SOMA-Net 3

Report of the

Social Science and Medicine Africa Network (SOMA-Net)

THIRD INTERNATIONAL CONFERENCE

Harare, Zimbabwe

20 - 24 July 1997

African Health in the 21st Century:
Social Science in Health Approaches

This conference was made possible by grants from the following organisations:

CARNEGIE CORPORATION OF NEW YORK
ROCKEFFELLER FOUNDATION
FORD FOUNDATION
SIDA/SAREC - Swedish Agency for Research Centre Cooperation with developing countries
IDRC, Canada - International Development Research Centre
WHO/Joint Program on Health Systems Research
COHRED
DATLAB Zimbabwe
Nestle Zimbabwe
GTZ/IEC Family Health Project, Zimbabwe
Blair Research Laboratory

Report of the

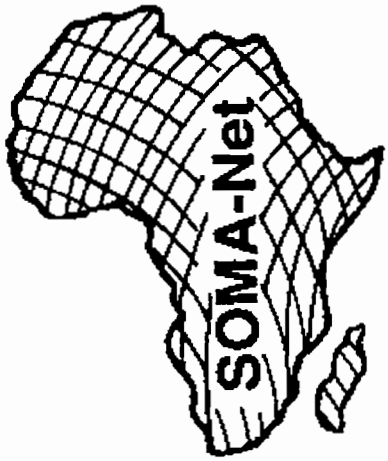
Social Science and Medicine Africa Network (SOMA-Net)

THIRD INTERNATIONAL CONFERENCE

Harare, Zimbabwe
20 - 24 July 1997

African Health in the 21st Century:
Social Science in Health Approaches

Contents



About SOMA-Net

SOMA-Net, the Social Science and Medicine Africa Network, is a non-profit, regional African network that brings together African scientists, institutions, and agencies working in health and social sciences in Africa.

SOMA-Net's *mission* is to seek lasting solutions to health problems in Africa by bringing to bear the combined wisdom and experience of both the social sciences and the medical and biomedical sciences.

SOMA-Net's *mandate* is to encourage and facilitate relationships, interactions, and capacity-building among African institutions, organizations, professionals, and policy makers engaged in health-related programs and research in the social, medical, and biomedical sciences.

The Network's *strategic role*, then, is to champion and advocate integrated and cross-disciplinary principles, approaches, methodologies, and practices that increase the effectiveness of health-related institutions, organizations, professionals, and policy makers in their own roles, functions, and disciplines in the African context.

SOMA-Net facilitates research, networking, and advocacy activities that seek to meld the interests and expertise of social scientists with those of health practitioners. SOMA-Net publishes a variety of documents and joins collaborators in convening biennial international conferences to focus on key topics of interest in the health field. SOMA-Net's routine business is conducted by a lean and efficient secretariat in Nairobi, Kenya, which supports individual members and focal points throughout the region.

SOMA-Net enjoys and appreciates the generous support of a variety of foundations, corporations, and government agencies. Contributions from institutions and individuals are welcome.

For more information, contact SOMA-Net at:

PO Box 20811, Nairobi, Kenya
Tel: 254-2-560569
Tel/fax: 254-2-567577
E-mail: somanet@ken.healthnet.org / somanet@africaonline.co.ke

Introduction

Conference Participants

SOMA-Net's biennial Social Sciences and Medicine International Conferences create fora for social and health scientists to exchange information and ideas and to foster greater collaboration for the development of health in Africa. The conferences also provide a favorable atmosphere for social science and health scientists to disseminate relevant research findings to policy and decision makers for the purpose of influencing health planning and policy.

The first SOMA-Net conference, held in Nairobi, Kenya, in 1992, provided participants with an opportunity to share their experiences and discuss major health challenges facing Africa in the 1990s under the theme "African Health and Economic Recession of the 1990s". The theme of the second conference, in Douala, Cameroon, in 1994, was "African Health in Crisis: Which Way Out?"

This third conference, which was held at the Holiday Inn Crowne Plaza Monomotapa Harare on 20–24 July 1997, focused on "African Health in the 21st Century: Social Sciences in Health Approaches"

Objectives

The objectives of the conference were to:

- Identify constraints and gaps in applying social science and health (SSH)
- Share lessons learned and examples of success stories in the use of SSH to solve health problems
- Formulate plans of action, methods, and strategies for strengthening SSH in research, training and program development

Subthemes

The conference had nine subthemes:

- Community participation for sustainable health and development
- Health sector policy reform
- Integrated reproductive health approaches
- Ensuring nutrition security
- Gender, health and development
- Facing the challenges of HIV/AIDS and other STIs
- Control and prevention of substance abuse
- Strengthening essential drugs programs
- Enhancing capacity in social sciences in health

Conference Structure

The scientific program included plenary sessions where position papers on the subthemes were presented. The plenary sessions were followed by brief questions and comments, after which the participants broke into

syndicate sessions to discuss research findings and formulate recommendations that would influence policy and programs. These recommendations were then submitted to the plenary for necessary modifications and adoption.

The conference was attended by over 80 participants who included researchers, trainers, policy and decision makers, representatives of funding agencies, and friends of SOMA-Net. They were drawn from 13 African countries and 3 countries outside Africa. In all, 47 papers were presented. (See Annex I for list of conference organizers, Annex II for the program, Annex III for a list of papers presented, and Annex IV for names and contacts of participants.)

The SOMA-Net General Assembly, which followed the conference, addressed constitutional questions and the leadership and management of SOMA-Net; consolidated the lessons and achievements of the last seven years; and planned the way forward.

Organization and Support

The organization of this conference was a joint effort by the Social Science and Medicine Africa Network (SOMA-Net), Council on Health Research for Development (COHRED), Health Systems Research Programme WHO/HSR, University of Zimbabwe, Blair Research Laboratory, and the SOMA-Net Zimbabwe Chapter.

The conference was supported by the Carnegie Corporation of New York, the Rockefeller Foundation, Ford Foundation, SIDA/SAREC, IDRC Canada, DATLAB Zimbabwe, Nestle Zimbabwe, and GTZ/IEC Family Health Project, Zimbabwe.

Opening Ceremony

The opening address was given by Dr. T. Stamps, Minister for Health in Zimbabwe. Dr. Stamps pointed out that sub-Saharan African countries face serious health problems and there is unequal distribution of health service resources. Privileged subgroups in the population continue to get the best health care, while the most vulnerable remain with inadequate care.

He stressed that with the right commitment and unity of purpose, Africa has the capacity and ability to address most health problems facing its peoples, and the art of blaming others, especially outsiders, should be eradicated.

Health is not a commodity, he said, and additional finances and personnel will not solve all health problems. Inadequacy and inequality in health care are also not products of demand.

Extensive and effective health initiatives such as provision of safe water, suitable housing, and primary health care are more appropriate than state-of-the-art technologies and equipment.

According to Dr. Stamps, social scientists should conduct more cost-benefit and cost-effectiveness studies on efficient options in health provision and advise governments and relevant agencies. They should find ways to tap the energies of local communities in the promotion of health, as was the case in the eradication of river blindness. They should develop a holistic approach to human health needs.

It is important, he said, to guard against practices such as genetic engineering that tend to go against known health values, for example, the process of producing human-like milk from cows in contrast to breastfeeding, an industry arising out of HIV/AIDS pandemic.

Setting the right priorities in health is vital, from improved nutrition at household level to appropriate budgetary allocations to the health sector. Social scientists must aggressively inform policy makers of the underlying causes of ill-health, factors that are commonly ignored by medics.

The HIV/AIDS pandemic must be treated with the urgency it deserves, Dr. Stamps stressed. The growing burden of disease for communities should be addressed with all the resources at our disposal.

Finally, he noted that ethical values must be inculcated in students and juniors, and role models should be developed to ensure that clients get what they deserve and are entitled to.

Keynote Addresses

The first keynote address was given by His Excellency Professor Twumasi, the Ghanaian High Commissioner to Zimbabwe who is also an editor of Social Science and Medicine Journal. Prof. Twumasi stressed the fundamental interplay between medical, social sciences, and social systems. He pointed out that illness was a deviation from normal life. It disrupts normal functioning socially, economically, and physically, and may also be seen as an evil spirit. Thus there is need to examine the social and cultural determinants of health. He emphasized the importance of understanding social interactions, group dynamics, and the philosophy of traditional medicines that influence health. He indicated the major role traditional and modern medicine can play together.

The second keynote address was given by Prof. G. L. Chavunduka, a medical sociologist and specialist in traditional medicine. Prof. Chavunduka emphasized the implications of traditional healers in health policy reform. He noted that African countries do not have coherent policies on traditional medicine and traditional health practitioners. Traditional health practitioners are merely tolerated and their medicines are not regarded as official medicines. There is suspicion and little official interaction between practitioners of modern and traditional medicine. Policies that promote rather than constrain the ability of traditional health care, that promote sound dialogue and genuine collaboration between modern and traditional practitioners, and that stimulate research and development of traditional medicine are needed.

Message from the Chair

Prof. J. K. Wang'ombe - Chair, SOMA-Net

I would like to first of all welcome you to Harare for your third international conference.

I am proud to note that SOMA-Net is emerging as an effective network with interested participants whose goal is to promote the integration of social science in health. Over the years linkages have been made among individuals and institutions to address a diverse range of issues at country and region levels that form the core of what members perceive as critical in social science.

This success of the network depends to a on relationships among members and how you relate the network to your personal motivations, culture, and the broader socioeconomic context within your specific environments.

The question to ask ourselves then is, Does SOMA-Net reflect your needs, goals, and resources in its design and mode of operation? This self-diagnosis by SOMA-Net is essential in order for the network to be self-propelling. It may also provide ideas on how you can mobilize your energies and resources to sustain links with each other to accomplish the tasks identified at the conference.

Communications

For effective networking, an effective communication system must exist among and between the SOMA-Net members and with the secretariat. It is evident from the conferences that members develop new ties and strengthen old ones in the four days and it is also clear that these conferences form the most effective "meeting fora" for the participants. In between these conferences, however, contact should be made. There must be intensive interaction among members, particularly to facilitate strategic thinking on the appropriate entry points for integration of social science in health.

For effective collaboration, members must interact directly with each other and more importantly, do things together in a manner that adds value to what they would otherwise have done individually. The ability of SOMA-Net members to contact each other cheaply and frequently is key to the process of networking. Communication (postage, telephone, fax) in the region is a problem and is expensive. Response to letters is slow, and these problems increase the costs of planning the conference and other networking activities. In some cases mail is sent by courier services to make sure that important documents reach their destination.

SOMA-Net is thus working to provide space and capacity for a variety of professionals to articulate new thinking free from institutional limitations through an e-mail provider, Satellife Healthnet, which is a fido-system with a store-and-forward mechanism with an off-line connection to the Internet.

Publications

SOMA-Net publications have attracted considerable interest from a number of regional and international agencies and libraries, but inadequate capacity in documentation and editorial skills slowed down SOMA-Net's ability to document and disseminate SSH information to partners and stakeholders. The intention of establishing a bilingual secretariat with French capacity was not realized, primarly because we were unable to find a competent French speaking person for a one-year contract as dictated by funds available. This was compensated for by contracting French expertise on part-time basis as necessary. Thus, only a few chapters in francophone countries could be established and bilingual publications and general networking with SSH practitioners in francophone remained sub-optimal. Thus the editorial capacity at the secretariat needs strengthening.

Despite the shortcomings over 1,000 copies of the annual reports and abstracts of past conferences have been published. These publications are sold at marginal price to cover production and postage costs. The second edition of the directory of scientists and institutions working in the field of social sciences and health in Africa was published in September 1996 and a computerized data base has now been set up.

Grant support

Currently SOMA-Net has two main grants. One is from the Carnegie Corporation of New York to set up a DTP unit and prepare for this conference as well as support the core activities of SOMA-Net. The other one is a effort between Academy for Education Development (AED) and Sustainable Approaches to Nutrition in Africa (SANA). The purpose of this project is to give technical assistance by training teams of health and social scientists and nutrition program managers in consultative research methods in nutrition and provide seed funds so that these teams can use the skills and knowledge acquired to improve the implementation of existing nutrition programs.

With support from the Carnegie Corporation of New

York. SOMA-Net has not only been able to spread its wings in Africa and establish an effective communication system, but has also consolidated the network's secretariat by securing funding for permanent staff.

Though donors have continued to express confidence in the network. Our traditional donors like Carnegie Corporation of New York feel that it is however high time the network stood on its own feet.

In a bid to become self-sustaining SOMA-Net has established a desk-top publishing facility. Initially this unit was used for in-house production and has tremendously reduced costs involved in publications. This unit is now beginning to penetrate the DTP market and has started subcontracting for small jobs from other institutions or individuals.

Sustainability

The main objective of the third phase in SOMA-Net's evolution is, therefore to stimulate further growth of the network and facilitate development of sustainability strategies that will ensure long-term viability of human and fiscal resources of the organization.

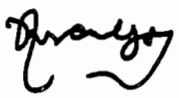
We shall take time during this General Assembly to brainstorm on the way forward for the network. We need to concern ourselves with sustainability. So far SOMA-Net has relied heavily on external funding for its activities this is now a major concern. Though SOMA-Net is supposedly a membership network the contribution from the members has been dismal as will be evidenced by the contributions. Institutions have not been forthcoming as members but individuals in these institutions are very interested.

Our brainstorming should address the following issues:-

- What are the gains derived by members by belonging to the network? i.e., what does payment of membership fee guarantee a member? What incentives attract outsiders to SOMA-Net? What keeps members in?
- What gaps is SOMA-Net filling? Is it any different from other networks?
- What tools does SOMA-Net have to enable potential and existing members to analyze and design health projects or situations to integrate social science?
- Do SOMA-Net members have a common conceptualization of social science in health? What common objectives do they want to achieve together?
- What monitoring and evaluation tools does SOMA-Net use? What are the milestones?

I would like to thank all our development partners, friends, and members of SOMA-Net whose financial and moral support has been invaluable. Support of this conference has come from a variety of sources. IDRC sponsored a workshop on HIV/AIDS prevention strategies in the region. SARA also supported the HIV/AIDS workshop with the theme Facing the Challenges of HIV/AIDS and Other STIs. Ford Foundation sponsored four participants who presented papers on gender, health and development. The Kenya Ministry of Health supported two participants. Rockefeller Foundation sponsored five African scientists and contributed to the core activities. WHO/HSR joint project sponsored seven scientists from six African countries. SIDA, and Carnegie Corporation of New York provided seed funding for the preparation of the conference. Unlike in the past the organization of this conference was difficult because our traditional donors did not come forward. Thus participants, with the help of the secretariat, had to look for their own funding using the abstracts of the papers.

Finally, I would like to thank the secretariat, which has worked tirelessly in coordinating the numerous activities of the network. Our progress would not have been possible without the joint efforts of all concerned.



Prof. J. K. Wang'ombe
Chair, SOMA-Net

Thematic issues

1. Community participation for sustainable health and development

Chair: Dr. Anita Nudelman
Presenter: Dr. G. Woelk
Discussant: Mr. A. Chingono

The position paper enumerated a number of issues in community participation for empowerment. Channels for community participation include community health organizations and community health workers. Actualizing the mechanisms depends on leadership versus representation; inclusion of the marginalized; the political environment; social stratification; and political, financial, managerial, and logistics support.

Lack of democracy is a constraint to full participation, and the growing linkage and globalization of the economy means community participation must also reach higher levels. Participation enables empowerment of individuals and groups.

Discussion

The four papers presented in the syndicate sessions addressed culturally significant health education; communication in primary clinical care; constraints in implementing a participatory program; community participation and the Bamako Initiative.

The papers showed how the failure to give communities full participation has led to the total collapse of many health related projects and programs.

The discussions highlighted the fact that we live in world that is changing socially, economically, politically, and culturally. This situation calls for the development of situation specific health education. In this context social scientists should understand people's health beliefs, attitudes, and behavior in order to integrate them into the health education system.

J. Makokha -NARESA and Z. Malumbe -Ford Foundation

In primary health care clinics, there are many stakeholders—planners, health providers, users. Communication among stakeholders is the major problem in effective primary clinical care in many African countries. The need for payment to participate in the health projects is an indicator of lack of involvement of the affected communities in problem identification. The recommendation that flowed from this was that communities should participate in problem identification, planning, implementation, and evaluation.

The marginalized groups like the poor, minority ethnic groups, and so on are excluded from active participation. Sometimes the political environment is not conducive. There is lack of financial, managerial, and holistic support for the programs.

Although preventive medicine should be the key for coping with some of these major health issues, it is often ineffective because it uses expertise developed for other continents, which may not be suitable for the African context and way of life. The development and implementation of culturally-significant health education is a challenge to social and health scientists in Africa. Medical professionals must be more flexible, even to the extent of incorporating traditional ideas and healing methods.

Applied social scientists must gear their research toward understanding different peoples' health beliefs, attitudes, and behavior in order to integrate them into primary health education. Thus, the interaction of health and social scientists will enable them to communicate important health concepts in ways that are culturally-significant, and therefore acceptable, to specific populations in their countries (ethnic groups, age groups, gender, high-risk groups).

This interdisciplinary and cross-cultural approach can be demonstrated through case studies of health education programs, for example, the presentation on Ethiopian immigrants in Israel.

The way forward...

Research

- ☞ The definition of community participation/ involvement in health should be re-visited. What is the process for empowering the community? What are the skills and knowledge needed? It is necessary to re-think the Bamako initiative: What has worked? What social problems are involved in its implementation? What is the role of women?

- ☞ Social scientists should study the actual process of empowerment and facilitation of democracy;

Advocacy

- ☞ Advocacy is necessary for the community participation process.

- ☞ Dissemination of information to donors should be regular.

- ☞ Given the failure of the top-bottom approach that seemed to have characterized the Bamako Initiative, the conference strongly recommended the enhancement of true community participation at the level of design, implementation, and evaluation of health related projects.

- ☞ Researchers should be encouraged to further share their results or findings with the communities who participated in the generation of research data. The organization of village workshops should not be mechanisms for the dissemination of results but should be used to assist the communities to define concrete actions based on the research findings.

- ☞ The community participation process should include a special effort to pull in marginalized sub-groups. Power within the community should be understood.

2. Health Sector Policy Reform

Chair: Dr. J. Mufunda
Presenter : Prof. J.K. Wang'ombe
Discussant: Dr. P.L.N. Sikosana

The position paper addressed the impact of macroeconomic reforms on the performance of the health sector: the options, availability, safety, efficacy, quality, access, and afford ability of health care.

Critical consideration of the balance between user fees and equity issues should ensure that there is accessibility, availability, and utilization of services even for the most vulnerable members in the society.

The problems of reforms implementation include administration as well as management of chosen strategies. Decentralization as part of the policy is hampered by lack of skills in the periphery as well as poorly adjusted civil services for this policy. Encouraging the private sector to increase participation, suggests the need for necessary regulatory agency.

There is lack of commitment by policy makers to health sector reforms and the health insurance movement seems to be neglected.

The issue of cost recovery was raised. What are the objectives? Is it meeting costs or increasing revenue? The issue and conflict of protecting patients' interests in terms of not allowing sub-professionals to be involved in some activities needs to be re-visited, and in some countries it might be necessary to overhaul the process of formulating health policy.

Discussion

The seven discussion papers showed some of the contextual and environmental difficulties observed in the development of coherent and viable health policies, strategies, and targets. These include: inadequately trained health managers to manage the health sector reforms, resulting in formulation of health policies by international financial lending institutions; lack of resources leading to burnout and job dissatisfaction; declining government health expenditure causing inequity; and failure to use research, reducing efficiency and hampering decision making.

D. Willms -Carnegie Corp. of N.Y., Khumalo-Sakutukwa - University of Zimbabwe

The present and projected morbidity and mortality indicators in sub-Saharan African countries are the worst of all the world regions. The deep cuts in amounts allocated to social sectors like health and education due to sluggish economic performance have hindered health policy revisions in most African countries.

This forces a revaluation of options available to improve the health of Africans. The problem is not the lack of policy, but rather who formulates it, for whom, and how it is formulated and implemented. In Africa it has been observed that health policy formulation has been relinquished to international financial lending institutions, leaving the countries only with the duty of implementing. This lack of ownership has resulted in policy reality that is at odds with espoused statements.

Research is being used to reduce inefficiency and come up with innovative management action to improve quality of care. Some examples are studies on user fees that protect the poor; equity studies that assure distribution of resources within and between districts; sustainability of health care, both financially and institutionally, with minimal external input; and the application of total quality management. Use of weekly disease surveillance (WDS) was useful in making informed decisions.

Collaborative efforts to redress the dearth of health economists in the country with particular reference to strengthening of health policy training is the other option.

However, improved performance standards of personnel, and thus organizational effectiveness and efficiency, do not automatically result from training. Rather they depend on the trainees' disposition toward the training and willingness to transfer the knowledge and skill acquired during the training on re-entry to the organization.

The way forward...

Capacity building remains an area in which SOMA-Net must invest its resources. There is a need to develop a critical mass of health economists and health managers to manage health sector reforms. Members should critically examine equity issues relating to access to health services to ensure that the most needy population members are taken care of. This can be achieved by creating units for monitoring the policy review process.

Options to improve the availability of health social scientists to improve health care delivery in both the short and medium term should include:

Training

- Identifying institutions that run courses.
- Organizing short-term courses to bridge the gap in capacity development in several areas of social sciences in health in Africa.
- Establishing ... regional research centers to provide training and the acquisition of skills in health economics and other critical areas.

Research

- Analyzing gaps in existing research results in order to determine what else needs to be done.
- Linking up with other networks in data generation, analysis, research, and dissemination of research results.
- Monitoring the process of reforms before initiating a situation analysis so as to clarify the significance and implications of the reforms. SOMA-Net members should look at this policy from the basis of the region's agenda and not from donor driven agendas.

Advocacy

- Adopting a holistic approach in addressing the problems in health care reforms and providing an appropriate working environment
- Bringing on board other providers of health care such as health insurance companies to assist in solving the problems of health cost and quality of health financing.
- Acting as lobbyists to ensure that reforms are implemented in totality rather than in compartments.

Networking

- Establishing a data base on health policy reform areas.
- Using the electronic media to disseminate the conclusions reached at this conference to organizations, NGOs, governments, etc., even before the proceedings are published.

3. Integrated Reproductive Health Approaches

Chair: Dr. G. Woelk
Presenter: Dr. F. Zawaira
Discussant: Ms M. Mathai

The position paper gave an overview of the program of action adopted at the 1994 International Conference on Population and Development (ICPD), held in Cairo, which articulated a comprehensive concept of reproductive health (RH), including family planning and sexual health. Reproductive health means having a satisfying sex life, the capacity to reproduce, and the freedom to decide if, when, and how to do so. Implied in this condition is the right of women to be informed and have access to safe, effective, affordable, and acceptable methods of family planning, and safe and accessible reproductive health programs throughout their life cycle. Integrating services means providing all the services under one roof -the proverbial supermarket approach. The implications are that all health personnel are trained to conduct all the services and that resources are available to provide the services.

The paper pointed out that women's biological makeup renders them more susceptible to HIV/AIDS and STIs. It also noted that the social and psychological burden of childbirth, side effects of contraceptives, inequality in sexuality, cultural practices such as FGM, and unequal distribution of power and status, have important bearing on reproductive health. The challenge therefore is to develop the right mix of services to cater for all these factors.

Discussion

The three papers focused on the context of implementing the ICPD plan of action at country level, integrating the special needs of adolescents, and reproductive mortality.

In attempting to take the ICPD plan of action forward, sharp practical contradictions and challenges are beginning to emerge at country level. These problems include a range of missed opportunities for integrating aspects of ICPD in other national policy and program processes. An examination of the relevance of the ICPD framework showed that the conceptual and practical constraints have brought contradictions between commitment to international ideals on the one hand and implementation dilemmas at the country level on the other. Intergrated reproductive health (IRH) is confined to the traditional approach of maternal child health/ family planning, which covers infertility, abortion, reproductive rights, and reproductive morbidity. STIs/HIV/AIDS are left outside the framework.

Practical contradictions for implementing IRH include the prominence of women and feminists at ICPD, while at the country level implementation is male dominated and policy makers have no grasp of the broad women's agenda. Conceptual and ideological constraints include the strong NGO prominence at ICPD, contrasted with weak NGOs at country level who are more preoccupied with the rights of women than with IRH.

Integration is possible at tertiary and secondary levels but more difficult at PHC level because of inadequacy of resources. Countries should therefore examine Cairo recommendations and integrate according to policies and abilities. Social science research can help here.

A. Pertet, SOMA-Net and M. Mathai, Kenya

The way forward...

Research

- Research needs to play a central role in the implementation. Gaps in the current provision of the various components of RH need to be identified. The research should be field based and participatory in order to address pertinent issues facing the community, grassroots health workers, and district level managers. This would generate information to not only convince policy makers of the need to act, but also provide the information for choosing the best approaches to adopt. New strategies need to be evaluated for effectiveness and efficacy. The implementation of strategies also needs to be monitored on a continual basis to ensure that results emanating from the research are used in effectively implementing integrated reproductive health and that lessons learned from the implementation process feed back into the process, benefiting the whole program and countries.

- Integrated reproductive health approaches were adopted by many countries after ICPD. But there is concern that there is no universal access to reproductive health by all those needing services. Data are required to determine access and acceptability of reproductive health services.

- Adolescent sexuality and its accompanying fertility are subjects that are currently attracting world-wide attention as social problems but are not adequately addressed in IRH. The traditional society sanctions against illegal sexual activity particularly among unmarried adolescents have broken down with modernization and thus currently there is high need for family planning for adolescents. However, service providers are unwilling to provide family planning services to this group.

- There is need to strengthen IRH at the community level because more maternal deaths occur in the community than in health facilities. Factors related to delivery at home include delay in seeking medical care, inadequate space at health facilities, poor referral systems, and lack of transport for referring complicated cases to hospital.

- IRH needs to be monitored continuously during implementation using social change approach research that is field based, participatory, and reflective of community needs and priority issues.

- Sexual and reproductive health needs of schoolage children, including the social-cultural factors involved in providing contraceptives to adolescents and appropriate interventions for teenage boys, should be looked into.

- Further research is required into the issue of vertically integrated service approaches. Some reproductive health pressure groups feel vertical services achieve better results, while some countries have found them counterproductive or inhibiting access due to some cultural beliefs.

Advocacy

- There is a need for political commitment to the implementation of integrated reproductive health approaches, as issues in reproductive health are politically sensitive especially in the African context.

- Efforts to coordinate IRH strategy with the involvement of NGOs and the women's movement in the implementation should be increased. Policy makers should be sensitized on issues such as abortion, infertility, reproductive morbidity, etc., that are not now tackled headlong.

4. Ensuring Nutrition Security

Chair: Dr. G. Woelk
Presenter: Ms. Julia Tagwireyi
Discussant: Dr. L. Ethangatta

The position paper addressed current and future nutritional problems, examined the strategies for dealing with them, and proposed ways for professionals to facilitate the process of improving nutrition status. The paper pointed at the gloomy picture of nutrition in sub-Saharan Africa (SSA), where the situation has continued worsen as gains made in the 1980s have been lost or deteriorated. Malnutrition is a significant global problem, with about 150 million children under five years old being underweight and more than 20 million suffering from severe malnutrition. In recent years malnutrition levels have increased dramatically and countries in sub-Saharan Africa have experienced worse malnutrition problems than the rest of the world. The problem of malnutrition is complex due to the socio, cultural, political, and environmental factors associated with it. The major causes of malnutrition include poverty, recurrent droughts, and internal displacements.

There has been an increase in the rates of childhood malnutrition in both mild-moderate and severe form. Infant mortality rate has gone up by as much as 20%, with malnutrition playing a major role. Morbidity for under-fives has escalated due to their vulnerability to infection when they are malnourished. Other problems include maternal malnutrition, chronic energy deficiency, and micronutrient deficiency, e.g., iron, iodine, vitamin A, and niacin deficiency (Pellagra).

Discussion

The four discussion papers looked at trends in the African nutritional situation: nutrition insecurity in Africa, the effect of the liberalization measures on nutrition security, the perceptions, beliefs and cultural practices contributing to under-five malnutrition, and improving the health of school children.

Reduction of malnutrition should no longer be approached through a single monofocal approach, but concentrate on the use of a conceptual framework that reflects the biological and social causes of nutrition problems.

In addition to issues of food availability, household food security, and the presence or absence of infection, the concept of care in child nutrition outcomes should be promoted.

The interplay between malnutrition and food production and the role of population growth are key elements in nutrition policy. Policy must also take into account essential micronutrients, rather than simply focusing on bulk calories.

There is inconsistency between health messages directed at the community by health workers, religious leaders, and others, and how the community views health, illness and disease.

School health services (SHS) are important though neglected resources for health and nutrition interventions and a link with communities. They can provide health education, particularly relating to sexuality and HIV/AIDS.

Africa has professionals who should collaborate as teams and examine how to provide answers to nutrition problems.

M. Niang, University of Dakar, A. Nudelman, Bengurion University Israel, M. Mathai, Kenya

The way forward...

Advocacy

- There is need to build on indigenous knowledge and practices and use them to improve nutrition. Such a policy should be based on a clear understanding of the perceptions and cultural traits of the beneficiary countries. This is a role for SSH

- The multi sectoral and multi disciplinary nature of nutritional problem calls for the involvement of biomedical and social science professionals. An important consideration in Africa is for professionals to examine existing national programs, which in most cases include primary health care, agriculture, education, socio-cultural divisions, and environmental issues, among others, and to reorient and focus these programs toward nutritional goals. In the long run these approaches will contribute to the achievement of sectoral goals as well as to increased program sustain ability.

- Political commitment and political and economic stability are crucial preconditions to nutrition security as liberalization measures intended to rejuvenate the economy led to concerns about nutrition security.

- Multi-sectorial collaboration among teachers, health professionals, and family should be promoted to help effective handling of problems facing children.

- Since SOMA-Net is a multi-disciplinary network it should examine how it can use the various disciplines to solve nutrition problems in Africa. Program managers, academics, and researchers in a variety of disciplines can provide sustainable approaches to the reduction of malnutrition. This should include finding economists to assess the impact of various policies on nutrition, and strengthening intersectoral action.

- The framework of the "Triple A approach" - access, analyze, and action - is useful in examing communities and develop community-based interventions.

- Nutrition surveillance should be strengthened.

- Research and training agendas should address problems in nutrition.

5. Facing the Challenges of HIV/AIDS and other STIs

Chair: Prof. A.S. Latif
Presenter : Dr.L. Mbengeranwa
Discussant: Mr. L. Kerkhoven

The position paper on HIV/AIDS pointed out that as of 30 June 1997 Africa had a total of 576,972 cases out of 1,644,183 reported globally, representing 35% of the total reported cases. In Zimbabwe some 61,037 AIDS cases were reported. The paper noted that AIDS was now in its second decade and despite intensive research there was yet no cure. The AIDS epidemic has resulted in escalation of costs in health care provision, dwindling household incomes, and escalating costs in training personnel for the labor market. Strategies for coping with the epidemic include emphasis on safe sex; efficient STD prevention, control, and treatment programs; and strengthening the social support mechanisms to enable families to cope with the epidemic. National employment codes of conduct to protect AIDS victims and structures and processes to enhance collaboration rather than competition from the various sectors should be put into place.

In Harare the tendency to discharge patients from hospitals has resulted in greater use of PHC services, which have limited budgets. There has also been a mushrooming of community home-based care by a multiplicity of agencies with little or no coordination or guidelines on standards of care to be provided to the patients. Poverty is a major constraint to home care as care givers often cannot afford basic commodities such as disinfectants, soaps, gloves, food, and other supplies.

Lack of counseling skills for care givers and inadequate testing facilities are areas of concern. Overcrowding and substandard housing are also constraints since the housing sector was not planned for home-based care of terminally ill patients. The care of the numerous AIDS orphans is a big burden even for the extended families, and calls for strengthening of traditional social networks and associations beyond the usual kinship ties.

The strategies the city of Harare has set include developing a comprehensive integrated decentralized approach to the management of sexually transmitted infections. This involves training of staff, providing well equipped clinics and adequate drug supplies, and providing a well equipped referral facility for resistant cases. The HIV/AIDS subtheme had two concurrent sponsored syndicate sessions. These were:

- HIV/AIDS prevention strategies in the African region: Individual and collective experiences of vulnerability, risk, and responsibility (sponsored by IDRC Canada and facilitated by Dennis Willms)
- HIV - Lessons learned and best practices for behavior change interventions for HIV and STI prevention (sponsored by the SARA/AED project and facilitated by Sambe Duale)

Discussion

HIV/AIDS prevention strategies in the African region: Individual and collective experiences of vulnerability, risk, and responsibility

The discussion papers covered the unique experiences and strategies being used in Africa to deal with HIV/AIDS. The issues included the importance of incorporating existing value systems and cultural norms into research, the traditional channels of communication in developing HIV/STI intervention strategies for rural female adolescents, substances used for sexual pleasure and prevention of STIs by African women, social-cultural factors affecting implementation of community based HIV/AIDS, the negative attitude of health personnel towards HIV/AIDS patients and how multidisciplinary teams of scientists have worked together to study HIV/AIDS.

These examples show that HIV/AIDS campaigns in Africa should take into account cultural aspects. The socio-cultural factors hindering efforts in AIDS prevention in Zambia and Kenya were discussed. Although government and non-government organizations have developed health education strategies to combat the spread of AIDS, their efforts are being threatened by attitudes of communities toward the disease. The challenge for health professionals is therefore to find new strategies for creating awareness. Individuals in rural areas who are knowledgeable on HIV/AIDS issues are influenced by the community's social-cultural perceptions, which tend to supersede the individual opinion. The community elders still maintain that the disease is a curse because people have given up their traditions and ancestral values and have in one way or another violated their traditional norms, e.g., through incest, adultery.

End-point evaluation to assess the success or failure of interventions use a combination of qualitative and quantitative methods to provided a valuable insights into what happened during the implementation period and whether the intervention was implemented as planned. Successes and failures of a program are often determined by contextual issues that are outside the scope of the intervention.

An example was given of a process of HIV/AIDS prevention aimed at interpersonal, socio-organizational, and policy level changes in farm worker communities in Zimbabwe. Program implementation was affected by

seasonal patterns of farming activity and the migration of seasonal labor during peak farming periods... Participation in intervention activities by working women, who are socially marginalized and educationally disadvantaged, was limited by time. Condom demand, which increased with the influx of migrant workers in the peak period, was not due to the intervention but because workers had less time to access health care.

Qualitative social science methods used in feasibility assessments, education campaigns, and public relations efforts contributed greatly to the understanding of the politics and logistics of conducting research. In preparation for conducting vaginal microbicide studies in Zimbabwe, the research methods also provided valuable cultural insight into gender dynamics, health and hygiene practices, sexual and contraceptive practices, and recruitment strategies. The level of awareness throughout the community regarding microbicides was raised.

The traditional channel of communication on sex for adolescents has proved effective in Uganda. The "Senga" model was studied with the aim of developing a culturally acceptable, cheap, and sustainable HIV/STI intervention strategy for rural female adolescents. The model comprises four components -social responsibility, moral authority, appropriate knowledge, and the socio-economic environment of the community. The model was easily conceptualized, culturally acceptable to the community, cheap, and therefore sustainable. It could fill the gap created by the absence of the natural Sengas, particularly for girls out of school, and could also be useful in the integration of the HIV/STI messages into the local cultures. With the existing infrastructure (HIV/STI / IEC intervention programs), the Senga model is an appropriate, cheap, and effective strategy in the control of HIV/STIs among female adolescents in rural areas.

Women, especially commercial sex workers, use various means of self-protection against HIV/ AIDS/STIs and increased sexual pressure. In South Africa vaginal agents used to produce a drying and tightening effect are common among sex workers. Douching using diluted antiseptics, soapy solutions and water, patent medicines, and herbal powders to keep the vagina "dry and tight" was also a common practice. Intravaginal substances are also used for treatment of vaginal symptoms. Given the high prevalence of HIV/STI in the region, the study suggests the need to investigate the prevalence and effect of traditional sexual practices in a larger group of women.

A big challenge facing the health sector in Malawi is changing the negative attitudes of health personnel who are responsible for caring for patients suffering from HIV/AIDS and TB.

An example from Cameroon showed how social scientists and physicians can constitute themselves in multidisciplinary teams to carry out together KABP (knowledge, attitudes, beliefs, and practices) surveys for evaluation of HIV/AIDS prevention activities. Physicians, who were initially reluctant to incorporate social scientists, finally realized their important role in the studies.

H. Muyinda, Medical Research Program Uganda, D. Willms, Mcmasters University Canada, P. Nkwi, University of Yaounde Cameroon

The way forward...

Research

- Further work is needed on risk and vulnerability to HIV/AIDS including how risk is socially constructed in different environments. Risk communication protocols that are culturally appropriate should be included in the intervention packages.

- In studying HIV/AIDS a broad methodology is needed to take care of all emerging issues, and intervention research should take over from KAP studies. This should include innovative conceptual frameworks that are appropriate to the African region. Some points to be addressed are:

  - co-factors for HIV, e.g., alcohol and substance abuse.

  - empowerment of women for self-protection (feasibility studies on the use of the female condom in Harare were welcome).

  - ways to improve relationships between health care givers and patients.

  - community and institutional initiatives with remarkable strategies for adaptation that can be emulated

Advocacy

- Since communicating sex is a major problem in Africa with patterns deeply entrenched in culture. There is need to revisit cultural perspectives. In some African countries traditional healers are being used in HIV/AIDS interventions, this effort should be encouraged and re-enforced.

- Popular perceptions, beliefs and practices about causation and treatment are deeply rooted in the culture and religion, a reality that no one discipline can fully address the issue of HIV/AIDS. Thus a multi disciplinary approach holds a stronger promise for resolving the HIV/AIDS epidemic and health problems in Africa. This requires the concerted efforts of policy makers, church people, programme managers as well as communities, researchers, NGO development and the academia.

HIV - lessons learned and best practices for behavior change interventions for HIV, STI prevention

The discussion papers included some predictive factors for condom use, use of research results in developing intervention strategies, approaches for studying adolescent reproductive health, education programs among the youth, efforts to reduce HIV/STI and infection by promoting safe sex practices. Greater dissemination of research results as well as user-friendly presentations could effectively assist in developing prevention strategies and program.

Follow up is important in AIDS interventions to how results are being used to determine their effectiveness and difficulties in utilizing research findings in program designs. Experiences from Zimbabwe show that research used to review clinical and behavioral STIs is not action-oriented and results were under-used in developing intervention strategies. Results are also poorly disseminated to relevant agencies and organizations for planning and developing interventions.

Sexual behavior is not solely responsible for HIV/AIDS; and research should focus on other issues like breast-feeding and environments that result in the spread of HIV/AIDS. These co-factors have not been studied and yet they impact on behaviors. Pender's health promotion model, which includes a set of general influences and a set of behavior specific influences, showed attitudes towards condom use (such as the frequency and methods of use), use of marijuana, the situational influences of bars, condom self-efficacy, marital status, awareness of how to use condoms, and attitudes toward condom use were predictive of quality of condom use in Zimbabwean men.

AIDS education programs have proved effective in Nigeria. Investigations on adolescent behavior regarding access to reproductive health care using peer interaction approaches showed a change in level of awareness, attitude, and motivation among in and out-of-school youths with respect to AIDS and general reproductive health care services.

In Zimbabwe an evaluation of an AIDS education project among the youth using music, drama, and poetry revealed a significant increase in AIDS-related knowledge, perceptions, and attitudes, and a decrease in misconceptions about the transmission of the AIDS virus.

Efforts to reduce HIV/STIs infection, including widespread promotion of condom use coupled with education on safe sex practices, among sex workers in the KwaZulu Natal Midlands indicated that although sex workers are at a high risk of HIV, infection because of their numerous sexual encounters, they did not perceive themselves as being at risk of contracting or transmitting the virus. Receiving a HIV result, whether positive or negative, did not necessarily result in a change in condom use because of the difficulty in getting the clients to use condoms.

The way forward...

Research

- In-depth studies, on interspousal sexual communication, for example, should be carried out in order to understand sexual behavior factors at a personal level and come up with solutions that work and knowledge of why they work.
- More research funds should be set aside for behavioral change studies, especially those advancing the science of intervention designs that go beyond KAP.
- The studies carried out and information gathered by country networks so far should be aggregated and a meta-analysis done to examine behavior changes and come up with interventions that have worked and lessons learned to be shared with other networks. SOMA-Net can be used as a starting point. This information should then be fed into NCAPS and the mass media in easily understood language.

Advocacy

- The SOMA-Net local networks should engage in a series of meetings/seminars on defined topics that engage people in debate and come up with plans of action on the way forward, e.g., meetings to disseminate information. Each local network can focus on a specific area of research for a given period and share results of these activities with policy makers.
- The political environment to support efforts on HIV/AIDS programs and the AIDS pandemic should be examined in a holistic approach and not by sectors.
- Appropriate messages, targeted at the youth are needed. Such messages should take cognizance of the traditional/existing social communication network and the prevailing socio-cultural situation.
- Research results in general should be summarized in a language that is user friendly to both lay people and policy makers.
- There is need to re-examine whether the methods used in communicating about sex are relevant and say what we want to say about AIDS.

Networking

- SOMA-Net should start a data base in behavioral research and suggest possible research areas.

6. Gender health and development

Chair: Mrs. R. Likwa
Presenter: Dr. A. Artuku
Discussant: Mrs. J. Kadandara

The position paper emphasized some of the factors that put women at health risk and gave strategies to deal with the problems.

The paper indicated that since poverty was closely associated with ill health, women are very much affected because of their unique vulnerability to poverty. Economic hardships result in sexual networking, which puts them at a greater risk of HIV/AIDS. Disorders and complications associated with reproductive roles makes women aged 15-44 years especially at risk. Long-term effects of disease burden have major implications for women's ability to perform their reproductive roles. Violence, including domestic abuse, continues to feed women's low self-esteem and interferes with their ability to negotiate sexual matters.

Strategies to deal with the situation include promoting social transformation in order to reduce practices that interfere with good health of women and girls and to promote the empowerment of women. Among these are education, access to economic activities, and protection and advocacy for equitable and accessible health care for women.

Discussion

The three discussion papers presented NGO grassroots communication links, low-cost interventions for protecting the girl-child, and the association of masculinity with sexual and reproductive health.

The communication gaps and weaknesses between NGOs and their target grassroots audiences require strengthening in order to enhance NGO-grassroots linkages. More effective means of communicating information and research findings should be established.

Guardians play a big role in encouraging youths to change behavior and hence protect themselves from the risk of HIV/STIs infection, unwanted pregnancies, and unsafe abortions.

The traditional model of male sexuality promotes certain sexual attitudes and behaviors that negatively affect sexual and reproductive health. Focusing on women only, therefore, is an inadequate approach to sexual and reproductive health. There is need for greater male participation in sexual health programs and for development of more in-depth understanding of gender health issues.

B. Tumbo, Ministry of Health Kenya and R. Mosong, SIDA/MOH reproductive health project, Kenya

The way forward...

Research

- Barriers to women acquiring health care need to be looked into, including ways of affording and accessing health care.
- The whole issue of men and masculinity needs to be addressed. The culture and socialization and associated effects on men as power-wielders in health policies affecting women need to be explored, including men's views so that these can be adapted. Ways in which religion can help in men's desirable re-socialization with gender orientation should be explored.
- Skills and analytical tools for application of gender issues in health for promotion of SSH should be developed.

Advocacy

- Laws should be enacted to protect and support the girl-child in reproductive health issues. Boys should also be considered in these strategies to inculcate responsible values for adulthood.
- Communication is required from researchers to grassroots levels with information regarding women's behavior being communicated in appropriate media and simple language.
- Both men and women should to be targeted when women's health is being examined because of the complexity of issues that affect women's health -poverty, environment, politics, culture, social values, etc.
- More resources need to be directed at national levels into programs that address women's health. There is need to re-examine health care facilities and to strengthen components that serve girls and women.

Mr. Dahoma M., MoH Tanzania, Dr. J. Obiegbu, University of Abuja Nigeria, Mrs. Z. Mgalla, Tanesa Project MwanzaTanzania

7. Strengthening essential drugs programs

Chair: Prof. J.K. Wang'ombe
Presenter: Norman Z. Nyazema
Discussant: Prof. S. W. Acuda

The position paper argues that though the 1993 World Bank Report, Investing in Health, recognized the importance of inputs from the private sector in improving health, the promotion of the private sector to invest in health carries with it the danger that the health ministry and its policy making coordination functions may be weakened rather than strengthened. Nowhere is this more apparent than in the area of pharmaceuticals, particularly in a country that has no national drug policy.

A national drug policy (NDP) is an indication that a government is committed to public health. It forms the context and background for any public and private drug supply. An essential drug action program should therefore be part of any NDP. The aim should be to make it possible for the majority of patients to be treated safely, effectively, and at reasonable cost.

In order to make this practical a complex combination of health related, cultural, economic, and political factors have to be taken into account during the selection of drugs, and formulation of treatment guidelines, drug procurement, distribution, rational usage, monitoring, and adjustment. Practical and enforceable statutory instruments need to be put into place.

In HIV/AIDS treatment for example, good quality, affordable tuberculosis drugs should form an integral component of the health care system. In other words an essential national drug policy forms part of a comprehensive national health care strategy. This is only possible if there is a political will to move from policy to practice and, it requires closer collaboration between social scientists and health care providers.

A case study was presented on issues on essential drug program in Zimbabwe, which included safety, efficacy, quality, availability, access, and affordability (SEQAAA).The study showed that though there was an enabling environment for implementation, and access and availability were good, the quality of drugs was an area of concern.

Areas needing improvement include a supplier monitoring system, expert committees to monitor quality issues, education on rational drug use for prescribers and dispensers, and a pricing policy for drugs.

There were no papers for the syndicate session.

The way forward...

Research

- Socioeconomic and cultural aspects of drug marketing require study, and strategies are needed to ensure that changes do not adversely affect public health.
- Studies should be carried out to find out why Africans have become so disempowered that they have forgotten how to use home remedies and other traditional treatments, before seeking expensive drugs at the pharmacy.
- Studies should be carried out to determine how people's perception of disease influences the supply of drugs; the role of the informal sector; and how the efficiency of health services influences drug utilization.

8. Control and prevention of substance abuse

Chair: Prof. J. K. Wang'ombe
Presenter: Prof. S.W. Acuda
Discussant: Norman Z. Nyazema

The position paper gave the results of a classroom survey of secondary school students in Zimbabwe. The survey measured health behavior, school performance, and environmental and socio-cultural factors that were assumed to be important predictors of substance abuse.

The results showed that drug use was quite prevalent among the students interviewed. The main drugs used were alcohol, tobacco, cannabis, and inhalants. Both girls and boys used alcohol in a similar trend, with more private school students using substances than those in public schools. Cannabis was used widely by children in both rural and urban schools. Glue was sniffed by both sexes more in urban than in rural schools. Cough mixture was used as a tranquilizer.

Compared with results of the 1990 survey, there was an increase in the use of alcohol, tobacco, cannabis, and inhalants. In addition, in 1994 a few students reported use of cocaine, heroin, LSD, and mandrax, which were not reported in the 1990 survey.

Use of tobacco and alcohol increased with age and increased socioeconomic status. Risk factors for drug abuse include early antisocial behavior, alienation and rebelliousness, lack of clear behavioral expectations, lack of monitoring and supervision, suspectibility to peer pressure, parents' attitude toward drug use, low expectations for children, and history of alcohol and drug abuse.

It was noted that substance abuse is becoming a common occurrence among young people in school systems in Africa and there is a relationship between substance abuse and high socioeconomic status of young people.

Youngsters with no career goals were more likely to abuse drugs than were those who had a vision for the future. This points to the importance of counseling.

The boundary between use and abuse of substances, including the cultural context in which the use and abuse occur, needs to be clarified. For example, when it is said that teenagers succumb to peer pressure, who is influencing whom?

There were no papers for the syndicate session.

The way forward...

Research

- ☞ SOMA-Net members should examine the cultural context in which drugs and substances are used and abused.
- ☞ Teenagers should be involved in research teams so that they can articulate issues related to substance abuse, and come out with recommendations.

9. Enhancing Social Science in Health for the Africa Region: Report of a Needs Assessment

Chair: Prof. P. Nkwi
Presenter: Dr. D. Willms
Discussants: P. Nkwi, M. Mohale, J. Wang'ombe, T. Katsumbe

The position paper emphasized the need to find more persuasive and compelling ways to represent, communicate, and promote the relevance of the social and behavioral sciences to health. Best case studies were suggested as critical in advancing these arguments. "Anchor persons" are the best communicators of these relevances or arguments, and SOMA-Net can adopt such a scheme.

Some of the critical areas suggested as present and emerging training needs are:

- balancing theories in medical anthropology and abstract analysis with training in the study of intervention design
- using indigenous African theory, literature, and ethnographies in training program
- balancing university-based training with field-site training, both urban and rural

The paper emphasized that persons and institutions should build research agendas that include transdisciplinary and interdisciplinary linkages of authentic affiliations (friendship common agendas, rather than externally imposed, artificial affiliations). It called for problem-oriented transdisciplinary research in health social sciences as well as operations research.

It is critical to identify, promote and train individuals in Africa who already have research questions that reflect vital health and social science issues.

As well, there is great need for programs that identify and publish best case studies in order to institutionalize ideas and research procedures, and to promote those individuals who are committed to making a difference in their "home countries."

Discussion

The health sector does not make optimum use of the social sciences. The effectiveness of SSH teams is hindered by dominance of the particular professions, be they clinical, biomedical and social. The future requires networking as opposed to unhealthy rivalry among individuals and groups for any pursuit to remain socially legitimate.

The health systems research approach that targets its training activities at operational health staff mainly based at district but some from provincial and central levels contrasts with many initiatives focused on academic/university based researchers. HSR as a concept has been developed with the explicit aim of improving the use of research results. Its concentration on action oriented research was given as a good example of something that works.

The presentations from the participants projected a wide diversity of conceptual understandings of social science in health. It was not immediately visible how the individual perceived social science and its integration into health. It was therefore unclear to most of the participants how SSH concepts, theories, and methodologies were applicable to the topics of their choice. As a result, no recommendations emerged on how SSH could be strengthened.

The way forward...

- The obvious gap in the conceptualization of SSH and capacity building emerged as a strategic requirement to steer all other activities ahead.
- There is need to develop appropriate analytical tools to enable future participants to isolate SSH issues and discuss how best they can be integrated into the health system delivery and services.
- SOMA-Net should make capacity building in social sciences in health a priority. For training to have impact it should take place locally.
- Policy makers, donors, and media need to be brought on board so that they can understand activities and the potential within SOMA-Net membership. Advocacy is crucial in this endeavor.
- An effort must be made to pursue methods of communicating "grey literature" that is available in many African countries.
- SOMA-Net members need to appreciate the importance of translating scientific information into simple language that will enhance its utility for implementation at the grassroots level as well as at policy level.
- The concept of networking is critical in Africa because the capacity is there, but most scientists and institutions have been badly injured by lack of resources to maintain the available potential.
- There is an urgent need for institutions to be hooked up to electronic mail via Internet, which would facilitate the networking for the entire region.
- It is, moreover, important for the process of social science in health networks to be reviewed. In particular membership in local country networks should be expanded to incorporate scientists in all spheres that affect health. These include political scientists, lawyers, traditional healers, and others who are not usually visible.
- Content for transdisciplinary research needs to be made robust so that it is explicit what issues are at stake. Similarly the issue of peer review is necessary for all scientific work done by members. This will give credibility to research and project initiatives taken up by local scientists.
- There is need to build a data bank for social and science issues in health. This way a credible reference will be started to support decisions for health programs in the region.
- Appropriate methods for linking with other agencies would form a critical entry point in sharing available resources; this should be looked into.
- The use of comparative advantages for the Africa region is seen in the linkage existing among people in academia, private sector, and public sector, and this should be tapped very seriously so as to benefit the health social sciences disciplines. When professionals in the region network in international agencies it is important that they be assertive and create an enabling environment that gives priority to critical issues.
- We need to build South-South collaboration to create centers of excellence. The potential is there to then catch up with the North-South linkages for more growth in the region.

Recommendations for advocacy, research, and capacity building

Advocacy

- Champion the social sciences in health in medical institutions using trained biomedical scientists
- Produce and disseminate information providing a balanced view of disease foci and social science
- Document, publicize and disseminate case studies demonstrating how behavioral sciences have been/ can be used to identify social/cultural determinants of disease and illness, reduce the burden and risk of disease, prevent disease, promote health, prompt health sector reform
- Repackage and disseminate research results to indicate how culturally sensitive interven-tions can improve health of a community
- Develop a strategic advocacy plan for social science in health
- Develop standard tools for application and evaluation of social science in health, including definitions, indicators, analytical tools, conceptual frameworks, and monitoring and evaluation strategies

Research

- Design and conduct culturally compelling interventions that address health concerns and demonstrate the synergy between social science and health:
  - the link between social/cultural factors and adoption and use of new technologies and information,
  - the entry points where interventions are feasible economically, managerially, and technically
  - the connection between behavior and risk of diseases
  - links between popular indigenous understanding and accomplishments with stakeholders at community level (and in partnership with private government and NGOs sectors)
- Identify individuals with important and critical research questions

Capacity Building

- Develop a cohort of trainers/trainees who can analyze career path opportunities in SSH
- Develop and document conceptual frameworks for capacity building in SSH
- Organize brainstorming sessions and discussions for multi-sectoral partners in SSH around specific key topics
- Convene and facilitate meeting for scholars and experts to develop continuing education
- Develop communication skills for researchers so that results can reach the intended audiences
- Develop teaching and instruction tools for fusing biomedical, behavioral, and indigenous knowledge systems
- Develop trandisciplinary research capacity for advocates of SSH
- Design and develop SSH indicators for project development, monitoring, and evaluation

Networking

- Develop effective communication systems for the network, e.g., WWW, workshops, meetings; piggy-back ongoing activities (meetings/conferences/seminars) to disseminate SSH information
- Develop joint data bases with stakeholders in SSH
- Establish effective links with IHPP, THIP, NCHR and other like-minded organizations
- Co-sponsor projects, meetings, and publications with collaborators
- Develop a clearinghouse for best practices and lessons learned in SSH
- Link researchers with other professionals and innovators in SSH

Sustainability

- Develop a fund-raising program with specific details on timing materials and frequency, develop a cost-recovery format
- Initiate a small grants program to implement activities

- Broaden the donor base
- Put activities into a project framework
- Promote democratic management practices that include members' needs and interests
- Develop a culture of transparency
- Develop a quality control system for all products and services of the network

Minutes of the SOMA-Net General Assembly meeting held on 24th July 1997, at the Crown Plaza Monomotapa Harare, Zimbabwe

Agenda

1. Call to order - Chair
2. Adoption of the agenda
3. Confirmation of the minutes of the previous General Meeting
4. Matters arising from the minutes
5. Report of SOMA-Net's activities - Chair
6. Consideration of the audited accounts
7. Ratification/amendment of current constitution
8. Election of Governing Council, Executive Board, and Trustees
9. Venue for the 4th International Conference
10. AOB
11. Meeting of the elected Governing Council

7.1.97 Dr Wang'ombe, the SOMA-Net chair, called the meeting to order at 12.15pm.

7.2.97 The agenda was adopted.

7.3.97. Confirmation of the minutes of the previous General Assembly
Dr. J. Obiegbu of Nigeria moved to confirm the minutes as the true record of the previous meeting. The motion was seconded by Dr. A. Ashira of Togo.

7.4.97. Matters arising from the minutes
The suggestions made by members on the constitution were incorporated and the constitution circulated for comments.

7.5.97. Report on SOMA-Net activities
7.5.1 The Chair guided the participants through his report, which had been circulated earlier.

7.5.2. The Chair noted that the development of chapters was disappointing because the chapters had not initiated activities and they were not self-propelling.

It was recommended that:

- In future the report should highlight achievements as well as constraints.
- A strategic plan should be developed to enhance the goals and objectives of SOMA-Net.
- The report should include the extent of linkages with other like minded organizations and the nature of collaboration.
- Since membership fees cannot sustain the network a small grants program especially in transdiciplinary research should be considered that would be administered by SOMA-Net. The interest accrued from this grant could be used for SOMA-Net activities.
- A bilingual secretariat needs to be set up. French embassies could be approached to provide support for anglophones to learn French as part of a technical assistance effort.
- Before leaving the conference a small committee should be set up to examine these issues raised. However, it was decided that the incoming Governing Council should take this responsibility.
- SOMA-Net should market itself to various funding agencies. The timing for this is crucial as many of these foundations have new leadership looking for new initiatives.

7.6.97 The audited accounts
The accounts were accepted.

7.7.97 Ratification of the amended constitution
7.7.1. The Chair proposed that the assembly adopt the constitution provisionally so that the meeting could proceed. The Governing Council should then review the constitution and make recommendations. The assembly agreed with this proposal. The constitution was too detailed and contained by-laws that should be separated from the main constitution.

7.8.97. Election of the Governing Council, Executive Board, and Trustees
Prof. Wang'ombe vacated the Chair and Dr. Matchaba-Hove took over as the presiding officer. He reported that the International Organizing Committee went through the list of individuals suggested for the various positions by members and after consultations appointed the various posts subject to approval by the General Assembly.

Zimbabwe as the host will have the presidency and Dr. G. Woelk was appointed President by acclamation. Prof. Wang'ombe (Kenya outgoing) became an automatic member of the governing council. Other members and officers are:

Prof. Paul Nkwi (Cameroon) Central
Prof. R. Owor (Uganda) East
Dr. M. Mugabe (Botswana) - Southern (Anglo)
Dr. G Augusto (Mozambique) - Southern
Prof. M. Niang (Senegal) - Western

The Task Force members are:
Prof. Mwaluko (Tanzania)
Prof. Mbanefoh (Nigeria)
Dr. L Ethangatta (Kenya) - Treasurer

The three other members are:
Dr. Assih Ashira (Togo)
Mrs. R. Likwa (Zambia)
Ms. Neetham Morar (South Africa)

7.9.97 Venue for the 4th International Conference
Nigeria and Senegal volunteered to plan the 4th International Conference. It was agreed that Senegal, which is francophone, host the 4th International Conference and that Nigeria hosts the 5th International Conference. This suggestion, however, would need to be ratified at the next Annual General Meeting.

7.10.97 AOB
Some members felt that elections should have been held, instead of appointments. It was impressed upon them that SOMA-Net needed a solid constitution of leadership by individuals who know its mission, goals, and objectives. Most of the General Assembly members are very new to the network, the majority having just registered at the conference. It was pointed out that the decision was by consensus, which is also part of democracy.

A history of the appointed officials should have been given so that members would have had the opportunity to appraise them and suggest alternatives.

Due to problems with visas and complications of travel in Africa in future the host country should arrange with the Foreign Affairs Ministry to facilitate foreign participants to get visas in time for travel.

Being no other business the meeting ended at 2.15pm.

Present at the General Assembly

Prof. Acuda S.W.	- Zimbabwe
Dr. Assih A.	- Togo
Mr. Babiker M.	- Sudan
Ms. Chidimu M G.	- Zimbabwe
Prof. D.G. Willms	- Canada
Dr. Duale S.	- Zaire
Dr. Ethangatta L.	- Kenya
Prof.Mbanefoh G.	- Nigeria
Dr. Gathere S.	- Kenya
Mrs. Kamaara E.	- Kenya
Dr. Kanjo C.	- Malawi
Mr. Kasongo Mukalay	- Democratic Republic of Congo
Mrs. Katahoire A.	- Uganda
Mr. Katsumbe T.	- Zimbabwe
Dr. Khumalo-Sakutukwa	- Zimbabwe
Dr. Laver S.M.	- Zimbabwe
Ms. Makokha J.	- Kenya
Mr. Makoni P.	- Zimbabwe
Dr. Mamadou N.	- Senegal
Dr. Matchaba-Hove R.	- Zimbabwe
Ms. Mathai M.	- Kenya
Dr. Mbanefoh N.	- Nigeria
Ms. Moalosi G.	- Botswana
Ms. Morar N.S.	- South Africa
Ms. Mosongo R.	- Kenya
Mrs. Moyo I.	- Zimbabwe
Ms. Mtero S.	- Zimbabwe
Dr. Mufunda J.	- Zimbabwe
Dr. Mugabe M.	- Botswana
Dr. Mumba E.	- Zambia
Dr. Mumba E.	- Zambia
Mr. Ndekha A.	- Zimbabwe
Mr. Njoumemi Z.	- Cameroon
Dr. Nudelman A.	- Israel
Dr. Obiegbu N.	- Nigeria
Dr. Obiegbu J.	- Nigeria
Prof. P. Nkwi	- Cameroon
Dr. Pertet A.M.	- Kenya
Dr. Sebit M. B.	- Zimbabwe
Prof. Soyibo A.	- Nigeria
Ms. Tumbo B.	- Kenya
Prof. Wang'ombe J.	- Kenya
Dr. Woelk G.	- Zimbabwe

Apologies:

Dr. David Mwaniki (Kenya)	- Secretary
Mr. Elly Oduol (Kenya)	- Asst. Secretary
Dr. Jane Muita (Kenya)	- Treasurer
Dr. Wilson Kisubi (Uganda)	- Vice Chair

Financial Report for the Third International Conference - Harare, Zimbabwe

	Carnegie Corporation of New York	Rockefeller Foundation	IDRC	SIDA	SOMA-Net	
Budget lines						**Expenditure**
Air travel		5,988.00	2,751.00		3,150.00	11,889.00
Per diem		2,700.00	2,820.00		8,600.00	14,120.00
Accomodation and meals		260.00		7,621.00	4,400.00	12,281.00
Communications (Phone, Fax & Postage)		909.00	2,102.00	4,937.00		7,948.00
Local Travel					281.00	281.00
Stationery, Photocoping and Printing		21.00	203.00		3,683.50	3,907.50
Computers		104.00				104.00
Preparation	10,045.00					10,045.00
Planning Workshop	11,241.00					11,241.00
Total Expenditure	**21,286.00**	**9,982.00**	**7,876.00**	**12,558.00**	**10,499.50**	**71,816.50**
Total Funded	21,252.00	9,980.00	7,870.00	12,519.00	10,499.50	
Balance (Overspent)	(34)	(2.00)	(6.00)	(39.00)	0	

Annex I

International organizing committee

Prof. J.K. Wang'ombe	Chair, Social Science and Medicine Africa Network (SOMA-Net), Nairobi, Kenya
Prof. L. Erinosho	Chair, Center for Health Research (CHR), Nigeria
Prof. P. Nkwi	Coordinator, Network of African Medical Anthropologists (NAMA), Cameroon
Prof. G.M.P. Mwaluko	Manager, World Health Organization, African Region Joint Program on Health Systems Research, Zimbabwe
Prof. R. Owor	Coordinator, Essential National Health Research (ENHR), Uganda
Dr. A.M. Pertet	Coordinator, Social Science and Medicine Africa Network (SOMA-Net), Kenya
Dr. J. Mufunda	Chair, Social Science and Medicine Africa Network (SOMA-Net), Zimbabwe Chapter

Local organizing committee (Harare)

Dr. G. Woelk	Department of Community Medicine, University of Zimbabwe Medical School
Prof. G. Mwaluko	Joint Program on Health Systems Research, Zimbabwe
Dr. J. Mufunda	Dean, Faculty of Medicine University of Zimbabwe
Ms. S. Mtero	Secretary, Blair Research Laboratories
Prof. M. Mbizvo	University of Zimbabwe, Dept. of OBS/ GYNE, Medical School
Mr. T. Katsumbe	CIMAS
Dr. R. Matchaba-Hove	Department of Community Medicine, University of Zimbabwe Medical School
Dr. S. Chandiwana	Blair Research Laboratories.
Dr. M. Wellington	City of Harare Health Department
Mrs. I. Moyo	City of Harare Health Department

Conference rapporteurs - Prof. P. Nkwi
Dr. L. Ethangatta
Dr. Matchaba-Hove
Dr. Gertrude-Khumalo - Sakutukwa

Conference facilitators - Dr. Anne Pertet
Ms. Shungu Mtero
Ms. I. Moyo

Conference administrators - Mr. Michael Waweru
Mr. Phineas Makoni

Annex II

List of papers presented[1]

1.0. Opening address - Dr T. Stamps, Honourable Minster of Health and Child Welfare, Government of Zimbabwe

2.0. Keynote address 1 - His Exellency Professor Twumasi, The Ghanian High Commisioner to Zimbabwe, Editor of *Social Science and Medicine International Journal*

3.0. Keynote address 2 - Prof. G.1. Chavunduka, medical sociologist and specialist in traditional medicine, University of Zimbabwe

4.0. Position paper: Community Participation for Sustainable Health and Development, by Dr. Godfrey Wolke

4.1. La participation communautaire des populations en matiere de sante dans 4 villages du Togo, by Assih Ashira

4.2. Culturally-significant health education: A challenge for dealing with African health problems, by Anita Nudelman

4.3. Communication in primary clinical care: Problems and prospects in Eastern Uganda, by Anne Katahoire, Hanne Mogensen, and Susan Reynold Whyte

5.0. Position paper: Health Sector Policy Reform, by Prof. J.K. Wang'ombe

5.1. Addressing the shortage of health managers in Nigeria: The health economics approach, by Gini Mbanefoh

5.2. Health policy: From policy to reality, by Tonderai Katsumbe

5.3. An evaluation of the weekly disease surveillance in Midlands Province, Zimbabwe, by C. Zishiri

5.4. Job satisfaction and burnout among health care personnel: A Zimbabwean case study, by E. Makwarimba

5.5. Economic adjustment policies and the availability of resources for health: The experience of Sudan, 1985–1995, by M.A. Babiker

5.6. Health financing in Botswana: Innovations in policy and action, by Gillina Moalosi

5.7. Training of health managers and effective management of health institutions in Northeastern Nigeria, by S. O. Okafor

6.0. Position paper: Integrated Reproductive Health Approaches, by Dr. F. Zawaira

6.1. What is the role of research in implementation of integrated reproductive health approaches? by Dr. Brian Pazvakavambwa

6.2. The relevance, practical contradictions and challenges of implementing ICPD plan of action at country level: The case of Botswana, by Mbulawa Mugabe

6.3. Maternal mortality study: Factors contributing to maternal mortality in Mongu District, Zambia, by Mrs. Rosemary Likwa

7.0. Position paper: Ensuring Nutrition Security, by J. Tagwireyi

7.1. Improving the health of schoolchildren: Role of school health services (SHS) in Kwazulu-Natal (KZN), South Africa, by M. Taylor, C.C. Jinabhai, N.S. Morar, and D. Nzimakwo

7.2. Trends in the African nutritional situation: Nutrition insecurity, by Linda Ethangatta

7.3. The nutritional situation in Zanzibar, by Mohammed Dahoma

7.4. Perceptions, beliefs, and cultural practices contributing to under-five malnutrition in Zambia, by Dr. E.M. Nangaire

8.0. Position paper: Gender Health and Development, by Dr. A. Arkutu

8.1. Gender issues in health: Strengthening the NGO-grassroots communication links, by Margaret Mathai

8.2. Protecting the girl-child: Experience with a low-cost intervention in primary schools in Mwanza, Tanzania, by Zaida J. Mgalla

[1] Full papers can be obtained from the authors or the SOMA-Net secretariat.

8.3. African defination of masculinity and sexual/reproductive health, by Eunice Kamaara

9A.0. Position paper: HIV/AIDS Prevention Strategies in the African Region: Individual and Collective Experiences of Vulnerability, Risk, and Responsibility - Prof. D. Willms - convenor

9A.1. Facing the challenges of HIV/AIDS and other STIs: Case of Zomba District, Malawi, HIV/AIDS patients vs other patients, by Chipo Kanjo

9A.2. The reported quality of condom use by young adult Zimbabwean males at higher learning centers, Belvedere Teachers College, and Harare Institute of Technology, by Mathilda Gavazvinavashe

9A.3. Multidisciplinary teams of research: The experience of KAPH surveys on HIV/AIDS prevention in Cameroon from 1989 to 1996, by Njoumemi Zakariaou

9A.4. Socio-cultural factors in AIDS prevention in Zambia, by Elizabeth C Mumba

9A.5. The conflict between individual knowledge and social reception of AIDS: Case study from Nyanza rural area, Kenya, by Kasango Mukalay

9A.6. Was it implemented as planned? Looking at the real context of a community-based AIDS prevention intervention in Zimbabwe, by Susan Laver, PhD

9A.7. Key informant interviews as a means of informing clinical research design, by N. Khumalo-Sakutukwa

9A.8. The potential of the Senga model in the control of HIV/STDs among female adolescents in rural Uganda, by Muyinda Herbert

9B.0. Position paper: HIV - Lessons Learned and Best Practices for Behavior Change Interventions for HIV/STI Prevention - Dr. S. Duale - convenor

9B.1. Clinical & behavioral studies in Zimbabwe: A need for utilizing research results, by D. Lindsey

9B.2. Vaginal insertion and douching practices among sex workers at truck stops in Kwazulu Natal, by N.S. Mora, G. Ramjee and S.S. Abdool-Karim Morar

9B.3. The evaluation of an AIDS education program with post "O"-level students, by F. Zindi

9B.4. Safe sex practices among sex workers at risk of HIV infection, by Z .Gwamanda, N.S. Morar, G. Ramjee, S.S. Abdool-Karim Morar

10.0. Position paper: Health behaviors and substance abuse prevention among adolescents in secondary schools in Zimbabwe, by Prof. S.W. Acuda

11.0. Position paper: Strengthening Essential Drugs Programs, by Dr. N.Z. Nyazema

12.0. Position paper: Enhancing Social Science in Health for the African Region: Report of a Needs Assesment, by Prof. D. Willms

12.1. The ideal role for social science in health, by Tonderai Katsumbe

12.2. Research capacity building: The health systems research approach, by Amanda le Grand and G.M.P. Mwaluko

Annex III

Conference program

SUNDAY 20 July

14.30 - 18.00	Registration of participants International Organizing Committee meeting
18.00 - 20.00	Special meetings

MONDAY 21 July

8.00 - 9.00	REGISTRATION
9.00 - 9.30	OPENING CEREMONY Chair: Dr. J. Mufunda Welcome: Chair, Local Organizing Committee Message: Chair, SOMA-Net Prof. J.K. Wang'ombe Opening address: Dr. T. Stamps, Honourable Minister of Health and Child Welfare, Government of Zimbabwe
9.30 - 10.00	Keynote address 1: Professor G L Chavunduka
10.00 - 10.30	Keynote address 2: His Exellency Professor Twumasi, Ghana High Commisioner to Zimbabwe Vote of thanks - Dr. R. Matchaba-Hove, Local Organizing Commitee
10.30 - 11.00	TEA BREAK
11.00 - 11.40	Position paper 1: Strengthening the Essential Drugs Programme Chair: Prof. J.K. Wang'ombe Presenter: Dr. S.P. Munjanja Discussant: Dr. N. Nyazema
11.40 - 12.20	Position paper 2: Health Sector Policy Reform Chair: Dr. J. Mufunda Presenter: Prof. J.K. Wang'ombe Discussant: Dr. P.L.N. Sikosana
12.20 - 13.00	Questions and Comments
13.00 - 14.00	LUNCH BREAK
14.00 - 14.40	Position paper 3: Community Participation for Sustainable Health and Development Chair: Dr. Anita Nudelman Presenter: Dr. G. Woelk Discussant: Mr. A. Chingono
14.40 - 15.00	Questions and Comments
15.00 - 15.30	TEA BREAK
15.30 - 17.30	Syndicate work papers 1, 2, 3
19.00 - 21.00	WELCOME COCKTAIL Master of ceremonies: Dr. J. Mufunda

TUESDAY 22 July

8.15 - 10.30	Plenary - Committee reports & resolution papers 1,2,3
10.30 - 11.00	TEA BREAK
11.00 - 11.40	Position paper 4: Integrated Reproductive Health Approaches Chair: Dr. G. Woelk Presenter: Dr. F. Zawaira Discussant: Ms. M. Mathai Questions and comments
11.40 - 12.20	Position paper 5: Ensuring Nutrition Security Chair: Dr. G. Woelk Presenter: Dr. Julia Tagwireyi Discussant: Dr. L. Ethangatta
12.20 - 13.00	Questions and comments
13.00 - 14.00	LUNCH BREAK
14.00 - 14.40	Position paper 6: Gender Health and Development Chair: Mrs. R. Likwa Presenter: Dr. A. Artuku Discussant: Mrs. J.Kadandara
14.40 - 15.00	Questions and comments
15.00 - 15.30	TEA BREAK
15.30 - 17.30	Syndicate work 4,5,6
18.00 - 20.00	Special meetings

WEDNESDAY 23 July

8.15 - 9.30	Plenary syndicate reports and resolutions 4, 5, 6A
9.30 - 10.10	Position paper 7: Control and Prevention of Substance Abuse Chair: Prof. J.K. Wang'ombe

	Presenter: Prof. S. W. Acuda Discussant: Mr. N.Z. Nyazema
10.10 - 10.30	Questions and comments
10.30 - 11.00	TEA BREAK
11.00 - 12.00	Position paper 8: Facing the Challenges of HIV/AIDS and Other STIs Chair: Prof. A.S. Latif Presenter: Dr.L. Mbengeranwa Discussant: Mr. L. Kerkhoven
	8A. Workshop I: HIV/AIDS Prevention Strategies in the African Region: Individual and Collective Experiences of Vulnerability, Risk, and Responsibility (Dennis Willms)
- 13.00	8B. Workshop II: HIV - Lessons Learned and Best Practices for Behavior Change Interventions for HIV/STI Prevention (Sambe Duale)
13.00 - 14.00	LUNCH BREAK
14.00 - 15.30	Syndicate work 7, 8A, 8B
15.30 - 16.00	TEA BREAK
16.00 - 17.00	Plenary syndicate reports and resolutions 7, 8A, 8B
18.00 - 20.00	Special meetings

THURSDAY 24th

8.15 - 9.30	Position Paper 9: Enhancing Social Science in Health for the African Region: Report of a Needs Assesment Chair: Prof. P. Nkwi Presenter : Dr. D. Willms Disscussants: P. Nkwi, M. Mohale, J. Wang'ombe, T. Katsumbe
9.30 - 10.30	PANEL DISCUSSION on Collaboration Chair: Dennis Willms
10.30 - 11.00	TEA BREAK
11.00 - 13.00	CLOSING CEREMONY Chair: Dr. J. Mufunda
13.00 - 14.00	LUNCH BREAK
14.00 - 15.30	GENERAL ASSEMBLY/ Professional Visits
15.30 - 16.00	TEA BREAK
16.00 - 19.00	EXECUTIVE COUNCIL MEETING

FRIDAY 25 July TRAVEL

Annex IV

List of conference participants

1. **Mr. ABDULLA Abdulla S**
Ministry of State (80) Planning/Invest
PO Box 874, Zanzibar, TANZANIA
Tel: 034-31172 / Fax: 054-31172

2. **Prof. ACUDA Wilson S**
University of Zimbabwe,
Faculty of Medicine, Dept of Psychiatry
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: samara.acuda.zw

3. **Ms. ADAMS Lesley**
37 Lewisam Avenue
Chisipite, Harare, ZIMBABWE
Email: ladams@healthnet.zw

4. **Dr. ASSIH Ashira**
Université Du Benni
BP 1515, Lome, TOGO
Tel: 228-250748 / Fax: 228-218595

5. **Dr. AUGUSTO Gerito**
Ministry of Health
Eudardo Mondlane Avenue
Maputo, MOZAMBIQUE
Tel. 258-1-431103 / Fax: 258-1-431103
Email: gerito@cdins.uem.nz

6. **Mr. BABIKER Muneef A**
University of Khartoum
Dept of Economics
PO Box 321
Khartoum, SUDAN
Tel: 775427 / Fax: 776282

7. **Mr. Chidarikire Aidan**
Ministry of Health and Child Welfare
PO Box CY 1122 Causeway,
Harare, ZIMBABWE
Tel: 791155 / Fax: 795353

8. **Mr. CHINGONO Alfred H**
University of Zimbabwe,
Faculty of Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

9. **Mr. JUNEJA Romi**
McMaster University
22 Hanover Rd, #1803
Bampton, Ontario L6S 5K8
CANADA

10. **Dr. CHITSIKE Inam**
University of Zimbabwe,
Faculty of Medicine Dept of Paediatrics
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

11. **Mr. DAHOMA Mohameed J V**
Ministry of Health,
PO Box 236, Zanzibar,
TANZANIA
Tel: 32640

12. **Dr. DUALE Sambe**
SARA Project
Tulane University
1255 23rd Street NW
Washington, D.C. 20037
Tel: 202-884-8809 / Fax: 202-884-8701
Email: sduale6aed.org

13. **Dr. ETHANGATTA Linda**
UNICEF, OLS
PO Box 20811, Nairobi, KENYA
Tel: 254-2-520168 / Fax: 254-2-212389

14. **Ms. EYEGA Zeinab M**
RAINB W
915 Broadway Suite 1109
New York, NY USA
Tel: 212-477-3318

15. **CHIKASHA Georgina**
Ministry of Sport, Rec & Culture
47 Arungton Road, Hatfield,
Harare, ZIMBABWE
Tel:794450-9 / Fax: 707580

16. **Mr. GOMO E**
Blair Research Laboratory
PO Box CY 573
Causeway, Harare, ZIMBABWE
Tel:792747

17. **Mrs. GWATIRISA Pauline R**
Blair Research Laboratory
PO Box CY 573
Causeway, Harare, ZIMBABWE
Tel : 792747

18. **Ms. KAMAARA Eunice K**
Moi University
PO Box 3900, Eldoret, KENYA
Tel: 312-43049 / Fax: 321-43047

19. **Dr. GATHERE Samuel K**
Ministry of Health
PO Box 720, Garissa, KENYA
Tel: 131-2284

20. **Dr. KANJO Chipo E**
University of Malawi
PO Box 280, Zomba, MALAWI
Tel: 265-522222 / Fax: 265-522046
Email: kanjo@Onima.wn.apc.org

21. **Dr. KARAKIRE Wilson G**
Bank of Uganda
PO Box 7120, Kampala, UGANDA
Tel: 41-257232

22. **Ms. KATAHOIRE Anne R**
Makerere University CHDC
PO Box 6717, Kampala, UGANDA
Tel: 541684/530325
Fax: 256-41-531677
Email: torch@chdc.uu.imul.com

23. **Mr. KATSUMBE Tonderai**
CIMAS Medical Aid Society
PO Box 1243
Harare, ZIMBABWE
Tel: +263-4-773666

24. **Dr. KERKHOVEN Russell**
SAFAIDS
PO Box A509
Avondale, ZIMBABWE
Tel: 263-4-336193 / Fax: 336195
Email: russell@safaids.org.zw

25. **Ms. KHUMALO-SAKUTUKWA Gertrude N**
Social Scientist/ Researcher
Dept. of Obs/ Gynae
Medical School
University of Zimbabwe
PO Box A178, Avondale
Harare, ZIMBABWE
Tel: +263-4-707780
Email: gertrude@pather.icon.zw

26. **Dr. KWANKYE Stephen O**
University of Ghana Legon
PO Box 96, Accra, GHANA
Tel: 233-21-500796 / Fax: 233-21-500310
Email: pip@ug.gn.apc.org

27. **Prof. LATIF Suleman A**
University of Zimbabwe,
Faculty of Medicine, Dept of Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: alatif@healthnet

28. **Dr. LAVER Susan**
University of Zimbabwe,
Faculty of Medicine, Dept of Community Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: slaver@healthnet.zw

29. **Mrs. LIKWA Rosemary N**
Ministry of Health
PO Box 30205, Lusaka, ZAMBIA
Tel: 2601-253182 / Fax: 2601-253173
Email: hritlu.b@zamnet.zm

30. **Mrs. MADZIMA Rufaro**
Ministry of Health
PO Box CY 1122,
Causeway, Harare, ZIMBABWE
Tel: 726910x130 / Fax: 791169

31. **Ms. MAHLANGU Nomvuyo M**
University of Zimbabwe,
Faculty of Medicine Dept of Nursing Science
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: mahlangu@nursesc.uz.zw

32. **Ms. MAKOKHA Jacqueline J.**
NARESA
PO Box 11771
Nairobi, KENYA
Tel: 254-4-564633 / Fax: 254-4-564633
Email: NARESA@Healthnet.0rg

33. **Dr. MAKWARIMBA E**
University of Zimbabwe
Dept of Sociology
A204 Manyame Court,
East View Gardens,
Eastlea, ZIMBABWE
Tel: 303211 ext 1331

34. **Ms. MALUMBE Zippy**
Ford Foundation
PO Box 41081, Nairobi, KENYA
Tel: 246584 / Fax: 252830
Email: z.malumbe@fordfoudn.org

35. **Dr. MAMADOU N.**
Master of Research
Dept of Social Science
IFAN CAD University of Dakar
27 citi de Professeurs Avedes Ambassadeures
FANN-Residenci, Dakar
BP 5608, Dakar, SENEGAL
Tel: +227-250090 / Fax: +227-244918

36. **Dr. MAPANGA Kudakwashe**
University of Zimbabwe,
Faculty of Medicine, Dept of Nursing Science
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: chairman@nurses.uz

37. **Mrs. MAPANGA Margo B**
University of Zimbabwe,
Faculty of Medicine, Dept of Nursing Science
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: chairman@nurses.uz

38. **Dr. MARINDO Ravai**
University of Zimbabwe
PO Box MP 167, Mount Pleasant,
Harare, ZIMBABWE
Tel: 303211x1331 / Fax: 333407
Email: ravai@zimbix.uz.zw

39. **Mrs. MATAURE Priscilla N**
University of Zimbabwe,
Faculty of Medicine Dept of Community Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

40. **Dr. MATCHABA-HOVE R**
Faculty of Medicine
Dept. of Community Medicine
University of Zimbabwe
PO Box A178, Avondale
Harare, ZIMBABWE
Tel: +263-4-791631
Fax: +263-4-724912 / 791995

41. **Ms. MATHAI Margaret M**
INFOWIDE Consultants
PO Box 61018, Nairobi, KENYA
Tel: 788237
Email: mmathai@ken.healthet.org

42. **Prof. MBANEFOH Ginigeme F**
University of Ibadan
Dept of Economics
Ibadan, NIGERIA
Tel: 234-2-8101701 Fax: 234-2-8103043

43. **Mrs. MBANEFOH Nkechi**
NISER
PMB 5 U.I. Post Office
Ibadan, NIGERIA
Tel: 234-2-8102904 / Fax: 234-2-8103043

44. **Mrs. MGALLA Zaida J**
Tanesa Project
PO Box 434, Mwanza, TANZANIA
Email: tanesa@tan2.healthent.org

45. **Mrs. MOALOSI Gillian M**
PB 038, Gaborone, BOTSWANA
Tel: 267-357115 / Fax: 267-314697

46. **Ms. MOHALE Makhamokha**
WHO/ Health Systems Research
PO Box 348
Harare, ZIMBABWE
Tel: +263-4-728991 / Fax: +263-4-728998

47. **Ms. MORAR Neetha S**
Medical Research Council
771 Umbilo Road
Congella 4013, SOUTH AFRICA
Tel: 31-251481 / Fax: 258840

48. **Mrs. MOSONG Rose M**
SIDA/Ministry of Health Reproductive Health Project
PO Box 43319, Nairobi, KENYA
Tel: 725105/8

49. **Mrs. MOYO Irene**
Research and Development
Harare City Health
PO Box 596
Harare, ZIMBABWE
Tel: +263-4-774141 / Fax: +263-4-752093

50. **Ms. MTERO Shungu**
Deputy Director
Blair research Laboratory
POBox CY 573, Causeway
Harare, ZIMBABWE
Tel: +263-4-792747/-9

51. **Dr. MUFUNDA Jacob**
University of Zimbabwe,
Faculty of Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

52. **Dr. MUGABE Mbulawa**
University of Botswana
National Institute of Research
PB 0022, Gaborone, BOTSWANA
Tel: 267-3552915 / Fax: 267-357374
Email: mugabem@naka.ub.bw

53. **DR. MUMBA Elizabeth C**
University of Zambia
PO Box 32379
Lusaka, ZAMBIA
Tel: (260-1) 292702 / Fax: (260-1)253952

54. **Mrs. MUTITI Clara**
City Health Department
PO Box 596, Harare, ZIMBABWE
Tel: 792981 / Fax: 752093

55. **Mr. MUYINDA Herbert**
Medical Research Programme
c/o UVRTI P O Box 49
Entebbe, UGANDA
Tel: 42-20042 / Fax: 42-21137

56. **Dr. NANGAWE Elihuruma**
Ministry of Health
PO Box 30205, Lusaka, ZAMBIA
Tel: 2601-221476 / Fax: 2601-22435

57. **Mr. NDAMBAKUWA Henry W**
12 Auld Crescent
Eastlea, Harare, ZIMBABWE
Tel: 78603535

58. **Mr. NDEKHA Addmore**
Blair Research Institute
PO Box CY 53, Causeway,
Harare, ZIMBABWE
Tel: 792747

59. **Mr. NJOUMENI Zakariaou**
Institute of Research and Behavioural Studies (IRESCO)
PO Box 13888
Yaounde, CAMEROON
Tel: 237-214133 / Fax: 237-21-41-33
Email: irescoyde@camnet.cm

60. **Prof. NKWI Paul**
University of Yaounde
BP 1862
Yaounde, CAMEROON
Tel: +237-234227 / Fax: +237-221873
Email: paul.nkwi@camnet.cm

61. **Mr. NNKO Soori E A**
National Insitute for Medical Research
PO Box 1462, Mwanza, TANZANIA
Tel: 68-500399
Email: tanesa@tan2.healthnet.org

62. **Dr. NUDELMAN Anita**
Ben Gurion University
PO Box 53161, Tel Aviv, ISRAEL
Fax : 972-3-6491297

63. **Prof. NYAZEMA N Z**
University of Zimbabwe,
Dept of Clinical Pharmacology
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: blair@healthnet.zw

64. **Dr. OBIEGBU James N**
University of Abuja
Department of History
PMB 117
Abuja, NIGERIA
Tel: 8821380 / Fax: 8821605

65. **Prof. OKAFOR S.O.**
Dept. of Political Science And Administration
University of Maiduguri
Maiduguri, NIGERIA

66. **Prof. OWOR Raphael**
Makerere University
Kampala, UGANDA
Fax: 256-4-234579

67. **Dr. PERTET Anne M**
SOMA-Net
PO Box 20811
Nairobi, KENYA
Tel: 560569 / Fax: 567577
Email: somanet@africaonline.co.ke

68. **PAZVAKAVAMBWA Brian C**
GTZ HSR
PO Box 2406, Harare, ZIMBABWE
Tel: 733696 / Fax: 733695
Email:bpazva@harare.iafrica.com

69. **Mr. SAMKANGE C A**
University of Zimbabwe,
Faculty of Medicine, ICHE
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

70. **Dr. SEBIT M B**
University of Zimbabwe,
Faculty of Medicine Dept of Psychiatry
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912

71. **Mr. SEVERIN Kasongo M**
Unversity of Nairobi
PO Box 30197
Nairobi, KENYA
Tel: 254-2741323

72. **Dr. SHODU Kalema L**
Ministry of Health
PO Box 206
Gweru, Zimbabwe
Tel : 153-51394/7 / Fax: 51227/4727

73. **Prof. SOYIBO Adedoyin**
University of Ibadan
Department of Economics
Ibadan, NIGERIA
Tel: 234-2-8101701 / Fax: 234-2-8103043
Email:doyino.soyibo@ibadan. skannet.com

74. **Dr. TSHIMANGA Mufuta**
University of Zimbabwe,
Faculty of Medecine, Dept of Com Medicine
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: tshimang@harare.iafrica.com

75. **Mrs. TUMBO Kavili B**
Ministry of Health
PO Box 30016, Nairobi, KENYA
Tel: 254-2-717077

76. **Prof. WANG'OMBE J K**
University of Nairobi
Dept of Community Health
PO Box 19766, Nairobi, KENYA
Tel: 254-2-724639 / Fax: 254-2-718204
Email: somanet@africaonline.co.ke

77. **Dr. WILLMS Dennis G**
McMaster University
CANADA
Fax: 519:893-4438
Email: dwillms623@aol.com

78. **Dr. WOELK Godfrey B**
Dept. of Community Health
University of Zimbabwe
POBox A178, Avondale
Harare, ZIMBABWE
Tel: 791631 / Fax: +263-7924912
Email: woelk@healthnet.zw

79. **Mr. ZAMBUKO Oliver**
University of Zimbabwe
PO Box CY 1195, Causeway,
Harare, ZIMBABWE
Tel: 303211x1331

80. **Dr. ZISHIRI Christopher**
PMD Midlands
PO Box 206, Gweru,
ZIMBABWE
Tel: 154-51227

81. **Dr. ZVINAVASHE M**
University of Zimbabwe,
Faculty of Medicine, Dept of Nursing Science
PO Box A178, Avondale,
Harare, ZIMBABWE
Tel: 791631 / Fax: 724912
Email: zvinavashe@nurses.uz

Members of SOMA-Net Governing Council

Dr. G. Woelk (Zimababwe) - President
Dr. L. Ethangatta (Kenya) - Treasurer
Prof. Paul Nkwi (Cameroon) - Central
Prof. R. Owor (Uganda) - East
Dr. M. Mugabe (Botswana) - Southern (Anglo)
Dr. G. Augusto (Mozambique) - Southern
Prof. M. Niang (Senegal) - Western
Prof. G.M. Mwaluko (Tanzania)
Prof. G. Mbanefoh (Nigeria)
Prof. J. Wang'ombe (Kenya)
Dr. Assih Ashira (Togo)
Mrs. R. Likwa (Zambia)
Ms. Neetham Morar (South Africa)

Members of the Executive Council

Dr. G. Woelk (Zimababwe) - President
Dr L Ethangatta (Kenya) - Treasurer
Prof. Paul Nkwi (Cameroon) - Central
Prof. G. Mbanefoh (Nigeria)
Prof. Wang'ombe (Kenya)
Dr. Anne M. Pertet (Kenya) - CEO/ Coordinator

This report was compiled by Dr. Anne Pertet
It was edited by Ms Margaret Crouch, and designed and produced by SOMA-Net. The statements made and views expressed are solely those of the authors.