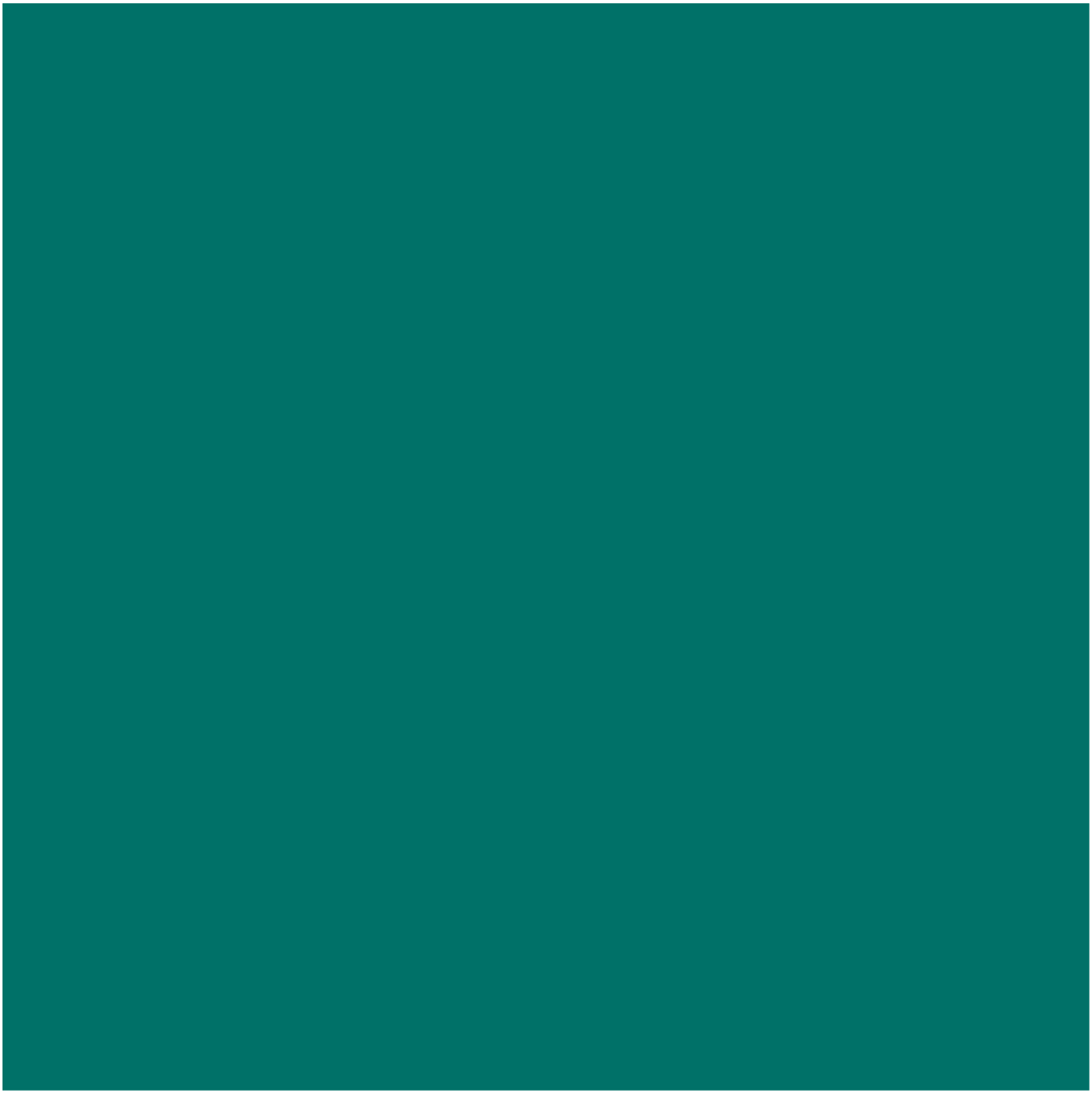
Sida

MAY 2005 • DEPARTMENT FOR RESEARCH COOPERATION

Sexual and Reproductive Health and Rights – research in Sub-Saharan Africa

Strengthening SRHR research networks



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Published by Sida 2005

Department for Research Cooperation

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Printed by Edita Communication AB, 2005

Art. no.: SIDA4613en

This publication can be downloaded/ordered from www.sida.se/publications

Acknowledgements

We would like to thank the many researchers from Canada, Denmark, Finland, Ethiopia, Kenya, Mozambique, the Netherlands, Sweden, Tanzania, Uganda, the United States and Zimbabwe who kindly took the time to talk with us and patiently answer our many questions. Their contributions, both written and oral, coupled with our participation in the sixth ECSAOGS scientific conference, held in Uganda, in August 2004, constitute the backbone of this assessment. While it has been our intention to present the vast array of views on regional sexual and reproductive health and rights research, and research capacity and training, based on interviews, our own experiences and numerous documents from Sida/SAREC and elsewhere, it would be impossible, if not counterproductive, to include all of the views of all who contributed. We have striven to do our best to amalgamate opinions and assess the current situation with regard to regional research capacity on sexual and reproductive health and rights and see this document as the basis for further discussions on the next action to take to strengthen research capacity in eastern, central and southern Africa.

We are especially grateful to the following for their assistance: Staffan Bergström, Elisabeth Faxelid, Anna-Berit Ransjö-Arvidsson and Roland Strand (Karolinska Institute); Kyllike Christensson (Mälardalen University); Peter Byass, Maria Emmelin, Ulf Högberg, Lennarth Nyström and Stig Wall (Umeå University); Gunilla Lindmark and Beth Maina Ahlberg (Uppsala University); Siriel Massawe (Muhimbili University College of Health Sciences, Tanzania); Josephat Byamugisha, Alia Godfrey, Dan Kaye and Pius Okong (Makerere University, Uganda); Jerome Kabakyenga (Mbarara University, Uganda); Nafissa Osman (University Eduardo Mondlane, Mozambique); Lise Munck (Konsultbyran Tres, Sweden) Vibeke Rasch (Copenhagen University and Karolinska Institute); Harshad Sanghvi (Johns Hopkins University); Grazyna Stanczuk (University of Zimbabwe); Solomon Kumbi (University of Addis Ababa, Ethiopia); Jennifer Liku (Family Health International, Kenya) Valentino Lema (University of Malawi); Richard Lema (University of Dar-es-Salaam, Tanzania); and Steven Munjanja (chairman of ECSAOGS).

List of abbreviations

AMRN	African Midwives Research Network
ECSAOGS	East, Central and Southern African Association of Obstetrical and Gynaecology Societies
MUCHS	Muhimbili University College of Health Sciences
NGO	Non-governmental organization
SAREC	Department for Research Cooperation, Sida
Sida	Swedish International Development Cooperation Agency
SRHR*	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STIs	sexually transmitted infections

* In this report "sexual and reproductive health and rights", "sexual and reproductive health", "reproductive health" and "SRHR" are used interchangeably to cover sexual and reproductive health and rights.

Executive summary

Background

Sida has supported the strengthening of sexual and reproductive health research capacity in sub-Saharan African since 1987. In addition to having the highest ratios of maternal morbidity and mortality in the world, the region is currently the most affected by the HIV/AIDS pandemic. At present, there are four Sida/SAREC-supported bilateral, collaborative programmes in sexual and reproductive health and rights (SRHR) research, with Ethiopia, Mozambique, Tanzania and Uganda. Earlier programmes with Zambia and Zimbabwe have ended, as well as support to the two-year old regional Centre for Reproductive Health Research and Training in Zimbabwe. Also, since 1996, Sida has been supporting regional research networks of obstetrician-gynaecologists (ECSAOGS) and midwives (AMRN).

Aims

The purpose is to assess the preconditions for a possible renewal of Swedish support for regional SRHR research and research training activities in sub-Saharan Africa. As such, this assessment will help guide future activities in the area. A second and complementary aim is to make an inventory of active researchers and relevant research institutions in Sweden and select sub-Saharan African countries working on SRHR issues.

Findings

All researchers interviewed unanimously agreed that the situation in sub-Saharan Africa, with regards to reproductive health, requires large-scale, evidence-based interventions. While the importance of local context was stressed, regional research cooperation was seen as imperative to design new studies testing hypotheses and interventions in the region. Moreover, with regard to specific solutions as well as research training, a regional collaboration, via a network/centre functioning as a catalyst, would be the optimal forum to address and actively work to improve the research capacity of obstetrician-gynaecologists, midwives and other SRHR researchers. Joint international training was seen as essential as there is seldom the necessary critical mass present in one country to hold specialised courses.

Such collaboration, functioning as both a physical and virtual network, could be based at a university in the region, preferably one with

the experience of participating in bilateral research activities with Sweden. Support to research and research training in SRHR should be more flexible and holistic than in the past and a reassessment of current bilateral collaborations in the area of SRHR appears to be a prerequisite for any new proposal for strengthening regional research capacity. Sida/SAREC and their advisors should hold stakeholder meetings in both Sweden and sub-Saharan Africa to plan the centre, which should also be seen as a means of strengthening bilateral collaboration. To the extent possible, the centre should be funded in collaboration with other donors and local universities.

Conclusions

A regional network/centre to strengthen research capacity on sexual and reproductive health and rights issues should be re-started. However, this centre should be designed differently than the previous centre, playing a coordinating and networking role and relying more on the member institutions, both Swedish and African, rather than creating an entirely new structure. Overall, Sida's support to health care and research strengthening within the area of SRHR should be synergistic, long-term and pragmatic.

Strengthening the regional sexual and reproductive health research networks in sub-Saharan Africa

Aims

The purpose of this study is to assess the preconditions for a possible renewal of Swedish aid for regional sexual and reproductive health and rights (SRHR) research and research training activities in sub-Saharan Africa. To facilitate this, an inventory of active researchers in Sweden and select African countries (see annexes) who are working on SRHR issues was prepared. At present, regional support from Sida/SAREC to strengthen SRHR research capacity in Africa has been frozen, but new initiatives will be taken. This assessment will serve to guide future activities in the area.

Methods and materials

This assessment is based on 19 face-to-face semi-structured interviews and 14 written responses to a questionnaire prepared by the assessors and sent to relevant researchers and groups in Sweden and sub-Saharan Africa. In addition, two of the team members participated in the sixth scientific conference of the East, Central and Southern African Association of Obstetrical and Gynaecology Societies, ECSAOGS, held in Uganda, in August 2004, at which more than 150 experts from the region (see Annex 2) met to discuss relevant ongoing research and research results. Finally, a thorough review was carried out of previous assessments and evaluations of Sida/SAREC's work related to SRHR research capacity in sub-Saharan Africa since 1987.

Background

Sida/SAREC activity in sub-Saharan Africa

The overall goal of research co-operation through SAREC is to strengthen research capacity locally and promote development-oriented research. Sida/SAREC has been supporting the strengthening of sexual and reproductive health research in Africa since 1987. The support began in four sub-Saharan African countries (Tanzania, Mozambique, Zambia and Zimbabwe) in which national research capacity building was the focus, and in 1991 the support was expanded to cover regional co-operation between the four countries. This support took the form of seminars and research training courses held in the region (Cameron and Molin 1998).

From 1991 to 1996 the network was coordinated by the Swedish universities of Umeå and Uppsala. It was the first attempt to create

repeated contacts between institutions in the region and also to bring midwives and doctors together. The annual seminars also included participants from Angola, Ethiopia, Kenya, Malawi, South Africa and Uganda. Regional meetings for both obstetrician-gynaecologists and midwives ultimately led to the establishment of regional associations for each of these groups.

The East, Central and Southern African Association of Obstetrical and Gynaecology Societies (ECSAOGS) was founded in 1997, and includes members from Angola, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe. A second network, the Africa Midwives Research Network (AMRN) was also started after 1996, in which it was agreed that Sida/Health Division, and not SAREC, would support research and training courses for midwives. With Sida support, AMRN and ECSAOGS took over the responsibility for the regional meetings mentioned above. For the purposes of this assessment, South Africa will also be included when referring to the "region".

In 1998, SAREC decided to support the creation of a regional Centre for Reproductive Health and Research Training in Harare, Zimbabwe, which officially opened in 1999. The centre was expected to co-ordinate, initiate and support research in the area of reproductive health in the region and through courses and training activities contribute to the dissemination of research results. It was also intended to address SRHR research in its broadest sense: obstetrics, paediatrics, public health epidemiology, nursing, sociology, anthropology and health economics. In effect, the Centre would be a regional coordinating body primarily for researchers who were part of the SAREC supported bilateral programmes.

Past and current evaluations

In June 2002, an evaluation of the aforementioned regional Centre for Reproductive Health Research and Training was completed by Ulf Högberg, of Umeå University (Högberg 2002). In this evaluation it was reported that after two years, and with a budget of SEK 3.75 million, the creation of an advisory board was hailed as the main achievement of the Centre. While one three-week course was held for ten students in 2000, the second and third components of the course were never held as only three students had moved from developing a research protocol to piloting their studies.

The Centre had a number of other good intentions ranging from close collaboration with ECSAOGS and AMRN, to the development of a reproductive health literature database to include grey literature from the region and proceedings and abstracts from the ECSAOGS and AMRN conferences. It was also planned to link electronically to the Health InterNetwork Access to Research Initiative, which provides free online access to medical/health institutions in least developed countries. However, in the assessment of the Centre's first two years, it was written that "the need for a homepage has so far not been clearly identified, nor have a capacity and planning for a website been achieved". The final recommendation of the evaluation was, though, that plans "should be developed into an application to SAREC for funding for a forthcoming period" (Högberg 2002).

In short, the Centre in that evaluation was seen as a positive pilot project, but due to political instability in Zimbabwe and staffing shortages at the Centre, Sida/SAREC did not renew funding. Regional

support from Sida/SAREC to SRHR research in Africa is currently still closed. However, Sida/SAREC has expressed interest in reviving a regional research and training centre, and assessing the possibilities of doing so is the main purpose of this study.

In addition to this assessment, there are currently two other current evaluations of Sida's work on SRHR:

1. Sida's Work Related to Sexual and Reproductive Health and Rights 1994–2003 (Geisler et al 2004); and
2. Assessment of Sida's International Training Programmes (ITP) on sexual and reproductive health training (Munck et al ongoing).

The report on Sida's work related to SRHR follows the original Sida SRHR agenda, formulated after the International Conference on Population and Development, which was held in 1994, and how this agenda has been brought into the core development discourses, i.e. the paradigmatic change from "population and development" to a rights-based holistic approach to SRHR, which places individuals at the centre. The report looks especially at how Sweden and specifically Sida included this agenda in its policies and strategies, its dealings with various Swedish stakeholders, the United Nations and other multilateral organisations, and within its funding priorities for international and regional non-governmental organisations. The study also reviews how the agenda has been operationalised in bilateral aid at the country level.

The assessment of Sida's international training programmes (ITP), on the other hand, focuses on SRHR courses in Sweden. Specifically, there are three elements:

- The training programme in SRHR run by the universities of Uppsala and Karlskrona, respectively;
- Suggested requirements of future SRHR courses;
- Suggested Swedish support via the ITP section, with the aim of strengthening midwifery.

The assessment is about to be delivered to Sida ITP and the Health Division. The authors will, inter alia, suggest improving synergies between different Sida activities in SRHR in all regions, including sub-Saharan Africa (SSA), notably through bilateral work (Sida/Health Division), courses and follow-up to courses (ITP), and research/research training. It is worth noting that SAREC is not mentioned by name in the latest draft of the report. Considering that SRHR is an overall goal of Swedish development assistance, the enormity of the challenges within this field in SSA, the scarcity of resources in SSA, and the relatively limited Swedish development budget, identifying and implementing synergistic support through these different Sida channels appears to be of paramount importance. Our report ends with similar conclusions, see below.

At present, Swedish support to research in the SRHR field in SSA is channelled through the bilateral agreements with Ethiopia, Mozambique, Tanzania and Uganda, and on a global level to the UNDP/UNFPA/WHO/World Bank special programme of research, development and research training in human reproduction (HRP). This assessment will contribute to how Sida/SAREC can best renew support to strengthen *regional* research capacity, including training and networking. Clearly, there are also synergies between SAREC's bilateral research support in SSA and the regional support.

Regional sexual and reproductive health context

Sexual and reproductive ill health remains a major public health issue in sub-Saharan Africa. As such, in low-resource settings, sexual and reproductive health must been seen as a medical, social, cultural, economic and developmental issue. The national burden of disease due to reproductive ill-health in the countries of the region is great – as much as 20–30%, though this is not fully documented in all countries. However, the causes of sexual reproductive health problems are in principal preventable, and include: a lack of access and availability to needed services, inequitable distribution, violations of human rights and the already existing high prevalence of SRH conditions.

During the last decade, the ECSAOGS countries, i.e. the 10 countries of sub-Saharan Africa mentioned above as well as South Africa have perhaps become best known for their very high prevalence of HIV/AIDS. Reported prevalence rates among adults of reproductive age range from 4% in Ethiopia and 6.4% in Uganda to 37% in Botswana (www.unaids.org). However, since before the advent of the AIDS pandemic, the region, in addition, has been plagued by high reproductive morbidity and mortality also in other fields. There is a high maternal mortality ratio, in part due to unsafe abortion, and high levels of all sexually transmitted infections (STIs). Adolescents are particularly vulnerable to all of these. Within this context, the fertility rate has remained quite high in several countries, e.g. Uganda (where the total fertility rate is 6.9), and the contraceptive prevalence rate, though increasing, is still low in many of the countries, varying from 5% to about 40%.

Healthcare provision is often poor and the overall health systems can be characterised as inadequate. They are poorly funded and unable to meet the needs of the population. For example, there are inadequate numbers of staff in many regions of most of the countries. Finally, links between institutions within and between countries are weak.

Findings

All researchers interviewed unanimously agreed that the situation in sub-Saharan Africa, with regards to reproductive health, requires large-scale, evidence-based interventions. However, to do this, much more health research, focusing especially on local context, is required. While many countries share the same problems, the same policies and interventions to resolve them will not always work. Nevertheless, in addition to country-specific research, regional research cooperation was seen as imperative to design new studies testing hypotheses and interventions in the region and to improve the base of competent researchers through joint trainings and joint research activities. At present, the research capacity is inadequate in all of the countries studied, in spite of bilateral research collaborations with Sweden in four of them and a regional network encompassing ten of them. Joint research between countries in sub-Saharan Africa and with collaborators from outside of the region can help improve this situation.

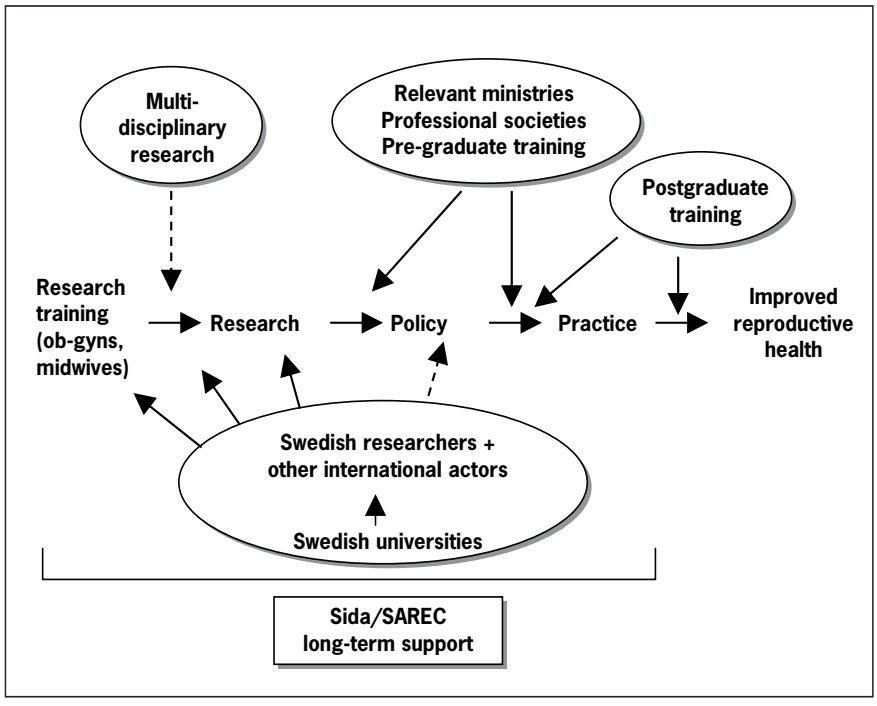
However, to ensure that the relevance is maintained, the research is best done, to the extent possible, within the countries of the region and led by the country nationals themselves, as also described in *The 10/90 Report on Health Research 2003–2004* (Global Forum for Health Research 2004). This report is backed up by a wealth of literature, since the publication of the Report of the Commission for Health Research and Development in 1990, supporting national research capacity strengthening as one of the most important activities in the correction of the so-

called 10/90 gap in global research funding, which refers to the fact that less than 10% of the estimated US $100 billion invested annually in global health research is devoted to research into the problems that account for 90% of the global disease burden.

The aforementioned publication was prepared for the Global Forum for Health Research, held in Mexico City in November 2004. A representative from Sida is one of the 20 Foundation Council members of the Forum, and as such one of the few donor organisations represented on the Council. The report echoes many of the needs emphasised to us in the process of preparing this assessment. For example, the need for sub-Saharan African countries to build a critical mass of able and qualified scientists who can undertake research on the main SRHR problems in their countries, and work in a coordinated fashion with other countries in the region and contribute to the international research agenda, was stressed repeatedly.

Figure 1 is a diagram of the key components needed for building research capacity in sub-Saharan Africa, and the links with Sida/SAREC, Swedish researchers and universities, and non-healthcare professional researchers. One would like to think that research, research training and research capacity strengthening in SSA contribute to improved sexual and reproductive health, but this is often not the case. The pathway leading to this goal has a number of necessary links, for instance:

Figure 1. Building research capacity to improve SRHR in sub-Saharan Africa



1. supporting development of critical masses takes a long time, even more so if inter-professional (obstetrician-gynaecologists and midwives) and interdisciplinary (social scientists including gender specialists, etc.) groups are aimed at;
2. it must support a group rather than individuals;
3. these groups should be able to be self-formed rather than always a part of a bilateral collaboration agreement;
4. for research to have an impact on policy, and on practice, even more critical ingredients are needed for a successful process. An example of the challenges is reflected in Box 1.

Below, the main findings of the assessment are presented in seven sections.

Regional research capacity

A full assessment of institutional research capacity was not undertaken, but through an inventory of researchers and research groups at each institution (medical faculty), coupled with interviews, it was apparent that research institutions in the region face many difficulties including training and retaining staff, in addition to being able to fund research against a backdrop of heavy clinical responsibilities for those researchers who are active doctors.

Box 1. Research and the process of change

A senior midwife in one sub-Saharan country recently defended her PhD thesis in Sweden after over ten years of research. The focus of the work consisted of a randomized trial of improved birthing care in a university hospital and health centres in the country in question. The improvement tested was that of having a companion, of the woman's choice, at her side during childbirth. The study confirmed results from other countries that having a companion improved birthing care and birthing outcomes.

However, very little of the birthing practices changed in the hospitals studied during the more than ten years of the studies. Birthing women are reportedly still routinely being left unattended, totally nude and deprived of drink and food during labour. The only reported change during the study period was that newborns no longer are routinely separated from their mother.

Moreover, while research collaboration and training with projects and programmes that are part of the Sida/SAREC bilateral-funded programmes are fragile (e.g. Tanzania, see Mellander et al. 2002), regional research collaboration is almost non-existent in spite of the ECSAOGS scientific conferences and the annual AMRN meetings. Some of the main constraints include:

1. Inadequate funding, especially from the national governments. Most of the available research funds are provided by donors (to universities, research institutes, ministries, NGOs and individuals);
2. The poor economic status of the individuals involved leads research training to be underprioritised;
3. Lack of coordination of research activities as well as efforts to operationalise them;
4. Lack of coordinated information on priorities, ongoing research and sources of funding (for e.g. access to scientific literature);
5. Lack of sufficient interaction between researchers, policy-makers, health workers and communities;
6. There is only a small pool of researchers in each country, making it difficult to conduct substantial and sustainable research (on this last point see Högberg 2002 and Annex 3 of this report).

Autonomous research groups, that have the necessary critical mass to formulate new research ideas and carry out the research, are the ultimate goal. Typically, such a strong, independent group will contain at least a few senior researchers (at the PhD+ level, i.e. professor, associate professor/"docent") with current strong ongoing research, a few recently graduated PhDs, pursuing postdoctoral research or similar, a few PhD

students and PhD student candidates. This means at least 10–12 persons, often more in the range of 15–20. Clearly, establishing such groups take considerable time and focused efforts. However, in our view, this is what is required to reach sustainability.

We also estimate that it would take from 10 to 20 years to build up a sustainable research level in most of the countries in the region. In a country like Angola, for example, there are no PhDs in the field of SRHR, though several Swedes are working on SRHR issues in Angola, while in Uganda there are only three PhDs and six PhD students (see Annex 3). Here, we are referring to PhDs among healthcare professionals, e.g. doctors, nurses and midwives, and not those working on SRHR issues in the social and natural sciences. In Mozambique, overall there were only ten teachers with a PhD in 1990, though this increased to 110 in 2002 (Alberts *et al* 2003).

Nevertheless, there has been progress since Sida/SAREC initiated their research capacity programmes. This includes:

1. Increasing number of researchers in the area. A multiplier effect where the trained are now supporting the research training of coming professionals;
2. Academic progression;
3. Attracting more research funds from other sources (e.g. WHO, the World Bank and UNDP);
4. Sida/SAREC supported research leading to policy changes, e.g. in Tanzania a retrospective study on rape led to a change in the punishment for rapists;
5. Internal (local) coordinated network and collaboration e.g. with the ministry of health and research institutions;
6. The development and strengthening of professional organisations, e.g. for obstetrician-gynaecologists;
7. Creation of opportunities for more people to participate in research and research training and the interest to do so.

In spite of many improvements since 1987, and the establishment of AMRN and ECSAOGS, many of the problems related to the development of reproductive health research in the region are the same as those raised in 1992 by two senior Swedish researchers (Lindmark and Nyström 1992). These include:

1. there are few competent senior researchers, who can take on a supervisory role, in part due to a heavy burden of clinical work;
2. research merits do not also give immediate advantages to junior doctors, making their recruitment to research projects difficult;
3. there is a lack of both formal and informal research training possibilities for inexperienced researchers due to institutional limitations;
4. the need to go to Europe or the US for training makes long-term development plans for the institution difficult, and contributes to brain drain;
5. there is limited research training for senior midwives

In addition, due to the local context, it has taken many PhD students a long time (often 6–9 years) to complete their PhD, while funding cycles are only for three years at a time. As one Swedish supervisor put it, "by the time students have prepared their proposal and figured out how to start, they have to apply for new funding". Nevertheless, when part of the

bilateral collaboration with Sweden, they do usually receive it. Particular barriers to completing a PhD in the region are discussed below.

With regard to the AMRN and ECSAOGS networks, the focus of network strengthening should be on knowledge diffusion, research collaboration between the member countries, interacting with non-governmental organizations, organizing preparatory methodology courses and operational research courses, and providing guidance to university research courses with the ultimate goal of networking for PhD training at a regional level. Moreover, these networks should be used to strengthen national professional associations, which in turn should work to support the following in their countries:

- Research;
- Dissemination; and
- Advocacy for the implementation of research findings and policy/programme changes.

A prerequisite for support to a network should be its local university affiliations. Research capacity building should primarily continue to be supported at the university/faculty level, while the processes of supporting national research capacity and regional networking should be carried out in parallel.

Another important role of network strengthening is to support networks to be promoters of professionalisation and to be bridge-builders in emphasizing the complementary roles of midwives and doctors as well as being in the forefront as regards interdisciplinary research and project work (see Box 1, above).

A final, major finding regarding the SSA resource base in SRHR research is that much has happened since SAREC first entered the field in 1987. Today, not only do most SSA universities have at least a few qualified PhDs in this field, and there is research and research training ongoing in many areas, and initiatives are to an increasing extent originating in the region and being (co-)managed from there. The recent ECSAOGS conference is a case in point. In spite of financial uncertainties, the conference was ultimately held and was successful, though some important participants did not receive the funding to attend. Several of the national societies have come a long way in recent years, with regards to inter alia annual meetings, membership base and research. This has implications for next steps as indicated further down.

The Swedish resource base in SRHR research

On the Swedish side, the resource base is also limited to a few well-known (medical faculty) university departments/units. Each of these, in turn, has a limited capacity and struggles considerably to maintain relevant research collaboration and research training for Swedish candidates, together with groups in SSA. The funding from SAREC via the "Swedish application" makes the desired level of collaborative research problematic for some Swedish departments/research groups.

At the same time, according to the policy for Swedish higher education, all universities should have a certain degree of internationalisation in their work, and be it through web-based courses or joint research and training courses, strengthening SRHR research capacity is an obvious area where this can be achieved. Such efforts could be better coordinated with Sida/SAREC and a new SAREC-supported centre based in SSA.

In addition, all other related Sida activities (such as bilateral health collaboration and being contracted to give SRHR courses) significantly improve the basis for any interested Swedish institution to stay, or become, involved in SRHR research in SSA. In so doing, both the functional synergy (having an impact in the SRHR field in SSA) and the financial synergy (being able to afford being involved) speaks clearly for better coordination as regards Sida/Health Division, ITP courses and SAREC activities in this important field.

Converging Swedish support to SRHR research in sub-Saharan Africa

In a study on global funding of SRHR, it was shown that official development assistance (ODA) has increased extensively for STI control including HIV/AIDS, while declining for family planning and reproductive healthcare. From 2000 to 2001, overall aid to SRHR declined, while the amount of Swedish ODA allocated to health declined from 1993–95 to 1999–2001 (Sinding 2003). In spite of the small sums of money, Swedish development assistance to the region has, however, played an important role in the area of sexual and reproductive health and rights. Unfortunately, the funding for research in this area has not always been delivered in a coordinated fashion. The funding has been provided in at least four ways:

1. Sida/Health Division's aid to reproductive health programmes within the bilateral collaboration agreements;
2. Sida/Health Division's research training courses;
3. Sida/SAREC aid to bilateral and regional research capacity programmes;
4. Sida/SAREC's Swedish application (for Swedish researchers/ research students).

With regard to the first point, the example of Zambia can illustrate how Sida/Health Division and SAREC could collaborate in the areas of SRHR research and research training. To help reduce the extremely high maternal mortality ratio, estimated at 729 per 100,000, Sida/ Health Division funds a position as gender advisor at the Central Board of Health (CBoH) in Zambia, which was created within the Ministry of Health to deal with the provision and delivery of services, as well as the implementation of the reforms (Geisler et al 2004). Such a position could draw on evidence from ECSAOGS countries in a coordinated, systematic fashion, if facilitated through a regional research network. Moreover, such a gender advisor could commission needed studies that would later also be presented at ECSAOGS and AMRN conferences, further strengthening the regional research base and disseminating new, relevant findings. While funding for this could come from both Sida/Health Division and SAREC budgets, at a minimum inter-country synergies such as this one should be reviewed at a joint meeting.

SAREC research capacity funding to the region is at present provided through the support of four bilateral programmes, as mentioned above. One limitation of this, pointed out in the evaluation of the bilateral programme in Tanzania, is that the three-year funding cycles in the programmes make the research collaboration "unbalanced" (Mellander *et al.* 2002). It is difficult if not impossible for a PhD student, working full time as a doctor and often a lecturer as well, to make significant progress before it is time to work on the next application for funding as mentioned above. In addition, potential PhD students from the region, as assessed

by potential supervisors based at Swedish universities, face significant barriers to acquiring funding if the student in question is not part of the bilateral programme or from a country with a bilateral programme.

It makes good sense for SAREC to support students and advisors within the bilateral programmes. This is the best way to build a critical mass of researchers at university institutions. But there are also those qualified candidates in the region who are either outside of the bilateral programme in their country (see Box 2) or from a country without a programme. A strategy that would provide funding to these candidates would ultimately contribute to strengthening regional research capacity. These few students could, for example, be funded via a regional research and training centre or directly via the Swedish application when collaborating with a Swedish university. Alternatively, they could in some way be linked to the bilateral programme in their country, when there is one. The dearth of motivated and qualified students necessitates that they be roped into a PhD programme in one way or another. Support to other funding agencies, such as WHO, is also a way to include these potential students.

Box 2. Funding a researcher

In this case, a composite story, an obstetrician-gynaecologist, who also teaches at a university in sub-Saharan Africa, comes into contact with a Swedish associate professor at an ECSAOGS conference where he has presented findings from a small study.

Together, they discuss a PhD on the subject. The preliminary plan is made by e-mail and an application for a planning grant is made to SAREC. The application is rejected as the potential student is not Swedish. Nor can he receive funding via the bilateral programme as he is not at the "right" university i.e. a university that is part of the bilateral programme. Ultimately, with a full workload at the hospital coupled with teaching at the university, the student gives up and potentially valuable research as well as a future PhD are lost.

WHO's Special Programme on Human Reproduction Research (HRP) has, for several decades, and through different approaches (e.g. several types of institutional grants, specific research sub-programmes and multicentre trials), also supported the strengthening of research capacity in sub-Saharan Africa. Advice to the programme is provided by a WHO Regional Advisory Panel. Sida has been one of the faithful co-funders of HRP for many years.

Research capacity strengthening in the region, as discussed above, requires longer periods of funding, depending on the local context, than the current project cycles, and SAREC's aim of improving research capacity would clearly benefit from synchronising the allocating mechanism with the reality of most students. This would mean funding cycles of at least four or five years though based on satisfactory annual reporting.

SRHR research groups and researchers

Within ECSAOGS, there is one international research group, the Maternal Mortality Taskforce, which has met only once, in Malawi, due to financial constraints. In addition, there are several research groups at the national level in the four countries with bilateral SRHR research programmes with Sweden:

- *Ethiopia:* Addis Ababa University, Faculty of Medicine, Department of Obstetrics-gynaecology: reproductive health research unit, which is a WHO collaborating centre;
- *Mozambique:* University Eduardo Mondlane, Faculty of Medicine, Department of Obstetric and Gynaecology: HIV and Reproductive Health research project.
- *Tanzania:* Muhimbili University College of Health Sciences (MUCHS), Dar es Salaam: 1. Reproductive Health Programme: Siriel Massawe (Programme Coordinator); 2. TANSWED HIV Programme: Fred Mhalu (Programme Coordinator)
- *Uganda:* Makerere University, Kampala, Professor Florence Mirembe, (Sexual and Reproductive Health and Rights Research Programme Coordinator) + five PhD students.

For details on individual researchers, including their titles and a list of recently published peer-reviewed articles, see annex 3.

Relevance of regional SRHR research activity

There are numerous advantages to a regional research training centre and network. Many of the countries share the same set of SRHR problems and the same capacity deficits, while research itself could benefit from shared tools, e.g. questionnaires with the same core questions that could later be compared, and multi-country research. In addition, solutions tested in one country could be disseminated via the network to be piloted in other countries of the region. In this sense, the Centre could fulfil its original objective to "initiate, stimulate and coordinate multidisciplinary research" (Högberg 2002).

Many donors demand "evidence" in order to fund SRHR and Safe Motherhood activities, as compared to earlier when photos and expert opinion of the problems in the region were enough to acquire funds. To date, the prevalence and economic and social consequences of HIV/AIDS is well documented in the region, for example "AIDS orphans". But what about children in homes affected by maternal mortality? This latter subject, for example, is farther down on the donor agenda, in spite of affecting tens of thousands of families in the region. Research needs to go more in-depth to illustrate SRHR problems in order to secure funding for the implementation of solutions and additional research.

Other examples of research priorities for the region raised by those interviewed include:

- Determining additional actions needed to be taken to reduce maternal mortality and morbidity;
- How to increase the use of contraceptives including emergency contraception;
- What providers have not done, in spite of it being financially feasible to do so, e.g. post-abortion counselling, testing for STIs or even saving lives at healthcare facilities;
- Testing innovative ways of improving adolescent SRHR;
- What new interventions need to be tested e.g. the use of misoprostol in obstetrical situations;
- Mapping midwifery services in the region;
- Carrying out Caesarean section audits in hospitals, to assess quality of care and practices;

- Investigating beliefs such as the one in which some men believe that only babies delivered at home are their real children;
- Following up on the SRHR components of poverty reduction policies and the Millennium Development Goals.

Brain drain

Most interviewees cited the problem of brain drain in the countries of sub-Saharan Africa as contributing to the low level of research capacity. There are two types of brain drain: international and domestic (internal) brain drain. Regarding the former, some 8,000 nurses leave sub-Saharan Africa annually. In Malawi, for example, there has been an outflow of nurses to the United Kingdom as well as to research projects and other positions at NGOs and UN agencies, while nine out of ten obstetrician-gynaecologist positions are unfilled. In Mozambique, on the other hand, similar to Malawi, local salaries are not sufficient. However, this leads to overburden, as many take on extra jobs to augment their income. Both countries need to recruit, train and retain staff. This is also the situation for other kinds of doctors as well as midwives.

Sida/SAREC must consider how their support to building SRHR research capacity can be maintained in the region, if not in the particular country of the individual trained in a context where health professionals are either leaving the country or working hard to fill gaps crated by those who have recently left. Sida already supports one initiative to address the problem of human resources with regard to health professionals, namely the Joint Learning Initiative (JLI) of the Global Health Trust (see www.globalhealthtrust.org). The goal of the Africa Working Group of the JLI is to landscape the human resource situation in Africa and advocate more effective human resource strategies in African countries and regional bodies. A part of their work is focused on priority diseases: to analyze current and future needs for human resources to fight select diseases of poverty, using a supply-demand lens, and to explore new models for control within an integrated health system. Anna-Carin Kandimaa of Sida is a part of this working group. Sida should draw on their counterparts in the JLI when planning next steps with regard to human resources in the field of SRHR research as many of these researchers are also healthcare professionals.

The information collected through this study clearly indicates that support to research and policy change, when well designed, and drawing on synergies as outlined above, does stimulate committed colleagues to institute change within reproductive health in SSA and contribute to their staying in their countries in responsible positions. Embedded into research training, post-doctoral support to enable researchers to continue in a university setting would be advisable.

Research training for midwives

While this entire report focuses on specialized reproductive healthcare providers – mainly obstetrician-gynaecologists and midwives – midwives also need to be discussed separately. While significant progress has been made in SRHR research capacity strengthening in SSA in recent years, very few midwives have so far completed research training. Clearly, baseline levels will have been lower than for specialized doctors, both as regards basic training and as regards the number of midwives exposed to and interested in research. In addition, importantly, the possibilities for midwives to benefit from meagre research (training) funds are quite limited especially when there is competition with doctors. Globally

speaking, in many countries midwifery is non-existent or weak, and midwives have a much lower status than doctors. While midwifery has a somewhat stronger position in SSA than in several other regions, hierarchical positioning and overwork due to brain drain and HIV/AIDS contribute to limited outlooks for midwives.

One can discuss to what extent slim funds should go to research training of midwives, recognizing the longer timeframe needed to reach critical numbers in a particular country. What would be the eventual output, as compared to doctors? And why midwives, when also other categories such as social scientists need to be part of research efforts to make them appropriate and multidisciplinary? A Swedish view on this question is that midwifery and nursing research contributes new, different and even vital aspects of an often innovative and gender-relevant nature; may contribute to the improvement of quality of care; and that it is an issue of gender equality. If this position is maintained, as the writers of this report would support, it should be clear that strengthening research capacity among midwives in SSA will require longer, separate efforts, and that the AMRN is a step in the right direction.

Suggestions for a regional research initiative

Based on this study and its main findings, as presented above, a set of concrete suggestions are here put forward. A point of departure is that any regional initiative requires a "hub" – i.e. a secretariat – irrespectively of if most activities will be virtual or not. Effective organization of such a hub requires a participatory approach, drawing synergistically on existing capacities.

While no research institute is sustainable unless fully endowed, it appears that there is interest in supporting both ECSAOGS and individual researchers in the region from other donors. A first priority should be for Sida/SAREC to secure long-term core financing (e.g. at least 75% for a minimum of five years, with the rest coming from universities in the region) either as the sole donor or in collaboration with others; the funding of special activities and partnership arrangements such as the AMRN and ECSAOGS networks (including larger research projects together with foreign and international institutions); and also the funding of commissioned research.

It is also suggested that a systematic follow-up be carried out of the PhD graduates of the last 10–12 years, to see to what extent they have been able to continue to carry out research, supervise or use their research training as educators. Information from such systematic retrospective detective work would be quite helpful when trying to decide how best to strengthen the development of national and international research groups.

Preconditions for SAREC support

The willingness of a university department, or preferably a group of departments and centres at a university, to host a network secretariat and provide partial support, e.g. in kind, such as office space and equipment, should be a prerequisite for SAREC support to a new secretariat. In developing the CRHRT, SAREC spent a large amount of money on refurbishing office space and purchasing equipment. A new centre should not outfit and run its own computer laboratory, but instead rely on university facilities, especially when providing courses that require a computer.

A second and equally important prerequisite is agreement among key stakeholders on not only the need for a regional centre on SRHR research and research training, but also on its location and mandate. Before creating a secretariat, a stakeholder workshop, in conjunction for example with the next ECSAOGS conference, should be held. Key stakeholders, who could later be considered for inclusion on an advisory board, could include:

1. A representative of the national association of obstetrician-gynaecologists from each country with a bilateral programme with SAREC;
2. A representative of the department of obstetrics and gynaecology of each university with a bilateral programme with SAREC;
3. A representative from ECSAOGS, preferably from a country without a bilateral programme with Sida/SAREC, to supplement point 2;
4. At least one representative from AMRN;
5. A representative from 2–3 Swedish universities;
6. A representative from or for Sida/SAREC;
7. A representative from the ministries of health and education in the country hosting the centre;
8. Other relevant and interested donors/collaborators.

Bilateral collaboration model

Reproductive health research by necessity encompasses a wide range of scientific disciplines, such as public health, obstetrics, paediatrics, nursing science, sociology, anthropology, epidemiology, health economics and the basic sciences. Consequently, a strategy for building and strengthening research capacity in reproductive health research should consider the complexity of this research field, which should be addressed by bilateral collaborations university/faculty-wise rather than by individual university departments. Thus, the field of reproductive health can only be addressed properly through collaboration between disciplines and institutions in long-term ventures, where there is enough room for methodological and theoretical development work. It is therefore important that the current bilateral SRHR research programmes be assessed bearing the above in mind. Such a review could begin with a self-assessment by the medical faculties themselves, followed up by interviews with other key stakeholders at the university.

It has been further pointed out by Swedish research institutions that a lack of coordination between Sida's health support and Sida/SAREC's bilateral research collaboration is a major obstacle for designing intervention studies within the reproductive health field. The importance of internal collaboration at Sida is discussed above.

Past bilateral agreement between Swedish and sub-Saharan African university-based research institutions were based on "twinning". Here, the Swedish universities played a key role in not just supervising PhD students and supervisors, and providing input in general, but in motivating the Africa-based researchers to research, and not to turn to purely clinical practice or clinical work in combination with teaching duties. From a distance, and with their better funding, the Swedish researchers played a key role in building SRHR research capacity in the region by working with their African counterparts. However, due to limited training in their countries, many African doctors, nurses and midwives went abroad for training and often ended up taking more lucrative jobs there.

To combat this "brain drain", Sida created a programme in which healthcare professionals could carry out the majority of the research in their own countries, only spending time in Sweden for supervision and required methodology and theory courses. This model, already initiated in 1984, became known as "sandwich" training and was evaluated as fitting in well with SAREC's strategy of strengthening research capacity (Högberg 2002) and as especially "appropriate" for the midwives and nurses involved, as they were mostly women with families (Geisler *et al* 2004). However, in a review of Sida's support to a university in Mozambique (Alberts *et al* 2003), it was pointed out that many students return to their home country only to teach or do administrative work, or attend to their job commitments. They need to be supported and encouraged to continue their studies while in their home country. Today, four Swedish universities (Karolinska, Lund, Umeå and Uppsala) offer training for research degrees in SRHR based on this model.

The question of motivating Swedish supervisors has been raised and it has been pointed out that Swedish supervisors do not get "credit" at their institution to supervise African students. In addition, several supervisors have never been to Africa, only meeting their students in Sweden, and thus are often ignorant of the harsh realities of carrying out research in a low-income setting, e.g. limited access to peer-reviewed journals and the internet. One solution for the former has been that the Karolinska Institute and Makerere University, Uganda, have created a joint degree programme in which students can defend their PhD at either university and obtain a joint degree as long as they have completed the requirements of both universities. With regard to improving the Swedish knowledge base, supervisors should be encouraged and funded to not only travel at least once to Africa for a supervisory meeting, but to try to time this with the ECSAOGS scientific conference or a research training course (though both events will preferably be held contiguously) in future.

Regarding this last point, it was mentioned by several interviewees that such meetings/courses should not be held in the summer months, as many Swedish universities effectively close down in July. Moreover, they should try and coincide with other events in the region, such as a major national meeting on e.g. maternal health.

At the regional level, a similar structure needs to be put in place to that of the bilateral programmes. Earlier, the regional centre (CRHRT) linked researchers from five countries, with a secretariat, including training facilities such as a computer laboratory, in Zimbabwe, and national coordinators in each of the countries. Regional coordination should again be based in the region itself, but key Swedish and other international researchers who are active in the region should be included by being on an advisory or even governing board. In such a case, meetings could be organised twice a year, to coincide with the scientific meetings of ECSAOGS and possibly the AMRN or other relevant national or international meetings and research training courses.

How a regional initiative could be organised

A regional network should grow organically from regional structures that are already in place, such as ECSAOGS and AMRN, discussed above. There should be a strong link between especially ECSAOGS and the establishment of any regional SRHR network or reproductive health and research training centre. As pointed out in the Sida evaluation of the CRHRT, a regional centre should play an active role in the planning of ECSAOGS conferences and arranging courses (Högberg 2002) in

addition to parallel or break-out sessions to discuss ongoing and future research activities at the conferences. This would be a cost-effective solution to strengthening networking and reducing duplication as many of the leading SRHR researchers would be involved in both ECSAOGS and a new network/centre. Capitalizing on the ECSAOGS as well as AMRN scientific conferences to hold advisory board meetings, supervisory meetings with students and training courses would also reduce the costs for holding meetings of the new network/centre. Recognizing the increased capacity in the region, more of the responsibility for designing a regional initiative should thus be among the national professional organizations in a next phase.

Regional secretariat

The now defunct CRHRT secretariat consisted of one director, one executive secretary, one research and one training coordinator. In addition, each of the five member countries had its own coordinator. This was expensive and had a structural problem. By having a full-time director, the salary had to compete with full-time positions outside of local institutions. This meant that the director had to consider that he or she would not be advancing at their own institution and would thus need to secure a higher than normal salary. In addition, it would be difficult for them to maintain strong relations with their own institution, in effect reducing the institution's capacity and effectively counteracting the aim of the research and research training institution: to build SRHR research capacity in the region.

To remedy this, a secretariat should start out smaller and grow as needed. With a single part-time coordinator and a full-time administrative assistant/webmaster, working in close collaboration with a part-time co-coordinator/webmaster in Sweden, for example, the network could establish a small physical base and establish itself electronically. Such a coordinator would ideally be a university lecturer, but not a professor. They would be expected to work e.g. 40–50% of their time at the centre, the rest in their home institution. This would allow them to continue to advance at their own institution, with the idea that the centre coordinator would not be a permanent position.

The main functions of such a secretariat would be to:

- Maintain and develop the network's website (see below);
- Organise and run research training courses;
- Collaborate with Sida on the awarding of "re-entry grants", which would enable recent PhDs to start 1–2 years of salaried post-doctoral activity, in collaboration with the regional centre, if they are to initiate their own line of research, or with the research groups in their country if part of a bilateral programme;
- Attend ECSAOGS and AMRN meetings in order to organise and run research training session;
- Seek to expand the financial base of the network by reaching out to funders;
- Manage all administrative functions including reporting to Sida/SAREC;
- Map the PhD requirements of universities in the region to ensure that courses provided by the centre would meet their requirements for accreditation.

This last point would be an important preliminary function of the centre and an essential part of building the foundation for a regional network. Ensuring that the there is an added value in the centre's courses could encourage participating institutions to support the centre's work.

In effect, core funding would be provided to a secretariat and not directly to conferences or for the participation of network members in conferences, other than members of the board or for students attending a course to be held just before or after the ECSAOGS and AMRN conferences. Researchers can often obtain funding to attend a conference from other sources, e.g. project funding or session organisers who invite them to speak.

Regardless of where the secretariat is placed, it is crucial that clear, achievable targets are set and that funding is on a performance-based arrangement.

Website

Initially, such a network should be established electronically, based on a website. The purpose of this would be to ensure that all interested parties are aware of the initiative and to provide a forum for preliminary linkages between researchers. It would also be useful for providing information on existing research training courses, scientific conferences and the like.

This website could be built by a partnering Swedish institution, and draw on research, research institutions and research groups listed in the annexes at the end of this report. Such a website could have the following functions:

- To list SRHR researchers in the ECSAOGS countries and South Africa, with contact details including email addresses;
- To list relevant research institutions and groups in the region;
- To list the abstracts and articles of members;
- To post calls for abstracts and papers for relevant journals and conferences;
- To post ECSAOGS and AMRN abstracts, papers, scientific meeting programmes and other relevant materials;
- To function as a bulletin board, divided by research themes, interlinking registered researchers in the region and Swedish counterparts.

Ultimately, the goal would be for the administration of such a website to be taken over by a partner institution in the region. The cost of building such a website would not have to exceed €15 000 and could be maintained at a low cost. An initial electronic network would have the added value of being able to be maintained regardless of where it is hosted (e.g. Sweden) via the internet and could thus be run by webmasters in different African institutions, depending on the structure of the physical regional centre.

The website of the newly established Danish Network for International Health Research (http://enrecahealth.ku.dk) offers one important model for consideration (Lansang and Dennis 2004). This network, which has replaced the now defunct Danida-funded ENRECA programme (Enhancement of Research Capacity in Developing Countries), works to facilitate and promote the exchange of information between researchers and development aid agencies, universities and research institutions in low and high income countries, Danida-supported sector programmes, NGOs, private firms, and relevant international and

regional organisations and networks. Its website is quite comprehensive with separate sections covering research news, research priorities, research projects, postgraduate studies, institutional profiles and sector programmes, to name a few.

Location

As mentioned above, the network secretariat should be housed at a university interested in hosting it and willing to provide, at a minimum, office space and basic utilities. Many institutions in the region are already based in Kenya and South Africa, and current conditions in Zimbabwe preclude basing a centre there. It was strongly recommended that the centre not be located in a lusophone country (Angola and Mozambique), as the language barrier would be problematic. Moreover, as stated elsewhere in this report, both countries have weak SRHR research capacity. A closer assessment needs to be made, but Kenya, Tanzania and Uganda stand out as strong candidates to house such a centre, as described below:

- Kenya: University of Nairobi: Both Family Health International and WHO have previously supported the Department of Obstetrics and Gynaecology at the University of Nairobi. It is centrally located in the region and does solid work on HIV and other sexual and reproductive health issues. There are three main institutions that would need to be approached to establish a sound collaboration. These are the Department of Obstetrics and Gynaecology, the Department of Reproductive Biology and the Institute of Primate Research (research on simian viruses). In addition, the International Clinical Epidemiology Network (INCLEN) has an office in Kenya (www.inclenafrica.org);
- Uganda: University of Makerere: The Department of Obstetrics and Gynaecology has a reproductive research unit which was developed in collaboration with WHO. This kind of a unit can accommodate such a regional secretariat.
- Tanzania: 1) Muhimbili University College of Health Sciences (MUCHS): The evaluation of the Swedish bilateral programme with MUCHS pointed out that huge changes have been made at the institution during the last ten years and that collaboration has been "ideal", though the number of completed PhD and MSc studies in the Reproductive Health programme had not reached its potential (Mellander et al. 2002)
  2) As a part of the Sida/SAREC support to the University of Dar es Salaam, the university library has been strengthened. Some US$ 95,000 was spent on increasing access to full text electronic journals. In addition, two workshops on web page design, with participants from 13 different institutions in Tanzania, were held. This and similar projects in the region should be linked to a future regional centre.

Participating institutions

Previously, only those countries with bilateral programmes with SAREC participated in the regional centre. That is to say that not all ECSAOGS countries were a part of the regional network. This should be reconsidered for the new network/centre. In addition, within countries, there are important individuals or research institutions outside of the bilateral programme that should be considered for inclusion in the network.

Also, research on public health issues is by nature multidisciplinary, and students from non-medical faculties working on sexual and reproductive health issues should be linked to the network as members or associate members. Building regional research capacity will be strengthened if bonds between all types of SRHR researchers can be made at training courses, conferences and via the electronic network.

One serious problem is that of language, at least for the Portuguese-speaking participants. Research capacity appears to be especially weak in Angola, and Swedish researchers cooperating with Angolans have pointed out their need to know Portuguese in order to collaborate. Lack of English will limit some Angolans and Mozambicans in actively participating in courses and scientific congresses, and publishing in English-language peer-reviewed journals.

Research training and other courses

In addition to research methodology, many researchers need skills in writing scientific articles based on their research. Training courses, based on need as expressed by members, could address:

- Research methodologies (qualitative and quantitative);
- Planning a project and writing a proposal;
- Epidemiology and field research methodology;
- Computer programmes to analyse data (e.g. Nu*dist, SPSS and Stata);
- Writing articles (e.g. doing a systematic review or meta analysis, or utilizing various author guidelines provided by journals);
- Submitting an article (e.g. how to choose a journal, write a covering letter, what to do if the article is rejected).

Courses should seek to focus on the above topics (i.e. processes) rather than content e.g. data on SRHR and country presentations. In the case of planning and writing proposals, Alberts et al points out that one major barrier to even initiating research in Mozambique is that many junior staff and lecturers need more training in conceptualising and preparing proposals. This is likely the case in many of the other countries in the region.

Courses could be held in situ but also electronically either via email or online chats. Lund University has already piloted a master's programme that is primarily run online and lessons could be learned from the extensive array of courses in public health provided by the London School of Hygiene and Tropical Medicine and Johns Hopkins University, for example. In addition, it is worth looking at how the Danish Network for International Health Research runs their international PhD courses (http://enrecahealth.ku.dk) as well as those run jointly by the Karolinska Institute and University of Oslo.

PhD students

Many of those interviewed raised the issue of the difficulty in completing a PhD. PhD students working with sexual and reproductive health are often doctors (obstetrician-gynaecologists) and often based at departments of obstetrics and gynaecology. In addition to their regular work as doctors or midwives and lecturers, they often take on extra medical jobs to top-up their salary. Most donors have a policy that aid does not go to salaries, as this is not sustainable. However, in order to help them complete their PhD, the SAREC aid, via the regional centre, could provide

stipends that were performance-based, e.g. article-based income in which money is provided for the PhD student during the process of finalising a paper for submission, e.g. during a 6–8 month period. These stipends should be evaluated annually and would supplement regular income.

Maintaining PhDs at the university
One problem Sida/SAREC should be aware of is the difficulty in maintaining highly qualified staff (e.g. those with a PhD) at the university. Competition from not just the private sector (both commercial and non-commercial) but also from non-university based research institutions is intense, and the university faces constraints in providing competitive salaries. This is more of a structural problem, than a direct issue that SAREC can remedy, but bonding PhD students in the bilateral collaboration to their institution for a fixed period of time after completion of their degree is one solution.

SAREC involvement at scientific meetings
A portion of the SAREC funding to a network/centre could be used to organise special sessions at the ECSAOGS and AMRN meetings for invited researchers and PhD students to discuss research coordination and propose training topics. This could be held in conjunction with a network meeting and strengthen encounters between Swedish and African researchers. Relevant Swedish supervisors, e.g. the coordinators of bilateral programmes, should be present at such meetings. Such a meeting would ensure ownership of the network by the members and that the network truly meets their needs, as well as serving as an informal rolling evaluation, so that problems are identified before the funding period has expired.

Conclusions

The challenges of improving sexual and reproductive health and rights in sub-Saharan Africa remain enormous. A clear strengthening of national and regional level research capacity has been taking place during the last ten years, and a limited but experienced group of researchers has emerged.

This assessment has determined that researchers from sub-Saharan Africa and Sweden agree that research capacity needs to be further strengthened, and that this could be through a regional initiative supported by Sida/SAREC and if possible in collaboration with other donors. Both groups of researchers felt that this was a top priority and a necessary complement to the bilateral research training programmes. Moreover, it was suggested that such a regional research training and networking centre should include all ECSAOGS countries and South Africa, and not be restricted to only those countries with a bilateral programme with Sida/SAREC.

The potential advantage of steering meagre resource funds to bilateral agreements is partly outweighed by the disadvantage of excluding some very strong African candidates, who are not part of a bilateral programme, on the one hand, and some experienced Swedish researchers on the other. More flexibility could be achieved by creating an advisory function for prioritizing among the totality of Swedish resources for SRHR research in SSA. Those researchers not part of bilateral agreements could, for example, be linked to the regional research and training centre, which could in turn provide some funding at both the doctoral and post-doctoral levels.

The possibilities for collaborating with multinational, international, regional and local partners on health interventions have previously been assessed as excellent (Geisler *et al* 2004). We feel that this is also the case for health research. Moreover, similar to the Geisler et al evaluation, this assessment should also serve as one of the background documents for the revised Sida policy on SRHR, which is expected to be finalised in mid-2005.

In order to develop a critical mass of beneficial SRHR research capacity in the countries of sub-Saharan Africa, the following points should be addressed:

1. Recognise that a broad SRHR research capacity programme must include departments of anthropology, economics, epidemiology, nursing, obstetrics, paediatrics, public health and sociology;
2. Improve institutional capacity (human, infrastructure and resources) at universities and maintain PhD-level researchers;
3. Support long-term bilateral agreements (e.g. five plus five years) that ensure that the PhD students really have time for their research studies at their home university and that further post-doctoral support is included, aiming towards local, national and regional research training capacity at the PhD level;
4. Evaluate current promising interventions: operational research or applied research, which should have practical spin-offs if proven beneficial;
5. Support research which is of direct significance for development in low-income countries (i.e. that reflect national priorities);
6. Address synthesising ever-increasing research findings (e.g. meta-analyses relevant for the region);
7. Develop innovative dissemination and communication strategies;
8. Link and coordinate with other donors: harmonised research;
9. Involve key national and international stakeholders in decision-making.

The next steps

We propose that Sida/SAREC initiate a process to reassess the current bilateral programmes dealing with SRHR research in sub-Saharan Africa, in Ethiopia, Mozambique, Tanzania and Uganda, in order to prepare the ground for a regional network, linking existing networks and other initiatives. The first step is to prepare discussion papers on each bilateral programme, followed by the holding of workshops/meetings with representatives from the aforementioned countries and other key national and international stakeholders to discuss how best to strengthen SRHR research capacity in the region.

Swedish researchers representing the Karolinska Institute, Lund University, Umeå University, Uppsala University and others should be included in this process as they play a key supervisory role in research undertaken in sub-Saharan Africa and in joint research activities. The meetings could further include select members of the evaluation teams of the two related Sida evaluations undertaken in 2004, described at the beginning of this study. The next ECSAOGS and AMRN conferences, in 2005, could be capitalised on as locations for such meetings.

It is essential that Swedish, sub-Saharan African and other relevant researchers and research institutions as well as donor organisations be involved in all steps of a new regional initiative with regard to strength-

ening SRHR research capacity. Sida/SAREC, as discussed, must consider how a regional network can strengthen existing bilateral research programmes, build on the current networks of obstetrician-gynaecologists and midwives, and strengthen university-based research capacity in the region as a whole.

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Annex 1. Terms of Reference

Terms of Reference for a Desk Study on Possibilities to Build a Regional Research Network within the Area of Sexual and Reproductive Health in Sub-saharan Africa

1. Background

Maternal mortality remains alarmingly high in low-income countries, while in high-income countries it has reached an almost irreducible minimum. The UN Millennium Development Goals (MDGs) acknowledge this with four out of the eight goals addressing sexual and reproductive health related issues: Promote gender equality and empower women; Reduce child mortality; Improve maternal health; and Combat HIV/AIDS, malaria and other diseases. The focus on obtaining the MDGs is clearly on the African continent. Out of a total of 31 countries where, according to UNDP, particular efforts to reach the MDGs are required, 25 are found in sub-Saharan Africa. Concerning maternal mortality the inequality is striking. For instance, each year an estimated 529,000 women die due to pregnancy and labour related complications. Of these, about half occur in sub-Saharan Africa.

Sida/SAREC has been supporting research within the area of sexual and reproductive health and rights (SRHR) in sub-Saharan Africa bilaterally, regionally and globally. At present, support to this area of research is channelled through bilateral agreements with Mozambique, Tanzania, Ethiopia and Uganda, and on a global level to the UNDP/UNFPA/WHO/World Bank special programme of research, development and research training in human reproduction (HRP).

At the regional level, SAREC has been supporting a research network since 1990 which emerged from bilateral common interests. This network has organised regional research meetings for scientists and health workers from Mozambique, Tanzania, Zimbabwe, Zambia and Ethiopia to present and discuss international, regional and national results. Common challenges within reproductive healthcare are also discussed. This network was in 1996 transformed into the East, Central and Southern African Association of Obstetrical and Gynaecology Societies (ECSAOGS) with members from Ethiopia, Malawi, Zimbabwe, Mozambique, Zambia, Tanzania, Uganda, Kenya, Angola and Lesotho. In 1997 ideas on a permanent research and training centre for sexual and reproductive heath research emerged. In 1999 the Centre for Repro-

ductive Health and Research Training (CRHRT) was established at the University of Zimbabwe, Harare, with support from Sida/SAREC and Sida/Health. The aim of CRHRT was to arrange regional courses and biannual meetings, as well as to function as a common platform for regional reproductive health research. However, in 2002, due to the political situation in Zimbabwe, Sida did not renew support and the Centre closed. At the same time, an evaluation pointed out that the activity was highly relevant but not completely satisfying. Although the Sida/SAREC funding of CRHRT stopped, the support to ECSAOGS continued. In total, Sida/SAREC has supported the network, ECSAOGS and CRHRT with SEK 10.7 million during the period 1990/91 to 2001. At present, Sida/SAREC does not support sexual and reproduction health research activities at the regional level.

2. Purpose and Scope of the Evaluation

The purpose of this desk study is to assess preconditions for a possible renewal of support to regional SRHR research activities in sub-Saharan Africa. A secondary objective is to make an inventory of active SRHR researchers in Sweden and select African countries (see below). The findings and recommendations will guide decisions on future Sida/SAREC support in this area.

The study is timely because regional support from Sida/SAREC to SRHR research in Africa has been closed and there is an interest in launching new initiatives.

3. The Assignment (issues to be covered in the evaluation)

The consultants shall describe the relevance of regional SRHR research activity.

The consultants shall discuss possible ways of building sustainable regional SRHR research capacity in the so-called ECSAOGS member countries (see above).

The consultants shall present an inventory of SRHR research groups and researchers in the ECSAOGS member countries (Angola, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe) and South Africa. The inventory shall contain affiliation, position and a brief description of the specific area of research including five recent articles published in scientific journals.

The consultants shall present an inventory of Swedish SRHR research groups and researchers within the area of sexual and reproductive health and rights. Registered PhD students shall be included. The inventory shall contain affiliation, position and a brief description of the specific area of research including the five latest original publications. Possible mentors for a long-term research programme should be indicated.

Areas that shall be included in SRHR in this inventory are maternal and newborn health including unsafe abortion, adolescent sex and reproductive health, coerced sexual relations, RHR aspects of HIV, relevant aspects of family planning research, relevant aspects of violence against women, relevant aspects of cervical cancer research.

The consultants shall present an inventory of departments or equivalent in sub-Saharan Africa with the capacity to take the role as coordinator or focal point for regional activities and as a partner to Sida/SAREC.

The consultants shall finally advise Sida/SAREC how a regional initiative could be organised to best contribute to the development of a sustainable research capacity in the region and how to best serve as a fruitful complement to national and global activities.

4. Methodology, Evaluation Team and Timeframe

The evaluation will be carried out by Jerker Liljestrand, Jeffrey V. Lazarus and Florence Mirembe. The three consultants are experts within international SRHR research and are well qualified for the task.

The consultants shall read required background documents presented by Sida/SAREC. The consultants will have unlimited access to registered background material at Sida/SAREC.

The consultants shall make his/her own travel and meeting arrangements to fulfil the assignment.

The Swedish consultants shall visit Sida/SAREC in Stockholm for introductory discussions in May 2004 and concluding discussions in September/October 2004.

The consultant Jeffrey Lazarus shall attend the 6th ECSAOGS conference, on 15 to 18 August, in Kampala, Uganda.

The study will start in May 2004 and be completed in October 2004.

5. Reporting

The desk study shall be written in English and should not exceed 50 pages, excluding annexes. The format and outline of the study shall be developed in dialogue with Sida/SAREC. One example of a suitable format and outline is the guidelines in Sida Evaluation Report – a Standardized Format (see Annex 1). The draft report shall be submitted to Sida electronically and in 2 hardcopies (air-/surface mailed or delivered) no later than 30 September 2004. A follow-up meeting between Sida/SAREC and the consultants will be held in mid-October. Within 2 weeks after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 2 hardcopies. The evaluation report must be presented in a way that enables publication without further editing. Subject to decision by Sida, the report will be published in the series *Sida Evaluations*.

Annex 2. ECSAOGS VI Scientific conference, registered participants

ECSAOGS VI Scientific conference, registered participants

LAST NAME	FIRST NAME	DESIGNATION	ADDRESS/EMAIL
Abseno	Nuru	Doctor	AAU, Ethiopia nuruab@telecom.net.et
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Akello	Susan	Student	Makerere Medical School, Box 7072, Kampala
Alia	Godfrey		Mulago Hospital, P.O. Box 7051, Kampala
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Asio	Alice	Midwife	Nsambya Hospital
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Birungi	Bertha	Midwife	Mulago Hospital, Kampala, Uganda
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Byamugisha	Josephat	Lecturer	Makerere Medical School, Box 7072, Kampala, Uganda
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Lule	John	Obst/Gynae	
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Namirembe		PNO	Nsambya Hospital
Namutebi	Sarah	E/Midwife	Mulago Hospital, P.O. Box 7051, Kampala
Namusisi	Jackie	R/Midwife	Rubaga Hospital
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Annex 3. Inventory of SRHR university-based researchers in the ECSAOGS member countries

Researchers with a PhD or who are PhD students are listed in alphabetical order by country together wi th up to five recent peer-reviewed publications.

Angola	
There are no university- based SRHR researchers with a PhD and no registered PhD students.	
Ethiopia	
Tobias Andersson	PhD dissertation (2000). Survival of mothers and their offspringin 19th century Sweden and contemporary rural Ethiopia, Umeå University. **Articles:** **1.** Byass P, Berhane Y, Emmelin A, Kebede D, Andersson T, Hogberg U, Wall S. The role of demographic surveillance systems (DSS) in assessing the health of communities: an example from rural Ethiopia. Public Health. 2002 May;116(3):145-50. **2.** Andersson T, Berhane Y, Wall S, Hogberg U. The impact of neonatal mortality on subsequent survival in rural Ethiopia. Ann Trop Paediatr. 2002 Mar;22(1):25-32. **3.** Berhane Y, Andersson T, Wall S, Byass P, Hogberg U. Aims, options and out-comes in measuring maternal mortality in developing societies. Acta Obstet Gynecol Scand. 2000 Nov;79(11):968-72. **4.** Andersson T, Bergstrom S, Hogberg U. Swedish maternal mortality in the 19th century by different definitions: previous stillbirths but not multiparity risk factor for maternal death. Acta Obstet Gynecol Scand. 2000 Aug;79(8):679-86. **5.** Andersson T, Hogberg U, Bergstrom S. Community-based prevention of perinatal deaths: lessons from nineteenth-century Sweden. Int J Epidemiol. 2000 Jun;29(3):542-8.
Yemane Berhane	PhD dissertation (2000). Women's health and reproductive outcome in rural Ethiopia, Umeå University. **Articles:** **1.** Simon C, Tesfaye F, Berhane Y. Assessment of the oral health status of school children in Addis Ababa. Ethiop Med J. 2003 Jul;41(3):245-56. **2.** Byass P, Berhane Y, Emmelin A, Wall S. Patterns of local migration and their consequences in a rural Ethiopian population. Scand J Public Health. 2003;31(1):58-62. **3.** Lulu K, Berhane Y, Tesfaye F. Sociodemographic differentials of adult death in a rural population. Ethiop Med J. 2002 Oct;40(4):375-85. **4.** Makonnen E, Yoseph M, Berhane Y. Quality of prescription at a tertiary care pharmacy in Addis Ababa. Ethiop Med J. 2002 Jul;40(3):233-9 **5.** Berhane Y, Demissie M. Cold chain status at immunisation centres in Ethiopia. East Afr Med J. 2000 Sep;77(9):476-9.

Mesganaw Fantahun PhD student, Umeå University	PhD research: Mortality patterns of women and infants in rural Ethiopia. **Articles:** **1.** Mesganaw Fantahun and Getu Degu. Health Service Utilization in Amhara Region of Ethiopia. Ethiopian Journal of Health Development Vol. 17, No. 2 (2003) **2.** Fantahun M. Patterns of childhood mortality in three districts of north Gondar Administrative Zone. A community based study using the verbal autopsy method. Ethiop Med J. 1998 Apr;36(2):71-81. **3.** Desta Z, Abula T, Beyene L, Fantahun M, Yohannes AG, Ayalew S. Assessment of rational drug use and prescribing in primary health care facilities in north west Ethiopia. East Afr Med J. 1997 Dec;74(12):758-63. **4.** Fantahun M, Chala F. Sexual behaviour, and knowledge and attitude towards HIV/AIDS among out of school youth in Bahir Dar Town, northwest Ethiopia. Ethiop Med J. 1996 Oct;34(4):233-42. **5.** Azeze B, Fantahun M, Kidan KG, Haile T. Seroprevalence of syphilis amongst pregnant women attending antenatal clinics in a rural hospital in north west Ethiopia. Genitourin Med. 1995 Dec;71(6):347-50.
Yegomawork Gossaye PhD student, Umeå University	PhD research: Women´s health, domestic violence and its association to adverse mental health and child survival in Ethiopia. **Articles:** **1.** Berhane Y, Gossaye Y, Emmelin M, Hogberg U. Women's health in a rural setting in societal transition in Ethiopia. Soc Sci Med. 2001 Dec;53(11):1525-39. **2.** Gossaye Y, Deyessa N, Berhane Y, Ellsberg M, Emmelin M, Ashenafi M, Alem A, Negash A, Kebede D, Kullgren G, Hogberg U. Women´s Health and Life Events Study in Rural Ethiopia. Eth J Health Development 2003;17:Second Special Issue: 2-50
Kenya	
JJ. Bwayo Department of Medical Microbiology University of Nairobi	**Articles:** **1.** Kaul R, Kimani J, Nagelkerke NJ, Fonck K, Ngugi EN, Keli F, MacDonald KS, Maclean IW, Bwayo JJ, Temmerman M, Ronald AR, Moses S; Kibera HIV Study Group.Monthly antibiotic chemoprophylaxis and incidence of sexually transmitted infections and HIV-1 infection in Kenyan sex workers: a randomized controlled trial. JAMA. 2004 Jun 2;291(21):2555-62. **2.** Voeten HA, O'hara HB, Kusimba J, Otido JM, Ndinya-Achola JO, Bwayo JJ, Varkevisser CM, Habbema JD. Gender differences in health care-seeking behavior for sexually transmitted diseases: a population-based study in Nairobi, Kenya. Sex Transm Dis. 2004 May;31(5):265-72. **3.** Baeten JM, McClelland RS, Corey L, Overbaugh J, Lavreys L, Richardson BA, Wald A, Mandaliya K, Bwayo JJ, Kreiss JK.Vitamin A supplementation and genital shedding of herpes simplex virus among HIV-1-infected women: a randomized clinical trial. J Infect Dis. 2004 Apr 15;189(8):1466-71. Epub 2004 Apr 02. **4.** Wakasiaka SN, Bwayo JJ, Weston K, Mbithi J, Ogol C.Partner notification in the management of sexually transmitted infections in Nairobi, Kenya. East Afr Med J. 2003 Dec;80(12):646-51.Partner notification in the management of sexually transmitted infections in Nairobi, Kenya. East Afr Med J. 2003 Dec;80(12):646-51. **5.** Gichangi P, Estambale B, Bwayo J, Rogo K, Ojwang S, Opiyo A, Temmerman M.Partner notification in the management of sexually transmitted infections in Nairobi, Kenya. East Afr Med J. 2003 Dec;80(12):646-51.
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Charles Owour University of Nairobi PhD student	Area of specialisation: Mother and Child Health Sexual and Reproductive Health
Zahida Qureshi Department of Obstetrics and Gynaecology, University of Nairobi zqureshi@nbnet.co.ke	**Articles:** **1.** Stanback J, Qureshi ZP, Sekkade-Kigondu C.Advance provision of oral contraceptives to family planning clients in Kenya. East Afr Med J. 2002 May;79(5):257-8. **2.** Qureshi ZP.Current management of hypertensive disease in pregnancy. East Afr Med J. 2002 Apr;79(4):169-71. **3.** Qureshi ZP, Solomon MM.A survey on the knowledge and attitudes of men in Machakos town towards vasectomy. J Obstet Gynaecol East Cent Africa. 1995;11(1):10-3. **4.** Stanback J, Qureshi Z, Sekadde-Kigondu C, Gonzalez B, Nutley T.Checklist for ruling out pregnancy among family-planning clients in primary care. Lancet. 1999 Aug 14;354(9178):566. **5.** Stanback J, Nutley T, Gitonga J, Qureshi Z. Menstruation requirements as a barrier to contraceptive access in Kenya. East Afr Med J. 1999 Mar;76(3):124-6.

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Fernanda Machungo Department of Obstetric/ Gynecology, Maputo Central Hospital Eduardo Mondlane University, Maputo Researcher, Karolinska Institute fmachungo@uninet.co.mz	PhD dissertation (2002): "Maternal outcome of pregnancy in Mozambique with special reference to abortion related morbidity and mortality **Articles:** **1.** Machungo F, Zanconato G, Persson K, Lind I, Jorgensen B, Herrmann B, Bergstrom S. Syphilis, gonorrhoea and chlamydial infection among women undergoing legal or illegal abortion in Maputo. Int J STD AIDS. 2002 May;13(5):326-30. **2.** Granja AC, Machungo F, Gomes A, Bergstrom S. Adolescent maternal mortality in Mozambique. J Adolesc Health. 2001 Apr;28(4):303-6. **3.** Machungo F, Zanconato G, Bergstrom S. Reproductive characteristics and post-abortion health consequences in women undergoing illegal and legal abortion in Maputo. Soc Sci Med. 1997 Dec;45(11):1607-13. **4.** Bugalho A, Bique C, Machungo F, Faundes A. Low-dose vaginal misoprostol for induction of labor with a live fetus. Int J Gynaecol Obstet. 1995 May;49(2):149-55. **5.** Bugalho A, Bique C, Machungo F, Bergstrom S.Vaginal misoprostol as an alternative to oxytocin for induction of labor in women with late fetal death. Acta Obstet Gynecol Scand. 1995 Mar;74(3):194-8.
Nafissa Osman Bique Department of Obstetric/ Gynecology, Maputo Central Hospital Eduardo Mondlane University, Maputo Researcher, Karolinska Institute osman@tvcabo.co.mz	PhD dissertation (2000): "The impact of maternal morbidity on fetal growth and pregnancy outcome in Mozambique", Karolinska Institute **Articles:** **1.** NB Osman, K Challis, M Cotiro, G Nordahl, S Bergström. Maternal and Fetal characteristics in an obstetric cohort in Mozambique. African Journal of Reproductive health 2000; 4(1):110-119 **2.** NBique Osman, K Challis, E Folgosa, M Cotiro, S Bergström. An intervention study to reduce adverse pregnancy outcomes as a result of syphilis in Mozambique. Sexually transmited Infections 2000; 76:203-207 **3.** NBique Osman, K Challis, M Cotiro, G Nordahl, S Bergström. Perinatal Outcome in an Obstetric Cohort of Mozambican Women. Journal of Tropical Pediatrics 2001; 47:30-38 **4.** Challis K, Bique Osman N, Nyström L, Nordahl G, Bergström S. Symphysis fundal height growth chart of an obstetric cohort of 817 Mozambican women with ultrasound-dated singleton pregnancies. Tropical Medicine and International Health 2002 Aug; 7(8):678-84 **5.** Dimitri Peffer, Nafissa B. Osman, Paula Vaz. Cost-benefit analysis of a PMTCT program in Mozambique. Evaluation and Program Planning 25 (2002) 433-445
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Elena Maria Pereira Folgosa Department of Microbiology f Faculty of Medicine Eduardo Mondlane University, Maputo Elena@health.uem.mz	PhD dissertation (2000): "Role of genital infections on pregnancy outcome in Mozambique with emphasis on syphilis", Lund University **Articles:** **1.** De Hulsters B, Barreto A, Bastos R, Noya A, Folgosa E, Fransen L. Geographical focusing: an intervention to address increased risk for sexually transmitted diseases during repatriation and resettlement in post-war Mozambique. Sex Transm Infect. 2003 Feb;79(1):77. **2.** Bique Osman N, Challis K, Folgosa E, Cotiro M, Bergstrom S. An intervention study to reduce adverse pregnancy outcomes as a result of syphilis in Mozambique. Sex Transm Infect. 2000 Jun;76(3):203-7. **3.** Melo J, Beby-Defaux A, Faria C, Guiraud G, Folgosa E, Barreto A, Agius G. HIV and HTLV prevalences among women seen for sexually transmitted diseases or pregnancy follow-up in Maputo, Mozambique. J Acquir Immune Defic Syndr. 2000 Feb 1;23(2):203-4. **4.** Folgosa E, Osman NB, Gonzalez C, Hagerstrand I, Bergstrom S, Ljungh A. Syphilis seroprevalence among pregnant women and its role as a risk factor for stillbirth in Maputo, Mozambique. Genitourin Med. 1996 Oct;72(5):339-42. **5.** Vaz RG, Gloyd S, Folgosa E, Kreiss J. Syphilis and HIV infection among prisoners in Maputo, Mozambique. Int J STD AIDS. 1995 Jan-Feb;6(1):42-6.

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Dr Projestine Mugonyizi PhD student, started in autumn 2004 Department of Obstetrics & Gynaecology	

David Urassa Department of Community Health	PhD dissertation (2004): Quality aspects of maternal health care in Tanzania. Uppsala University **Articles:** **1.** Urassa DP, Nystrom L, Carlstedt A, Msamanga GI, Lindmark G. Management of hypertension in pregnancy as a quality indicator of antenatal care in rural Tanzania. Afr J Reprod Health. 2003 Dec;7(3):69-76. **2.** Urassa DP, Carlstedt A, Nystrom L, Massawe SN, Lindmark G. Quality assessment of the antenatal program for anaemia in rural Tanzania. Int J Qual Health Care. 2002 Dec;14(6):441-8. **3.** Tarimo DS, Urassa DP, Msamanga GI. Caretakers' perceptions of clinical manifestations of childhood malaria in holo-endemic rural communities in Tanzania. East Afr Med J. 1998 Feb;75(2):93-6. **4.** Ahmed AM, Urassa DP, Gherardi E, Game NY. Patients' perception of public, voluntary and private dispensaries in rural areas of Tanzania. East Afr Med J. 1996 Jun;73(6):370-4. **5.** Ahmed AM, Urassa DP, Gherardi E, Game NY. Capabilities of public, voluntary and private dispensaries in basic health service provision. World Health Forum. 1996;17(3):257-60.
Ernest Urassa Department of Obstetrics and Gyanecology Muhimbili University College of Health Sciences (MUCHS)	**Articles:** **1.** Urassa E, Massawe S, Mgaya H, Lindmark G, Nyström L. Female mortality in reproductive ages in Dar-es-Salaam, Tanzania. East Afr Med J 1994;71:226-31. **2.** Urassa E, Lindmark G, Nyström L. Maternal mortality in Dar es Salaam, Tanzania. Socio-economic, obstetric history and accessibility of health care factors. Afr J Health Sci 1995;2:242-9 **3.** Urassa E, Massawe S, Lindmark G, Nyström L. Maternal mortality in Tanzania. Medical causes are interrelated with socio-economic and cultural factors. South Afr Med J 1996;86:436-43. **4.** Urassa E, Massawe S, Lindmark G, Nyström L. Operational factors affecting maternal mortality in Tanzania. Health Pol Plann 1997;12:963-7. **5.** Massawe SN, Urassa EN, Nyström L, Lindmark G. Anaemia in women of reproductive health in Dar-es-Salaam, Tanzania. East Afr Med J 2002;79;461-6.
Willy Urassa Senior lecturer, MUCHS PhD student, registered at Karolinska Institute	TanSwed HIV Programme: Immunology/Virology **Articles:** **1.** Westheimer EF, Urassa W, Msamanga G, Baylin A, Wei R, Aboud S, Kaaya S, Fawzi WW. Acceptance of HIV Testing Among Pregnant Women in Dar-es-Salaam, Tanzania. J Acquir Immune Defic Syndr. 2004 Sep 1;37(1):1197-1205. **2.** Bakari M, Urassa W, Pallangyo K, Swai A, Mhalu F, Biberfeld G, Sandstrom E. The natural course of disease following HIV-1 infection in dar es salaam, Tanzania: a study among hotel workers relating clinical events to CD4 T-lymphocyte counts. Scand J Infect Dis. 2004;36(6-7):466-73. **3.** Urassa W, Bakari M, Sandstrom E, Swai A, Pallangyo K, Mbena E, Mhalu F, Biberfeld G. Rate of decline of absolute number and percentage of CD4 T lymphocytes among HIV-1-infected adults in Dar es Salaam, Tanzania. AIDS. 2004 Feb 20;18(3):433-8. **4.** Sandstrom E, Urassa W, Bakari M, Swai A, Mhalu F, Biberfeld G, Pallangyo K. Estimation of CD4 T-lymphocyte counts from percent CD4 T-lymphocyte determinations in HIV-1-infected subjects in sub-Saharan Africa. Int J STD AIDS. 2003 Aug;14(8):547-51. **5.** Massambu C, Pyakurel P, Kaaya E, Enbom M, Urassa W, Demirhan I, Loewer J, Linde A, Chandra A, Heiden T, Doerr HW, Chandra P, Biberfeld P. Serum HHV8 DNA and Tat antibodies in Kaposi's sarcoma patients with and without HIV-1 infection. Anticancer Res. 2003 May-Jun;23(3B):2389-95.
Uganda	
Godfrey Alia MD, Department of Obstetrics and Gynaecology, Makerere University of Science and Technology	**Articles:** **1.** Weeks AD, Alia G, Ononge S, Mutungi A, Otolorin EO, Mirembe FM. Introducing criteria based audit into Ugandan maternity units. Qual Saf Health Care. 2004 Feb;13(1):52-5. **2.** Weeks AD, Alia G, Ononge S, Mutungi A, Otolorin EO, Mirembe FM. Introducing criteria based audit into Ugandan maternity units. BMJ. 2003 Dec 6;327(7427):1329-31. **3.** Weeks A, Alia G. Ultrasonography may have role in assessing spontaneous miscarriage. BMJ. 2001 Sep 22;323(7314):694.

Lynn Atuyambe MPH, Department of Public Health, Makerere University of Science and Technology, Uganda. PhD student, Karolinska Institute Country coordinator (Uganda) for the European Commission-funded research project "Bridging gaps between public and traditional health care sectors, a model to improve STI/HIV/AIDS care in sub-Saharan Africa.	PhD topic: Health seeking behavoiour and coping strategies of adolescent mothers in Wakiso District, Uganda **Articles:** **1.** Hanson K, Atuyambe L, Kamwanga J, McPake B, Mungule O, Ssengooba F.Towards improving hospital performance in Uganda and Zambia: reflections and opportunities for autonomy. Health Policy. 2002 Jul;61(1):73-94.
Josephat Byamugisha MD, Department of Obstetrics and Gynaecology, Makerere University of Science and Technology PhD student, Karolinska Institute	PhD topic: Emergency contraception among young people in Uganda
Dan Kaye MD, Department of Obstetrics and Gynaecology, Makerere University of Science and Technology PhD student, Karolinska Institute	PhD topic: Domestic violence during pregnancy in Ugandda. Medical consequences and social context **Articles:** **1.** Kaye DK. Gender inequality and domestic violence: implications for human immunodeficiency virus (HIV) prevention. Afr Health Sci. 2004 Apr;4(1):67-70. **2.** Kaye DK. Gestational trophoblastic disease following complete hydatidiform mole in Mulago Hospital, Kampala, Uganda. Afr Health Sci. 2002 Aug;2(2):47-51.
Jerome Kabakyenga MD, MPH, Dean, Medical Faculty, Mbarara University of Science and Technology PhD student at Lund University	PhD topic: Maternal mortality in Uganda **Articles:** **1.** Lundberg P, Cantor-Graae E, Kabakyenga J, Rukundo G, Ostergren PO.Prevalence of delusional ideation in a district in southwestern Uganda. Schizophr Res. 2004 Nov 1;71(1):27-34. **2.** Priotto G, Kabakyenga J, Pinoges L, Ruiz A, Eriksson T, Coussement F, Ngambe T, Taylor WR, Perea W, Guthmann JP, Olliaro P, Legros D.Artesunate and sulfadoxine-pyrimethamine combinations for the treatment of uncomplicated Plasmodium falciparum malaria in Uganda: a randomized, double-blind, placebo-controlled trial. Trans R Soc Trop Med Hyg. 2003 May-Jun;97(3):325-30. **3.** Legros D, Johnson K, Houpikian P, Makanga M, Kabakyenga JK, Talisuna AO, Taylor WR. Clinical efficacy of chloroquine or sulfadoxine-pyrimethamine in children under five from south-western Uganda with uncomplicated falciparum malaria. Trans R Soc Trop Med Hyg. 2002 Mar-Apr;96(2):199-201. **4.** Bitekyerezo M, Kyobutungi C, Kizza R, Mugeni J, Munyarugero E, Tirwomwe F, Twongyeirwe E, Muhindo G, Nakibuuka V, Nakate M, John L, Ruiz A, Frame K, Priotto G, Pepper L, Kabakyenga J, Baingana S, Ledo D.The outbreak and control of Ebola viral haemorrhagic fever in a Ugandan medical school. Trop Doct. 2002 Jan;32(1):10-5.
Frank Kaharuza Presiden of the Association of Obstetrician-Gynaecologists in Uganda	**Articles:** **1.** Lugada ES, Mermin J, Asjo B, Kaharuza F, Downing R, Langeland N, Ormaasen V, Bruun J, Awor AC, Ulvestad E. Immunoglobulin levels amongst persons with and without human immunodeficiency virus type 1 infection in Uganda and Norway. Scand J Immunol. 2004 Feb;59(2):203-8. **2.** Lugada ES, Mermin J, Kaharuza F, Ulvestad E, Were W, Langeland N, Asjo B, Malamba S, Downing R.Population-based hematologic and immunologic reference values for a healthy Ugandan population. Clin Diagn Lab Immunol. 2004 Jan;11(1):29-34. **3.** Were W, Mermin J, Bunnell R, Ekwaru JP, Kaharuza F.Home-based model for HIV voluntary counselling and testing. Lancet. 2003 May 3;361(9368):1569. **4.** Kaharuza F, Sabroe S, Scheutz F.Determinants of child mortality in a rural Ugandan community. East Afr Med J. 2001 Dec;78(12):630-5.
Edward Kirumira Professor and Dean, Faculty of Social Science	**Articles:** **1.** Kirumira EK. Uganda: why a re-think is needed of AIDS control policy. AIDS Anal Afr. 1992 Sep-Oct;2(5):8-9. **2.** Okoth JO, Kirumira EK, Kapaata R. A new approach to community participation in tsetse control in the Busoga sleeping sickness focus, Uganda. A preliminary report. Ann Trop Med Parasitol. 1991 Jun;85(3):315-22.

Florence Mirembe Professor and Head of Department, Department of Obstetrics and Gynaecology Makere University	Sexual and Reproductive Health and Rights Research Programme Coordinator, Makere University **Articles:** **1.** Weeks AD, Alia G, Ononge S, Mutungi A, Otolorin EO, Mirembe FM. Introducing criteria based audit into Ugandan maternity units. Qual Saf Health Care. 2004 Feb;13(1):52-5. **2.** Weeks AD, Alia G, Ononge S, Mutungi A, Otolorin EO, Mirembe FM. Introducing criteria based audit into Ugandan maternity units. BMJ. 2003 Dec 6;327(7427):1329-31. **3.** Kaye D, Mirembe F, Bantebya G. Risk factors, nature and severity of domestic violence among women attending antenatal clinic in Mulago Hospital, Kampala, Uganda. Cent Afr J Med. 2002 May-Jun;48(5-6):64-8. **4.** Kaye D, Mirembe F, Aziga F, Namulema B. Maternal mortality and associated near-misses among emergency intrapartum obstetric referrals in Mulago Hospital, Kampala, Uganda. East Afr Med J. 2003 Mar;80(3):144-9. **5.** Nakakeeto M, Okui O, Cowley P. Uganda: improving maternal health care efficiency and financing. Health Reform Prior Serv. 1999 Summer-Fall;:7-9.
Twaha Mutyaba MD and PhD student	PhD topic: Cervical Cancer Screening in a low resource setting **Articles:** **1.** Mutyaba ST, Mmiro FA. Maternal morbidity during labor in Mulago hospital. Int J Gynaecol Obstet. 2001 Oct;75(1):79-80.
Fred Nuwaha Research manager, Glazer Pediatric AIDS Foundation Formerly at Mbarara University of Science and Technology fnuwaha@iph.ac.ug	PhD dissertation (2000). Karolinska Institute. **Articles:** **1.** Nuwaha F, Okware J, Timbyetaho HN. Community chloroquine distribution for malaria control in Bushenyi district of Uganda. East Afr Med J. 2003 Nov;80(11):569-74. **2.** Nuwaha F, Okware J, Ndyomugyenyi R.Predictors for compliance with community directed ivermectin treatment in Bushenyi district of Uganda: qualitative results. East Afr Med J. 2004 Feb;81(2):92-6. **3.** Nuwaha F. Risk factors for recurrent sexually transmitted infections in Uganda. East Afr Med J. 2000 Mar;77(3):138-42. **4.** Nuwaha F, Kabatesi D, Muganwa M, Whalen CC. Factors influencing acceptability of voluntary counselling and testing for HIV in Bushenyi district of Uganda. East Afr Med J. 2002 Dec;79(12):626-32. **5.** Nuwaha F. People's perception of malaria in Mbarara, Uganda. Trop Med Int Health. 2002 May;7(5):462-70.
Pius Okong Doctor, PhD student at Karolinska Institute pio_okong@yahoo.co.uk	PhD topic: Maternal mortality and severe morbidity in Uganda **Articles:** **1.** Giuliano M, Palmisano L, Galluzzo CM, Amici R, Germinario E, Okong P, Kituuka P, Mmirro F, Magoni M, Vella S. Selection of resistance mutations in pregnant women receiving zidovudine and lamivudine to prevent HIV perinatal transmission. AIDS. 2003 Jul 4;17(10):1570-2. **2.** Lalonde AB, Okong P, Mugasa A, Perron L. The FIGO Save the Mothers Initiative: the Uganda-Canada collaboration. Int J Gynaecol Obstet. 2003 Feb;80(2):204-12. **3.** Okong P, Biryahwaho B, Bergstrom S. Post-abortion endometritis-myometritis and HIV infection. Int J STD AIDS. 2002 Nov;13(11):729-32. **4.** Buonaguro FM, Tornesello ML, Salatiello I, Okong P, Buonaguro L, Beth-Giraldo E, Biryahwaho B, Sempala SD, Giraldo G. The uganda study on HPV variants and genital cancers. J Clin Virol. 2000 Oct;19(1-2):31-41. **5.** Kasumba IN, Nalunkuma AJ, Mujuzi G, Kitaka FS, Byaruhanga R, Okong P, Egwang TG. Low birthweight associated with maternal anaemia and Plasmodium falciparum infection during pregnancy, in a peri-urban/urban area of low endemicity in Uganda. Ann Trop Med Parasitol. 2000 Jan;94(1):7-13.
Julius Wandabwa Senior Lecturer Department of Obstetrics/Gynaecology Makerere University	Current research on maternal mortality and morbidity **Articles:** **1.** Wandabwa J, Tom TO, Kiondo P. Spontaneous rupture of bladder in puerperium. Afr Health Sci. 2004 Aug;4(2):138-9. **2.** Odar E, Wandabwa J, Kiondo P. Maternal and fetal outcome of gestational diabetes mellitus in Mulago Hospital, Uganda. Afr Health Sci. 2004 Apr;4(1):9-14. **3.** Odar E, Wandabwa J, Kiondo P. Sexual practices of women within six months of childbirth in Mulago hospital, Uganda. Afr Health Sci. 2003 Dec;3(3):117-23.
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Christine M. Kaseba-Sata	**Articles:** **1.** Chin KA, Kaseba CM, Weaver JB. Mallory-Weiss syndrome complicating pregnancy in a patient with scleroderma: diagnosis and management. Br J Obstet Gynaecol. 1995 Jun;102(6):498-500.

Margaret Maimbolwa	PhD dissertation (2004): Maternity care in Zambia, with special reference to social support. Karolinska Institue. **Articles:** **1.** Maimbolwa M, Ahmed Y, Diwan V, Arvidson AB. Safe motherhood perspectives and social support for primigravidae women in Lusaka, Zambia. Afr J Reprod Health. 2003 Dec;7(3):29-40. **2.** Maimbolwa MC, Yamba B, Diwan V, Ransjo-Arvidson AB. Cultural childbirth practices and beliefs in Zambia. J Adv Nurs. 2003 Aug;43(3):263-74. **3.** Maimbolwa MC, Sikazwe N, Yamba B, Diwan V, Ransjo-Arvidson AB. Views on involving a social support person during labor in Zambian maternities. J Midwifery Womens Health. 2001 Jul-Aug;46(4):226-34. **4.** Faxelid E, Ahlberg BM, Maimbolwa M, Krantz I. Quality of STD care in an urban Zambian setting: the providers' perspective. Int J Nurs Stud. 1997 Oct;34(5):353-7. **5.** Maimbolwa MC, Ransjo-Arvidson AB, Ng'andu N, Sikazwe N, Diwan VK. Routine care of women experiencing normal deliveries in Zambian maternity wards: a pilot study. Midwifery. 1997 Sep;13(3):125-31.
Phillimon Ndubani Country coordinator (Zambia) for the European Commission- funded research project "Bridging gaps between public and traditional health care sectors, a model to improve STI/HIV/AIDS care in sub-Saharan Africa. pndubani@yahoo.co.uk	PhD dissertation (2002): Young men's sexuality and sexually transmitted infections in Zambia **Articles:** **1.** Brugha R, Donoghue M, Starling M, Ndubani P, Ssengooba F, Fernandes B, Walt G. The Global Fund: managing great expectations. Lancet. 2004 Jul 3;364(9428):95-100. **2.** Ndubani P, Bond V, Liljestrom R, Hojer B. Understanding young men's sexual health and prospects for sexual behaviour change in rural Zambia. Scand J Public Health. 2003;31(4):291-6. **3.** Guinness L, Walker D, Ndubani P, Jama J, Kelly P. Surviving the impact of HIV-related illness in the Zambian business sector. AIDS Patient Care STDS. 2003 Jul;17(7):353-63. **4.** Ndubani P, Hojer B. Sexual behaviour and sexually transmitted diseases among young men in Zambia. Health Policy Plan. 2001 Mar;16(1):107-12. **5.** Ndubani P, Hojer B. Traditional healers and the treatment of sexually transmitted illnesses in rural Zambia. J Ethnopharmacol. 1999 Oct;67(1):15-25.
Jane Ndulo	**Articles:** **1.** Ndulo J, Faxelid E, Krantz I. Traditional healers in Zambia and their care for patients with urethral/vaginal discharge. J Altern Complement Med. 2001 Oct;7(5):529-36. **2.** Ndulo J, Faxelid E, Tishelman C, Krantz I. "Shopping" for sexually transmitted disease treatment: focus group discussions among lay persons in rural and urban Zambia. Sex Transm Dis. 2000 Oct;27(9):496-503. **3.** Faxelid E, Ahlberg BM, Ndulo J, Krantz I. Health-seeking behaviour of patients with sexually transmitted diseases in Zambia. East Afr Med J. 1998 Apr;75(4):232-6. **4.** Faxelid E, Ahlberg BM, Freudenthal S, Ndulo J, Krantz I. Quality of STD care in Zambia. Impact of training in STD management. Int J Qual Health Care. 1997 Oct;9(5):361-6. **5.** Faxelid E, Ndulo J, Ahlberg BM, Krantz I. Individual counseling of patients with sexually transmitted diseases. A way to improve partner notification in a Zambian setting? Sex Transm Dis. 1996 Jul-Aug;23(4):289-92.
N. Sikazwe	**Articles:** **1.** Maimbolwa MC, Sikazwe N, Yamba B, Diwan V, Ransjo-Arvidson AB. Views on involving a social support person during labor in Zambian maternities. J Midwifery Womens Health. 2001 Jul-Aug;46(4):226-34. **2.** Maimbolwa MC, Ransjo-Arvidson AB, Ng'andu N, Sikazwe N, Diwan VK. Routine care of women experiencing normal deliveries in Zambian maternity wards: a pilot study. Midwifery. 1997 Sep;13(3):125-31. **3.** Bradley J, Sikazwe N, Healy J. Improving abortion care in Zambia. Stud Fam Plann. 1991 Nov-Dec;22(6):391-4.
Zimbabwe	
Miriam Bonduelle Department of Obstetrics and Gyanecology Parirenyatwa Hospital, Harare	**Articles:** **1.** Mbizvo MT, Bonduelle MM, Chadzuka S, Lindmark G, Nyström L. Unplanned pregnancies in Harare: what are the social and sexual determinants? Soc Sci Med 1997;45:937-42. **2.** Mbizvo MT, Bonduelle MM, Chadzuka S, Lindmark G, Nyström L. Unplanned pregnancies in Harare, Zimbabwe: what is the contraceptive history and awareness of the mothers. Cent Afr Med J 1997;43:200-5.

Singatsho Chadzuka-Ndhlovu Research midwife Department of Obstetrics and Gyneacology Parirenyatwa Hospital, Harare	**Articles:** **1.** Mbizvo MT, Bonduelle MM, Chadzuka S, Lindmark G, Nyström L. Unplanned pregnancies in Harare: what are the social and sexual determinants? Soc Sci Med 1997;45:937-42. **2.** Mbizvo MT, Bonduelle MM, Chadzuka S, Lindmark G, Nyström L. Unplanned pregnancies in Harare, Zimbabwe: what is the contraceptive history and awareness of the mothers. Cent Afr Med J 1997;43:200-5. **3.** Johnson BR, Ndhlovu S, Farr SL, Chipato T. Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception. Stud Fam Plann 2002;33:195-202.
Tsungai Chipato Senior lecturer Department of Obstetrics and Gynaecology University of Zimbabwe chipato@uz-ucsf.co.zw	**Articles:** **1.** Whitney CG, Daly S, Limpongsanurak S, Festin MR, Thinn KK, Chipato T, Lumbiganon P, Sauvarin J, Andrews W, Tolosa JE; Global Network For Perinatal And Reproductive Health.The international infections in pregnancy study: group B streptococcal colonization in pregnant women. J Matern Fetal Neonatal Med. 2004 Apr;15(4):267-74. **2.** Majoko F, Chipato T, Iliff V.Trends in maternal mortality for the Greater Harare Maternity Unit: 1976 to 1997. Cent Afr J Med. 2001 Aug;47(8):199-203. **3.** Festin MR, Lumbiganon P, Tolosa JE, Finney KA, Ba-Thike K, Chipato T, Gaitan H, Xu L, Limpongsanurak S, Mittal S, Peedicayil A, Pramono N, Purwar M, Shenoy S, Daly S.International survey on variations in practice of the management of the third stage of labour. Bull World Health Organ. 2003;81(4):286-91. **4.** Johnson BR, Ndhlovu S, Farr SL, Chipato T.Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception. Stud Fam Plann. 2002 Jun;33(2):195-202. **5.** Moench TR, Chipato T, Padian NS. Preventing disease by protecting the cervix: the unexplored promise of internal vaginal barrier devices. AIDS. 2001 Sep 7;15(13):1595-602.
Jeremiah Chikovore Behavioural social scientist Department of Pyschiatry Univsersity of Zimbabwe	PhD dissertation (2004).Gender power dynamics in sexual and reproductive health. A qualitative study in Chiredzi District, Zimbabwe. Umeå University. **Articles:** **1.** Chikovore J, Lindmark G, Nystrom L, Mbizvo MT, Ahlberg BM. The hide-and-seek game: men's perspectives on abortion and contraceptive use within marriage in a rural community in Zimbabwe. J Biosoc Sci. 2002 Jul;34(3):317-32. **2.** Chikovore J, Mbizvo MT. Beliefs about sexual relationships and behaviour among commercial farm residents in Zimbabwe. Cent Afr J Med. 1999 Jul;45(7):178-82. **3.** Chikovore J, Mbizvo MT. AIDS related knowledge and sexual behaviour among commercial farm residents in Zimbabwe. Cent Afr J Med. 1999 Jan;45(1):7-10.
J. Chirenda	**Articles:** **1.** Chirenda J, Murugasampillay S. Malaria and HIV co-infection: available evidence, gaps and possible interventions. Cent Afr J Med. 2003 May-Jun;49(5-6):66-71. **2.** Chirenda J, Siziya S, Tshimanga M. Association of HIV infection with the development of severe and complicated malaria cases at a rural hospital in Zimbabwe. Cent Afr J Med. 2000 Jan;46(1):5-9. **3.** Chirenda J.Low CD4 count in HIV negative malaria cases and normal CD4 count in HIV positive and malaria negative patients. Cent Afr J Med. 1999 Sep;45(9):248.
Mike Chirenje Dept of Obstetrics and Gynaecology University of Zimbabwe	**Articles:** **1.** Mbizvo EM, Msuya SE, Hussain A, Chirenje MZ, Stray-Pedersen B.HIV prevalence in Zimbabwean women: 54-67% knowledge and perceived risk. Int J STD AIDS. 2003 Mar;14(3):202-7. **2.** Mbizvo EM, Msuya Sia E, Stray-Pedersen B, Chirenje MZ, Munjoma M, Hussain A. Association of herpes simplex virus type 2 with the human immunodeficiency virus among urban women in Zimbabwe. Int J STD AIDS. 2002 May;13(5):343-8. **3.** Mbizvo EM, Msuya SE, Stray-Pedersen B, Sundby J, Chirenje MZ, Hussain A. HIV seroprevalence and its associations with the other reproductive tract infections in asymptomatic women in Harare, Zimbabwe. Int J STD AIDS. 2001 Aug;12(8):524-31. **4.** Kambarami RA, Chirenje M, Rusakaniko S. Situation analysis of obstetric care services in a rural district in Zimbabwe. Cent Afr J Med. 2000 Jun;46(6):154-7. **5.** Kambarami RA, Chirenje MZ, Rusakaniko S. Perinatal practices in two rural districts of Zimbabwe: a community perspective. Cent Afr J Med. 2000 Apr;46(4):96-100.
Thulani Magwali Dept of Obstetrics and Gynaecology University of Zimbabwe	**Articles:** **1.** Majoko F, Magwali T, Zwizwai M. Uterine rupture associated with use of misoprostol for induction of labor. Int J Gynaecol Obstet. 2002 Jan;76(1):77-8. **2.** Magwali TL, Chipato T, Majoko F, Rusakaniko S, Mujaji C. Prophylactic augmentin in prelabor preterm rupture of the membranes. Int J Gynaecol Obstet. 1999 Jun;65(3):261-5.

Franz Majoko Dept of Obstetrics and Gynaecology University of Zimbabwe. PhD student at Umeå University	**Articles:** **1.** Tarwireyi F, Majoko F. Health workers' participation in voluntary counselling and testing in three districts of Mashonaland East Province, Zimbabwe. Cent Afr J Med. 2003 May-Jun;49(5-6):58-62. **2.** Majoko F, Munjanja S, Nystrom L, Mason E, Lindmark G. Field efficiency of syphilis screening in antenatal care: lessons from Gutu District in Zimbabwe. Cent Afr J Med. 2003 Jul-Aug;49(7-8):90-3. **3.** Mathole T, Lindmark G, Majoko F, Ahlberg BM. A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. Midwifery. 2004 Jun;20(2):122-32. **4.** Majoko F, Zwizwai M, Nystrom L, Lindmark G. Vaginal misoprostol for induction of labour: a more effective agent than prostaglandin F2 alpha gel and prostaglandin E2 pessary. Cent Afr J Med. 2002 Nov-Dec;48(11-12):123-8. **5.** Makuyana D, Mahomed K, Shukusho FD, Majoko F. Liver andkidney function tests in normal and pre-eclamptic gestation--a comparison with non-gestational reference values. Cent Afr J Med. 2002 May-Jun;48(5-6):55-9.
Thuba Mathole PhD student, Uppsala University	**Articles:** **1.** Mathole T, Lindmark G, Majoko F, Ahlberg BM. A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. Midwifery. 2004 Jun;20(2):122-32.
Stephen Munjanja Division of Obstetrics and Gynaecology Harare Hospital Head of ECSAOGS	**Articles:** **1.** Majoko F, Munjanja S, Nystrom L, Mason E, Lindmark G. Field efficiency of syphilis screening in antenatal care: lessons from Gutu District in Zimbabwe. Cent Afr J Med. 2003 Jul-Aug;49(7-8):90-3. **2.** Nilses C, Nystrom L, Munjanja S, Lindmark G.Self-reported reproductive outcome and implications in relation to use of care in women in rural Zimbabwe. Acta Obstet Gynecol Scand. 2002 Jun;81(6):508-15. **3.** Majoko F, Nystrom L, Munjanja S, Lindmark G. Usefulness of risk scoring at booking for antenatal care in predicting adverse pregnancy outcome in a rural African setting. J Obstet Gynaecol. 2002 Nov;22(6):604-9. **4.** Munjanja SP. Ethics in reproductive health: clinical issues in Zimbabwe. Cent Afr J Med. 2001 Jun;47(6):159-63. **5.** Nilses C, Lindmark G, Munjanja S, Nystrom L. A community based study of HIV in women in rural Gutu District, Zimbabwe 1992 to 1993. Cent Afr J Med. 2000 Feb;46(2):32-7.
Nester Murira Research midwife Department of Obstetrics and Gyneacology Parirenyatwa Hospital, Harare	**Articles:** **1.** Murira N, Munjanja S, Zhanda I, Lindmark G, Nyström L. Health education for pregnancy care in Harare. A survey in seven primary health care clinics. Cent Afr Med J 1996;42:297-301. **2.** Murira N, Munjanja S, Zhanda I, Lindmark G, Nyström L. Effect of a new antenatal care programme on the attitudes of pregnant women and midwives towards antenatal care i Harare. Cent Afr Med J 1997;43:131-5. **3.** Murira N, Lutzen K, Lindmark G, Christensson K. Communication patterns between health care providers and their clients at an antenatal clinic in Zimbabwe. Health Care Women Int 2003;24:83-92.
S Rusakaniko Biostatistician Department of Community Medicine University of Zimbabwe	**Articles:** **1.** Tarwireyi F, Chirenje ZM, Rusakaniko S. Cancer of the cervix: knowledge, beliefs and screening behaviours of health workers in Mudzi District in Mashonaland East Province, Zimbabwe. Cent Afr J Med. 2003 Jul-Aug;49(7-8):83-6. **2.** Chidzonga MM, Rusakaniko S. Ranula: another HIV/AIDS associated oral lesion in Zimbabwe? Oral Dis. 2004 Jul;10(4):229-32. **3.** Chishawa O, Ziyambi Z, Ndhlovu P, Rusakaniko S, Moyo O, Zijenah LS. Comparative evaluation and assessment of the diagnostic usefulness of four commercial HIV-1/HIV-2 antibody assays using two well-characterized serum panels from Blood Transfusion Service and the National Health Laboratory Services in Zimbabwe. Cent Afr J Med. 2001 Jan;47(1):1-8. **4.** Situation analysis for cervical cancer diagnosis and treatment in east, central and southern African countries. Bull World Health Organ. 2001;79(2):127-32. **5.** Chirenje ZM, Rusakaniko S, Kirumbi L, Ngwalle EW, Makuta-Tlebere P, Kaggwa S, Mpanju-Shumbusho W, Makoae L. Kundodyiwa TW, Majoko F, Rusakaniko S. Misoprostol versus oxytocin in the third stage of labor. Int J Gynaecol Obstet. 2001 Dec;75(3):235-41.

Grazyna Stanczuk Department of Paediatrics University of Zimbabwe Researcher, Karolinska Institute grazyna87@hotmail.com	Cervical cancer in Zimbabwe: Host and viral factors **Articles:** **1.** Sibanda EN, Stanczuk G, Kasolo F. HIV/AIDS in Central Africa: pathogenesis, immunological and medical issues. Int Arch Allergy Immunol. 2003 Nov; 132(3):183-95. **2.** Stanczuk GA, Thomsen M, Soerensen AM, Sibanda EN. Acetyl salicylic acid (aspirin), micronutrients and chloroquine in the management of the acquired imm unodeficiency syndrome (AIDS). Cent Afr J Med. 2002 Mar-Apr;48(3-4):42-9. **3.** Stanczuk GA, Kay P, Allan B, Chirara M, Tswana SA, Bergstrom S, Sibanda EN, Williamson AL. Detection of human papillomavirus in urine and cervical swabs from patients with invasive cervical cancer. J Med Virol. 2003 Sep;71(1):110-4. **4.** Stanczuk GA, Kay P, Sibanda E, Allan B, Chirara M, Tswana SA, Bergstrom S, Williamson AL. Typing of human papillomavirus in Zimbabwean patients with invasive cancer of the uterine cervix. Acta Obstet Gynecol Scand. 2003 Aug;82(8):762-6. **5.** Govan VA, Carrara HR, Sachs JA, Hoffman M, Stanczuk GA, Williamson AL. Ethnic differences in allelic distribution of IFN-g in South African women but no link with cervical cancer. J Carcinog. 2003 May 16;2(1):3.
Irene Zhanda Research midwife Department of Obstetrics and Gyneacology Parirenyatwa Hospital, Harare	**Articles:** **1.** Murira N, Munjanja S, Zhanda I, Lindmark G, Nyström L. Health education for pregnancy care in Harare. A survey in seven primary health care clinics. Cent Afr Med J 1996;42:297-301. **2.** Murira N, Munjanja S, Zhanda I, Lindmark G, Nyström L. Effect of a new antenatal care programme on the attitudes of pregnant women and midwives towards antenatal care i Harare. Cent Afr Med J 1997;43:131-5.

ECSAOGS Maternal mortality taskforce

The ECSAOGS maternal mortality taskforce has six members and has met formally only once, in Malawi, due to financial constraints.

Members	Affiliation	E-mail
Florence Mirembe (Chairperson)	Makerere University, Uganda	aogu@africaonline.co.ug flomir2002@yahoo.com
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Annex 4.
An inventory of…

Swedish university-based research groups and researchers within the area of sexual and reproductive health and rights

This annex focuses on SRHR researchers based at the medical faculty of four Swedish universities: Karolinska Insitute, Lund University, Umeå University and Uppsala Univeristy. They are listed in alphabetical order by university, together with up to five recent peer-reviewed publications.

Karolinska Institute

The Division of International Health (IHCAR), Department of Public Health Sciences at the Karolinska Institute has two research groups on sexual and reproductive health and rights (SRHR):

1. SRHR: led by Professor Staffan Bergström. This group gives priority to research related to maternal mortality and severe morbidity. Particular emphasis is given to abortion research and reproductive health issues concerning adolescents. There are ongoing projects in HIV/AIDS related areas with a focus on obstetric infections, postpartum haemorrhage and outcome for orphans after maternal death. Female genital mutilation and infertility belong to other areas of priority research.

2. Sexual and reproductive health with a focus on youth: led by Elisabeth Faxelid. Several projects focus on health seeking behaviour, coping strategies and quality of care for pregnant adolescents, the role of the nurse/midwife in meeting young people's needsm, STIs including HIV prevention, the needs and role of young men/fathers, emergency contraception and other contraception, working chiliren and their health and sexual education in schools. Other topics not exclusively focusing on youth deal with improvement of STI/HIV/AIDS care, cervical cancer screening, female genital mutilation and domestic violence.

Lars Almroth, MD, Department of Pediatics, Kristianstad Central Hospital. PhD student at Karolinska Institute l.almroth@telia.com	PhD topic: Female genital cutting in Somalia **Articles:** **1.** Almroth L, Almroth-Berggren V, Bergstrom S. Need for more research on female circumcision. Lack of communication between women and men conserves the traditional practice] Lakartidningen. 2001 Nov 21;98(47):5355-8, 5360. **2.** Almroth L, Almroth-Berggren V, Hassanein OM, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S. Male complications of female genital mutilation. Soc Sci Med. 2001 Dec;53(11):1455-60. **3.** Almroth L, Almroth-Berggren V, Hassanein OM, El Hadi N, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S. A community based study on the change of practice of female genital mutilation in a Sudanese village. Int J Gynaecol Obstet. 2001 Aug;74(2):179-85.
Vanja Almroth-Berggren, RN, MPH Kristianstad University. PhD student at Karolinska Institute vanja.berggren@hv.hkr.se	PhD topic: Female genital cutting in Somalia **Articles:** **1.** Almroth L, Almroth-Berggren V, Bergstrom S. Need for more research on female circumcision. Lack of communication between women and men conserves the traditional practice] Lakartidningen. 2001 Nov 21;98(47):5355-8, 5360. **2.** Almroth L, Almroth-Berggren V, Hassanein OM, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S. Male complications of female genital mutilation. Soc Sci Med. 2001 Dec;53(11):1455-60. **3.** Almroth L, Almroth-Berggren V, Hassanein OM, El Hadi N, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S. A community based study on the change of practice of female genital mutilation in a Sudanese village. Int J Gynaecol Obstet. 2001 Aug;74(2):179-85.

Gunnel Balaile Registered nurse/midwife PhD student, Karolinska Institute	PhD topic: Sexuality and HIV infection: a study of men's and women's experiences of sexualtiy from their life world.
Staffan Bergström Professor, International Health Care Research (IHCAR), Karolinska Institute Staffan.Bergstrom@phs.ki.se	PhD dissertation (1971): Surface ultrastructure of mouse blastocysts at implantation", University of Uppsala. **Articles:** **1.** Mathai E, Thomas RJ, Chandy S, Mathai M, Bergstrom S. Antimicrobials for the treatment of urinary tract infection in pregnancy: practices in southern India. Pharmacoepidemiol Drug Saf. 2004 Sep;13(9):645-52. **2.** Bergstrom S, Petersson PO. [Swedish assistance and goals of the millennium: it's necessary to increase the Swedish resource basis!] Lakartidningen. 2004 Jul 22;101(30-31):2442-3. Swedish. **3.** Mathai M, Schramm M, Baravilala W, Shankar V, Antonisamy B, Jeyaseelan L, Bergstrom S. Ethnicity and fetal growth in Fiji. Aust N Z J Obstet Gynaecol. 2004 Aug;44(4):318-21. **4.** Dreilich M, Bergstrom S, Wagenius G, Brattstrom D, Bergqvist M. A retrospective study focusing on clinical predictive factors in 126 patients with oesophageal carcinoma. Anticancer Res. 2004 May-Jun;24(3b):1915-20. **5.** Andreasson J, Bergstrom S, Carlsson B, Graham LP, Lindstrom G. Hydrological change--climate change impact simulations for Sweden. Ambio. 2004 Jun;33(4-5):228-34.
Kenneth Björklund MD, PhD, postdoctoral researcher	Current research on Quality maternity care in Tanzania **Articles:** **1.** Bjorklund K. Minimally invasive surgery for obstructed labour: a review of symphysiotomy during the twentieth century (including 5000 cases). BJOG. 2002 Mar;109(3):236-48. **2.** Bjorklund K, Nordstrom ML, Odlind V. Combined oral contraceptives do not increase the risk of back and pelvic pain during pregnancy or after delivery. Acta Obstet Gynecol Scand. 2000 Nov;79(11):979-83. **3.** Bjorklund K, Bergstrom S, Nordstrom ML, Ulmsten U. Symphyseal distention in relation to serum relaxin levels and pelvic pain in pregnancy. Acta Obstet Gynecol Scand. 2000 Apr;79(4):269-75. **4.** Bjorklund K, Kimaro M, Urassa E, Lindmark G. Introduction of the Misgav Ladach caesarean section at an African tertiary centre: a randomised controlled trial. BJOG. 2000 Feb;107(2):209-16. **5.** Bjorklund K, Bergstrom S. Is pelvic pain in pregnancy a welfare complaint? Acta Obstet Gynecol Scand. 2000 Jan;79(1):24-30.
Ulla Bredberg-Rådén, PhD	PhD dissertation (1994): Detection of HIV infection, especially in Africa (Karolinska Institute) **Articles:** **1.** Pallangyo KJ, Mbaga IM, Mugusi F, Mbena E, Mhalu FS, Bredberg U, Biberfeld G. Clinical case definition of AIDS in African adults. Lancet. 1987 Oct 24;2(8565):972.
Kenneth Challis PhD, Researcher	**Articles:** **1.** Challis K, Osman NB, Nordahl G, Bergstrom S. The impact of adjustment for parity and mid-upper-arm circumference on sensitivity of symphysis-fundus height measurements to predict SGA foetuses in Mozambique. Trop Med Int Health. 2003 Feb;8(2):168-73. **2.** Challis K, Osman NB, Nystrom L, Nordahl G, Bergstrom S. Symphysis-fundal height growth chart of an obstetric cohort of 817 Mozambican women with ultrasound-dated singleton pregnancies. Trop Med Int Health. 2002 Aug;7(8):678-84. **3.** Challis K, Melo A, Bugalho A, Jeppsson JO, Bergstrom S. Gestational diabetes mellitus and fetal death in Mozambique: an incident case-referent study. Acta Obstet Gynecol Scand. 2002 Jun;81(6):560-3. **4.** Osman NB, Challis K, Cotiro M, Nordahl G, Bergstrom S. Perinatal outcome in an obstetric cohort of Mozambican women. J Trop Pediatr. 2001 Feb;47(1):30-8. **5.** Osman NB, Challis K, Cotiro M, Nordahl G, Bergstrom S. Maternal and fetal characteristics in an obstetric cohort in Mozambique. Afr J Reprod Health. 2000 Apr;4(1):110-9.

Kyllike Christensson On leave from Karolinska Insitute as Professor, Division of Nursing Sciences and Public Health, Mälardalen University kyllike.christensson@mdh.se	**1.** Ekeus C, Christensson K, Hjern A. Unintentional and violent injuries among pre-school children of teenage mothers in Sweden: a national cohort study. J Epidemiol Community Health. 2004 Aug;58(8):680-5. **2.** Pettersson KO, Christensson K, de Freitas Eda G, Johansson E. Adaptation of h Rööst, M., Johnsdotter S, Liljestrand J, Essen B. Qualitative study of traditional birth attendants in a rural area in Guatemala, BJOG, in press 2004. eking behavior during childbirth: focus group discussions with women living in the suburban areas of Luanda, Angola. Health Care Women Int. 2004 Mar;25(3):255-80. **3.** Nisell M, Ojmyr-Joelsson M, Frenckner B, Rydelius PA, Christensson K. How a family is affected when a child is born with anorectal malformation. Interviews with three patients and their parents. J Pediatr Nurs. 2003 Dec;18(6):423-32. **4.** Blix-Lindstrom S, Christensson K, Johansson E. Women's satisfaction with decision-making related to augmentation of labour. Midwifery. 2004 Mar;20(1):104-12. **5.** Ekeus C, Christensson K. Reproductive history and involvement in pregnancy and childbirth of fathers of babies born to teenage mothers in Stockholm, Sweden. Midwifery. 2003 Jun;19(2):87-95. 4(2):83-92.
Elisabeth Dahlbäck RNM, lecturer at Department of Nursing, Karolinska Institute PhD student	PhD topic: Adolescent reproductive health and life skills in Zambia **Articles:** **1.** Dahlback E, Makelele P, Phillimon N, Bawa Y, Bergtrom S, Ransjo-Arvidson AB. "I am happy that God made me a boy": Zambian adolescent boys' perceptions about growing into manhood. Afr J Reprod Health. 2003 Apr;7(1):49-62.
Elisabeth Faxelid PhD, Associate professor, Registered nurse/midwife elisabeth.faxelid@phs.ki.s (+46) 8-517 76488 International coordinator: "Bridging gaps between public and traditional health care sectors, a model to improve STI/HIV/AIDS care in sub-Saharan Africa.	PhD dissertation (1997): Quality of STD Care. **Articles:** **1.** Goransson M, Faxelid E, Heilig M. Beliefs and reality: detection and prevention of high alcohol consumption in Swedish antenatal clinics. Acta Obstet Gynecol Scand. 2004 Sep;83(9):796-800. **2.** Olin RM, Faxelid E. Parents' needs to talk about their experiences of childbirth. Scand J Caring Sci. 2003 Jun;17(2):153-9. **3.** Ndulo J, Faxelid E, Krantz I. Traditional healers in Zambia and their care for patients with urethral/vaginal discharge. J Altern Complement Med. 2001 Oct;7(5):529-36. **4.** Nuwaha F, Faxelid E, Wabwire-Mangen F, Eriksson C, Hojer B. Psycho-social determinants for sexual partner referral in Uganda: quantitative results. Soc Sci Med. 2001 Nov;53(10):1287-301. **5.** Nuwaha F, Kambugu F, Nsubuga PS, Hojer B, Faxelid E. Efficacy of patient-delivered partner medication in the treatment of sexual partners in Uganda. Sex Transm Dis. 2001 Feb;28(2):105-10.
Bengt Höjer, MD, Professor in international health	Former research coordinator of "Interdisciplinary research for HIV/AIDS prevention in southern Africa (Kenya and Zambia). **Articles:** **1.** Ndubani P, Bond V, Liljestrom R, Hojer B.Understanding young men's sexual health and prospects for sexual behaviour change in rural Zambia. Scand J Public Health. 2003;31(4):291-6. **2.** Khe ND, Toan NV, Xuan LT, Eriksson B, Hojer B, Diwan VK.Primary health concept revisited: where do people seek health care in a rural area of Vietnam? Health Policy. 2002 Jul;61(1):95-109. **3.** Nuwaha F, Faxelid E, Wabwire-Mangen F, Eriksson C, Hojer B.Psycho-social determinants for sexual partner referral in Uganda: quantitative results. Soc Sci Med. 2001 Nov;53(10):1287-301. **4.** Ndubani P, Hojer B.Sexual behaviour and sexually transmitted diseases among young men in Zambia. Health Policy Plan. 2001 Mar;16(1):107-12. **5.** Nuwaha F, Kambugu F, Nsubuga PS, Hojer B, Faxelid E.Efficacy of patient-delivered partner medication in the treatment of sexual partners in Uganda. Sex Transm Dis. 2001 Feb;28(2):105-10.

Annika Johansson PhD, BSc, Research fellow annika.johansson@phs.ki.se	Main research areas are on the social context of reproduction, maternal mortalit, the sexual and reproductive health of adolescents, and abortion. **Articles:** **1.** Walther SM, Jonasson U, Karlsson S, Nordlund P, Johansson A, Malstam J; The south-Eastern Intensive Care Network Of Sweden. Multicentre study of validity and interrater reliability of the modified Nursing Care Recording System (NCR11) for assessment of workload in the ICU. Acta Anaesthesiol Scand. 2004 Jul;48(6):690-6. **2.** Johansson A, Gotestam KG.Internet addiction: characteristics of a questionnaire and prevalence in Norwegian youth (12-18 years). Scand J Psychol. 2004 Jul;45(3):223-9. **3.** Nordenvall C, Edgren G, Gillispie A, Larsson M, Adami J, Johansson A, Hartman M. [Health care services during summer--a dilemma?]. Lakartidningen. 2004 Jan 22;101(4):290-2. **4.** Ostgren CJ, Johansson A, Grip B, Johansson A, Heurgren M, Melander A. [Result of a CPP-project at a primary health care center. Diabetes care in primary health care is resource-demanding]. Lakartidningen. 2003 Nov 6;100(45):3600-4. **5.** Hubinette A, Cnattingius S, Johansson AL, Henriksson C, Lichtenstein P. Birth weight and risk of angina pectoris: analysis in Swedish twins. Eur J Epidemiol. 2003;18(6):539-44.
Hege Langli Medical student and PhD student	PhD topic: Late effects of symphysiotomy in Zimbabwe
Karen Odberg Pettersson, MNSc. PhD student	PhD topic: Quality of care during childbirth and the immediate postpartum period with a focus on midwifery in two low-income countries. **Articles:** **1.** Pettersson KO, Christensson K, de Freitas Eda G, Johansson E. Adaptation of health care seeking behavior during childbirth: focus group discussions with women living in the suburban areas of Luanda, Angola. Health Care Women Int. 2004 Mar;25(3):255-80. **2.** Pettersson KO, Svensson ML, Christensson K. The lived experiences of autonomous Angolan midwives working in midwifery-led, maternity units. Midwifery. 2001 Jun;17(2):102-14. **3.** Pettersson KO, Svensson ML, Christensson K. Evaluation of an adapted model of the World Health Organization partograph used by Angolan midwives in a peripheral delivery unit. Midwifery. 2000 Jun;16(2):82-8. **4.** Pettersson KO. [Greetings from the C.A.O.L. (Coordination of Obstetric Care Luanda) in Luanda, Angola] Jordemodern. 1994 Jan-Feb;107(1-2):40-3. **5.** Pettersson KO. [Da Luz--give light] Jordemodern. 1989 Dec;102(12):466-8.
Anna-Berit Ransjö-Arvidson, PhD, RN MW, Senior lecturer in Reproductive and Perinatal Health Care, Department of Women and Child Health Anna-berit.ransjo-arvidson@phs.ki.se	Main research areas are health systems in relation to maternity practices in childbirth and adolescent sexual and reproductive health in low-income countries and Sweden. **Articles:** **1.** Maimbolwa M, Ahmed Y, Diwan VK, Ransjö-Arvidson AB. Safe motherhood perspectives and social support for primigravidae women in Lusaka, Zambia African Journal for Reproductive Health, 2003;7:26-36. **2.** Maimbolwa MC, Yamba B, Diwan V, Ransjo-Arvidson AB. Cultural childbirth practices and beliefs in Zambia. J Adv Nurs. 2003 Aug;43(3):263-74. **3.** Svedberg P, Jormfeldt H, Arvidsson B. Patients' conceptions of how health processes are promoted in mental health nursing. A qualitative study. J Psychiatr Ment Health Nurs. 2003 Aug;10(4):448-56. **4.** Mngadi PT, Zwane IT, Ahlberg BM, Ransjo-Arvidson AB.Family and community support to adolescent mothers in Swaziland. J Adv Nurs. 2003 Jul;43(2):137-44.. **5.** Dahlback E, Makelele P, Phillimon N, Bawa Y, Bergtrom S, Ransjo-Arvidson AB. "I am happy that God made me a boy": Zambian adolescent boys' perceptions about growing into manhood. Afr J Reprod Health. 2003 **6.** Mngadi PT, Zwane IT, Ransjo-Arvidson AB, Ahlberg BM, Thembi IT. Quality of maternity care for adolescent mothers in Mbabane, Swaziland. Int Nurs Rev. 2002 Mar;49(1):38-46. Erratum in: Int Nurs Rev 2002 Sep;49(3):194. Thembi IT [corrected to Zwane IT].

Vibeke Rasch MD, PhD Associate professor, Copenhagen University and researcher at Karolinska Institute	**Articles:** **1.** Rasch V, Massawe S, McHomvu Y, Mkamba M, Bergstrom S. A longitudinal study on different models of postabortion care in Tanzania. Acta Obstet Gynecol Scand. 2004 Jun;83(6):570-5. **2.** Rasch V, Massawe S, Yambesi F, Bergstrom S. Acceptance of contraceptives among women who had an unsafe abortion in Dar es Salaam. Trop Med Int Health. 2004 Mar;9(3):399-405. **3.** Rasch V, Wielandt H, Knudsen LB. Living conditions, contraceptive use and the choice of induced abortion among pregnant women in Denmark. Scand J Public Health. 2002;30(4):293 **4.** Rasch V. Cigarette, alcohol, and caffeine consumption: risk factors for spontaneous abortion. Acta Obstet Gynecol Scand. 2003 Feb;82(2):182-8. **5.** Rasch V. Contraceptive failure--results from a study conducted among women with accepted and unaccepted pregnancies in Denmark. Contraception. 2002 Aug;66(2):109-16.
Hans Rosling Professor, IHCAR, hans.rosling@phs.ki.se	**Articles:** **1.** Rosling H. [New map of world health is needed. North and South is changed to healthy and ill and West to rich and poor] Lakartidningen. 2004 Jan 15;101(3):198-201. **2.** Oluwole OS, Onabolu AO, Cotgreave IA, Rosling H, Persson A, Link H. Incidence of endemic ataxic polyneuropathy and its relation to exposure to cyanide in a Nigerian community. J Neurol Neurosurg Psychiatry. 2003 Oct;74(10):1417-22. **3.** Rosling H, Ekstrom AM, Ortendahl C. [The global health development--what is the status and what can be done?] Lakartidningen. 2001 Nov 21;98(47):5382, 5385. **4.** Onabolu AO, Oluwole OS, Bokanga M, Rosling H. Ecological variation of intake of cassava food and dietary cyanide load in Nigerian communities. Public Health Nutr. 2001 Aug;4(4):871-6 **5.** Banea-Mayambu JP, Tylleskar T, Tylleskar K, Gebre-Medhin M, Rosling H. Dietary cyanide from insufficiently processed cassava and growth retardation in children in the Democratic Republic of Congo (formerly Zaire). Ann Trop Paediatr. 2000 Mar;20(1):34-40.
Roland Strand rolandstrand@swipnet.se	PhD topic: Severe maternal pathology during pregnancy and childbirth in Angola. **Articles:** **1.** Strand RT, da Silva F, Bergstrom S.Use of cholera beds in the delivery room: a simple and appropriate method for direct measurement of postpartum bleeding. Trop Doct. 2003 Oct;33(4):215-6. **2.** Strand RT, Franque-Ranque M, Bergstrom S, Weiland O.Infectious aetiology of jaundice among pregnant women in Angola. Scand J Infect Dis. 2003;35(6-7):401-3.
Linnea Warénius PhD student, Karolinska Institute	PhD topic: Quality of sexual and reproductive health care for adolescents in Kenya and Zambia: the role of the nurse/midwife in meeting adolescents' expressed needs.
Hans Wessel Researcher, Karolinska Institute	**Articles:** **1.** Wessel HF, Herrmann B, Dupret A, Moniz F, Brito C, Bergstrom S.Genital infections among antenatal care attendees in Cape Verde. Afr J Reprod Health. 1998 Apr;2(1):32-40. **2.** Herrmann B, Nystrom T, Wessel H.Detection of Neisseria gonorrhoeae from air-dried genital samples by single-tube nested PCR. J Clin Microbiol. 1996 Oct;34(10):2548-51 **3.** Wessel H, Cnattingius S, Bergstrom S, Dupret A, Reitmaier P.Maternal risk factors for preterm birth and low birthweight in Cape Verde. Acta Obstet Gynecol Scand. 1996 Apr;75(4):360-6.
Catarina Widmark RN, RM, PhD student at the Department of Nursing, Karolinska Institute	**Articles:** **1.** Leval A, Widmark C, Tishelman C, Maina Ahlberg B.The encounters that rupture the myth: contradictions in midwives' descriptions and explanations of circumcised women immigrants' sexuality. Health Care Women Int. 2004 Sep;25(8):743-60. **2.** Sarkadi A, Widmark C, Tornberg S, Tishelman C.The 'hows', 'whos', and 'whens' of screening: gynaecologists' perspectives on cervical cancer screening in urban Sweden. Soc Sci Med. 2004 Mar;58(6):1097-108. **3.** Hilton LW, Jennings-Dozier K, Bradley PK, Lockwood-Rayermann S, DeJesus Y, Stephens DL, Rabel K, Sandella J, Sbach A, Widmark C.The role of nursing in cervical cancer prevention and treatment. Cancer. 2003 Nov 1;98(9 Suppl):2070-4. **4.** Widmark C, Tishelman C, Ahlberg BM. A study of Swedish midwives' encounters with infibulated African women in Sweden. Midwifery. 2002 Jun;18(2):113-25. **5.** Widmark C, Tishelman C, Lundgren EL, Forss A, Sachs L, Tornberg S.Opportunities and burdens for nurse-midwives working in primary health care. An example from population-based cervical cancer screening in urban Sweden. J Nurse Midwifery. 1998 Nov-Dec;43(6):530-40.

Ann-Sofi Åsader Head of Infectious Diseases Clinic, Karolinska Hospital Associated with the IHCAR research group "Seuxal and reproductive health with a focus on youth"	**Articles:** **1.** Asander AS, Berglund T, Persson C, Ramstedt K. [Prevention of HIV by contact tracing. Follow-up of persons with newly diagnosed infections] Lakartidningen. 1996 Oct 30;93(44):3907-10. **2.** Asander AS, Belfrage E, Bohlin AB, Bengtsson AB, Lidman K, Lindgren S. [Children of HIV-infected women. An exposed group] Lakartidningen. 1994 Feb 9;91(6):499-502.
Lund University Lund University's Department of Community Medicine has a small sexual and reproductive health and rights research group, working on issues in Uganda and on African immigrants in Denmark and Sweden. The Department coordinates the multidisciplinary HIV/AIDS research group of some 15 researchers from eight departments.	
Anette Agardh RN MW MPH, Senior lecturer Department of Community Medicine	PhD topic: Peer education in Uganda
Birgitta Essen MD, PhD, Department of Obstetrics and Gyaecology	**Articles:** **1.** Essen B, Johnsdotter S. Female genital mutilation in the West: traditional circumcision versus genital cosmetic surgery. Acta Obstet Gynecol Scand. 2004 Jul;83(7):611-3. **2.** Rööst, M., Johnsdotter S, Liljestrand J, Essen B. Qualitative study of traditional birth attendants in a rural area in Guatemala, BJOG, in press 2004. **3.** Essen B. [Pregnant immigrant women in Scandinavia] Ugeskr Laeger. 2003 Nov 10;165(46):4425-8. **4.** Essen B, Wilken-Jensen C. How to deal with female circumcision as a health issue in the Nordic countries. Acta Obstet Gynecol Scand. 2003 Aug;82(8):683-6. **5.** Essen B, Bodker B, Sjoberg NO, Gudmundsson S, Ostergren PO, Langhoff-Roos J. Is there an association between female circumcision and perinatal death? Bull World Health Organ. 2002;80(8):629-32.
Jeffrey V. Lazarus MA, MIH, PhD student Department of Community Medicine Jeffrey.lazarus@smi.mas.lu	PhD topic: Real and perceived barriers to the use of contraception among youth in the enlarged European Union **Articles:** **1.** Lazarus JV, Liljestrand J, Nadisauskiene R. Observations on reproductive health programs in the Baltic States. Int. J Gynaecol Obst (Nov 2004) **2.** Lazarus JV, Lalonde A. Reducing postpartum hemmorhage in sub-Saharan Africa. Int. J Gynaecol Obst (in press 2004) **3.** Lazarus JV, Liljestrand J, Rasch V. Midwifery at the Crossroads in Estonia: Attitudes of midwives and other key stakeholders. Acta Obstetrica et Gynecologica Scandinavica (in press 2004). **4.** Lazarus JV, Liljestrand J, Essner G. ICPD@10: Is reproductive health under fire? Scandinavian Journal of Public Health (in press 2004). **5.** Lazarus JV, Oestergaard LR, Himedan HM, Liljestrand J. HIV/AIDS Knowledge, attitudes and practices among Somali and Sudanese immigrants in Denmark (submitted).
Jerker Liljestrand MD, PhD, Associate professor Department of Community Medicine Jerker.liljestrand@smi.mas.lu.se	PhD dissertation: Maternal mortality in Mozambique **Articles:** **1.** Lazarus JV, Liljestrand J, Nadisauskiene R. Observations on reproductive health programs in the Baltic States. Int. J Gynaecol Obst (2004) **2.** Austveg B, Liljestrand J. New global efforts for safer motherhood. BJOG. 2004 May;111(5):397-8. **3.** Liljestrand J. [Maternal survival--a question of women's value] Lakartidningen. 2004 Feb 5;101(6):478-81. **4.** Lendahls L, Ohman L, Liljestrand J, Hakansson A. Women's experiences of smoking during and after pregnancy as ascertained two to three years after birth. Midwifery. 2002 Sep;18(3):214-22. **5.** Lendahls L, Ohman L, Liljestrand J, Hakansson A. Women's experiences of smoking during and after pregnancy as ascertained two to three years after birth. Midwifery. 2002 Sep;18(3):214-22.

Per-Oluf Östergren Professor of Social Medicine	**Articles:** **1.** Lundberg P, Cantor-Graae E, Kabakyenga J, Rukundo G, Ostergren PO.Prevalence of delusional ideation in a district in southwestern Uganda. Schizophr Res. 2004 Nov 1;71(1):27-34. **2.** Dejin-Karlsson E, Ostergren PO.Psychosocial factors, lifestyle, and fetal growth: the added value of both pre- and post-natal assessments. Eur J Public Health. 2003 Sep;13(3):210-7. **3.** Lindholm M, Dejin-Karlsson E, Ostergren PO, Uden G.Nurse managers' professional networks, psychosocial resources and self-rated health. J Adv Nurs. 2003 Jun;42(5):506-15. **4**. Jeppsson A, Ostergren PO, Hagstrom B. Restructuring a ministry of health - an issue of structure and process: a case study from Uganda. Health Policy Plan. 2003 Mar;18(1):68-73. **5.** Svenson GR, Ostergren PO, Merlo J, Rastam L.Action control and situational risks in the prevention of HIV and STIs: individual, dyadic, and social influences on consistent condom use in a university population. AIDS Educ Prev. 2002 Dec;14(6):515-31.
Umeå University The main researchers involved in public health and reproductive health research in sub-Saharan Africa work in the Division of Epidemiology and public health sciences, (EPIPH) within the Department of Public Health and Clinical Medicine and its International School of Public Health, UISPH. EPIPH collaborates with the International Maternal and Child Health, Uppsala University, on research in Tanzania and Zimbabwe. There is a bilateral research collaboration with Ethiopia, Tanzania, Nicaragua, Indonesia and South Africa as well as international collaboration via INDEPTH, the International Network of Field Sites with Continuous Demographic Evaluation of Populations and their Health in Developing Countries (www.indepth-network.net). EPIPH is a WHO Collaborating Centre for Epidemiological Surveillance and Public Health Training.	
Lars Dahlgren, Professor of medical sociology, Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine & Dept of Sociology, Umeå University.	Swedish supervisor for social behaviour studies in the Kagera Project, Tanzania **Articles:** **1.** Dahlgren L, Dahlstrand HM, Lindquist D, Hogmo A, Bjornestal L, Lindholm J, Lundberg B, Dalianis T, Munck-Wikland E. Human papillomavirus is more common in base of tongue than in mobile tongue cancer and is a favorable prognostic factor in base of tongue cancer patients. Int J Cancer. 2004 **2.** Lugalla J, Emmelin M, Mutembei A, Sima M, Kwesigabo G, Killewo J, Dahlgren L. Social, cultural and sexual behavioral determinants of observed decline in HIV infection trends: lessons from the Kagera Region, Tanzania. Soc Sci Med. 2004 Jul;59(1):185-98. **3.** Fernstrom MC, Dahlgren L, Ranby M, Forsgren A, Petrini B. Increased sensitivity of Mycobacterium tuberculosis Cobas Amplicor PCR following brief incubation of tissue samples on Lowenstein-Jensen substrate. APMIS. 2003 Dec;111(12):1114-6. **4.** Emmelin M, Weinehall L, Stegmayr B, Dahlgren L, Stenlund H, Wall S. Self-rated ill-health strengthens the effect of biomedical risk factors in predicting stroke, especially for men -- an incident case referent study. J Hypertens. 2003 May;21(5):887-96. **5.** Sjostrom B, Dahlgren LO. Applying phenomenography in nursing research. J Adv Nurs. 2002 Nov;40(3):339-45.
Maria Emmelin, PhD Lecturer in qualitative methodology and medical sociology	Sida/SAREC bilateral collaboration with Ethiopia and Tanzania PhD dissertation (2004): Self-rated health in public health evaluation **Articles:** **1.** Lugalla J, Emmelin M, Mutembei A, Sima M, Kwesigabo G, Killewo J, Dahlgren L. Social, cultural and sexual behavioral determinants of observed decline in HIV infection trends: lessons from the Kagera Region, Tanzania. Soc Sci Med. 2004 Jul;59(1):185-98. **2.** Emmelin M, Wall S. Our editorial process--some experiences and reflections. Scand J Public Health. 2003;31(3):161-8. **3.** Emmelin M, Weinehall L, Stegmayr B, Dahlgren L, Stenlund H, Wall S. Self-rated ill-health strengthens the effect of biomedical risk factors in predicting stroke, especially for men -- an incident case referent study. J Hypertens. 2003 May;21(5):887-96. **4.** Christianson M, Johansson E, Emmelin M, Westman G. "One-night stands" - risky trips between lust and trust: qualitative interviews with Chlamydia trachomatis infected youth in North Sweden. Scand J Public Health. 2003;31(1):44-50. **5.** Berhane Y, Gossaye Y, Emmelin M, Hogberg U. Women's health in a rural setting in societal transition in Ethiopia. Soc Sci Med. 2001 Dec;53(11):1525-39.

Ulf Högberg Professor in Obstetrics and Gynaecology Departments of Epidemiology and Public Health Science	Research group: Bilateral Sida/SAREC collaboration with Ethiopia **Articles:** **1.** Hogberg U. The decline in maternal mortality in Sweden: the role of community midwifery. Am J Public Health. 2004 Aug;94(8):1312-20. **2.** Hakansson S, Farooqi A, Holmgren PA, Serenius F, Hogberg U. Proactive management promotes outcome in extremely preterm infants: a population-based comparison of two perinatal management strategies. Pediatrics. 2004 Jul;114(1):58-64. **3.** Kero A, Hogberg U, Lalos A. Wellbeing and mental growth-long-term effects of legal abortion. Soc Sci Med. 2004 Jun;58(12):2559-69. **4.** Hogberg U. An "American dilemma" in Scandinavian childbirth: unmet needs in healthcare? Scand J Public Health. 2004;32(1):75-7. **5.** Postpartum care should provide alternatives to meet parents' need for safety, active participation, and 'bonding'. Midwifery. 2003 Dec;19(4):267-76.
Lennarth Nyström, statistician/ epidemiologist Associate Professor lennarth.nystrom@epiph.umu.se	Research group: Reproductive health in Tanzania project Kagera AIDS research project (Tanzania) Previously project: Reproductive health in Zimbabwe **Articles:** **1.** Majoko F, Munjanja S, Nystrom L, Mason E, Lindmark G.Field efficiency of syphilis screening in antenatal care: lessons from Gutu District in Zimbabwe. Cent Afr J Med. 2003 Jul-Aug;49(7-8):90-3. 29 **2.** Urassa DP, Nystrom L, Carlstedt A, Msamanga GI, Lindmark G. Management of hypertension in pregnancy as a quality indicator of antenatal care in rural Tanzania. Afr J Reprod Health. 2003 Dec;7(3):69-76. **3.** Tswana S, Nyström L, Moyo S, Nzara M, Chieza L, Tianani J. A sero-epidemiology cross-sectional study of the prevalence of human immunodeficiency virus in Zimbabwe 1989-91. Afr J Health Sci 1996;86:436-43. **4.** Munjanja SP, Lindmark G, Nyström L. Randomised controlled trial of a reduced-visits programme of antenatal care in Harare, Zimbabwe 1996;348:364-9 **5.** Urassa E, Massawe S, Lindmark G, Nyström L. Maternal mortality in Dar-es-Salaam, Tanzania. A community-based incident case-referent study in Ilala District February 1991-January 1993. Socio-economic, obstetric and community risk factors. Afr J Health Sci 1995;2:242-9
Stig Wall Professor and Head of Department, Epidemiology and Health Care Research stig.wall@epiph.umu.se	Research group: Indepth Network in Ethiopia (reproductive health is a main theme) and South Africa (health behaviour) **Articles:** **1.** Lespinasse AA, David RJ, Collins JW, Handler AS, Wall SN. Maternal support in the delivery room and birthweight among African-American women. J Natl Med Assoc. 2004 Feb;96(2):187-95. **2.** Khoshnood B, Wall S, Pryde P, Lee KS.Maternal education modifies the age-related increase in the birth prevalence of Down syndrome. Prenat Diagn. 2004 Feb;24(2):79-82. **3.** Wall S, Janlert U. The World Health Report 2003: conveying new insights while refurbishing old ideas. Scand J Public Health. 2004;32(1):1-2. **4.** Byass P, Berhane Y, Emmelin A, Wall S.Patterns of local migration and their consequences in a rural Ethiopian population. Scand J Public Health. 2003;31(1):58-62. **5.** Wall S. Bridging the Gaps - can we afford not to invest in global health? Editorial. Scand J Public Health 2002; 30:162-65.

University of Uppsala

International Maternal and Child Health (IMCH) is a part of the Department of Women's and Children's Health, which focuses on research, teaching and diagnostic work. This department is integrated with the Department of Obstetrics and Gynaecology, University Hospital and Children's Hospital in Uppsala. IMCH has well-established research groups, in which PhD and licentiate students work under the supervision of IMCH researchers. In addition to collaboration with Umeå University on research in Tanzania and Zimbabwe, projects currently underway deal primarily with:

- Reproductive and maternal health and health care
- Maternal and child nutrition, micronutrient deficiencies, and breastfeeding
- Integrated management of childhood illness
- Public health in humanitarian assistance.

Beth Maina Ahlberg Associate professor and sociologist, also has a post at Karolinska Institute beth@skaraborg-institute.se beth.ahlberg@vgregion.se Uppsala/Skövde	**Articles:** **1.** Krantz I, Lowhagen GB, Ahlberg BM, Nilstun T. Ethics of screening for asymptomatic herpes virus type 2 infection. BMJ. 2004 Sep 11;329(7466):618-21. **2.** Mathole T, Lindmark G, Majoko F, Ahlberg BM. A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. Midwifery. 2004 Jun;20(2):122-32. **3.** Ahlberg BM, Krantz I, Lindmark G, Warsame M. It is a tradition: Making sense of female circumcision, migration and persistence in a Swedish context. Critical Social Policy 2004;24 (1): 50-78. **4.** Ahlberg BM, Jylkäs E, Krantz, I. Gendered construction sexual risk: implication for safer sexual practices among young people in Kenya and Sweden. Reproductive Health Matters 2001; 9(17): 26-36. **5.** Ahlberg BM. Is there a distinct African sexuality? A critical response to Caldwell. Africa 1994; 64 (2):220-42.
Pia Axemo Department of Obstetrics and Gynaecology	**Articles:** **1.** Carlsson CP, Axemo P, Bodin A, Carstensen H, Ehrenroth B, Madegard-Lind I, Navander C.Manual acupuncture reduces hyperemesis gravidarum: a placebo-controlled, randomized, single-blind, crossover study. J Pain Symptom Manage. 2000 Oct;20(4):273-9. **2.** Axemo P, Fu X, Lindberg B, Ulmsten U, Wessen A.Intravenous nitroglycerin for rapid uterine relaxation. Acta Obstet Gynecol Scand. 1998 Jan;77(1):50-3. **3.** Axemo P, Rwamushaija E, Pettersson M, Eriksson L, Bergstrom S.Amniotic fluid antibacterial activity and nutritional parameters in term Mozambican and Swedish pregnant women. Gynecol Obstet Invest. 1996;42(1):24-7. **4.** Axemo P, Liljestrand J, Bergstrom S, Gebre-Medhin M.Aetiology of late fetal death in Maputo. Gynecol Obstet Invest. 1995;39(2):103-9. **5.** Axemo P, Ching C, Machungo F, Osman NB, Bergstrom S.Intrauterine infections and their association with stillbirth and preterm birth in Maputo, Mozambique. Gynecol Obstet Invest. 1993;35(2):108-13.
Ingela Krantz Professor of Epidemiology and Infectious Diseases	**Articles:** **1.** Krantz I, Lowhagen GB, Ahlberg BM, Nilstun T. Ethics of screening for asymptomatic herpes virus type 2 infection. BMJ. 2004 Sep 11;329(7466):618-21. **2 .**Poggensee G, Krantz I, Kiwelu I, Feldmeier H. Screening of Tanzanian women of childbearing age for urinary schistosomiasis: Validity of urine reagent strip readings and self-reported symptoms. Bull WHO 2000; 78(4): 542-8. **3.** Ahlberg BM, Njau W, Kiiru K, Krantz I. Gender masked or self-inflicted pain: female circumcision, eradication and persistence in Central Kenya. Afr Soc Rev 2000; 4(1): 35-54. **4.** Ndulo J, Faxelid E, Tishelman C, Krantz I. "Shopping" for STD treatment: Focus group discussions among lay people in rural and urban Zambia. Sex Transm Dis 2000 Oct;27(9):496-503. **5.** Ahlberg BM, Jylkäs E, Krantz, I. Gendered construction sexual risk: implication for safer sexual practices among young people in Kenya and Sweden. Reproductive Health Matters 2001; 9(17): 26-36.
Gunilla Lindmark MD, PhD, Professor of International Maternal and Reproductive Health, Department of Obstetrics and Gynaecology/International Maternal and Child Health (IMCH) gunilla.lindmark@kbh.uu.se	Head of the International Maternal and Reproductive Health research group **Articles:** **1.** Althabe F, Belizan JM, Villar J, Alexander S, Bergel E, Ramos S, Romero M, Donner A, Lindmark G, Langer A, Farnot U, Cecatti JG, Carroli G, Kestler E; Latin American Caesarean Section Study Group. Mandatory second opinion to reduce rates of unnecessary caesarean sections in Latin America: a cluster randomised controlled trial. Lancet. 2004 Jun 12;363(9425):1934-40. **2.** Majoko F, Munjanja S, Nystrom L, Mason E, Lindmark G. Field efficiency of syphilis screening in antenatal care: lessons from Gutu District in Zimbabwe. Cent Afr J Med. 2003 Jul-Aug;49(7-8):90-3. **3.** Mathole T, Lindmark G, Majoko F, Ahlberg BM. A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. Midwifery. 2004 Jun;20(2):122-32. **4.** Urassa DP, Nystrom L, Carlstedt A, Msamanga GI, Lindmark G. Management of hypertension in pregnancy as a quality indicator of antenatal care in rural Tanzania. Afr J Reprod Health. 2003 Dec;7(3):69-76. **5.** Nilses C, Lindmark G, Munjanja S, Nystrom L. A community based study of HIV in women in rural Gutu District, Zimbabwe 1992 to 1993. Cent Afr J Med. 2000 Feb;46(2):32-7.

Carin Nilses International Maternal and Child Health (IMCH)	PhD dissertation (2000).Health in women of reproductive age. A survey in rural Zimbabwe. Uppsala University. **Articles:** **1.** Nilses C, Lindmark G, Munjanja S, Nystrom L. A community based study of HIV in women in rural Gutu District, Zimbabwe 1992 to 1993. Cent Afr J Med. 2000 Feb;46(2):32-7. **2.** Nilses C, Knutsson A. [Obstetrics in Addis Abeba, Ethiopia: In spite of access to clinics the most women give birth at home] Lakartidningen. 2002 Sep 26;99(39):3862-4. **3.** Nilses C, Nystrom L, Munjanja S, Lindmark G. Self-reported reproductive outcome and implications in relation to use of care in women in rural Zimbabwe. Acta Obstet Gynecol Scand. 2002 Jun;81(6):508-15. **4.** Nilses C, Nystrom L, Munjanja SP, Lindmark G. Symptoms and findings related to HIV in women in rural Gutu District, Zimbabwe, 1992 to 1993. Cent Afr J Med. 2000 Sep;46(9):242-6. **5.** Nilses C, Lindmark G, Munjanja S, Nystrom L. Trends in fertility patterns of women in rural Zimbabwe. Health Care Women Int. 1997 Jul-Aug;18(4):369-82.
Pia Olsson International Maternal and Child Health (IMCH)	**Articles:** **1.** Olsson P, Jansson L.Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations. Scand J Caring Sci. 2001;15(2):113-22. **2.** Olsson P, Jansson L, Norberg A.A qualitative study of childbirth as spoken about in midwives' ante- and postnatal consultations. Midwifery. 2000 Jun;16(2):123-34. **3.** Olsson P, Armelius K, Nordahl G, Lenner P, Westman G.Women with false positive screening mammograms: how do they cope? J Med Screen. 1999;6(2):89-93. **4.** Olsson P, Jansson L, Norberg A.Parenthood as talked about in Swedish ante- and postnatal midwifery consultations. A qualitative study of 58 video-recorded consultations. Scand J Caring Sci. 1998;12(4):205-14. **5.** Olsson P, Sandman PO, Jansson L.Antenatal 'booking' interviews at midwifery clinics in Sweden: a qualitative analysis of five video-recorded interviews. Midwifery. 1996 Jun;12(2):62-72.
Lars-Åke Persson, MD Professor of International Child Health and Chair, Department of Women's and Children's Health, Uppsala University, lars-ake.persson@kbh.uu.se	**Articles:** **1.** Lind T, Lonnerdal B, Stenlund H, Gamayanti IL, Ismail D, Seswandhana R, Persson LA.A community-based randomized controlled trial of iron and zinc supplementation in Indonesian infants: effects on growth and development. Am J Clin Nutr. 2004 Sep;80(3):729-36. **2.** Moore SE, Fulford AJ, Streatfield PK, Persson LA, Prentice AM.Comparative analysis of patterns of survival by season of birth in rural Bangladeshi and Gambian populations. Int J Epidemiol. 2004 Feb;33(1):137-43. **3.** Persson LA. [Children's right of survival--vulnerable status in spite of progress] Lakartidningen. 2004 Feb 12;101(7):574-7. **4.** Baqui AH, Zaman K, Persson LA, El Arifeen S, Yunus M, Begum N, Black RE. Simultaneous weekly supplementation of iron and zinc is associated with lower morbidity due to diarrhea and acute lower respiratory infection in Bangladeshi infants. J Nutr. 2003 Dec;133(12):4150-7 **5.** Lind T, Lonnerdal B, Persson LA, Stenlund H, Tennefors C, Hernell O. Effects of weaning cereals with different phytate contents on hemoglobin, iron stores, and serum zinc: a randomized intervention in infants from 6 to 12 mo of age. Am J Clin Nutr. 2003 Jul;78(1):168-75

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