses. One cannot distinguish between them, however, without improving the tools that currently are available for assessment of the nutritional status of pregnant and lactating women.

An number of different indicators of nutritional status are available for use among women during the reproductive period. These indicators include both those used at other periods in the life cycle (such as weight, height, and blood chemistry values) and those specific to this period (such as weight gain during pregnancy and size of the infant at birth). Unfortunately, interpretation of these indicators often is much more difficult during the reproductive period. The meaning of changes in hemoglobin values during gestation, for example, is complicated because such values reflect both the increase in plasma volume and decrease in iron stores that are characteristic of pregnancy. Values for various blood constituents at various stages of pregnancy have been assembled from studies among well-nourished women, but there is agreement for only a few nutrients on what cut-off points characterize malnutrition. Furthermore, biochemical indicators of malnutrition are useful primarily at extreme values.

Anthropometric indicators of malnutrition are useful in a wider range of circumstances. To compensate for the short stature of malnourished women, investigators have examined various indices of

weight-for-height and then declared women below an arbitrary cut-off value to be "malnourished". Unfortunately, there is no consensus in the scientific literature about what constitutes an appropriate cut-off point. Still in widespread use are tables that are based on an insured American population in which "desirable" weight-for-height was defined in terms of mortality that generally occurred long after the end of the reproductive period. Standards for various anthropometric indicators in adult women recently have been constructed based on the distribution of values for subjects in the NHANES samples. However, the appropriateness of both of these standards is questionable because so few women in either population were as short as most malnourished women in developing countries. Furthermore, no attempt has been made to evaluate potential cut-off points for the classification of women as malnourished by relating either set of reference weight-for-height values to any kind of relevant functional outcome.

Researchers have come to recognize that optimal weight gain during pregnancy is dependent upon prepregnant size and have proposed standards that take this into account. However, the reference values in all of these efforts are the same insured American population whose applicability to short women of small frame size is questionable. Implicit in these standards for weight gain during pregnancy is that bigger babies are "better". This may be true when pelvic size is not limiting, but is open to debate for small women who lack access to operative delivery. In developing countries, it is not obvious that small size at birth per se explains poor outcomes during infancy.

It is clear that knowledge about how to assess nutritional status in pregnant and lactating women lags far behind that available for children. The time has come to apply to women during the reproductive period some of the lessons learned from the study of nutritional assessment in children. Inasmuch as indicators based on anthropometric measurements are easy to use in field settings, research should focus on the development of these indicators first. This can be accomplished by using data obtained from women in developing countries living under a range of circumstances. The sensitivity and specificity of cut-off points for the classification of individuals as malnourished must then be evaluated in terms of relevant functional outcomes. For pregnant women, such outcomes would include birth weight as well as mortality among mothers and their babies during the perinatal period. For lactating women, such outcomes would include both direct (milk yield) and indirect (infant growth) measures of lactational performance. The outcome of this research would be a set of indicators of maternal nutritional status during the reproductive period applicable to a broad range of women.

file Pew

COPY

The World Bank / 1818 H Street, N.W., Washington, D.C. 20433, U.S.A. • Telephone: (202) 393-6360 • Cables: INTBAFRAD

July 10, 1985

Ms. Rebecca W. Rimel
Vice President
The Glenmede Trust Company
229 South 18th Street
Philadelphia, Pennyslvania 19103

Dear Ms. Rimel:

I was very pleased to learn that the Board of Directors of the Pew Memorial Trust has approved a grant for the exploratory phase of the international health policy program. We look forward to receiving formal notification as to the amount approved and the time period envisioned for exploratory phase activities.

We have reviewed and slightly modified the proposed Memorandum of Understanding between the Bank and the Pew Trust prepared by Davidson Gwatkin. In our view, the modified version provides a sound framework for cooperation between our respective institutions. If you are in agreement with the provisions of the Memorandum in its present form, kindly sign and return to us one of the enclosed copies.

Once again, we look forward to cooperating with the Pew Memorial Trust in this important endeavor.

Sincerely,

John D. North
Director
Population, Health and Nutrition Department

Attachments

bcc: Mr. Doud (LEGVP), Mr. Richardson (OPSVP), Ms. Birdsall, Dr. Measham, Mr. Berg (PHN), Mr. de Ferranti (WUD), Mr. Gwatkin (HPP)

MEMORANDUM OF UNDERSTANDING BETWEEN

THE PEW MEMORIAL TRUST AND THE

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT (THE WORLD BANK)

Regarding Cooperation in the
Exploratory Phase of an
International Health Policy Program

1. The Pew Memorial Trust (the Trust) and the International Bank for Reconstruction and Development (hereinafter the "World Bank" or the "Bank") share a common concern about the health and well-being of poor people in the developing countries. Both believe that further health policy research, especially research to help improve the utilization of health resources, and to improve approaches to mobilization of resources affecting the health condition, can make a significant contribution to this end.

2. Both institutions also believe that cooperation betweem them would be highly beneficial for the development of such a research program. The Trust welcomes the participation of the Bank so that the program might gain the benefit of the Bank's wide knowledge of the developing countries and of institutional possibilities there for productive health policy work. The Trust also believes that the likelihood of tangible results emerging from research supported by the program would be greatly enhanced through association with the activities of an international financial institution like the Bank. The Bank welcomes the entry of the Trust into this area for several reasons. As a matter of general principle, the Bank believes that private organizations have a great deal to contribute and should be encouraged to participate in development efforts. Also, and more directly, the Bank has a strong interest in further health policy research, because of the potential value of such research for the design and implementation of Bank-supported health and nutrition projects.

3. In view of the overlapping interests described above, the Trust and the Bank agree to cooperate in an exploration of possibilities for institutional support to health policy research in the developing countries. This exploration would last for approximately one year, to be followed up by a multi-year program implementation phase, the details of which would be subject to agreement by the Bank and the Trust.

4. This Memorandum applies solely to exploratory phase activities, which will be led by a small staff and feature project identification visits to selected countries over a period of approximately 12 months. Exploratory phase activities will be guided by an Advisory Committee etablished by the Trust, whose members would include two representatives nominated by the World Bank, as well as representatives from the World Health Organization and distinguished individuals in the international health field.

5. To facilitate exploratory phase activities, the Trust and the Bank agree to provide the following support:

--The Bank will provide, at no cost to the program, adequate furnished accommodation for the program director and one or more research assistants/ consultants, working space for an administrative assistant/secretary and communications (telephone, telex and postage).

--The Trust will cover the following costs: salaries and benefits of program personnel and consultants; travel, subsistence, and other costs of the project identification visits; costs of the work of the Advisory Committee; and the costs of any necessary office equipment not readily available from the Bank.

--The Trust will, subject to the agreement of the Bank, arrange for an administrative mechanism which will handle funds for the payment of those items to be supported by the Trust.

--The Bank will authorize two of its senior staff members to serve on the Advisory Committee during the exploratory phase.

--The Bank will assign staff members to participate in selected project identification visits, provided such participation is, in the Bank's judgement, compatible with the staff members' other responsibilities and the program's needs. The Trust will absorb the travel and subsistence costs of such participation. Similarly, the Trust agrees that the program director will be available to participate in Bank missions, subject to the time constraints imposed by his other responsibilities and when such participation is judged to be of mutual interest. If program personnel or consultants participate in Bank missions, the Bank will reimburse the individuals concerned for the travel and subsistence costs of their participation in such missions.

--The Bank will arrange for its field offices in the countries visited to provide such logistical support as is necessary and reasonably within their capacity during the project identification visits. The Trust agrees that the project funds will be used to pay for any additional expenses incurred by the field offices in the provision of such support.

--The Bank will arrange for the program staff to have access to the relevant professional and logistical facilities and programs of the Bank (such as library and documentation services, mailroom facilities, assistance with visas and other travel documentation, parking facilities, professional seminars and training programs, and cafeterias), to the maximum extent consistent with Bank administrative policies. The Bank will also

ensure that the program director is appropriately integrated into the relevant professional activities of the Bank, in order that he might keep informed of developments at the Bank of potential relevance for health and nutrition policy research. The program director, staff and consultants shall maintain the confidentiality of any information which is not public knowledge to which they gain access as a result of their work with Bank personnel and programs.

--The Trust and the Bank will ensure that both parties are clearly identified as participating agencies in all descriptive material related to the program.

6. It is anticipated that continuing cooperation between the Bank and the Trust will prove desirable, but nothing in this Memorandum is to be construed as committing either of the parties to further cooperation without their explicit agreement.

Agreed:
Pew Memorial Trust

By_____
Authorized Representative

International Bank for
Reconstruction and Development

By_____
Director
Population, Health & Nutrition
Department

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

file : Pew

DATE March 18, 1985

TO Messrs. North, Measham, Hodgkinson, PHN
Ms. Birdsall, PHNPR

FROM David de Ferranti, PHNPR

EXTENSION 61579

SUBJECT **Pew Proposal**

As requested, I called Herman van der Tak and described the Pew proposal. His response was very positive and he raised no danger signals. He did not think that any special approvals would be required, but did ask that before the memo of understanding is signed, a note be sent to Shahid Husain with the draft memo attached.

Becky Rimel (of Pew) has agreed to come on March 28, Thursday. I thought we might have one meeting for all of us in John's office at 2:30, after which she might meet with some of us individually and perhaps the lawyer.

DdeFerranti:lcj

N. Birdsall

file: Pew Mem. Trust

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE March 6, 1985

TO Mr. John D. North, Director, PHN

FROM David de Ferranti, PHNPR

EXTENSION 61579

SUBJECT Further Developments in the Pew Memorial Trust Proposal to Support Research and Policy Work in Health in Developing Countries

1. Tony Measham's memo (attached) describes the origins of discussions on this topic and reviews developments through the end of December. Since then, Becky Rimel, on behalf of the Pew Trust, has been in touch with me. The current situation seems to be as follows.

i. Pew definitely wants to go ahead. As discussed at the December 13 meeting, they want to proceed in two phases. The first phase will be a detailed planning effort, lasting a year or less -- possibly just 6 to 9 months. The second phase will disburse approximately US$5 million in grant funds to support policy research and strengthening of research capabilities in a few developing countries over several (e.g. 4 or 5) years. Ms. Rimel wants to begin the first phase as soon as possible. She will need to get her board's approval at various points; but based on past experience, she does not expect this to be a problem.

ii. The program will focus on the areas of health economics, resource allocation, financing, and sectoral organization (e.g., public/private roles).

iii. Pew will hire a Program director to be responsible for developing and administering the program. He or she will begin immediately with the presumption of staying through the duration of the second phase if all goes well. Pew will cover the full cost of the Director's salary, benefits, and travel. The Director will have a small support staff, also fully funded by Pew. This staff may include a full-time secretary and an administrative assistant. Ms. Rimel has made an offer to Dave Gwatkin to be Director. He has indicated he will probably accept.

iv. An advisory committee will be formed during the first phase, with a continuing role in the second. This committee will review and advise on the progress of the program, based on reports by the Director. The extent of the committee's authority and its precise relationship to the Director and Pew have not yet been determined. But it is clear that Pew itself does not have the staff or time to become actively involved in technical oversight. Ms. Rimel expects to invite the same group that met in December to

..../2

become the committee's members, possibly with a few additions or deletions at the margin. That would mean including the Bank, WHO, and a few individuals not repesenting institutions.

v. Ms. Rimel very much hopes that the Bank will agree to collaborate with Pew in this enterprise. Besides being represented in the advisory committee, she hopes that the Bank will:

   a. allow the Director and support staff to be located at the Bank (e.g., in PHN office space); and

   b. agree to handle the payment of the Director's and staff's expenses (see vi below).

   A close Pew-Bank link along these lines is attractive to Pew for several reasons. First, they seem to like what they have heard about and from us so far, and want to benefit from our experience in the field to date. Second, they recognize that the Bank can help point out and put together promising country opportunities where their grants can have significant impact. Third, they feel they are unable to administer payment of the Director and his staff directly, and want to work through another institution instead.

vi. Regarding the last point, Pew would like to make one or more lump sum payments to the Bank. The Bank would then pay the salaries and travel expenses of the Director and his staff, and provide whatever benefits coverage would be agreed.

2. Ms. Rimel appears to agree with a number of program-related ideas raised by us at the December meeting. One of these ideas is that in each country selected, the aim should be to bring together emerging local researchers/policy analysts (e.g., from a university or government agency) with a team of international experts with special expertise or experience in the topics to be examined. Together, the two groups would start and complete a specific study of major policy significance to the host country government. In addition, the international experts, during extended stays in the country, would give courses, lectures, seminars, etc., aimed at helping one or more local institutions to strengthen their capacity to carry out similar research in future without further outside assistance. The degree of interest, involvement and cooperation of the host country government would be an important consideration in assessing grant possibilities. Ideally, the study to be undertaken should be one which the government recognizes as central to its future strategy choices.

..../3

What would be the costs and benefits to PHN of collaborating with PEW along the lines they have proposed?

3. Since PEW would pay the Bank an amount sufficient to cover all salaries, expenses, and benefits for the Director and support staff, there would be no net cost to the Bank for those items. The main cost to the Bank would be associated with providing office space (one or two small offices, plus a secretarial station). Processing the paperwork required to pay the Director and staff regularly is also a cost, but not a large one.

4. The benefits, on the other hand, could be substantial. When PHN staff identify a need for a study or evaluation in their project work, sector studies, or as part of the PRD work program, they could suggest possibilities to the Pew program Director and help shape the final package. Where interests coincided, PHN would in effect be tapping PEW funds and their consultants' time (for designing and carrying out studies) to perform work serving PHN and borrower country interests. PRD in particular could conceivably accomplish much more than would be feasible through Bank funds alone.

Would the arrangement proposed by Pew be consistent with Bank policy and previous practice?

5. At our request, the Legal Department is examining alternative arrangements for establishing a relationship with Pew. Their tentative conclusion is that the most trouble free arrangement would be to have Pew hire the Director and staff as their employees, with the Bank providing office space.

6. For tax reasons, it may be necessary for Pew to channel their funds through a non-profit foundation. The Legal Department is investigating the implications of this requirement and seeking to determine whether the Bank can or should establish a special conduct for Pew funds.

cc and cleared in substance with: Ms. N. Birdsall
Mr. D. Hodgkinson
Dr. A. Measham

DdeFerranti/DHodgkinson:lcj

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

file

Date: January 2, 1985

To: Mr. John D. North, Director, PHND

From: Anthony R. Measham, Health Adviser, PHND

Extension: 61571

Subject: Proposed Pew Memorial Trust Program in International Health

1. As agreed in our November 30, 1984 meeting with Dr. John Bryant, Dave de Ferranti and I attended an informal exploration of the referenced topic from 10 to 3 pm December 13, 1984. The main agenda item, "Notes on the Concept: The Pew International Health Policy Program", is attached as Annex I. The detailed agenda and participants for the December 13, 1984 meeting are at Annex II. There were ten participants, Khanna and Hellberg from WHO, Rimel and Bass from Pew, Blendon and Thorne from the Robert Wood Johnson Foundation, Dr. Julius Richmond from Harvard, Dr. Bryant, and ourselves.

2. Dave and I gave strong support to the Pew initiative, while emphasizing that it was too early for the Bank to consider more than informal involvement in the proposed five year program of health policy research and institutional development in a limited number of developing countries. We stressed the need for focus, and suggested that the areas of resource allocation and health care financing be given high priority by the program.

3. The meeting was productive, with a good deal of support for the initiative from all quarters. Dr. Bryant and the Pew representatives said the discussions helped them in further refining the proposal and deciding on appropriate next steps. The decision was to proceed to a more formal exploration over the next 6-9 months with a view to presenting a detailed proposal to the Pew board in the latter part of 1985. The plan is to hire a consultant, who would be the presumptive project director, and have him or her develop a detailed proposal based on at least two field trips to about six countries, and further consultations with the informal advisory group and other agencies and individuals. The informal advisory group would meet at least twice more, once before an once after the proposed field trips. This proposed program is of considerable interest to PHN, especially if it focuses on resource allocation and health care financing: there would be a strong complementarity between the program's research effort and PHN policy and research interests. Dave and I believe, therefore, that there may be a case for Bank collaboration along the lines of that with the ACC/SCN, i.e. providing space and limited support for secretariat activities. As you know, Pew may be interested in such an arrangement. WHO offered to conduct the further exploration, but it seems clear that the foundation prefers to move ahead independently, at least for the moment.

4. The next step is to appoint a consultant. May we discuss these developments, especially para. 3 above, on your return?

cc: Mr. de Ferranti ✓

Attachment

NOTES ON A CONCEPT

THE PEW INTERNATIONAL HEALTH POLICY PROGRAM

THE NATURE OF THE PROBLEM

A serious weakness in developing countries is the lack of capacity for research that can support national policy-making and administrative decision-making in the health sector. Policy makers are not accustomed to using research to support policy formulation, and researchers are not oriented toward shaping their research to fit the needs of policy makers.

Policies are often formulated on limited and even inaccurate data, and policy makers are unsupported in either making or evaluating those policies. Since most services are provided by national governments, inadequacies in policy-making can have widespread harmful impacts.

A dual approach is required. First, policy makers and researchers need to be oriented toward working together, so as to identify the decisions that need to be made, the kinds of information required for those decisions, and the information retrieval and research necessary to support decisions and subsequent implementation and evaluation.

Second, the capacity for information management and research related to policy has to be developed. The nature of the problems calls for multiple disciplines --health services management, economics, public health sciences, educational technology, social sciences, etc.-- and a willingness to work in interdisciplinary relationships.

Very few developing countries have a capacity for policy-related research. Where some strength is present, it is usually spotty and isolated from policy-making processes. Strengthening such capacities will require long-term support specifically directed toward the current weaknesses and needs of the poorer countries.

But those countries are not without important assets for beginning such efforts. Many of them have strong social and political commitments to improving their health systems; many also have well established and stable institutions, both inside and outside of government, to serve as focal points for such initiatives.

Another important idea is that developing countries can learn from one another, particularly from those that are close to them socially, economically and politically. Those developing countries that have some capabilities in this area can serve as intermediaries in helping those who have little, while further building their own strengths.

A PROPOSAL

Establish a series of health policy programs in developing countries with the objectives of:

- building capabilities of selected institutions in areas supportive of health policy formulation, including policy-related research, information retrieval, and training;

- developing stronger linkages between such health policy programs and policy-making levels of government;

- forming a stronger international capacity for training in fields relevant to health policy formulation and implementation in relation to the needs of developing countries;

- strengthening national capacities for policy-making, program implementation and evaluation.

The Pew Memorial Trust would provide basic funding to support the development of five or more health policy programs in developing countries, together with arrangements for consultative support, collaboration with established institutions, training, and communications among the participating institutions and with other interested parties, as appropriate.

The World Health Organization and the World Bank are invited to join the Pew Memorial Trust in co-sponsoring the program, participate in its governance, and strengthen its conceptualization and implementation.

The structures and components of the Program would include the following:

A Program Board would provide oversight for the Program. The Board would have nine members, three of which would be proposed by each of the three sponsoring institutions, and all would be acceptable to the sponsors.

A Program Director acceptable to all three sponsoring institutions would manage the program on a day to day basis, working closely with WHO and WB staffs and their international organizational structures, and maintaining close communications with the Pew Memorial Trust.

A Program Proposal would be developed by the Program Director in collaboration with the sponsoring institutions for consideration through their governing processes, as appropriate.

Program Guidelines would emerge from the process of considering the Program Proposal by the sponsoring institutions, so as to be acceptable to each of them.

The Program Board would oversee the implementation of the Program Guidelines. The Program Director would take day to day responsibility for the Program under the Board's directives, working closely with WHO and WB in doing so. The location of the Director's base of operations and the mechanisms whereby he would relate to the sponsoring institutions would be worked out in mutually acceptable terms.

The Program Board would function within the Program Guidelines, formulating the scope, objectives, size, and numbers of programs to be funded, as well as the supportive consultation, communications, and training required. The Board would also establish whatever peer review process would be appropriate for both initial assessment and subsequent evaluation of programs. The Program Director would provide managerial support for peer review and evaluation processes.

The Pew Memorial Trust would provide the necessary direct funding for the Program, including: grants to applicant institutions, costs of the Program Director's office and activities, costs of Board meetings, peer review process, consultative visits, brochures, mailings, etc.

WHO and the WB would be asked to use their extensive experience, highly talented staffs and continued association with the realities of the developing world to help connect this Program effectively with current needs and opportunities. WHO and the WB would also be asked to make staff available for consultation and to participate in field site visits, facilitate and provide space for meetings including hosting periodic meetings of the Program Board, and help to relate the Program to the ongoing activities of their organizations--without charge to the Program Budget. A substantial or continuous expenditure, such as the assignment of a person to the Program, would be covered by the Pew Memorial Trust.

TIME TABLE FOR DEVELOPMENT

An approximate time table would be as follows:

PLANNING MEETING

Assuming WHO and WB wish to pursue the matter, a date for a planning meeting involving WHO, WB, and Pew Memorial Trust, would be set.

December 14 is proposed as the time, and the World Bank as the place for the planning meeting.

WHO and WB are asked to come to that meeting with:

- Reflections on the Proposal;

- Indications of steps required for them to consider co-sponsorship;

- Identification of person(s) within their organizations that would serve as the focal point for relationships with the Program, recognizing that the Program Director would actually manage the Program;

- Proposals for (or indications of how they would proceed to identify) three members of the Program Board. Their proposals could be for either staff of their institution, or experts in the field, or both. Developing country members would be particularly welcome;

- Recommendations of candidates for position of Program Director.

Decisions that would be desirable at the planning meeting would include:

- Decision to proceed with sponsorship and development of the Program;

- Selection of a Program Director;

- Agreement on procedures and a time schedule whereby the Program Director would develop a Program Proposal in collaboration with the sponsoring institutions;

- Agreement on membership of the Program Board, and the time and date of its first meeting in order to consider the Program Proposal;

SUBSEQUENT EVENTS

A key event in initiating the Program would be submission of the Proposal to the Pew Memorial Trust Board, presumably in the Fall of 1985. If approved, the Program would begin immediately thereafter, with solicitation of institutional candidates for the Health Policy Program, and other supportive activities.

PERSONNEL

In addition to representatives of WHO and the World Bank, the planning meeting will be attended by:

Rebecca Rimel	Robert Blendon	John H. Bryant
Assistant Vice President	Vice President	Consultant
Health Sciences	Robert Wood Johnson	Washington, D.C.
Pew Memorial Trust	Foundation	
Philadelphia, PA	Princeton, NJ	

Dr. MEASHAM

DISCUSSION OF A PROPOSAL

FOR A PEW INTERNATIONAL HEALTH POLICY PROGRAM

The World Health Organization

The World Bank

The Pew Memorial Trust

Washington, D.C.

The Carlton Sheraton Hotel

(The Wine Bar)

December 14, 1984

10:00 a.m. - 3:00 p.m.

PARTICIPANTS

The World Health Organization

Mona Khana

Hakan Hellberg

The World Bank

Anthony Measham

David de Ferranti

The Pew Memorial Trust

Rebecca Rimel

Marion Bass

Advisors

Robert Blendon, The Robert Wood Johnson Foundation

Rolando Thorne, The Robert Wood Johnson Foundation

Julius Richmond, Division of Health Policy Research and Education, Harvard University

John Bryant, Special Assistant to the Assistant Secretary for Health for International Health Policy

AGENDA

Open	John Bryant, Chair
Welcome	Rebecca Rimel
Reflections on the Roles of U.S. Foundations in Health Policy and Health Services Development	Robert Blendon
Background and Programmatic Interests of the Pew Memorial Trust	Rebecca Rimel
Rationale for a Health Policy Program Focused on the Needs of Developing Countries	John Bryant
WHO -- Problems Encountered in Pursuing the Goal of Health for All	
Proceeding from Policies to Programs and Monitoring Progress	Hakan Hellberg
Managerial Issues in Health System Development-- Shifts Toward New Approaches to Planning	Mona Khana
The World Bank -- National Health Policies in an International Context	
Generic Problems Encountered at Country-Level	Anthony Measham
Financing and Resource Allocation Issues	David de Ferranti

AGENDA CONTINUED

Opportunities for New Initiatives in Supporting

National Health Policy Development and Implementation:

What is needed at the national level?

What are the organizational alternatives at the national level?

What kinds of international back-up and support are required?

How much capacity exists -- nationally and internationally -- and how much must be developed?

What would be the extent of national and international interest in initiatives in this area?

An International Health Policy Program:

Principles and objectives

Organizational structure, governance and relationships

Size, scope, longevity

Financing

Monitoring

Role of WHO

Role of World Bank

Roles of other institutions and agencies

Next Steps

4/29

To: Nancy Birdsall

Nancy.

Here's a draft submission to the Peru Board about the project. Would welcome a chance to talk it over at your convenience to discuss how the project's shaping up + how you think it should do so. Will check with Mply about possible times.

Paul Lee

file: Pew

Preliminary Draft
DRG: 4/27/85

A PEW/WB/WHO PROGRAM OF SUPPORT FOR HEALTH POLICY RESEARCH IN THE DEVELOPING COUNTRIES

A Proposal

The Problem

The many pressing health problems of the United States pale in comparison with those of the Third World. All but 500,000 of the world's 15,000,000 annual infant and child deaths occur in the developing countries.1/ Each week, some 100,000,000(?) healthy and potentially productive days of life are lost because of illness.2/ Infants born in the typical developing country are over ten(?) times as likely to die before reaching the age of five than they are in the United States.3/

The suffering represented by such figures is a source of intense concern to those directly affected and to others alike. Each year, at least $50-75 billion, are spent on direct efforts to deal with these problems;4/ and many billions more go to broader development programs -- to food production, education, and other efforts -- of importance for improvements in health status. Over one-half of the $50-75 billion or more expended for health services are paid by directly by individuals.5/ Most of the remainder comes from Third World governments for networks of public facilities and programs. About $2.5 billion are provided annually by public and private sources in the developed nations.6/

When spread among the Third World's 3.5 billion inhabitants, the amount of funds being spent directly for health services

works out to roughly $20-25 per person per year. This is only around 2-3%(?) of the $1200(?) spent annually for each person in the United States.7/ Even after allowing for the lower wage rates that make activities in the developing countries less expensive, it is obvious that resource constraints seriously limit the amount of service that can be provided.

Significant as they are, however, resource limitations are not the only -- and perhaps not even the most important -- problem faced by efforts to improve health conditions in the Third World. For, as is the case in the United States, the resources available in the developing countries are not being used nearly as well as they can and should be.

A large proportion of the individual expenditures noted above, for example, is now going for traditional medical treatments of questionable therapeutic value; much of the remainder is being used for the treatment of acute conditions which could have been prevented through such inexpensive or costless measures and behaviors as better hygiene and improved nutritional practices. In the public sector, the services available are oriented disproportionately toward the expensive high-technology medicine of the West. Thus, hospital services in urban areas, although hardly extravagant by American standards, typically absorb most of the limited public funds available for health programs. As a result, the major causes of illness and death among the 70-80 percent of the population unserved by such facilities -- such as diarrheas and respiratory infections which can be treated through simple,

inexpensive interventions -- remain largely untouched.8/

Numerous studies suggest that even the limited funds presently available could lead to significantly lower rates of death and disease. Several pilot projects have shown that infant and child mortality can be reduced by one-third, one-half, or more at annual per capita cost of under $5.00 or $10.00, through reliance on simple technologies such as those just noted.9/ According to one recent prominent estimate co-authored by the Director of the Rockefeller Foundation's health activities, services based on a judicious selection of these technologies could save a life for every $200-250 expended -- suggesting that the number of deaths in the Third World could be reduced by one-half at a cost of $4-6 billion annually, or under 10% of the amount now being expended.10/ Large-scale immunization campaigns have been shown capable at preventing an infant or child death or every $100-150 spent, implying that it should be possible to prevent the one-third of all infant and child deaths caused by immunizeable diseases for some $500-750 million annually, or less than 1 percent of current expenditures.11/

The potential gains from more effective resource utilization are equally impressive when assessed in financial terms. A 1 percent rise in the efficiency with which health resources are applied, for example, would be equivalent to an increase of at least $500-750 million in the volume of resources available. An increase of under 5 percent would be adequate to equal the financial value of all the foreign assistance currently available

in the health sector.

The Program

The principal objective of the program proposed here is to stimulate more effective health resource utilization in the Third World, in order to help realize gains such as those just indicated. This focus is proposed instead of the more common emphasis on increasing resource availability because it addresses a particularly central, overlooked issue in field notable for the inadequate attention paid to economic and managerial considerations; and because it represents a way in which the limited but flexible resources of a small private institution might reasonably be expected to make a significant contribution to the effectiveness with which the much greater resources of others are expended.

The means for working toward this objective is a program of institutional grants in the developing countries for health policy research and analysis, developed in cooperation with the World Bank and the World Health Organization. This development is to begin with an initial year of exploration, the organization and costs of which are covered by this proposal.

The Approach

The institutional grant program to be developed will feature research and analysis of value to policy makers in the Third World, and to those in international aid agencies responsible for the allocation and administration of health resources. This former group includes officials in health, finance, and planning minis-

tries; and also in the large private voluntary organizations and financial institutions which are important providers or funders of services in many areas. As noted above, over 90% of health expenditures represent funds originating in the Third World itself, making this group of people an indispensable audience. Among the leading donor and international professional agencies are the World Health Organization, the World Bank, UNICEF, and the U.S. Agency for International Development. Funds from these agencies, while a small percentage of the total, are of importance because they represent the principal source of support for experimental, innovative, and development activities.

The research and analysis supported will be undertaken cooperatively by these policy makers and by research institutions in the developing countries. Support will be provided on a regular basis by experienced researchers and institutions from the United States; from Europe; and, where possible, from advanced institutions in the Third World itself.

The program will emphasize the development of institutional programs to undertake continuing research and analyses and to provide regular guidance and advice based on their findings, in recognition of the fact that the health resource utilization problems to be addressed are pervasive, profound ones in need of ongoing attention. In some instances, where institutional capacities are too weak to permit the immediate initiation of programs of this sort, smaller project grants might be considered as a means of preparing the way for institutional programs at

a later stage. The activities undertaken within this framework will include the analysis of data from ongoing programs, and field experimentation with approaches thought likely to be particularly effective.

Particular attention will be given to a limited number of topics of special importance for health resource utilization. Thus far, two such topics have been tentatively identified. These will be reviewed and supplemented by a few additional ones selected on the basis of advice from policy makers and researchers in developing countries and donor agencies. The topics so far identified are:

-- Resource allocation. One obvious reason why money spent to improve health conditions is not producing more impressive results is that mix of approaches and programs employed is poorly suited to developing country health problems. The excessive reliance on Western high-technology medicine has already been noted. Problems are also arising in the development of potentially more relevant services. The prevention of neonatal tetanus through maternal immunization, for example, has been emphasized where where neonatal tetanus is not a major cause of illness or death;12/ primary care programs relying on young female high school graduates for service delivery are being developed for rural areas where social norms make it extremely difficult for young women to live, travel, or be accepted as sources of useful advice or service.13/ Comparative cost-effectiveness studies could be expected to point toward much more more promising service mixes; field investigations

into the widely varying causes of illness in the developing countries and of popular attitudes toward services could provide an empirical basis for program design that is now largely absent.

-- Financing. The recent global recession and the poor performance of many developing country economies has led to a sharply increased pressure on governmental funds for health services. With the encouragement of such international agencies as the International Monetary Fund, the social sectors have been frequently been singled out for special attention as governments have sought to adjust to slower economic growth. While this pressure on government health funding has caused obvious problems, it has also helped bring a notable benefit: an increasing if still limited interest on the part of health policy makers in exploring alternate, potentially more effective sources of health financing and patterns of service delivery. It has, for example, contributed to interest in private or semi-private health insurance programs or health maintenance organizations as a way of reducing dependence on the government treasury -- and, in the process, of providing services more effectively than typical public facilities. It has helped create a climate more favorable to the distribution of essential drugs through commercial or quasi-commercial channels. Experimentation with innovative approaches of this sort could produce potentially significant improvements.

Not so.

Good. P.4 seems to eliminate this sort of work.

Prior to the completion of the exploratory year for which support is here being proposed, it would be premature to talk with any specificity about the institutions and programs that

will be recommended for support. It is, however, possible to note for illustrative purposes a few of the many possibilities that have been suggested for further exploration. Annex I presents some of the more interesting such possibilities.

The Exploratory Phase

In recognition of the important differences between work in the United States and the developing countries, the proposed program of support will begin with an initial year of exploration. This will feature visits by knowledgeable professionals to the most promising developing countries in order to familiarize policy makers and researchers with the Pew Charitable Trusts and the program, and in order to explore grant possibilities such as those indicated in annex I. The result will be a firm set of program guidelines incorporating the principles indicated above as modified in light of the year's experience; and a list of grants likely to be recommended for support during the succeeding period. At present, five to six multi-year grant possibilities on the order of $1 million each appear likely to be recommended over the project's anticipated five-year life. It is possible, however, that a significantly larger number of possibilities will be recommended should circumstances warrent.

The exploration will be directed by an Advisory Committee appointed by the Pew Memorial Trust. This Advisory Committee will make recommendations to the Board of the Trust for institutions to be supported under the program. It will also monitor and report to the Board on progress during the subsequent years of the program.

The Committee will be chaired by Dr. John R. Evans. Dr. Evans, a physician, is Chairman and Chief Executive Officer of the Allelix Corporation, a bioengineering firm in Toronto. A recognized leader in the field of international health, he is member of the Rockefeller Foundation Board, a former Director of the health, nutrition, and population activities of the World Bank, and a past President of the University of Toronto.

The exploration will be undertaken in cooperation with two leading international institutions to which the United States belongs: the World Bank, which is the principal source of long-term development finance for the developing countries; and the World Health Organization, the leading international professional organization working in the health field. These two agencies, both of which have extensive networks of offices and experienced representatives in the developing countries, will help the program identify grant possibilities. Each will be represented on the Advisory Committee by two ranking staff members.

The World Bank and the affiliated International Development Association make $12-13 billion(?) of long-term loans annually to the developing countries.14/ The Bank's President, A.W. Clausen, is a former President of the Bank of America. It has rapidly been extending its activities beyond its original emphasis on economic infrastructure. It is currently making $100-150 million(?) of loans in health, nutrition, and population each year. As a financial institution, it is a leading force for the introduction of economic and managerial considerations into the planning

and implementation of health activities; through its good offices, it is possible to gain unparalleled access to a wide range of governmental and research institutions, especially Finance and Planning Ministries, throughout the developing world. The Bank hopes to expand its health lending; and it is participating in the program's development in anticipation that the program's research findings can help it identify innovative approaches to serve as the basis for future loans. Bank participation thus increases significantly the likelihood that sizeable financial support can be made available for the implementation of new programmatic initiatives suggested by the program's research.

The World Health Organization is the specialized agency of the United Nations system most directly concerned with health. It is widely recognized as one of the best U.N. agencies, known for its ability to pursue its mission effectively while avoiding the general political arguments which have caused serious disruptions in some of the system's other organizations.15/ WHO and its Director-General, Dr. Halfdan Mahler, have been at the forefront of efforts to reform health care in the developing countries through an emphasis on primary care in place of the high-technology approaches of the West which, as noted earlier, have tended to shape Third World medical thinking.16/ WHO has welcomed the proposed research initiative because its findings can be expected to provide further support for this shift; and because Dr. Mahler and his colleagues have been among the first to realize that successful primary health care programs will require far more managerial

and economic expertise than has thus far been applied. Association with WHO will be especially valuable to the program in the establishing working relationships with Third World Health Ministries and other health institutions, with which it enjoys particularly close ties.

The program secretariat will be located in Washington, D.C., in the headquarters of the World Bank, which is providing office accomodation and other logistical support. The Program Director will be Davidson R. Gwatkin. Mr. Gwatkin, the immediate past Chairman of the National Council for International Health, is an administrator and author with ten years of overseas residential experience in Asia and Africa development of health, nutrition, and population grants for the Ford Foundation. He has consulted on developing country health issues with such other organizations as the Rockefeller Foundation, the Carnegie Corporation, the International Labor Office of the United Nations, the United Nations Nutrition Committee, UNICEF, the U.S. Agency for International Development, and the World Bank. The grant will be administered by _____. A proposed budget is attached as annex II.17/

Annex I

Illustrative Grant Possibilities to be Explored

-- In Jamaica, the Department of Preventive Medicine of the University of the West Indies has cooperated with the management consultancy division of Price Waterhouse and the Health Ministry to analyze the effectiveness of the Ministry's clinic programs. The study, currently nearing completion, has suggested a set of personnel and other reforms which would bring about an estimated doubling(?) of the system's capacity at minimal additional expense. The Ministry's initial reaction to the study's finding has been favorable; and it is considering implementing them on an experimental basis in two districts, using its own resources. Should it do so, additional funding would be required to permit the continued participation of the University of the West Indies and Price-Waterhouse. Further support could institutionalize this kind of cooperative activity at the University with continuing support at Price-Waterhouse; and the Price-Waterhouse people involved could be employed as technical consultants to assist the development of similar activities in other countries.

-- In Haiti, the poorest country of the Latin American and Caribbean Region, half of all health services are provided by private and voluntary organizations, whose clinical activities are considered much more effective than those of the government. The highly-respected Association of Private Health Organizations, which coordinates their work, is in the process of establishing a Child Survival Institute which would, among other things, investigate ways of improving the effectiveness of alternate strategies for improving child health. External support would make possible the provision of the considerable outside expertise likely to be required for the institute to realize its potential.

-- In Tanzania, the Division of Community Medicine of the Medical Faculty of the University of Dar es Salaam has a long-standing relationship with the unusually effective Planning Unit of the Ministry of Health. Recently, for example, Division staff members have be examining the priority that should be given to malaria control relative to other program possibilities, and have been looking into the effectiveness of the Ministry's new community health worker program. The Division has expressed a strong interest in obtaining the assistance from Boston University's well-known Program in Health Management and Economics (approximate title) in strengthening work like this but has thus far been prevented from doing so by financial constraints.

-- In Kenya and Morocco, the World Health Organization has been organizing assessments of new nutrition initiatives. The national programs to be assessed are two among the twenty(?) being supported by $75,000,000(?) provided through WHO

and UNICEF by the Italian Government. Technical expertise and support are being provided by the Antwerp, Belgium Royal Institute of Tropical Medicine (approximate title) and the Johns Hopkins University School of Hygiene and Public Health. The objective is to determine whether the approaches being adopted are the most effective among those available, or whether funds can be better spent in other ways. The two projects are at present in the very early stages of development. The executing agencies in Kenya and Morocco remain to be identified, and the relationships between those institutions and the governmental agencies operating the programs to be assessed have yet to be worked out. If the institutional arrangements eventually agreed to appear attractive, assessment efforts such as those proposed could be starting points for the development of longer-term institutional efforts to assess and compare a wide range of nutrition and health interventions.

-- In Thailand, the National Economic and Social Development Board, the Government's planning agency, is establishing a semi-autonomous(?) policy research institute to provide guidance for its decisions. Among the interests of this institute, which is receiving core support from the U.S. Agency for International Development, are health policies and programs. It has a valuable resource in the person of the former chief economic advisor to AID and later to the United Nations Development Program, now in residence at the institute, who is well known for his work in nutrition and health. Of equal importance are several able Thai researchers at the Mahidol University of the Health Sciences, a leading medical faculty established with long-term Rockefeller Foundation support(? -- principal institution supported by the Rockefeller Foundation may have been Chulalongkorn University). They have been working closely over the years with the World Health Organization and the Ministry of Health on analyses and assessments of governmental primary health care, nutrition, and family planning programs. The existence of such resources points to the possibility of a joint Mahidol-institute program to provide the analyses and information needed by the governmental planning authorities for decisions concerning health resource allocation and use.

-- In China, the World Bank has begun negotiations toward a possible $40,000,000(?) loan to the health sector. Among the proposed components of this loan is a large-scale experiment with health insurance in rural areas. The insurance program, which would be supported to a significant degree by individual payments, would mark the first(?) important shift toward reliance on market forces in what has traditionally been an exclusively state-controlled sector. If the experiment is successful, the World Bank would plan to provide major support for an expanded program in future loan agreements. The experiment, which would be monitored by the Government's Institute of Medicine(?) with extensive technical support from the Rand Corporation, is strongly

supported by the Health Ministry, which shares the World Bank's interest in exploring the potential for market approaches. But the Finance Ministry(?), faced with a need to conserve the country's critically scarce foreign exchange, has adopted a general rule against using borrowed foreign exchange for research activities without an immediate economic return. Since outside technical expertise is indispensable for any economic analyses of health activities, especially activities involving concepts so new and inadequately understood in China as market forces, it appears unlikely that the experiment can be mounted unless some alternate source of outside funding can be identified. Aside from the value of the experiment per se, it would provide an opportunity for the development of economic expertise and an institutional capacity in China to deal with other issues of health resource utilization as they arise in the future.

-- In India, the Indian Institute of Management in Ahmedabad, established in the 1950s with long-term support from the Harvard Business School, has long been recognized as one of the Third World's premier management institutions. Since the late 1960s(?), it has been gaining expertise in health and family planning through the provision of research and consulting services to a series of projects supported by the World Bank. A number of opportunities exist for using the Institute as a source of technical expertise for innovative projects elsewhere in India. An example concerns the Southern state of Tamil Nadu, with a population of over 50,000,000(?). There, a highly respected economist, a former Finance Secretary (the highest-ranking civil servant in the State Finance Ministry) and senior staff member of the Brandt Commission(?), has just left the civil service to establish a development research institution supported by the state government(?) for the purpose of providing it with policy guidance. For personal as well as professional reasons, he had a strong interest in health: his father, a prominent physician, is the founder and director of a large-scale, non-profit, highly-successful health maintenance organization that is unique in South Asia. Both the state government and the World Bank have expressed interest in careful assessments of this organization's experience as a basis for determining the applicability of its approach to projects elsewhere in the state, in other states of India, and in other countries. The new institute, with technical support from Ahmedabad, would be an obvious institution to undertake such analyses and, building on the experience gained through them, other policy studies on resource utilization issues for the use of the state government.

Draft Footnotes

1. Gwatkin, American Journal of Public Health article, citation to be provided.

2. Arbitrary number. If a figure of this sort is thought useful, a rough estimate can be worked out on the basis of approach used by and information provided in Ghana Health Assessment Project Team article in International Journal of Epidemiology.

3. Approximately correct figure based on memory of Coale-Demeny model life tables. Figure to be checked and citation to be provided.

4. Estimate based on information presented in David de Ferranti 1985 World Bank staff working paper. (This estimate is well below the latest Lee Howard/WHO/PAHO figure of $130 billion. Howard is to be consulted before adoption of final figure.)

5. Estimated from de Ferranti, table 2, page 9, 1985 World Bank staff working paper. Weighted average ratio of private to total expenditure for thirty-five developing countries covered works out to about 0.55, implying that slightly over half of total expenditures are private. (Howard uses figure of 4.0 instead of 0.55, which is principal source of variation between his overall expenditure figure and that in the text. Howard is to be consulted before adoption of final figure.)

6. Figure from Lee Howard draft 1985 paper. Excludes assistance for water and sanitation.

7. Notional numbers. More accurate figures and citation to be provided in final version.

8. Readers to be referred to appropriate sections of WHO Sixth Report on the World Health Situation and 1980 World Bank Health Sector report for further information on the current situation as described here. Full references to be provided.

9. Gwatkin, Wilcox, and Wray, Can Health and Nutrition Interventions Make a Difference? Full citation to be supplied.

10. Walsh and Warren, Social Science and Medicine report on Bellagio Conference. Figures in text (based on memory of what Walsh and Warren article says, not yet checked against article itself) to be confirmed; full citation to be provided.

11. Figures to be more carefully worked out. Full citation to Zachariah/Cochrane World Bank staff working paper and other sources to be provided.

12. Nancy Williamson article on Bohol, the Philippines, from Studies in Family Planning. Full reference to be supplied.

13. Judith Justice Social Science and Medicine article on Nepal. Exact citation to be provided.

14. Supplementary basic information about WB and IDA to be provided in this footnote. WB loans $8-9(?) billion per year at approximately market rates, from funds raised through the sale of bonds in international capital markets. IDA makes $3-4(?) billion in additional, (almost) interest-free loans annually to the poorest countries from funds raised through subscriptions by developed country governments. WB and IDA funds are administered jointly, by the same professional staffs and for the same purposes.

15. Possible reference to the Heritage Foundation report on the World Health Organization, which gave it the cleanest -- or at least the most nearly clean -- bill of health of any of the several United Nations organizations it has examined thus far in the course of its United Nations project.

16. Reference to and discussion of Alma Ata Conference and Declaration as illustrations of WHO's central role in this movement.

17. Annex II currently under preparation.

International Health Policy Program

An Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

A PROGRAM OF SUPPORT for HEALTH POLICY ANALYSIS AND DEVELOPMENT in ASIA AND AFRICA

Guidelines for Applicants

Introduction

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy leaders have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization have all been working to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to use such resources as are presently available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions by the participating policy makers from governmental and non-governmental organizations concerned with the health of the poor; 2) the development of promising younger analysts through the experience gained in the studies' execution; and 3) the establishment of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Their size and composition will necessarily vary from setting to setting. In most cases, they will probably consist of between three and five or six people, including:

- **Policy analysts,** one to three people who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would likely be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant analytical work is undertaken within ministries. The typical analyst would be the recent recipient of a doctoral or equivalent degree in a field like economics, epidemiology, a behavioral science, or management with a demonstrated capacity for policy-relevant analytical work; some analysts might have master's degree supplemented by records of subsequent analytical accomplishment.

- **Research advisers,** one or two senior researchers who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to meet regularly with other group members and to

Work Program

The activities of each health policy analysis and development group are to center around a set of original empirical analyses providing practical guidance concerning policy issues of importance to the senior policy adviser's agency. Analyses which identify ways major development investment programs can be most effectively designed and executed will be among those of particular interest.

Each study within the set is to be discrete and limited in duration, normally requiring a year or less to complete. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses will be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

- **The allocation and utilization of health program resources.** The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and experimentation with new and potentially more cost-effective approaches.

- **The financing of health programs.** The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services,

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

- **Research and seminar costs.** Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; of the portion of analysts' time spent on project work; of honoraria for program advisers if in accordance with local custom; and of equipment and supplies.

- **Short-term orientation/interchange/training activities.** Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

• **Longer-term overseas internship, training or data analysis opportunities for analysts.** Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

In addition, consultations by or collaboration with outside specialists can be arranged. The use of such specialists will be strongly encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities. Supplementary funds can be provided for this purpose.

Meetings of program participants will be organized at yearly intervals. All group members will be strongly encouraged to take part if requested and will be provided with supplementary IHPP travel awards for this purpose.

Support provided for the purposes indicated is seen as a means of initiating a longer-term institutional development effort. An IHPP grant carries no commitment of further assistance to the group for which it is made; but should the IHPP's sponsors find the results of the current stage adequately promising, additional development support may later be considered for those groups whose initial work proves especially valuable for policy formulation.

Support cannot be considered for construction, for institutional overheads, or for long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications should be brief, of no more than four to five pages plus attachments. They should provide:

- **Basic information about each institution with which group members are affiliated.** This information may be in the form of attached public reports from the institutions concerned.

- **The name and affiliation of each group member.** A *curriculum vitae* for each person should be attached. The *curriculum vitae* of each policy analyst should contain the names and addresses of at least two referees not associated with the group who may be asked for assessments of the analyst's potential for creative, responsible policy work. (A copy of the accompanying form should be sent to each of these referees for completion and forwarding to the IHPP secretariat.) Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome.

- **A discussion of the health policy issue with which the group is to deal.** The discussion should deal with the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

- **A letter of support from a responsible official of each participating institution other than that submitting the application.** Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group will be participating with its approval, and that the agency anticipates giving careful consideration to the results of the group's analyses in formulating its policies.

- **A preliminary budget.** Accompanying this should be an indication of any complementary funds available from other sources for program support, and of any technical collaboration with external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, **in time to arrive no later than January 15, 1987,** to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will be in terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are: 1) the significance of the issues covered for improvements in the health status of the poor; 2) the capacity of the applying individuals and institutions to produce relevant, high-quality analyses; 3) the prospects for effective collaboration among the participants in designing, executing, and assessing the policy implications of IHPP-supported analyses; and 4) the likelihood that the analyses produced can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to prepare fuller study proposals for discussion with representatives of the IHPP during site visits planned for April and May 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. It is expected that grant recipients will be publicly announced by June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

INTERNATIONAL HEALTH POLICY PROGRAM
N-561 1818 H Street, N.W.
Washington, D.C. 20433, U.S.A.

Telephone: (202) 676-9453

Cables: PHN INTBAFRAD

Telexes: 440098 WORLDBANK
64145 WORLDBANK

file 'Pew'

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

August 21, 1987

Ms. Rebecca Rimel
The Pew Charitable Trusts
Three Parkway, Suite 501
Philadelphia, PA 19102-1305

Dear Beckey:

I am writing to follow up on our conversations in Geneva concerning analysis of ways of strengthening the management of health care systems. This is an area where I'd like to see our unit in the Bank do a bit more work (mostly guidelines, case studies, etc.; some training); this is also an area that I'm not too comfortable with myself and so will be turning to others for help.

Several areas within management seem critically important:

(i) information systems (epidemiological, vital, and service delivery);

(ii) staff and institutional training and development activities; and

(iii) financial reform designed to strengthen user and provider incentives.

I expect to be replacing Tony Measham at your October 5 Advisory Panel meeting in Philadelphia. Perhaps we can chat again then, unless you are down in Washington soon.

It may be worth noting in passing that this Department's Education Division has a very similar set of concerns. If we embark on any collaborative efforts, their experience would be worth drawing on.

Sincerely,

A. Berciano for:
Dean T. Jamison
Chief
Population, Health and Nutrition Division

bcc: Messrs. Gwatkin, Haddad, Verspoor

DTJamison/am
(Signed in his absence.)

Conferences

WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE : August 21, 1987

TO : Mrs. Ann O. Hamilton, Director, PHR

FROM : Dean T. Jamison, Chief, PHRHN (D. Memo for:)

EXTENSION : 33226

SUBJECT : Back-to-Office Report: Meeting on "Health Research for the Developing World: Priorities and Strategies", Bellagio, July 18-22.

1. According to your terms of reference dated June 30, 1987, I attended this meeting. Attached are an agenda for the meeting and a list of participants. The attendees mostly comprised a distinguished group of medical scientists; a few bureaucrats (representing WHO, UNDP and the Bank) were invited to provide a sense of the market for proposals to increase research funding.

2. The discussion proceeded at a high level of abstraction that was occasionally difficult for me to follow. Several points were generally agreed:

(i) there remains gross imbalances between the developed and developing world in terms of both of capacity to construct research and of the relevance of the subjects of ongoing research to the needs of differing patterns of health problems in the developing countries;

(ii) that while more research would likely have high social payoffs, realistically there were limited prospects for new funding; therefore

(iii) establishing priorities (the subject of the meeting) was essential.

3. I got little out of the discussions of how to set priorities. Most illuminating was an example of an extensive analysis of priorities for vaccine research undertaken over a period of one to two years in a relatively quantitative way by a group of experts assembled by NAS/IOM. The group had the good sense on Day 1 to come to a quick and dirty set of judgments. The final results were rather close to the initial judgments. I'm not sure I'd buy the implicit conclusion about the value of analysis, but there is certainly a lesson in the story.

4. The conference organizers left ample time for informal discussions and, as is often the case, this proved very valuable. There was a good deal of skepticism, in these informal discussions, about the priority that ought to be accorded a series of country health surveys; but some of the skeptical also seemed attracted (Caldwell, Chen, Muller) and jumped straight into the technical issues. I had initial discussions about starting a look at PHN priorities for the Bank and received useful ideas and encouragement. Richard Peto of Oxford reviewed the extremely interesting epidemiological

work he is involved with on China, and I invited him to give us a seminar here at the Bank.

5. All-in-all, Ken Warren and Rockefeller posed a set of questions and assembled a group that yielded a productive outcome -- even if some of the structured sessions drifted a bit. The relation of the outcome of the Bellagio deliberations to the immediately preceeding ones in Boissy[1] was unclear, but the hope was expressed that the record (forthcoming) of Bellagio would be of value to the newly established Independent International Commission on Health Research.

Attachment

cc: Messrs. Haddad, van der Gaag
Mss. Birdsall, Herz
PHN Group Staff

DTJamison/am
(Signed in his absence.)

---

[1]See Back-to-Office report of July 28 from Measham and me.

"Health Research for the Developing World:
Priorities and Strategies"
Bellagio, Italy, July 18-22, 1987

PARTICIPANTS' LIST

John Caldwell
Department of Demography
Research School of Social Sciences
Australian National University
G.P.O. Box 4
Canberra, A.C.T. 2601
Australia

Lincoln C. Chen
Takemi Professor of International Health
Harvard School of Public Health
Building 1, Room 1104
665 Huntington Avenue
Boston, MA 02115

Joseph A. Cook
Director
Program in Tropical Disease Research
The Edna McConnell Clark Foundation
250 Park Avenue
New York, NY 10017

William H. Foege
Executive Director
The Task Force for Child Survival
Carter Presidential Center
One Copenhill Northeast
Atlanta, Georgia 30307

Donald Fredrickson
President & Chief Executive Officer
Howard Hughes Medical Institute
6701 Rockledge Drive
Bethesda, MD 20817

Tore Godal
Director
Special Programme for Research and
Training in Tropical Disease
World Health Organization
20 Avenue Appia
1211/27 Geneva
Switzerland

Scott B. Halstead
Associate Director
Health Sciences Division
The Rockefeller Foundation
1133 Avenue of the Americas
New York, NY 10036

Aleya Hammad
Intersectoral Action for Health
World Health Organization
1211 Geneva 27
Switzerland

Dean Jamison
Chief of Policy and Research Division
Population, Health and Nutrition Department
The World Bank
Room N452
1818 H Street N.W.
Washington, D.C. 20433

Gerald T. Keusch
Chief, Division of Geographic Medicine
and Infectious Diseases
New England Medical Center Hospitals
750 Washington Street, Box 041
Boston, MA 02111

Adetokunbo O. Lucas
Program Chair
Strengthening Human Resources in
Developing Countries
Carnegie Corporation of New York
437 Madison Avenue
New York, New York 10022

Adolfo Martinez-Palomo
Centro de Investigacion y de Estudios
Avanzados del Instituto Politecnico Nacional
Apartado Postal 14-740
Mexico 14, D.F.

Alexander S. Muller
Director
Department of Tropical Hygiene
Royal Tropical Institute
University of Amsterdam
Mauritskade 63
1092 AD Amsterdam
The Netherlands

Richard Peto
Clinical Trial Service Unit
Radcliffe Infirmary
University of Oxford
Oxford OX2 6HE
England

Nathaniel Pierce
Diarrhoeal Diseases Control Programme
World Health Organization
20 Avenue Appia
1211/27 Geneva
Switzerland

V. Ramalingaswami
Visiting Professor of International Health
Harvard School of Public Health
Building 1, Room 1104
665 Huntington Avenue
Boston, MA 02115

Jon E. Rohde
USAID/PRITECH American Embassy
New Delhi 110021, INDIA

Timothy Rothermel
Director
Division for Global and
Interregional Projects
United Nations Development Programme
FF 12-102
1 U.N. Plaza
New York, NY 10017

Ruhakana Rugunda
Minister of Health
Box 8 Entebbe
Uganda

Jaime Sepulveda
General Director
Epidemiology Directorate
Aniceto Ortega 1321
Col del Valle
Mexico, D.F.

John Stremlau
Director
Pocantico Project
c/o Rockefeller Group, Inc.
1230 Avenue of the Americas
New York, NY 10020-1579

Samuel Thier
President
Institute of Medicine
National Academy of Sciences
2101 Constitution Avenue
Washington, D.C. 20418

Peter Tugwell
Chairman
Dept. of Clinical Epidemiology & Biostatistics
Faculty of Health Sciences
McMaster University
1200 Main Street West
Hamilton, Ontario, L8N 3Z5
Canada

Kenneth S. Warren
Director
Health Sciences Division
The Rockefeller Foundation
1133 Avenue of the Americas
New York, NY 10036

Prawase Wasi
Faculty of Medicine Siriraj Hospital
Dept. of Medicine
Division of Hematology
Mahidol University
Bangkok, 10700, Thailand

Julia Walsh
Consultant to the
Health Sciences Division
The Rockefeller Foundation
19 Bagdad Road
Durham, New Hampshire 03824

HEALTH RESEARCH FOR THE DEVELOPING WORLD:
PRIORITIES AND STRATEGIES
BELLAGIO, ITALY
July 18-22, 1987

AGENDA

Saturday, 18 July	
afternoon	Arrivals
7:00 p.m.	Cocktails
7:30 - 8:30 p.m.	Dinner
After dinner (40 minutes)	Report of planning meeting of the Independent International Commission on Health Research - Chen
Sunday, 19 July	
8:00 - 9:00 a.m.	Breakfast
9:00 - 9:30 a.m.	Summary of Working Paper - Health Research for the Developing World: Priorities Based on Effectiveness and Cost - Walsh
9:30 - 10:30 a.m.	Priorities: Diseases of Underdevelopment/Development Opening Remarks - Foege Chair - Rugunda
10:30 - 11:00 a.m.	Coffee
11:00 - 12:30 p.m.	Summary - Rugunda Chair - Foege
12:30 - 1:00 p.m.	Aperitifs
1:00 - 1:50 p.m.	Lunch
3:00 - 4:00 p.m.	Priorities: Burden of Illness (Specific Diseases) Opening Remarks - Tugwell Chair - Martinez-Palomo
4:00 - 4:30 p.m.	Tea
4:30 - 6:00 p.m.	Summary - Martinez-Palomo Chair - Tugwell
7:00 p.m.	Cocktails
7:30 - 8:30 p.m.	Dinner

WHO strengthening programs, now, rather than Depts through TDR

Monday, 20 July

8:00 - 8:30 a.m.	Breakfast
8:30 - 10:00 a.m.	Priorities: Modes of Intervention - e.g. Preventive/Curative* Opening Remarks - Rohde Chair - Muller
10:00 - 10:30 a.m.	Coffee
10:30 - 11:30 a.m.	Summary - Muller Chair - Rohde
11:30 - 12:30 p.m.	Priorities: Level - e.g. Basic/Applied/Social Opening Remarks - Ramalingaswami Chair - Thier
12:30 - 1:00 p.m.	Aperitifs
1:00 - 1:50 p.m.	Lunch
2:00 - 3:30 p.m.	Summary - Thier Chair - Ramalingaswami
3:30 - 4:00 p.m.	Tea
4:00 - 5:00 p.m.	Priorities: Venue - e.g. North/South/International/Industry Opening Remarks - Wasi Chair - Jamison
5:00 - 6:00 p.m.	Summary - Jamison Chair - Wasi
7:00 - 7:30 p.m.	Cocktails
7:30 - 8:30 p.m.	Dinner

World Bank problem & from higher ed issues
- comparative advantage:
  - location of subject
  - scale economies
  - career paths of scientists; responsibility for res.
  - role of univs + training

how to strengthen capacity in LDCs
- emphasize c.e.

*Preventive/Curative
Vaccines/Drugs
Environment/Pesticide
Water/Oral rehydration
Sanitation/Antibiotics

epidemiologic / clinical diagnostic
sectoral / inter-sectoral

international/regional/national institutes/links
international training programs

role of universities

10^5 cases/yr. : 2×10^{10}
2×10^5 $/case = 2×10^{10}/yr

Tuesday, 21 July

8:00 - 9:00 a.m.	Breakfast
9:00 - 11:00 a.m.	Priorities: Funding - e.g. National/Bilateral/Multilateral Opening Remarks - Rothermel Chair - Lucas
11:00 - 11:30 a.m.	Coffee
11:30 - 12:00 p.m.	Summary - Lucas Chair - Rothermel
12:30 - 1:00 p.m.	Aperitifs
1:00 - 1:50 p.m.	Lunch
2:00 - 4:30 p.m.	Overall Summary and Discussion Opening Remarks - Walsh Chair - Warren
7:00 - 7:30 p.m.	Cocktails
7:30 - 8:30 p.m.	Dinner

Wednesday, 22 July

morning	Departure

file: IHPP

NOTE OF INVITATION AND EXPLANATION

to: Prof. Brian Abel-Smith, London School of Eonomics
Dr. John Akin, World Bank
Prof. Ralph Andriano, University of Wisconsin
Dr. Nancy Birdsall, World Bank
Mr. Andrew Creese, WHO
Dr. Fred Golladay, World Bank
Dr. Michael Jancloes, WHO
Dr. Alex Kamugisha, Ministry of Health, Uganda M.P.
Mr. Serge Kananiye, National Assembly, Burundi
Dr. Sumedha Khanna, WHO
Dr. Anthony Measham, World Bank
Dr. Germano Mwabu, University of Nairobi, Kenya
Prof. John Ohiorhenuan, University of Ibadan, Nigeria

from: Dr. Davidson Gwatkin, Director, IHPP
Dr. Katja Janovsky, IHPP Consultant

re: Discussion of IHPP Proposals from Burundi, Kenya, Nigeria and Uganda with a panel of Pew, WHO and IBRD economists and planners

The International Health Policy Program (IHPP) of the Pew Foundation is taking the opportunity of the forthcoming technical discussions on health economics at the World Health Assembly in Geneva to organize a meeting. The invited participants are a group of applicants for IHPP grants from Africa, and Pew, WHO and World Bank staff and consultants attending the technical discussions. The four applicants concerned come from Burundi, Kenya, Nigeria and Uganda. Their proposals have been selected by the IHPP Advisory Committee in the first round and they have been requested to submit fuller proposals. Copies of the key sections of each of the preliminary proposals are enclosed for your information.

The purpose of the proposed meeting is to provide an opportunity for the IHPP applicants to present their proposals to a panel of experienced economists and planners and to obtain useful comments and suggestions for further development.

Since the time available for this meeting is limited, with only 30 minutes scheduled for presentation and discussion of each of the four proposals, it is hoped that individuals will have an opportunity to discuss proposals during their remaining time in Geneva and also to establish a basis for further communication later on.

The meeting is scheduled for Tuesday, 5 May 1987, 10 am, in Room E 110 of the main building at WHO and will be followed by a short lunch. Dr. David Gwatkin, Director of IHPP will serve as chairperson and Dr. Katja Janovsky as secretary. Prior to the meeting, Dr. Gwatkin can be reached at the Hotel Cornavin and Dr. Janovsky at the Division of Strengthening Health Services, c/o Mme Joan Pibouleau, Room 5143, extension 2883.

All participants are cordially invited for drinks and dinner at the restaurant Diligence, the same evening at 7.30 p.m.

Katja Janovsky

Geneva, 27 April 1987

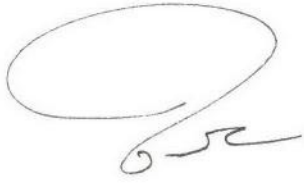
Davidson R. Gwatkin

Nov. 1

To: Nancy Birdsall

Nancy,

For your information.



International Health Policy Program

file: Pew (or switch entire file to new name: IHPP

An Initiative of the Pew Memorial Trust in Cooperation with the World Bank and the World Health Organization

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Program Developments

DATE: October 31, 1986

Support from the Pew Memorial Trust

I am pleased to report that the Grants Committee of the Glenmede Trust Company has approved the staff's recommendation and committed $3,350,000 for three years of support to the IHPP. I attach a copy of the proposal on which the Committee's action was based.

The first $1,216,000 has already been made available to the Institute of International Education to cover policy workshops, the annual meetings of participants, secretariat costs, and IIE's administrative fees. Funds for support to health policy analysis and development groups are to follow as soon as the Advisory Committee has determined the groups to be supported and the Grants Committee has had its customary opportunity to see the list of grantees.

Program Implementation

I attach also the printed guidelines for applicants, produced following discussions of an earlier draft with Advisory Committee members, and with potential applicants during a September visit to Southeast Asia. The guidelines have been distributed to approximately 100 policy makers and analysts in Africa and Asia, selected on the basis of our exploratory discussions and with the help of Advisory Committee members and World Bank and WHO staff members familiar with the countries concerned.

I am off this weekend for program discussions in Africa. Upon my return in late November, I shall be sending you a report on both my discussions there and the Asian discussions in September, along with the list of those receiving guidelines which is currently under preparation.

Kellogg Discussions

As you will remember, Becky Rimel indicated at our July meeting that we would discuss with the Kellogg Foundation the possibility of its increasing its support for health policy work in Latin America, to complement our focus on Africa and Asia. Accordingly, Becky and I went to the Kellogg Foundation's offices in Battle Creek, Michigan on October 6 for lunch and an afternoon of discussions with Kellogg's President and four senior officers dealing with health.

The conversations were cordial and informative, but they did not lead to a sense of any strong Kellogg interest in increased activity in this area. Recent organizational and personnel changes make Kellogg's future directions somewhat unclear. For the immediate future, however, any Kellogg health policy activity seems likely to feature a distillation of the policy implications of earlier work, and an effort to apply the lessons learned from this work more effectively in policy development.

Personnel Changes

Along with the gratifying action of the Glenmede Grants Committee reported above comes the unfortunate news that Glenmede and we shall be losing Marian Bass. Marian has made the difficult decision to move with her family to Princeton, New Jersey where her husband is employed. She is leaving Glenmede at the end of October. We join with Becky Rimel in mourning the loss of Marian's effective assistance and in wishing Marian well in her next incarnation working with New Jersey's Commissioner for Human Services.

Marian's successor is Nadya Shmavonian, who comes to Glenmede from the Wharton School of the University of Pennsylvania, where she has just received a Master's of Business Administration degree with a specialization in health care administration. Among other things, Nadya has served as a volunteer in a Cambodian refugee camp and has worked on health care issues at both the federal and state level in the United States. We'll look forward to working with Nadya; I have indicated to her that she should feel free to call anyone of us should she have any questions about the IHPP or about other dimensions of work in international health.

cc: Rebecca W. Rimel
Marian E. Bass
Nadya K. Shmavonian

Enclosures

PHASE II
INTERNATIONAL HEALTH POLICY PROGRAM

REQUEST: For a grant of $3.35 million, over three years, for a program to improve health policy capacities in a number of less-developed countries.

INTRODUCTION

As in the United States, the resources available to improve health conditions in the developing countries could lead to significantly lower rates of death and disease if more effectively used.

When considered in relation to the pressing needs of the developing world's 3.5 billion inhabitants, the funds available for health are far from adequate. In absolute terms, however, the amounts involved are significant. Each year, some $125-150 billion go for direct efforts to deal with health problems; and many billions more are spent on broader development programs -- on food production, education, and other activities -- of importance for improvements in health status. Well over one-half of the $125-150 billion expended for health services is paid directly by individuals. Most of the remainder comes from Third World governments for networks of public facilities and programs. About $2.5 billion -- around 2% of the total -- is provided by public and private sources in developed nations.

These funds could produce much greater health benefits than they now do. At present, individuals are spending far too much for traditional medical treatments of questionable therapeutic value, and for the expensive treatment of acute conditions which could have been prevented through inexpensive or costless approaches like better hygiene and improved nutritional practices. In the public sector, the services available are disproportionately oriented toward the expensive technology of the West, such as hospital services in urban areas. Yet, resources remain inadequate for the promotion of simple, inexpensive technologies capable of producing dramatic reductions in the most common ailments among the 70-80% of the population remaining outside the hospitals' reach.

The gains of even modest improvements in this pattern of resource use would also be impressive in financial terms. A 1% rise in the efficiency with which health resources are applied would be equivalent to an increase of over $1 billion in the volume of resources available. An improvement of 2-3% would be adequate to equal the financial value of all the external assistance currently available in the health sector.

EXPLORATION

At its June 1985 meeting, The Committee on Grants approved an exploration of health policy program possibilities in developing countries. The exploration, which has just been completed, was guided by an Advisory Committee appointed by The Pew Charitable Trusts and undertaken in cooperation with the World Bank and the World Health Organization. It included discussions with well over 300 policy makers, analysts, and external assistance agency representatives in 13 developing countries, the United States, and Europe.

The exploration confirmed the value of the proposed emphasis on more efficient

resource use. The Third World's recent economic difficulties and other developments were found to have been producing a growing concern for resource issues. Two dimensions of this concern are particularly evident:

-- An increasing appreciation of the need for greater efficiency in health services generally, and in governmental health services in particular. Recent constraints on governmental resources are emphasizing the importance of seeing that the limited health funds available are applied to programs which can bring the greatest benefits to the disadvantaged. Increasingly, health program managers are asking and being asked for data concerning the numbers and kinds of people their services are reaching, for evidence on the effects of these services related to their cost, and for information about more effective approaches to service delivery.

-- A rising interest in looking beyond conventional governmental programs for the provision of health services and for improvements in health status. As a result of their recent encounters with severe resource scarcity, increasing numbers of developing country governments are, in the words of Pakistan's Finance and Planning Minister, "at last becoming more realistic" about their capacities. This is leading many to question the feasibility of their earlier hope to provide adequate free health care for all, and to begin searching for supplementary or alternative approaches. This means an emerging interest in such things as patient- and employer-financed health insurance in China and elsewhere in Asia; closer cooperation with private voluntary organizations for service delivery in many sub-Saharan African countries; the strengthening of commercial and nonprofit pharmaceutical distribution programs in Southeast Asia; and greater reliance on community-based efforts in many areas.

Although views like these are not yet well established, the exploration found that they are appearing at a time when the climate is favorable to their spread. For, rather than being isolated developments, they are manifestations of broader changes in thinking about economic and social development. They are closely related to the growing realization that inefficient resource use represents as important a deterrent to overall development as the inadequate resource availability which had earlier been the focus of attention, and to the resulting concern for greater efficiency in government services, and for increasing involvement of the private sector in development generally.

Because the rise of a concern for resource issues has been so recent, the capacity of developing country health policy makers to deal with them remains limited. Many of the questions being raised are quite different from those traditionally asked in the administration of governmental health programs; different skills are needed to answer them. In most developing countries, there is only a handful of people equipped with such skills; many countries lack even that. Where they exist, they are usually not organized to link the relevant disciplines or bridge the gulf between policy making and implementation. Far more qualified people will be required if the new ideas about resource use now surfacing are to be assimilated into the design and implementation of health activities with enough sensitivity for the ideas to realize their full potential.

To begin filling this need, the Advisory Committee has drawn upon its exploration's findings to suggest an approach derived from several successful experiences in related areas. The approach features the establishment of a network of health policy analysis and development groups consisting of developing country policy analysts and policy makers, supported by outside specialists, working together on resource issues of importance. Special

efforts would be made to ensure effective interactions among participating groups, and to promote the spread of knowledge about their work in order to increase its impact.

HEALTH POLICY ANALYSIS AND DEVELOPMENT GROUPS

The health policy analysis and development groups proposed for support will typically consist of four to six policy makers and analysts. At the heart of their activities will be analytical work carried out by promising younger professionals. These will be recent recipients of doctoral or master's degrees, usually from American or European institutions, holding positions in leading research and training institutes like faculties of public health, university economics/sociology departments or institutes of development studies, management institutes, or research/analysis divisions of government ministries. Their work will be supervised by senior people in their organizations: the director of planning in a government health ministry or private voluntary organization; a department chairman or dean in a university faculty; or the director of an autonomous research institute or consulting firm. Also participating will be senior representatives of the policy organization most directly concerned: a ministry of health, a ministry of finance or planning, a social insurance agency, or a private voluntary health service organization. Where group members have not yet had extensive experience with resource issues, external consultants will be associated with their work to provide further technical expertise.

Applications for support and participation in the program will be invited from people and institutions identified during the exploratory phase as having particular promise. Support will be provided through leading local non-profit institutions -- such as universities, private voluntary organizations, recognized independent research and training institutions, and government ministries -- with extensive experience in the effective administration of funds from external sources.

Three-year support will be provided for 10 to 12 groups in four to eight developing countries. This support will have three objectives. The first will be the production of analyses of importance for formulating policies in the countries concerned and for demonstrating to policy makers and analysts elsewhere the value of greater attention to resource issues. The second will be the development of younger analysts in order to help overcome the shortage of qualified people available for work on resource questions. The third will be the strengthening of institutional relationships between policy makers and analysts in order to promote continuing cooperative work.

Highest priority will be given for support to groups in Asia and sub-Saharan Africa. Because of less well-developed institutional frameworks in these areas, particularly in sub-Saharan Africa, work is likely to prove more challenging there than in Latin America. But Asia and Africa are the areas of greatest need, where the advisory committee believes a successful program could make the greatest difference.

SUPPORTING ACTIVITIES

The work of the individual health policy analysis and development groups will be complemented by activities designed to strengthen links among them and to spread awareness and the impact of their work. Three types of activity will be featured: periodic participants' meetings; special policy workshops; and professional support from the program secretariat.

Meetings of program participants will be held annually to provide participants with an opportunity to review each other's work and to exchange ideas. Policy makers and analysts from other developing countries will also be invited to attend, in order to extend knowledge about the program's activities.

In addition, two to four policy workshops will be held each year to provide further opportunities for other potentially interested policy makers and analysts to become familiar with important resource issues. The workshops will be organized in selected African and Asian countries in collaboration with experienced local, developed country, and international institutions. They will have two purposes. First, especially in the program's initial stage, they will be designed to help policy makers and analysts to define their interests and develop high-quality proposals for program support. There will be a special focus on Africa in this regard. Second, as the program progresses, they will come increasingly to represent a channel through which the program-supported groups might become better known and achieve wider influence.

ORGANIZATION AND ADMINISTRATION

The program will be guided by a professional advisory committee, appointed by the Glenmede Trust Company, which will review applications and prepare recommendations concerning the health policy analysis and development groups to be supported. The committee will be chaired by Dr. John R. Evans, who will continue the role he played during the exploratory phase. Dr. Evans, a physician, is Chairman and Chief Executive Officer of the Allelix Corporation, a bioengineering firm in Toronto, a member of the Rockefeller Foundation Board, a former Director of health, nutrition, and population activities of the World Bank, and a past President of the University of Toronto.

The program director will be Davidson R. Gwatkin, who served in this capacity during the exploratory phase. Mr. Gwatkin, the immediate past Chairman of the National Council for International Health, is an administrator and author with ten years of residential experience in Asia and Africa developing health, nutrition, and population grants for the Ford Foundation.

As during the exploratory phase, grant funds will be administered by the Institute of International Education (IIE) in New York. IIE acts as an administrative clearinghouse for students and scholars coming to the United States to study, and for Americans seeking to study abroad. In addition, IIE administers the Fulbright Program.

ANTICIPATED RESULTS

As with other Trust-initiated activities, staff will carefully monitor the program's progress. A principal feature of the monitoring process will be a thorough review to be undertaken approximately two years after the program's initiation.

At that time, it will probably still be too early for more than limited policy changes attributable to program-supported work to be visible. Also, the experience of comparable institutional development efforts suggests that it would not be realistic to anticipate that all the program-supported groups would prove immediately successful. Within the first two years, the training program and technical assistance should be in place. In a significant proportion of cases, groups of capable people could be expected to be working

effectively on relevant and high-quality analyses of important resource issues of significant concern to policy makers; and this work could reasonably be expected to make a progressively significant difference as it proceeds. In addition, as a result of the participants' meetings, workshops, and other supporting activities described earlier, there should be evidence of an effective exchange of valuable ideas among group members, and of increasing interest on the part of others made familiar with resource issues through the program.

An additional dimension of program progress would be the extent to which it strengthens the capacity of developing countries to work effectively with other agencies, especially with the World Bank and the World Health Organization. In the case of the Bank, this would mean the identification of innovative approaches which could serve as a basis for future Bank loans in health and involvement of individuals supported in policy studies. The greater appreciation of resource issues would also be stimulating more rapid movement toward the relevant primary health care which WHO has been effectively pioneering.

If the program fulfills these expectations, selective further support to the most successful groups is likely to be highly attractive. The Kellogg Foundation has expressed an interest in providing support to expand the program into Latin America. In addition, inquiries about the program have been received from the Australian Development Assistance Bureau.

MEB 9/86

INTERNATIONAL HEALTH POLICY PROGRAM

PROPOSED BUDGET

	YEAR ONE	YEAR TWO	YEAR THREE	TOTAL
Support for Health Policy Analysis and Developing Groups in Developing Countries	$1,184,000	$ 600,000	$ 350,000	$2,134,000
Support for Networking Activities among Groups		150,000	150,000	300,000
Support for Policy Workshops	84,000	84,000	81,000	249,000
Salaries and Benefits	150,000	150,000	150,000	450,000
Administrative Fee	82,000	66,000	69,000	217,000
TOTAL	$1,500,000	$1,050,000	$ 800,000	$3,350,000

ADVISORY COMMITTEE MEMBERS

David E. Bell, Director
Center for Population Studies
Harvard University
Boston, MA

Robert J. Blendon
Senior Vice President
The Robert Wood Johnson Foundation
Princeton, NJ

John R. Evans (Committee Chairman)
Chairman & CEO
Allelix, Inc.
Mississauga, Ontario CANADA

David de Ferranti
Chief, Operations Policy and
Research Division
Water Supply and Urban
Development Department
The World Bank
Washington, DC

William H. Foege
Executive Director
The Task Force for Child Survival
Decatur, GA

Sumedha Khanna, Director
Health Strategy Co-ordination
World Health Organization
Geneva, SWITZERLAND

Adetokunbo Lucas
Chair, Human Resources in
Developing Countries Program
Carnegie Corporation of New York
New York, NY

Anthony R. Measham
Health Advisory
Population, Health and Nutrition
Department
The World Bank
Washington, DC

Jayantilal K. Satia
Professor, Public Systems Group &
Production & Quantitative Methods Area
Indian Institute of Management
Gujerat, INDIA

Albert van der Werff
Consultant on Health Policy, Planning
and Management
Health Strategy Co-ordination
World Health Organization
Geneva, SWITZERLAND

INTERNATIONAL HEALTH POLICY PROGRAM

An Initiative of the Pew Memorial Trust in cooperation with
the World Bank and the World Health Organization

N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.
Telephone (202) 676-9453; Telexes 440098 WORLDBANK, 64145 WORLDBANK
Cables PHN INTBAFRAD

Reference for Policy Analyst

Introduction

The individual named in section I below has been nominated to serve as a policy analyst in a group of health policy makers and analysts applying for financial support from the International Health Policy Program (IHPP). With this support, the group would undertake a three-year program of original empirical analyses dealing with policy issues of importance for the health of the poor, and providing practical guidance for policy decisions. Through such support, the IHPP hopes to assist the development of promising younger analysts by the experience gained in the analyses' execution; and to help establish more effective working relationships between policy makers and analysts.

Policy analysts like the individual named below are to be the groups' principal workers. Each analyst is to devote 25-50% of his or her time to the project, analyzing the policy issue(s) indicated in section I. Analysts are to work in cooperation with the groups' policy and research advisers whose names and designations are also provided.

Instructions

Each individual nominated as a policy analyst is requested to complete section I of this form and to mail the form to a person, not associated with the group applying for IHPP assistance, whom the nominee considers well qualified to provide a professional reference. (Each individual nominated should mail a form to at least two such people.)

Each referee receiving this form from a nominee is requested to complete section II as fully and as candidly as possible. A supplementary statement may be attached if desired. *The completed form should be airmailed, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director, International Health Policy Program, N-561 1818 H Street, N.W., Washington, D.C. 20433, U.S.A.*

The help of referees is greatly appreciated. The contents of their references will be held in strict confidence.

* * * * * * *

Section I: Background Information (to be completed by individual nominated as policy analyst prior to submission to referee)

1. Name, job designation, and institutional affiliation of individual nominated as policy analyst:

   _____

2. Brief description of policy issue(s) to be analyzed: _____

   _____

   _____

3. Names, job designations, and institutional affiliations of other group members:

   A. Other analysts (if any): _____

   _____

   B. Research adviser(s): _____

   _____

   C. Policy adviser(s): _____

   _____

Section II: Professional Reference (to be completed by referee)

1. When, for how long, in what capacity, and how well have you known the individual who has been nominated? _____

2. In comparison with other individuals you have known in a similar capacity, would you consider the qualifications of the individual being nominated as excellent (upper 10%), good (upper 25-10%), above average (upper 50-25%), below average (upper 75-50%), or poor (lowest 25%) with respect to:

   A. Intellectual potential: _____ Comments: _____

   B. Initiative: _____ Comments: _____

   C. Reliability: _____ Comments: _____

   D. Ability in written expression: _____ Comments: _____

   E. Ability in oral expression: _____ Comments: _____

   F. Policy orientation: _____ Comments: _____

3. Does the individual have particular strengths or weaknesses in relevant areas other than those just noted?

4. How well do you feel that the individual's education and experience qualify him or her to deal analytically with the particular policy issue(s) described in section I? Do you have suggestions concerning ways in which his or her qualifications for work on this issue/these issues might be strengthened? _____

5. Is there other information about the individual you feel would be helpful in assessing the individual's qualifications to serve as a policy analyst? _____

Referee's Signature: _____ Date: _____

Name (Please Print): _____ Title: _____

Mailing Address: _____

Mailing address for completed form: Davidson R. Gwatkin, Director
International Health Policy Program; N-561 1818 H Street, N.W.
Washington, D.C. 20433; U.S.A.

Deadline for receipt of completed form: January 15, 1987

INTERNATIONAL HEALTH POLICY PROGRAM

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Policy analysts like the individual named below are to be the groups' principal workers. Each analyst is to devote 25-50% of his or her time to the project, analyzing the policy issue(s) indicated in section I. Analysts are to work in cooperation with the groups' policy and research advisers whose names and designations are also provided.

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Each referee receiving this form from a nominee is requested to complete section II as fully and as candidly as possible. A supplementary statement may be attached if desired. *The completed form should be airmailed, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director, International Health Policy Program, N-561 1818 H Street, N.W., Washington, D.C. 20433, U.S.A.*

The help of referees is greatly appreciated. The contents of their references will be held in strict confidence.

* * * * * * *

Section I: Background Information (to be completed by individual nominated as policy analyst prior to submission to referee)

1. Name, job designation, and institutional affiliation of individual nominated as policy analyst: _____

2. Brief description of policy issue(s) to be analyzed: _____

3. Names, job designations, and institutional affiliations of other group members:
   A. Other analysts (if any): _____
   B. Research adviser(s): _____
   C. Policy adviser(s): _____

Section II: Professional Reference (to be completed by referee)

1. When, for how long, in what capacity, and how well have you known the individual who has been nominated? _____

2. In comparison with other individuals you have known in a similar capacity, would you consider the qualifications of the individual being nominated as excellent (upper 10%), good (upper 25-10%), above average (upper 50-25%), below average (upper 75-50%), or poor (lowest 25%) with respect to:

   A. Intellectual potential: _____ Comments: _____

   B. Initiative: _____ Comments: _____

   C. Reliability: _____ Comments: _____

   D. Ability in written expression: _____ Comments: _____

   E. Ability in oral expression: _____ Comments: _____

   F. Policy orientation: _____ Comments: _____

3. Does the individual have particular strengths or weaknesses in relevant areas other than those just noted?

4. How well do you feel that the individual's education and experience qualify him or her to deal analytically with the particular policy issue(s) described in section I? Do you have suggestions concerning ways in which his or her qualifications for work on this issue/these issues might be strengthened? _____

5. Is there other information about the individual you feel would be helpful in assessing the individual's qualifications to serve as a policy analyst? _____

Referee's Signature: _____ Date: _____

Name (Please Print): _____ Title: _____

Mailing Address: _____

Mailing address for completed form: Davidson R. Gwatkin, Director
International Health Policy Program; N-561 1818 H Street, N.W.
Washington, D.C. 20433; U.S.A.

Deadline for receipt of completed form: January 15, 1987

INTERNATIONAL HEALTH POLICY PROGRAM

An Initiative of the Pew Memorial Trust in cooperation with
the World Bank and the World Health Organization

N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.
Telephone (202) 676-9453; Telexes 440098 WORLDBANK, 64145 WORLDBANK
Cables PHN INTBAFRAD

Reference for Policy Analyst

Introduction

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The help of referees is greatly appreciated. The contents of their references will be held in strict confidence.

* * * * * * *

Section I: Background Information (to be completed by individual nominated as policy analyst prior to submission to referee)

1. Name, job designation, and institutional affiliation of individual nominated as policy analyst:

   _____

2. Brief description of policy issue(s) to be analyzed: _____

   _____

   _____

3. Names, job designations, and institutional affiliations of other group members:

   A. Other analysts (if any): _____

   _____

   B. Research adviser(s): _____

   _____

   C. Policy adviser(s): _____

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Section II: Professional Reference (to be completed by referee)

1. When, for how long, in what capacity, and how well have you known the individual who has been nominated? _____

2. In comparison with other individuals you have known in a similar capacity, would you consider the qualifications of the individual being nominated as excellent (upper 10%), good (upper 25-10%), above average (upper 50-25%), below average (upper 75-50%), or poor (lowest 25%) with respect to:

   A. Intellectual potential: _____ Comments: _____

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   D. Ability in written expression: _____ Comments: _____

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3. Does the individual have particular strengths or weaknesses in relevant areas other than those just noted?

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International Health Policy Program

An Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

A PROGRAM OF SUPPORT for HEALTH POLICY ANALYSIS AND DEVELOPMENT in ASIA AND AFRICA

Guidelines for Applicants

Introduction

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy leaders have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization have all been working to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to use such resources as are presently available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions by the participating policy makers from governmental and non-governmental organizations concerned with the health of the poor; 2) the development of promising younger analysts through the experience gained in the studies' execution; and 3) the establishment of effective working relationships between policy makers and analysts conducive to further cooperative work.

Groups qualifying for support may already exist or may be newly created. Their size and composition will necessarily vary from setting to setting. In most cases, they will probably consist of between three and five or six people, including:

- **Policy analysts,** one to three people who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would likely be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant analytical work is undertaken within ministries. The typical analyst would be the recent recipient of a doctoral or equivalent degree in a field like economics, epidemiology, a behavioral science, or management with a demonstrated capacity for policy-relevant analytical work; some analysts might have master's degree supplemented by records of subsequent analytical accomplishment.

- **Research advisers,** one or two senior researchers who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to meet regularly with other group members and to

ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

• **Policy advisers,** one or two responsible senior, policy-level officials from governmental or non-governmental organizations centrally concerned with health: the director of policy in a health ministry, for example; the director of a large private voluntary agency providing health services; or the head of the health/social welfare division of a planning ministry. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions by their agencies concerning the health of the poor, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: for example, support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency. Overlapping membership among groups is also permissible: for instance, a director of health or social service programs in a planning ministry might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group are to center around a set of original empirical analyses providing practical guidance concerning policy issues of importance to the senior policy adviser's agency. Analyses which identify ways major development investment programs can be most effectively designed and executed will be among those of particular interest.

Each study within the set is to be discrete and limited in duration, normally requiring a year or less to complete. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses will be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

- **The allocation and utilization of health program resources.** The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and experimentation with new and potentially more cost-effective approaches.

- **The financing of health programs.** The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services,

and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

• **The contribution of non-governmental and private health services.** In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

• **Health implications of policies outside the health sector.** Activities outside the health sector — nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others — have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

• **Health consequences of individual behavior.** How individuals behave — whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support — is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

• **Adoption and implementation of effective health policies.** If potentially effective health policies are to do any good, they must be adopted and implemented as well as formulated. Getting this done, especially when doing so involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

- **Research and seminar costs.** Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; of the portion of analysts' time spent on project work; of honoraria for program advisers if in accordance with local custom; and of equipment and supplies.

- **Short-term orientation/interchange/training activities.** Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

• **Longer-term overseas internship, training or data analysis opportunities for analysts.** Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

In addition, consultations by or collaboration with outside specialists can be arranged. The use of such specialists will be strongly encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities. Supplementary funds can be provided for this purpose.

Meetings of program participants will be organized at yearly intervals. All group members will be strongly encouraged to take part if requested and will be provided with supplementary IHPP travel awards for this purpose.

Support provided for the purposes indicated is seen as a means of initiating a longer-term institutional development effort. An IHPP grant carries no commitment of further assistance to the group for which it is made; but should the IHPP's sponsors find the results of the current stage adequately promising, additional development support may later be considered for those groups whose initial work proves especially valuable for policy formulation.

Support cannot be considered for construction, for institutional overheads, or for long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications should be brief, of no more than four to five pages plus attachments. They should provide:

- **Basic information about each institution with which group members are affiliated.** This information may be in the form of attached public reports from the institutions concerned.

- **The name and affiliation of each group member.** A *curriculum vitae* for each person should be attached. The *curriculum vitae* of each policy analyst should contain the names and addresses of at least two referees not associated with the group who may be asked for assessments of the analyst's potential for creative, responsible policy work. (A copy of the accompanying form should be sent to each of these referees for completion and forwarding to the IHPP secretariat.) Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome.

- **A discussion of the health policy issue with which the group is to deal.** The discussion should deal with the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

• **A letter of support from a responsible official of each participating institution other than that submitting the application.** Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group will be participating with its approval, and that the agency anticipates giving careful consideration to the results of the group's analyses in formulating its policies.

• **A preliminary budget.** Accompanying this should be an indication of any complementary funds available from other sources for program support, and of any technical collaboration with external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, **in time to arrive no later than January 15, 1987,** to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will be in terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are: 1) the significance of the issues covered for improvements in the health status of the poor; 2) the capacity of the applying individuals and institutions to produce relevant, high-quality analyses; 3) the prospects for effective collaboration among the participants in designing, executing, and assessing the policy implications of IHPP-supported analyses; and 4) the likelihood that the analyses produced can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to prepare fuller study proposals for discussion with representatives of the IHPP during site visits planned for April and May 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. It is expected that grant recipients will be publicly announced by June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

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Telephone: (202) 676-9453

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Telexes: 440098 WORLDBANK
64145 WORLDBANK

file, Pew Foundation

International Health Policy Program

An Initiative of the Pew Memorial Trust in Cooperation with the World Bank and the World Health Organization

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Proposals and Meeting Information

DATE: August 13, 1987

Proposals

I attach:

-- Report on Project Development. The report describes efforts since the March Advisory Committee meeting to assist the development of fuller proposals from each of the fourteen groups whose work was found worthy of further consideration; and it provides information about the present status of those proposals.

-- The Nairobi University Proposal, Background Note, and Assessment Form. The proposal is one of three under consideration for Carnegie Corporation support.[1] It is being circulated for assessment at this time in accordance with the schedule earlier adopted. If the assessments received from Committee members by the end of August indicate a consensus in favor of support, the Carnegie staff is prepared to submit it for consideration at the early October meeting of Carnegie's Board. Otherwise, no recommendation will be made to the Carnegie staff until after a discussion of the proposal at our October 5 meeting, and Carnegie Board consideration will be deferred.

On the basis of the contents of the proposal and the background note attached to it, I suggest:

-- We recommend that the Carnegie Corporation provide support at the level requested; and

-- We discuss at our October 5 meeting how best to assist the project's continuing development during the implementation phase.

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[1] The other two are from Nigeria and Uganda. They are expected to be available for consideration by the time of our October meeting.

Whatever your view, I urge you to complete promptly the assessment sheet which accompanies the proposal, and to ensure that it reaches my office no later than Monday, August 31.[2]

Meeting

As noted in my July 29 memorandum, the next meeting of the Advisory Committee will be on Monday, October 5. The principal item of business will be the consideration of proposals.

The meeting will take place in the meeting room of the Pew Charitable Trusts' new offices at Three Parkway, Philadelphia, Pennsylvania. Sunday night accomodation will be available at the Four Seasons Hotel.

Jeanne Bright will be in touch with you early next month to provide further information and any desired assistance in arranging travel and/or accommodation.

Best wishes,

cc. Rebecca W. Rimel
Patricia L. Rosenfield
Nadya K. Shmavonian

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[2] I'll be away from Washington until September 1, but Jeanne Bright will be available to receive your assessment in my absence; and I have asked Jeanne to follow up in an effort to obtain as complete a response as possible before my return. She would welcome a telexed or telephoned message in advance of your completed assessment form should that be more convenient for you.

INTERNATIONAL HEALTH POLICY PROGRAM

Report on Proposal Development

Davidson R. Gwatkin

August 13, 1987

Since the March Advisory Committee meeting, the focus of effort has been on stimulating the further development of the fourteen projects identified by the Committee for further consideration.[1] As of this writing, more fully developed (but not necessarily final) proposals have been received from ten of the fourteen groups. Proposals from the remaining four are due by early September.[2] If these arrive on schedule, fuller proposals from all fourteen groups will be available by the time of the October Advisory Committee meeting.

The steps taken with respect to each of the fourteen groups are described in attachment I. Although these steps are too varied to permit easy categorization, they have included three identifiable clusters of activity:

-- Preparation and distribution to group members of suggestions for proposal development based on the views of Advisory Committee members, outside reviewers, and the IHPP secretariat.

-- Discussions at WHO's World Health Assembly in Geneva in early May. A small morning seminar, organized and financed by the IHPP at the time of the Assembly, provided an opportunity for five investigators (four from Africa and one from Asia) to discuss their proposals among themselves and with several economists attending the Assembly's technical discussions.[3] (Attachment II is a list of meeting participants.) Also, further conversations were held with the many Assembly participants who were members of or closely associated with IHPP groups.

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[1] The Carnegie Corporation of New York has expressed interest in providing support for three of the projects: Kenya (Nairobi University), Nigeria, and Uganda. Those of the remaining eleven which are approved would be supported with funds from the Pew Memorial Trust.

[2] And three of the ten groups which have already sent fuller proposals are to send submissions incorporating further refinements.

[3] This IHPP support also allowed several of the African participants to participate in and contribute to the WHO technical discussions.

-- Site visits. All but one of the fourteen potential project sites were visited at least once by an IHPP representative during May and June[4]; some received multiple visits.

The people involved in these activities are too numerous to name individually. Members of the World Bank, WHO, and Carnegie Corporation staffs, as well as Advisory Committee members, have been extremely generous with their time. Those whose names appear most frequently in the attached project reports are:

-- Yours truly. I visited eleven of the fourteen sites in May and June and have now been to all but one of them (Korea) at some time or other since the IHPP began.

-- S. Ibi Ajayi. Dr. Ajayi is Professor of Economics and former Dean of Social Sciences at the University of Ibadan, Nigeria. Through support provided with the Carnegie Corporation, he was able to participate in visits to the five African sites. (Dr. Ajayi's report is attachment III.)

-- Katya Janovsky. Dr. Janovsky, formerly Director of Program Management and of Research and Evaluation at AMREF in Nairobi, is now an independent consultant based in Geneva, where she works with both WHO and the World Bank. Dr. Janovsky organized the Geneva activities described above, participated in the discussions held there, and also discussed the IHPP proposal during her regular visits to Uganda on World Bank business.

Comments or suggestions, especially concerning further project development activities which might be considered, would be very welcome.

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[4] And discussions were held with the principal investigator of the one exception (Pakistan, which had been covered during the earlier round of introductory site visits) during two trips he made to Washington.

ATTACHMENT I

Attachment I

REPORT ON PROPOSAL DEVELOPMENT

Project Reports

I. AFRICA

Burundi

The Burundi proposal originated from the Office of the Inspector General in the Ministry of Health. Its objective is to determine the unit costs for different kinds of health services. The resulting information would serve as the basis for establishing financial norms for budgetary purposes, and for use in setting insurance premia/reimbursement schedules. The proposed work would be undertaken by Ministry staff in cooperation with two Burundian academic institutions and the University of Montreal.

Discussions with the Burundi team members have focussed on the three topics of principal concern to the Advisory Committee members and professional reviewers. The first has been the need for greater focus (the scope of the original proposal having been much broader than that of the more recent version just described); the second has concerned the desire for greater methodological specificity; the third has been the importance of ensuring that the principal investigators would have adequate time available for the work proposed.

Discussions on these points have taken place on two occasions. The first was at the May World Health Assembly in Geneva. At that time, a team member presented a description of the project plans at the IHPP seminar; consultant Katya Janovsky and Davidson Gwatkin were able to discuss the plans with him at some length; and Gwatkin also spoke briefly with the Health Minister and the Ministry's Inspector General, under whose direct supervision the proposed work is to take place. Second, consultant Ibi Ajayi and Gwatkin spent two and a half working days in Burundi in late June.

A revised proposal was received in early August. It is currently being translated into English from the original French and will be distributed to Advisory Committee members prior to the October meeting.

Kenya -- Nairobi University

The Kenya/Nairobi University proposal is an initiative of three younger social scientists (two economists and a sociologist; two at the Medical School's Department of Community Health, one at the Institute for Development Studies). It has two emphases. One is on the demand for health services. Among other things, the work proposed would permit an estimate of whether the Government's tentative plan to introduce clinic fees would significantly reduce clinic attendance by the poor, as the plan's opponents

fear. The second emphasis concerns the relative cost-effectiveness of different health improvement measures. The cost-effectivenesswork would take place at the district level and be oriented to the district-level authorities responsible for an increasing number of resource allocation decisions under the Government's new decentralized approach to health planning. The proposal has the support of the Ministry of Health, whose Deputy Director of Health Services is to serve as a policy adviser to the group.

Discussions with the team members have been primarily on three questions raised about the original proposal by reviewers and the Advisory Committee members. One has concerned the breadth of focus (which was considerably wider than that of the later proposal just described). The other two questions dealt with the need for a clearer policy orientation, and with methodological issues.

These and other topics were covered during three rounds of meetings. The first was during the WHO World Health Assembly in May, in which one of the investigators participated as a WHO expert. He presented a description of the project at the IHPP seminar organized in connection with the Assembly; and Davidson Gwatkin held an extended discussion with him at that time. Second, Ibi Ajayi and Gwatkin spent a morning discussing a preliminary revised proposal with the investigators in Nairobi in mid-June. Third, Patricia Rosenfield was able to discuss the same preliminary revised proposal at length with one of the investigators in early July at Harvard University, where she and he were both attending a Harvard-WHO workshop. (Gwatkin was able to participate in part of these discussions.)

A fuller, further refined proposal was received in early August. It is presently being distributed to Advisory Committee members with a request for early advice about whether it should be recommended for support.

Kenya -- VADA/AMREF

The joint proposal by VADA[1] and AMREF[2] is to be an amalgamation of two separate preliminary proposals previously submitted: one by AMREF in cooperation with VADA, the other by VADA in cooperation with AMREF. The single joint proposal is being prepared at IHPP's request, and in response to an IHPP suggestion concerning its orientation. This suggestion, which originated from one of the IHPP's professional reviewers, would focus on policy issues of concern to the Catholic and Protestant medical associations, whose members provide most of the health services available through the private voluntary sector in Kenya. The leaders of these organizations

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1 Voluntary Agencies' Development Association, a consortium of Kenyan voluntary organizations.

2 African Medical Research and Education Foundation, a large Nairobi-based international private voluntary organization active in several East African countries.

would identify a set of policy issues of concern to their members; and these issues would be analyzed by analysts based at VADA, at AMREF, and possibly at other Kenyan institutions.

Ibi Ajayi and Davidson Gwatkin met with the principal figures involved in the proposal in Nairobi in mid-June. The representatives of the Catholic and Protestant organizations seemed quite attracted by the approach suggested by the IHPP and had begun to identify issues for analysis. The VADA secretariat appeared equally interested. The AMREF representatives seemed to consider it distinctly less attractive than an AMREF-led effort focussing on PVO-government relations, but also distinctly preferable to no project at all.

A revised proposal from the VADA/AMREF group is due in early to mid-September. It will be sent to Advisory Committee members as soon as it arrives, for discussion at the October meeting.

Nigeria

The Nigeria proposal was submitted by a group from the University of Ibadan Economics Department. Like the work featured in the Nairobi University proposal, the Ibadan activities would concentrate on the factors influencing the demand for health services. The work undertaken would allow the group members to estimate things like the increase in the number of patients attending presently-underutilized rural clinics following such reforms as improved location, reduced charges, and/or better-trained personnel. Related work would permit estimates of the health benefits of shifting a greater proportion of health resources from secondary and tertiary to primary care.

Among the items discussed with group members have been the points raised by the reviewers and Advisory Committee members. These include: the value of a greater orientation toward policy makers' concerns, a clearer relationship with other health economics activities under way in Nigeria, and a reduction in the ambitious scope of the initial proposal.

These discussions have taken place in Geneva and Ibadan. In Geneva, the Ibadan project coordinator discussed the proposed activities at the IHPP seminar organized at the time of the WHO World Health Assembly in early May, and he met at that time with Davidson Gwatkin for a detailed conversation about the Advisory Committee's views. It was also possible for him and Gwatkin to meet briefly with the Nigerian health minister. In Ibadan, a discussion with group members was organized by Adetokunbo Lucas and Ibi Ajayi in early June.

A more fully developed proposal was received on schedule in late July. Upon receipt of the Federal Health Ministry's letter of support, which has been delayed by a sudden ministerial reorganization, the proposal is to be circulated to Advisory Committee members.

Uganda

The source of the Uganda proposal is the Ministry of Health, where the lead has been taken by the Minister. According to the preliminary proposal, most of the work would by done by younger staff members in the Ministry's Planning Unit and in the Ministry of Planning and Economic Development. The topic is health financing: the exact focus of the work remains to be determined, as does the composition of the research team.

As with most of the other African proposals, discussions of these issues started in Geneva, where the principal Ugandan investigator presented his ideas at the early May IHPP meeting held in connection with the WHO World Health Assembly. There was also an extended discussion with Davidson Gwatkin and Katya Janovsky at that time.

Since then, there has been a steady stream of visitors to Uganda on business related to the IHPP proposal's development. The first was Andrew Creese of the World Health Organization. Creese, earlier the thesis supervisor of the IHHP Ugandan project's principal investigator, was in Uganda for ten days as an economic consultant to the Government's National Health Policy Commission, whose forthcoming findings are expected to represent an important input into the IHPP project design. Shortly thereafter, health economist Kenneth Lee and two colleagues spent a month in Uganda under World Bank auspices preparing a health financing report for the Government. The IHPP project principal investigator worked full-time with them as their Ugandan counterpart; and their report is to be another important input in to the next version of the IHPP proposal.

Also, Katya Janovsky spent a month in Uganda in connection with her ongoing responsibilities as the coordinator of World Bank technical assistance in health there. And the Ugandans, including the Health Minister, were further harrassed by the two-day visit of Ibi Ajayi and Davidson Gwatkin, which overlapped with that of Creese.

The next step of project preparation is to come in late August, when the Ugandan principal investigator will spend ten days in the United Kingdom and Geneva (with IHPP support), drafting the next version of the proposal in light of his summer experiences and in consultation with Lee, Creese, and Janovsky. He is to discuss this draft with his Ugandan colleagues upon his return to Entebbe in early September. It is to be submitted in time for circulation to Advisory Committee members before our October meeting, at which it is to be discussed.

II. ASIA

China -- Beijing Medical University

The Beijing Medical University proposal is for the development of a health service delivery approach which can deal effectively with the health problems of the remaining high-mortality areas of China -- particularly the poor, remote, sparsely-populated autonomous regions in the West of the

country. The idea was -- and is -- to do a set of household and facility studies and to apply the findings to the development of an approach which could be tested in the region concerned. If successful, the approach would be applied in other regions as well. The Minister of Health, who serves as the project's policy adviser, is said to have been directly involved in its submission.

In considering the preliminary proposal, which featured work in Tibet, the Advisory Committee members had raised a number of issues for further exploration. These included a lack of precision in the study design, the apparent lack of Tibetan involvement, and inadequate attention to the development of Tibetan institutions.

These points were raised in the course of a lengthy discussion between Davidson Gwatkin and the Beijing Medical University team members during a visit by Gwatkin to China in late May. The discussion featured an oral presentation of the team's plans in uncertain English to an audience totally incompetent in Chinese. The outcome was an agreement that the group members would submit a written version of their presentation for the consideration of the Advisory Committee, as a basis for determining the next steps in project development.

(Among the issues arising in this and other conversations in Beijing was the project's location. The investigators' choice of Tibet seemed controversial within China; and they presently appear inclined to propose Inner Mongolia instead.)

The promised written version of the Beijing proposal was submitted promptly, in late June. It is currently being circulated to a number of authorities, who are being requested to prepare written suggestions for its further development. The suggestions are to be for the use of both the investigators and the IHPP.

Those asked for suggestions are:

-- William Hsiao of the Harvard School of Public Health, whom the Beijing group members had requested as an external collaborator;

-- Eric Goon and William Kean from the Beijing and Western Pacific Regional Offices of WHO, which had been associated with the proposal's submission through Mona Khanna;

-- William Parker of UNICEF's Beijing office, a Johns Hopkins School of Public Health faculty member with relevant prior research experience in India.

If all goes well, commentaries from some or all of these people will be available by the time of the next Advisory Committee meeting.

China -- Shanghai Medical University

The subject of the Shanghai proposal is the government's policy toward new medical technology. The investigators would look particularly at the Chinese medical establishment's recent emphasis on highly sophisticated equipment, to determine which types of equipment are and are not justified. The focus is to be particularly on equipment purchased with World Bank loan funds. The work is to be carried out in cooperation with the Ministry of Public Health's Bureau of Medical Administration.

The Advisory Committee's and reviewers' questions about the original proposal were primarily ones of clarification, in response to the proposal's brevity and resulting vagueness on essential matters of study design. These were among the issues discussed during a day which Davidson Gwatkin spent in Shanghai in late May. The discussion was based on an expanded and revised draft of the proposal which the team members had prepared for the occasion. At the discussion's conclusion, it was agreed that the project investigators would submit an edited and modestly revised version of their draft for circulation to specialists in technology policy, and to members of the Advisory Committee.

This edited and revised draft arrived on schedule in late June, and it has been forwarded to two specialists commissioned to prepare written suggestions for the investigators' and the IHPP's use:

-- David Banta, formerly Deputy Director of the Pan American Health Organization and organizer of a major series of health technology studies for the U.S. Office of Technology Assessment. Banta is currently in China as a member of a World Bank mission whose scope includes technology issues. He and other mission members are to meet with the investigators in the course of this work.

-- William Hsiao of the Harvard University School of Public Health, under whose guidance the principal investigator recently studied for a year. Hsiao will be consulting with others on the Harvard faculty in the preparation of his response.

The suggestions are due by early September. If they appear on time, they will be distributed along with the draft proposal itself prior to the next Advisory Committee meeting.

China -- Tianjin Coordinating Center of Non-Communicable Disease Research, Prevention, and Control

As indicated by the title of the implementing agency, the Tianjin proposal deals with non-communicable diseases. The principal thrust is on experimentation with preventive approaches to such conditions as lung cancer, other respiratory ailments, and strokes. The action elements of the program would be executed by various units of the city government; the results would be assessed by people working in several Tianjin universities

and research institutions. The work is to be undertaken in cooperation with the Bureau of Medical Affairs of the Ministry of Public Health.

Program discussions began in late March, shortly after the Advisory Committee's decision to invite a fuller proposal from Tianjin. At that time, a Chinese-speaking epidemiologist from the Centers for Disease Control in Atlanta spent two weeks in Tianjin on related World Bank business. In the course of his visit, he talked at length with the authors of the IHPP proposal and helped them with methodological issues which had been of principal concern to the initial proposal's reviewers and to the Advisory Committee.

Davidson Gwatkin visited Tianjin for two and a half days in late May during his China trip. By that time, a considerably revised and expanded version of the proposal had been prepared, and this formed the basis for discussions. In the end, it was agreed, as in the case of the other Chinese proposals, that the text of that proposal would be modified slightly to incorporate clarifications emerging from the discussion and submitted for review by the Advisory Committee.

It was also agreed that the IHPP would provide support for two members of the Tianjin team to visit the United States for three weeks in September-October. They will be accompanied by four to six NCD specialists from other parts of China, whose expenses are being covered by the Chinese government with funds from a World Bank loan.

The visit, being arranged by CDC, will allow the Tianjin participants to attend and present a paper on the Tianjin experience at an international NCD research conference; to visit relevant NCD control experiments; to attend a workshop in NCD epidemiological research methods at the CDC in Atlanta; and to hold further discussions with researchers at CDC about the Tianjin research plans. Among other things, these discussions will cover the possibility of an on-going Tianjin-CDC relationship, which was included in the Tianjin request and in which CDC has expressed interest.

Like the other Chinese proposals, the Tianjin submission arrived promptly in late June. It and an informal report on the first week or so of the Tianjin team's U.S. visit will be available for Advisory Committee discussion at the next meeting. (Advisory Committee views on the proposal are to be transmitted immediately to the Tianjin team members so that they can be taken into account during the team members' discussions at CDC, which are to take place a few days after the Advisory Committee's meeting.)

Indonesia

The Indonesia proposal deals with the posyandu program, a major governmental initiative to stimulate communities to organize health posts. It is also concerned with household use of other health services.

The proposal originated in the Ministry of Health. The project team is a mix of Ministry people and faculty members from the University of Indonesia Psychology Department and Faculty of Public Health.

The Advisory Committee's and professional reviewers' comments on the original proposal were directed primarily toward the need for greater specificity about focus, objectives, and study methods. These have been discussed with team members in Jakarta in three rounds.

The first discussion were in March-April, during an extended visit to Indonesia by Albert Van der Werff on other, WHO business. During his visit, the team members met three times (twice with Van der Werff) and produced a considerably expanded draft proposal. The resulting draft was then discussed with Davidson Gwatkin during his three-day visit in mid-May. After that, a few further clarifications were entered, primarily with respect to project objectives. This version was the subject of further discussions with New Delhi-based WHO social scientist Soon-Young Yoon, whom WHO arranged to come to Jakarta for two weeks in late June and early July to work with the group. (Concurrently, Gwatkin has been exploring from Washington the relationship between the work proposed for IHPP support and the considerable volume of other research on similar topics reportedly under way in Indonesia.)

The latest draft proposal currently in hand is that prepared following Gwatkin's visit. The more recent version, prepared following the Yoon visit, has been requested. Barring some unforeseen delay, it will be available for the October Advisory Committee meeting.

Korea

The Korean proposal was submitted by the Institute for Health Services and Management of Hallym University. The focus is on medical insurance, with work to be undertaken in cooperation with the Health and Social Affairs Ministry's Social Insurance Bureau.

The preliminary proposal was highly rated by the Advisory Committee and by the outside reviewer. The principal comments concerned the need for further specificity and for assurance that the work would be playing a central role in broader research program under development by the Health and Social Affairs Ministry.

These issues were discussed with the principal investigator by IHPP consultant K.K. Kanagaratnam in June, during the course of one of Kanagaratnam regular visits to Korea on World Bank business. In addition, Gwatkin has been seeking the advice of several people knowledgeable about Korea concerning the position of the Hallym investigators relative to others known to be active in the insurance field.

The next version of the proposal is due in early September -- a relatively late submission date agreed upon in order to allow the investigators to begin orienting their proposal toward the recommendations

for needed research of a Health Ministry medical insurance workshop scheduled for late August. If the investigators can handle the close timing involved, a revised proposal should be available for distribution in advance of the next Advisory Committee meeting.

Pakistan

The Pakistan proposal comes from the Department of Community Health Sciences of the Aga Khan University Medical Faculty in Karachi. It consists of two components: the establishment of a governmental-academic Advisory Council on Health Policy Research, whose secretariat would consist of Aga Khan faculty members; and the execution of two field studies by younger staff members at Aga Khan under the aegis of the Council. Both studies would be assessments of action projects presently being undertaken by Aga Khan with support from donors other than the IHPP, each project involving an approach thought to be of potentially broader relevance for Pakistan. One study concerns the use of community health workers in a rural area; the other deals with the mobilization of community leaders in urban slums.

The Advisory Committee's and reviewers' comments dealt primarily with the unclear degree of Pakistani interest in the proposed Advisory Council, and with methodological issues with respect to the proposed field studies. Davidson Gwatkin has discussed these points on two occasions with the principal investigator, during visits by the investigator to Washington. Efforts are currently being made to arrange for a health economist to visit Karachi to discuss methodological issues, and to develop an ongoing relationship with WHO's health economics activities.

A revised proposal was received in mid-July. It is to be sent to members of the Advisory Committee and discussed at the October meeting.

The Philippines

The Philippine proposal was submitted by the Philippine Institute of Development Studies, (PIDS) a research institution attached to the National Economic and Development Authority.[3] The work would be performed by younger analysts in several institutions around Manila, with the PIDS is serving as the coordinator of an incipient consortium among them. The institutions include the School of Economics, the School of Public Administration, and the College of Public Health at the University of the Philippines; the Department of Economics of the Ateneo de Manila University; the de la Salle University Graduate School of Business and Economics; and the PIDS itself. The analysts' activities would be supervised by a committee of senior professionals from the institutions concerned.

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[3] The equivalent of the Planning Ministry in other countries.

The proposed analyses would deal with several topics: policy options with respect to health maintenance organizations, the policy consequences of private drug consumption behavior, the health implications of urban housing policies, approaches to increasing the employment and productivity of health manpower, and factors influencing the demand for health services. The studies would be linked to the Department of Health through the Department's seniormost Undersecretary (Deputy Minister), who has agreed to serve as a policy adviser.

The principal points raised about the preliminary proposal by the reviewers and the Advisory Committee members concerned the large number of topics to be covered, uncertainty about the strength of the links with policy organizations, and the lack of methodological specifity. Discussions of these points began when Gwatkin met with the group's Health Department policy adviser in Geneva during the WHO World Health Assembly in early May; they continued during Gwatkin's three-day visit to Manila later in the month.

A revised proposal, consisting of detailed descriptions of the studies to be undertaken, was received in mid-July. The investigators have been told the revised proposal is insufficient, and they have been requested to prepare an overview statement of their larger objectives. This is due in early September, for distribution to Advisory Committee members in advance of the October meeting.

Thailand -- Mahidol University

The Mahidol proposal came from the University's Center for Health Policy Studies, with strong support from the Planning Division of the Ministry of Public Health. It featured (and features) a series of studies, the majority of which were designed to provide an empirical basis for government policies concerning the private sector. Although the proposal was generally well received, the Advisory Committee members and reviewers expressed a number of concerns about its ambitious scope, about the proposed study approaches, and about the apparent overlap with the Thammasat University proposal also recommended for further consideration.

The principal investigator's participation in the WHO World Health Assembly as a member of the Thai Government delegation provided an opportunity to discuss these and other issues with him. It also allowed him to participate in the IHPP meeting referred to above in connection with the African proposals; and he helped arrange an opportunity for Davidson Gwatkin and Katya Janovsky to discuss the Thailand program generally over lunch with the Permanent Secretary and other officials of the Ministry of Health. The discussions were continued in Bangkok the following week, where Gwatkin was able to meet and talk and length with the other team members.

More recently, it has been possible to arrange a discussion in Bangkok between the team members and economist Charles Myers of the Harvard Institute of International Development, the author of a noted Thailand health financing study who was visiting the country on other business.

Myers has been commissioned to prepare a set of suggestions for further project development. If all goes well, these suggestions and a revised Mahidol/Ministry proposal should be available for discussion at the next Advisory Committee meeting.

Thailand -- Thammasat University

The Thammasat proposal features of a series of health sector financing studies, with particular reference to the public sector, which build upon work in which some of the group members had participated earlier. Among the topics are:

-- The unit costs of services provided in public hospitals and the extent to which they are covered by the fees charged.

-- An investigation of which population groups benefit most from public services and how these groups would respond to changes in service fees.

-- A determination of the extent to which the several government agencies providing services adhere to the Health Ministry's pricing guidelines.

As with the Mahidol proposal, the general reaction on the part of the Advisory Committee was favorable. But there were also questions: about the ambitious scope of the original proposal, about the apparent overlap with the activities proposed by the Mahidol group, and about the absence of any evidence of interest or support on the part of Thai policy makers.

Such matters were raised with Thai policy makers in Geneva, during the luncheon discussion with Health Ministry officials described above; and with group members during Davidson Gwatkin's May visit to Bangkok. In addition, Charles Myers, who had earlier worked closely with the Thammasat group, met with the group members during his July Bangkok visit and is preparing suggestions about future directions for their activities.

A revised Thammasat proposal -- with a narrower focus on the public sector to complement the Mahidol private sector emphasis, and with a letter of strong support from the Ministry of Public Health's Planning Division -- was received in late June. It and the Myers suggestions will be available for discussion at the October Advisory Committee meeting.

August 13, 1987

ATTACHMENT II

Attachment II

Participants in
International Health Policy Program Meeting

Geneva, 5 May 1987

Brian Abel-Smith, London School of Economics and Political Science

John Akin, The World Bank

Ralph Andreano, University of Wisconsin

Nancy Birdsall, The World Bank

Andrew Creese, World Health Organization

Frederick Golladay, The World Bank

Davidson Gwatkin, International Health Policy Program

Michel Jancloes, World Health Organization

Katya Janovsky, International Health Policy Program

Alex Kamugisha, Ministry of Health, Uganda*

Serge Kananiye, National Assembly, Burundi*

Germano Mwabu, University of Nairobi, Kenya*

John Ohiorhenuan, University of Ibadan, Nigeria*

Thavitong Hongvivatana, Mahidol University, Thailand*

Cesar Vieira, Pan American Health Organization

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*Applicant for IHPP support.

ATTACHMENT III

ATTACHMENT III

A REPORT OF THE VISIT TO SITE PROJECTS IN KENYA, UGANDA, AND BURUNDI JUNE 17 - 27 1987

by

S. Ibi Ajayi

June 17th 1987

We arrived in Nairobi in the early hours of June 17th, 1987. Our first appointment was at 11a.m in the VADA office. Amongst the people present were Mr. Nwangi the Executive Director of VADA, Mr. Geoffrey Irvine, Medical director PCMA; Directors of the Kenyan Catholic Secretariat; and also Director of the Anglican Secretariat, Mr. Leckey, Deputy Director General AMREF; Liz Ngure, Consultant VADA; M.R. Kariuki (AMREF). An agenda was drawn up for this meeting by the coordinator of the team.

After introduction by the executive Director of VADA, Dr. Davidson Gwatkin (hereafter referred to as Dr. DG) after introducing me and himself gave the background information on the IHPP, the Carnegie Corporation link and the purpose of our mission to Nairobi. He also told the team about the number of proposals received and their geographical spread. After this, the comments of the advisory committee on suggestions for proposal development were gone through one at a time.

In response to a question on how funds should be shared between VADA and AMREF, we felt the major issue as of that time was the sharing of responsibilities and also the matching of expertise with the various tasks that have to be performed on the project.

The issue of the deadline on the submission of proposal was raised. It was finally agreed that the team should stick to the present deadline stipulated in the suggestions for Proposal Development.

We were told of the problems confronting the NGO'S in Kenya - in particular, the pronouncements of Governments in the area of minimum wages which have had some effects on the capabilities and operational efficiency of the NGO's.

We were told that the various members of the team met the previous week in an attempt to narrow the focus of the study and seek new ways of addressing issues. The Chairman of one of the committees could not, however, properly articulate to us the new focus of the study as well as the new ways of addressing it. I got the impression that even though some meetings might have taken place, the new focus of the study has not been well articulated.

More is said later about the VADA/AMREF collaborative effort.

In the afternoon about 3.30p.m we had appointment with the World Bank office in Nairobi. We had discussions with Mr. M. Mills and D. Sebina. Both men were briefed on the purpose of our mission, the group we intended to see and what topics they had proposed. The two men assured us of the importance of these studies for Kenya and their relatedness to other studies on efficiency and user charges which were being funded. They told us also of the congenial atmosphere in the University - Ministerial relationship prompted by new appointments including that of the Director of the Board of Kenyatta Hospital, a new Minister of Health who is a University Professor and a new Permanent Secretary in the Ministry of Health. The meeting was very useful in providing useful insights for our work. They were also willing to provide whatever cooperation was needed to ensure the success of the project. We did not leave the office till well after 5p.m.

Thursday 18th June 1987

We had two appointments on this day. The first was in the morning with Mr. David Court, Representative of the Rockefell Foundation in the morning and Mr. Michael Bratten, Program officer of the Ford Foundation in the afternoon. As usual, Dr. DG took time to explain our mission to them and the organiza-

tion which we represented, including what the IHPP was all about. They were also told about the group we had spoken with as well as the groups we were still to have discussions with.

The discussion which we had with them were very useful within the context of understanding the Kenyan perception of international organizations. One of the prominent issues in our discussion was the VADA/AMREF relationship, including their perception of the relative qualities of both organizations; their ability to deliver, the sustainability of the different organizations, the administrative organizational structure of both, administrative cohesion and stability of personnel. The subsequent scheduling of other meetings with both the heads of VADA and AMREF was not unrelated to some of the issues that arose during these meetings. Our primary concern being the feasibility of a VADA/AMREF joint venture, and proper execution of a widely accepted policy relevant qualitative work among others. D. DG made further appointments with the Director of VADA and Mr. Lackey, Deputy Director of AMREF.

Friday June 19th, 1987

Our first appointment was at 9.30a.m with the executive Director of VADA, Mr. Nwangi. Our questions were pointedly directed at the general situation of things at VADA including the staff and the team that would be put up to implement the health project if approved for funding.

The executive director of VADA Mr. Nwangi informed us that some members of the team they intended to put together would include: Liz Ngure who would replace Annie N. Wainaina, Mr. Geoffrey Irvine, the present Medical Coordinator, PCMA who is retiring; M. Katziro, a social science person with Medical Research and presently doing a PhD in the area of Health, and Dr. M. R. Kariuki (AMREF). We were also told that other resource personnel would be drawn from the Institute of Development Studies at the University of Nairobi. The executive director also planned to participate effectively in the research program.

We met the University of Nairobi team at the Department of Community Health, University of Nairobi at about 11a.m. Present were:

Violet N. Kimani

Germano M. Nwabu

Joseph K. Wang'Ombe

The team had given some thought to their topic and have changed their topic from Policy Analyses to Innovations in Technology and Resource use to a different topic.

On Thursday night, June 18th, a revised version of the proposal incorporating the new topic was brought to our hotel. We had time to read it before our meeting.

Dr. DG explained the purpose of our mission, the IHPP Carnegie connection, and the likely source of funding for the Nairobi proposal if positively recommended.

The relevant comments of the advisory committee in view of the revised topic on suggestions for proposal Development were thoroughly gone through.

The new topic: Issues of Innovation in Health Care Delivery in Kenya focused on (i) better use of available resources (ii) patterns of health service utilization and (iii) alternative ways of financing government health services.

The overall objective of the study was the development of practical models for explaining the behaviour of the providers and consumers of health services with a view to aiding efficient policy decision-making and better utilization of health resources.

The specific objectives as enumerated in the revised version included

(i) the identification and explanation of inefficiencies both in the provision and use of health services.

(ii) The study of alternative methods of cost recovery in the Kenyan health care system with a view to suggesting to the ministry of health the most appropriate methods.

(iii) developing at the district level practical methods of predicting the amount of health finance that could be generated.

(iv) simulation of efficiency and equity effects of alternative methods of health services financing.

The analytical framework of the proposal consisted of a demand model or health care-seeking model and a cost-effectiveness model.

A substantial period of time was spent at the meeting discussing the new version. We wanted to know what the new proposal was all about and assess whether it was better than the original proposal in terms of its focus. Not having met the three researchers before, I also wanted to have an idea of their capabilities to ensure that the research could be successfully carried out.

Apart from glaring omissions in the new proposal which was pointed out to the team, the revised proposal to my mind was still not properly focused. The methodological issues were still in many respects hanging in the air. The distinction between the quantitative and qualitative aspect of the work seemed not to have been very clear to the authors.

We tried to point out what we thought were the weaknesses in the revised proposal and suggested that the proposal be allowed to benefit from a wider audience of colleagues at IDS, the University department of economics and the staff at the Bank Office in Nairobi.

My assessment of the Nairobi team at present is that the capability to do the job is there. Hopefully, the revised version of their work would eliminate those aspects that cannot be meaningfully done. Additionally, the revised version of their proposal would still need to be more focused with a properly delineated methodology. These comments are not meant to detract from the fact that the revised version submitted to us was a significant improvement on the preliminary proposal submitted earlier.

From the discussion, Mr. Nwabu seemed to me to be the leader of the team. He seemed to have a better grasp of the issues in particular in the areas of focus, objectives and

the methodological issues. He saw issues and conceded to analytical issues which he might not have thought of earlier on when brought to his notice. The rapport between the group appeared good. It seems to me, however, that if the group is finally supported, the research methodological issues would have to be discussed with senior colleague(s) at some intervals, in particular about the start of the project. Such discussion(s) will also help to put the work in its right perspective.

Given the more conducive environment between academics and the ministry of health in particular, a tip received from discussion with other people, the gap that usually exists between policy analysts and policy makers in the case of Kenya can be bridged. The support of the ministry I believe can be taken for granted.

Later in the afternoon, we had an appointment with Mr. Douglas E. Lackey Deputy Director General, AMREF. The meeting was held in Mr. Lackey's office. It was a cordial conversation to size up (as it were) the capability of AMREF and to acquaint ourselves (in particular myself) with the facilities at AMREF.

It is my considered opinion at this point that a VADA/ AMREF joint research proposal is feasible and can be successfully executed if the team is well-balanced. There are two

approaches to a VADA/AMREF proposal. The first, based on evidences from our discussion with various people is to make a grant to AMREF as the leader of the team to ensure prompt delivery of the final product. This is based on the stability of the organizational structure of AMREF and the capability which they have developed over the years. Second, tasks can be broken down into watertight compartments so that delineated tasks can be given to either party. In such a case, the costing will be along tasks and each organization VADA or AMREF can have its own portion of the tasks and funds directly. The onus for delivery will then be on each of the organizations or agencies.

These two approaches to my mind represent polar cases. There is no need to worry about in whose name (or organization) the contract is written provided both parties are made to be aware of it and adequate caveats are added to monitor progress of projects with provision for termination in the case of unsatisfactory performance.

Sunday June 21st 1987

Dr. Gwatkin and I left Nairobi for Uganda. We arrived in Entebbe, Uganda in the evening at about 6 p.m and arrived at our hotel at about 6.30 p.m. We were met by Dr. Alex K. Kamugisha and Mr. Andrew Creese.

Monday June 22nd 1987

The meeting with the Ugandan team started at about 10a.m in the Planning Unit of the Ministry of Health. There were other health or health related personnel at the meeting. The following people attended the meeting.

	Name		
1.	John Korn	HPU	EEC Deleg. Kla
2.	Joseph Atiku*	MPED	P OB 1086 Kla
3.	Andrew Creese	WHO	Division of Strenghthening Health Services, Geneva
4.	Z.E.A. Kaija	MPED	Box 13 Entebbe
5.	A. Kwarmogi	TFCS	Atlanta, Ga30032 U. S. A.
6'	A. K. Kamugisha*	HPU	MOH
7.	A. S. Nzabamita	HPU	MOH
8.	Katougole	HPU(Computer)	MOH
9.	H. Annett	HPU	Entebbe.

Notes: * Policy analyst(s) on the original proposal

HPU, MPED, TFCS an MOH refer to Health Planning Unit,

Ministry of Planning and Economic Development, Task Force on Child Survival and Ministry of Health respectively.

The Director of Medical Services who was to join us was otherwise engaged and couldn't come. The two people from the Institute of Public Health, Makerere University were absent. We subsequently learnt that they were outside Kampala doing some field research.

Mr. Nzabanita was introduced as the Chairman of the meeting by Dr. Kamugisha. Mr. Nzabanita welcomed Dr. DG and I. He then acquainted us with the various aspects of his Ministry's work, the problems and the tasks ahead. From his accounts (and also from the presence of various people at this meeting), there was abundant evidence of international research collaboration on some various aspects of health services in Uganda. In fact, a 12 man commission to "examine and inquire into the present health system and policy in Uganda" was recently inaugurated. Additionally, there is a Health Policy Review Commission with a memorandum on cost and financing issues prepared by Andrew Creese (WHO). Additionally there is a World Bank study which would be completed within the next couple of months.

Dr. DG spent time to explain the background to the evolution of the IHPP and the collaboration of the Cargenie Corporation.

He also told them of the number of proposals received and their geographical spread. Time was spent also to address the Key suggestions for proposal development viz issue Definition, Institutional capacity, budget and schedule for proposal submission and onward transmission to the fund-granting agency. On the issue of definition, we got the impression that the advisory committee misunderstood the intention of the team about what they intended to do. From the ensuing discussion at the meeting, it seemed that the concentration of the Ugandan study would deal with the cost recovery aspect of health financing. I got the impression that some aspects of the results of the studies by the world Bank would form a useful input as well as point of departure for the study.

The need to ensure that adequate time required for the study was devoted to it was particularly stressed. We suggested the possibility of collaborating with some members of staff of the University in particular the department of Economics. Our concern related not only to the possible tight and busy schedule of ministry personnel but also to possible inter-departmental deployment at a future date which might jeopardise the continual pursual of the study during its expected life Span. From questions asked by the members at the meeting, the impression was given that there

might be changes in the composition of the team. Such changes we made clear were not objectionable provided the quality of personnel would not be adversely affected.

Later in the afternoon, we met with the WHO representative in Entebbe. We took some time to explain the purposes of our mission. It was a courtesy call to WHO. He was very receptive.

Tuesday 23rd June 1987

We went to Kampala where we met the World Bank representative. He was acquainted with the program. My impression of his attitude during my short stay was one of indifference, I had earlier on gone to see the Governor of the Central Bank. We left the Bank's office after we had exchanged pleasantries.

Later in the afternoon, we had an appointment with the Minister of Health in Entebbe who apart from being pleasant was deeply interested in our mission and programs. We were warmly received.

He narrated the crisis Uganda had gone through, the tasks ahead and the approaches to tackling them. He believed in the need for total rehabilitation of Uganda in which the health sector remained an integral part of the rehabilitation process. Under the circumstances, he explained the role

of international donors in all facets including health research. With him were the Director of Medical Services who due to unavoidable circumstances could not join us in our meeting with the Ugandan health team the previous day. In addition, Mr. Andrew Creese and of course our major contact person Dr. Alex K. Kamugisha was at the meeting.

I left with the impression that we met a devoted and competent minister willing to render all assistance to the success of our research endeavor in Uganda. We left him about one hour before our flight from Uganda. We left for Nairobi that evening, arriving there without any hitches.

My personal view on the Ugandan team are as follows:

Given the base of the members of the team in the Ministry, the involvement of policy makers and the present favourable disposition of Uganda to donors (assistance in whatever form), the linkage between researchers and policy makers is already established.

There are two issues which I believe have to be considered in the Ugandan case. The first is the need to get some members of the department of economics from the University who have a macro background interested in the project. This would be important for the development of the Research methodology, focus etc of the study. Such collaboration would also additionally enhance, I believe, the quality of

work. The need to involve some people from the department of Economics was at various times pointed out to Dr. Kamugisha by Dr. DG and I. Second, there is need to ensure that those who would be involved with the project would remain on it at least for a significant period of the project's duration! This is necessary not only for consistency and continuity but for qualitative control once the right team is put together.

Wednesday 24th June, 1987

We arrived in Bujumbura, Burundi in the morning about 10.30 a.m local time. We were impressively met by representatives of the Hotel Novotel and three members of the research team - Mr. Kananiye, plamondon and Baturimi.

We left immediately after lunch to visit one of the hospitals already arranged for our visit. We were accompanied by Mr. Rene Plamondon and Mr. Serge Kananiye. Let me say at the outset that the health organizational structure in Burundi is not only different but certainly interesting,
There are for example!

(i) Hopital Provincial (ii) Hopital De Secteur
(iii) Hopital De Zons (iv) Centre De Sante
(v) Dispensaries.

I have no meaningful literacy in French. Dr. DG had the additional responsibility of not only translating what went on to me but also had to put across my questions in French. The two people who accompanied us could speak English to some extent. I am sure this was not an easy task but he coped excellently and he ensured at every stage to explain what was said in French and deemed important that I should know.

Our visit to Bubanza - a distance of about 45km (13km of which were tarred) was interesting. We saw a hospital which was being run by a Swedish Catholic organization. The occupancy rate of the beds in the hospital was about 55-65%. The occupancy rate we were told had a seasonal element in it. The rate charged for health care delivery was not the outcome of studies (or casual empiricism) on costs but rather on a rate agreed between the hospital authorities and the appropriate authorizing agency in the Ministry of Health. The Rev. Sister in charge of the hospital conducted us round all the various sections of the hospital and explained adequately th procedure for health care delivery. The research team in Burundi told us that they expect to include this hospital as one of their samples.

Thursday 25th June, 1987

We started the day with a meeting with an equivalent of a Permanent Secretary in the Ministry of Health. The conversation was in French! As I was later to understand, he knew of the program and was well-disposed towards it. We left to see other health centres in Burundi. These were (i) Dispensaire Kivogaand (ii) Muramvya Hopital Rural.

At Kivoga, a distance of about 60km from Bujumbura, the head of the unit who was not a medical doctor but a medical technician took us around. A number of pre-natal patients were being attended to when we arrived. He showed us all the different sections. From his account, a fee of about 30 Burundi Francs is paid for card and registration after which treatment is given free. Referral cases which were rare (because no serious cases ever emerged) could be made to a nearby hospital where specialists could be seen. The medical technician told us that he was easily accessible. He gave us the impression of a man who really was in charge and could cope with any health problem. Drugs were delivered at reasonably regular intervals. Wherever shortfall in drugs occured, contact was made to a nearby store from where a quick response was often received.

We later went to Muramvya Hopital Rural where a medical doctor - a native of Burundi conducted us round the hospital.

Some Chinese doctors were also in the hospital who had interpreter(s) in order to communicate with the ~~local~~ indigenes ~~hospitals~~. We did not talk to them. The acupuncture practised by the Chinese was reportedly popular. This hospital contained many sections. The bed occupancy rate was low. The most challenging jobs to the doctor were the administrative duties that he had to do, and the urgent decisions that had to be taken without the privilege of referral to a superior officer who in bigger hospitals would normally be responsible for such decisions. His position contrasted markedly with the medical technician at Kivoga who not only thought himself competent ~~with~~ of taking all medical decisions but also competent of dealing with all health issues. Payments which were in existence in the hospital were administratively determined. They were not based on the result of any study on costs or other such factors. Drugs in general were available but they sometimes ran out. When the doctor was asked what happened when he ran out of drugs, he was not forthcoming on the answer. He gave the impression that drug would normally come from Bujumbura.

We arrived in Bujumbura in time to make the 4.30 appointment schedule with the WHO Director Dr. V. N. Eyakuze (Inter-country Health Development Team - 2). He was very pleasant. Even though he was not familiar with the IHPP program he listened to Dr. DG's usually thorough background information

on the program and the collaborative efforts of the Bank, WHO and Carnegie Corporation. Mr. Eyakuze explained the role of his office and in particular his office's supportive inclination to country studies. He offered to attend the meeting with the country team provided it was in the morning of the following day as he intended to travel in the afternoon.

Friday June 26th 1987

We met with the following members of the Burundi team to discuss their proposal: Serge Kananiye, Rene Plamondon, Emmanuel Baturimi. The team explained to us that the focus of their research has changed from the topic of analysis previously submitted. The main focus of their new proposal seemed to be the determination of unit cost of health delivery services in Burundi. The objective of the study being to emphasize the need for standards in health delivery, decision on appropriate charges for health care delivery and insurance scheme within the economy, as well as budget projections for the economy.

While there is advantage is a focussed research, there is need to realise the danger of a topic that might be seemingly trivial. Hopefully, the revised version would cover a well focused topic that can be meaningfully done within the allowable period.

A number of issues arising mainly from our discussion stood out in the Burundi study. First, I got the impression of a fairly heavy reliance on external assistance from the University of Montreal. There is nothing bad in external collaboration. I believe, however, that one of the purposes of the grant which is the development of indigenous capabilities would be defeated if the Montreal team were to be solely depended on for data gathering and analysis. The second issue relates to the composition of the team. Mr. Emmanuel Baturimi who was slated in the original proposal as the coordinated would be going on study leave in September, 1987. The seeming leader of the team Mr. Rene Plemondon, a French Canadian who is the Technical Coordinator of the Health and population project of the Ministry of Public Health and the World Bank is on a contract which may not last till the life time of the project. One could, however, say that a substantial part of the work would have been concluded (If his contract is not renewed) before his departure if that could be a consolation. Third, the others on the team are people in the Ministry occupying important positions (Mr. Gerard Minyurano's designation (one of the policy analysts) is not given). Mr. Kananiye, an economist is a member of the National Assembly. He might of course have some spare time. In reality then, there would be on the

team Mr. Kenaniye, and Plamondon. Of course, for policy purposes and possible accessibility to data, the coordination and liason with the Ministry would of course be essential.

We discussed with the group the need to involve the superior school of commerce (Ecole Superieure de Commerce) which we were told was of excellent quality and also the University.

Infact we were told that as part of the fulfilment of the requirement for the award of their Diploma, some of the students in the School of Commerce have worked on two topics in the area of health, viz:

(1) Analyse Des Couts Dans Les Etablisements De Sante: CAS Du Centre De Sante De Ntita.

and (2) Rapport de Stage Effectue Au Project et Population Analyse Des Couts Daus L'Hopital De Bubanza

We subsequently went to the University where we discussed with the Dean of the relevant Faculty and the head of the Research Unit, Monsieur Dayer. The conversation was in French and seemed fairly long! I was in the dark during most of the conversation as a result of my inadequacy in the French language! Dr. DG, however, explained to me later that while one of the two men was supportive, the other was lukewarm and wanted to find out if the University rules would permit

it. The possibility of the team meeting later to set up a unit within the University for health study was left open for further discussion.

At this juncture it is unrealistic to meaningfully discuss what the contents of the next proposal would be in terms of (i) the exact composition of the team (ii) the exact title of the research (iii) extent of external collaboration required or requested. (iv) the exact methodology of the research. The issue of methodology is important to me as I have intimated earlier because not only is it necessary to know <u>what</u> is to be done, it is also important to know <u>How</u> it is to be done (at least a significant amount of the <u>How</u> even if assistance may be sought to tidy it up later). I am sure, however, that some of the methodological issues can be sorted out through appropriate links and discussion with consultants on the monitoring team once an appropriate and feasible topic has been developed and an appropriate team put together.

Some of the studies already done at Ecole Superieure de Commerce would be useful as inputs in the Burundi study, and some of students can be used in the survey or questionnaire administration work.

B. Report on The Ibadan Health Policy Research Group.

The meeting with the above group was held in my office at the University of Ibadan on June 11, 1987. Those present (apart from Professor Lucas and myself) were the following members of the team:

Dr. John Ohiorhenuan

Dr. Gini Mbanefoh

Dr. A. Soyibo

The meeting opened with the introduction of those present. Professor Lucas explained the IHPP - Carnegie Corporation's link. He also further explained the interest of Carnegie in funding the Ibadan proposal if recommended for funding.

Attention was then turned to the comments on suggestions for proposal development. These suggestions included the proposal's orientation toward policy makers' concerns, Relationship with other Resource Allocation work, scope of proposal, Budget and schedule for submitting the revised proposal. For emphasis, the need to ensure that the Ibadan team's work was not just a purely theoretical exercise was stressed. Additionally, the collaborative effort with the Ministry of Health was emphasized to ensure that the issues considered are those

relevant to the ministry and are important to policy makers.

In reply to these issues, Dr. Ohiorhenuan speaking for the group informed us that two policy makers in the Ministry of Health have already been approached. These were Dr. Kolawole (the coordinator of Primary Health care) and Dr. Oluyemi. He also informed us that another appointment with Dr. Kolawole had been scheduled for June 24, 1987.

Dr. Ohiorhenuan informed us that in taking due advantage of the comments sent to them, the scope of the project in the revised proposal would be reduced. Most of the activities related to the supply side of the project would be dropped if the necessary data could be obtained from the Federal Ministry of Health/World Bank Study on health financing. The group seemed aware of this study.

Dr. Ohiorhenuan further explained that attempts were being made in the revised proposal to concentrate on policy relevance from two angles. The first from demand side where a survey of characteristics of health care would ask such questions as to who goes where for health care? Other questions to be addressed would include those related to pricing, financial resources

of government, the amount needed for meeting the demand for health care on the one hand and what could be affordable by both government and users on the other. Additionally, the team would consider other alternatives to financing such as taxation, insurance, etc. The second aspect would deal with the optimization model. This model would be used to demonstrate in a meaningful policy relevant sense the impact of shifts in resources from one area of health care to another. All these would be important for policy makers in the health area.

On the budget issue, it was explained to us by Dr. Ohiorhenuan that the intended cutdown on the scope of the study would affect the budget. With a well-focused theme, the upper limit allowed in the guidelines would not be reached. He told us, however, the existence of a ceiling below which the budget could not be further reduced without affecting the quality and usefulness of the study.

If tasks were to be properly broken down in phases, the two different budgetary scenarios implying different levels of activity and/or the number of studies that could be undertaken and tasks completed at each stage/

phase would be easily known.

The revised proposal of the Ibadan team is not available at this time, a few observations can nevertheless be made.

I have no doubt that the group would be able to put together an excellent piece of work if recommended for funding. This conclusion is based on the existence of brain-storming sessions where progress on the project can be aired in the department in addition to taking advantage of the advice of someone familiar with their work. The team is no doubt made up of excellent researchers

The very cordial relationship that exists between the ministry of health in Kenya, Burundi and researchers/academics, for example, cannot be meaningfully said to exist in Nigeria. This cannot be directly attributed to the relative size of the respective countries even though size in terms of ministerial operations and jurisdiction may play a part, albeit a significant one. The organizational structure of the Ministry of health may be an important factor. The Ministry of Health at the Federal level in Lagos, Nigeria is fairly large with overlapping responsibilities between sections/units. Consequently, bureaucratic delays (usually unnecessary) sometimes occur. The team

will, however, be able to receive the necessary approval to carry out their research project. Additionally, they will have access to necessary information from the appropriate ministry. The outcome of the research would also be disseminated through workshops, seminars etc. Given the state bias of the study, necessary cooperation of the states would be obtained. Dr. Ayorinde, consultant Ogun State Health Board is a member of the research team. His inclusion would be very useful.

The topic of the Study - Policy Analyses of Health Resource Allocation Issues is germane to policy makers at any time but particularly more so at this time of dwindling governmental financial resources and increasing competing demand on the available scarce resources.

C. FUTURE MONITORING OF PROJECTS IF SUPPORTED

There would be need to monitor these projects, at various stages. Two of the monitoring processes that I have thought through are seminars/workshops at specified stages; and contacts with consultants.

A. Seminars/Workshops: I like to recommend three types of seminars:

(1) At early stages: There is need to get together all the research teams and/or their leaders together for a seminar at a convenient venue before any field work gets underway. This would be a forum for the research teams to discuss their research themes, and the methodology etc. of their research. Representatives of IHPP, Carnegie Corporation plus their consultants and/or a few other professionals in the areas of Economics and health should be invited for the workshop or seminar. The number of people so invited to participate will depend on what the traffic can bear (costs)! The number invited should be professionally balanced.

Each research team would be expected to circulate a 10-20 page paper on their research theme, methodology etc. Some selected people may be specifically invited

to make positively constructive critique of the research methodology while participation from the floor would be welcome.

This kind of seminar/workshop at the very early stage will serve as a brain-storming session that would give the research team the right orientation. The meaningful interaction expected will be very beneficial.

(2) Progress Report Seminar: About a year or so after the start of the project, another seminar should take place to allow researchers tell us the progress they have made in their research. The Seminar will serve the purpose of ensuring that the focus of the research is not lost, and that necessary rectification can still be made if need be. Secondly, it will be a way of checking if researchers have been devoting the required time to their work.

A small committee to be put together by IHPP and Carnegie Corporation can at this stage advise on whether progress made so far is satisfactory to warrant further disbursement of funds to the project.

3. Seminar after the First Draft of the Final Report

The above seminar is for a selected group to make comments on the draft final report before final finishing touches are put to it. It will ensure among others orderliness of presentation and to some extent control the quality of the final product.

It would be useful to utilize the services of a given set of people who would then be familiar with the work for the three stages.

B. Contacts with Consultant(s)

It would be desirable for the research teams in the countries where funding has been provided to have access at reasonable intervals to interact with consultant(s). The visits of such consultant(s) to the countries will to my mind serve two purposes. First, the research teams will be able to discuss further with him (them) on their research tasks including problems. Second, the consultant(s) will keep the head office informed about progress of work and possible problems if any with the research project, and advise accordingly. The consultant(s)

will also have the opportunity of seing the sites selected for the studies and give appropriate appraisal.

The number of such visits to the countries per year would be determined by IHPP and Carnegie.

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International Health Policy Program (Pew Memorial Trust)	1104154

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Correspondents / Participants

Subject / Title
A Stage II Proposal to the International Health Policy Program for Support to a Health Policy Analysis and Development Group

Exception(s)
Information Provided by Member Countries or Third Parties in Confidence

Additional Comments

The item(s) identified above has/have been removed in accordance with The World Bank Policy on Access to Information. This Policy can be found on the World Bank Access to Information website.

Withdrawn by	Date
Chandra Kumar	06-Feb-15

N. BIRDSALL

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: November 4, 1986

TO: Distribution

FROM: John D. North, Director, PHNDR

EXTENSION: 61571

SUBJECT: International Health Policy Program

1. This memorandum is to inform you of the establishment of a program in support of health policy analysis in developing countries, financed by the Pew Memorial Trust, and developed in cooperation with the Bank and the World Health Organization. The Pew Memorial Trust, a private U.S. foundation, in September 1986 approved a three-year grant of $3.35 million for this program. The Bank and the World Health Organization are providing technical advice and guidance; the Bank is also providing office space and logistical assistance. A special effort is being made to identify opportunities where Program support and Bank activities can reinforce one another.

2. The objective of the program is to assist developing countries to find ways of using available resources more efficiently and effectively to improve the health status of the underserved and the poor. It will do so by providing grants of up to US$150,000 each for up to three years, for health policy analysis to be conducted by institutions in Asia and Africa. A major goal of the Program is to stimulate greater collaboration between policy makers and analysts, so as to increase the probability that important findings from analytical work lead to action. Details of the Program are set forth in the attached brochure.

3. We believe this Program represents an important effort to strengthen health policy analysis and related institutional development in Asia and Africa. If the first phase is successful, the Pew Memorial Trust intends to continue the Program for a further period of years. There is substantial complementarity between the aims of the Program and those of PHN and other departments in the Bank concerned with health. We request, therefore, that you bring the Program to the attention of relevant staff at headquarters and in resident missions. We would, of course, be pleased to learn from them of promising opportunities for Program assistance; in such instances they should contact the Program or relevant Bank staff (see below).

4. Further information about the Program and additional copies of the brochure are available from Program Director, Davidson Gwatkin (ext. 69453); and from David de Ferranti, Chief, Policy and Advisory Division, WUD (ext. 61465) and Anthony Measham, Health Adviser, PHN, (ext 61573), the Bank's representatives on the Program's Advisory Committee.

Attachment

Distribution: Mr. Stern VPOPS, Messrs Husain, Hasan OPS, Regional Vice Presidents, Program Directors, Regional Project Directors, Directors, OPS & EIS Messrs. de Ferranti, Gwatkin and Measham

INTERNATIONAL HEALTH POLICY PROGRAM

An Initiative of the Pew Memorial Trust in cooperation with
the World Bank and the World Health Organization

N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.
Telephone (202) 676-9453; Telexes 440098 WORLDBANK, 64145 WORLDBANK
Cables PHN INTBAFRAD

Reference for Policy Analyst

Introduction

The individual named in section I below has been nominated to serve as a policy analyst in a group of health policy makers and analysts applying for financial support from the International Health Policy Program (IHPP). With this support, the group would undertake a three-year program of original empirical analyses dealing with policy issues of importance for the health of the poor, and providing practical guidance for policy decisions. Through such support, the IHPP hopes to assist the development of promising younger analysts by the experience gained in the analyses' execution; and to help establish more effective working relationships between policy makers and analysts.

Policy analysts like the individual named below are to be the groups' principal workers. Each analyst is to devote 25-50% of his or her time to the project, analyzing the policy issue(s) indicated in section I. Analysts are to work in cooperation with the groups' policy and research advisers whose names and designations are also provided.

Instructions

Each individual nominated as a policy analyst is requested to complete section I of this form and to mail the form to a person, not associated with the group applying for IHPP assistance, whom the nominee considers well qualified to provide a professional reference. (Each individual nominated should mail a form to at least two such people.)

Each referee receiving this form from a nominee is requested to complete section II as fully and as candidly as possible. A supplementary statement may be attached if desired. *The completed form should be airmailed, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director, International Health Policy Program, N-561 1818 H Street, N.W., Washington, D.C. 20433, U.S.A.*

The help of referees is greatly appreciated. The contents of their references will be held in strict confidence.

* * * * * * *

Section I: Background Information (to be completed by individual nominated as policy analyst prior to submission to referee)

1. Name, job designation, and institutional affiliation of individual nominated as policy analyst:

   _____

2. Brief description of policy issue(s) to be analyzed: _____

   _____

   _____

3. Names, job designations, and institutional affiliations of other group members:

   A. Other analysts (if any): _____

   _____

   B. Research adviser(s): _____

   _____

   C. Policy adviser(s): _____

   _____

Section II: Professional Reference (to be completed by referee)

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   C. Reliability: _____ Comments: _____

   D. Ability in written expression: _____ Comments: _____

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Name (Please Print): _____ Title: _____

Mailing Address: _____

Mailing address for completed form: Davidson R. Gwatkin, Director
International Health Policy Program; N-561 1818 H Street, N.W.
Washington, D.C. 20433; U.S.A.

Deadline for receipt of completed form: January 15, 1987

INTERNATIONAL HEALTH POLICY PROGRAM

An Initiative of the Pew Memorial Trust in cooperation with
the World Bank and the World Health Organization

N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.
Telephone (202) 676-9453; Telexes 440098 WORLDBANK, 64145 WORLDBANK
Cables PHN INTBAFRAD

Reference for Policy Analyst

Introduction

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2. Brief description of policy issue(s) to be analyzed: _____

   _____

   _____

3. Names, job designations, and institutional affiliations of other group members:

   A. Other analysts (if any): _____

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   C. Policy adviser(s): _____

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2. Brief description of policy issue(s) to be analyzed: _____

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   _____

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International Health Policy Program

An Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

A PROGRAM OF SUPPORT for HEALTH POLICY ANALYSIS AND DEVELOPMENT in ASIA AND AFRICA

Guidelines for Applicants

Introduction

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy leaders have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization have all been working to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to use such resources as are presently available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions by the participating policy makers from governmental and non-governmental organizations concerned with the health of the poor; 2) the development of promising younger analysts through the experience gained in the studies' execution; and 3) the establishment of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Their size and composition will necessarily vary from setting to setting. In most cases, they will probably consist of between three and five or six people, including:

- **Policy analysts,** one to three people who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would likely be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant analytical work is undertaken within ministries. The typical analyst would be the recent recipient of a doctoral or equivalent degree in a field like economics, epidemiology, a behavioral science, or management with a demonstrated capacity for policy-relevant analytical work; some analysts might have master's degree supplemented by records of subsequent analytical accomplishment.

- **Research advisers,** one or two senior researchers who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to meet regularly with other group members and to

ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

• **Policy advisers,** one or two responsible senior, policy-level officials from governmental or non-governmental organizations centrally concerned with health: the director of policy in a health ministry, for example; the director of a large private voluntary agency providing health services; or the head of the health/social welfare division of a planning ministry. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions by their agencies concerning the health of the poor, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: for example, support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency. Overlapping membership among groups is also permissible: for instance, a director of health or social service programs in a planning ministry might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group are to center around a set of original empirical analyses providing practical guidance concerning policy issues of importance to the senior policy adviser's agency. Analyses which identify ways major development investment programs can be most effectively designed and executed will be among those of particular interest.

Each study within the set is to be discrete and limited in duration, normally requiring a year or less to complete. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses will be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

- **The allocation and utilization of health program resources.** The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and experimentation with new and potentially more cost-effective approaches.

- **The financing of health programs.** The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services,

and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

• **The contribution of non-governmental and private health services.** In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

• **Health implications of policies outside the health sector.** Activities outside the health sector — nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others — have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

• **Health consequences of individual behavior.** How individuals behave — whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support — is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

• **Adoption and implementation of effective health policies.** If potentially effective health policies are to do any good, they must be adopted and implemented as well as formulated. Getting this done, especially when doing so involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

- **Research and seminar costs.** Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; of the portion of analysts' time spent on project work; of honoraria for program advisers if in accordance with local custom; and of equipment and supplies.

- **Short-term orientation/interchange/training activities.** Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

• **Longer-term overseas internship, training or data analysis opportunities for analysts.** Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

In addition, consultations by or collaboration with outside specialists can be arranged. The use of such specialists will be strongly encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities. Supplementary funds can be provided for this purpose.

Meetings of program participants will be organized at yearly intervals. All group members will be strongly encouraged to take part if requested and will be provided with supplementary IHPP travel awards for this purpose.

Support provided for the purposes indicated is seen as a means of initiating a longer-term institutional development effort. An IHPP grant carries no commitment of further assistance to the group for which it is made; but should the IHPP's sponsors find the results of the current stage adequately promising, additional development support may later be considered for those groups whose initial work proves especially valuable for policy formulation.

Support cannot be considered for construction, for institutional overheads, or for long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications should be brief, of no more than four to five pages plus attachments. They should provide:

- **Basic information about each institution with which group members are affiliated.** This information may be in the form of attached public reports from the institutions concerned.

- **The name and affiliation of each group member.** A *curriculum vitae* for each person should be attached. The *curriculum vitae* of each policy analyst should contain the names and addresses of at least two referees not associated with the group who may be asked for assessments of the analyst's potential for creative, responsible policy work. (A copy of the accompanying form should be sent to each of these referees for completion and forwarding to the IHPP secretariat.) Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome.

- **A discussion of the health policy issue with which the group is to deal.** The discussion should deal with the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

• **A letter of support from a responsible official of each participating institution other than that submitting the application.** Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group will be participating with its approval, and that the agency anticipates giving careful consideration to the results of the group's analyses in formulating its policies.

• **A preliminary budget.** Accompanying this should be an indication of any complementary funds available from other sources for program support, and of any technical collaboration with external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, **in time to arrive no later than January 15, 1987,** to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will be in terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are: 1) the significance of the issues covered for improvements in the health status of the poor; 2) the capacity of the applying individuals and institutions to produce relevant, high-quality analyses; 3) the prospects for effective collaboration among the participants in designing, executing, and assessing the policy implications of IHPP-supported analyses; and 4) the likelihood that the analyses produced can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to prepare fuller study proposals for discussion with representatives of the IHPP during site visits planned for April and May 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. It is expected that grant recipients will be publicly announced by June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

INTERNATIONAL HEALTH POLICY PROGRAM
N-561 1818 H Street, N.W.
Washington, D.C. 20433, U.S.A.

Telephone: (202) 676-9453

Cables: PHN INTBAFRAD

Telexes: 440098 WORLDBANK
64145 WORLDBANK

file: Pew

Draft
9/86

International Health Policy Program

A PROGRAM OF SUPPORT

for

HEALTH POLICY ANALYSIS AND DEVELOPMENT

in

ASIA AND AFRICA

Guidelines for Applicants

The International Health Policy Program is an Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy makers have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization are working together to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to using the resources available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which would emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies

support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions made by the participating policy makers; 2) the development of promising younger analysts through the experience gained in the studies' execution; 3) and the development of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Typically, they will consist of between three and five or six people, including:

— One to three policy analysts, who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant work is undertaken intra-ministerially. Analysts would typically be the recent recipients of a doctoral degree in a field like economics, epidemiology, a behavioral science, or management; some might have master's degrees and be working

toward their doctorates.

-- One or two senior research advisers, who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to be meet regularly with other group members and to ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

-- One or two senior policy advisers, responsible policy-level officials from government or non-government organizations centrally concerned with health: the director of policy in a health ministry, for example; the head of the health/social welfare division of a planning ministry; or the director of a large private voluntary agency providing health services. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research search adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions faced by the

advisers' agencies, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency, for example. Overlapping membership among groups is also permissible: a director of health or social service programs in a planning ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group is to center around a set of empirical studies or analyses of policy issues of importance to the senior policy adviser's agency and of interest to the group members. Each study within the set is to be discrete and limited in duration, normally occupying a year or less of an analyst's time. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses are to be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

-- The allocation and utilization of health program resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and the experimentation with new and potentially more cost-effective approaches.

-- The financing of health programs. The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services, and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

-- The contribution of non-governmental and private health services. In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

-- Health implications of policies outside the health sector. Activities outside the health sector -- nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others -- have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

-- Health consequences of individual behavior. How individuals behave -- whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support -- is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

-- Adoption and implementation of effective health policies. if potentially effective health policies are to do any good, they must be adopted and implemented as well as formulated. Getting this done, especially when doing so involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

-- Research and seminar costs. Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; and of the portion of analysts' time spent on project work.

— Short-term orientation/interchange/training activities. Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers

in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

— Longer-term overseas internship, training or data analysis opportunities for analysts. Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

— Equipment and supplies.

In addition, consultations by or collaboration with outside specialists can be arranged without cost to the group. The use of such specialists will be encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities.

Meetings of program participants, which all group members will be expected to attend if requested, will be organized at yearly intervals. Supplementary funds will be provided to support such attendance.

Support cannot be considered for construction, vehicle purchase, institutional overheads, or long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications may be brief, of no more than two to four pages plus attachments. They should provide:

-- Basic information about each institution with which group members are affiliated. This information may be in the form of attached public reports from the institutions concerned.

-- The name, affiliation, and curriculum vitae of each group member. The curriculum vitae of each policy analyst should contain the names and addresses of at least two references not associated with the group who may asked for assessments of the analyst's potential for creative, responsible policy work. Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome if readily available.

-- A six- to eight-paragraph discussion of the health policy issue with which the group is to deal, the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

— A letter of support from a responsible official of each

participating institution other than that submitting the application. Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group would be participating with its approval, and that the agency would anticipate giving careful consideration to the results of the group's analyses in formulating its policies.

— A preliminary budget and an indication of any technical collaboration external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will in be terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are the significance of the issues to be addressed for improvements in the health status of the poor; and the capacity of the applying individuals and institutions to work together effectively and produce high-quality analyses which can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to

prepare fuller study proposals for discussion with representatives of the IHPP during site visits to be undertaken in March and April, 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. Grant recipients will be publicly announced no later than June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation of the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Guidelines for Support of Policy Workshops

DATE: August 26, 1986

Following our discussion at the July Advisory Committee meeting, approximately $250,000 has been allocated over the Program's next three years for policy workshops. What follows represents an initial effort to develop guidelines for the use of these funds.

PREMISES

The guidelines presented for discussion below are based on two premises, derived from my understanding of our July 15 deliberations:

1. <u>The principal purpose of our support for workshops is to facilitate the establishment and work of health policy and analysis groups</u>.

In our discussion, the idea of workshops and dialogues emerged following our recognition that there are many places where we would like to provide support, particularly in sub-Saharan Africa, where the establishment of policy groups would be very difficult. In such cases, workshops or dialogues were thought to represent a potentially effective way of bringing about the greater appreciation of resource issues necessary for effective policy work.

In other words, we were -- and are -- talking about workshops not as a program element separate from the policy groups which represent our principal focus, but as a means of supporting our assistance for such

groups. Among other things, this means that as we assess the effectiveness of our workshop activities at some point in the future, it will not be enough that important people attended, that the discussions were stimulating, and/or that highly-regarded publications were produced. What we'll want to show is that the workshops led to the establishment of ongoing programs of health policy analysis and development in countries most in need of them.

2. Our strategy is to emphasize cooperation with other agencies with expertise in health policy and/or workshop organization, rather than independent activity.

While I don't think anyone ruled out the possibility that we might want to organize workshops ourselves at some point, the thrust of our conversation was on working in a mutually supportive manner with some of the many institutions with a demonstrated capacity in this area. In most cases, the collaborative agency would probably take the lead in logistical matters. There was a widespread hope, I believe, that collaboration with the Bank and WHO might often prove particularly attractive, although I did not sense that anyone meant to exclude the possibility of also working with other institutions.

GUIDELINES

From these two premises, it seems to me, flow a number of propositions or guidelines. Among them are the four which appear below. The first three follow more or less naturally from the first proposition; the fourth is a consequence of the second proposition.

1. The subject matter covered in an IHPP-supported workshop would lie within the range of resource issues outlined in the IHPP discussion note.

Within this range, highest priority would be given for support to workshops dealing with resource issues of greatest interest to policy makers and analysts in the countries concerned, as determined in the exploratory discussions. This is because of the greater likelihood that health policy analysis and development groups could subsequently be formed to undertake ongoing work if the issues covered in a workshop are those of greatest interest to those concerned.

2. IHPP's interest would be greatest in workshop participants who could play central roles in the subsequent formation of health policy analysis and development groups in their countries.

Such participants would normally be at a moderately high level. Examples would include people who meet the qualifications for "senior research advisers" or "senior policy advisers" in health policy analysis and development groups, as described in our program material; and their superiors, who could provide important political support.

People with the qualifications just described might be reached in either of two ways. One way would be through IHPP core support for workshops where a high proportion of participants have those qualifications. Alternately, support could be provided directly to such individuals, to permit them to participate in workshops which might not for some reason otherwise qualify for IHPP support.

3. Highest priority would be given to reaching people in regions where further exposure to resource issues is of greatest importance for the initiation of ongoing health policy analysis programs.

This means a particular focus on sub-Saharan Africa where, as we

discussed in July, a greater awareness of resource issues will often be a prerequisite for long-term work. Parts of South Asia would also qualify for attention in this regard.

This probably implies that most workshops receiving support would take place in one of these areas, although collaboration in activities elsewhere might well prove attractive upon occasion. It might, for example, prove desirable to support participation by Africans and South Asians in relevant programs in East/Southeast Asia, Latin America, Europe, or North America; or to assist activities in East/Southeast Asia which would draw together the experience in those regions in a way which would permit its use as comparative resource material for workshops in Africa or South Asia.

4. Beyond the common characteristics implied by the preceding three points, the nature of workshop activities supported would vary widely.

The organizations with which the IHPP would collaborate can be expected to differ significantly in their orientations and in their reasons for collaborating with the IHPP in workshop activities. In many cases, the collaborating organization(s) or other donors will be providing a significant portion of the total funding and will have their own objectives for the use of their funds, just as the IHPP has its objectives. While expecting other sponsors/donors to appreciate our interest in achieving our objectives, we'll want to be flexible in other respects in order to accommodate the other sponsors' objectives as well. This necessity to accommodate multiple objectives, coupled with the diversity of organizational collaborators just mentioned, suggests a considerably "messier" -- but commensurately more productive -- configuration of activity than would be the case were the IHPP to work independently.

Division circulation
We should be aware of potential for collaboration — Nancy

MEMORANDUM

TO: Members of the PHN Management Group

FROM: Davidson R. Gwatkin

SUBJECT: International Health Policy Program

DATE: September 30, 1986

I attach two documents concerning the International Health Policy Program, which is to be discussed at the October 2 PHN Management Group meeting:

1. Guidelines for applicants

Support for the health policy analysis and development groups in Africa and Asia described in the guidelines represents the IHPP's principal focus. Proposals are shortly to be invited from African and Asian policy makers and analysts potentially interested in work on health resource issues like those indicated on pp. 5-6. We have enough money to provide three-year grants for up to ten or twelve groups. Situations where the work of such groups can be linked with and support Bank-assisted activities are of particular interest, and suggestions concerning such situations would be greatly appreciated.

2. Memorandum concerning guidelines for support of policy workshops

In addition to the support for health policy analysis and development groups just noted, we have available a modest amount of funds (approximately $250,000 over three years) for policy workshops. As indicated in the draft guidelines of the attached memorandum, these workshops are intended to increase awareness of resource issues on the part of African and Asian policy makers, particularly in settings where conditions are not yet conducive to larger-scale support for health policy work. The workshops are seen as a means of preparing the way for the subsequent initiation of such work in general and for the establishment of IHPP-supported groups in particular. It is anticipated that workshops will prove particularly relevant for sub-Saharan Africa. Bank (and WHO) participation in their design and implementation would be welcome.

Enc:

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groups. Among other things, this means that as we assess the effectiveness of our workshop activities at some point in the future, it will not be enough that important people attended, that the discussions were stimulating, and/or that highly-regarded publications were produced. What we'll want to show is that the workshops led to the establishment of ongoing programs of health policy analysis and development in countries most in need of them.

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Draft
9/86

International Health Policy Program

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— One to three policy analysts, who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant work is undertaken intra-ministerially. Analysts would typically be the recent recipients of a doctoral degree in a field like economics, epidemiology, a behavioral science, or management; some might have master's degrees and be working

toward their doctorates.

-- One or two senior research advisers, who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to be meet regularly with other group members and to ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

-- One or two senior policy advisers, responsible policy-level officials from government or non-government organizations centrally concerned with health: the director of policy in a health ministry, for example; the head of the health/social welfare division of a planning ministry; or the director of a large private voluntary agency providing health services. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research search adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions faced by the

advisers' agencies, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency, for example. Overlapping membership among groups is also permissible: a director of health or social service programs in a planning ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group is to center around a set of empirical studies or analyses of policy issues of importance to the senior policy adviser's agency and of interest to the group members. Each study within the set is to be discrete and limited in duration, normally occupying a year or less of an analyst's time. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses are to be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

-- The allocation and utilization of health program resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and the experimentation with new and potentially more cost-effective approaches.

-- The financing of health programs. The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services, and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

-- The contribution of non-governmental and private health services. In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

-- Health implications of policies outside the health sector. Activities outside the health sector -- nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others -- have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

-- Health consequences of individual behavior. How individuals behave -- whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support -- is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

-- Adoption and implementation of effective health policies. if potentially effective health policies are to do any good, they must be adopted and implemented as well as formulated. Getting this done, especially when doing so involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

-- Research and seminar costs. Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; and of the portion of analysts' time spent on project work.

— Short-term orientation/interchange/training activities. Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers

in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

— Longer-term overseas internship, training or data analysis opportunities for analysts. Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

— Equipment and supplies.

In addition, consultations by or collaboration with outside specialists can be arranged without cost to the group. The use of such specialists will be encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities.

Meetings of program participants, which all group members will be expected to attend if requested, will be organized at yearly intervals. Supplementary funds will be provided to support such attendance.

Support cannot be considered for construction, vehicle purchase, institutional overheads, or long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications may be brief, of no more than two to four pages plus attachments. They should provide:

-- Basic information about each institution with which group members are affiliated. This information may be in the form of attached public reports from the institutions concerned.

-- The name, affiliation, and curriculum vitae of each group member. The curriculum vitae of each policy analyst should contain the names and addresses of at least two references not associated with the group who may asked for assessments of the analyst's potential for creative, responsible policy work. Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome if readily available.

-- A six- to eight-paragraph discussion of the health policy issue with which the group is to deal, the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

— A letter of support from a responsible official of each

participating institution other than that submitting the application. Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group would be participating with its approval, and that the agency would anticipate giving careful consideration to the results of the group's analyses in formulating its policies.

— A preliminary budget and an indication of any technical collaboration external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will in be terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are the significance of the issues to be addressed for improvements in the health status of the poor; and the capacity of the applying individuals and institutions to work together effectively and produce high-quality analyses which can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to

prepare fuller study proposals for discussion with representatives of the IHPP during site visits to be undertaken in March and April, 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. Grant recipients will be publicly announced no later than June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation of the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

Division circulation
We should be aware of potential for collaboration — Nancy

MEMORANDUM

TO: Members of the PHN Management Group

FROM: Davidson R. Gwatkin

SUBJECT: International Health Policy Program

DATE: September 30, 1986

I attach two documents concerning the International Health Policy Program, which is to be discussed at the October 2 PHN Management Group meeting:

1. Guidelines for applicants

Support for the health policy analysis and development groups in Africa and Asia described in the guidelines represents the IHPP's principal focus. Proposals are shortly to be invited from African and Asian policy makers and analysts potentially interested in work on health resource issues like those indicated on pp. 5-6. We have enough money to provide three-year grants for up to ten or twelve groups. Situations where the work of such groups can be linked with and support Bank-assisted activities are of particular interest, and suggestions concerning such situations would be greatly appreciated.

2. Memorandum concerning guidelines for support of policy workshops

In addition to the support for health policy analysis and development groups just noted, we have available a modest amount of funds (approximately $250,000 over three years) for policy workshops. As indicated in the draft guidelines of the attached memorandum, these workshops are intended to increase awareness of resource issues on the part of African and Asian policy makers, particularly in settings where conditions are not yet conducive to larger-scale support for health policy work. The workshops are seen as a means of preparing the way for the subsequent initiation of such work in general and for the establishment of IHPP-supported groups in particular. It is anticipated that workshops will prove particularly relevant for sub-Saharan Africa. Bank (and WHO) participation in their design and implementation would be welcome.

Enc:

Draft
9/86

International Health Policy Program

A PROGRAM OF SUPPORT

for

HEALTH POLICY ANALYSIS AND DEVELOPMENT

in

ASIA AND AFRICA

Guidelines for Applicants

The International Health Policy Program is an Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy makers have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization are working together to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to using the resources available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which would emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies

support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions made by the participating policy makers; 2) the development of promising younger analysts through the experience gained in the studies' execution; 3) and the development of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Typically, they will consist of between three and five or six people, including:

— One to three policy analysts, who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant work is undertaken intra-ministerially. Analysts would typically be the recent recipients of a doctoral degree in a field like economics, epidemiology, a behavioral science, or management; some might have master's degrees and be working

toward their doctorates.

— One or two senior research advisers, who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to be meet regularly with other group members and to ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

— One or two senior policy advisers, responsible policy-level officials from government or non-government organizations centrally concerned with health: the director of policy in a health ministry, for example; the head of the health/social welfare division of a planning ministry; or the director of a large private voluntary agency providing health services. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research search adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions faced by the

advisers' agencies, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency, for example. Overlapping membership among groups is also permissible: a director of health or social service programs in a planning ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group is to center around a set of empirical studies or analyses of policy issues of importance to the senior policy adviser's agency and of interest to the group members. Each study within the set is to be discrete and limited in duration, normally occupying a year or less of an analyst's time. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses are to be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

-- The allocation and utilization of health program resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and the experimentation with new and potentially more cost-effective approaches.

-- The financing of health programs. The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services, and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

-- The contribution of non-governmental and private health services. In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

-- Health implications of policies outside the health sector. Activities outside the health sector -- nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others -- have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

-- Health consequences of individual behavior. How individuals behave -- whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support -- is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

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The volume and kinds of support provided will vary from situation to situation.

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-- Research and seminar costs. Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; and of the portion of analysts' time spent on project work.

-- Short-term orientation/interchange/training activities. Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers

in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

— Longer-term overseas internship, training or data analysis opportunities for analysts. Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

— Equipment and supplies.

In addition, consultations by or collaboration with outside specialists can be arranged without cost to the group. The use of such specialists will be encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities.

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Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

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— Basic information about each institution with which group members are affiliated. This information may be in the form of attached public reports from the institutions concerned.

— The name, affiliation, and curriculum vitae of each group member. The curriculum vitae of each policy analyst should contain the names and addresses of at least two references not associated with the group who may asked for assessments of the analyst's potential for creative, responsible policy work. Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome if readily available.

-- A six- to eight-paragraph discussion of the health policy issue with which the group is to deal, the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

— A letter of support from a responsible official of each

participating institution other than that submitting the application. Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group would be participating with its approval, and that the agency would anticipate giving careful consideration to the results of the group's analyses in formulating its policies.

— A preliminary budget and an indication of any technical collaboration external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will in be terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are the significance of the issues to be addressed for improvements in the health status of the poor; and the capacity of the applying individuals and institutions to work together effectively and produce high-quality analyses which can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to

prepare fuller study proposals for discussion with representatives of the IHPP during site visits to be undertaken in March and April, 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. Grant recipients will be publicly announced no later than June 30, 1987.

Program Organization

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Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Guidelines for Support of Policy Workshops

DATE: August 26, 1986

Following our discussion at the July Advisory Committee meeting, approximately $250,000 has been allocated over the Program's next three years for policy workshops. What follows represents an initial effort to develop guidelines for the use of these funds.

PREMISES

The guidelines presented for discussion below are based on two premises, derived from my understanding of our July 15 deliberations:

1. <u>The principal purpose of our support for workshops is to facilitate the establishment and work of health policy and analysis groups</u>.

In our discussion, the idea of workshops and dialogues emerged following our recognition that there are many places where we would like to provide support, particularly in sub-Saharan Africa, where the establishment of policy groups would be very difficult. In such cases, workshops or dialogues were thought to represent a potentially effective way of bringing about the greater appreciation of resource issues necessary for effective policy work.

In other words, we were — and are — talking about workshops not as a program element separate from the policy groups which represent our principal focus, but as a means of supporting our assistance for such

groups. Among other things, this means that as we assess the effectiveness of our workshop activities at some point in the future, it will not be enough that important people attended, that the discussions were stimulating, and/or that highly-regarded publications were produced. What we'll want to show is that the workshops led to the establishment of ongoing programs of health policy analysis and development in countries most in need of them.

2. Our strategy is to emphasize cooperation with other agencies with expertise in health policy and/or workshop organization, rather than independent activity.

While I don't think anyone ruled out the possibility that we might want to organize workshops ourselves at some point, the thrust of our conversation was on working in a mutually supportive manner with some of the many institutions with a demonstrated capacity in this area. In most cases, the collaborative agency would probably take the lead in logistical matters. There was a widespread hope, I believe, that collaboration with the Bank and WHO might often prove particularly attractive, although I did not sense that anyone meant to exclude the possibility of also working with other institutions.

GUIDELINES

From these two premises, it seems to me, flow a number of propositions or guidelines. Among them are the four which appear below. The first three follow more or less naturally from the first proposition; the fourth is a consequence of the second proposition.

1. The subject matter covered in an IHPP-supported workshop would lie within the range of resource issues outlined in the IHPP discussion note.

Within this range, highest priority would be given for support to workshops dealing with resource issues of greatest interest to policy makers and analysts in the countries concerned, as determined in the exploratory discussions. This is because of the greater likelihood that health policy analysis and development groups could subsequently be formed to undertake ongoing work if the issues covered in a workshop are those of greatest interest to those concerned.

2. IHPP's interest would be greatest in workshop participants who could play central roles in the subsequent formation of health policy analysis and development groups in their countries.

Such participants would normally be at a moderately high level. Examples would include people who meet the qualifications for "senior research advisers" or "senior policy advisers" in health policy analysis and development groups, as described in our program material; and their superiors, who could provide important political support.

People with the qualifications just described might be reached in either of two ways. One way would be through IHPP core support for workshops where a high proportion of participants have those qualifications. Alternately, support could be provided directly to such individuals, to permit them to participate in workshops which might not for some reason otherwise qualify for IHPP support.

3. Highest priority would be given to reaching people in regions where further exposure to resource issues is of greatest importance for the initiation of ongoing health policy analysis programs.

This means a particular focus on sub-Saharan Africa where, as we

discussed in July, a greater awareness of resource issues will often be a prerequisite for long-term work. Parts of South Asia would also qualify for attention in this regard.

This probably implies that most workshops receiving support would take place in one of these areas, although collaboration in activities elsewhere might well prove attractive upon occasion. It might, for example, prove desirable to support participation by Africans and South Asians in relevant programs in East/Southeast Asia, Latin America, Europe, or North America; or to assist activities in East/Southeast Asia which would draw together the experience in those regions in a way which would permit its use as comparative resource material for workshops in Africa or South Asia.

4. Beyond the common characteristics implied by the preceding three points, the nature of workshop activities supported would vary widely.

The organizations with which the IHPP would collaborate can be expected to differ significantly in their orientations and in their reasons for collaborating with the IHPP in workshop activities. In many cases, the collaborating organization(s) or other donors will be providing a significant portion of the total funding and will have their own objectives for the use of their funds, just as the IHPP has its objectives. While expecting other sponsors/donors to appreciate our interest in achieving our objectives, we'll want to be flexible in other respects in order to accommodate the other sponsors' objectives as well. This necessity to accommodate multiple objectives, coupled with the diversity of organizational collaborators just mentioned, suggests a considerably "messier" — but commensurately more productive — configuration of activity than would be the case were the IHPP to work independently.

MEMORANDUM

TO: Members of the PHN Management Group

FROM: Davidson R. Gwatkin

SUBJECT: International Health Policy Program

DATE: September 30, 1986

I attach two documents concerning the International Health Policy Program, which is to be discussed at the October 2 PHN Management Group meeting:

1. Guidelines for applicants

Support for the health policy analysis and development groups in Africa and Asia described in the guidelines represents the IHPP's principal focus. Proposals are shortly to be invited from African and Asian policy makers and analysts potentially interested in work on health resource issues like those indicated on pp. 5-6. We have enough money to provide three-year grants for up to ten or twelve groups. Situations where the work of such groups can be linked with and support Bank-assisted activities are of particular interest, and suggestions concerning such situations would be greatly appreciated.

2. Memorandum concerning guidelines for support of policy workshops

In addition to the support for health policy analysis and development groups just noted, we have available a modest amount of funds (approximately $250,000 over three years) for policy workshops. As indicated in the draft guidelines of the attached memorandum, these workshops are intended to increase awareness of resource issues on the part of African and Asian policy makers, particularly in settings where conditions are not yet conducive to larger-scale support for health policy work. The workshops are seen as a means of preparing the way for the subsequent initiation of such work in general and for the establishment of IHPP-supported groups in particular. It is anticipated that workshops will prove particularly relevant for sub-Saharan Africa. Bank (and WHO) participation in their design and implementation would be welcome.

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Draft
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International Health Policy Program

A PROGRAM OF SUPPORT

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HEALTH POLICY ANALYSIS AND DEVELOPMENT

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Guidelines for Applicants

The International Health Policy Program is an Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy makers have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization are working together to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to using the resources available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which would emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies

support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions made by the participating policy makers; 2) the development of promising younger analysts through the experience gained in the studies' execution; 3) and the development of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Typically, they will consist of between three and five or six people, including:

— One to three policy analysts, who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant work is undertaken intra-ministerially. Analysts would typically be the recent recipients of a doctoral degree in a field like economics, epidemiology, a behavioral science, or management; some might have master's degrees and be working

toward their doctorates.

-- One or two senior research advisers, who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to be meet regularly with other group members and to ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

-- One or two senior policy advisers, responsible policy-level officials from government or non-government organizations centrally concerned with health: the director of policy in a health ministry, for example; the head of the health/social welfare division of a planning ministry; or the director of a large private voluntary agency providing health services. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research search adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions faced by the

advisers' agencies, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency, for example. Overlapping membership among groups is also permissible: a director of health or social service programs in a planning ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

Work Program

The activities of each health policy analysis and development group is to center around a set of empirical studies or analyses of policy issues of importance to the senior policy adviser's agency and of interest to the group members. Each study within the set is to be discrete and limited in duration, normally occupying a year or less of an analyst's time. The overall set of studies is to last over a period of not longer than three years.

In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses are to be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

-- The allocation and utilization of health program resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and the experimentation with new and potentially more cost-effective approaches.

-- The financing of health programs. The large number of poor in need of service means that the provision of even simple care poses a significant financial challenge. In many places, this is giving rise to a desire to explore alternative ways of financing services, and to experiment with new forms of service organization to increase effectiveness through increased consumer participation.

-- The contribution of non-governmental and private health services. In many countries, non-governmental and private organizations and practitioners participate actively in the provision of health care: mission hospitals, other voluntary organizations, community groups, and private physicians deliver services; pharmaceutical products are distributed commercially; traditional healers treat common ailments. Recognition of the formidable administrative and financial challenges involved in expanding public services is resulting in a growing interest in identifying ways in which such networks can complement them in reaching the poor.

-- Health implications of policies outside the health sector. Activities outside the health sector -- nutrition and education programs, family planning services, agricultural development efforts, macroeconomic policies, and others -- have long been recognized as important contributors to better health. This has caused many to argue that non-health approaches deserve more attention; and that policies outside the health sector might be modified to increase their contribution to health. This will require careful empirical investigation as a basis for identifying and selecting from among the many alternatives under discussion.

-- Health consequences of individual behavior. How individuals behave -- whether they use their money to buy nutritious foods, maintain adequate hygiene at home, or have only as many children as they can support -- is as important for their health as is the availability of medical services. A recognition of this has led an increasing number of observers to suggest an exploration of possible ways of improving health-related individual behavior.

-- Adoption and implementation of effective health policies. if potentially effective health policies are to do any good, they must be adopted and implemented as well as formulated. Getting this done, especially when doing so involves difficult political choices, is rarely an easy matter. The obstacles encountered by those seeking the implementation of better policies has produced an interest in systematic investigations of the strategies potentially available to advance such policies, and to shape them in ways that can increase their acceptability to policy makers.

Support Provided

The volume and kinds of support provided will vary from situation to situation.

The maximum direct support available for a health policy analysis and development group will range from $80-100,000 over three years for a group with one policy analyst to $150,000 over three years for a group with three policy analysts. The initial commitment of funds will be for two years, with funds for the third year to be made available upon determination that satisfactory performance has been achieved during that time.

Examples of the expenses qualifying for support include:

-- Research and seminar costs. Among these could be the expenses of field investigations, including vehicle use and other transportation expenses; of secretarial and other direct administrative assistance; of seminars and publications to disseminate research findings; and of the portion of analysts' time spent on project work.

— Short-term orientation/interchange/training activities. Examples include study tours to other countries where the resource issues under study have been effectively handled; participation by senior advisers

in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

— Longer-term overseas internship, training or data analysis opportunities for analysts. Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

— Equipment and supplies.

In addition, consultations by or collaboration with outside specialists can be arranged without cost to the group. The use of such specialists will be encouraged where a group's senior advisers have had limited analytical experience with the issues under study and/or are too heavily burdened with other responsibilities to provide adequate technical guidance to the project's research activities.

Meetings of program participants, which all group members will be expected to attend if requested, will be organized at yearly intervals. Supplementary funds will be provided to support such attendance.

Support cannot be considered for construction, vehicle purchase, institutional overheads, or long-term residential advisers.

Application and Selection Procedure

Applications for support to a health policy analysis and development group will be accepted from governmental or non-profit non-governmental institutions in Asia and Africa in which the program analysts of the group requesting assistance are employed. Each application should be submitted by duly authorized official of the institution concerned, who will normally be a senior member of the group to be considered for support.

Applications may be brief, of no more than two to four pages plus attachments. They should provide:

-- Basic information about each institution with which group members are affiliated. This information may be in the form of attached public reports from the institutions concerned.

-- The name, affiliation, and curriculum vitae of each group member. The curriculum vitae of each policy analyst should contain the names and addresses of at least two references not associated with the group who may asked for assessments of the analyst's potential for creative, responsible policy work. Brief examples of recent work by program analysts, whether on health policy or some other development topic, would be welcome if readily available.

-- A six- to eight-paragraph discussion of the health policy issue with which the group is to deal, the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

— A letter of support from a responsible official of each

participating institution other than that submitting the application. Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group would be participating with its approval, and that the agency would anticipate giving careful consideration to the results of the group's analyses in formulating its policies.

— A preliminary budget and an indication of any technical collaboration external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

Applications should be sent, in time to arrive no later than January 15, 1987, to: Davidson R. Gwatkin, Director; International Health Policy Program; N-561 1818 H Street, N.W.; Washington, D.C. 20433; U.S.A.

Applications will be reviewed by professionals knowledgeable about the countries concerned and then assessed by the IHPP's Advisory Committee. The assessment will in be terms of the prospects for achieving the three objectives stated at the outset. Among the aspects of the application to be reviewed in this regard are the significance of the issues to be addressed for improvements in the health status of the poor; and the capacity of the applying individuals and institutions to work together effectively and produce high-quality analyses which can make a potentially significant difference in the work of the participating policy/service agency. Of special interest will be situations where IHPP support can complement and enhance the effectiveness of programs assisted by the World Bank and the World Health Organization.

Groups considered likely to qualify for support will be invited to

prepare fuller study proposals for discussion with representatives of the IHPP during site visits to be undertaken in March and April, 1987. Further information about these proposals and site visits will be provided to the institutions concerned following the Advisory Committee's assessment of their initial applications. Grant recipients will be publicly announced no later than June 30, 1987.

Program Organization

The IHPP is an initiative of the Pew Memorial Trust in cooperation of the World Bank and the World Health Organization. Professional advice and guidance for the Program is provided by a ten-person international Advisory Committee chaired by John R. Evans. Committee members include representatives of the World Health Organization and the World Bank, which are providing active professional and logistical support.

Financial support for the Program is from the Pew Memorial Trust. Office facilities have been made available by the World Bank. Program funds are administered by the Institute of International Education.

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Guidelines for Support of Policy Workshops

DATE: August 26, 1986

Following our discussion at the July Advisory Committee meeting, approximately $250,000 has been allocated over the Program's next three years for policy workshops. What follows represents an initial effort to develop guidelines for the use of these funds.

PREMISES

The guidelines presented for discussion below are based on two premises, derived from my understanding of our July 15 deliberations:

1. <u>The principal purpose of our support for workshops is to facilitate the establishment and work of health policy and analysis groups</u>.

In our discussion, the idea of workshops and dialogues emerged following our recognition that there are many places where we would like to provide support, particularly in sub-Saharan Africa, where the establishment of policy groups would be very difficult. In such cases, workshops or dialogues were thought to represent a potentially effective way of bringing about the greater appreciation of resource issues necessary for effective policy work.

In other words, we were -- and are — talking about workshops not as a program element separate from the policy groups which represent our principal focus, but as a means of supporting our assistance for such

groups. Among other things, this means that as we assess the effectiveness of our workshop activities at some point in the future, it will not be enough that important people attended, that the discussions were stimulating, and/or that highly-regarded publications were produced. What we'll want to show is that the workshops led to the establishment of ongoing programs of health policy analysis and development in countries most in need of them.

2. Our strategy is to emphasize cooperation with other agencies with expertise in health policy and/or workshop organization, rather than independent activity.

While I don't think anyone ruled out the possibility that we might want to organize workshops ourselves at some point, the thrust of our conversation was on working in a mutually supportive manner with some of the many institutions with a demonstrated capacity in this area. In most cases, the collaborative agency would probably take the lead in logistical matters. There was a widespread hope, I believe, that collaboration with the Bank and WHO might often prove particularly attractive, although I did not sense that anyone meant to exclude the possibility of also working with other institutions.

GUIDELINES

From these two premises, it seems to me, flow a number of propositions or guidelines. Among them are the four which appear below. The first three follow more or less naturally from the first proposition; the fourth is a consequence of the second proposition.

1. The subject matter covered in an IHPP-supported workshop would lie within the range of resource issues outlined in the IHPP discussion note.

Within this range, highest priority would be given for support to workshops dealing with resource issues of greatest interest to policy makers and analysts in the countries concerned, as determined in the exploratory discussions. This is because of the greater likelihood that health policy analysis and development groups could subsequently be formed to undertake ongoing work if the issues covered in a workshop are those of greatest interest to those concerned.

2. IHPP's interest would be greatest in workshop participants who could play central roles in the subsequent formation of health policy analysis and development groups in their countries.

Such participants would normally be at a moderately high level. Examples would include people who meet the qualifications for "senior research advisers" or "senior policy advisers" in health policy analysis and development groups, as described in our program material; and their superiors, who could provide important political support.

People with the qualifications just described might be reached in either of two ways. One way would be through IHPP core support for workshops where a high proportion of participants have those qualifications. Alternately, support could be provided directly to such individuals, to permit them to participate in workshops which might not for some reason otherwise qualify for IHPP support.

3. Highest priority would be given to reaching people in regions where further exposure to resource issues is of greatest importance for the initiation of ongoing health policy analysis programs.

This means a particular focus on sub-Saharan Africa where, as we

discussed in July, a greater awareness of resource issues will often be a prerequisite for long-term work. Parts of South Asia would also qualify for attention in this regard.

This probably implies that most workshops receiving support would take place in one of these areas, although collaboration in activities elsewhere might well prove attractive upon occasion. It might, for example, prove desirable to support participation by Africans and South Asians in relevant programs in East/Southeast Asia, Latin America, Europe, or North America; or to assist activities in East/Southeast Asia which would draw together the experience in those regions in a way which would permit its use as comparative resource material for workshops in Africa or South Asia.

4. Beyond the common characteristics implied by the preceding three points, the nature of workshop activities supported would vary widely.

The organizations with which the IHPP would collaborate can be expected to differ significantly in their orientations and in their reasons for collaborating with the IHPP in workshop activities. In many cases, the collaborating organization(s) or other donors will be providing a significant portion of the total funding and will have their own objectives for the use of their funds, just as the IHPP has its objectives. While expecting other sponsors/donors to appreciate our interest in achieving our objectives, we'll want to be flexible in other respects in order to accommodate the other sponsors' objectives as well. This necessity to accommodate multiple objectives, coupled with the diversity of organizational collaborators just mentioned, suggests a considerably "messier" -- but commensurately more productive -- configuration of activity than would be the case were the IHPP to work independently.

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International Health Policy Program

file: Pew

An Initiative of the Pew Memorial Trust in Cooperation with the World Bank and the World Health Organization

MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Program Material

DATE: August 26, 1986

I attach the two items to which I referred in my August 20 memorandum:

-- "A Program of Support for Health Policy Analysis and Development in Asia and Sub-Saharan Africa: Guidelines for Applicants."

-- "Guidelines for Support of Policy Workshops."

I'll be away from Washington until September 13. As soon as possible after my return, I'll be telephoning for any comments or suggestions you might have. Any written comments you would like to send before then would be very welcome. I'd also welcome suggestions concerning people and institutions to receive application guidelines.

Best wishes,

N-561, 1818 H Street, NW, Washington, DC 20433, U S A • Telephone (202) 676-9453 • Cables INTBAFRAD

Draft
8/86

International Health Policy Program

A PROGRAM OF SUPPORT

for

HEALTH POLICY ANALYSIS AND DEVELOPMENT

in

ASIA AND SUB-SAHARAN AFRICA

Guidelines for Applicants

The International Health Policy Program is an Initiative of the Pew Memorial Trust in cooperation with the World Bank and the World Health Organization

The International Health Policy Program (IHPP) offers as many as twelve three-year institutional grants of up to $150,000 each for health policy analysis and development activities in Asia and sub-Saharan Africa. The purpose of the grants is to find ways of using available resources more effectively for improving the health status of the poor. Policy makers and analysts in Asian and sub-Saharan African institutions who are interested in working together for this purpose are eligible to apply.

Background

In recent years, especially since the 1978 Alma Ata Conference on primary health care, interest in effective action to improve the health status of vulnerable population groups has been rising steadily. Unfortunately, severe resource constraints associated with difficult economic conditions have often hampered such action.

This situation has highlighted the role of resource considerations in the achievement of better health. As more and more policy makers have come to realize, necessary improvements in the condition of those at risk will require additional financial and human resources, and the most effective possible use of those resources.

The Pew Memorial Trust, the World Bank, and the World Health Organization are working together to address such issues. In addition to their continuing efforts to generate additional resources, they are cooperating to support the attempts of developing country policy makers to find more effective ways to using the resources available.

Following an exploration featuring discussions with over 200 policy makers and analysts in developing countries to solicit their advice, program guidelines have been developed which would emphasize the enhancement of local capacities to deal with resource issues. At the program's heart lies

support for a network of groups of developing country policy makers and analysts working together on resource issues of importance for the poor of their countries.

The support to be provided has three objectives: 1) the production of analytical studies of practical value for decisions made by the participating policy makers; 2) the development of promising younger analysts through the experience gained in the studies' execution; 3) and the development of effective working relationships between policy makers and analysts conducive to further cooperative work.

Health Policy Analysis and Development Groups

Groups qualifying for support may already exist or may be newly created. Typically, they will consist of between three and five or six people, including:

— One to three policy analysts, who would devote 25-50% of their time to the project and be its principal workers. The analysts would be promising younger people currently employed in a policy analysis and research organization, people considered likely by their superiors to play an important role in the organization's future development. Most would probably be in institutions like university economics or sociology departments, schools of public health, institutes of development studies, or management institutions; some might come from governmental organizations like the planning units of health ministries or the health divisions of planning ministries, in situations where significant work is undertaken intra-ministerially. Analysts would typically be the recent recipients of a doctoral degree in a field like economics, epidemiology, a behavioral science, or management; some might have master's degrees and be working

toward their doctorates.

— One or two senior research advisers, who would normally be the analysts' superiors. Typical would be a university faculty dean or department chairman; the director of a quasi-governmental development or management institute; or the director of policy and research in a government ministry. The research advisers, while devoting less time than program analysts, would be expected to be meet regularly with other group members and to ensure an institutional responsibility for the successful execution of project activities: by seeing that the analysts are able to spend the full amount of time envisioned on program work, for example; and by assuring that any grant funds flowing through the institution are smoothly administered. In some cases, senior research advisers would have had extensive health policy experience. In others, their experience would be in some related area: as a development or agricultural economist directing a development research institute, for example; or a clinician heading a medical research institute.

-- One or two senior policy advisers, responsible policy-level officials from government or non-government organizations centrally concerned with health: the director of policy in a health ministry, for example; the head of the health/social welfare division of a planning ministry; or the director of a large private voluntary agency providing health services. (In cases where the policy analysis takes place within a ministry, the policy adviser would normally be the analysts' superior; and where possible there would be a research search adviser from a local outside institution.) Policy advisers would be responsible for ensuring that the analyses performed are relevant and useful for decisions faced by the

advisers' agencies, and for seeing that the findings of program-supported work are disseminated within their organizations.

Support can be considered for two or more cooperating groups with complementary interests in the same city or country: support for a group featuring work with a health ministry by epidemiologists in a medical faculty, and for a group with economists from a faculty of social sciences studying a related issue for the same ministry or for some other agency, for example. Overlapping membership among groups is also permissible: a director of health or social service programs in a planning ministry, for instance, might serve as senior policy adviser to two or more groups from different universities or different faculties; or sociologists from one group might serve as research advisers to public health physicians in another.

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In some circumstances, the studies might be executed within the context of a larger program supported by other donors. When a large-scale, long-term primary data collection effort is already under way in a participating institution, for example, IHPP funds might be used to support analyses of

those data of particular interest for policy purposes; and the senior people directing or advising the larger study might serve as senior research advisers in an IHPP-supported health policy analysis and development group.

The resource issues addressed by the IHPP-supported analyses are to be those determined by group members to be of greatest importance for improving the health status of the disadvantaged in their country. Most support can be expected to go for work on issues in six broad areas of concern to the policy makers and analysts interviewed:

-- The allocation and utilization of health program resources. The recent constraints on health program resources have emphasized for many the importance of ensuring that the limited resources available are applied to programs which can bring the greatest health benefits to the disadvantaged. This will require careful assessments of the effectiveness and cost of the different approaches currently in use, and the experimentation with new and potentially more cost-effective approaches.

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in short-term courses on relevant topics outside their area of expertise (an introductory program in health economics for a policy adviser with a clinical background, for example; or a short-term course on epidemiology/public health for a research adviser who is a rural sociologist); and attendance at particularly important international meetings on the issues being studied.

— Longer-term overseas internship, training or data analysis opportunities for analysts. Support for up to a year of overseas training or professional experience can be considered for one or two analysts in each group after the completion of an initial data collection phase. It is anticipated that analysis of the data collected (with external expert assistance, if necessary in cases where the analysts are not initially qualified to undertake independent research) will constitute an important focal point of any overseas experience supported.

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-- A six- to eight-paragraph discussion of the health policy issue with which the group is to deal, the issue's significance for the poor population of the country concerned, the issue's relevance for decisions to be made by the participating policy agency, the kinds of analyses to be performed, and the ways in which the results of the analyses are to be disseminated to the relevant decision makers.

— A letter of support from a responsible official of each

participating institution other than that submitting the application. Among these should be a letter from a major governmental or non-governmental health policy and/or service agency confirming that the issues to be studied had been selected in consultation with it, that the agency's member of the group would be participating with its approval, and that the agency would anticipate giving careful consideration to the results of the group's analyses in formulating its policies.

— A preliminary budget and an indication of any technical collaboration external specialists desired. (Names of desired collaborating institutions or individuals, if identified, are welcome.)

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MEMORANDUM

TO: Members of the Advisory Committee

FROM: Davidson R. Gwatkin

SUBJECT: Guidelines for Support of Policy Workshops

DATE: August 26, 1986

Following our discussion at the July Advisory Committee meeting, approximately $250,000 has been allocated over the Program's next three years for policy workshops. What follows represents an initial effort to develop guidelines for the use of these funds.

PREMISES

The guidelines presented for discussion below are based on two premises, derived from my understanding of our July 15 deliberations:

1. <u>The principal purpose of our support for workshops is to facilitate the establishment and work of health policy and analysis groups</u>.

In our discussion, the idea of workshops and dialogues emerged following our recognition that there are many places where we would like to provide support, particularly in sub-Saharan Africa, where the establishment of policy groups would be very difficult. In such cases, workshops or dialogues were thought to represent a potentially effective way of bringing about the greater appreciation of resource issues necessary for effective policy work.

In other words, we were -- and are -- talking about workshops not as a program element separate from the policy groups which represent our principal focus, but as a means of supporting our assistance for such

groups. Among other things, this means that as we assess the effectiveness of our workshop activities at some point in the future, it will not be enough that important people attended, that the discussions were stimulating, and/or that highly-regarded publications were produced. What we'll want to show is that the workshops led to the establishment of ongoing programs of health policy analysis and development in countries most in need of them.

2. Our strategy is to emphasize cooperation with other agencies with expertise in health policy and/or workshop organization, rather than independent activity.

While I don't think anyone ruled out the possibility that we might want to organize workshops ourselves at some point, the thrust of our conversation was on working in a mutually supportive manner with some of the many institutions with a demonstrated capacity in this area. In most cases, the collaborative agency would probably take the lead in logistical matters. There was a widespread hope, I believe, that collaboration with the Bank and WHO might often prove particularly attractive, although I did not sense that anyone meant to exclude the possibility of also working with other institutions.

GUIDELINES

From these two premises, it seems to me, flow a number of propositions or guidelines. Among them are the four which appear below. The first three follow more or less naturally from the first proposition; the fourth is a consequence of the second proposition.

1. The subject matter covered in an IHPP-supported workshop would lie within the range of resource issues outlined in the IHPP discussion note.

Within this range, highest priority would be given for support to workshops dealing with resource issues of greatest interest to policy makers and analysts in the countries concerned, as determined in the exploratory discussions. This is because of the greater likelihood that health policy analysis and development groups could subsequently be formed to undertake ongoing work if the issues covered in a workshop are those of greatest interest to those concerned.

2. IHPP's interest would be greatest in workshop participants who could play central roles in the subsequent formation of health policy analysis and development groups in their countries.

Such participants would normally be at a moderately high level. Examples would include people who meet the qualifications for "senior research advisers" or "senior policy advisers" in health policy analysis and development groups, as described in our program material; and their superiors, who could provide important political support.

People with the qualifications just described might be reached in either of two ways. One way would be through IHPP core support for workshops where a high proportion of participants have those qualifications. Alternately, support could be provided directly to such individuals, to permit them to participate in workshops which might not for some reason otherwise qualify for IHPP support.

3. Highest priority would be given to reaching people in regions where further exposure to resource issues is of greatest importance for the initiation of ongoing health policy analysis programs.

This means a particular focus on sub-Saharan Africa where, as we

discussed in July, a greater awareness of resource issues will often be a prerequisite for long-term work. Parts of South Asia would also qualify for attention in this regard.

This probably implies that most workshops receiving support would take place in one of these areas, although collaboration in activities elsewhere might well prove attractive upon occasion. It might, for example, prove desirable to support participation by Africans and South Asians in relevant programs in East/Southeast Asia, Latin America, Europe, or North America; or to assist activities in East/Southeast Asia which would draw together the experience in those regions in a way which would permit its use as comparative resource material for workshops in Africa or South Asia.

4. Beyond the common characteristics implied by the preceding three points, the nature of workshop activities supported would vary widely.

The organizations with which the IHPP would collaborate can be expected to differ significantly in their orientations and in their reasons for collaborating with the IHPP in workshop activities. In many cases, the collaborating organization(s) or other donors will be providing a significant portion of the total funding and will have their own objectives for the use of their funds, just as the IHPP has its objectives. While expecting other sponsors/donors to appreciate our interest in achieving our objectives, we'll want to be flexible in other respects in order to accommodate the other sponsors' objectives as well. This necessity to accommodate multiple objectives, coupled with the diversity of organizational collaborators just mentioned, suggests a considerably "messier" -- but commensurately more productive -- configuration of activity than would be the case were the IHPP to work independently.