PREPARING PUBLIC HEALTH AND LEGAL PROFESSIONALS TO ASSUME A LEADERSHIP ROLE IN SOCIAL MANAGEMENT, HEALTH LAW AND PUBLIC HEALTH ADVOCACY

Fostering the development of a programs in public administration, health law and public health advocacy requires a critical mass of public health and law professionals with preparation in administrative, legislative and judicial matters related to health law in Brazil and knowledge, an ability to work collaboratively with the local community, and competency in the use of public health advocacy strategies. Once adequately prepared these professionals can work with faculty to provide technical assistance to governmental, non-governmental and community agencies. The programs described below, that is the Social Management, Health Law Program and the Public Health Advocacy Program are designed to prepare such leaders. They complementary in nature, yet have distinctly different objectives and program elements.

ACADEMIC PROGRAMS, APPLIED AND POLICY RELATED RESEARCH, COLLABORATIVE RELATIONSHIPS AND DISSEMINATION

SOCIAL MANAGEMENT STUDIES PROGRAM

Fernando Tenorio
Escola Brasileira de Administraçao Publica
Fundaçao Getulio Vargas

The Social Management Studies Program originated from a recognition of the need for new forms of management to accompany the process of democratization of public administration; shifting the focus to a participatory process based on a collaborative approach to program development and management. The Program attempts to contribute to the development of instruments to be utilized by social movements to improve their administrative capacity, and at the same time to increase the knowledge and understanding of academics and public policymakers.

The principal objective of the academic program is to relate theory and practice. It is based on an analysis of concrete experiences and with effective and "active" participation of diverse groups, thus reducing barriers created by "accepted" scientific thinking. The academic program for this specialization in public administration includes course work in the following areas:

- Social administration and management;
- Administration at the community level;
- Administration and political science;
- Social transfer of the technology (of social administration).

Since its inception, more than ninety students, at the masters and post graduate level and others matriculated in the public administration specialization course, have participated in the program. The participants have been professionals from diverse areas of administration and different regions of Brazil, as well as from other countries in Latin America.

In addition to the formal courses, students work with faculty to provide technical assistance to scial movements (community based groups), assist in the preparation of material related to social administration for use by social movements, and in conducting applied studies.

Use of a Participatory Process to Develop Planning Instruments for Use by Communities

With the objective of providing simplified planning instruments that can be used effectively by community based organizations, the Program faculty developed a participatory methodology designed to facilitate an exchange of knowledge between technical professionals and community based organizations. Basic texts have been published using a three part process:

- Preparation of conceptual material on program planning in technical language, using appropriate bibliographical references;
- Critical analysis of the texts by representatives of community based organizations and non- govvernmental organizations for whom the material is necessary but for whom the technical language is innapropriate; and
- Preparation of final texts for use at the community level, using such criteria as maximum number of pages under 100, and illustrations to facilitate reading in an effort to make the presentation dynamic.

Using this methodology, one text has been published, two are in press and two are currently being prepared. The following description of a text on program

development illustrates how th methodology is applied and the usefulness of its content.

"Elaboracao de Projetos communitarios: Uma Abordagem Pratica" (Tenorio, Bertho da Silva, and Carvalho, 1991) was written in simple and direct language and designed to de- mystify technical concepts. It is divided in several sections in a practical format which describeds program development from a basice yet conceptual perspective, examines all of the basic steps in the process; provides fictitious examples of community based projects that demonstrate each step in the process; provides a glossary with a definition of more than 20 terms and expressions used in the text: and includes a bibliography focussing on topics related to community participation and development.

Since the publication of the first text, two additional works "*Administracao de Projetos Communitarios: Uma Abordagem Pratica*" and "*Avaliacao de Projetos Communitarios*" are in presss. Two new texts are under development and will focus on "Gestao Social" and "Gestao de Organizacoes Nao Governamentais."

HEALTH LAW PROGRAM

Sueli Gandolfi Dallari
Centro de Estudos e Pesquisas de Direito Sanitário
Universidade de Sao Paulo

The Health Law Program was established by CEPEDISA in I988. The training of Public Health Law specialists is a necessity in modern public administration as well as in private/voluntary organizations. All of those who must make decisions in the public health area are confronted with the need to understand legal factors influencing policy development and implementation, the legality of the measures and the attribution of responsibilities.

The objective of the course is to train such professionals in the domestic and international aspects of the laws affecting existing doctrines, legislation and jurisprudence related to health. The program for the course is the result of intense discussions between national and foreign academic and law professionals who have been meeting at the International Health Law Seminars sponsored by CEPEDISA over a period of several years. The course objectives are designed to provide participants with the ability to:

- Understand the theories that explain Health Law.
- Understand the relation between health law and health related to facts and social values.
- Know the international norms that regulate health protection.
- Analyze actions relating to international control of illnesses.
- Know the structure of the health planning system and norms that regulated health protection.
- Analyze actions relating to international control of illnesses.
- Understand the structure of the health planning system.
- Evaluate the health priorities that determine program development.
- Understand the legal organization of the health administration.
- Analyze the issues related to ethical, civil and penal responsibilities of health professionals and health services.
- Analyze the norms that have as objective to protect the health in the specific fields of labor.
- Understand the legal and health implications involved in treating mental health patients.
- Know the norms relating health protection in the fields of environmental law and consumer law.
- Understand the legal implications of the system of epidemiological surveillance for health protection.

Since this is a highly specialized course that requires close teacher/student interaction, the number of openings is limited. In the three years in which the course has been offered, 44 professionals have completed the course. They have been from all of the Brazilian states and other countries in Latin America. There has been a 50/50 balance between professionals in the area of health and law who have enrolled (Gandolfi Dallari, 1993).

Every two years, CEPEDISA also sponsors a series of International Health Law Seminars. Nearly 300 public health and legal experts from Sao Paulo and other states

in Brazil have participated in these seminars. The main themes of these seminars have been:

Seminar 1	"Principles of Health Law"
Seminar 2	"Responsibility for Health"
Seminar 3	"Responsibility for Diseases Caused by the Environment: The Problem of Intra and International Borders."

CEPEDISA provides a number of specialized courses at the request of officials of municipalities regarding the provisions of the Brazilian Constitution, health law and regulations, and local applications. Other specialized courses were developed at the request of the Order of Magistrates of Sao Paulo.

Policy Related Research and Dissemination

In an effort to stimulate broader understanding of health law and health policy development in Brazil, CEPEDISA has engaged in several research projects. First, a data base of health legislation of twenty Brazilian states was developed with funding from the Pan American Health Organization. This work resulted in the publication of a recent book published in Sao Paulo on the "Right to Health" and the Brazilian States (Gandolfi Dallari, 1994)

The program has convened meetings and workshops with experts in law and public health in order to examine questions related provisions of the Brazilian Constitution and health policy. For example, The Workshop on the Constitutional Concept of Public Relevance, co- sponsored by the Pan American Health Organization and CEPEDISA, in Sao Paulo, Brazil, in October 1991. Twenty five lawyers, judges, public health specialists, physicians and faculty from the Faculties of Law and Public Health, USP participated.

In a series of technical reports sponsored by the Pan American Health Organization entitled "Health Law" several themes and issues were analyzed: *"O Conceito Constitucional the Relevancia Publica," "Saude e Revisao Constitucional: Controle Social e Formas organizacionais da SUS"* and *"O Direito Sanitario an Constituicao Brasileira de 1988: Normatividade, Garantias e Seguridade Social."*

PUBLIC HEALTH ADVOCACY PROGRAM

Rosemary Barber-Madden
Center for Population and Family Health
Columbia University School of Public Health

Sueli Gandolfi Dallari
Centro de Estudos e Pesquisas de Direito Sanitário
Universidade de Sao Paulo

The Public Health Advocacy Program was launched in Sao Paulo, Brazil in 1987 by CEPEDISA at the Faculty of Public Health/USP in collaboration with the International Public Health Internship Program at CPFH/Columbia. This effort was made possible by a collaborative agreement between the two institutions which provides a mechanism for faculty/student exchange and for joint teaching and research in the area of public health advocacy.

The purpose of the Public Health Advocacy Program is to promote the "right to health" and develop strategies through which this right could be realized. The overall goal of the program is to develop a theoretical and practical model for public health advocacy in Brazil in promoting changes in the health system and assuring participation of the community in the health planning process. The passage of the Brazilian Constitution in 1988 was the major enabling force in establishing this Program and in the development of its mission and structure as it exists today.

The Public Health Advocacy Program is guided by five basic concepts:

- Health as a Right - Guaranteed by the Brazilian Constitution.
- Principles, Assumptions and Basic Processes of Advocacy.
- Advocacy Strategies - Administrative, Legislative, Judicial, Media, and Community.
- Use of Quantitative and Qualitative Research Methods to Identify Problems/Barriers and Evaluate the Impact of Advocacy Strategies.
- Understanding the Role of Community, Professional, and Non-governmental Organizations and Governmental Agencies in Advocacy.

A 330 hour public health advocacy curriculum, consisting of formal classes and field work, was developed by USP and Columbia faculty in 1991 and was approved for the MPH and specialization in public health programs of the Faculty of Public Health

at USP. Fifty seven graduate and post graduate level students have completed the course. All students who participated in this course served a short term internship in public health advocacy. They are professionals of diverse disciplines, including law, pharmacy, occupational therapy, nursing, medicine, international affairs, epidemiology, engineering (sanitary), veterinary medicine, and biology. The students must be enrolled in the masters, doctoral or public health specialization course at USP or Columbia to be eligible to participate in the program. Most of the USP students have been employed in mid- and upper level management or policy positions in public health departments in municipalities in Brazil. Columbia students are usually professionals who have held mid level management positions in the US or abroad. Students are invited to informational meetings in which the course and fieldwork requirements are discussed. Each student is interviewed individually to determine the extent to which the student's career goals and interests are in concert with program goals. In general 50-70% of the students who express an interest are selected (Gandolfi Dallari and Barber-Madden, 1993).

Applied Research in Public Health Advocacy

The research projects undertaken by the Public Health Advocacy Program have two objectives: to develop baseline information and document the experience, opinions and perceptions of community and non-governmental organizations and governmental agencies about health needs, participation in advocacy, and constitutional guarantee of "health as a right"; and to provide technical assistance when requested to community and professional organizations and other governmental and non-governmental groups in developing and evaluating advocacy projects.

From the outset, it was determined that it was equally as important to understand the advocacy experience in both poor and middle class communities. The community of Vila Romana, a middle class community, was selected in response to a request for technical assistance from the Secretariat of Health of the Municipality of Sao Paulo in 1989. This request was to assist in a community health needs assessment to determine health needs based on perceptions of community residents. A second request for technical assistance was from a community based organization in Vila Brasilandia, a poor community. Their objective was to ascertain reasons why community residents did not participate in community health advocacy. Building upon the experience of these two projects, we have continued work in these two communities.

The following project description of the Vila Romana Project illustrates how both quantitative and qualitative research methods have been used and the results obtained:

"Improving Access to and Quality of Health Series Based on Health Needs, Opinions and Perceptions of Residents, and Health Professionals in Vila Romana."

At the request of the Sao Paulo Municipal Health Department, a study was undertaken to analyze health needs of this community of 0,000, examine new health policy mandates, ascertain the opinions and perceptions of residents and health professionals, and develop a plan to meet the needs of the Vila Romana population.

A mix of quantitative and qualitative methods was used in the needs assessment process. This included a survey of 117 randomly selected residents of Vila Romana, analysis of demographic and epidemiologic data and focus group interviews with the staff of the local Health Post. Results of the survey showed that the residents were older than expected and respondent comments to interviewers indicated a perception by the community that the Health Post offers primarily pediatric services. Thirty nine percent of respondents surveyed were unfamiliar with the health post, 11% used the Health Post in the past, but did not consider themselves current consumers of such services. The 13% who reported current use of the health post were families with young children. The most frequently indicated need to non-users was for cardiology services.

Opinions and perceptions of Health Post staff were ascertained through focus group interviews with two groups of staff, that is, those with professional university training and those without. Results showed that both groups believed that the majority of the user population is poor, does not live n Vila Romana, but rather on the periphery of the city and in other municipalities. Participants believed that non-residents primarily seek Maternal and Child Health services and do not return for necessary follow- up visits nor do they follow treatment regimens. They indicated that Vila Romana residents who use the Health Post are workers in local factories or retired persons. These groups need cardiology and gerontological services. It was also reported that there was a shortage of medications to be dispensed by physicians at the Health Post.

The methodologies used were found to be complementary in nature and reinforce the results of both methods. Recommendations made to the Municipal Health Department included introduction of evening hours for pediatric services, expansion of cardiology and gerontological services, re-allocation of space and equipment so that all programs can function equally efficiently, and development of an on-going evaluation plan to assess the extent to which community needs are being addressed and a mechanics for on-going consultation with community residents.

Several improvements were made based on the findings of the survey and focus groups. These include re-distribution of space in the Health Post and more efficiency in medical service delivery, making medications more available to clients of the Health

Post, establishment of an appointment system for clinical services, improvement of the administration and supervision system (Nakao, Westphal and Barber-Madden, 1991)

Case Studies

Case study methods and situation analysis have been used to document the experience of community, professional and non-governmental organizations in advocacy.

The Experience of Community and Professional Organizations and Worker Unions in Advocating for Health Rights

A survey was undertaken to develop a profile and examine the experience of a sample of twelve community and professional organizations and unions engaged in some aspect of public health advocacy in Sao Paulo. Information regarding constituents, memberships, history, funding, advocacy objectives and strategies used and results obtained was collected. The organizations surveyed reported involvement in major efforts to improve access to health care, to provide specialized courses in women's health including family planning, to improve housing and living conditions and/ or school conditions, or to secure recognition of rights.

The organizations surveyed in this study were primarily engaged in administrative advocacy, using petitions and public assemblies of local residents. all used print media, mainly newsletters, while a few used television and radio to reach constituents and to inform the public about their advocacy concerns. Results of their advocacy varied from introducing proposals to governmental agencies, to securing resources from the government for new hospitals and health posts in one region of the city. Several of these organizations indicated that they had received technical support from several sources including lawyers, journalists, social workers, the Catholic Church and academic institutions. Many indicated a need for assistance in preparing proposals, understanding legal issues related to the particular focus of their work, or in collecting data related top problems in their communities. This information helped form the baseline to be used in developing a technical assistance program in public health advocacy (Pedalini, Gandolfi Dallari and Barber-Madden, 1993). "Public Health Teams and Community Participation: How Do Health Teams Relate?"

The objective of this project was to analyze and disseminate the principles and concepts of Health Advocacy as they relate to health professionals and public participation in the reform of the Unified Health System (Sistema Unico da Saude).

An analysis of the experience of residents of a favela in advocating for improvements in water supply and sanitation in the city of Sao Paulo and the inter-relationships between the residents and health professionals in the region was completed. It was concluded that the experience of the local health team at the BASIC Health Unit (UBS) in this community was likely similar to that of other health teams at UBS in similar communities in regard to the process of problem identification on the part of the community, the level of popular organization, the relationships of the health team with the local population and its representatives (Macruz Feuerweker, 1994).

A Situation Analysis in Social Policy and Health Advocacy

This project examined the evolution of social policy, in particular health policy, in three parts: the development of the concept of advocacy within the context of the health care reform which resulted in the Unified Health System (SUS); the second analysis used a situation analysis (a strategic planning method), and the third part which is an analysis of concrete applications in the health advocacy process.

The analysis shows that there have been significant changes that have occurred in Brazilian social policy particularly in the legal-political sphere resulting from changes enabled by the Brazilian Constitution (1988) and resultant changes in the law, state constitutions and municipal health law. These changes have facilitated, from a legal perspective, the decentralization of the health system influencing universalization and equity in health care (Lisboa, 1994).

Collaboration with Community and Non-Governmental Organizations and Dissemination of Project Results

Through the program's efforts to promote the concept of public health advocacy and "health as a right", collaborative linkages have been developed and strengthened. Applied research projects were carried out with the Sao Paulo Municipal Department of Health, the Pastorate for Health Promoter Training, East Zone Health Movement, Pastorate for Marginalized Women, and the Human Rights Commission of the Brazilian Bar Association.

Another objective was to create an environment in which professionals in diverse fields could discuss, debate and analyze these concepts and begin to operationalize them. To this end, international seminars and workshops provided such a forum for nearly 100 senior public health and legal specialists who hold high level positions in governmental, non-governmental, academic and international institutions and agencies, not only in Brazil but also in New York and Washington. While it is not

possible to conclude that the overall impact of these activities has served to change the health care system in Brazil, the program has served as a catalyst for broad examination of these concepts, principles and strategies; for dissemination of information to policy-shapers and decision-makers; and to form the basis for a new program that will create a direct link with the public.

Efforts to expand collaborative linkages through the Public Health Advocacy Program also include collaboration with the Pan American Health Organization which co-sponsored two seminars in Washington and New York. Each of these events was designed to inform and upgrade the knowledge of professionals in public health and law. Each seminar examined specific aspects of health law, the Brazilian Constitution, the right to health, and advocacy strategies. More than 70 public health and legal specialists participated in the seminars and the workshop as outlined below:

Two international seminars both in the US, and one in Sao Paulo, and one workshop in Sao Paulo were sponsored by the Columbia University's School of Public Health and the Institute for Latin American and Caribbean Study, CEPEDISA, Pan American Health Organization and the Brazilian Consulate of New York. Each of these events was designed to examine different aspects of advocacy, the right to health and health law. Professionals representing UNICEF, United Nations Fund for Population Activities, United Nations Development Fund, public health agencies in New York, Columbia University's Institute for Human Rights and Schools of Public Health and Law participated.

The seminar entitled "The Right to Health and The 1988 Brazilian Constitution" was sponsored by the Pan American Health Organization, in Washington, DC in January 199. Fifteen staff members, including public health and legal specialists, from the Pan American Health Organization participated.

"The Brazilian Constitution, Health Law and Public Health Advocacy" co-sponsored by the Institute for Latin American and Iberian Studies and the Center for Population and Family Health, School of Public Health, Columbia University, Pan American Health Organization, and Brazilian Consulate/New York, New York, January 199. More than 60 public health and legal professionals from New York City and State agencies, academic institutions, PAHO, UNICEF and UNFPA participated.

Several years ago, public health advocacy was in its embryonic stage in Brazil. This was largely due to the paucity of literature, reports and dialogue about the concept and its application with the "reinstitutionalization of citizen rights" based on the 1988 Constitution. Support from external funding sources has enabled the Public Health Advocacy Program conduct research, carry out technical assistance projects and prepare papers and technical reports for publication. A number of works were presented at Brazilian national meetings and international conferences. In addition to contributing to the body of knowledge about public health advocacy in Brazil, these

papers represent a serious attempt to analyze health policy related to the "right to health" and other constitutional provisions, to document the experience of diverse groups in Brazilian society who are engaged in advocacy and the factors that will potentially improve their efficacy, and to identify mechanisms through which new strategies and approaches can be studied.

COMMUNITY PARTICIPATION

Models of Community Participation: Columbia University's International Experience

Martin Gorosh*
Center for Population and Family Health
Columbia University School of Public Health

For more than twenty years, the international programs of the Center for Population and Family Health (CPFH) of Columbia University's School of Public Health have collaborated with programs in all regions of the world to strengthen institutional capacities to plan, manage, and evaluate health and family planning programs. Our goal has been to improve the quality of life of families through increased access to, and use of, primary health care and family planning services. One of our principal approaches has been to collaborate with institutions to strengthen their capacities to develop innovative community-based service delivery systems to meet the needs of unserved and undeserved urban and rural communities.

The material presented in this paper is drawn from experience in collaborative projects in Brazil and in several countries in Africa. In Brazil, we collaborated with BEMFAM during the decade of the 1970's in the development of community-based family planning programs in the northeast. In Africa, we draw on our experience in strengthening institutional capacities in the Sudan, Nigeria, Senegal, Kenya, Ghana, Niger, and Swaziland. Briefly, in the Sudan we worked with a new medical school to develop a short term training program to improve rural hospital management. In Nigeria, we assisted a University department and the State Government to develop and test new primary health care and family planning service delivery approaches. In Senegal, we worked with a management training institution to develop a new training program in primary health care and family planning for french-speaking Africa. In Kenya, we worked with a regional training institution to expand their capacity beyond family life education into training in contraceptive technology and family planning program management. In Ghana, we collaborated with the Midwives association to strengthen the private practice of family planning. In Niger, we worked with the

*Summary of written presentation

Ministry of Health to develop MCH/FP services. In Swaziland, we worked with the private family planning association to develop sustainable funding.

While most of our collaborative work has been technical in nature and described as assisting in strategic planning, conducting operations research on alternative delivery systems, improving management and training systems, and developing evaluation methods, our efforts may also be characterized as having a clear advocacy dimension. Our technical efforts are designed to bring services closer to communities, to break down barriers to service delivery, to introduce participatory training approaches, and to use evaluation findings for program improvement. Also, while most of our collaborative work has been with regional, national, and local institutions, our experience falls short of actually working directly with grass-roots community groups. This is not an appropriate role for a U.S. University; it is best carried out by the organizations with whom we collaborate. Nevertheless, our experience in strengthening the capacities of our collaborating institutions contains lessons for strengthening capacities for carrying our community-based health advocacy programs.

While there are many dimensions to collaboration for health advocacy, this presentation focuses on only three: the choice of issues and the choice of collaborating institutions; the process of collaboration and institutional strengthening, and the evaluation of capacity building.

Choice of Issues and Collaborating Institutions

Often referred to as "community diagnosis" and "needs and resources assessment," this is a critically important first step in the establishment of collaborative advocacy relationships. It is a step that involves extensive qualitative and quantitative research and astute political awareness.

At a technical level we are concerned with vital statistics and epidemiological data and analysis of service delivery organization and utilization of services by various "at-risk" population sub groups. In Brazil in the 1970's, the decision to pursue community based family planning services was based largely on the finding that while couples in the urban areas were well-served by private practitioners and clinic services, couples in the rural areas had poor access to contraceptive and related family planning services.

The technical assessment will lead to a long list of issues with the potential for becoming the targets of advocacy. Among the issues likely to be identified are: urban-rural access and utilization differentials, childhood immunization rates, use of prenatal services, attended deliveries, breast feeding, prevalence of preventable

diseases, contraceptive prevalence, malnutrition, access to safe water and sanitation, social and private insurance coverage.

It is tempting to try to choose the broadest possible grouping of problems for attention. Our experience suggests caution here and to focus on a specific issue of a specific group of related issues (such as child health or women's health) and to phase activities in a way that will maximize the success of the program. The technical assessment is a first step. It must be followed by a political or policy assessment to determine the feasibility of the selected intervention. Here again, we can learn from the Brazilian community-based family planning experience in which the municipio-level political situation provided an opportunity for family planning program development.

Having defined the technical and political basis for developing an advocacy program, one must now consider the choice of the local community group with whom to work. The choice must be made on the basis of a thorough inventory and appraisal of community formal and informal groups, their mandates, and their successes and failures. Such an appraisal will identify groups that are already working on the problem (as well as groups that are opposed to working on the problem), groups with health agendas, group with community development agendas, public and private groups, voluntary groups, unions, cooperatives, educational groups, occupational groups, service groups, women's groups, political groups, and many others. It is unlikely to encounter a situation in a community where no suitable groups exist and where a new group must be created for advocacy purposes. The challenge is to choose the group (or consortium of groups) that will maximize the potential for success of the advocacy program.

There is no simple solution or formula to selecting the group(s) with whom to work. In fact, the only truism is that in any given setting, a variety of groups will be involved in carrying out an effective advocacy program. Again, we refer to the Brazilian community-based family planning experience. The successful program utilized a variety of community agents including: health workers, teachers, restauranteurs, bus drivers, social workers, politicians, etc. Our work in Africa supports the rich variety of organizations with whom we work to deal with similar issues, including: a medical school, a research unit in a medical school, a private management training institution, a regional training center, a midwives association, a national government, and a private family planning association.

The first challenge to the working groups is to develop a methodology for carrying out the "community diagnosis" or "needs and resources assessment" that will facilitate the choice of an area or an issue for advocacy.

The second challenge is to develop a typology of community organizations at the municipio (and other) level and along with the typology, a set of criteria for selecting local advocacy groups.

Collaboration and Institutional Strengthening

The CPFH model for collaboration and institutional strengthening has evolved over the years. The model includes a cycle of staff development, systems development, modelling mentoring, network development, phased handover, and development of new areas of collaboration. The model requires long term commitment, trust, hard work and flexible funding to work. The model begins after the topic of the joint venture and the collaborating institution have been identified.

Staff Development is a part of our approach to institutional strengthening. This includes participation in formal long term and short term training and on he job training as part of continuous technical assistance visits and work long term resident advisors. In Nigeria, for example, staff were trained in the four-week international training program of our center. In addition to the technical training received, participants were able to visit our center in New York and to become familiar with the resources available to support their efforts. The trip to New York was also seen as an incentive for participation in the project. A core team or "critical mass" of trained staff is essential to provide continuity in the phase of absence and turnover, colleagues with whom to discuss problems and new ideas and to promote moral.

Systems Development is a key component of institutional strengthening. In Kenya and Swaziland it was essential to develop new strategic plans, and in Kenya we assisted in improving the marketing of programs and the accounting function in order to help the organization become competitive in obtaining funding from international donors and responsive in accounting for the expenditure of these funds.

Modelling and Mentoring is an often overlooked component of capacity building. In effect it is a transitional stage between learning a new skill and practicing it independently. Our approach often takes the form of jointly developing new proposals for funding, making joint presentations at professional meetings, and jointly providing technical assistance to other projects. In Nigeria, colleagues accompanied our staff in providing technical assistance to other states in Nigeria prior to undertaking independent consultant assignments in other African countries.

Network Development refers to creating and maintaining contacts among professional colleagues involved in similar work elsewhere. Part of our approach to capacity building is to ensure that our colleagues become part of the professional networks of which we are part.

Phased Handover refers to an "end-point" of capacity building, i.e., the point at which and institution has been sufficiently strengthened so that further technical assistance in that area is no longer required. In fact many of our collaborators in Africa are now providing the type of technical assistance we initially provided to them to other institutions in other African nations. Many of the training institutions are now independently offering training programs that were developed jointly. Indeed, our New York training program was put out of business by African Training Institutions offering similar courses in Africa.

Trust, Commitment, Time, and Flexible Funding are essential facilitating factors. These are the ingredients that make the model work. Trust, Commitment, and Time are illustrated in Nigeria where our work has now spanned almost fifteen years. These components also exist in our collaboration in Brazil, with more than ten years of joint efforts with BEMFAM and more recently with our collaboration with the School of Public Health in Sao Paulo. I hope this new venture involving the Fundacao Getulio Vargas signals another major chapter in our collaboration with Brazilian institutions.

Funding. We would not be dealing with reality if we did not acknowledge the critical role of funding in collaboration and institutional strengthening. All of the components of capacity building cost money, and secure and flexible funding is an essential ingredient of success.

The model of collaboration and institutional strengthening is offered as an approach to capacity building. We have found it to be a useful model and one that works. Typically the steps in the model are repeated several times in the process of capacity building. In Nigeria, the process was repeated as new program objectives were developed and the program shifted from rural to urban to adolescent population targets. The process was also recycled when the decision was made to establish a new non governmental organization to assume work of the medical school department with whom we initially collaborated.

The challenge to the working groups is to develop a model of the process of institution strengthening that reflects the philosophies of the participating institutions and the realities of the Brazilian context.

Evaluation of Capacity Building

Capacity strengthening, as is the case with other programs, must be evaluated to determine the degree of achievement and to examine the underlying processes that contributed to the achievement. Evaluation requires use of quantitative and qualitative approaches and findings should be fed back into programs to improve capacity building approaches. There are three important areas involved in evaluation of capacity building.

Changes in the baselines obtained in Community Diagnosis and Needs and Resources Assessment. Look for changes in the vital statistics and epidemiological data and analysis of service delivery organization and utilization of services by various "at-risk" population sub groups.

Changes in the legal, regulatory, and administrative environment. Many of the efforts of advocacy lead to new laws, policies, regulations, and new service delivery strategies. These should be documented and where possible attributed (in whole or in part) to the advocacy efforts.

Progress and success in the capacity building process. At a USAID sponsored meeting in Washington in November 1990, representatives of USAID, TVT Associates, Columbia University, Management Sciences for Health, Tulane University, and University Research Corporation developed some indicators for progress and success in capacity building. Specifically,the indicators of organizational capacity include:

Established process for reviewing its own performance and makes changes based on the findings of the review.

Reduced need for external technical assistance and in some instances may be providing technical assistance to other similar organizations.

Ability to generate funds and other resources.

Trained staff in place who are providing services.

Ability to adapt to changes in the environment.

The quality and quantity of services provided meets accepted performance standards.

Ability to work with and assist other organizations.

The challenge to the working groups is to develop an evaluation framework and evaluation criteria to be used for monitoring and evaluating the achievement of advocacy objectives and for assessing the effectiveness of capacity building efforts. This paper has touched on three important aspects of institutional strengthening for community-based health advocacy: the choice of the topic for intervention and selection of collaborating community organizations, the process of institutional strengthening, and a framework for evaluating the process and outcome of institutional strengthening and community-based health advocacy. In each area, examples have been drawn from previous work in Brazil and in several African nations. Each section concludes with a challenge to small working groups to adapt, modify, or develop new approaches, models, and criteria that reflect the realities of the Brazilian context. As these new approaches are developed, applied, field tested, and documented, we will be in the forefront of advancing the technical-professional aspect of institutional strengthening for health advocacy. At the same time, we must strive to maintain the "grass roots" and community-based aspects of health advocacy.

CONCEPTS AND PRINCIPLES TO GUIDE FUTURE COLLABORATION BETWEEN ACADEMIA AND COMMUNITY AND NON-GOVERNMENTAL ORGANIZATIONS IN FOSTERING CITIZENSHIP AND COMMUNITY PARTICIPATION

The purpose of the Rio meeting was to discuss the role of academic institutions and their teaching, research and service programs, in fostering community participation and citizenship and to examine the experience of each of the participating institutions in such efforts. Participant agreed on several principles that should guide collaboration of academic institutions with community and non-governmental organizations as discussed below:

- This process involves a major commitment to placing technology of whatever type at the disposal of the community. It is a form of "conquest" of power for the community which enables the community to assume and exercise citizenship. Participants agreed that, based on their experience, there are several principles that should guide their activities in promoting citizen participation.

- Ideological commitment is not sufficient nor will it empower communities to assume their rightful role in planning and decisionmaking. This means that research without actual practical applicability in the community will not advance the community's capacity to exercise citizenship. This type of academic activity is a departure from the traditional role that academic institutions have played in which research was carried out for the community often with the purpose of providing students with field experience and with future publication of project findings a major goal.

- The community or non-governmental organization should be actively involved in the proposed project. It is important that the project be clearly defined jointly and that the products that will result from any form of technical assistance are also defined, so that the community or non-governmental organization is clear what it can expect. Active participation of the community in the design and conduct of the proposed project from the beginning of the project produces.

- Academic institutions should enter into this type of collaboration with the idea that a "return" to the community or non-governmental organization is a component of the collaborative project. That is, once there is a concern recognized by academia about community problems and questions related to their resolution, there should be an appropriate and useful response for the community. This "return" to the community should be clearly defined at the outset. This will involve a report or a pre-defined product but may also include a formal presentation of findings and recommendations.

- Student involvement is an important element but should also be clearly defined. Collaboration of this nature is a clear departure from the traditional concept of an academic student field placement or internship. While collaborative projects with community and non-governmental organizations may provide excellent opportunities for student involvement, a clear definition of the role of students in the project and how and by whom students will be supervised and the products they will produce is important.

- Collaborative projects of whatever type will necessarily involve research methods. However, research is not the primary objective of such collaboration. Further, the use and adaptation of research methods in collaboration with community and non-governmental organizations and governmental agencies is often a complex issue. It involves adapting methods for rapid data collection and analysis so that results can be produced in a short period. This not only requires skill among researchers in the use of a mix of quantitative and qualitative methods and in adapting these methods for applied purposes but also requires an understanding from all collaborators of the complexities involved in producing short term results.

- Evaluation of the process of collaboration and the various phases of a given project is critical if we are to learn from and build upon these experiences. Similarly, evaluation of the impact of these efforts on program and policy development and of the impact of citizen participation not only in the process of policy and program development but upon the long term well being of the community.

FUTURE DIRECTIONS

It was agreed that ongoing dialogue in the future among the three participating institutions might take the form of a collaborative agreement. This would extend the network of institutions and agencies with which each might collaborate; integrate and broaden the focus of the social administration, health law and public health advocacy work currently underway.

Joint teaching efforts and field work opportunities will strengthen academic programs and provide students with a broader scope and vision of emerging issues, problems and application of techniques to ensure that solutions to problems are developed.

Increased involvement of faculty of the three institutions in project development will broaden the focus and multidisciplinarity of projects undertaken with community and non-governmental organizations; improve consultation on projects with community groups, NGOs and other organizations; and improve the quality of publications such as technical reports, manuals and other materials that have application at the community level.

ANNEX I

PARTICIPANTS

FUNDAÇAO GETULIO VARGAS

Professor Fernando Tenorio
Director, Social Administration Program
Escola Brasileira de Administracao Publica

Professor Valeria de Souza
Chief, Departamento de Pesquisa e Publicaçoes
Escola Brasileira de Administraçao Pública

Jose Maria Arruda
Mestre em Administraçao Pública
Student Representative

UNIVERSIDADE DE SAO PAULO

Professora Sueli Gandolfi Dallari
Director
Centro de Estudos e Pesquisas de Direito Sanitário
Faculdade de Saude Publica

COLUMBIA UNIVERSITY

Professor Rosemary Barber-Madden
Director
International Public Health Internship Program
Center for Population and Family Health
School of Public Health

Professor Martin Gorosh
Director,
International Training Unit
Center for Population and Family Health
School of Public Health

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