

INTRODUCTION

The visionary goal of ‘Health for All’ remains as vital today as when it was first expressed in the Alma-Ata Declaration on Primary Health Care in 1978 [1]. Interest in comprehensive primary health care (CPHC) is rising on national and global institutional agendas, and for three principal reasons:

1. Despite impressive developments in bio-medicine there has been mixed progress in improving health [2, 3].
2. Inequities in both wealth and health have increased over the past two decades, and in many countries health status has stagnated or even worsened. Action on social determinants of health will contribute to reducing these health inequities [4-14].
3. Emphasis on selective, vertical and disease centered approaches has led to an unsustainable patchwork of health interventions that is increasingly recognized as an impediment to progress on the Millennium Development Goals in many parts of the world [15-23].

There is also a long and impressive experience with CPHC approaches to health system planning and delivery [24, 25]. Too little attention, however, is often given to the importance of the local context within which CPHC efforts take place. These contexts, in turn, both condition and constrain the full implementation of CPHC, leading to numerous partial implementations and a need to understand not only their accomplishments, but how those that have moved closer to an idealized CPHC have been able to do so [26-29]. Our initiative will fill this knowledge gap by bringing together practitioners, researchers and research users to document more fully CPHC lessons from the past, and to conduct research on CPHC activities in the present. Our goal is to increase an understanding of, and support for, CPHC as a basis for health system revitalization. In short, we intend to renew, expand and deepen the evidence base for CPHC, recognising that no such systematic effort has occurred since the 1970s and 1980s.

Our work proceeds from three key propositions that inform our vision for this initiative:

1. Provision of effective, efficient, equitable and sustainable health care (including disease prevention and health promotion) depends on a broad programmatic approach which is directed to meeting the primary health care needs of communities (including vulnerable and marginalized people) while also addressing the social conditions threatening their health. CPHC provides the basis for such a programmatic approach, although the need to interrogate and expand upon the evidence base of its effectiveness remains.
2. CPHC principles have been sharply contested by other models of health care delivery. The controversy results partly from a perception of an inadequate evidence-base and from unresolved policy debates including selective versus comprehensive programming; the roles and interrelationships of the public and private sectors; and the role/importance of popular participation and mobilisation in programs of care and prevention. There is an urgent need to synthesize and provide new evidence that addresses these areas of controversy.
3. Research to provide such evidence poses many methodological challenges, including the plurality of knowledge systems (e.g. technical, lay, culturally-embedded) and methods for gathering the required evidence; issues of voice and power in defining, generating and interpreting such evidence; the need to address the concerns of local practitioners and research users; and, above all, the need to integrate the context-specificity of CPHC implementation into generalized lessons about its impact and effectiveness,

There are three overarching research questions that drive our initiative:

Question 1. What is the evidence of the effectiveness of comprehensive primary health care on:

- a. increased equity in access to health care and other services/resources essential to health
- b. reduced vulnerabilities through changes in community empowerment (capacities)
- c. reduced exposures to risk through changes in social and environmental determinants of health
- d. improved participatory mechanisms and opportunities and political capabilities of marginalized population groups reached by comprehensive primary health care initiatives
- e. increased community resilience to enable effective responses to promote and protect health
- f. equitable increase in population health outcomes

Question 2. To what extent will an international capacity building program on research skills for CPHC, facilitated by the People's Health Movement (PHM) and involving practitioners, managers and policy makers, contribute to strengthening the evidence base for the effectiveness of CPHC?

In answering the above two questions, we will attend to, and develop new knowledge on:

- a. What strategies or mechanisms used by CPHC in different contexts work best to achieve the outcomes specified above.
- b. How the development level and political and policy context of countries, or within-country inequities in wealth and/or regional differences in policy, affect these impacts.
- c. What combinations of resources, policy and state/civil society/university relationships facilitate and sustain appropriate and effective comprehensive primary health care.
- d. What types of strategies or forms of mobilisation have secured the above resource and organisational arrangements.
- e. What are the enabling and constraining international conditions for establishing sustainable comprehensive primary health care systems, including a consideration of how the macro economic and health sector reform (HSR) policies, concepts and methods of the industrialized countries and international financial institutions have influenced these international conditions.
- f. What research skills and methodological approaches are necessary to underpin the effective operation of CPHC and the production of a convincing evidence base.
- g. What is the role of locally conducted research projects in contributing to development of local CPHC systems and to the international evidence base on CPHC.

Question 3. What approaches to research, and what research/evaluation tools and methods, are most useful in advancing understanding of, and action on, CPHC implementation? Under this broad third question, we anticipate a number of important questions to arise from new local projects developed by research teams participating in our training courses. An indicative set of questions, based on discussion with our strategic research users, include:

- a. What program evaluation methods are most suited for use in a CPHC setting?
- b. How can the effectiveness of community empowerment in CPHC be measured?
- c. What research and implementation knowledge, skills and values may be required for the advocacy component of CPHC in particular contexts?

- d. To what extent do existing methods of quality assurance designed for community health settings capture the effectiveness of CPHC?
- e. How can health information systems be modified to take greater account of local and culturally-specific health frameworks and indicators, particularly for Indigenous groups?
- f. What is the cost-effectiveness of CPHC in particular settings?
- g. To what extent do the health care reform processes being implemented in particular settings support the implementation of CPHC?
- h. What indicators can be used to measure the extent to which a health system has re-orientated towards CPHC?

These questions will be answered through development of a conceptual framework of CPHC, a comprehensive narrative review of past CPHC experiences, and a unique ‘research-in-action’ training program that partners new health researchers with research users. The combined training/research program builds upon the networks established by the People’s Health Movement, the training programs of the International People’s Health University, and the reservoir of CPHC research and practice experiences of the initiative core research team and their strategic research partners in three geographic regions: India (extending to others of South Asia), Africa (focussing first on South Africa, Tanzania, Zimbabwe), and Latin America (focussing first on El Salvador, Nicaragua, Bolivia, Ecuador, Colombia, Brazil); and one cross-regional population group (Indigenous communities in Australia and Canada).

The rationale for including Indigenous groups in Canada and Australia is the well-known fact that they are often referred to as the ‘fourth world’ within these high-income countries. Key Indigenous health organizations, researchers and research users from both countries are part of our core team. The African countries have been selected because their past CPHC experiences have been substantial, while also partial and amenable to new research and knowledge generation. The same applies to the sub-continent of India, where the Indian People’s Health Movement has been active in promoting a ‘right to health care’ campaign for the past several years, providing a strong community mobilization base upon which to build. The two Central American countries (El Salvador and Nicaragua) have been selected because they both had promising CPHC experiences that subsequently stagnated, are experiencing resurgence in interest in CPHC and have been sites for recent evaluative studies of past CPHC initiatives with which two of our core team were heavily involved. Of the South American countries, Bolivia’s new government is committed to a rapid ‘roll out’ of CPHC, as is the Mayor of Bogota, Colombia, creating new natural experiments. Ecuador has existing CPHC projects, and is also strengthening new ones with the *indigena* in the Amazonia regions; and several states in Brazil have recent large CPHC initiatives, some of which have been evaluated, others not. Our initiative includes researchers and research users familiar with, and/or working in, all of these sites. All selected sites lack adequate research capacity and are committed to research capacity-building, both generally and with specific reference to CPHC.

1. CPHC as a policy and programmatic model

CPHC is the most widely recognised model for developing comprehensive community health services. It is a ‘whole-of-health-system’ approach that incorporates district administrative and specialist support to the primary level of care. Intrinsic to CPHC is community empowerment as

part of a strategy for better and more equitable health outcomes and improved health system accountability. CPHC arose, in part, as a response to the increasing recognition of the limitations of a bio-medical and technological approach to improving health and as an affirmation of numerous experiences of community based health care [30]. These included the use of auxiliary health workers in many developing countries, the massive expansion of rural medical services in Communist China and the impacts of (comparatively) low-cost yet comprehensive health, education and (in some cases) welfare programs in Tanzania, Cuba, Vietnam, Nicaragua and Sri Lanka [25, 31, 32]. The three essential features of these CPHC approaches were their recognition that promotion of health depends fundamentally on improving socio-economic conditions and alleviating poverty and underdevelopment; that, in this process, people in their community/citizen roles should be both major activists and the main beneficiaries; and that health care systems should be restructured to support priority activities at the primary level because these respond to the most urgent health needs of the people [16, 25].

CPHC can be considered a political philosophy of health as well as an implementation strategy. As a philosophy it emphasizes equitable distribution in access to basic health care; disease prevention and health promotion; community participation in program and service planning; intersectoral coordination of programs and services; and use of appropriate technologies. As an implementation strategy CPHC, in its earliest iteration, had eight essential elements [1]:

1. education concerning prevailing health problems and the methods of preventing and controlling them;
2. promotion of food supply and proper nutrition;
3. adequate supply of safe water and basic sanitation;
4. maternal and child care, including family planning;
5. immunization against the major infectious diseases;
6. prevention and control of locally endemic diseases;
7. appropriate treatment of common diseases and injuries;
8. provision of essential drugs.

We provide below three brief ‘indicative’ cases of CPHC implementation, as well as the research approaches used to achieve their objectives. As is common in other experiences of implementation of complex, multifaceted policies, these cases differently demonstrate in varying degrees the achievement of CPHC, with certain of its principles being fully realised in some cases and in others partially or not at all.

1. CPHC in rural and Indian villages eliminates preventable infant mortality

Fourteen years ago, infant mortality was higher in Bolivia than in any other area of Latin America, and in some Quechua villages more children died than lived. In response, a team of medical volunteers and Quechua personnel was formed, mostly from the same villages. A participatory needs assessment was conducted, health care was offered from a Health Center in the village of Sapanani and health education activities commenced with the peasant unions, children and village leaders. Later, more distant villages became involved by constructing health

centers that were connected by 24 hour radio communication, allowing coordination of the medical activities of a nurse, nursing assistants and health promoters. The role of traditional medicines was explored and a solidarity fund established, contributed to by all families and administered by villagers. Community health work focused on basic sanitation, and development of potable water systems in all the surrounding villages. Since malnutrition was the principal cause of child death its prevention and treatment was established through a Center for Nutritional Recovery that also worked in the villages, helping mothers in rehabilitating their children with moderate malnutrition. This led to an agro-veterinary project that increased the production of nutritious food through the raising of small animals, trout farms and improving farm production through irrigation systems. An educational component now includes construction of a training center for village groups, adult literacy training, teacher upgrading, school construction and participation in democratization of government structures. By the end of 2005 this program had achieved an infant mortality of zero from malnutrition, diarrhea, pneumonia and infanticide, and zero maternal mortality, with 97% of the most common diseases being resolved at village level. Universal child immunization coverage has also been achieved through a large network of health promoters and organized mothers groups.

2. Community empowerment in CPHC creates healthy change, but can also create political conflicts.

The SILOS (Local Health Systems) Zona Norte is a CPHC example that developed in 6 municipalities of San Salvador in the enabling socio-political environment immediately after the peace-agreements (1992) that ended El Salvador's civil war. The initiative to develop a CPHC project in one of the main former conflict areas involved local governments and community-based and non-governmental organizations, and built upon the history of participation/organization of many of the former refugee population, as well as upon opportunities provided by external donors and the Ministry of Health. The project's participatory focus (which extended to all phases of research and evaluation, using community empowerment and popular education methods), its intersectoral approach and the formal agreement to address the underlying causes of the conflict in a non-violent way favoured the development of the SILOS. The effectiveness and the impact of the actions were illustrated by a reduction in violence and illiteracy rates, improved sanitation and water access and the limited impact of a cholera epidemic compared to other areas of the country. However, the model also produced serious contradictions. Despite strong support from local officials, central government officials perceived the reinforced organization and community empowerment as not conflicting with the dominant political priorities of the still heavily polarized Salvadorian society, and as a potential threat to political control over the area. In 1996 the central government suspended all official support by the Ministry of Health. The local communities were able to continue the development for some time, but the Ministry of Health withdrawal reinforced managerial weaknesses and organizational deficiencies in the SILOS project. An alternative health care project has since been set up by the World Bank in the area, but it changed the participatory and intersectoral emphasis to one of SPHC that is fundamentally biomedical [33].

3. Participatory health systems research meets primary health care needs

Research and development activities to improve the management of severe childhood

malnutrition in rural hospitals have been continuing in the impoverished former Transkei “homeland” in South Africa since 1998. The research has involved detailed situational assessments and analyses by paediatric ward staff of the Eastern Cape Department of Health, working with an outside research team from the University of the Western Cape. The research revealed unacceptably high fatality rates and serious deviations from the WHO management protocol on malnutrition resulting from knowledge and skills deficits, inadequate resources and staff, and poor supervision and support from managers. Responses included additional resources and sustained training and supportive supervision, together with ongoing monitoring that is now a routine activity. This process has been successful in reducing case-fatality rates by, on average, 33% across 11 district hospitals. Ongoing research is attempting to elucidate why some hospitals perform consistently better than others with equivalent infrastructure and resources, and indicates that differences in management and leadership are key explanatory factors. Follow-up research of the children showed that they returned to food insecure homes and, although all households qualified for a government welfare provision to poor families (the Child Support Grant or CSG), none was receiving it, despite strenuous efforts on the part of most caregivers. Their testimony and these research findings were used in an advocacy campaign mounted by an alliance of researchers, practitioners and a consortium of child welfare organisations, comprising formal submissions to government, newspaper articles prompting questions in parliament and a prime-time television documentary. The latter prompted immediate intervention by the Minister of Social Development, and resulted in a sharp and sustained increase in CSG distribution and greater attention to the role of household food insecurity as a causal factor in malnutrition, which has since catalyzed into a nation-wide campaign. This case illustrates the powerful potential of implementation research in developing capacity for self-evaluation, the first step in improving quality of care, as well as in providing evidence for advocacy that has resulted in intersectoral collaboration to address (some of) the determinants of child malnutrition.

There is a history of strong policy support for CPHC at the international level, spearheaded by the World Health Organization which has repeatedly endorsed the concept and published reports and manuals on its implementation [34-38]. The WHO in particular has advocated for strengthened district health services, use of community health workers and as a facet of the later health promotion initiative, intersectoral coordination of implementation strategies. It has also identified CPHC as a priority in its General Programme of Work [39] for the next decade, and AFRO (WHO’s Africa Regional Office) has recently resolved to revitalize PHC as a strategy to reconstitute health systems [38]. The WHO’s Commission on the Social Determinants of Health (with which several of this initiative’s applicants are involved) will give increased prominence to CPHC [40]. The Commission is targeting both health determinants and health systems in its work, with the intent of defining ‘best practices’ that are reducing health inequities within countries. CPHC potentially offers one of the best responses health systems can make, and will be an area of study of one of the Commission’s knowledge networks. Finally, CPHC continues to inspire community health workers around the world, partly indicated by its centrality in the work of the PHM. The PHM called for CPHC revitalisation at both of its People’s Health Assemblies (2000, 2005) and in the documents that were produced following these meetings – the People’s Health Charter [41] and the Cuenca Declaration [42]. The rapid rate at which the movement has grown is testimony to the desire for a revitalisation of CPHC principles and strategies and of a strong civil society movement backing the thrust of this application.

Implications for this initiative

Since CPHC arose first in the context of the greater burden of disease faced by (especially poorer) groups in low and middle income countries (LMIC), the emphasis was logically on communicable diseases and their basic vectors, and maternal/child health. They are now compounded by an incomplete ‘epidemiological transition’ in which chronic disease and its multiple causes increasingly accompany barely diminished (in some countries worsened) these ‘pre-transitional’ disease burdens [43-50]. Moreover, many high income countries (HIC) experience serious inequities in access to community health services and the underlying determinants of health. This has particularly been the case for marginalized populations, in Canada and Australia most strikingly so for Indigenous/Aboriginal peoples [51-53]. Thus, CPHC took on philosophical and programmatic significance in many HICs which did not face (at least to the same degree) the communicable disease burden experienced by LMICs. Simultaneously, the rise in health policy discourse of health promotion, population health and the social determinants of health has directed practitioners, policy-makers and researchers in both LMICs and HICs to the implications of deeper social structures and conditions for health outcomes. These shifts in both disease burden and understanding of its causes require an updating of the ‘essential elements’ of CPHC first identified by the Alma-Ata Declaration. One potential tool for this is Article 12 (the Right to Health) of the International Covenant on Economic, Social and Cultural Rights, which obligates States Parties (of which there are over 150) to ensure “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” General Comment 14 on this Article further clarified that the right to health encompasses not only timely and appropriate health care, but also key underlying health determinants, including “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health”[54-61] .

This updating of CPHC’s ‘essential elements’ will guide the narrative summary of past CPHC experiences to be conducted in Year 1. This synthesis will be organized around our three core research questions, and will build upon a number of recent regional studies of CPHC, including *Rescate* (Rescue of Innovative Health Initiatives in Central America) [33], papers from the WHO CSDH and new population-specific syntheses such as the one on child health (see attached letter). Comparative case study analyses that form part of this narrative summary will help to identify policy environments that enable or constrain CPHC, broader political and economic changes that have caused CPHC momentum to regress and other contextual elements (e.g. civil society mobilizations, media, positions adopted by health professional organizations, the role of international non-governmental organizations and other aid agencies in health services delivery). Such analyses will permit a richer and more precise understanding of CPHC implementation lessons. Finally, we emphasize that most experiences with CPHC have been partial, and that implementation of CPHC can be considered to fall somewhere along a spectrum ranging from an idealized ‘full’ implementation, to varying degrees of partial implementation, to community health systems that are dominated by selective primary health care (SPHC) or simply primary care (basic medical treatment only). This underscores our interest in emphasizing an examination

of the social and political contexts that function as independent variables, predicting the extent to which a fuller implementation of CPHC is possible.

2. CPHC's contested principles and implementation strategies

One of the reasons why CPHC implementation falls along a continuum is that the CPHC model of community health services is not the only one. Others include the intervention packages promoted by the World Bank [62] and the WHO Commission on Macroeconomics and Health [63]; primary (medical) care - a *de facto* model which identifies general medical (clinical) services as the core of local service delivery or, if taking a broader view of the services to be provided locally, retains a largely biomedical approach to delivery; and selective (vertical) programs such as those funded through the Global Fund for AIDS, TB and Malaria. The principles of CPHC have been sharply contested by many of these models, the roots of which in CPHC "explicitly outline a strategy that would respond more equitably, appropriately, and effectively to basic health needs and also address the underlying social, economic, and political causes of poor health" [16]. Policy makers, donor agencies and national leaders soon realized the "liberating nature of PHC," which quickly resulted in "resistance to its implementation" [25]. Selective Primary Health Care (SPHC) quickly arose as a competing concept, in which only interventions that contributed most to reducing child (< 5 years) mortality were given priority. SPHC advocates argued that CPHC was too idealistic, expensive and unachievable in its goals of achieving total population coverage, with greater gains possible through a focus on growth monitoring, oral rehydration therapy, breastfeeding and immunisation [64]. SPHC took the decision-making power and control central to CPHC away from the communities and delivered it to foreign consultants with technical expertise in these specific areas [16]. SPHC was attractive to political leaders for a number of reasons: it was expected to give spectacular results within a short time; it would deal with high prevalence health problems; it was assured support from international organisations and donor nations; and it promised a simple and less resource-demanding alternative to establishing a network of permanent and equitably accessible health services [65]. SPHC also had the effect of shifting focus from the awkward political issues of underlying health determinants rooted invariably in pervasive poverty or inequality, and offered more easily quantifiable and achievable outcomes. At issue has been the sustainability of selective programs over the longer term, their tendency to multiply and create greater incoherence and inefficiency in health systems, and their lack of attention to root causes of particular disease. Selective interventions were also likely to depend upon a more comprehensive health service setting [65]. Recent experience in Africa shows that where health systems are weakened, selective multiple parallel selective strategies compound rather than solve problems. CPHC services may be more costly initially to set up than SPHC programs but are crucial to the support, acceptability, impact, and sustainability of any disease specific interventions [65-69].

Recent international policy prescriptions also emphasize the role of the private sector in health system reform, whether as privatization of public services, public-private partnerships, two-tiered insurance and/or delivery schemes or cost-recovery (user-fee) financing models, often promoted by the International Financial Institutions. During the 1980s and 1990s, the IFIs promoted market oriented approaches where the priority was the need to protect funds to pay debts rather than to develop health systems, essentially globalizing a 'residual' model of welfare. The weight of evidence of such privatized systems (much of it coming from Latin American

countries where many are attempting to reverse their privatization schemes of the 1980s and 1990s) is that, regardless of the safety nets in place for the poor, privately insured and delivered health services and systems increase inequities in health care access and widen health gaps between population groups [2]. Poorer women, rural populations and indigenous peoples are often the most affected [70].

Implications for this initiative

A distinguishing element of CPHC is its comprehensiveness via the integration of clinical service delivery with local level disease prevention and health promotion through intersectoral efforts community involvement. Alternative models envisage greater separation of clinical services and population health programs. Cutting across these different structural models are different funding arrangements and configurations of public and private providers. The Alma-Ata Declaration was not explicit about funding mechanisms or about the role of private providers, although the CPHC movement has generally assumed government funding as the primary revenue source and a predominant role for publicly accountable service provision. The sector of direct service delivery (public or private) may be less important than the principles of organisational coherence, public management and public accountability. Our narrative summary will address rigorously and empirically the substantive criticisms of the CPHC model implied by these alternative models. A critical gap our initiative will attempt to fill is the evidence base for the cost-effectiveness argument that has been used to justify SPHC interventions (e.g. World Bank's *Investing in Health* Report and *Disease Control Priorities in Developing Countries* [71]project) to the implicit or explicit exclusion of CPHC. Finally, key claims of CPHC have been its ability to engage citizens in empowering forms of local, regional or national campaigns; to prioritize its community development to the most marginalized or vulnerable groups; and to create linkages across sectors and amongst civil society organizations. Evaluative studies of these claims are often more descriptive than analytical, with little information on how such actions have affected health outcomes or health determinants. The principles of efficiency and cost effectiveness are important and there is an urgent need for rigorous cost effectiveness studies of CPHC but it is also vital that these conceptualise both 'cost' and 'effectiveness' in terms which correspond to the principles and objectives of CPHC.

3. Methodological challenges for new research and evaluation

Research on CPCH faces a range of methodological challenges, principally concerned with the context sensitive nature of CPHC development. The principles of Alma-Ata are not the equivalent of treatment protocols in medicine. They are broad directional statements which can have very different implications in operational terms depending on context. Two of the methodological challenges this poses have been the ways in which 'evidence' and 'scaling up' have been positioned in much of the policy discourse on health services. Specifically, traditional research methods that 'control out' context, while proving powerful in generating information and new technologies that are effective when context is less important (e.g. clinical interventions), are less relevant to interventions based on complex social interactions, where knowledge is not singular, causality is multiple and interpretation of significance is related more to social relations of power and policy pragmatism than to statistical significance [72]. These points were underscored by research undertaken by the Joint Learning Initiative [26]:

First, ... international public health efforts are deeply influenced and critically shaped by their political context. ... Second, the culture of international health organizations must be acknowledged in order to understand what priorities will emerge at any particular time and which will survive ... Third ... [t]he translation of plans into actual programs requires a great deal of persistence and negotiating skill to make them real and keep them functioning. Fourth, international health initiatives must reckon with deep-seated historical and cultural traditions, local realities, and global forces. ... Fifth, top-down initiatives cannot expect to succeed without real bottom-up support. ... A single agenda or set of priorities cannot suit all circumstances [26].

The consequent need to accept evidence of broadly 'social' health interventions as inherently pluralistic and often contested, with careful attention to issues of voice, experience and context, has also been acknowledged as central to the work of the WHO's Commission on Social Determinants of Health:

Taking an evidence based approach does *not* mean relying on ... only one kind of method ... and it does *not* mean an epistemological commitment to objectivity above subjective positions or methods. ... [M]ethods include, but are not limited to, case studies, large scale data sets, historical reports, qualitative data drawn from interviews, focus groups, or observation, social surveys, economic and econometric reports, epidemiological data, evidence synthesis, systematic reviews, other forms of literature reviews, meta analysis, and accounts of lay or tacit knowledge [73].

Finally, given the contextual nature of CPHC processes, and the diversity in human populations and histories [26, 27], whether particular interventions that worked in one context can be 'scaled up' across other contexts or even in other countries is called into question. The very notion of 'scaling up,' unless careful attention is paid to both context and community processes, can undermine the CPHC principle of 'bottom-centered' planning, in which local knowledge is combined with other forms of knowledge or evidence to make reasoned and usable judgments about new interventions.

Implications for this initiative

There are two major implications that these methodological challenges pose for our initiative. The first is the need for detailed, context-sensitive and specific information on the implementation of CPHC, in order to understand better how or why it affects health outcomes and health determinants (core research question 1). Recent reviews of health promotion evaluation research have established that the success (or lack) of any multiple intervention strategy (and multiple intervention is one of the ways in which CPHC is differentiated from SPHC) depends on the broader social and political context in which the interventions take place [74]. The important evaluation findings thus pertain to the relationship *between* context and strategy, rather than to one or the other alone. While multi-level research designs can provide some useful information about this relationship, these are expensive, require reliable data sets and still attempt to control for the relative importance of one set of variable relations over another, limiting their usefulness in capturing the *dynamic* elements of community participation, civil society campaigns, policy shifts and other contingencies [75]. These dynamics are best captured through sophisticated case study designs with 'thick description,' and which utilize data triangulation to strengthen their reliability. But even detailed case studies in themselves do not offer generalizable knowledge about these dynamics. As two of our team members have argued at different times [76-78], there are ethical as well as scientific and pragmatic imperatives to seek

generalizable lessons from such case studies; this is the second major implication for our CPHC research undertakings. Generalizability of knowledge about the dynamic relationship between context and implementation that allows CPHC to create desired improvements in health, health determinants and community empowerment can be inferred using the methods employed in narrative summary (described later), which incorporate comparative case study design and analysis, and evidence-informed logical argument and judgment.

Summary

Persisting and, in some regions, increasing inequities in preventable mortality and morbidity amongst poor and/or marginalized groups have renewed calls for urgent attention and action. CPHC has been identified as one way of achieving this, although translating this concept into practice remains controversial and insufficiently documented. Particularly lacking are detailed syntheses and new studies that pay closer attention to the context in which CPHC implementation has been attempted, including analyses of the political, policy and resource dynamics at different geographic scales (local, national, regional, global). Such comparative and comparable studies will allow generalisation about the success factors associated with CPHC. Our proposal intends to fill this gap through a capacity-building process that begins with a rigorous retrospective study of recent CPHC experiences, building upon existing accounts, some of which have involved members of our core research team. With that as a base, our initiative will train research teams comprised of junior researchers and research users (supported by local or regional research mentors) and support new research on CPHC questions particular to their own contexts, albeit framed within the three core research questions that guide our initiative. This research will significantly improve our understanding of how CPHC works, and of the contextual factors that aid its implementation. It will also strengthen the networks of local practitioners and activists engaged with policy makers in promoting CPHC as an important basis for ongoing health system revitalization. Our initiative is based on existing South-North as well as an extended network of researchers, the research group collaborations involving the core by inviting research teams to, The initiative and research users in all of the four regions -will also create new North, participate in staged training courses and regional network meetings, importantly, South and South-South, linkages. The design of the initiative integrates capacity strengthening, knowledge generation and evidence-informed policy and management to improve the health of people in low and middle-income countries, especially the most vulnerable, and will cultivate a strong training and mentoring environment in partner countries.

GENERAL OBJECTIVES

Strengthen the evidence/knowledge base for how efforts to implement CPHC can (1) more completely embody the principles of the Alma-Ata Declaration and subsequent knowledge on the social determinants of health, and (2) function more effectively and efficiently to improve equity in health outcomes between population groups.

SPECIFIC OBJECTIVES

- Develop a common framework for describing and evaluating the impact of CPHC;
- Undertake a rigorous retrospective assessment of publicly available materials describing the features and experience of CPHC, emphasizing, although not restricted to, experiences in

partnering countries;

- Train a cohort of junior/mid-level researchers and research users (policy/program managers) in participating countries who have some familiarity with CPHC in their countries, and who are committed to producing knowledge that will inform policy, management and practice in CPHC;
- Initiate and support a program of new research on critical issues facing CPHC development and sustainability in partnering countries;
- Strengthen links between researchers and research users in partnering countries to ensure that ongoing research is relevant, responsive and accessible to various research users;
- Develop a sustainable infrastructure (based on IPHU) within the PHM for capacity building in CPHC development, including research capacity;
- Strengthen across the PHM familiarity with and skills in research methods appropriate to CPHC evaluation;
- Build and/or strengthen through the PHM networks of CPHC researchers and research users;
- Evaluate the impact of the entire program on new knowledge about, implementation of and support for CPHC in partnering countries.

METHODS

The research plan and methods consist of five linked and overlapping stages (see Figure 2: Timelines, below):

1. Conceptual framework development
2. Retrospective research
3. Research training/capacity building
4. Participant team research
5. Research-in-action

1. Conceptual Framework Development

No single model or theory is sufficient to inform a study of CPHC. Rather, our Draft Conceptual Framework flows from our three sets of core research questions that deal, respectively, with the determinants of health, actions to affect health outcomes and health determinants, and enabling or constraining conditions for such actions.

Our comprehensive understanding of the determinants of health is summed up by the stated desire of the CSDH to avoid the situation whereby people are treated for an illness and then given no choice but to return to the conditions that made them sick in the first place. Our Conceptual Framework is designed to understand a system in which health services can play an integral part in avoiding this. Thus while biomedical approaches to health and curative services are essential elements of CPHC they are only parts of a larger whole. What demarcates CPHC from primary (medical) care is its added emphasis on disease prevention and health promotion through interventions that act on “the causes of the causes” of ill-health [79]. The original Alma-Ata conceptualization of PHC restricted itself to such determinants as food, water and sanitation and such preventive measures as health education, immunization, maternal/child and reproductive care and control of endemic diseases. Since then knowledge of the importance of a vastly larger set of health determinants and intervention strategies has grown. There are many

models for identifying and mapping the dynamic interrelationships of these many causes. The one we chose is adapted from the WHO CSDH model (Figure 1), and has the advantages of comprehensiveness and likely dissemination to potential research users through the work of the CSDH. In this model, HEALTH OUTCOMES is the ultimate dependent variable, better understood as a collection of variables comprised of death, diseases, predisposing conditions and self-rated experiences of health ('positive health,' 'well-being'), the choices of which in any one CPHC study would depend on study's scope, availability of data and issues of greatest concern to local communities, practitioners and research users. HEALTH OUTCOMES also function as both explanatory and dependent variables if, for example, the economic success or otherwise of a community were being considered. In turn, HEALTH SYSTEMS, DIFFERENTIAL EXPOSURE/VULNERABILITY and SOCIAL STRATIFICATION might be considered independent or explanatory variables but could also be dependent variables. No single study is capable of determining which sets of variables in this model are more or less explanatory of health outcomes for any given population at any given time. Considerable knowledge of how these various determinants act separately, or together, to create disparities in health outcomes for different groups does exist. More knowledge about how these determinants affect health outcomes, particularly in developing world contexts, is expected to be synthesized by the different knowledge networks of the WHO CSDH. This broad model, which demonstrates the complexities and feedbacks of the system in which CPHC is situated and seeks to have impact, is an essential backdrop to our study. Our concern is to assess and analyze how the different strategies utilized by CPHC *affect* these many determinants. That is, our research initiative will create a better understanding of how CPHC affects health outcomes, and how it affects many of the health determinants in this model, but it will not study how the determinants themselves affect health outcomes.

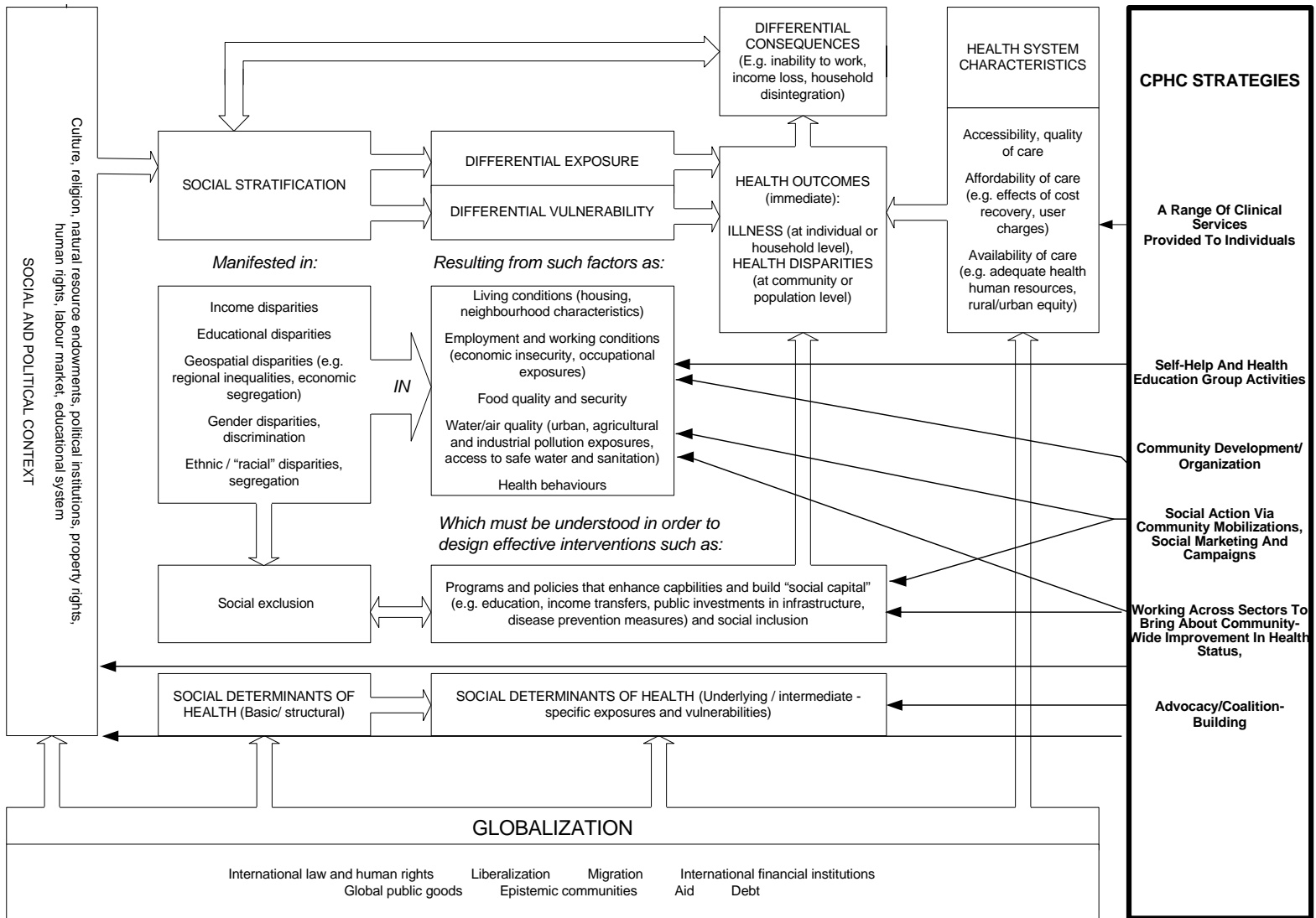
To understand how CPHC affects health outcomes and health determinants it is necessary to present the full range of strategies that CPHC uses, or could use, linking these in simplified fashion to different elements in the CSDH model. We have noted already that few examples of fully implemented *comprehensive* PHC exist. The strategies listed below, adapted from existing theory- and/or evidence-informed models, comprise an ideal typology that will be further developed through the retrospective research undertaken in Year 1. Several of our core research group (especially Baum, Sanders, Labonte and Legge) have been involved in previous and current research that has defined the main strategies of CPHC. Key strategic elements include:

- a range of clinical services provided to individuals (the mix differing depending on the context but including medicine, pharmaceuticals, counselling, physiotherapy)
- self-help and health education group activities
- community development/organization
- social action via community mobilizations, social marketing and campaigns
- working across sectors to bring about community-wide improvement in health status
- advocacy and coalition-building

Figure 1 shows where these strategies act on different health determinants. (The positioning is approximate and illustrative only.) Each of these strategies is designed to involve local people and result in their empowerment. Empowerment is based upon core social theories of power, community and social change, and is central to our CPHC framework and to CPHC evaluation (see, for example, the appended letter from CACHCA, one of our strategic research users). One

of the co-principal applicants has published extensively on the theory, implementation and evaluation of empowerment and his work is being used in a current study of how CPHC in Canadian community health centres contributes to empowerment.

Figure 1. CPHC and the determinants of health [40, 80, 81]



Contextual Factors that Enable or Constrain Strategies

All of these CPHC strategies entail human interactions at different levels (e.g. health worker – patient, health worker – community members – policy maker) and at different scales (e.g. individuals, small groups, formal organizations, institutionalized bureaucracies, the latter of which may be local, regional, national or even global). The important point is that these interactions occur in complex and dynamic systems. These systems create conditions that enable or constrain the range of possible strategies any one CPHC initiative (or local, regional or national health system) might employ, as well as the effectiveness of such a strategy. One might

envision a CPHC strategy that included mobilizing communities to press for certain policy changes to improve access to water or housing. The political context would determine how ‘far’ such a strategy might be permitted to go; as well as the receptivity to the policy changes the mobilization seeks to gain. The political context, in turn, might be shaped by explicit or implicit requirements from international financial institutions or other global economic actors with respect to how far it could go in responding to local demands for such policy changes. The effectiveness of this particular CPHC strategy, in turn, would also depend on the skill and experience levels of health workers, the degree of overall health worker shortages (‘brain drain’), the competing demands for primary care or SPHC interventions that could reduce the capacity to engage in actions on broader determinants, and so on; all of which could be influenced by the political context and how it is enabled or constrained by more global forces or institutions. It also depends on how well health workers understand the need for a population approach to their work as opposed to being committed to simply the provision of quality individual services. Even the capacity of a community to mobilize will be affected by a broad range of conditions both internal to its geography, demographics and cultural make-up, and external to the range of capacity resources to which it has (or has not) gained prior access. A more nuanced understanding of how these conditions influence the range, selection, deployment and effectiveness of different CPHC strategies is part of increasing our overall understanding of how CPHC affects health outcomes and health determinants. Comparative case study analysis and narrative summary will play an important role in this. Several theoretical approaches to contemporary social change will guide this part of Conceptual Framework development, including: new social movement/cognitive praxis theory (which describes how popular mobilizations create new ‘movement leaders’ and reframes social discourses that open up new space for policy alternatives) [82], interest group/pluralist state theory (which describes the means by which social groups with competing policy interests gain political favour) [83], new institutionalism theory (which describes, in path-dependent fashion, how governing systems replicate policies within a delimited range of ‘institutionalized’ boundaries, and the conditions under which this self-reinforcement becomes ‘ruptured’) [84], critical state theories (which account for the ‘crisis of crisis management’ faced by the modern state in balancing the competing demands of the market and of civil society) [85], globalization theories (which assess the changes in ‘policy space’ capacity affected by recent global market integration) [81], and theories of ‘epistemic communities’ (which explains the dominance of certain economic or political discourses by mapping the flows of intellectual leaders through global institutions and major political advisory groups to national governments) [86].

2. Retrospective Research

The retrospective research will be the foundation for the whole initiative. This research will be conducted by the core research group (principal and co-investigators) supported by the Research and Training Coordinators and four research assistants (graduate students). Detailed search parameters and inclusion/exclusion criteria for data collection for this retrospective assessment will be developed in the first two months of our initiative to guide data collection, utilizing techniques for comprehensive narrative literature review developed by Labonte and colleagues for their recent CIHR-funded study of ‘needs, gaps and opportunities’ in research on the income/health relationship [87]. The assessment will seek to fill gaps in existing recent reviews, some of which have been undertaken by members of our core research group, e.g., Barton,

Legge, Espinoza. Apart from usual internet search strategies (utilizing a number of different search engines for both peer-reviewed and ‘grey’ literature sites), we will use a snowball sampling method for grey literature building upon the list-serves of the People’s Health Movement, and the contacts of our strategic research users.

Data analysis methodology will be based on narrative summary (also known as interpretive synthesis) [88]. Narrative summary “involves the selection, chronicling and ordering of evidence to produce an account of the evidence... [and] can account for complex dynamic processes, offering explanations that emphasise the sequential and contingent character of the phenomena.” Narrative summaries respond to the needs of key stakeholders within the research and civil society organization (CSO) communities: the 2004 WHO Task Force on Health Systems Research Priorities for Equity in Health concluded that a growing evidence base on the social and environmental determinants of health is accompanied by “a lack of policy-relevant synthesis” [89]. Analytically, triangulation of data for such summaries is similar to what is referred to in comparative historical sociology as process tracing, “in which hundreds of observations are marshalled to support deductive claims regarding linkages in a causal chain” [90]. The ‘causal chains’ in our initiative are defined in our first core research question. Causality in narrative summary is determined using different methodological assumptions from those associated with positivist research. First, rather than relying upon systematic reviews or meta-analyses with rigid criteria for study design, narrative summaries incorporate the broader data collection strategy associated with comprehensive narrative reviews. Second, causality is not established through statistical tests of correlations but by a ‘burden of evidence’ that supports logically coherent chains of relations that emerge through a contrasting and comparison of findings from all extant forms of evidence. Each of these forms of evidence, in turn, is assessed for its rigour according to its own methodology, e.g. descriptive ‘grey’ literature of program implementation experience would be assessed using criteria associated with qualitative studies; experimentally designed intervention studies would be assessed using criteria associated with more conventional controlled trials. The outcome of such an interpretive synthesis is a rigorous, evidence-informed and policy-relevant ‘narrative’ of key factors that appear to account for the effective implementation of CPHC. .

The Conceptual Framework and results of the retrospective narrative summary of CPHC experiences will be presented for critical peer review and engagement at a small invitational international meeting at the end of Year 1. Participants will include core researchers, research users and regional research mentors/training faculty associated with the initiative. The total number of participants will depend on the initiative team’s ability to obtain additional resources for this meeting, separate from the minimal budget contained within this proposal. This meeting will be the ‘springboard’ for the IPHU training courses that commence in Year 2.

3. Research Training/Capacity Building

Central to our initiative is training a cohort of researcher activists through courses that will be conducted in four regions under the aegis of the IPHU and the broad umbrella of the PHM. This will develop local capacity to support CPHC practice in each of the regions. Preparatory activities for the course will be completed during Year 1. Details of the training nature of these courses are provided below. Pertinent here is the selection process for research teams that will

participate in the training. Candidates will be asked to apply as teams of researcher and research user. They will have to be sponsored/supported by an experienced researcher (research mentor) working in the field of CPHC and located in an organization capable of holding research grants (usually but not exclusively a university). Teams will be asked to prepare an 'Expression of Interest' (or EOI, similar to a short letter of intent) in which they indicate the local/regional CPHC initiatives they wish to study, with supporting rationale; and how these studies will contribute to a stronger evidence-base for our initiative's core Research Question 1. These EOIs will reflect questions for which answers, however preliminary, might be obtained within 12 – 18 months of actual research. A transparent process for review and selection of research teams to participate in the training program will be developed by the Training Coordinator in Year 1, based upon the review processes used by the CIHR Strategic Training Institutes, one of which was designed and headed by Labonte. At a minimum, the reviewers will comprise members of our initiative's core group (both researchers and research users), and ensure a balance of persons with knowledge of CPHC across the four regions. The selection process will also strive to ensure equity in terms of gender, culture and geographic representation.

The IPHU Capacity-Building Training/Research Program

There are several different sets of capacities that this initiative seeks to enhance: individual researcher capacity (see curriculum below), mentoring capacity (support to the regional research mentors, including sessions at the regional meetings on the topic of mentorship), institutional and network capacity within regions (through the use of research teams, paired with mentors and aligned with broader civil society groups and policy makers during regional meetings), and research to implementation capacity ('research-in-action') by closing the researcher/research user loop in the research teams, ensuring regional questions have been vetted through regional CPHC program managers and policy makers, and engaging in findings analysis and implications during regional meetings with a broad range of stakeholders. The heart of the capacity-building component is the IPHU courses on CPHC concepts, research and research-in-action. Detailed curriculum content will be designed by the training coordinator and the core research group in consultation with research users; a preliminary set of topics is presented in Table 1. The pedagogical approach of the courses will be informed by popular education theory and methods, which emphasize co-learning and active participation. Courses will also incorporate mixed educational styles (lectures, workshops, practice sessions, and working with mentors) in recognition of the variety of ways in which different adults learn.

See Appendix 1: IPHU Training Topics

Between courses there will be organized mentoring and feedback, using Skype, *Elluminate* site-licensed software (made available through UO), and development of mentoring teams in each region. These mentoring teams will form the nucleus of a regional CPHC network that will continue to be expanded with each regional meeting, constrained only by our ability to raise additional funds to support expanded participation. Prior to each course/regional meeting, research teams and their mentors will participate in related learning activities via a dedicated, interactive web-site, using the relevant distance-learning materials and expertise of several of our academic partners, notably UWC and Flinders University, which have worked collaboratively on providing post-graduate distance education for CPHC. Flinders has been providing distance

education through a Master of Primary Health Care since 1989 and a professional doctorate in public health since 2001. The School of Public Health at UWC hosts the largest continuing education programme in Public Health in Africa, a large post-graduate programme and a large number of research and service development programmes, attracting students from all regions within South Africa and, by 2006, from 14 additional Sub-Saharan African countries. Both Flinders and UWC post-graduate programmes are offered in mixed mode (distance and face-to-face learning), and have organised and hosted short courses over more than a decade involving many thousands of students. Both institutions have long histories of offering regular in-service training on research methods for practitioners and regularly offer PHC organisations specially tailored training programs. Their expertise will be critical to longer-term initiative sustainability, as it forms a platform for translating our materials into distance education modules. Our intent is to make available all training materials, methods and research experiences, as well as overall initiative evaluation, for use by others engaged in CPHC research and implementation in other global regions. We will also seek to embed ongoing CPHC research training within the university, NGO and government institutions that participate in our initiative.

4. Participant Team Research

Our initiative is designed to support new research initiatives in CPHC. Research teams will enter the training program with CPHC EOIs. During the first course teams will have an opportunity to develop their research EOIs into a more detailed proposal, under the mentorship of the training faculty and, via internet communication, with their regional mentor. Immediately following the course, research proposals will be reviewed by a committee consisting of core faculty and strategic research users (i.e., the same group that reviewed the EOIs), supplemented by regional research mentors. A protocol for evaluation of the research proposals, adapted from the Teasdale-Corti criteria, will be developed by the Research Coordinator in Year 1, and reviewed for approval during the international invitational research meeting at the end of Year 1. The intent of this review is to distinguish between those proposals that are ready for one-year funding, and those that require more development via seed grant funding. Each of the four regions will be allocated a roughly equal portion of the research funds set aside for team research, adjusted for average regional purchasing-power-parity, or some other metric to reflect the different costs of conducting research in different parts of the world. Our initiative has no desire to become or function as a small grants agency; rather, we have designed it to review candidate research team proposals and then disburse funding from within the Teasdale-Corti budget to ensure that the research team proposals address local concerns, in a capacity-building and sustainable partnership. As with EOIs, careful attention will be given to issues of equity in selection of the research teams' proposals for one-year funding. All proposals will go through the UO Ethics Review Board and whatever ethics procedures may be required by the sponsoring regional university or organization in which the regional research mentors is located, and which will be the fund-holder for the disbursed research funding or, in the case of work within communities, whatever ethical review or norms of community consent that may be required by local leaders. The 'roll-out' of the training courses, and their relationship to regional meetings that will deepen the analyses of research findings and build larger regional networks of CPHC researchers, is described in more detail below.

It is not possible to determine *a priori* what methods any of the research teams will utilize, as

method selection will depend on their research questions, availability of data, needs of research users and so on. However, the benefits of a mixed-methods approach (one using both quantitative and qualitative data, whenever feasible) will be emphasized to increase the robustness of the findings. The overall methodology (as distinct from methods) favoured by our initiative, and underscored in the training, is that of *participatory action research* or PAR. PAR, which does not specify or privilege one set of methods over another, proceeds from an emancipatory epistemology that regards research as one form of knowledge important to advance action, i.e., it orients to applied and contextualized knowledge rather than to ‘pure’ scientific knowledge. Its core assumptions include “good research [is] an ongoing learning process involving continual management and change throughout any project ... [PAR] encourages integrative, interdisciplinary social science based on both local knowledge and social science expertise ... participation improves the quality of the research [and] is important because self-management is a moral and political value” [91]. These characteristics elide with the goals and values of CPHC, notably the emphasis on increasing citizen participation, which have caused PAR for some time to be promoted as an appropriate methodology for ‘Health for All’ initiatives {Berkely, 2006 #68; 1996 #69}. Several of our core research group have extensive experience in PAR and its variants, including collaborative inquiry, community/university research partnerships and research-as-intervention, including development of new research methods and evaluation of PAR projects [92-94] .

5. Research-in-Action

Findings of the first phase of research – the development/refinement of the CPHC framework and the retrospective assessment – will be presented and discussed at the first international meeting. We describe this as ‘research-in-action’ rather than research-to-action, or the more passive ‘knowledge translation’. We have planned our initiative so that research users are engaged from the start. They will attend the first international meeting where the results of the retrospective studies will be discussed in terms of regional application to policy and program actions; and where indicative questions for consideration in the review of research team proposals will be refined to ensure that new research ‘acts’ on issues of immediate importance. They will form part of the research teams. They will be invited to participate in all of the regional meetings, during which the implications of findings, within the social and political dynamics of each region, will be discussed. We anticipate that the research users involved in the research teams, and the regional and international meetings, will also function as ‘knowledge brokers’ or ‘social entrepreneurs;’ that is, they will engage with peers nationally and regionally around the policy and program issues arising from the evidence base on CPHC. The third training course (associated with the second regional meeting) will focus primarily on methods and technologies for dissemination and utilization of research team results. We will also use this meeting to prepare research teams to provide a rudimentary monitoring of the impacts of their own work, and that of the initiative more generally, on policy and program decisions within their own countries for presentation during the final international meeting. Either in direct engagement or via the internet, core research group members will also support both researchers and research users in their national and regional dissemination efforts throughout the initiative. This will include assisting them in assessing the ‘receptor capacity’ of their own organizations or ministries to absorb research findings (a shortcoming noted in recent reviews of knowledge translation efforts in developing countries [95]); aided by Labonte’s work as a co-applicant on a

CIHR-funded Canadian study of receptor capacity in Canada. We will also work extensively through the local and regional networks represented by our core research group and strategic research users. Our core group of researchers will meet periodically with policy makers of national and international bodies, local CPHC projects in their own regions, and other researchers/research users through the normal scholarly channels (publications, policy briefings, meetings, conferences). These will be planned (a minimum number of policy 'targets' in each region identified during the first training course) and opportunistic (responding to invitations from CPHC projects, and to health systems policy and program decision-makers). The current buy in from several regional, municipal and national government researchers, policy makers and decision makers already provides us with some audiences interested in further discussions about our research. Other, more specific 'knowledge translation' activities and products will include:

- ⌚ The results of Year 1, including the debates taking place during the meeting, will also form the basis of the inputs into the Global Health Watch II which is scheduled for release in 2008, and of which one of the Co-Principals (Sanders) is a Managing Editor.
- ⌚ Wide dissemination in the 1-3-25+ format (1 page policy brief, 3 page summary, 25+ page detailed report) of all research knowledge products (we will seek separate funding for translation in Spanish and French);
- ⌚ Posting of knowledge products on the People's Health Movement and all affiliated institutional websites (pending their authorization to do so), with particular attention given to summaries in language appropriate to the different communities of users (community members, CPHC workers, managers/planners, etc.);
- ⌚ Distribution of summaries and URLs of knowledge products through numerous list-serves;
- ⌚ Publication of peer-reviewed articles and a book;
- ⌚ Creation of a 'CPHC Advisory Team' from core and new researchers trained under our initiative, under the auspices and with the support of the Peoples Health Movement, who would be available to advise, on request, policy makers in other countries/regions on the evidence synthesized and generated by our initiative on 'best CPHC practices' and enabling conditions for CPHC implementation. (This is analogous to what others have described as a 'rapid response unit' that could provide written summaries, telephone or in-person consultations on evidence-based 'best practices' on short notice [96].)

Initiative Management

A core management group for the initiative will consist of the two co-principal applicants, the research and training coordinators, a representative from each of the four regions where the training and new research will take place, and a representative of the IPHU that will be responsible for the training courses. It will meet around five times, usually taking advantage of major events that most members would be attending. Regularly scheduled internet meetings of an Executive comprised of the two co-principal applicants and the two coordinators will also occur, at least quarterly or as needed. Periodic ('as needed') internet meetings with the larger group of co-applicants on this project will also take place, with at minimum an annual report on progress to the whole group for their commentary and participation in ongoing planning and initiative roll out. Day-to-day planning and coordination of the training and the research initiatives will be managed by the Training Coordinator (based at UWC) and the Research Coordinator (based at UO), respectively.

ETHICS

The initiative as a whole will go through the Ethics Committees of UO and UWC. Research funded through this initiative will be reviewed by the Ethics Research Board of UO. Formal ethics review, however, does not necessarily ensure compliance with broader and more empowering approaches to ethics. Through the IPHU course there will be a thorough ethics mentoring process. This mentoring on ethics will be in the context of developing participatory action research and a rights-based approach to research and development, and will involve the course faculty, the sponsoring organizations, the mentors and research users.

GENDER AND EQUITY CONSIDERATIONS

Our initiative focuses on countries which not only have a rich experience with CPHC programs but also come under the LMIC group. In Canada and Australia (the HIC exceptions) the initiative focuses on experiences of Indigenous peoples. CPHC, in practice, often prioritizes gendered health issues of importance to women (e.g. maternal and reproductive health, child health). We would request from our EOIs for the training course and research funding administered through our initiative an indication that gendered health (and other issues of social stratification) issues have been considered. A gendered analysis of CPHC will form part of our first year retrospective study.

EVALUATION AND ONGOING LEARNING

As per our initiative's objectives, the main outputs will be the development and ongoing refinement of a Conceptual Framework for CPHC, draft elements of which are incorporated in this proposal; the completion of retrospective and current studies of experiences in CPHC implementation and impact; training of a cohort of new researcher activists and research users; new CPHC research; development and strengthening of networks of researchers and research users; and creation of a sustainable infrastructure within PHM for ongoing capacity building and CPHC research. Evaluation of these outputs will be both formative and summative. The general evaluation approach will be informed by realist and 'third generation' evaluation methodologies, the first emphasizing data on the logical pathways linking activities to objectives/outcomes while taking account of the context; and the second emphasizing evaluation as a process for learning in which all stakeholders participate. Data for the evaluation will be collected on an ongoing basis and will be coordinated by the research and training coordinators. As well, an independent evaluator will be contracted to evaluate the training program and assist in design of other evaluation components. Representative indicators for the evaluation of the initiative are presented in Table 2. Finally, we regard evaluation of the initiative, in its totality, as an important means of ongoing learning more not only about CPHC, but also about the research to implementation ('research-in-action') process.

SECTION C- PROGRAM DETAILS
RELEVANCE, PROBLEM AND JUSTIFICATION

ATTACHMENT B

Table 1: Evaluation Indicators and Methods

Objectives	Indicators and Methods	Comments
1. Develop CPHC Framework	<p>Feedback from participants, first international meeting</p> <p>Journal submission and peer review comments</p> <p>Feedback from EOIs</p>	<p>Major refinement of the draft framework will be completed by the first international meeting, each course/regional meeting, the different research initiatives by the training program teams, and interactions with other research users will continuously feedback to evolve and refine the framework further.</p>
2. Retrospective CPHC Research	<p>As above, plus:</p> <p>Circulation to Regional WHO Offices for commentary on usefulness</p> <p>Circulation to other CPHC and PHC experts for commentary on usefulness</p> <p>Reviewers' comments from chapter inclusion in GHW II</p>	<p>A short survey of strategic research users in the regions of the training programs (both those involved directly in our initiative, and those whom we contact subsequent to its commencement) may be considered if financially and technically feasible. If so, this would be conducted by the independent evaluator responsible for design of training course evaluation.</p>
3. Training Program	<p>Potential indicators include:</p> <ul style="list-style-type: none"> - number of courses conducted - number of students successfully attending - number of student pairs submitting and undertaking research projects - feedback on the quality of the courses from the students - feedback from the organizations that sponsored/supported the students - feedback from the mentor - pre/post assessment of knowledge and skills - feedback on mentorship provided by the core research group between courses/regional meetings 	<p>An independent evaluator will be employed to design and undertake a thorough training course evaluation, including all elements of recruitment (advertising) of EOIs, review process of EOIs, actual courses, review process of research proposals and extent and quality of engagement with research users in all phases of the initiative. Thus, the indicators provided for the course are indicative only.</p>
4. New Research by Research Teams	<p>Potential indicators include:</p> <ul style="list-style-type: none"> - range of topics chosen for research and their relevance to CPHC - extent of involvement of research user in all phases of the research project - amount of additional funding obtained by research teams - successful completion of the research projects - role of the core research group and regional mentors in assisting in successful completion of the research projects 	<p>This research will be conducted by the research teams that are trained in the courses, and supported by sponsoring organizations, regional mentors and our initiative's core research group. As with the course, these are indicative indicators only.</p>

**SECTION C- PROGRAM DETAILS
RELEVANCE, PROBLEM AND JUSTIFICATION**

ATTACHMENT B

	<ul style="list-style-type: none"> - feedback from research users and the community where the research project was conducted - feedback from regional mentors - feedback from regional meetings where findings presented/discussed - publications (and in which journals, with what peer review feedback), media stories, new proposals arising from the one supported by this initiative 	
5. Strengthen Links, Researchers/ Research Users	<p>Potential indicators include:</p> <ul style="list-style-type: none"> - extent of involvement of research user in all phases of the research project - feedback from research - feedback from regional meetings where findings presented/discussed - invitations to core research group and to research teams to brief policy makers - requests for findings from, and evaluation of usefulness by, CPHC program managers - downloads and citations of published articles emanating from the initiative 	<p>In conjunction with evaluation of the second objective, a short survey of strategic research users in the regions of the training programs (both those involved directly in our initiative, and those whom we contact subsequent to its commencement) may be considered if financially and technically feasible. Specific questions would be posed on their perception of changes in the relationship between researchers and research users, and the role of the initiative in these changes.</p>
6. Develop Sustainable Infrastructure	<p>Potential indicators include:</p> <ul style="list-style-type: none"> - development of new funding strategy/plans in Year 2 - increased cash or in-kind support from universities, NGOs, CPHC projects and other research users in the regions where training and new research is undertaken - incorporation of ongoing regional CPHC training programs by regional institutions - proposals for new training and research modeled on our initiative from other regions 	<p>The sustainability of the infrastructure will be difficult to evaluate fully after only four years. The potential indicators are indicative milestones, but should not be regarded independently of measures of strengthened networks and researcher/research user linkages.</p>
7/8. Strengthened PHM Knowledge and Networks on CPHC	<p>Potential indicators include:</p> <ul style="list-style-type: none"> - number of networks formed and/or strengthened - scope of network membership and activities - trends in network membership and activities over time between two regional and final international meetings - feedback from network members over time between two regional and final international meetings - recognition of networks by peers, other organizations, other research users 	<p>These two objectives are entwined, one describing enhanced CPHC knowledge and skills, the other describing strengthened regional and global CPHC networks through the PHM. The latter is one of the important means of achieving the former.</p>

9. Overall Initiative Evaluation	To be developed cooperatively with the independent evaluator	The overall initiative evaluation will comprise the sum of evaluation of its components, with some invited critiques by attendees at the final international conference. Arms' length international experts in CPHC (e.g. the WHO and its regional offices) may be invited to review documents of the initiative design and documentation of effects (as per the potential indicators noted above).
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INSTITUTIONS AND PERSONNEL

See Appendix 2.

PROPOSAL DEVELOPMENT PROCESS

A team meeting took place in Cape Town, South Africa over 3 days in early June. Team members were selected to represent all regions identified for the initiative. Six members (Labonte, Espinoza, Legge, Baum, Gaitonde and Barten) required domestic or international flights, which accounted for \$11,000 of spending on the grant. The remaining team member (Sanders) was located at the School of Public Health at the University of the Western Cape, which hosted the meeting. The School arranged accommodation and some ground transport at reasonable cost. All members participating claimed a modest per diem of \$32 to cover additional costs such as food and communications. These per diems, along with local costs for the meeting accounted for another \$2,300 of the grant. The remaining \$1,700 of the seed grant was spent on research assistants (Gaitonde and Kagis) who helped draft portions of the final proposal and prepare the proposal for submission. Additional research assistant funding (in excess of the \$15,000 seed grant) was provided by the Canadian Alliance of Community Health Centre Associations (CACHCA), which also provided funding for translation of draft materials into French and Spanish. Strategic research users and regional research mentors were provided written summaries and other materials on the project, and gave close attention to the 'research-in-action' and research questions sections. Face-to-face meetings were held with most of the strategic research users, taking advantage of conferences and other meeting opportunities; and, at minimum, lengthy phone conversations with the others. As noted in their CVs and, often, covering letters (attached), interest in the initiative is high, and several have already begun to identify regional specific indicative research questions.

INITIATIVE TIMELINE

See Appendix 3

APPENDIX 1: IPHU TRAINING TOPICS

Course	Topics	Comments
First course	<p>CPHC history, philosophy/principles Political theories of health/health systems/health theories Indigenous concepts of health/healing (non-Western) Alternative health practices Services/skills sets (multidisciplinary team work) Organizational characteristics and case exemplars Research design (asking the right questions) Research methodologies (PAR as epistemological stance) Types of evidence (plurality, valorization, strengths/weaknesses) Methods of triangulation and quality control Methods of research synthesis Proposal development Formal and normative research ethics (including community consent, power relations, data ownership)</p>	<p>2 weeks in duration Developed with regional research mentors, who will also be recruited as course faculty</p>
Second course	<p>Research analysis methods Detailed instruction on analytical techniques, based on research undertaken by pairs (e.g., qualitative/quantitative, integrating mixed methods, use of software packages) Issues in criteria for rigour (positivist/post-positivist/realist paradigms) Introduction to issues of post-research knowledge translation</p>	<p>4 days, including a 1 or 2 day regional meeting (budget details for second and third regional courses are included under the details for regional meetings)</p>
Third course	<p>Research-in-action (knowledge translation) Role of evidence in policy making Region-specific knowledge/research on processes of policy-making Working with communities/methods of mobilization Advocacy and lobbying techniques Working with media SWOTs of political context Building cross-class and regional/global alliances Building networks for sustainability</p>	<p>As for second course; emphasis will be given to encouraging a broad range of research users to attend the regional meeting, and to stay on for the course (within budget limitations)</p>

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APPENDIX 2: RESEARCHERS, RESEARCH USERS, INSTITUTIONS, ROLES AND COMMITMENTS

Name	Institution	Qualifications, Expertise and Role in Initiative	Time to Initiative	Comments
Ronald Labonte	University of Ottawa, IPH (6 year old interdisciplinary unit with capacity and experience in international and global health research, knowledge translation and indigenous health research)	PhD, Canada Research Chair >20 years work experience in health promotion and CPHC prior to academic / research career. Researcher, research mentor, course trainer, member of Initiative management group.	10 – 15%	Co-principal applicant. Participate and contribute to all phases of the Initiative.
David Sanders	University of Western Cape, School of Public Health , long term multidisciplinary school with extensive training and research projects throughout southern Africa Member Global Steering Group of PHM, Managing Editor Global Health Watch 2.	Researcher, research mentor, course trainer, member of Initiative management group. Paediatrician, Public Health Specialist, >25 years work in Southern African health policy, PHC and health systems development. Adviser to governments and UN agencies.	10 – 15%	Co-principal applicant. Participate and contribute to all phases of the Initiative.
Fran Baum	Department of Public Health & South Australian Community Health Research Unit, Flinders University, Adelaide. SACHRU has 20 years experience of conducting research with PHC agencies. & the DPH has extensive experience of teaching and	PhD Social Science 25 years experience of community based public health and PHC research and training for research. Commissioner on Commission on Social Determinants of Health SACHRU's Senior Researchers will also devote effort to this initiative – all have extensive experience in	Approx 5%	Contribute to research training & mentoring within CRAH and South Australia

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	research in PHC	PHC research.		
Eduardo Espinoza	Director of International Relations, University of El Salvador	M.D.; Community health expert; researcher and trainer; Knowledge translation to university network.	2-7%	Contribute to research, research training, capacity development & mentoring in El Salvador, Latin America and with IPHU
Francoise Barten	Njimegen Institute for International Health :coordinator of network program at University involving collaborative research in EU; Latin America, and Africa.	Medical Doctor; Epidemiologist; experienced researcher, experience in capacity development and programme development in developed and LMIC's; Advisor to WHO "healthy Municipalities" program	5%	Contribute to research training & mentoring within Latin America, Holland and Africa
Rakhal Gaitonde	M.D. Research and Training Fellow, Community Health Cell, Bangalore; Medical Advisory Committee, Rural women's Social Education Center	Many years of community work and primary health care experience Research mentor, researcher	2-7%	Contribute to research training & mentoring in India and through IPHU
David Legge	La Trobe University, School of Public Health: long established academic unit with particular expertise in primary health services, health policy and health management; Centre for Development and Innovation in Health, Melbourne; Cooperative Research Centre for Innovation in Health: leading indigenous research network with focus	MD, FRACP; Experienced researcher and research training supervisor; research mentor, research trainer and member of project management group.	10-15%	Contributing to all stages of proposed project; initiating IPHU courses

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	on primary health care; International People's Health University: organizer and short course provider focusing on primary health care in developing countries.			
Claudio Schuftan	Independent consultant and researcher in Health and human rights; public health and nutrition.	M.D. Public health and nutrition specialist; Health and Human rights specialist: researcher, mentor and training.	2-7%	Research, human rights research, mentoring and capacity development
Maija Kagis	Independent consultant and researcher. Executive of International People's Health Council, NGO sponsoring parts of International People's Health University	M Health Admin; specializing in health policy, health systems, CPHC history, research and development and research-policy to action.	2-10%	Research, retrospective studies, knowledge translation. Researcher, strategic research user
Jack McCarthy	President, Canadian Association of Community Health Centre Associations (CACHCA); CEO, Somerset West Community Health Centre.	MSW; specialist in community health centres in Canada; experienced facilitator	2-5%	Case studies; strategic research user. See Note below.
Shirley Woods	Northern Inter-Tribal Health Authority, SK, Canada (NITHA formed in 1996 to coordinate and plan integrated health care, with a focus on CPHC, to members of the Lac La Ronge Indian Band, Peter Ballantyne Cree Nation, Prince Albert Grand Council and Meadow Lake Tribal Council in northern	MPH, BSN Nurse epidemiologist with several years experience as an Aboriginal public health professional working in northern First Nation communities, including research and evaluation projects. Research mentor, research user.	2 - 7%	Researcher and Strategic research user in work with Indigenous health authority.

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	Saskatchewan)			
Patrick Odnokon	NITHA (see Woods above)	MSc, BSc New researcher/evaluator with NITHA, prior experience in community-based research partnerships. Research mentor, research user.	2 – 7%	Researcher and Strategic research user in work with Indigenous health authority. .
Bonnie Jeffery	University of Regina and Saskatchewan; Population Health and Evaluation Research Unit.	PhD Social work and health services research	2-7%	Researcher, with emphasis on northern and indigenous health issues; research mentor, trainer
Janet Smylie	University of Saskatchewan, Indigenous People’s Health Research Centre; First Nations University of Canada: Adjunct professor	M.D.; M.P.H.	2-5%	Researcher, indigenous health issues.; contribute to research and mentoring of researchers
Georgina McDonald	Athabasca Health Authority Saskatchewan	Delivery of health services and public health to indigenous peoples in northern Sask.	2-5%	Strategic research user
Lori Hanson	University of Saskatchewan, Department of Community Health and Epidemiology	Ph.D. candidate, Interdisciplinary program M.Sc. Community health Sciences	2-7%	Researcher; mentor in community based research;
Sylvia Abonyi	Canada Research Chair: Aboriginal Health; and Associate professor, Community Health and Epidemiology, University of Saskatchewan.	PhD Anthropology, leading researcher and disseminator of research with/for indigenous groups	2-5%	Researcher, mentor, trainer, knowledge translation
Maria Teresa Losada Monsalve	M.D. Director, Creamos,	NGO in Primary care in Bolivia	2-7%	Strategic research user; researcher

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German Crespo	M.D. Director of Planning of Ministry of Health, Bolivia	Advisor to Minister and in charge of senior portfolio in changing health environment Strategic research user; advisor	2-4%	Strategic research user.
Vigmar Munoz Alvarado	M.D. Pediatrician, MPH University Mayor of San Simon (public university) Bolivia, post graduate professor; Advisor with regional health department (SEDES)	Academic and public policy/action background. Researcher; research mentor and Strategic research user	2-5%	Researcher, Strategic research user
Ciro Larrazabal Cordova	M.D. Psychiatrist , professor of Psychiatry, University Mayor of San Simon (public university)	Long term professor/researcher at UMSS Coordinate activities of University in research, researcher	2-3%	researcher
Maria Hamlin Zuniga	CISAS: health promotion and consulting in Nicaragua; El Salvador, Guatemala and Latin America	Founder and long time Director of largest health education NGO in Nicaragua; internationally recognized in integrating health promotion/education into primary care.	2- 7%	Strategic research user; mentor and trainer.
Luz Margarita Posada	Director of APROCSAL: Association of Community promotion workers, El Salvador Coordinator APSAL	Years of health promotion/primary health work in Central America through a variety of health networks.	2-7%	Strategic research user
Hugo Icu	Director, ASECSA: Clinic and health promotion network	Health promotion in clinical settings amongst poor populations in Guatemala and Salvador	2-5%	Strategic research user
Maria Anthoanet Palacios Parada	M.D. ; Professor Community Health Services, University of El Salvador	Professor at University of El Salvador; community health focus	2-5%	Researcher

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Giovanni Salazar Moreno	M.D.; Master of Public Health; Professor, University of San Carlos of Guatemala	Professor University of San Carlos Examining role of community organizations in health reform in Guatemala	2-5%	Researcher, mentor and trainer
Miguel San Sebastian	M.D.; Senior lecturer in public health at Umea University in Sweden; Research in Amazon basin with indigenous groups and centre for Epidemiology and Community Health.	Researcher with indigenous peoples in Sweden; Ecuador and Papua New Guinea; mentor in research; capacity development with indigenous peoples; research to action in policy development for indigenous peoples..	2-7%	Researcher; research mentor; capacity development
Hernan Hermida	Dean, Faculty of Medicine, University of Cuenca, Ecuador	Dean of Medicine with ample research, training and management experience.	2-4%	Researcher, research mentor: will also draw on university team
Arturo Quizhpe	Professor, Faculty of Medicine, University of Cuenca	Professor Pediatrics, Director child to child Foundation Professor, researcher, research mentor and strategic research user through the Child to Child Foundation	2-5%	Researcher, research mentor, strategic research user.
Roman Rafael Vega	M.D. PhD in Administration University Javerian, Bogota, Colombia	Researcher and public health advisor, City of Bogota	10-15%	Bogota Team: Strategic research user, researcher, research mentor, trainer
Paula Andrea Mosquera	Psychologist with Specialty in Epidemiology, University of Javeriana.	Researcher, children's health issues	2-5%	Bogota Team: researcher
Janeth Carillo	M.D. Health Monitor for National Observatory on Health and Social Security.	Health promotion and public health researcher; health systems expertise. Researcher	2-5%	Bogota Team: researcher

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Martha Lucia Rubio Mendoza	B.Sc. Nursing; M.P.H. Director of Health Activities, Dept of Health of Bogota.	Experienced nurse, administrator, Researcher and strategic research user.	2-5%	Bogota Team: researcher
Libia Esperanza Forero	M.P.H. Doctor of dentistry Advisor in health policy and situational analysis in health, Dept. of Health of Bogota.	Researcher/strategic research user	2-5%	Bogota Team: researcher, strategic research user
Sandra Isabel Lozano	M.D. Specialization in administration and management	CEO SUBA hospital, reports to Dept of Health of Bogota. Strategic research user and researcher	2-5%	Bogota Team researcher, Strategic research user.
Carolina Zarate Arcos	M.S.W. Coordinator of Primary Care, SUBA Hospital; Dept. of Health, Bogota	Strategic research user.	2-5%	Bogota Team: researcher
Jorge Bernal	M.D. Specialty in Occupational Health	Sub secretary (i.e.: Deputy Director) Dept. of Health, Bogota Strategic research user	2-5%	Bogota Team:
Giovanni Apraez Ippolito	M.D. MPH Professor and Ph.D. student; Dept of Public Health, Public University of Colombia	Researcher.	2-5%	Bogota Team: researcher
Ivana Barreto	M.D.; paediatrician; MPH; Federal University Ceara State.	Professor and researcher at University	2-5%	Researcher, research mentor
Prof.Dr. Luiz Odorico Monteiro de Andrade	Secretary for Health of Fortaleza province President of Council of Health of Brazil	Strategic Research User	2-5%	Strategic Research User
Beatus Leon	M.D. ; M.P.H. Research Scientist: National Institute for Medical Research,	Researcher and Strategic research user, with experience at clinical, research and	2-5%	Researcher Strategic Research user

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	Tanzania	policy levels in Tanzania		
Aidan Njau	M.D. Hospital based researcher and trainer; Tanzania	Hospital Director; and paediatric physician with clinical, research and management expertise.	2-5%	Strategic research user; Researcher
Benedict Ndawi	M.D. and Dr. Public Health Directs Primary Health Care Institute, Iringa, Tanzania, Reporting to Permanent Secretary of Health in Ministry of Health and Social Welfare.	Director of Public Health Institute, within the Ministry, overview of primary and public health in Tanzania	2-5%	Strategic research user.
Ivan Toms	M.D. Executive Director, City of Cape Town, Health Department.	Senior manager in local Cape town government; Medical doctor with post graduate qualifications in Health Management	2-5%	Strategic research user in municipal health department With letter of support
Antonia Carolina Muchaneta Mubaira	Community Working Group on Health, Programme Manager ZIMBABWE	Senior manager in NGO, strategic research user	2-5%	
Parliament of Zimbabwe				Strategic research user ...with letter of support, work with Community Working Group on Health
KC Househam	Western Cape Province, South Africa Superintendent General (Director) of Health	Paediatrician and Health Manager in province of 4.5 m population. Strategic research user.		Strategic research user..letter of support
Itai Rusike	CEO, Community Working Group on Health, Zimbabwe	35 civil society organizations involved in enhancing community participation Strategic research user.	2-5%	
Thelma Narayan	Professor and Evaluator, M.Sc. Epidemiology;	Researcher, evaluator, professor.	2-7%	Researcher, research mentor

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	Ph. D. Health Policy Community Health Cell, Indian NGO.			
Dr T. Sundararaman	M.D. Director State Health Resource Centre; Raipur, Chattisgar	Experience physician, Director of Health for large poor state. Research user.	2-5%	Strategic research user
K.R.John	M.D.; M.Sc. Epidemiology; Doctor of Public Health	Professor Community Medicine, Christian Medical College; Health economist Strategic input as researcher and research mentor	2-7%	Researcher research, mentor
Pat Anderson	Manager, Community Activist, Community Resource Centre for Aboriginal Health	Strategic input on aboriginal health issues, strategic research user, and researcher	2-5%	Strategic research user.
Chris Mcgowan	CEO, Noarlunga Health Services MA Applied Science Bachelor of Business	Primary Health services specialist, for indigenous people. Strategic research user with broad network	2-5%	Strategic Research User
Kaisu Vartto	CEO, SHINE, leading sexual health agency in Australia RN with extensive aboriginal experience	Strategic research user	2-5%	

Note:

It is not possible to estimate completely the time commitments for the regional researchers, research mentors or research users, since it depends on the number of EOIs that emanate from that region and the range of their potential involvement. Below is an estimate of time for each of the different roles:

Research course trainers:	5% - 7%	(declining in Years 3 and 4)
Research mentors:	2% - 5%	(declining in Year 4)
Research teams:	7% - 12%	(declining in Year 4)
Other research users:	2%	(those who are not members of research teams)

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