



TOWARDS
UNITY
FOR HEALTH

**MANAGING A SUCCESSFUL
TUFH FIELD PROJECT**

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MANAGING A SUCCESSFUL TUFH PROJECT

Introduction

by Charles Boelen and Buz Salafsky

In their quest for improving quality, equity, relevance and cost-effectiveness, pioneers in health system development advocate the need for a unity of purpose and action among key health partners, namely policy-makers, health managers, health professions, academe and community representatives.

Declarations and statements have been made over the years worldwide for fostering coordination of interventions to better serve the health of individuals and populations, witnessing the will of nations, governments and organizations to break away from conventional health services delivery. The Alma Ata Declaration on primary health care in 1978 was an important landmark which further inspired health system developers. Close to a quarter of a century later, one may question whether significant progress has been achieved in reorienting health systems to better meet people's priority health needs.

Across the globe, inequities of access to basic health services still exist, and in some contexts, increase. Quality of care is threatened by the galloping fragmentation in the ways individual health problems are being addressed, while insufficient quality control measures continue to be seen. Policies fail to address, in pragmatic terms, the determinants to create more coherent and people-focussed health systems.

Discrepancies, overlapping, undue competition and lack of coordination among main stakeholders in the health field remain largely observed and continue to upset the optimal management of health systems. In any given population, the majority of decisions with bearing on people's health fail to be guided by an objective and continuous analysis of facts, and an optimal mobilization of forces and resources to cope with people's most prevalent health problems and risks.

Public health actions meant to serve the general public and medical care given to the sick are poorly coordinated. While educational institutions for health professions may be creative in readjusting their programmes for a better fit of their graduates with most pressing health issues in society, they are not assured that they will be used as planned, as their prospective employers may be less socially conscious.

Representatives of health service organizations, academic institutions and professional associations have been aware, over the years, of the need to work towards a better match of their agendas as an important condition to make the best use of available resources to serve people's health. In 1999, the World Health Organization (WHO) organized an international conference in Phuket, Thailand, named Towards Unity for

Health (TUFH): Challenges and Opportunities for Partnership in Health Development. A consensus paper was issued highlighting the imperative requirement of a social contract bounding health partners. A working paper was published, providing a general framework enabling the creation of a momentum towards unity of view and sustainable partnership among stakeholders.

As few methodological approaches are available to lead practical actions towards unity for health in different socioeconomic contexts, the emphasis has been put on the development of action research in several field projects.

The main questions identified were:

- How can the wide spectrum of health actions be better coordinated or integrated for a given population, with current multiplicity of service providers?
- What can lead each stakeholder to adapt its program of work to better respond to societal needs and makes the necessary institutional changes?
- How can sustainable partnerships be warranted among health actors with different agendas?

These issues represent also main challenges in the TUFH approach. In TUFH, the word “towards” indicates the importance given to a research/development philosophy. Lessons learnt from field experience should be the principal sources in suggesting practical guidelines and methodologies in creating a steady movement towards “unity”.

The first sample of 12 TUFH field projects, resulting from a worldwide competition, provides a unique opportunity to stimulate the design and implementation of creative approaches, and accumulate new knowledge in translating concepts into reality. Other TUFH field projects will come to reinforce this first group and will further contribute to international collaboration.

Very early in the process, it was felt necessary to concentrate efforts in the design of an evaluation framework, both to guide current TUFH field project managers and obtain useful answers to our questions.

This monograph contains a list of indicators for measuring progress towards “unity” and provides a brief profile of current TUFH field projects. Obviously, it does not contain the final truth, but hopes to be a step in the right direction and a help to all those who are interested in embarking on a TUFH project.

Indicators for Monitoring TUFH Projects

The planners of the TUFH Mini-symposium in Rockford have recognized the importance of indicators that encompass the following parameters:

- program implementation indicators;
- stakeholders' involvement indicators;
- partnerships indicators.

Drawing on the experiences of the TUFH projects, Eric Ruland's material on indicators at Hartslag, in the Netherlands, is presented.

Further is the importance of arranging these indicators—program, stakeholders, partnership—in a matrix relationship with the following parameters:

- baseline;
- source;
- periodicity;
- use;
- other concerns.

Again, drawing on TUFH projects, Amina Balafrej presents a matrix describing the interactions of the above indicators in Morocco.

Indicators for the TUFH Project

Eric Ruland

Program Manager, Hartslag, Limburg

Indicators of impact on health services: quality

- increases in health promotion, healthy policies and facilities;
- better services for high-risk patients;
- more adequate support for GPs and cardiologists;
- increases in multi-disciplinary efforts.

Indicators of impact on health services: equity

Stronger focus on the needs of the low socioeconomic status (LSES) areas, regarding:

- municipal health policies;
- health facilities (e.g. access to sport facilities);
- health education (e.g. special products);
- individual care for LSES high-risk patients;
- reduction of socioeconomic health inequalities.

Indicators of impact on health services: relevance

- stronger focus on public health;
- facilitating health promotion, making it easier to choose a healthy life style;
- medicine, occupational medicine, public policies (welfare and community development policies), food industry, etc.

Indicators of impact on health services: cost-effectiveness

- a cost-effective reduction of CVD through integration of primary and secondary prevention:
 - decrease in risk factors, morbidity, length of stay in hospitals, etc.;
- a cost-effective support for MD's through health advisors (nurse practitioners).

Indicators of stakeholder's activity:

- in general
 - show commitment to a common goal
 - invest in the joint enterprise
- policy makers and health managers
- Active participation, setting priorities in policy documents, money, promotion of the project towards others.

Indicators of stakeholder's activity:

- Health professionals
 - Implementation into their daily practice, contribute to health promotion activities;
- Academic institutions
 - Scientific input, evaluation, rendering feed back, involvement of students and researchers (inside out) and practitioners (outside in).

Indicators of partnerships: level of involvement

- each partner contributes from own resources;
- long term agreements for performance of work.

Indicators of partnerships: synergies

- integrated care, integrated focus on LSES;
- integration of health and welfare;
- stronger political lobby;
- researcher for practice and vice versa.

Indicators of partnerships: sustainability

- from a project towards a lasting inter-organizational structure with:
 - formal/legal basis;
 - regular funding;
 - involvement of a substantial part of each partner organization;
 - over a lengthy/unlimited period of time.

Indicators for Monitoring TUFH Projects

Amina Balafrej

Matrix showing interactions of the above indicators in Morocco.

Towards unity for the health of diabetic children

Program Indicators	Definition	Baseline 2000	Target 2005	Source	Periodicity	Use	Other concerns
Quality							
Mortality due to diabetic ketoacidosis (DKA)	Numerator: number of children died due to DKA in the center Denominator: Number of child patients admitted to the center	3%	2%	Hospital records	Yearly	This indicator measures the extent to which the center provides health care in compliance with quality standards	Subsidy and human resources allocation maintained
Metabolic control among diabetic children Average glycosylated hemoglobin (HbA1c)	Numerator: Average annual HbA1c among the diabetic children Denominator: Total number of diabetics monitored in the outpatient clinic	9%	8.5%	Center database	5 years	Idem	
Equity							
Health care delivered to all diabetic children with onset of diabetes under 15 years	Patients' social and economic profile 1986 low income families 2000: Profile corresponding to social and economic distribution in the area	2-3% high income 40% employees with health insurance 50% low income, no health insurance 10% very low income	Same distribution	Center database	Yearly	This indicator measures equity in access to services. Currently, the access is universal. The project aims to keep the same satisfactory level.	Maintained resources and autonomous management of the center
Relevance							
Satisfactory level of care	Admission of newly diagnosed cases Estimated incidence in the Rabat-Salé area: 8/100.000 children under 15 years per year	80 new cases admitted	80 new cases admitted	Center database	Yearly	This indicator measures relevance of the project to the local incidence level. The successful outreach of new cases in the catchment area will continue.	Partnership with medical school and with regional centers
Training of health professionals	Number of requests per year from the constellation of 10 peripheral clinics	No request	5 nurses and 5 physicians trained each year	Records from medical school and from regional centers	Yearly	This indicator will measure improvement of quality of care in the regional centers	Implemented
Cost-effectiveness							
Rate of readmissions for DKA	Numerator: Number of readmissions for DKA Denominator: Total number of diabetic children and youths monitored	3%	2%	Center database	Yearly	This indicator will measure the number of readmission for DKA. A decrease in this indicator will have an impact on the recurrent cost of treatment.	

Stakeholder involvement	Definition	Baseline	Target	Source	Periodicity	Use	Other
Health managers	Dissemination of treatment standards	Standards developed but only used at Rabat CH	Dissemination to all diabetic centers	Regional centers records	2 years	This indicator reflects the commitment of health managers	
Health professionals	Quality of care in the regional centers	Average HbA1c over 9.5%	Average HbAC 9%	Data from national laboratory (Pasteur)	2 years	Involvement of health professionals and successful training	Continuity in coverage by sponsor of expenses related to measurements
Community	Number of events planned to raise awareness	Less than 1 per year	4 per year newspaper	Radio			

Indicators of partnership

Center administration	Board of directors with representatives of health managers, health professionals, academic institutions, and community		At least 1 annual meeting	Annual reports		Partnership implemented through this board	Autonomous status allocated to the center of diabetic children in Rabat
Education materials development	Educational advisory board with health professionals, representatives of academic institutions	1 guide produced with health professionals from regional centers	1 annual meeting			Appropriated to the local needs education material adoption by all partners	

Dissemination

Through the provincial centers

Sustainability of partnership

Depends on population needs and community commitment

The Project Profiles

TUFH field projects

In January 2001, a first set of 12 TUFH field projects was selected based on their potential and plans to adhere to preestablished criteria. Selected TUFH field projects have received a WHO grant and will submit progress reports twice a year according to a predetermined format.

AFRICA

Kenya: Project-linked innovative management by integrative-participatory research approach

Dr. Solomon Nzioka, Moi University, Eldoret, Kenya

Nigeria: Community empowerment for health financing and co-management

Dr. Akin Osibogun, University of Lagos, Lagos, Nigeria

AMERICAS

Brazil: Rural internship and family health: a compromise for “Towards Unity for Health”

Drs. Francisco Campose and Geraldo Cunha Cury, Federal University of Minas Gerais, Brazil

Brazil: A strategy for integrating education and services in family health

Professor Ellen Marcia Peres, Rio de Janeiro State University, Brazil

Canada: Integrated cardiovascular health programme: a commitment for “Towards Unity for Health”

Dr. Paul Grand'Maison, University Sherbrooke, Québec, Canada

United States of America: Towards unity for health in the greater Rockford area

Mr. Raymond W. Empereur, Rockford Health Council, Rockford, Illinois

EASTERN MEDITERRANEAN

Morocco: Towards unity for the health of diabetic children

Dr. Amina Balafrei, Rabat, Morocco

EUROPE

Czech Republic: Integrated community health care institute in the Czech Republic

Dr. Jana Zrejkova, for Postgraduate Medical Education, Prague

Italy: Towards unity for health in Sicily

Dr. Pina Frazzica, Centre for Training and Research in Public Health, Caltanissetta, Italy

The Netherlands: “Hartslag Limburg”: Community-based prevention of cardiovascular disease integrated with a high-risk group approach in general practices and in the hospital

Dr Eric C. Ruland, Maastricht, The Netherlands

Spain: Towards unity for health: Barceloneta’s project. A population approach in a district of Barcelona

Dr. A. Oriol Bosch, Institute d’Estudis de Salut, Barcelona, Spain

SOUTHEAST ASIA

Indonesia: Towards a healthy city in a decentralized health system: a partnership model for medical school

Dr. Soenarto Sasrowijoto, Gadjah Mada University

AFRICA

KENYA

Kenyan Partnership for Health: Project-linked Innovative Management by Integrative-participatory Research Approach (KPH-PIMIRA)

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Project Description

Lack of safe drinking water, personal hygiene and latrine facilities have led to high case fatality rates due to water-related and helminthic infections in the project area. To reverse the trend, any interventional project should be geared towards technology transfer and promotion of health information utility through active participation of all stakeholders in the National Health Service. It involves all the community members, but with a specific focus on maternal and child health, which encompasses the most prone group, health managers and health professionals from the Ministry of Health, policy makers and Moi University–Faculty of Health Sciences. The first phase, planned to last two years, will focus on water and sanitation, including malaria, while the next phase will incorporate HIV/AIDS and all MCH/FP activities.

Strengths

Success of the KPH-PIMIRA lies in the mutual working relationship between the faculty and the Ministry of Health. The Ministry of Health established the training institution in order to produce high-cadre professionals in the area of environmental health/public health, medicine and nursing. The resulting synergy is expressed in the KPH-PIMIRA project, which is committed to providing service, education and research by addressing immediate problems, and also forecasting on the prevention of future health problems. This provides mutual relationships through active participation of all stakeholders in decision making about the project, as well as providing new challenges and opportunities in training and practice to the present and future health professionals.

Challenges

The most eminent problem facing the project has been its innovative nature amidst the traditional project management, where tailor-made approaches are applied with minimal participation of all stakeholders. In addition, the financial support to the

project has been difficult due to policy requirements on health financing. Most of the health-managing establishments (financiers) operate only through the Ministry of Health. Our immediate role is to convince the national health administrative structure of the eminent importance of the project in order to provide for opportunity costing in favour of KPH-PIMIRA. To achieve this, several consultative meetings have been held at the district level with the Ministry of Health Departmental heads that will climax in an official launching of the project at a national workshop being jointly organized by the Environmental Health Students Association of Moi University (EHSAMU) and the Ministry of Health, amongst other potential partners.

Coordination

To maximise effectively and efficiently on overall appropriateness of the KPH-PIMIRA project, a memorandum of understanding has been developed defining the minimum terms of references in consultation with the different potential partners. It defines the different management levels of the project, ranging from village health committees (VHCs) through district project consultative committee (PICC) and institutional consultative committee (ICC) to the national consultative committee (NACOC).

Moi University–Faculty of Health Sciences, being the host institution, forms the bulk of the ICC and provides for the project operations team (POT). Trans-Nzoia District, being the base of project operations, constitutes the PICC, while the WHO Kenya country office has been proposed to host the NACOC. POT is the main project coordination unit and is comprised of the project contact person and a co-investigator.

AFRICA

NIGERIA

The Odogbolu Health Project: Working Together for Progress Community Empowerment for Health Financing and Co-management

*Dr Akin Osibogun
University of Lagos, Lagos, Nigeria*

Description

The major problems facing the delivery of health services in many communities in Nigeria are those of inadequate funding, poor managerial capacities and insufficient involvement of key stakeholders, such as members of the community in the decision-making process. The often over-centralized decision-making process has inevitably led to a loss of relevance and poor cost effectiveness of the health services. A concomitant result has been a decline in the utilization of PHC facilities and a corresponding increase in advertisements from, and patronage of practitioners of alternative/traditional medicine, whose practices are yet to be regulated and monitored.

Strengths

The TUFH approach does offer an opportunity for a partnership between members of the community, policy makers, health workers, administrators and training institutions. It is expected that such a partnership will result in improved funding of health services, shared decision making and increased relevance of health services; extension of services to underprivileged members of the community; adoption and use of cost-effective health interventions; and improved utilization of services.

There is a strong possibility for project success in this environment, as previous study has shown the willingness of members of the community to contribute to the provision of health services on the condition that such services address predominant health problems in cost-effective ways. There already exists an alliance between members of the community in one of the districts of the LGA, health workers and a university researcher. This alliance resulted in the formation of a community-based health insurance scheme that has contributed to improved funding for services, promotion of equity and community involvement in health management.

The relative success of the existing scheme has attracted the attention of administrators and policy makers at local, state and federal levels. The chairman of the local government council has been eager to see how the scheme could be spread throughout

the areas under his jurisdiction. Both the state and the national councils on health have been briefed, at their request, about the existing project and there is tremendous goodwill for similar projects to be established. The new democratic environment in the country is also supportive of community mobilization initiatives.

Strengths

Participation in the partnership by training institutions is expected to impact on training programmes by making them more relevant to the health problems on the ground. It is also expected that trainees will be involved in research that will further help in defining win situations for health development.

The new democratic environment in the country will contribute to the reduction of resistance from policy makers and health workers as long as the project planning and implementation strategies carry everybody along at all stages.

Challenges

The challenge is to expand the existing scheme both in scope and in coverage. It is necessary to expand the scope beyond community involvement for health financing and to energize the decision-making process for improved relevance through active community participation.

Coordination

The project is being coordinated by Dr Akin Osibogun from the host institution, the Department of Community Health of the College of Medicine of the University of Lagos.

AMERICAS

Minas Gerais, BRAZIL

Rural Internship Program and Brazilian Family Health: A Compromise for “Towards Unity for Health”

*Drs. Francisco Campose and Geraldo Cunha Cury
Federal University of Minas Gerais, Brazil*

Description

Driven by the new medical curriculum implemented in the School of Medicine of Federal University of Minas Gerais (FM-UFMG), the public health services and others sought recognition as partners in the medical education provided by the University. With introduction off the Rural Internship program in 1978, one of the oldest programs of its kind in the country, the health system has become a privileged work place, integrating medical education and public health.

In 1974, the Brazilian Health Ministry created the Family’s Health Program (FHP). According to the official documentation: “the main aim of the FHP is reorganize medical practice along new lines, and to replace the traditional model, making health care more accessible to the family to improve Brazilians’ life quality”. It is inherent in the FHP expansion proposal—a strategy to change the current assistance model in our country—that it requires professionals who have experienced this curriculum in their medical education. The Rural Internship is formulated to be more fully integrated into the FHP, leading to the development of highly trained professionals who will become the future Family’s Health Team.

Strengths

The family health program strategy seeks to transform the existing health care model centered around the doctor and hospital into a new model which encompasses partnership with a broad range of health professionals and other segments of society. Between the the health sectors and other education-related sectors, the environment and rural work would stand out.

This new proposal suggests that, along with the Rural Internship, the family’s health team would require participation of “community health agents”, (people who live in the communities and act in the FHP, forming the connector link between the population and health teams). This wholly formed group work together to develop the following activities:

1. Women’s and children’s health care, through implementation in the programs

related to this part of the population. The Health Ministry and municipal departments of health have already developed these programs (prenatal, puerile culture, nutritional assistance, vaccination, intestinal parasitism, cancer prevention, etc.) Nongovernmental organizations acting in this field will participate. Brazilian example of one of these: “Pastoral da Criança”.

2. Degenerative, chronic diseases, through the proposal presented in the CARMEM/OPS Program: our objective is to improve the health of the population, decreasing mortality and morbidity caused by the main non-transmissible diseases, e.g., smoking, inadequate alimentation, alcoholism, sedentarism, and psychosocial stress.
3. Health education: developing the concept of education as an instrument for growth and changing patterns, as opposed to the use of education as a conduct and practice recipe.
4. Health promotion based on the idea of education for growth, developing attitudes and activities within the population, focusing on sanitation issues, e.g., potable water, trash and garbage collection, sewers and vectors. The objective is to present these questions to the population, in such a way as to ensure public participation. The population always participates quite competently when they are given an opportunity to do so.

Challenges

Through the available data in the Municipal Secretariats of Health, morbidity data produced by the trainees, and the forms submitted by families participating in the FHP, it will be possible to evaluate short-, medium- and long-term effectiveness of the measures. Evaluation of the FHP/RI will entail interviews with the municipal secretary of health, members of the FHP team, and municipal health council members, with the evaluation tools available in all cities where the Rural Internship is active. Through the use of updates and comparison of existing data, it will be possible to evaluate the effectiveness of preventive measures and health promotion with the use of quantitative pointers, such as those of morbidity-mortality, and qualitative studies such as focus groups. The cities with the Family Health Program and the Rural Internship Program will be the object of comparison with those having only the Family Health Program.

The relevance to the TUFH approach to this project is close to Brazilian reality. It reinforces the belief that involvement of stakeholders, such as health systems and university, are important to the attainment of unity for health.

AMERICAS

BRAZIL

Rio de Janeiro's Training Center in Family Health: Impact Evaluation of its Educative Interventions upon Primary Health Care Services Delivery

Professor Ellen Marcia Peres, Rio de Janeiro State University, Brazil

Description

In the context of its health sector reform, Brazil launched, in 1995, the Family Health Program (FHP), the aim of which is to reorient primary health care and help turn into reality the constitutional principles of universality, equity, integration, hierarchy of health actions, administrative decentralization and social control. One of the critical problems to implementing FHP is the lack of human resources with competencies to respond to the new demands. To face this problem, Brazilian Health Ministry “pushed” the organization of Training Centers in Family Health (TCFH), regionally distributed, which actions are expected to produce the following outcomes: new skills acquired by health workers; practices of health delivery services and of health workers reoriented; curricula of health workers reoriented; post-graduate courses in Health Family Strategy developed.

This project, elaborated by Rio de Janeiro State University's TCFH, seeks to evaluate the impact of its processes upon the profile of human resources engaged in primary health care. The impact will be demonstrated by a shift in health professionals' practices, from one turned to early specialization and frequent and unnecessary use of high technology procedures, to another, emphasizing health promotion and preventive care, but without forgetting curative care. It is directed toward a reference population in a defined territorial basis, and based in a broad concept of health that makes use of interdisciplinary and intersectoral actions to improve life quality. If the TCFH actions are effective, primary health care services delivery will improve in quality, equity, relevance and cost-effectiveness.

Strengths

Great political interest of all levels – federal, state and municipal – in supporting and stimulating the dissemination of Family Health Strategy as a form of reorienting the Health Care Model, rationalizing health system costs and improving health conditions of the population in the perspective of healthy cities, guarantees the long-term commitment of all the partners to the TCFH Project. The federal interest is in funding Rio de Janeiro's TCFH. The actual partners are: policy-makers–Brazilian Health Ministry;

health managers—RJ Health Secretary; Municipal Health Secretaries of RJ State towns; academic institutions—five universities and two other academic institutions situated at RJ State, which make all their resources (human or not) available; health professionals—physicians, nurses, dentists and other professionals of public health services and family health units, and their respective professional associations; communities—community representatives at municipal and state health councils (taking part in decision-making of the health sector at the political and management levels).

Challenges

One of the main challenges is to overcome the resistance of the faculties to reorient their curricula in order to train health professionals with a different profile, although the new curricular directions established by the Educational Ministry have already been elaborated in this direction; thus, it is necessary to narrow the relationships between health and educational instances, beginning at the political level. The social accountability of academic institutions also needs to be improved. Another important challenge is to change the practices of professionals who have always worked in private practice and are heavily specialized, in order to engage them in interdisciplinary and intersectoral activities, linking medicine and public health for the benefit of peoples' health.

Coordination

The host institution is Rio de Janeiro State University (UERJ) / Center of Studies and Research in Collective Health (CEPESC), with the coordination of Ellen Marcia Peres (who is also the coordinator of Rio de Janeiro's TCFH) and the participation of Thereza Christina Varella and Ana Maria de Andrade, also from UERJ.

AMERICAS

CANADA

Sherbrooke-Estrie Integrated Cardiovascular Health Program: A Commitment for TUFH

*Dr. Paul Grand'Maison
Université de Sherbrooke, Québec, Canada*

Description

The Sherbrooke-Estrie Integrated Cardiovascular Health Program aims to improve the physical and psychological health and well-being of people with, or at risk of developing, a cardiac disease through education, research, and service. Initiated in 2000, the program focuses on the implementation of an integrated health service delivery system based on the needs of a defined population, including complementary population-based and individual interventions that are supported by a comprehensive health information system. Development of new professional roles and interdisciplinary teamwork, fostering multilevel partnerships and commitment to the measurement of the program's impact are other program characteristics. Stakeholders have committed themselves to pursue the planning, implementation and evaluation phases of the program using the TUFH values and principles. Present research includes assurance of patients' and family needs in the post-acute rehabilitation period, including optimal access to specialty care plus prevention for those without disease.

Figure 1. Location of the Estrie Region within Québec and Canada



Strengths

Cardiovascular health has been identified as a 2000-2005 priority by the Regional Health Authority, as well as the province and nation. The program stands on a strong partnership between Sherbrooke University Hospital (the only hospital offering cardiovascular tertiary

care in the region) and the Sherbrooke Faculty of Medicine. An organizational model involving the five groups included in the TUFH partnership pentagon is being progressively implemented. All stakeholders have accepted TUFH as the development framework. The model includes a strategic level (general orientations, policies, formal agreements), a tactical or implementation level (development of specific tools, protocols, information systems) and an operational (direct patient actions) level. The Regional

Health Authority is accountable for the strategic level while the University hospital, which has recently implemented a client-program approach in cardiovascular health, is in charge of the tactical level. Lessons learned will provide a template for the establishment of similar approaches for other complex health care problems.

Challenges

Since the program was initiated by a relatively small group of persons, the challenge is to make sure that all stakeholders share the TUFH values and principles of equity, relevance, quality and cost effectiveness, and that a regional consensus is developed which minimizes vested interests. Unfortunately, the present budgeting approach could result in more competition than collaboration among institutions and that will have to be overcome. Ensuring that all complementary cardiovascular health clinical services being implemented in the region will be included in the program is going to be a challenge. Finally, another challenge will be to make sure that the evaluative research projects already in place, or that will be implemented in cardiovascular health, will be synergistic without limiting researchers' creativity and interest and that indicators measure the impact of the program. Program visibility among partners is ensured, and we hope that regional legitimacy should be confirmed in the next few months.

Coordination

Host institution: Centre Hospitalier Universitaire de Sherbrooke and Sherbrooke Faculty of Medicine.

TUFH Field Project Coordinator: Paul Grand'Maison, MD, MSc., FCFPC, Vice Dean to the community and Secretary, Faculty of Medicine, Université de Sherbrooke, 3001, 12th Avenue North, Sherbrooke (Quebec) Canada J1H 5N4

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Other members of the development committee:

- Michel Nguyen, MD, FRCP, cardiology, medical coordinator
- Serge Trachy, assistant chief executive officer, Sherbrooke University Hospital

AMERICAS

UNITED STATES

The Rockford Healthy Community Project Rockford, Illinois

Description

The Rockford Healthy Community Project seeks to address 16 priorities identified in the 1999 Rockford Healthy Community Study, a comprehensive analysis of health and health services needs. The action approach has been to organize and field “Priority Project Teams” of community volunteers to find innovative collaborative approaches to address each of these identified needs which include: Access to Dental and Medical Care, Alcohol and Substance Abuse, Minority Health, Cardiovascular Diseases, Childhood Immunizations, Crime and Violence, Diabetes, Economic Development, Infectious diseases, Maternal and Infant Health, Mental Health, Respiratory Diseases, and Single Parenthood. About 400 persons are working on these teams to address these priority issues and to provide leadership.

Our vision is to improve the health of the region’s residents through multi-sector collaborative efforts including business, government, not-for-profit agencies and citizens to find and bring solutions to the community by linking resources and building and using local assets effectively to improve health. Using the TUFH model of engaging key stakeholders among policy makers, health managers and professionals, academic institutions, and other community groups and individuals, we seek to advance the four principal TUFH values, those of quality, equity, relevance, and cost-effectiveness.

Actions are linked to the determinants of health based on clinical, epidemiologic, social and behavioral information developed locally. We seek to minimize health disparities in the community, especially for individuals who lack good access to care.

Strengths

In terms of opportunities that exist, our project has formed an organizational model based upon a past history of community collaboration in performing shared needs assessments among several key health care and human services organizations including a locally based College of Medicine.

In terms of partnership, a favorable environment exists in which to continue to seek new opportunities for mutual action along several fronts, including innovative programming, public policy advocacy, and grantsmanship.

In terms of lessons for wider dissemination, our success in benchmarking the long-term improvement of the health of our community will prove the viability and desirability of collaborative action.

Challenges

An initial challenge is to achieve shared community ownership of the mission and vision of the project so that we can move ahead pro-actively to create change.

In order to sustain the collaborative over time, the project will need to demonstrate a definite “value added” component for key stakeholders, as well as for the broader community. We seek to benchmark where we stand currently and to measure progress through indicators by monitoring change as a result of our actions.

Coordination

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EASTERN MEDITERRANEAN

MOROCCO REGIONS/PROVINCES

Rabat, Sale

Dr Amina Balafrei, Rabat, Morocco

Description

In 1986, an outpatient clinic for diabetic children (age of diabetes onset under 15) was established at Rabat children's hospital. In 2000, this "virtual" clinic was accessible to almost all diabetic children in the Rabat-Sale area. A dedicated team with regular, but limited funding by private sponsors drove the success of the clinic's activities. Moreover, starting 1992, 10 regional centers were established, which replicated the model of the Rabat clinic.

This clinical success needs to be consolidated through the implementation of a sustainable and autonomous institution. Currently, the clinic operates within the university medical center. Consequently, human and physical resources allocated to the clinic can be withdrawn by the hospital administration at any time. Moreover, community participation is limited due to the internal hospital regulation and policy.

The ultimate goals of the Morocco TUFH project are to ensure sustainable quality health care for diabetic youth and equitable access for all to these services. The project aims to achieve these goals through building effective partnerships with the Ministry of Health, medical school, the community and the private sector.

Main expected outcomes:

- Training of the health professionals working in the provincial centers
- Implementing a resource center for all the diabetic children
- Integrating the local association into the center's activities
- Implementing an autonomous management of human and financial resources.

Relevance of TUFH, Local level, National level

- Satisfactory level of care for all diabetic children
- Reduced mortality and morbidity (number of readmissions decreased)
- Training of interns and health professionals from other provincial centers (number of requests and providers trained)
- Community supports and accommodates the project
- Population uses the services
- Quality of care in the provincial centers (glycated hemoglobin)
- An effective partnership model developed and implemented

Strengths

- Strong and committed team
- Almost universal coverage of diabetic youth in the Rabat-Sale area
- Existing standards of care
- Monthly subsidy from a sponsor
- Active community involvement
- Clinical team has capacity to train patients and their relatives.

Challenges

- Lack of interest among public sector decision-makers
- Some provincial health professionals are poorly motivated
- Prices of insulin and strips are too high
- Lack of universal health insurance coverage
- Need for a major advocacy plan

EUROPE

CZECH REPUBLIC

Integrated Community Care

Dr. Jana Zrejkova, for Postgraduate Medical Education, Prague

Description

In the framework of this project, Integrated Community Care is understood as an effective integration and coordination of primary health services, social services and public health services provided at the community level. The aim of the project is to improve the current situation in community care for chronically ill patients who are dependent on the help of others in two socially disadvantaged areas: Kladno and Slavkov. The target groups are defined as follows: chronically ill patients; elderly; handicapped people; and children with serious chronic illness. The emphases will be on availability, quality and cost-effectiveness of community services (as defined above). Special attention will be paid to the role of primary care providers and their links to secondary health care and to social care. The project is split into two parts: pilot and implementation. In a pilot phase, needs assessment of selected patients from the point of view of users themselves, their relatives and caregivers, physicians, home care nurses, social workers, other health professionals and local authorities will be implemented.

Expected outcomes of this phase:

- A complex description of a real situation in provision of community care in both selected areas;
- Identification of the weaknesses in coordination of existing services as well as identification of needed but missing services.

Questionnaire surveys and focus group interviews will be used for collecting needed information. Setting up the key points for effective intervention will follow this phase of the project. In the implementation phase, a new, innovative model of coordination of community services will be proposed and implemented. Changing of educational curricula for the key health personnel is necessary to be prepared to work more effectively in accordance with real needs of above-mentioned groups of patients. Evaluation of impact of project implementation will be performed through a measurement of users' satisfaction and their quality of life, job satisfaction of the key providers in the community, and related cost-effectiveness analysis.

Strengths

- The project as whole is in accordance with national health policy oriented to integration of existing health services with special attention to the role of primary

care. The project may be included in the Plan of Health and Prevention Development Programs of the Ministry of Health with financial support from government.

- There is developing partnership between policy-makers and project teams at the local level. Project is supported by the mayors of both participating towns.
- Participating physicians and other providers are highly motivated to collaborate.

Challenges

If the project is developing successfully, there is a chance to apply a new innovative approach and experience in a large national context, mainly through

- educational activities of all participating academic institutions
- activities of Association of General Practitioners (Vice President of this professional organization is a member of the project team)
- National Program of Quality Assurance which is being developed at Ministry of Health.

Coordination

The responsible institution: Institute of Postgraduate Medical Education in Prague. The Advisory Board of the project is now being created. There are three levels of project management:

- The steering project team, working in the frame of Institute of Postgraduate Medical Education. Meetings are organized on regular basis.
- Two local project teams (one in each area) led by the local coordinators. Coordinators are already nominated in the both areas (Slavkov, Kladno).
- “Performing” teams: In each area 10 community teams consisted of the health and social providers in the community. These teams are led by the participating general practitioners. There are five general practitioners for adults and five general practitioners for children in both selected areas.

EUROPE

Sicily, ITALY

“Towards Unity for Health” in Sicily

*Dr. Pina Frazzica,
Centre for Training and Research in Public Health
Caltanissetta, Italy*

Goal and Objectives of the TUFH project

The Sicilian TUFH project aims at reducing fragmentation in health delivery and health promoting systems by integrating individual and public health interventions from public and private institutions.

These are the main project's general objectives:

- to develop and test at least two applied models that aim at building multi-sectorial alliances for the development of coherent and cohesive health systems at district and at provincial level, using an approach which is based on equity, quality, relevance and cost-effectiveness principles;
- to train multi-professional groups on TUFH strategies;
- to promote a new proactive role for Schools of Public Health, closer to the institutions, to health personnel, to the individuals and to the population for a holistic and innovative approach for the promotion of health;
- to give ample publicity to the initiative at regional and national level in order to promote satellite projects in the country;
- to monitor and evaluate constantly the progress of the project implementation and diffuse the results.

Project description

The “TUFH in Sicily” project works on integrating fragmented systems through innovative modeling and uses a bottom-up approach. The territory where the project is being implemented is the province of Ragusa and its 12 communes and four health districts, with 300 000 people living over an area of 1700 Km².

More than one integration approach will be used in this project. One model works on building multi-sectorial alliances in progressing stages. It starts with the most natural stakeholders, that is, the preventive and the curative services—and proceeds towards other relevant but less “traditional” health related “actors”. The first alliance to be developed is the one between curative and preventive services.

Another model will unite all stakeholders into one large group focusing on a fairly

important issue of common interest. The initial task will be simple, easy to monitor and to evaluate. When the groups become mature, more complex tasks can be assigned to them. This approach is difficult and constant negotiations will be needed for it to work.

The Sicilian TUFH project is community-based, and particularly at the beginning, is task-oriented. Integration is achieved through operational platforms placed at community level that become “natural” bases for alliance negotiation and synergy development, whereby the population becomes direct mediator and promoter of greater social accountability and change through empowerment.

Three micro-projects have been developed with the main stakeholders in order to pilot the above approaches. The first micro-project aims at reducing the demand for inappropriate emergency care and hospitalizations, laboratory and x-ray services by general practitioners (GPs). The main stakeholders that participate to this project are public hospital-based clinical specialists and GPs working with the National Health System.

The second micro-project means to improve the health of humans and decrease the number of new cases of zoonotic diseases, particularly Brucellosis in humans and in animals. The main stakeholders are: hygienists, veterinarians, GPs, infectious diseases specialists, farmers and consumers.

The third project works on Health Impact Assessment (HIA) evaluating provincial and city determinations that may have an impact on the health of humans, of the environment, and of animals, and providing recommendations for the improvement or the exclusion of those determinations that are found to have a negative effect. The main stakeholders are: the population, decision makers, clinical specialists, environmental and occupational health experts, hygienists, GPs, economists, veterinarians.

The Sicilian TUFH project promotes the development of “five–star doctors and other health promotion personnel” so that they become more effective and efficient care providers, good decision-makers, effective communicators, strategic community leaders and sound managers. At the same time, it empowers the population and other stakeholders to be active participants in a rational process that focuses its efforts on equity, quality, relevance and cost-effectiveness for the promotion of a better health for all, and for a sustainable community development.

EUROPE

Maastricht, THE NETHERLANDS

“Hartslag Limburg”: Community-based prevention of cardiovascular disease integrated with a high-risk group approach in general practices and the hospital

Dr Eric C. Ruland, Maastricht, The Netherlands

Description

Initiated in June 1998, the Hartslag Limburg project aims to reduce cardiovascular disease in the Maastricht region. Specific attention is paid to low socioeconomic status (LSES) groups and individual high-risk patients (20% risk/10 yrs) in medical practices. To meet this challenge, the Regional Public Health Institute Maastricht, the Maastricht University, the University Hospital, the five municipal councils of the Maastricht region and others have joined forces. Collaboration is realized through nine local Health Committees and by means of a new intermediary function: the health advisor. Health advisors support general practitioners (GPs) and cardiologists: they guide high-risk patients in acquiring a healthier life-style and they promote the use of facilities realized by health committees, such as nutrition education tours in supermarkets. The nine local Health Committees each consist of a community development worker, a civil servant, a health educator and several representatives of local organizations. Four of these nine committees are located in LSES areas. Since June 1998, health committees have realized over 300 different activities that promote a healthy life-style. So far, 2500 high risk patients have enrolled in the high risk-research scheme.

Strengths

Strengths are:

1. a transparent organizational structure
2. program planning
3. commitment of stakeholders
4. structural efforts aimed at strengthening commitment and
5. scientific evaluation.

To illustrate:

1. The organizational structure of Hartslag Limburg combines participation of the community with the input of various professionals, without disturbing the different organizational scopes (domain consensus).
2. To manage collaboration a detailed operational scenario has been produced,

containing guiding principles, research protocols, tasks and competencies, specified goals for each partner, timetables and a strategic plan for long term sustainability.

3. Program development started early 1995, involving a mayor and an alderman, scientists and professionals. Since 1998 all partner-organizations are members of the Steering Committee. Collaboration is based on signed mutual agreements. One criterion for collaboration is partner investment in the project.
4. Commitment is strengthened by regular meetings, newsletters, presentations, etc.
5. Extensive scientific evaluation of the effects, processes and cost-effectiveness of the entire project is carried out by the Maastricht University and the University Hospital. Future research is prepared aimed at management strategies sustaining collaboration.

Challenges

The main challenges are:

1. how should we proceed in order to reduce inequalities and integrate preventive services, and
2. how can collaboration be sustained?

To illustrate:

1. GPs, civil servants and local companies should become even more involved, especially in LSES areas; low fat food products should be more easily available; health advisors' skills must be integrated into existing GPs' and cardiologists' practice routines.
2. Initial project funding by the Netherlands Heart Foundation must be replaced by structural municipal funding and health insurance companies' funding. Our ultimate goal is a new and lasting organizational structure in which the collaboration between the main Hartslag Limburg partners should reach a formal and permanent basis (a Regional Development Center for Towards Unity for Health).

Coordination

Regional Public Health Institute Maastricht; Erik Ruland, MD, project manager;

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EUROPE

Catalunya, SPAIN

Towards Unity for Health: Barceloneta's project, a population approach in a district of Barcelona

Dr. A. Oriol Bosch, Institute d'Estudis de Salut, Barcelona, Spain

Description

(Key issues/relevance to TUFH approach)

The Barceloneta's Primary Health Care Team (BPHCT) has developed a model to give the best care to the health needs of the population, based on the recovery of professionalism; the empowerment of citizens; the collaboration with other health professionals like community pharmacists; the use of quality improvement procedures of their own direct activities, and last, but not least, the implementation of a comprehensive health information system.

Strengths

(What lessons could be learnt? What opportunities/support already exist?)

The Catalan Health System is a good frame for the TUFH project since the primary health care acts as a gate keeper of the system. The existence of a motivated team of self-employed professionals, jointly with an open attitude from the other Barceloneta's health professionals like the community pharmacists, and the accountability to the served population, have been the main factors in obtaining the trust of the people and health authorities. The WHO's recognition has been an opportunity to increase the existing support and to facilitate and expand such an experience.

Challenges

(What to improve: local/national level to involve other stakeholders. To obtain support/visibility/legitimacy)

The main difficulties are related to the potential conflicts of interest among some stakeholders, particularly from the academic institutions and in the health administrations. To solve this type of problems it becomes necessary to persuade stakeholders about the benefits of an integrated action. On the other hand, the private provision of health care services at the primary level is at its beginnings, and the present criteria of funding are not yet adequate.

Coordination

The host institution is the Barceloneta's Primary Health Care Center. The project coordinator is Andreu Segura, MD. As a consequence of the TUFH award, a steering

committee with the participation of the Catalan Health Administration, health professionals representatives and community members will be constituted. Later on we will see if an academic representation will also be invited.

SOUTHEAST ASIA

INDONESIA

The Districts of Mergangsan, Danurejan, and Kraton; Yogyakarta City, The Special Province of Yogyakarta

Towards Health Development in the City of Yogyakarta: The Improvement of a Healthy Behavior and a Clean Environment Towards the Prevention of Dengue Hemorrhage Fever

Dr. Soenarto Sastrowijoto, Gadjah Mada University

Description

Dengue Hemorrhage Fever (DHF) has continuously been an epidemic that is very difficult to eradicate in Indonesia. This viral disease is considered very dangerous because it can cause mortality just within a few days after incubation due to shock. The clinical manifestations are continuous high fever for 2-7 days and hemorrhage throughout the body. The main vector for DHF is the *Aedes aegypti* mosquito, most commonly known as the garden mosquito. Their natural habitats are dark, humid, and dense environments. Also, these mosquitoes naturally lay their eggs in clear and clean pools of water formed by everyday objects such as used cans, bottles, and pots.

We have chosen the districts of Kraton, Mergangsan, and Danurejan as the target communities of this project. The high occurrence of DHF every year has proven the difficulty in the eradication of this disease in those areas. These three districts are known as the old city because of its old Javanese and colonial Dutch architecture. Buildings and houses are built very close together, which makes a perfect breeding ground for the *Aedes aegypti* mosquito. Thus, due to the very dense living conditions and unsanitary behavior, the inhabitants of the targeted areas are at very high risk to suffer from DHF. Many areas in these three districts are inhabited by large groups of people with low educational levels and low income, thus these areas we considered to be special attention areas. These special attention areas will be heavily monitored in the beginning and throughout the implementation of the project.

Strengths

The eagerness of the target population in each community to eradicate DHF never fades. That is the most important component in implementing this project successfully, besides:

1. a strong partnership and commitment between the projects stakeholders,
2. program objectives that involve the community members as key role players in eradicating DHF, and

3. the cost effective approach in the alteration and/or improvement of the community health behavior by seeking their opinion on the subject, rather than one way intervention from health authorities.

Finally, in recent developments, we have managed to seek the participation of a few local and international NGOs, which, it is hoped, will insure the continuity and sustainability of the project.

Challenges

Our main challenges in this project are:

1. immense difficulty in changing the lifelong habits and behavior of the target population to keep themselves and their environment clean
2. even though the local government has been very helpful, their complicated bureaucracy tends to delay some of the progress, and
3. how can collaboration between the stakeholders be sustained?

Other minor obstacles are experienced, but we feel that these are not a major burden. Most importantly, from this project we expect that the community will have increased knowledge and awareness of health issues, other than DHF, and also hope there will be a new and lasting organizational structure in which the collaboration between the main stakeholders should reach a formal and permanent basis.

Coordination

Department of Medical Education, Gadjah Mada Medical School

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Reflections on the TUFH Projects

By Jack Bryant

Reading through the project profiles provides insights into the interests, creativity and commitments of the participant institutions in the TUFH initiative. The key concepts and values that are inherent in TUFH, and that gave rise to its formulation, are expressed again and again. There are three perspectives that could be usefully pursued in reflecting on the projects:

1. One would be to consider the ways in which they have responded to the criteria put forth in the TUFH guidelines for project formulation;
2. A second would be to observe some of the problems that stand in the way of proceeding with establishing the TUFH projects;
3. A third perspective would be to consider how the projects, diverse as they are, can be seen to contribute collectively to the interests and concerns inherent in the TUFH initiative.

Let consider these three perspectives in that sequence.

1. Criteria

There are four main clusters of criteria set forth as challenges to those who would establish TUFH projects:

- A. Innovative patterns of services for integrating medicine and public health
- B. Implications for the health professions
- C. Partnerships
- D. Evidence of impact

We will consider them sequentially.

- A. Innovative patterns of services: Health services are to focus on defined populations who will have access to a range of carefully delineated individual and community health services. Information on health status, risks and interventions regarding the reference population is made available to principal stakeholders—health managers, professionals and consumers—to promote evidence-based decisions.

Responsiveness to this criterion

Sherbrooke, Canada

Initiated in 2000, the program focuses on the implementation of an integrated health service delivery system based on the needs of a defined population including complementary population-based and individual interventions that are supported by a comprehensive health information system.

Czech Republic

In the framework of this project, Integrated Community Care is understood as effective integration and coordination of primary health services, social services and public health services provided at the community level. The aim of the project is to improve the current situation of community care for chronically ill patients who are dependent on the help of others in two socially disadvantaged areas.

Rio de Janeiro, Brazil

In the context of its health sector reform, Brazil launched, in 1995, the Family Health Program (FHP) that aims to reorient primary health care and help to turn into reality the constitutional principles of universality, equity, integrality, hierarchy of health actions, administrative decentralization and social control.

- B. Implications for the health professions: With the advent of integrated patterns of health service delivery, changing roles of health professionals are expected. The project encourages educational institutions to adapt their education, research and health services delivery missions to meet the priority health concerns of the society, and through partnerships with other agencies to work towards the improvement of quality, equity, relevance and cost-effectiveness in health care.

Responsiveness to this criterion

Minas Gerais, Brazil

The family health program, which in truth, is a strategy, works with a proposal for change, introduces a promising new logic, and a new component—community health agents—people who live in the communities and act in the family health program, forming the connector link between the population and health teams.

Czech Republic

Changing educational curricula for key health personnel will prepare them to work more effectively in accordance with the real needs of chronically ill, elderly, and handicapped patients, and children with serious chronic illness.

Sherbrooke, Canada

Program characteristics include development of new professional roles and interdisciplinary teamwork, fostering multilevel partnerships and commitment to the measurement of the program's impact. Stakeholders have committed themselves to pursue the planning, implementation and evaluation phases of the Program using the TUFH values and principles.

Eldoret, Kenya

Success of the KPH-PIMIRA lies in the mutual working relationship between the Faculty and the Ministry of Health. The Ministry of Health established the Training Institution in order to produce high cadre professionals in the area of environmental health/public health, medicine and nursing.

Rio de Janeiro, Brazil

One of the main challenges is to surpass the resistance of the faculties to reorient their curricula in order to train health professionals with a different profile. Although the new curricular directions established by the Educational Ministry have already been elaborated in this direction; it is necessary to narrow the relationships between Health and Educational institutions, beginning at the political level.

- C. Partnerships – The project intends to involve five principal partners—health policy-makers, health managers, health professionals, academic institutions and the community (the TUFH Pentagon). The project is an opportunity for the different partners to contribute to attainment of the values of quality, equity, relevance and cost-effectiveness in health care.

Responsiveness to this criterion

Czech Republic

The project is in accordance with national health policy oriented to the integration of existing health services with special attention to the role of primary care. There is developing partnership between policy-makers and project teams at the local level.

Sherbrooke, Canada

All stakeholders have accepted TUFH as the development framework. The model includes a strategic level (general orientations, policies, formal agreements), a tactical or implementation level (development of specific tools, protocols, information systems) and an operational level (direct patient actions).

Lagos, Nigeria

The TUFH approach does offer an opportunity for a partnership between members of the community, policy makers, health workers, administrators and training institutions. It is expected that such a partnership will result in improved funding of health services, shared decision-making and increased relevance of health services; extension of services to underprivileged members of the community, adoption and use of cost-effective health interventions, and improved utilization of services.

Rabat, Morocco

The ultimate goals of the Morocco TUFH project are to ensure sustainable quality health care for diabetic youth and equitable access for all to these services. The project aims to achieve these goals through building effective partnerships with the MoH, medical school, the community and the private sector.

Lagos, Nigeria

The new democratic environment in the country will contribute to the reduction of resistance from policy makers and health workers as long as the project planning and implementation strategies carry everybody along at all stages.

Yogyakarta, Indonesia

The eagerness of the target population in each community in eradicating Dengue Hemorrhagic Fever never fades. Besides there is a strong partnership and commitment between the projects stakeholders, program objectives that involve the community members as key role players, and the cost effective approach in the alteration of the community health behavior by seeking their opinion on the subject, rather than one way intervention from health authorities.

- D. Evidence of impact – The project publishes and disseminates information regarding its contribution to create unity for health at local and national levels with the intention of influencing decision-making processes for the furtherance of the concepts and approaches imbedded in the TUFH project. Further, the project will provide evidence for contributions to improving the quality, equity, relevance and cost-effectiveness of health care for the reference population.

Responsiveness to this criterion

Sherbrooke, Canada

In order to sustain the collaboration over time, the project will need to demonstrate a definite “value added” component for key stakeholders as well as for the broader community. We seek to benchmark where we stand currently and to measure progress through indicators by monitoring change as a result of our actions.

Barcelona, Spain

The Barceloneta’s Primary Health Care Team (BPHCT) has developed a model to give the best care to the health needs of the population based on the recovery of professionalism; the empowerment of citizens; the collaboration with other health professionals (like community pharmacists); the use of quality improvement procedures of their own direct activities; and, last but not least, the implementation of a comprehensive health information system.

Minas Gerais, Brazil

Through the use of the updates and the comparison with existing data it will be possible to evaluate the effectiveness of the preventive measures and promotion of the health with the use of the quantitative pointers such as those of morbi-mortality and the qualitative study such as focal groups. The cities with the Family Health Program and the Rural Internship Program will be object of comparison with the cities with the Family Health Program without the Rural Internship Program.

2. Problems

A series of problems faced in establishing TUFH projects become apparent in reading the project profiles. Each of the projects faced difficulties, at times extreme obstacles, in planning and implementing programs. Here, it is useful to quote some of them.

Lagos, Nigeria

The major problems facing the delivery of health services in many communities in Nigeria are those of inadequate funding, poor managerial capacities and insufficient involvement of key stakeholders such as members of the community in the decision-making process. The often over-centralized decision-making process has inevitably led to a loss of relevance and poor cost-effectiveness of the health services.

Eldoret, Kenya

Lack of safe drinking water, personal hygiene and latrine facilities have led to high case fatality rates due to water-related and helminthic infections in the project area. The most eminent problem facing the project has been its innovative nature amidst the traditional project management, where tailor made approaches are applied with minimal participation of all stakeholders.

Barcelona, Spain

The main difficulties are related with the potential conflict of interests among some stakeholders, particularly from the academic institutions and in the health administrations. To solve this type of problems, it becomes necessary to persuade stakeholders about the benefits of an integrated action. On the other hand, the private provision of health care services at the primary level is at its beginnings, and the present criteria of funding are not yet adequate.

3. Collective contributions

Let us now consider how the projects, diverse as they are, can be seen to contribute collectively to the interests and concerns inherent in the TUFH initiative.

The question regarding collective contribution is made sharper by the diversity among the projects in terms of the stage of development of each country, and of each institution that is sponsoring the project, as well as of the resources available. We have to ask if there is sufficient commonality among them to set a stage for comparative assessments, for meaningful interpretations that would lead to a true sharing of ideas, insights and learning from doing. At this stage of project design and early implementation, the answer to that question appears to be quite positive. Time will tell us more. Let us look at some of the content areas that guide the project toward a commonality.

The principles and values of TUFH—quality, equity, relevance and cost-effectiveness—are fundamental features of each of the projects, and that contributes to similarities among the totality of the projects. In fact, the importance of these principles is not diminished by project diversity, but is enhanced by it.

The health information system (HIS) has a special place. Its importance was one of the reasons for the mini-symposium at Rockford. The indicators have a crucial place in developing strategies for the projects and for monitoring their implementation and impacts. It is this recognition of the importance of HIS and its use in the projects that provides the possibilities of achieving a convergence of purpose and process among the 12 projects, and others to come.

An evaluation framework

Beyond the larger purpose of the HIS in planning and monitoring the projects, we can also ask about the HIS serving as the glue for bringing together individual health interventions and community health interventions, such as those that focus on personal life style. Several of the projects include this notion in their plans.

Strengths and weaknesses of stakeholders

To what extent are they part of the problem, or part of the solution, or both? There are descriptions in the projects that specify the problem side—institutional stubbornness, centralized control and reluctance to release power, disciplinary walls, promotion of self-interest. What might be learned that could help to move them toward greater positive action? There are examples of working toward institutional leadership roles. There may be a place for careful and deliberate focus on institutional development.

Developed as contrasted with developing countries

Given the dual strategy of TUFH: on the one hand, to seek unity in concept and collaboration among the many stakeholders guided by the value base, and on the other hand, to assess and monitor effectiveness of strategies, implementation and outcomes, projects from both developed and developing countries are strong and insistent in their efforts. Differences in patterns of disease between developed and developing countries do not seem to be a major factor. While differences are there, and call for disease-specific responses, the overall approaches are more system- and process-oriented in both kinds of countries.

Deficiencies in health system development

These are pervasive in both developed and developing countries. Of course, the depth and breadth of the problems are much more extensive in the developing countries, but there are similarities in the nature of the reforms, the principles on which they are based, and the directions of change that are called for. The paradox that faces the developing countries is that while their problems have more devastating impacts on humanity, the capabilities and resources required to cope with them are chronically depleted. The projects provide multiple examples of these realities.

TUFH as a context for the exchange of ideas

This, of course, is the central theme underlying the TUFH initiative. Principles, framework, process. The pentagon of stakeholders/partners. The social contract of Phuket. Trust. How much can they learn from one another? How much can TUFH learn from all of them and feed back to them and onward to others that will follow? For the next round, will the criteria be the same? Or will there be new emphases? These questions typify the spirit of TUFH—openness, flexibility, constructive advances, continuous questioning—all in the interest of humanity. [Phuket Consensus: pages 83-84, *Toward Unity for Health: Challenges and opportunities for partners in health development. A working paper.* World Health Organization, Geneva 2000]

Health Information System

by Theo Lippeveld

Director, John Snow Inc./Morocco

“Towards Unity For Health” activities aim at the integration of individual health and public health interventions. The assumption is that such activities would contribute to the development of a coherent and cohesive health system, able to improve the health status of individuals in a population. Health status is classically known to be determined by at least four main groups of factors: (1) biological assets; (2) personal lifestyle; (3) the environment; and (4) the health care system. The potential impact of interventions within each of these groups can be debated, but several authors have stressed that the contribution of the health care system alone is only marginal compared to the potential impact of interventions on personal life style and on the environment. While health care interventions focus primarily on individuals, interventions on personal life style and on the environment are in essence community oriented. Clearly, individual health interventions and community health interventions are complementary and interdependent and need coherence to ensure maximum impact on the health status. The question is where to find the glue to stick them together.

Information and integration

Well conceived health information systems can definitely play a major role in facilitating the integration of individual health and public health interventions. In fact, poor use of information for evidence-based decision making is probably one of the main causes of the present lack of linkages between individual care and public health systems.

A well conceived health information system (HIS) generates the necessary information for rational decision making at each level of the health services system: the primary level, the secondary level and the tertiary level. Each of these levels has specific “management” functions, which can be grouped in three categories: (1) individual care management functions, directly related to the delivery of quality care to individuals consulting the health services system; (2) health unit management functions, related to the provision of health care to a defined population in the catchment area surrounding the health unit; and (3) health system management functions, which include, in addition to coordination and management support for delivery of health services, a set of public health functions for a particular reference population. Based on clearly defined management functions, the identification of information needed to make appropriate decisions at each management level is relatively easy.

The next question is how to obtain this information in the most effective and efficient way? Classically, two main sources of information exist: routine data systems, mainly health unit-based, and non-routine data systems, for example surveys. No single

data source can provide all of the information required for planning and management of health services. A national health information system in support of health services will always use a combination of data collection methods, depending on the nature and the use of the information for which data need to be collected. Since both individual health care and public health interventions are being carried out within the health services system, it seems obvious that the main information source for integration of both activities should be the routine health information systems (RHIS).

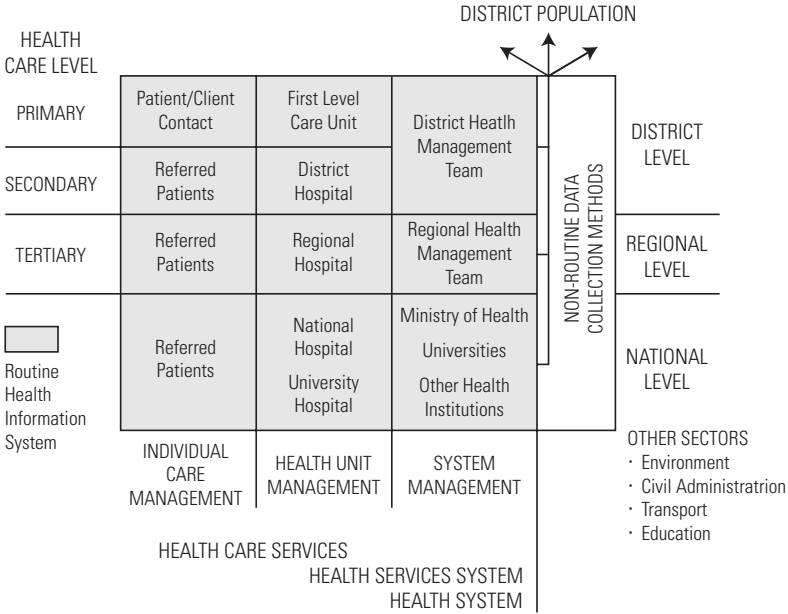
Yet, most experts agree that routine health information systems in most countries, industrialized as well as third world countries, are generating irrelevant and low quality information. Various reasons to explain this situation have been cited in the literature, but one is particularly detrimental to the TUFH approach: centralization of information management. RHIS in most countries are centrally planned and managed. Indicators, data collection instruments, and reporting forms usually have been designed by centrally located epidemiologists, statisticians and administrators (called “data-people”), with minimal involvement of lower level line managers and providers of the health services (called “action-people”). Data processing and analysis are mainly the responsibility of a centrally located office. Complex data transmission and compiling systems slow down the production of feedback, so that information is frequently obsolete for decision making, when it arrives at the lower levels. The result is that information use is found to be the weakest at the district and health unit levels, where the main individual and community health interventions are planned, implemented, and monitored.

The challenge of simple, efficient, and integrated data collection

In order to transform RHIS into management tools for integration of both individual health and public health functions, the key strategy is to decentralize the information system management responsibilities to the district level (see figure 1). Yet, the task of developing such district-managed routine information systems is both formidable and complex, particularly in the context of government bureaucracies in developing countries. Broad participation of future users in the system design is required, especially at critical steps such as the definition of information needs and of key indicators. The challenge is to combine simple, efficient, and integrated data collection with the production of high quality action-oriented information. District managers need training in the use of this information in order to implement both individual care and community interventions in a coherent manner.

Most of all, the district level is the ideal starting point for the development of community health and information systems. Community health systems stress local participation of communities in responding to the health needs of the population. Thus, within the district health system, the community adds another management level, with its own information needs. The community itself provides information for the management of most essential public health functions. Examples include reporting of births and deaths; notification of cases of infectious diseases and outbreaks; identification of

Figure 1. Relationship between the Routine Health Information system and the Health System



high-risk children, pregnant women, and families; coverage and defaulters of critical services; coverage and quality of water and sanitation; monitoring air, water, land, and noise pollution; coverage of disadvantaged populations with health and social services. Most examples of community-managed health information systems come from research settings, for example, Matlab (Bangladesh), Kasongo (Zaire), and Aga Khan University (Pakistan). Private voluntary or nongovernmental organizations in numerous developing countries, as well as in developed countries, have also adopted this approach.

Concrete steps

Although they are clearly ambitious and long-term efforts, district-managed and at least partially community-managed RHIS could provide the glue to bind together individual and community health interventions. Concrete steps are being undertaken to strengthen this role of routine health information systems:

1. Creation of the Routine Health Information Network (RHINO)

In March 2001, 80 HIS experts and managers from all over the world gathered for a three-day workshop on “Issues and Innovation in RHIS in Developing Countries”, held in Potomac, Delaware (USA). The workshop was supported by major donors, including

WHO, the World Bank, and USAID. The objective of the workshop was to exchange experiences on RHIS in developing countries and to propose state-of-the-art interventions to improve existing RHIS. Based on the outcomes of various work sessions during the workshop, the participants drafted a statement, clarifying the role of RHIS, and proposing an agenda for action. The Potomac Statement stresses the role of RHIS in forging the necessary link between individual and community health interventions. It also calls for coordinated investment and learning in routine health information systems.

For this purpose, a network was created to gather organizations and professionals concerned with improving the quality and sustainability of RHIS in developing countries. This Routine Health Information Network (RHINO) is managed through the MEASURE project, a USAID managed project on use of information for evidence-based decision making. RHINO has opened a web page which contains a bibliography on RHIS and a consultants database. Through a listserv, RHINO subscribers can participate in moderated discussions on RHIS related issues. RHINO plans, in the near future, to organize research and pilot projects to improve RHIS, as well as international meetings to disseminate lessons learned and best practices on RHIS.

2. Linking RHINO and TUFH

Based on the shared vision of both RHINO and TUFH concerning the role of information systems in creating a unified health system, it is hoped that advocates of both networks can collaborate in the future. The following actions are suggested to facilitate such collaboration:

- Invite health professionals involved in TUFH projects to subscribe to RHINO by sending an e-mail to The_Rhino@jsi.com and to consult the RHINO web site at www.cpc.unc.edu/projects/measure/rhino/rhino.html
- Present the TUFH approach at the next meeting of the RHINO International Steering Committee in Atlanta on October 24, 2001.
- Disseminate further information on TUFH via the RHINO listserv.
- Gather documentation on existing community-based HIS in various settings throughout the world and post it on the RHINO web site
- Start up RHINO/TUFH pilot projects to test comprehensive information systems in support of both individual and public health interventions.

3. Organize RHIS research projects

Further research and experiences are required to expand and scale up existing projects. First of all, a comprehensive review study should be set up to gather existing scientific evidence that decentralized routine HIS really contribute to more effective and efficient integration of individual and community health interventions.

Other important questions to be answered are:

- How can service providers and particularly communities, as key information users, be more actively involved in HIS development efforts?
- What structural interventions could better link routine service statistics with other data collection systems (surveys, vital events registration, rapid assessments methods, etc.)?
- What is the relationship between the format in which information is displayed (maps, action oriented graphs, etc.) and its use for decision making?
- How to develop large scale community managed health information systems?

For more information and discussion on TUFH and RHINO, please contact Theo Lippeveld at tlippeveld@jsi.com.

Objective Setting, Indicators And Outcome: Measurement For Good Management

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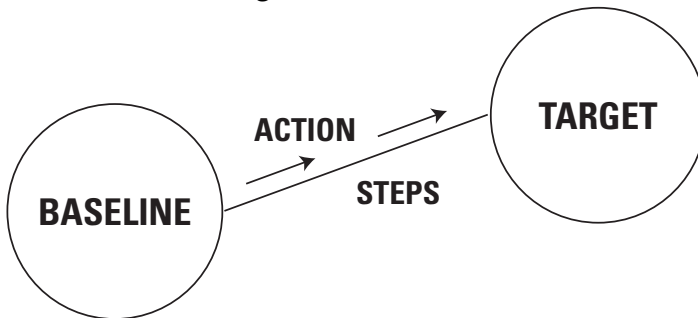
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Introduction

TUFH funded field projects may be viewed as proceeding through three major steps—planning, doing, and impacting. The most effective project will be guided by a strategic planning process, which is evidence based and applies an organizational structure whereby actions are linked clearly to objectives with evaluation in place to monitor impacts, while also allowing for fine tuning. Unfortunately, all too often, demonstration projects rely on inertia from past activities and accept whatever may accrue.

Figure 1 displays the role that the TUFH grant plays in acting as a catalyst for action by moving the current situation toward an improved target level through the funding of action steps that can bring about the required change. This paper discusses the steps required along the way to reach this target, and the best methods for achieving each step.

Figure 1. Role of the TUFH grant



Assessment

Assessment (sometimes called environmental assessment) is the process that determines what problems or needs exist in a target population or system. In planning a project, the organization has usually already carried out an assessment of needs, which provided problem identification and prioritization of needs. In some cases, the problem identification may have been derived from a broad needs assessment, which analyzed the characteristics of the population, their health status in terms of mortality and morbidity, and the characteristics of the health system and health behaviors of the population residing in the community, region or state under study. In some other situations, the

“problem” may have been identified within a population during the delivery of services so that the additional resources required or outreach targeting needed becomes known.

Assessment is vital to assuring that health organizations are doing what they should be doing. Without formal assessment, actions may be based on conjecture—assuming that needs are known without sufficient evidence. Assessment reduces the uncertainty that:

1. A problem is unknown or its severity is unrealized.
2. Prioritization has not taken place, so that the greatest resources are not going to the highest priorities, or the most important and relevant problems are not being tackled first.
3. The problem is being addressed, but the targeting of the population requires greater precision in order to reach the “right people.”

TUFH is substantially concerned about equity. So that health gains are available to everyone, assessments of the health system should be sure to focus on the desired health system characteristics including availability, accessibility, quality, continuity, and acceptability. Barriers to achieving these may involve such factors as cost effectiveness, language, distance and transportation, lack of knowledge, and cultural preferences.

Some individuals involved in community action believe that the assets of individuals and communities should also be considered during assessment. Focusing on assets builds local relationships for problem solving and identifies existing resources, while imposition of external solutions may create dependence without “buy-in” by those affected.

Using Indicators

Indicators are the information bits which measure where we are (baseline) or express where we are going (goal, objective). They are the way that progress is measured. Indicators quantify and simplify complex realities. When desired direction of change is specified along with the proposed date of accomplishment, indicators provide the target that actions are seeking to achieve.

Not every measure is appropriate to be used as an indicator. Most importantly, one must be sure that the measure is valid, that is, that it measures what is to be assessed. The measure also must be practical, available with relative ease, and at a reasonable cost. Of course, the item should be available over time for subpopulations and comparative populations in order to allow comparison. Lastly, the measure should be sensitive, able to distinguish the required movement from the baseline to the objective. Some measures change little over time, or exhibit a long latency period before significant change can be observed, so that they may not be effective indicators for tracking change over a short period.

Indicators typically relate either to the process involved, those action steps carried out, or to outcome, the improvement in the health status or health system sought. Examples are shown below in Figure 2.

Figure 2. Examples of Indicators

PROCESS (Action steps carried out by the project)	OUTCOME (Improvement in population health status or health system characteristics)
· Students enrolled	· Percent of villages with potable water (health system)
· Degrees granted	· Percent of persons who smoke (health behavior)
· Community Meetings	· Dental caries per person (health status)
· number held	
· persons attending	
· Curriculum developed	· Program Cost per unit (system cost-effectiveness)
· Supplies ordered, distributed	· Services to underserved (system equity)
	· Meet accreditation standard (system quality)

Choosing Goal and Objective Levels for Indicators

Once the baseline level for an indicator is known in the target population or community, goals and objectives are chosen. Both goals (five years or timeless) and shorter term objectives (1-5 years) need to be specified. Objectives may reflect the length of the grant.

Goals and objectives should not be chosen in an arbitrary manner, but rather by applying available norms. The comparative approach assumes that indicator levels achieved elsewhere can be reached. These could highlight other geographic areas (state or nation) or other medical systems such as HMOs or model programs. Guidelines from professional or governmental bodies might be adopted such as those in Healthy People 2010.¹ These levels are normative, having been developed by experts. Expressed values, on the other hand, are those which the target population says are required for their needs.

Another possibility is that the entity is already achieving satisfactory indicators overall, but that certain geographic subareas or population groups do not share in the positive levels. An example would be infant mortality among blacks in the United States, whose level could be potentially reduced to the white level for an objective. Differences in health status or service receipt may also exist among age groups, genders or other demographic groups.

No single “correct” answer exists for goal levels. However, goal choice should be rational for the locale and population. One should always be clear, though, what assumptions underlie acceptance of the goal. Otherwise, the meaning of the goal level may not be as clear as possible and revisions may be more difficult to make.

Objectives are short-term goals. They express the distance along the path to the goal that will be covered by the actions being implemented, and the potential impact of the interventions over the designated time period. Clues to the expected impact may come from previous experience, or those seen in other places with similar interventions.

Data Sources for Indicators

Data are required for those indicators used in goals or objectives. The sources may either be primary, collected by the researchers as part of the assessment, or secondary, existing in published sources or collected by others.

Primary methods of data collection include population surveys, group processes, and interviews. Surveys may take place face-to-face, by mail, phone or on-line. Group processes include focus groups which are small group discussions, usually with individuals sharing a certain demographic characteristic. Town meetings, on the other hand, are open to everyone and meant to attract diverse persons. Meetings assuring that everyone is heard are termed nominal group process. Key informant interviews involve knowledgeable individuals, often agency heads, community leaders or experts in a field. An iterative method with key informants is “delphi”, which digests each round of responses before generating new questions based on the responses from the panel.

Secondary data include census data, governmental series like vital statistics and measures of health status such as those which track mortality, morbidity, and health behaviors.

Using Appropriate Actions

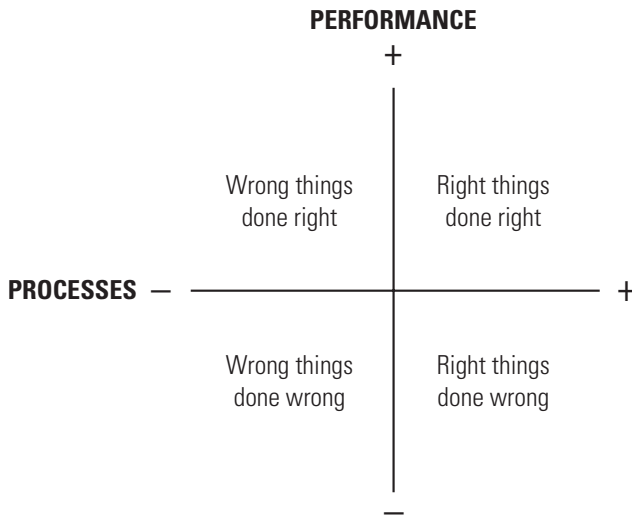
In terms of the actions set forth, those steps chosen should relate clearly to the causes of the problems or needs being addressed. In order to assure such concurrence, planning should include creation of a health problem analysis, sometimes referred to as a logic model in the human services, to help in choosing strategies or interventions. Completion of such a worksheet for a health problem involves first understanding the risk factors for the health status problem, then, clarification of contributing factors, both direct and indirect. As an example, one cardiovascular disease risk factor is hypertension. Hypertension is caused by, among other things, obesity, high cholesterol, and the failure to obtain medical attention. Poor eating habits contribute to obesity and high cholesterol; lack of exercise and stress to obesity. Heredity and lack of nutrition knowledge can result in high cholesterol. Various medical barriers including cost or language may result in a medical attention shortfall. Actions which affect the specified causes can reasonably be expected to improve the health problem. However, clear evidence should be available of the link between the contributing factor where intervention is taking place and the health problem or its risk factors.

Evaluation

Evaluation involves the monitoring of indicators, usually at intervals such as quarterly or semiannually, to assure the WHO and TUFH that the project is meeting the expectations as set out in the grant proposal. Certainly, measuring indicators at the time points specified in objectives is critical. All too often, the press of business to implement actions keeps investigators from checking on where they stand in terms of process or outcome indicators. Attention to evaluation is absolutely critical. Even the best of projects cannot “tell its story” without evaluation which verifies its successes. For those not achieving at the expected level, evaluation acts as feedback for modifying the actions and makes sure that performance is effective.

Figure 3 from Leebov and Ersoz illustrates the variety of findings that evaluation may yield.

Figure 3: A dichotomy of processes and performance for public health departments



Source: *Adapted from The Health Care Manager's Guide to Continuous Quality Improvement*, by Wendy Leebov, EdD, and Clara Jean Ersoz, MD, published by American Hospital Publishing, Inc., copyright 1991.

Summary

In summary, TUFH grant recipients would do best by being sure that they are able to answer the questions below as the project proceeds.

- Have you adopted process and outcome indicators that are QUANTIFIED and TIME-SPECIFIED?
- Do you have BASELINE measures based on an assessment prior to the start of your actions?
- Do you have a method by which to check whether your PROCESS OBJECTIVES are carried out on time?
- Do you have a method by which to check OUTCOME OBJECTIVES at the specified reference points to evaluate your impact?

If the response is affirmative for each of these, chances are that they will be successful in evaluating their project and in improving the health of the population being addressed.

The WIZ-model for inter-organizational collaboration

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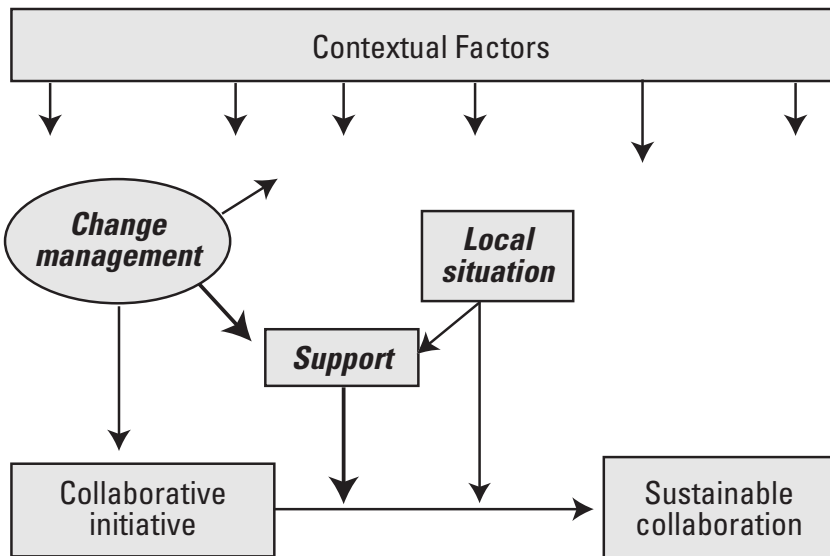
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Since 1998, the Hartslag Limburg project realizes a collaboration between 12 regional partners in the Maastricht region. Their common aim is to reduce cardiovascular disease, both at the level of the general population, as well as at the level of individual high-risk patients.

The second purpose of the project is to establish sustainable collaboration between all partners involved. To meet this target a research project has been developed, aimed at factors that facilitate or restrain inter-organizational collaboration. The study is based on the WIZ-model, a theoretical model developed by the department of Health, Organization, Policy & Economics (HOPE) of the Maastricht University.

The WIZ-model distinguishes four clusters of factors that influence sustainable collaboration (figure 1). Table 2 shows on what individual factors and assumptions the clusters of factors are based in the case of the Hartslag Limburg project. In general, the clusters of contextual factors and local situation are difficult to change. This is why emphasis is laid on change management as a specific type of management aimed to increase support for collaboration between organizations at the regional level.

Figure 1: The WIZ-model for inter-organizational collaboration.



(WIZ Model, Dpt. of HOPE, UM)

Table 2: Factors and assumptions of the theoretical model for inter-organizational collaboration (from: *Working group Integrated Care (WIZ), Maastricht University, Dpt. of HOPE*)

Cluster	Factors	Assumptions
1. Support (factors influencing support)	Collaboration: a) Objectives b) Judgment c) Importance	In order to ensure support individual participants should agree on the objective to be achieved by collaboration (they should share a view on mutual dependency for reaching the common goal). More-over, the objective should fit in with their own goals and interests (judgment), and collaboration should be considered important for their own organization.
	d) Win-win situation (mutually beneficial)	In order to ensure support among partners, individual participants should see more advantages than disadvantages in joining forces.
2. Support (factors expressing support)	Agreement: e) Domain consensus f) Ideological consensus	An essential condition for a strong commitment is that partners agree on tasks, responsibilities, procedures and organizational scopes (domain consensus) and have matching cultures, sharing ideas on collaboration, the importance of prevention, public health, meeting local needs (ideological consensus).
	a) Mutual relations	The type of relationship can either be competitive or collaborative. A competitive relationship indicates a lower level of mutual trust, which results in a lower level of commitment to collaboration.
	b) Commitment	Partners show their commitment by signing an agreement and transferring resources.
	c) Adaptation	If collaboration results in innovative adjustments within participating organizations, in adjustments aimed at improving collaboration, this indicates support for sustained collaboration.
3. Local situation	a) Existing relationships	Partners (organizations and individuals) who have already established a satisfactory collaborative relationship, have largely completed the process of introduction and trust-building. This is an advantage when new initiatives need to be developed.
	b) Organizational characteristics	Motivation for collaboration is low when organizations are distracted by developments that are of greater importance, such as government policies, budget deficits, take-overs, et cetera.
4. Change management	a) Vision: design and objectives	In order to meet judgment and importance in relation to individual goals of politicians and professionals the project design (proposed interventions) should be convincing compared to alternatives (e.g. evidence-based, practice-based, target population based and patient-based). Project design should fit with existing policies and interests to create win-win situations. In order to evaluate progress, objectives should be formulated according to SMART principles: specified, measurable, acceptable, realistic and time-bound.

	b) Social entrepreneurship	In order to create a <i>window of opportunity</i> a social entrepreneur must mix the three streams of peoples and ideas that affect political agendas: problems, proposals and decisions. The entrepreneur identifies who are the visible and invisible participants in this process and pushes favorable alternatives.
	c) Influencing strategies: - Power strategies - Positive feedback - Image building	Support for collaboration can be enhanced by use of influencing strategies: power strategies, positive feedback and image building. Power strategies include the identification of (in)visible actors and their interests, coalition building and the use of money or other attractors. Communication of progress and success (positive feedback) should be combined with image building through mass media, focusing on positive emotions of a shared identity.
	d) Networking and linkage	In order to manage change, up-to-date and informal information from different levels within organizations is crucial. Networking is an important medium to obtain this information. Barriers between organizations can be bridged by individuals who operate as a linchpin.
5. Contextual factors	a) Government policies and regulations	Government policies, laws and regulations should be clear. The more explicit local health policies support sustainable long-term collaboration between stakeholders, the better it is. Lack of resources, financial partitioning, and the promotion of free-market principles (increasing competitive attitudes) are disadvantageous.
	b) Attitude of funding agencies	The attitude of funding agencies should be supportive and stimulating towards the collaborative effort. Hence, funding should be guaranteed for a period that is long enough to prevent employees from leaving.

Looking Ahead

by Charles Boelen

The application of the principles of the TUFH approach can be initiated by any health actor. The creation of a common vision and commitment among different stakeholders to promote awareness that sustainable achievement can only be obtained through partnership with others, with priority on serving the public good, requires a clear understanding of forces and limitations of one another, a conviction in the strength of a collective project, and a strategy to get the momentum started.

A project as complex as a TUFH project can start with the motivation of just one person. The persuasion of a few colleagues in a given institution or group in the value of “unity” then follows. And a larger mobilization outside the inner circle involving other stakeholders will progressively take place. However, the initial momentum can only be maintained and amplified if supported by evidence of results.

The evidence that TUFH field projects can contribute to better coordination in various health interventions towards a reference population, to improved awareness and action from stakeholders to become more socially accountable, and to durable partnerships will be the best advocate for dissemination of the approach. Its usefulness should also be demonstrated in the context of any disease control or risk prevention program.

TUFH field projects can best share their achievements and failures by adopting a common evaluation framework. The accumulated wisdom and knowledge will be an additional booster for the reorientation of health systems for better meeting people’s priority health needs and expectations. It is expected that consolidated reports will periodically be published to communicate progress made in the implementation of TUFH in the field.

Those interested in knowing more about the TUFH approach, its concepts and applications, are invited to contact The Network: Towards Unity for Health.
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