External review of the Council on Health Research for Development (COHRED) – full report

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ABBREVIATIONS

ACHR Advisory Committee on Health Research
AfHRF African Health Research Forum
AIDS Acquired Immune Deficiency Syndrome
ART Anti Retroviral Treatment
Bangkok 2000 The International Conference on Health Research for Development in Bangkok, year 2000.
CARK Central Asian Republic and Kazakhstan
CHRC Caribbean Health Research Council
COHRED Council on Health Research for Development
DANIDA Danish International Development Aid
DGIS Dutch budget for International Cooperation
DfID Department for International Development, UK
EETT External Evaluation Task Team
ENHR Essential National Health Research
EMRO Eastern Mediterranean Regional Office (WHO)
EU European Union
FTE Full Time Equivalent
GVI Global Alliance for Vaccine Initiative
Global Forum: Global Forum for Health Research
HIV Human Immune Deficiency Virus
HPSR Health Policy and System Research
HQ Head Quarters
HRC Health Research Council
HRD Human Resource Development
HRS Health Research Systems
HRU Health Research Unit
IAVI International Aids Vaccine Initiative
ICCDRB International Centre for Diarrhoeal Research, Bangladesh
IDRC International Development Research Centre
INCLEN International Clinical Epidemiology Network
MDG Millennium Development Goals
MoE Minstry of Education
MoF Ministry of Finance
MoH Ministry of Health
MoPS Ministry of Public Service
MoS&T Ministry of Science & Technology
MRC Medical Research Council
NGO Non Governmental Organisations
NHRS National Health Research System
NIH National Institute for Health (USA)
NORAD Norwegian Agency for Development Cooperation
NRS National Research System
PAHO Pan American Health Organisation
PDR Peoples Democratic Republic
PHC Primary Health Care

PRSP Poverty Reduction Strategy Papers
RCB Research Capacity Building
RPC Research Policy and Cooperation
SDC Swiss Agency for Development and Cooperation
SEARO South East Asia Regional Office (WHO)
SEAMEO-TROPMED Southeast Asian Ministers of Education Organization. Regional Tropical Medicine and Public Health Network
S&T Science and Technology
SAREC SIDA's Department for Research Cooperation
SIDA Swedish International development Agency
SWAPs Sector Wide Approach Programmes
TB Tuberculosis
TDR UNICEF, UNDP, World Bank and WHO's Special Programme for Research and Training in Tropical Diseases
TropEd The Network of European Institutions for Higher Education in International Health
ToR Terms of Reference
UK United Kingdom
UNCST Uganda National Council for Sciences and Technology
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNHRO Uganda National Health Research Organisation
UNICEF United Nations International Children Education Fund
UNFPA United Nations Population Fund
USD United States Dollars
WHA World Health assembly
WHO World Health Organisation
WPRO Western Pacific Regional Office (WHO)

1. INTRODUCTION

The Council on Health Research for Development (COHRED) was created in 1993 with a mandate for advocacy of the Essential National Health Research (ENHR) strategy and provision of technical assistance to countries within the framework of the seven strategic elements of ENHR – (*i) promotion and advocacy,(ii) devising ENHR mechanisms,(iii) health priority setting at the country level,(iv) capacity building,,(v) networking,(vi) financing and(vii) evaluation*. For the next several years, with technical and, in some cases, financial assistance from COHRED, many countries, especially low-income countries; actively engaged in health research priority setting and in the implementation of the ENHR strategy. Their level of involvement ranged from 'discussing ENHR' to actively organising activities related to one or more of its strategic elements.

COHRED's focus has been on empowering countries to better manage their health research , using priority setting and ENHR as a starting point. Entry into countries was usually through individuals linked to government (department of health, research directorates or similar), who were expected to mobilize all relevant stakeholders ('country focal points').

The external interim assessment of COHRED in 1996 emphasized the need to share country experiences with ENHR. These competencies included the original strategic elements of ENHR plus two new ones: '*community participation*' and '*research into policy and action*'. The evaluation team stated that the '*definition, elaboration and use of this technology represents COHRED's niche, its value added contribution to the global health and development endeavour*'. Finally, the evaluation team recommended '*a comprehensive approach to capacity development'* for ENHR with special attention to the roles of the multiple stakeholders.

Since then a number of important events and developments have taken place that have had an influence on COHRED's mandate, role and functions as follows:

- In 1996 the "Ad Hoc Committee on Health Research" paid renewed attention to the need for increased investments in global health research. This led to the creation of the Global Forum for Health Research (Global Forum) which serves as a global market place and catalyst for analysis and debate of ways to correct the "10/90 gap".
- In 1998 WHO established a Department of Research Policy & Co-operation (RPC), and revitalised the Advisory Committee on Health Research (ACHR). In addition, health research was integrated into the "cabinet projects" and operational divisions (clusters) of the WHO.

- In February 1999, an informal internal review outlined COHRED's key challenges as the growing importance of knowledge management and innovative communication technologies; the emergence of new global health research initiatives; and the fact that health equity seemed to have been forgotten in favour of cost-effectiveness and efficiency. Based on this review, COHRED re-emphasized its niche as; *'putting countries first', 'working for equity in health'*, and *'linking research to policy and action'*.

- During 1999 and 2000, COHRED played a major role in the regional consultations and analyses leading up to the discussion paper presented to the International Conference on Health Research for Development in Bangkok (Bangkok, 2000). The conference was jointly organized by COHRED, Global Forum, WHO and the World Bank. It reviewed progress achieved since the Commission on Health Research for Development and proposed a revitalisation of health

research. In the plan of action resulting from Bangkok, 2000 the need to strengthen health research systems at the national, regional and global level was emphasized.

The environment in which health research operates has undergone major changes since COHRED was established in 1993.

During the last decade health has been seen more and more as a good investment and health related goals have won a place on many international agendas, including the United Nations Millennium Development Goals (MDGs). At the country level there has been more intense concentration on Health Sector Reforms, SWAP, PRSP and multi-donor budget support. Globally the number of new players in health has steadily increased, including a large number of global initiatives, such as the Global Alliance for Vaccines Initiative (GAVI); the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (The Fund); the Bill and Melinda Gates Foundation; the International AIDS Vaccine Initiative (IAVI); and most recently the WHO "3 by 5" initiative. Most of these global health initiatives are huge vertical projects that reflect "thinking globally". They have a sharp but narrow health focus and a massive amount of funding, which easily overshadows local budgets and national priorities.

Currently most health research spending in developing countries stems from pharmaceutical trials of new drugs, most of which will rarely be used in the countries where they are tested. It is estimated that over US$5 billion is spent annually on this type of research, which, at best, might contribute to keep advanced research expertise, equipment and logistics in the developing countries.

There have been internal developments at COHRED as well. The Secretariat and Board embarked upon a strategic planning process in 2001, which gave rise to the Strategic Framework for Action 2003-2007 endorsed by the Board in early 2003. Furthermore, in January 2004, a new director was appointed. At the Board meeting in April 2004 he presented a new vision for COHRED for the next decade, building upon, and expanding, the existing framework of action. The new vision pictures COHRED as an international organization with activity networks across the globe focused on bolstering up countries to manage their own health research, and in partnership with Global Forum, and bringing unity and synergy to the field of health research for development.

This external evaluation was formally requested by the Swiss Agency for Development and Co-operation (SDC) in 1997 and referred to COHRED and Global Forum. Since that time both organizations have received a joint funding allocation from the SDC. The evaluation of Global Forum was conducted in 2001. However, due to prolonged changes in the leadership of COHRED and a period under an interim coordinator and the absence of a permanent director from 2002 to 2004, the evaluation of COHRED was repeatedly delayed. It is eight and five years respectively since the last external and internal evaluation. The environment in which COHRED operates has changed considerably since then. The recent new leaderships of both COHRED and Global Forum reflect a willingness to engage in a new, more unified vision aimed at deriving benefits from their complementarity and synergy in advancing health research for development.

2. METHODOLOGY

The present external evaluation was conducted on a part-time basis within a total of eight-person weeks with very limited resources from August to November 2004. The external evaluation team consisted of Dr. Pia Rockhold (team leader), Dr. M. Jegathesan and Dr. Sam Adjei. The team made a desk review of selected literature and conducted telephone interviews with key people at the country, regional and global level. The detailed terms of reference (TOR), the list of questions asked, people interviewed and literature reviewed are outlined in Annexes , B, C and D respectively.

As a result of the time and resource constraints, this external evaluation does not provide an in-depth, comprehensive, quantitative assessment and analysis of the efficiency and effectiveness of COHRED, but rather a more qualitative appraisal based on views and visions expressed by key stakeholders in written form and in interviews. The evaluators strived to be neutral in the description and analysis of the information collected, but some degree of interviewer bias cannot be excluded, particularly as the instrument devised for telephone interviews was rather flexible to allow for innovative and spontaneous reflections by interviewers as well as interviewees.

2.1 Purpose and Scope

The overall purpose of the evaluation was to assess, as systematically and objectively as possible, the global relevance, efficiency and effectiveness of COHRED in terms of its stated mission and values, its functional structures and operating environment, both in the past and, wherever possible to judge, in the future. Taking special note of the original report of the Commission on Health Research for Development 1990, the report of the Task Force on Research for Development proposing to establish COHRED in 1993, the Ad Hoc Commission on Health Research in 1996, and the Report from Bangkok, 2000, the external evaluation has provided an overview of the major changes in the global research and development environment since 1993. Focusing on the period 2000 to 2004 the external evaluation of COHRED:

A. Assessed COHRED’s global, regional and national achievements since 1996 including the possible direct and indirect effects and impacts in terms of reinforcing essential national health research systems, improving equity in health through research, and reducing the 10/90 gap.
B. Assessed how COHRED achieves progress in development (a SWOT analysis including the potentials that could be realized if certain conditions were met (e.g., staff, funding, scope)).
C. Identified COHRED’s possible added value in enhancing the efficiency and effectiveness of all-round collaboration between the wide range of institutions active in health research at global, regional and national level, including its relationship with Global Forum and other potentially useful partnerships or alliances that COHRED could embark upon to optimize the use of available resources.
D. Assessed and commended the continued relevance of COHRED, including its vision, mission and strategies, taking into account the changes in the external health research and development environment since COHRED’s inception in 1993.
E. Reflected upon COHRED’s comparative advantages in relation to other partners, and the relevant present and possible future developments in the health research environment, and provided inputs to a possible vision for the way forward (including the need for prospective changes in COHRED’s vision, mission, and strategies, as well as its governance, management and resource mobilization to enhance its future relevance and performance).

2.2 Concepts and Definitions

The external evaluation examined the following criteria:

Efficiency: *How available resources had been converted into outputs.*
The budgetary and human resources available at the global level were compared to the work done and the outputs. The team assessed the adequacy of the available resources for optimizing efficiency and made recommendations for enhancing efficiency, including a possible decentralization of COHRED HQ.

The key inputs were: The staff and other human resources, office premises, furniture and fittings, equipment, financial resources and supplies, communications and the Board.

The key outputs were:

a. Country-level support and capacity building of national health research systems, situation analysis, strategy development and monitoring;
b. National, regional and global co-operation;
c. Promotion of ENHR and equity analysis;
d. Publications produced and used;
e. Advocacy and communications;
f. Research and Development, knowledge generation and management.

Effectiveness: *The extent to which COHRED's objectives have been achieved*
The extent to which COHRED, based on its outputs, has achieved the following key outcomes;

a) Promoted, supported and evaluated the ENHR strategy at the country, regional and global level;
b) Worked with countries;
c) Focused on research for equity;

The key indicators are:

a. Countries (low, middle and high income) involved and still active in ENHR (research priority-setting exercises, financing, capacity building and networking);
b. Networks initiated and partnerships established and still active at the global, regional and national level (including Global Forum),
c. Knowledge gained through COHRED actually distributed and used (knowledge management); and
d. COHRED's contribution to the MDGs and to the reduction of the 10/90 gap.

Relevance: *the extent to which the objectives of COHRED are consistent with the global, regional and national needs to enhance the ENHR strategy for equity.*
The relevance of the outcomes to facilitate the process of reaching the objectives was assessed.

2.3 Organizational arrangements

COHRED set up an External Evaluation Task Force for the evaluation (EETF) consisting of three COHRED Board members, the Director and the Deputy Director. The EETF provided the TOR and monitored the external evaluation inn the capacity of a continuous reference group for the evaluation process.

2.4 Information sources, biases and constraints.

This external evaluation report is an exploratory and qualitative study of the activities of COHRED within the broad context of the characteristics of health research nationally, regionally and globally. The contents of the report were assembled by a review of the literature and telephone interviews with selected persons. The external evaluation team made one global, three regional and four in-depth country studies. The regional assessments covered Asia, Africa, Latin America and the Caribbean. The in-depth country studies covered Laos, Indonesia, Uganda and Ghana. These assessments focused on what COHRED (1) has done, (2) could have done, and (3) should be doing in the future to enhance essential health research for equity. The choice of countries for the in-depth assessments was made by the external evaluators based on prospective greater involvement of COHRED.

Initially, a general review of the literature was undertaken to summarize the essentials of COHRED's global support and provide greater insight into its fundamental purpose, its distinguishing features and how effective it has been in promoting health research. Critical attention was paid to key achievements, challenges and observations of what COHRED hoped to achieve. In addition to this, a brief review of the policies and programmes of the countries chosen was carried out to put the subsequent interviews and findings in context.

Most of the literature available was 'grey' literature, not to be found in the indexed medical literature. Some papers were COHRED publications to which reference could be made, others were papers prepared for COHRED or documents from related meetings and conferences, unpublished in any form. Most of the documentation was made available by COHRED upon request from the evaluators. Thus, the literature review may have had a "COHRED" bias.

A flexible open-ended questionnaire was used as a guide rather than a mechanical tool. In effect, the questions were both open-ended and closed-end. The choice to administer the questionnaire in an interview situation aimed at exploring issues and appreciating the feelings and values confided in the responses.

The interviewees were selected to ensure a broad representation of organizations, initiatives and other entities active in international development aid. The selection of individuals within the organizations was based on one or more of the following criteria:

a. Direct present or past involvement with COHRED through networks, institutions or other activity supported by COHRED;
b. Knowledge of the role and function of COHRED, GHFR, TDR and other global, regional or local organizations or initiatives linked to health research or international development;
c. Working in or knowledgeable of the international health research environment;
d. Working in international development aid.

All the interviews were conducted in English and recorded manually. A diary of the dates of critical events was also kept. Issues that interviewees wanted to remain confidential were not reported. In the findings interviewees were not identified by name. Time and resource constraints limited the number of people interviewed. It would have been particularly valuable to interview more people outside traditional health research areas and of the younger generation of researchers, policy makers and civil society, as well as non-English speaking stakeholders.

All in all, selection bias cannot be excluded, as all interviews were conducted in English, and most of the persons chosen for interview were familiar with COHRED. Only a few had limited or no knowledge of the organization. Most of the interviewees selected were willing and able to participate, but a non-respondent bias cannot be excluded, as some people preferred not to participate or were unavailable for interview.

The telephone interviews constituted an essential basis in favour of the opinions and conclusions expressed in this report. They did not, however, provide the same opportunities as on-site visits would have done; e.g., the value of talking to respondents 'face to face' in their own settings, or taking a closer look at the local health research environment in its full complexity.

At times, documentary information on the exact nature and impact of COHRED activities was fragmented and incomprehensible. In just the same way, poor recollection by some interviewees might also have resulted in the occasional factually inaccurate response. To mitigate some of these difficulties, data was qualitatively analysed and meaning was constructed on the basis of a basic understanding of the explanations given of social and organizational practices. Statements of fact are presented as such, especially if they were supported by data. However, no value judgements were made of interviewee statements since responses were considered rather as individual opinions than accurate reflections of the situation. Seen in this light, attention was focused on internal consistency even though divergent views were acknowledged.

Finally, COHRED works in close corporation with global, regional and local partners and engages in multiple activities to enhance the performance of National Health Research Systems (NHRS) in the countries of the South. Naturally these processes are influenced by multiple other factors and it becomes highly speculative to judge the distinctive contributions of COHRED. Assessing the effectiveness and the impact of COHRED in isolation is, therefore, not possible, as it is, by the same token, impossible to assess whether it is COHRED's contributions, based on its outputs, that have in fact achieved desirable key outcomes, such as strengthening the ENHR or NHRS at the country level.

In summary: The external evaluation provides an assessment of COHRED's performance from 1996 to 2004. Since the major limitations were a lack of resources and time that resulted in a small sample size, confounding selection and information biases cannot be excluded. The findings and conclusions might not fully represent the truth, but do paint a picture of COHRED, past and present, contributing to the vision for the future.

3 FINDINGS

3.1 Vision, mission and strategies

The statutes of COHRED states that:

The Objective of COHRED is health and quality of life for everyone in every country on the basis of equity and social justice.

COHRED will:

1. Promote ENHR defined as a comprehensive strategy for organising and managing national research;
2. Pave the way for implementing the strategy in countries that wish to use it;
3. Set up international and regional networks through which countries can share their experiences with the ENHR strategy,
4. Analyse the global effectiveness of the strategy and assist countries in their national analysis and assessment;
5. Convene meetings to provide countries with information about the strategy and an opportunity to share their experiences with it;
6. Organize international collaboration, including special projects, to identify and resolve common health problems among countries and gaps in their knowledge of health.

The Strategic Framework for Action 2003 to 2007 developed by the Board in early 2003 mentions the need to reposition COHRED in the broad scope of global research, and proposes to move forward by means of renewed strategies. The document states that: "**The vision** of COHRED is the attainment of a system of effective health research as a tool for improved health and development in all countries, based on the values of equity and social justice. We believe that all countries, no matter how poor, should have the capacity to identify their priorities, conduct essential research that guides their health policies and practices, and manage a system that harmonizes the efforts of all players. In pursuit of these beliefs, special attention must be paid to the most vulnerable countries- those in development and those in economic transition".

The mission is to work for the better health and development by enhancing effective NHRS, particularly in developing countries, on the basis of the ENHR strategy. COHRED's work will contribute to the development and bolstering of countries' capacity to manage research on priority health problems and to utilise the results to improve the health of their populations.

The strategic framework lists five objectives for COHRED and outlines the strategies.

At the Board meeting in April 2004 the new Director presented a new formulation of COHRED's vision for the next decade, building on and expanding the existing action framework.

- **The new vision is as follows**: "COHRED works for a world in which health research is recognized as essential for optimizing health and reducing inequity and poverty".
- **The new mission states**: "We are ardent to enable countries to put into place and make good use of health research to foster health, health equity, and development. We work globally in prioritizing the poorest countries.

The objectives, strategy, plan and budget beyond 2004 are presently under development and will be presented to the Board at the end of November 2004.

Most of the interviewees found COHRED to be a relevant organization with an important mission, namely to enhance the South's capacity for ENHR in a broad sense, based on a wide-ranging inter-sectoral understanding of health in line with the original concept of primary health care.

"The three essential pillars of COHRED are Equity, Research for action and Country Focus". "COHRED is the voice of the South". "Countries first" "Inclusiveness and participation." "*If COHRED was no longer there, we would have to create an organization with similar roles and functions. We need COHRED to include the developing countries."*

Others find COHRED completely irrelevant or that "*COHRED is a victim of its own success in promoting ENHR*" that has made it irrelevant in this relation.

COHRED's original mandate has perhaps expired. The last external evaluation in 1996 proposed that the Board consider a "sunset clause" looking towards WHO or the World Bank. Task Force asserted that; "*Once ENHR is self-sustaining there will no longer be a need for inputs from COHRED*". The question arose as to whether the Board saw "*itself as eventually completing its work, and if so, what the target phase-out date and operational indicators might be*" "*Even long-running programmes only last 10 years"*

"*History has moved on, but there are things we have to hold on to. Presently it appears that those who wish to work at the "grassroots" or "institutional capacity building for research" have a very hard time finding funding*". *"There is a need for a broader definition of health and health research, research at "lower" levels with local actors is also research". "The world has changed; there is a new context, new challenges. We have to adapt to the MDGs and the "3by5"; these are but some of the many vertical programmes at country level. There is a lack of stewardship". "There is a strong need to strengthen health research at country level - a coordinating platform at country level".*

The external environment has changed since 1993. The focus in health is increasingly on service delivery and curative medicine. Health research systems are seen by some as equal to health delivery system research. Donors increasingly want to see tangible outcomes. They want to know how many people are provided with ART or treated for malaria and TB. They do not care much about how (for example, how many people were trained and how). While the equity dimension remains globally recognized as of major importance, it tends to be replaced with cost-effectiveness and efficiency when resources are scarce.

The target is to reach the MDGs. It is very difficult to get money for locally planned research, and even harder to build up local research capacity; the research institutions in Africa particularly are in dire need. There is a need for sound, transparent and accountable leadership; managing research institutions and qualified researchers doing planned, prioritized research of high quality. Internal and external brain drain is a problem. Most researchers in developing countries either work as consultants, do research planned and paid for by donors, or completely abandon research to work for the MoH, NGO's or other entities. The employment conditions of qualified researchers are as problematic or even more so, as they are for other public sector workers in the developing world. It is important to address attrition, provide a career perspective and acceptable salaries. People should feel accountable to their institutions. "*We have many proposed solutions, but little happens and the capable people leave the continent (brain drain) or move out of research into other sectors*

(internal brain drain)." It is essential that COHRED's strategic plans are not only short-term, but also for the longer term, capable of adapting to the changing environment.

3.2 Governance, management and administration

3.2.1 Legal status and governance

COHRED's legal status at its inception was that of a NGO linked to UNDP by a Trust Fund Agreement. This agreement was terminated by UNDP at the end of 2001, whereupon COHRED's legal status changed to that of an international NGO operating under Swiss law.

A Board of maximum 18 members, most of which are medical doctors or academics with doctorates (some being public health specialists), governs COHRED. The Board is constituted and operates in accordance with the Statutes adopted at the constituency meeting of COHRED in March 1993 and was amended in December 2003. According to the Statutes, two thirds of the members are country nominees. Presently the developing countries make up more than half of the Board. Africa is especially well represented. Several former board members commented that "*The South was very influential in the COHRED Board*". The Board meetings are conducted in English. The percentage of women members has increased over time from less than 25% to 33% (for further details see Table 1).

Table 1: COHRED Board members 1996 to 2004.

	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Total (*Women*)	18 (*4*)	19 (*7*)	18 (*6*)	16 (*4*)	17 (*7*)	13 (*7*)	17 (*6*)	16 (*6*)	14 (*5*)
Doctors	17	17	17	15	16	12	15	14	12
Europe/USA/Canada	5 (*1*)	7 (*3*)	6 (*2*)	3 (*1*)	3 (*1*)	1 (*0*)	4 (*3*)	3 (*0*)	3 (*0*)
Central & Eastern Europe	0	0	0	0	1(*0*)	0	1(*0*)	1 (*0*)	1 (*0*)
Asia	4 (*2*)	3 (*2*)	4 (*2*)	3(*1*)	3 (*1*)	1 (*0*)	4 (*3*)	3 (*0*)	3 (*0*)
Africa	5 (*1*)	4 (*1*)	4 (*1*)	4 (*1*)	6 (*3*)	5 (*3*)	4 (*3*)	4 (*3*)	3 (*3*)
LAC	4 (*0*)	4 (*0*)	3 (*0*)	3 (*0*)	2 (*0*)	2 (*1*)	3 (*1*)	3 (*1*)	3 (*1*)
Arabia	0	1 (*1*)	1 (*1*)	0	0	0	1 (*0*)	1 (*0*)	1 (*0*)

At the Board meeting in April 2004 the new Director expressed a need to strengthen the COHRED Board. According to the statutes the Board adopts plans and budgets, approves special projects, determines the size and location of the secretariat (now the Executing Board), and appoints the Director and review progress reports, financial statements and audit reports. Many perceive the Board to have failed to address the periodic leadership problems of COHRED in a timely and adequate fashion. It has been proposed that the Board play a more proactive role in advocacy, fund-raising and the provision of strategic advice and guidance.

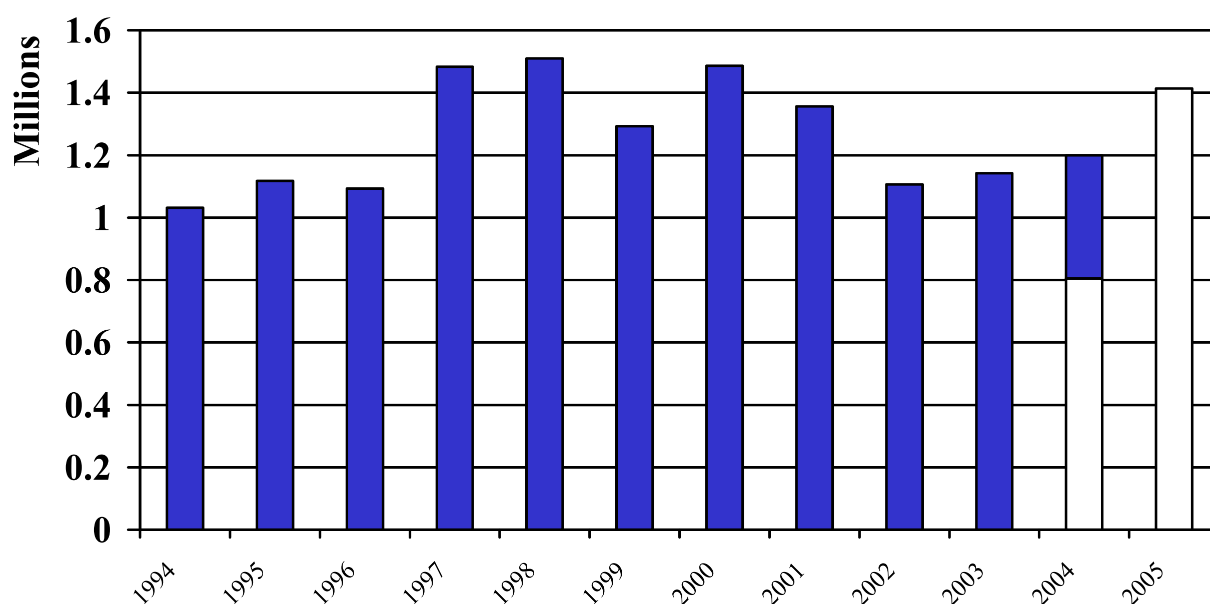
Until April 2004, COHRED's activities were coordinated through a small secretariat in Geneva, which now functions as a directorate, supported by a Board Executive Committee. This arrangement was agreed upon to encourage the NGO potential and operational efficiency of COHRED.

3.2.2 The Budgetary process and financing of COHRED

From 1996 to 2004 COHRED was supported by the Carnegie Corporation (USA), Danida (Denmark), DGIS (Netherlands), IDRC (Canada), NORAD (Norway), the Rockefeller Foundation (USA), SDC (Switzerland) and Sida/SAREC (Sweden). In 2004 the Academy for Educational Development (USA) supported COHRED with about US$ 70,000. Carnegie last funded COHRED in 2000, DGIS in 2001 and NORAD in 2003. The annual budget has been down-sized since 1996, ranging from US$1.5 million to US$ 1 million (see Figure 1).

About half the budget goes towards administration and management. This includes consultants and temporary staff. A fifth of the budget is used for regional activities. The support for country level activities appears to be less than 10 % for the entire period with the exception of 1998-99. This was partly due to the budgeting process prior to 2004, where all staff and technical assistance costs at the country level were budgeted under the central secretariat. Unfortunately, it has not been possible to reformulate the budgets retrospectively due to lack of detailed specific expenditures at the various levels. COHRED has adjusted for this in its planned budget for 2005, where around 50% of the funds are to be used for direct country and project support (see appendix E).

Figure 1. Annual Budget of COHRED from 1994 to 2005 (the black areas represent actual income, the grey expected)



All in all the budgets for 1996 to 2004 provided only limited details. It is the impression that most allocations were made in response to *ad hoc* requests from individual focal points in the various countries. It is not clear how the requests fit into the institutional and organizational set-up, and the overall NHRS within the respective countries. Furthermore, some choices must have been made with regard to where to allocate resources and where not to. The detailed strategic planning, budgetary, monitoring and decision making processes of COHRED were until recently rather weak. During the last couple of years, however, there has been a slow but steady improvement.

At present the requests reaching COHRED far outstrip its ability to act and respond. In July 2004, there were over 30 outstanding requests for work with COHRED, many relating to initial or recurrent priority-settings in health research. 21 countries and three regional networks requested COHRED's assistance. In Asia these were Cambodia, Laos, certain countries in the Pacific and Philippines, as well as the Central Asian Republics of Kyrgyzstan, Tajikistan, and Kazakhstan.

3.2.3 Personnel

Historically COHRED the coordinator of COHRED served for a very long period, namely from January 1994 to July 2001 (7.5 years). Thereafter, the post was held by a coordinator who served for only 1.3 years from July 2001 to November 2002, followed by a period of 1.2 years under an interim coordinator from Nov 2002 to Jan 2004. As of January 2004 COHRED has had both a Director and a Deputy-Director.

The total number of staff members varies over time, as COHRED has had seconded staff from UNDP (98-99), the Dutch Government (1998-99) and the Swiss Government (1999-2000), as well as for the Bangkok Conference (1999-2000). COHRED has also financed staff overseas in Uganda (1998-2004), South Africa (1999-2001) and Ghana, covering French-speaking Africa, (1999). However, overall, if management time is charged to available professional time, COHRED has functioned with less than one full-time equivalent (FTE) professional staff member for most of its life, and currently still has only 1.8 FTE. In comparison, Global Forum, which has a very limited portfolio of out-reach activities, has around 6 FTE professional staff.

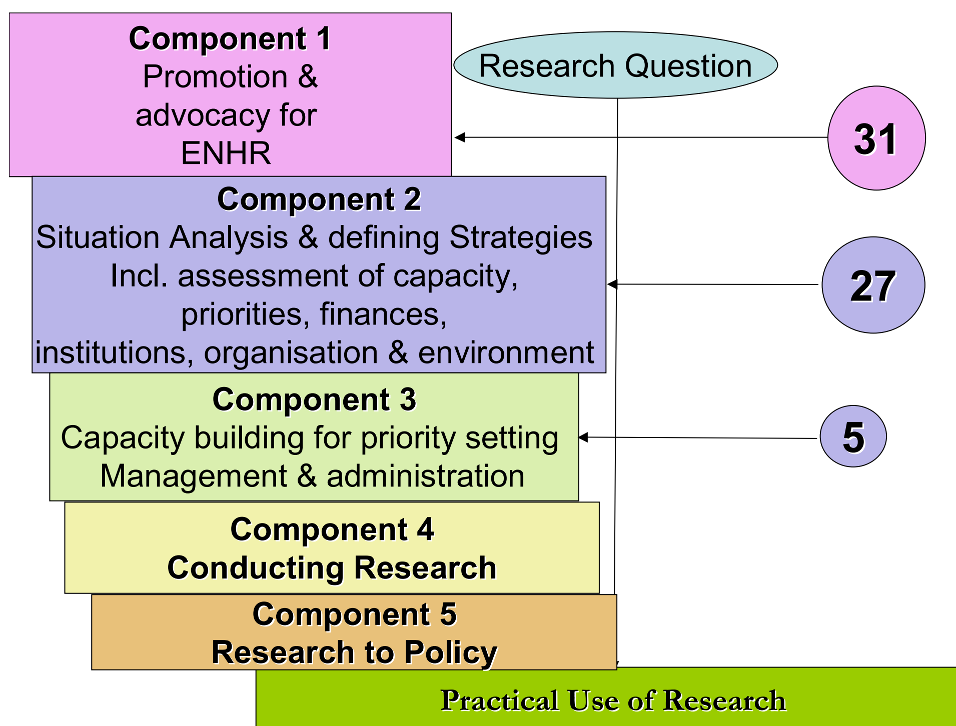
Many interviewees indicated that the first Director of COHRED was charismatic and engaged with a strong personal network, within which he was capable of achieving a lot. Many opportunities for stronger institutional linkages and closer co-operation with WHO, TDR and other important international partners and institutions were, however, not taken and the network largely vanished when he left.

3.3 Outputs

3.3.1 Analysis, monitoring, country support and capacity building for NHRS

Over the years COHRED has worked in 52 countries, prior to 1996 in 22 countries, and since then, in 47 (30 new and 22 recurrent). In 12 of these countries COHRED has only conducted a workshop or a one-off study mainly in relation to Bangkok 2000. In the other 40 countries COHRED embarked on the actual process of strengthening national health research and health research systems, a process that was divided into five components for monitoring purposes (see Figure 2).

Figure 2. The five key components of COHRED's contributions at the country level.

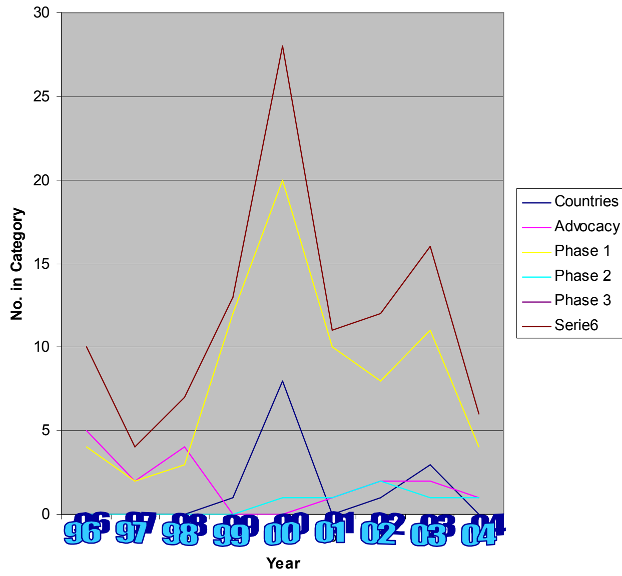


In most, but not all, countries COHRED began its activities with support for either 'Promotion or advocacy of ENHR' (component 1) or 'Situation analysis and defining strategies, including capacity assessment, priorities, institutions, finances, organization and environment' (component 2). Subsequently, COHRED provided limited support to 'capacity building for priority-setting, planning, management and administration' (component 3), but never actually supported 'conducting research' (component 4) or 'research into policy' (component 5) based on country level priorities and plans.

Over the years, COHRED has supported 'Promotion and advocacy for ENHR' in 31 countries, 22 prior to 1996 and 13 since (9 of these were 'new' countries and 4 were for the second or third time). Of these 31 countries 27 have gone on to conduct 'Situation analysis and defining strategies' with the support of COHRED, 10 prior to 1996 (see appendix F for a more detailed overview of COHRED's country level activities).

Before 1996, all countries received support for doing component 1 before component 2, but since then 8 countries went straight into component 2. Overall, 35 countries have received COHRED support for component 2 on average two to three times. Only 5 countries have received COHRED support for component 3 and none for components 4 and 5. That a country has not received support for a given component does not exclude the possibility that it has implemented the component. As can be seen from the above, COHRED has mainly focused on support for components 1 and 2, and only occasionally moved into component 3. Components 4 and 5 were never reached, but represented the goals for longer term partnerships. The majority of countries supported by COHRED are low income and lower-middle income countries, mainly in Africa, Asia and Latin America and Caribbean. During the three-year period from 1996 to 1998, COHRED's activity level

was very low, while peaking in 1999 to 2003 in preparation for the follow-up to the Bangkok Conference. If country involvement in regional networking is included, COHRED was especially active in 1999 and 2000.


Country Activities 96 to 2004
No. in Category
30
25
20
15
10
5
0
96
97
98
99
00
01
02
03
04
Year
Countries
Advocacy
Phase 1
Phase 2
Phase 3
Serie6

Globally 153 States are categorized as low income and lower-middle income countries. The regional and country demands for assistance exceed by far the available resources. "*COHRED suffers from a lack of money, resources and people. They have only had one full-time scientist to support research proposals and grant writing"*. Proposed solutions ranged from; *"Instead of covering the whole world COHRED should focus its activities on certain selected countries". "COHRED should decentralize to the regions or the countries"*.

Overall, COHRED's support at the country level appears to have taken place in an *ad hoc* piecemeal fashion, with limited (if any) linkage to a larger longer term national plan for NHRS strengthening. Apart from coordination of policy and decision makers with researchers, COHRED has worked in a limited way to reinforce the link between policy and research. While this might be "*a niche to fill*", as proposed by the 1996 internal review, it is also known to be a very difficult and debatable issue. Much literature has been published on why. The interviewees mentioned some of the problems *"Health researchers are not interested in development issues." "It is essential to guarantee the freedom of scientists to define their own research priorities". "Policy makers do not have time to wait for research to provide reliable answers to their often urgent problems. This makes the definition of basic research very broad; whereas operational research will be narrowed down to just quicker "lower" quality research"*.

Finally, the importance of the growing private sector, which is especially large in Asia and the Americas, appears to have received very little, if any, attention from COHRED. The need to enhance public–private sector collaboration is clear. The private sector is a major donor to research.

Research capacity building in the South is an aspect of COHRED's work that apparently still needs to be further defined. Workshops and meetings have been held but a more systematic approach to NHRS building still needs to be adopted. *"Health research people have not learned from the Sector Wide Approach Programmes (SWAPs)"*. COHRED's efforts, it seems, have been limited in this very complex area; *"There is a conflict between the need for capacity building in the southern and northern research base"*. While most northern countries are willing to invest in their own research in the South, the willingness to invest in research identified and conducted by the South is still very limited. Despite the fact that many interviewees stressed the importance of investing in national and regional capacity building, they all have their own model for how this can best be done. There is a need for more insight into how to strengthen a NHRS in the South on the South's terms, owned and financed by the South.

3.3.2 Promoting equity analysis and advocacy

From 1996 to 2004, COHRED organized task forces and working groups on ENHR competencies (1997), Priority-setting (1997-99), Promotion and advocacy (1999) Research into action and policy (1999-2000), Community participation (1999), and Resource Flows (1998-2000). These task forces and working groups were important for COHRED's advocacy work and contributed valuable "grey publications" to the analysis of equity, which fed straight into Global Forum work in the areas of "Priority- setting" and "Resource Flows".

"*The good thing about the Task Forces is that the studies are done by local researchers*." "*Most of COHRED's money goes for meetings and workshops". "COHRED is not really mentioned very much in the South by research institutions". "COHRED has too little money to be important". "COHRED's ambitions and its resources do not match up". "How to prioritize the countries to*

help?" "COHRED has no money for research and the education of researchers"." Human resources are the key to development".

3.3.3 Publications

Based on the recommendations of the external review conducted in 1996, COHRED has certainly expanded the number of publications during the last eight years (ref. Annex D). Publications, which have provided guidance and served to document and exchange experiences and knowledge gained in ENHR and NHRS, either as individual or cross-country analysis. Since 1996 COHRED has published 23 documents or manuals and three journal articles. Many of these have been widely distributed and served as practical hands-on tools for implementing ENHR at the country, regional and global level.
COHRED has contributed to 56 country or regional reports on ENHR-related projects throughout the world. These reports are mainly produced by local counterparts, with some support from COHRED. They too have been widely distributed and not only served a major function in the exchange of information and experiences between countries involved in the implementation of ENHR, but also contributed to local resource capacity building.

COHRED played a major role in the preparation of Bangkok, 2000 and served as the secretariat of the conference. In this role COHRED published a series of country and regional reports on the consultative processes in Africa, Asia, the Caribbean, Central & Eastern Europe, the NIS, Eastern Mediterranean and Latin America. They are all summarized in the document "Health Research for Development", an essential document that contributed to the success of Bangkok, 2000. It enabled valuable discussions of rich content and led up to the final conference report, "International Conference on Health Research and Development", itself a wealth of valuable recommendations for the future.

COHRED has a very rich and heavily used website, where the majority of its publications and others with interest in ENHR and NHRS are readily available. The remaining documentation can be obtained directly from the COHRED secretariat in Geneva free of charge. In addition COHRED has a wide range and large amount of very rich information on ENHR and NHRS from national, regional and global levels worldwide. Many interviewees stressed the importance of printed material, especially for use in less developed countries where access to downloading information on the internet is often difficult due to poor, irregular, slow and at times nonexistent local connections to the web.

There has been no review of the actual usefulness and quality of the documentation produced, but it was the sense of the interviews conducted that most people interviewed had used or knew some or other of COHRED's publications.

3.3.4 The Regional Activities

3.3.4.1 Asia and Europe

The Asian Region is a very heterogeneous one with countries spread across the whole spectrum of development status. At one end there are highly developed countries such as Japan, South Korea and Singapore, whilst at the other there are some of the least developed countries in the world. Accordingly the status of health, health services and health research also varies greatly. Here only countries that came within the realm of COHRED's attention and interest are dealt with. These countries can be clustered into a number of sub-regions, namely South Asia, South-East Asia, the

Middle East and the Central Asian Republics. COHRED's involvement was not spread uniformly across these countries or regions, and it has only occasionally worked through the organizational hierarchy of other international organizations active in the area, e.g. WHO. The status of health research in these countries was, however, reflected by COHRED's Health Research Profile study conducted prior to Bangkok in 2000 and will be part of WHO's ongoing analysis of Health Research Systems. Needless to say they will vary widely but essentially most of them would have some form of HRS in place. The majority were led by their respective MoH, while others take the form of a Medical Research Council (MRC) or a similar body.

Many of these countries have advanced both their health systems and their NHRS in the reporting period. However their progress has been hampered by a number of factors, which may perhaps be exemplified by the situation in the Philippines where a recent analysis of the HRS was conducted. It showed that while the basic elements of a functioning health research system were in place, there were shortfalls because of limited government subsidies; poor private sector investment; weak resource mobilization initiatives; an unstable economic situation; and change of political leadership. It was also found that there was a need for better communication to optimize research utilization; and for convergence between the subsystems in the HRS.

As a follow-up to Bangkok, 2000, most of the international players in the field of health research have moved from ENHR to the strengthening of the NHRS. COHRED has also planned its future activities in this context.

A major impetus for the Asian Region was COHRED's initiative and leadership in spearheading the Bangkok, 2000 Conference. The choice of Bangkok itself was a plus for the Asian region as it allowed many participants from nearby countries to attend, arguably with the spin-off effect of stimulating not only health research but the principles of ENHR in their countries of origin.

Furthermore, the full usefulness of Bangkok, 2000 was not just the Conference itself, but the preparatory phase as well. Through the convening of delegations and the gathering of inputs from countries and regions, the Conference had a catalytic effect of generating or reactivating networks as well as jumpstarting those that were already operating. This was particularly felt in the Asian region where the preparatory regional consultation in Manila in February 2000 was a milestone in a series of dialogues that had started nearly two years earlier and carried the Asia and Pacific voices to the conference itself. The vibrant Asia Pacific Health Research Forum that convened in Bali in 2001 also had its genesis in the Conference. With Indonesia serving as an interim focal point, a steering committee was set up and has met three times since with COHRED funding.

The future vision is of the Forum becoming an independent body that will work with international development partners, including WHO, COHRED, Global Forum and INCLEN. The main thrust of the forum in the coming years will be the strengthening of the NHRS essentially by providing it with tools and technical assistance. However, at this point in time there is no budget for this purpose. In general, while taking note of WHO's interest in the analysis of HRS, the Forum would like to restrict the assessment to internal use only so as to strengthen the systems and not to make a comparison between countries.

COHRED has also supported networking in the EMRO region for ENHR and NHRS. In May 2001 this approach was pursued at an informal regional consultation in Iran on NHRS, with 10 participants from five countries in the region.

Apart from its support for regional fora and networks, COHRED has also supported subregional groups, which has made effective collaboration possible on the basis of common historical, cultural, linguistic and university systems. In this way groups have been supported in South-East Asia (Cambodia working with Thai support) and in the Central Asian Republics and Kazakhstan (CARK) which gave rise to the Bishkek declaration on ENHR in 1999.

As a result of increased visibility of these networks a regional dimension for ENHR has been acknowledged. These are seen as platforms for co-operation and collective research for development.

COHRED, through its working groups also addresses the crosscutting issues in selected countries. A multi country study on resource flows in health research systems was conducted in Thailand, Malaysia and Philippines in 1998. After Bangkok 2000, COHRED formed three analytical working groups on NHRS in collaboration with country teams from, amongst others, Thailand, the Philippines, Indonesia, Laos and Cambodia.

3.3.4.2 The African Region.

In recent years, health research activities in the African region have seen a relative increase. There has been an intensification of research in the context of infectious diseases, clinical trials and operational research, health systems research and policy analysis. However, overall the achievements of health research for action in the African region have been very limited. It is common knowledge that:

- Health spending in most African countries continues to be less than 4% of gross domestic product, and only 0.2% of the health budget goes into research
- Of the 1,393 new drugs developed over the last 25 years, only 16 were of any direct relevance to tackling tropical diseases.
- The management of intellectual property is weak, leading to poor accreditation of African research practice.

Most of the qualified research personnel in the African region are demoralised, desperate and de-motivated due to the lack of funding, facilities and recognition. The consequence is an exodus of trained staff to richer countries offering better salaries and facilities. The cost to the region is high. It has been estimated that “the United States, with 130,000 foreign physicians has saved about $26 billion in training costs”. Based on these data Africa loses approximately $4 billion per annum through migration of an estimated 20,000 professionals, at a loss of $184,000 per migrating African professional. This must, however, be adjusted for the revenue gained by doctors and others stationed overseas, which constitutes a considerable percentage of developing countries’ GNP.

To minimize the present brain drain from “South to North” it is essential to actively seek to develop a programme of research that will retain the qualified researchers in the countries of the African region, e.g. to respond to the needs to analyse the effects of stewardship, policy, human resources, financing and other elements on health systems throughout Africa.

A number of institutional initiatives have evolved in support of these efforts both nationally and regionally. The African ENHR Network supported by COHRED was one of these initiatives that provided a basis for developing an African regional perspective of research. The enthusiasm of

research professionals on the continent culminated in the twelve-point message presented to Bangkok, 2000. The result was the creation of the African Health Research Forum (AfHRF) with seed funding from IDRC and COHRED.

The AfHRF has initiated a supporting system for research guided by respect for ethical principles, leadership development and communication systems for information sharing throughout Africa. It is a network for health research governance, which, acting jointly with COHRED, envisages a pluralistic regional HRS that will nurture productive national scientific groups, linked together in transnational networks, to address both national and regional health problems. The AfHRF, however, is not as effective as the now defunct African ENHR Network for reasons that include the lack of funds to undertake its activities, such as monitoring the research agenda and providing opportunities to link national, regional and international institutions together.

The cluster of relationships that the requirements of the global initiatives bring to the research environment for both national and international institutions are complex, and sometimes need a redistributive trust for the mobilisation, management, coordination and allocation of revenue. To a large extent, the donor organizations and countries in the African region have responded positively within resource limitations.

Nationally, the ENHR efforts have enabled countries to undertake effective priority-setting while enjoying the protection of a global consensus for research.

3.3.4.3 The Latin American and Caribbean Region

The Latin American and the Caribbean (LAC) regions, like the Asian Region, are very heterogeneous, with countries spread across the entire spectrum of the various development levels. Brazil, Cuba and Costa Rica already had a strong health research tradition before the arrival of COHRED. While Nicaragua and other less resource-rich countries still need substantial support.

In the case of Brazil and Argentina, National Science and Technology Councils were established in 1950s. Since their inception these councils have been strongly influenced by scientific policies in the USA. They differ conceptually between basic (knowing in order to understand) and applied (knowing in order to utilise) research. Furthermore, they have been influenced by the supply approach, focusing on strengthening the capability with no equivalent concern about linking these capabilities to the demands arising from the social, economic and political environment. All in all, the approach leads to a centralized vision of planning with limited influence of the different social actors in defining the science and technology (S&T) policies. The result has been a chronic weakening of the ties between science and society.

During the 1990s the mode of knowledge production was transformed due to changes in the transfer, dissemination and utilisation of information. At present "*problems are formulated and research are developed in a problem solving context involving a complex interaction between specialist users and funders*". To reinforce these trends PAHO has developed a series of initiatives, a co-operation strategy known as DECIDES (democratizing knowledge and information for the right to health). This strategy was designed to help to overcome some of the main problems within health research in the LAC-region, namely: (1) limited participation in the definition of the research agenda, (2) low utilization of research results in policies and health programmes, (3) limited researcher co-operation and exchange between countries, and (4) inequity in access to knowledge and health information.

Coordination and financial support for multi-centric research projects are among one of the DECIDES initiatives. Another important one is Bireme, the LAC Centre on Health Science Information, a virtual health library universally available on the Internet (www.bireme.br). Bireme promotes an equitable, universal, modern and efficient access to relevant information on public health generated in the region. It stimulates technical co-operation and promotes the coordination and use of health scientific and technical information. It aims at meeting the needs of governments, health systems, education and research institutions, health professionals and the public. It is based upon national health science information networks or systems. It also aims to coordinate, operate and promote the bibliographical control, dissemination, evaluation, and improvement of the scientific and technical literature published in the countries of the Region.

The research coordination programme of the Division of health and human development in PAHO co-operates with the countries in the region to strengthen health research and regional coordination. PAHO supports the national research councils and the research units of the MoH in the region. The research coordination programme serves as the secretariat for the Advisory Committee and Internal Advisory Committee on Health Research and the Ethical Review Committee on Health Research. Finally, it coordinates the PAHO/WHO collaborating centres in the region.

Historically, it has been important for local and regional networks for health research to have strategic linkages with developed countries in the north, for example, the USA, Canada and the EU. Several of the countries in the region are, however, very capable, and COHRED could play a very important role in strengthening the NHRS in country and regional co-operation.

Traditionally, medical doctors have dominated health research. To reach the MDGs and improve the overall development within the region there is a need for more social-oriented research and upgrading of the overall knowledge base, ensuring a more equitable distribution of people able to set their own priorities, implement and use their own research. "*COHRED is a small organization, but it could help in networking and linkages between countries, to decrease the North American influence*"." *COHRED is a poverty-and equity-oriented organization, owned by the poor people of the South*". "*COHRED provides a unique opportunity for the small countries to talk against the big agenda*". "*COHRED consist of a board of people who actually do things at country level. It is essential that the Board continues to consist of strong independent people. New board members should be trained to prevent passive "yes-sayers*". COHRED has an important regional role in the provision of regional advice, support for analytical work and publications, advocacy of ENHR, and monitoring and evaluation of the regional situation. "*It is essential not to leave the original principles behind*"." *Make the donors see that COHRED delivers from advocacy to actually make it work*".

3.3.5 Country level activities

At the country level COHRED has supported selected countries, mainly in the English-speaking part of the African region, the Asian region, the Caribbean and Nicaragua. Most support has been launched with a situation analysis, followed by national or regional workshops promoting the ENHR concept, priority-setting for ENHR, and at times a national plan for health research with a budget. Over time COHRED has focused more and more on strengthening the NHRS.

3.3.5.1 Asian and European Mediterranean Region

COHRED has continued to support individual countries in various aspects of the ENHR strategy.

Its contribution to the countries in the Asian region can be classified as: (i) no contribution (ii) some input (iii) significant input. The countries in which COHRED has made significant inputs since its inception are Bangladesh, Philippines, Thailand, Laos, Indonesia, and the former Soviet bloc countries of Central Asia. On the other hand, COHRED has only provided limited inputs in Malaysia, India, and Pakistan. It has, over the years, also provided support of various kinds to individual countries. These have included:

Bangladesh
Bangladesh was one of the initial recipients of COHRED support through a 10-year work plan launched in 1990 and ending in 1999. This involvement is detailed in the document "ENHR in Bangladesh", which was used as a model for other countries. A new five-year plan has been adopted to succeed it. However, there is a great need to investigate possible modalities for ensuring sustainability.

Uzbekistan
A national ENHR network was formed in 2002 as an inclusive process with some 80 national organizations, mainly funded by private sector resources. This exercise constituted one of the first occasions for the MoH to interact with the non-government sector and reflects the often-cited comparative advantage of COHRED, namely its ability to interact outside the government sector.

Azerbaijan
In 2002 the MoH decided, with COHRED collaboration, to develop a NHRS based on ENHR. COHRED documents were translated into Azeri. This was followed by a three-day workshop on ENHR in August 2003.

Kazakhstan
In 2002, with the support of COHRED, an ENHR team was formed to strengthen the HR and an association of young researchers was set up to provide the critical mass to ensure its implementation.

Two countries to which COHRED has made substantial inputs over time are the **Lao PDR** and Indonesia.

Laos People's Democratic Republic
Laos is a small, less developed country in South-East Asia with a population of 5.2 million people. After many years of war, Laos has developed faster since peace was restored in 1975. The IMR is 84 and the MMR 530 per 100.000. IDRC helped Laos to launch its first five-year National Health Research Plan (1992-97). WHO and COHRED joined in the later stages of the plan by contributing to the 2nd five-year plan (1997-2001). This collaboration was took the form of a priority setting workshop organized in 1997. COHRED's involvement was given a boost in 1998, when the MoH hosted a COHRED-funded Asian Regional Workshop in Vientiane, which attracted participants from many Asian countries. Their participation was financed by COHRED. In line with COHRED's strategy of providing a voice for smaller and poorer countries in International meetings, COHRED has further supported Laotian participation in a number of regional meetings.

COHRED inputs to Laos decreased substantially after 1998, but COHRED training in research methodology provided the basis for the manner in which the National Health Survey, 2000 was

conducted. Many agencies and departments in the country have used the results of this survey in formulating their own development plans.

In 2002, COHRED supported Laos' participation in a regional NHRS workshop in Thailand. Together with the University of New South Wales, COHRED provides technical and financial assistance to Laos for the development of a strategy to strengthen the NHRS, based on the midterm review of the third Five-year NHR Master Plan (2002-2006) and a national consultation in February 2005.

With the support of COHRED the Laotian health research programme has undergone a steady evolution, which is highly regarded by most stakeholders in the country. In supporting this national achievement COHRED collaborated with other international agencies, such as IDRC and WHO.

Indonesia

Indonesia is the 4th largest country in the world with an ethnically diverse population of around 200 million people spread across 18,000 islands. The gaps in wealth are large and health expenditures are low compared to other countries in the region, only 2.5% of public spending.

Indonesia has a long tradition of health research carried out by universities and government institutes. Government directives in 1992 and 1995 enabled the National Institute of Health Research and Development to implement, supervise and monitor NHR, as well as facilitate the use of selected findings for policy.

The ENHR approach has been used since 1994. It has especially facilitated the use of research results to ensure equity in health development. A study conducted in 2001 found definite improvements in the health status of the population, but how much of this was due to the ENHR strategy was hard to tell. The same study found a marked disparity between provinces and suggested strategies for enhanced equity.

COHRED has certainly helped Indonesia with the reinforcement of its NHRS, partly through financial support, but more so through the provision of tools and materials, and the transfer of concepts, motivation, stimulation and mentorship. Asian researchers have, throughout the support period, conducted activities to support Indonesia's NHRS.

From 1999 to 2001 Indonesia conducted a priority-setting exercise as part of the development of NHRS with a $10,000 dollar grant and technical support from COHRED. The concept of ENHR has certainly taken root in Indonesia. Although the country's link with COHRED may not be as widespread as that, key players in the country appreciatively acknowledge ENHR. There also appears to be no difficulty on the ground in distinguishing between the different roles of WHO (which brings in concepts) and COHRED (which deals directly with country assistance).

Future support from COHRED would be useful in achieving the MDGs and improving the health system. COHRED must, however, reinforce its resource base both in terms of human and financial resources to be able to assume this role.

Over the last few years about 10 senior researchers from 3 to 4 Indonesian institutions have been trained through the COHRED mechanism. Another exciting development is the formulation of National Priority-setting and an Agenda for Health Research 2002-2005. This exercise was

completed at the end of 2001 in collaboration with WHO and COHRED. The outcome is a very detailed document that not only lists priority areas for research but also specifies specific projects to address the priorities, who will run them, and budget requirements. The ultimate aim will be to achieve the vision of "A healthy Indonesia, 2010"

As a follow-up to the International Conference in Bangkok 2000, and a recommendation of the ACHR of WHO and SEARO in 2002, it was decided to strengthen NHRS in Indonesia. COHRED, therefore, included Indonesia amongst the eight countries in the case study of the Working Group on the strengthening of NHRS (2001 to 2004). The study provided valuable information on the NHRS and how to move the agenda forward. This includes efforts to disseminate the concept of ENHR, emphasize commitment to NHRS, fine-tune its increased components and indicators and introduce the component of decentralization. A need to map health inequities and devise strategies to overcome them was also recognized. These are areas for COHRED to consider for future involvement in Indonesia.

3.3.5.2 The African Region.

Generally, COHRED's activities in the African region are widely acknowledged and have recorded notable achievements in providing technical and financial support to countries for priority-setting, coordination networks and research capacity building.

The countries where COHRED has made significant inputs since its inception are Uganda, Tanzania, Kenya, South Africa, Ghana, Senegal, Burkina Faso and Nigeria. On the other hand, it has made only lesser inputs to Ethiopia, Lesotho and Botswana. In **Malawi**, based on a methodology developed by COHRED, there was a clear focus on the quality, quantity and key stakeholders in research for priority-setting .

Uganda

Research for development has long existed in Uganda and indeed in the whole of East Africa since the 1930s. In 1977 when the East African community collapsed, countries undertook research at their own national level. Several institutes that specialized in research on specific target diseases such as trypanosomiasis were absorbed by the MoH. A coordinating body, the National Research Council set up in 1970, was replaced by the Uganda National Council for Science and Technology (UNCST) in 1990 and mandated by law to supervise all types of research, including health research. Although several institutions have their own research review boards, they act to supplement information from the UNCST database. In 1992, the UNCST set up an Ad hoc ENHR committee that brought together the three main stakeholders, decision makers, researchers and communities, to set national research priorities and produce a national research plan. In 1993 an initial 3-year research plan was elaborated and a national research priority established. This was done to strike a balance between biomedical, clinical and community-related research and to give consideration to national health needs.

With the support of COHRED, research coordination has been successfully reinforced through collaboration between the UNCST and Uganda's Health Research Organization (UNHRO) whose functions are based on ENHR principles. In 1996 the MoH recognized the need for research coordination as an essential tool in underpinning research development. Accordingly it set up the UNHRO secretariat to coordinate research and advise the government on research policies. Thus, in 1997 a Five-Year ENHR Plan was drawn up on the basis of identified priority research areas.

The greatest significance of COHRED's efforts in research development was in the area of advocacy of the increased involvement of stakeholders in research agenda setting. A mechanism for interaction among all the key actors was established, thus facilitating dialogue between policy makers, researchers, healthcare providers and communities, and enhancing research utilization by relevant stakeholders. Until early in the 1990s agenda-setting for health research was dominated by academics and medical scientists with the limited participation of end users and beneficiaries. The ENHR concept brought together the universities, health providers, civil society, donors and others in setting a joint research agenda and disseminating research. Most importantly, ENHR ensured holistic priority-setting. Stakeholder participation increased, thus giving districts and communities the opportunity to actively participate in national research agenda setting and addressing the imbalance of research priorities. The ENHR not only made the research agenda relevant for the national priorities, but also introduced the element of research ownership by the users.

With the support of COHRED, the UNCST developed a database of health research projects, publications and research capacity in the country. This information revealed the gaps in research and guided decisions on research agenda-setting. Recent analysis of the UNCST database revealed that most research projects were relevant to policy utilization as they related to national health priority concerns.

Uganda has also benefited from institutional capacity building, particularly at the district level. This has enabled the districts to analyze their own health situation and develop effective and efficient interventions. Research capacity was strengthened through sensitization workshops in nearly all the districts.

A major contribution by COHRED was effective research networking that enhanced implementation of multidisciplinary and cross-sectoral collaboration in research implementation and sharing of research findings. A process of consultation and sharing of information now exists among more than 50 institutions and departments, academic and non-academic, including the Ministry of Health, local and international NGOs and donor agencies. Networking among local institutions has further enhanced research coordination and advocacy in the country of increased financial support and involvement of the universities in conducting relevant health research.

Uganda has benefited enormously from COHRED. It has served as a member of the COHRED Board and a 'focal point' for ENHR in Africa for resource mobilization for research at all levels of activity. However, the greater proportion of funding for research (99 %) still comes from bilateral, multilateral and other foreign donor agencies, with very little from the Ugandan Government.

Ghana

Ghana, by promoting the linkage between health research and health service delivery and systems development, adopted ENHR as an approach that would enhance the organization and management of health related research. In this respect, representatives from Ghana participated in various meetings of the African Essential Health Research Network and reprioiritized its activities in order to respond to the new agenda of essential health research for equity and development.

The crucial input from COHRED was bringing together the key players for potential health research at a time when operational health research was almost non-existent. The emphasis on a country-led approach for making health research an integral part of development, guided by the principle of linking policy makers, researchers, healthcare providers and the community through COHRED

brought an added value to the development of a national framework for health research in Ghana. Rather than develop a separate mechanism, a conscious decision was taken to use the existing Health Research Unit of the MoH to advance the ideals that were being advocated.

With both financial and technical support from COHRED, the Health Research Unit (HRU) undertook a situational analysis of the status of health research as a basis for improving its programmes. This was followed up by a document and an action plan for 1997 to 2001. The document outlined the agenda to be followed, the mechanisms needed for building the necessary research capacity, and the coordination mechanism to be set up. In order to implement this policy framework, there was a conscious decision to build capacity and strengthen the research process and the institutions available. COHRED also funded the 'Research into Policy' study in Ghana and a study on 'Community participation in research'. The significance of the various items of support for Ghana in the words of an interviewee "*made the role of the HRU more acceptable in the research community in that a non-academic institution can become a lead agency in operational health research"*.

It was generally acknowledged that without the initial support of COHRED, it would probably have been a much more arduous task to gain the current level of peer acceptability.

The need to develop integrated modules for capacity building, the sharing of resources and information based on the findings of the COHRED-funded study on resource flows in a number of Asian countries (1998-2000) is now widely accepted. The presence of this strategic document and the subsequent strengthening of the HRU have promoted the image of the unit as a competent research body.

Ghana has also benefited extensively from COHRED's alliance with the WHO, participation in the interim board of the Alliance for Health Policy and Systems Research, the Core Group on Resource Flows of the Global Forum for Health Research among others. The publications emanating from the COHRED Communications Team are widely acknowledged for the practical and succinct information they provide and their material on advancing the ideals of ENHR. The Ghana-Dutch Collaboration for Health Research is a model based on the participatory principles advocated by COHRED, and in the words of an interviewee, "*... it is an innovative North-South Partnership that is a model to be followed*'.

The pathfinder role of COHRED is generally considered to have been most useful. Its continuing support at country level is still very valuable. In the opinion of one official, *"...there is no credible international body to provide a regular advocacy back-up for nationals wanting to influence government to fund and use research. For now COHRED, is not doing this as effectively as it should and this is likely to affect the efficiency with which the HRU can operate".* The impression created is that the role of COHRED is not sufficient at the country level. Ghana, despite its many achievements, is still too weak institutionally to convince policy makers to allocate adequate funds to support research into priority issues.

Francophone Africa
The Francophone countries consist of 28 of the 58 African countries, mainly located in West Africa. A subregional francophone African Network started in 1998 after the 5th African ENHR Network meeting in Accra. This was formalized in 1999 after the 6th ENHRT meeting in Harare. A

coordinator was appointed and the countries opted for the secretariat to be located in Accra, Ghana, which provided good study-tour opportunities during visits to the secretariat.

The coordinator appointed by COHRED spent a year visiting all the francophone countries and assisting them to strengthen national mechanisms, networking, capacity building and dissemination of research results. The countries through their various reforms were determined to implement a decade programme and COHRED support in appointing a focal person was seen as a strategic move. Unfortunately, the field person's work lasted for one year only and the momentum generated has since been lost.

In **Mali** COHRED supported the first national workshop on health research priority-setting and provided a unique opportunity for a consultative process between national and development partners to set and identify health research priorities based on a set of basic values and principles.

In **Cameroon**, based on a COHRED-supported promotion and advocacy workshop, new methods and technologies for addressing health problems were defined and a provisional list of health research priorities was drawn up.

The present situation in the francophone region is as follows:

- A prioritized research agenda exists in some countries, but most have difficulties in establishing one;
- Capacity building is weak in all countries and the brain drain has heavily diminished the availability of human resources with the capacity to conduct research;
- The research output is extremely low;
- Funding is a major constraint. Most of these countries, especially those in the Sahel region, are among the poorest in the world;
- Linkages and co-operation with decision makers range from limited to non-existent, leading to poor dissemination and utilization of research.

In short, COHRED has shifted the emphasis of its country support activities since Bangkok, 2000, paying more attention to countries in greater need and allowing countries already showing signs of success to continue activities with their own resources.

In its country involvement, COHRED has collaborated with the Global Forum and WHO, for example, conducting a joint workshop on resource flows with Kazakhstan, Uzbekistan, Cameroon, Burkina Faso, Hungary, Brazil, and Cuba; or in supporting an international workshop on NHRS attended by 16 countries worldwide initiated by the Thai Health Forum .

Many of the countries believe that the COHRED philosophy is still relevant and appropriate for circumstances that need advocacy and lobbying for resources, for emphasis and development of national mechanisms and a capacity for sustainability.

3.3.5.3 The Latin American and Caribbean Region.

COHRED's support to countries in the region has been limited and *ad hoc*, focused mainly on the Caribbean and Nicaragua.

The Caribbean is a mixture of rich and poor Dutch-, French-, English- and Spanish-speaking countries. There are 21 countries in the region, most of which are English-speaking. The Medical Research Council (MRC) was established 50 years ago with a focus on tropical medicine and malnutrition. It has since been changed into the Caribbean Health Research Council (CHRC), which focuses rather on ENHR. CHRC consists of medical doctors, but during a recent evaluation the need for more social scientists was acknowledged. *"The ENHR is a broader concept oriented towards development not only health services research – or operational research".*

COHRED's first contacts with the Caribbean were in the 1990s, since when the Caribbean has maintained two representatives on the COHRED Board. COHRED's main input to the Caribbean has been a number of successful regional workshops on ENHR and some technical assistance. Resources for continued support have been very limited.

The CHRC has institutional ties to COHRED, but they are of a more formal nature. "*COHRED needs to be more aware of the Health Research Councils*" Middle income countries are more left to look after themselves. There is need for sharper focus; limited investments could make these countries more successful in supporting the economically weaker countries in the region and, thus upgrade regional research capacity. At present the Caribbean sends its researchers to be educated in the USA, Canada and the UK. Support for middle-income countries in the region, such as for example, Barbados and Costa Rica, could improve the situation for people from less developed countries, such as Haiti and Nicaragua.

Today, collaboration within the region is difficult. *"The orientation of life is North-South, even the planes fly North-South". "TDR has done a lot to build research capacity. This needs to be replicated. There is a need to look at long-term RCB not only short term investments!". "There is a need to help the poorest countries by helping those a little bit better off. Foster collaboration. Triangulation South-South! " It is a problem that development co-operation goes directly for the poor. There is a fragmentation of support in the poorest regions of the world, e.g., middle income countries like Jamaica need qualified staff, but they do not get support." There is a need to change the equity concept. The northern countries should not drive the process. There is a need to drive the process more from the South. The time you do your PhD trains you in this way to work. When you go back you keep working in the same way. There is a need to start afresh. Train in a new way-create good Universities in the South – a more socially relevant way. The southern universities should create the programmes. The northern universities should only be invited on demand."* Brazil, Chile, Mexico and Costa Rica could help in research capacity building for regional training of researchers**.** COHRED has recently supported a very welcome initiative to strengthen co-operation between Nicaragua and Brazil.

In certain areas of the LAC, limited resources, poor facilities, lack of recognition and low salaries in the universities have led to external and internal brain drain, with a clear flow towards the resource richer countries. Many university researchers end up doing consultancies to survive – "*they do what the donors want*". "*Researchers are not negotiating a research agenda good for their country – they are driven by the need to survive*".

Curacao (Netherlands Antilles)
In 1995, the MoH in Curacao commissioned an NGO called "ISOG 2000" to promote and further develop the ENHR strategy within the country. A national ENHR workshop was held and a task force established in 1996. "The Curacao health study" was used as a starting point for the

institutionalization of health research in a systematic and sustainable manner, as a managerial tool for more informed decision making. The key linkage-institution within Health Research at Curacao is the Epidemiology and Research Unit under the Department for Communicable Diseases in the MoH. Among the other organizations active in health research in Curacao are PAHO and SHARED.

Jamaica

In Jamaica an ENHR task force, formally recognized by the MoH, was established in 1995. It consists of representatives from the Epidemiology Department in MoH, the universities and the Planning Institute of Jamaica. During a national forum in 1996, the ENHR concept was introduced to the research community. Some of the other organizations active in health research in Jamaica are PAHO and SHARED. Most local research groups are small, vulnerable, underfunded and lacking in basic equipment, experienced researchers and other support staff. Enhanced collaboration and a more jointly-owned strategy for research capacity building has been achieved during the last five years. Sustainable funding of planned activities and other essential resources for health research (for exaample, human and institutional) remain a problem.

Trinidad and Tobago

Research was introduced to Trinidad and Tobago with the CMRC in 1992. In November 1995, Trinidad and Tobago along with Barbados, Curacao and Jamaica participated in a regional workshop and shortly thereafter set up a national ENHR organization involving researchers, policy makers and the community. In 1999 Trinidad and Tobago was part of a global study on community participation and ENHR. The study found that community participation consisted mainly of being a subject for research study. The community had, however, specified areas of research that were important to them, and were interested and willing to participate in all aspects of ENHR.

Nicaragua

Nicaragua has no national research agenda, and no formal or central management of research. A review in 2001 of 59 research projects conducted in Nicaragua found a clear link between national health priorities and the areas researched. This could be due to the interests of the research-funding agencies in Nicaragua, most of which are international donor agencies. National funding is scarce and mainly hidden within the budget of the hospitals and universities. A number of international publications have emerged from biomedical research. While health-services research has the lowest number of scientific publications, COHRED is currently supporting Nicaragua in its efforts to strengthen the relationship between national health research investment and human resource development.

Brazil

Brazil is unique in as much as it created, from early days, a research tradition where the majority of the funding is internally generated and the research community is educated within the country. When compared globally to other countries of the same size and level of development, probably only China and India share this profile. But in Brazil most graduates finalize their PhD in-country. There are an estimated 3,500 research groups in Brazil, with a total of about 15,000 researchers. Approximately half the groups are health science-based; one-quarter biological and the remainder are in the humanities, engineering, agro-sciences and others. Health research includes clinical, biomedical, public health and others. Historically health research in Brazil has adhered little to the priority health needs of the population and the country’s social and economic needs. There is a need for a more balanced, but complete agenda of priorities, encompassing all issues and actors. The

national health S&T conferences have provided a forum for interaction between health researchers, health authorities and the community..

Key institutions in the Brazilian NHRS include the National Research Council for Science and Technology (S&T) and the Coordination Unit for Enhancement of Advanced level Personnel affiliated to the MoE. Both were established in 1951. The largest state agency for sponsoring science is the Sao Paulo State Research Sponsorship Foundation created in 1961. In addition to these, Brazil has the Project and Financing Agency, which has funded University research since 1969.

The Ministry of S&T (MoS&T) assumed responsibilty for NHR upon its creation in 1985. The first national conference on health research took place in 1994. In 1999 the so-called "Sectoral Fund" was established as private-funded supplements to the federal funded S&T. The Federal Government allocation for S&T in 2001 was around US$1,700 million. An important component of this was indirect fiscal incentives regulated by law. The State governments allocation to S&T has been stable since 1996 at about US$450 million per year. In 1999 the private funds used for S&T were estimated at US$1.25 billion. Overall, the federal and state levels contribute about 60 % and the private sector about 40% of national S&T expenditures.

The main challenge for the NRS in Brazil is the need for more equity-oriented research and enhanced coordination between sponsorships granted by the federal, state and municipal levels, and the internal initiatives of the MoH. To a large extent, health research in Brazil remains uncoordinated, leading to dispersion of efforts and funds. The possibility for a sectoral fund for health research funded by taxation on tobacco and alcoholic beverages or directly from the Health Fund under the MoH has been discussed as a possible scenario.

The introduction of ENHR into Brazil strengthened health research for public health and health equity. NHR priorities have been identified since 1997. The health research agenda plays an important role in the MoH's allocation of financial resources for health research. While Brazil may wish to address the health needs of the larger section of the population, including those who live in poverty, it is in need of substantial finances, infrastructure, equipment, technology, human resources and other elements to remain competitive in international S&T.

3.4 The Partnerships

COHRED works in partnership with many organizations, global initiatives among other things. One of the most important at the global level is **the Global Forum, which was** created four years after COHRED in 1997 and to a large extent by the same people involved with COHRED. The vision behind it was most likely, as stated by several interviewees; "*They were to be two legs of the same body*". But organizations are no better than the people who constitute them, and over the years to come COHRED and Global Forum did not enjoy the easiest of relationships. However, since January 2004 with the appointment of new directors for both organizations, collaboration has increased considerably. The evaluation of Global Forum in 2001 recommended "*the Global Forum should try to work more closely with COHRED, complementing each others perspectives – the Global Forum, a global perspective and COHRED, a national health research perspective. Their increased collaboration is possible within the existing organizational structures. The Evaluation Team has not found any compelling reasons for recommending a merger of the two organizations at this stage.*"

Many interviewees, especially at the country level, had a hard time distinguishing between the Global Forum and COHRED. *"What is the difference?" "Global Forum is based on a rational basis (evidence) for research priority-setting" – COHRED focuses on a poverty approach". "COHRED has completely lost its profile by being too much involved with Global Forum". "COHRED is too small!" Global Forum has lost touch with the countries; it focuses on methodology". "Global Forum has overtaken COHRED in sitting around the table with the countries from the South". " We do not need a global centre of excellence – local experience and knowledge is better for local policy making". "The scientists in developing countries have to prioritize their use of time, as they need to teach and write a certain number of articles a year. For most researchers there is no time for participation in the Annual Global Health Research Forums or Task Force work"." Many of the jobs done by COHRED have been identified with Global Forum, e.g. the priority setting process and the Resource flow studies were both started by COHRED".*

An other important partnership is COHRED's relationship with **WHO**, especially but not only, the RPC. Officially health research is one of the pillars of WHO, since it is a knowledge-based organization, but WHO has no clear research policy and strategy, which is apparently to be an integral part of all clusters, programmes and projects. WHO's related research has, over the years, to a large extent and with few exceptions (for example, RPC), become concentrated on the Special Programmes and other health research-related initiatives outside WHO, including COHRED and Global Forum. In recent years, the RPC has spearheaded a global analysis of the National Health Research Systems as the main contents of the Annual World Health Report and an important contribution to the World Summit on Health Research in Mexico 2004. The RPC would like to enhance global awareness of the importance of health research for health and health equity. The recent focus on '3 by 5' and other curative services, however, tend to narrow the research focus towards a more restricted analysis of the National Health Systems. WHO relates to the MoH, and WHA consists of MoH. Health Research, however, requires a much broader and flexible approach including various public and private players. Closer co-operation between WHO and COHRED could facilitate WHO's very important role as a normative knowledge-based organization. *"WHO is yet to take ownership of research". "The image of WHO ought to be one of a knowledge-based research organization".* WHO is, however, an organization with many faces, and some of the regional offices have been quite heavily involved and played a major role for Health research in their region (for example, PAHO and South-East Asia).

The Alliance for Health Policy and Systems Research was established in November 1999 under the legal umbrella of Global Forum. The Alliance aims to promote the generation and use of knowledge to enhance health systems performance. The objectives are to stimulate the generation of knowledge, facilitate capacity building and promote dissemination. The key actors for the Alliance are policy makers, service mangers and researchers. The Alliance has ties with, and supports or collaborates with, 341 institutions in 88 countries. About 68 % are researchers, 28 % private institutions and 4% policy-related. The annual budget is US$ 2 million. The key contributors are IDRC, NORAD, SIDA, DfID, USA, the World Bank and WHO. In collaboration with WHO, the Alliance has developed a methodology for assessing the impact of research on policy and will contribute to the assessment of HPSR in selected countries. It funds research-to-policy studies and supports teaching programmes to address HPSR in an *ad hoc* fashion. The Board has 15 members, the majority from international organizations, donors or more developed countries. Only two members are from least developed countries. The Alliance appears to be closely linked to the RPC

in WHO. Its collaboration with COHRED is less pronounced. COHRED is represented on the Board of the Alliance through its Director.

The UNICEF, UNDP, World Bank and WHO Special Programme for Research and Training in Tropical Diseases (TDR) was created in 1975. It is co-sponsored by the World Bank, WHO, UNDP and UNICEF. Since its inception TDR has been continuously supported by a large number of the same bilateral and multilateral donors and others with interest in promoting the global involvement in poverty-related tropical disease research with the focus on: African Trypanosomiasis, Chagas disease, Dengue, Leishmaniasis, Leprosy, Malaria, Lymphatic Filariasis, Onchocerciasis, Schistosomiasis and TB. TDR sponsored research has led to the development and practical application of new medicines, vaccines, diagnostics among others to improve the control of the above-mentioned largely neglected diseases. TDR-supported projects cover the entire range from basic science to operational research. TDR has further developed an excellent strategy for Research Capacity Building with the focus on the development and application of better tools and interventions in treating and controlling major tropical and neglected diseases. TDR publishes a regular newsletter via mail instead of online electronic messages, which are difficult to access in the poorest areas of Africa and other least developed countries. TDR's publication and grant writing workshops received high praise from several interviewees, especially at country level. TDR has moved from individual to institutional capacity building; the lesson learned is that there is a need for a balance between the two. Many interviewees from the South found TDR to be doing good essential work for research capacity building. They would like to see more of this kind of work.

International Clinical Epidemiology Network (INCLEN) is an important cooperative partner with a decentralised organizational structure that could be used as a model for a possible decentralisation of COHRED. INCLEN has many global, widely-distributed, decentralised offices linked by a strong communications system based on solid modern technology and knowledge management. INCLEN is an organization with strong links to university-based, methodology-oriented departments or networks with the focus on strengthening research quality and methodology throughout the world. There would be clear comparative benefits from closer co-operation between COHRED and INCLEN at the country level. INCLEN could strengthen the research methodology in country-based research facilitated by COHRED, and COHRED in turn could link the university level of academic excellence with the needs of the communities, ensuring field-applicable research useful for the poor and the decision and policy makers.

Bilateral Donors and other closely related development agencies paint a very varied picture. Some have their own research arms and clear policies and strategies (DfID, IDRC and SIDA), while others still appear to be attempting to define the role of research within their development assistance. The general trend is towards operational research '**with**' the South', and to a lesser degree as was earlier the case: by the North '**for**' the South'. Product development and basic science is, however, still mainly taking place in the developed world, with the exception of clinical trials for diseases of major prevalence in developing countries. The need for a more systematic strategy ensuring sustainable development, not only from a financial perspective, but also with regard to the long-term needs for qualified human resources remains to be addressed.

For the international development agenda on health research and health equity to succeed, there is an urgent need for overall long-term national HRD policies, strategies and plans that will ensure adequate capacity building with development, management, motivation and attrition of researchers,

including the necessary support for in-country teaching institutions (incl. the universities). This agenda will require broad co-operation among all partners within development aid.

NIH Fogarty programme and others offer scholarships to young prospective researchers from the South, an option to be further investigated with a view to future collaboration with COHRED. Many low income countries would, however, benefit from access to properly managed national or regional training programmes to minimize brain drain and contain some of the local cultural values and ethics, as well as a more down to earth research code of conduct with less 'inbreeding' in the peer reviewed articles and publications. The **EU** is one of the few donors who are able to support middle income countries and regional networks. Here COHRED has a clear added value.

The World Bank encourages allocations for NHR and NHRS, but these possibilities are often inadequately utilized. The Bank's willingness to support tertiary education, regional activities and middle income countries provides unique possibilities for strengthening NHRS, which should be further looked into. All in all, it appears that countries facilitated by COHRED, could benefit more from these and other possibilities. The UN agencies with an interest in health, **UNICEF, UNFPA**, **UNDP** and WHO, are all part of the **UNDAF** process at the country level. Getting coordinated research efforts with local ownership integrated into this plan would be extremely valuable. In countries with PRSPs and SWAP approaches, research should be an integrated component. Ideally health research should be an integral part of the National Research System (NRS) as a component of a national Secondary and Tertiary Educational Sector Support Programme.

Northern support for a Masters in Public Health (MPH) and similar degrees, for example, the European Association for a Masters in International Health (MIH) - **TropEd** could be valuable collaboration partners for COHRED in the future.

Whatever the future holds, it is clear that the need for coordination at the country level will be essential to ensure national ownership and capacity building. It is possible that **COHRED** could play an important role in assisting governments in the coordination of the many global initiatives within health research at the country level, and open the way for the creation of a common (health) research platform. This would make a more efficient and effective use of limited resources for health equity possible, while preventing vertical project 'pollution' (with questionnaires), which still seems to be the rule rather than the exception in health research.

At this point in time, we have a lot of knowledge that is not being used and a lot of ongoing research addressing questions already answered. The **'***Know-Do-Gap***'** needs to be addressed to ensure an ethical code of conduct. We need better knowledge management. There should be no research for the sake of personal promotion. The researchers need to address the problems of the poor "**with** the poor" and not "**for** the poor". "***COHRED plays** an important role as a transmitter and facilitator of the voices of the poor*".

We need to analyse the structure of the NHRS, including the resources available at the local level and the possible need for greater efforts to improve coordination. The many well-meaning partners investing in uncoordinated research at the country level have led to a situation, where the limited country resource persons are worn out. '*One tired horse with many Jockeys*' often describes the health research situation in the developing countries.

Finally, the management and proper use of huge amounts of funds available for g**lobal initiatives** at the national level could be supported by a well coordinated country-based research platform that bolsters up the local efficiency and effectiveness of recognized cost-effective interventions, for example, condom use, antenatal care and immunization.

4 DISCUSSIONS

4.1 Efficiency

Considering the very limited human and financial resources at its disposal, COHRED has been very efficient in converting available resources into outputs. Lots of work has been done and the outputs are many. Based on the factual data, efficiency was low from 1996 to 1998, but peaked from 1999 to 2003 in preparation for and follow-up to the Bangkok Conference.

About 50 percent of the limited annual budget goes on administration and management. To further enhance efficiency, the percentage of the budget that goes directly into activities aimed at achieving the desired outputs will have to be increased. This would require an increase in the overall budget, as it is hard to imagine a global organization with a smaller administrative budget than COHRED. The present annual budget is clearly inadequate in terms of the organization's vision, mission and strategies. COHRED does not have the necessary resources to foster and support the initial and longer term support necessary for a sustainable reinforcement of ENHR and NHRS, not even in the less developed countries of the world.

A possible decentralization of COHRED's headquarters in Geneva may or may not enhance efficiency since it could increase operational costs. Clearly this would depend upon the chosen decentralization model. If COHRED chose to focus on only one region, for example, shift its headquarters to Africa, this would probably cut costs, but might lower the effectiveness of the outputs and soften the voice of the "South's" position in the northern "development aid market". These disadvantages could, however, be addressed through more effective advocacy, communication and knowledge management strategies that allow for a global network with several decentralized outposts and a loud voice at the right time and place.

COHRED's headquarters is not staffed to provide the necessary support for countries in the regions. Traditionally this has been done through the use of experienced local researchers based in the regions. To enhance the capacity of COHRED, one possible solution would be to fund more fulltime or part-time staff at the central, regional and country level. One estimate was that COHRED would probably need at least 40 FTE to cover the 61 poorest countries in the world, the majority of which are countries in Africa and Asia. A more feasible and practical approach that contributes to local capacity building and is likely to decrease the brain drain, would be to designate personnel in existing entities in the selected countries as COHRED national and regional centres and equip them with additional inputs in terms of secretariat support, facilities, books and the like. This could be profitably incorporated in closer co-operation with existing regional and global networks, such as SEAMEO-TROPMED and INCLEN to maximize impact and minimize duplication. Local administrative and technical advisors living among and reaching the world's poorest could enhance COHRED's efficiency. This would be especially true if these advisors paved the way for a more coordinated redistribution of locally available resources (for example, from Global Funds, "3 by 5" and others) to tangible research outputs for local use, while enabling a more equitable, sustainable upgrading of the institutional and organizational NHRS set-up .

The various scenarios and possibilities for the decentralization of COHRED and its activities should be seriously explored and evaluated, taking into consideration all the pros and cons.

A key partner in global health research for equity is WHO. This is a field where both COHRED and WHO would clearly gain from enhanced co-operation at all levels, global, regional and national.

But COHRED should remain organizationally independent and work with not through WHO. As an independent NGO, COHRED has a clear comparative advantage; it is free to choose any partner in strengthening health research for equity, while WHO is tied to the ministries of health throughout the world. COHRED is in a unique position to foster a successful multi-sectoral approach to the promotion of ENHR and the strengthening of NHRS through the inclusion of multiple partners at the country level, for example, the MoF, MoH, MoE, MoPS, the universities and the private sector. WHO, on the other hand, has close ties with key decision makers within the health sector. Enhanced co-operation between the two partners could ease the promotion and use of health research for health equity and increase resource allocations for health research, thus enabling a stronger NHRS.

COHRED should remain organizationally independent, but intensify its co-operation with Global Forum in selected areas of work likely to increase synergy, while avoiding duplication and the administrative costs of the two organizations, for example, databases. As an independent NGO, COHRED has its own voice at the World Health Assembly (WHA). It is one of the few global organizations with a Board consisting largely of representatives from small countries and the poorest of the poor worldwide. Therefore, while Global Forum plays an important role in global advocacy and fund-raising for health research for equity, COHRED is important in ensuring that Global Forum, and other global partners, not only act on behalf of the poor, but in response to the needs and demands of the poor, as identified by and with the poor themselves.

To further strengthen global health research for equity, COHRED could consider enhancing present coordination with selected bilateral donors and multilateral organization, like UNESCO, UNFPA, UNDP and the World Bank, as well as leading universities and the private sector. In its original organizational set-up COHRED was linked to UNDP. The present set-up promotes ownership by the smaller and poorer countries of the world, which makes it is essential to retain this organizational strength and if possible to boost it even further.

The external evaluation team recognizes COHRED's efficiency in converting available resources into outputs. But COHRED needs to make strategic choices. A more demand-based focus with intensified efforts and the use of locally available human and institutional resources in selected countries and regions, combined with support for subregional and regional networking, would seem desirable.

4.2 Effectiveness

COHRED is efficient, but is it effective? COHRED has, in view of its limited resources, produced a lot of outputs, but have these outputs contributed to key outcomes? Has COHRED promoted, facilitated, supported and evaluated the ENHR strategy at the country, regional and global level? Has it worked with countries; focused on research for equity?

In Asia, COHRED has contributed to strengthening regional networks and the NHRS in selected countries. In Africa COHRED represents the much-needed human, financial and institutional arrangements for moving health research forward. COHRED has contributed to the internalisation of ENHR and strengthening of the NHRS in a relatively large number of African countries. In comparison, it has had only limited influence in LAC, but still there is no doubt that the ENHR strategy promoted by COHRED has added value, even for the areas of LAC and Asia, which had NHRS before COHRED intervened. While other international organizations have contributed to health research in the geographical areas where COHRED has operated, COHRED is one of the few organizations that have managed to reintroduce the equity dimension and strengthen health research

for better public health at the country level. COHRED has enhanced the adherence of individual countries' NHR to the priority health needs of the local population with growing consideration for equity and the socio-economic factors that influence the various health-outcomes.

It is difficult to find indicators for efficiency or effectiveness in achieving an idea, in this case the idea of ENHR. There is a need to find a way to evaluate this change in working practise. Possible models could be: how has COHRED raised awareness? Has the awareness-raising influenced the mode of operation? Has COHRED influenced today's research agenda? Are we more concerned with ENHR these days? Are there links with other partners – networking organizations? Has COHRED narrowed the gap between poverty and research, the interphase between the researchers and the decision makers? Personal links are very important. Has COHRED put people in touch, paved the way for interpersonal contacts? Has it contributed information of the ENHR idea, enhanced understanding, and incorporated new ideas. Has COHRED done what it set out to do in 1993?

Although COHRED has only been operational in selected countries globally, it has successfully developed strategies for and promoted ENHR in other areas throughout the world. With its very limited funds, COHRED has been able to change our mentality and the way we look at health research systems. Of course, it might have been desirable for COHRED to foster the creation of sustainable NHRS, long-term training programmes and sustainable policies and strategies that enhance RCB in the South, but we have to be realistic! That was not feasible within the COHRED budget. Through its work, COHRED has contributed to a coalition of people from less developed countries, who by working together have learned how to work in a different way; learned to function in networks and negotiate goals. The concept of ENHR has been widely accepted as a broader concept oriented towards equitable development and not merely focused on health services research. COHRED has expanded the equity concept into a process driven more by the South for "the South".

The inventory of outputs at the country and regional level indicates COHRED's continuing presence in the Asian, African and Caribbean regions. The majority of its activities are essentially directed towards process within the traditional areas of ENHR competencies. A few new initiatives, especially in the realm of NHRS, have been started. Countries have been brought into the COHRED ENHR fold while activities in other countries may have ceased altogether. What is commendable is that this has been managed in the face of dwindling resources and high turnovers in the leadership of COHRED. Some perceived that COHRED's activities had slackened somewhat after Bangkok, 2000, the momentum created not being fully utilized. Others found the lack of follow-up to initiatives and disruptions of the continuity a major problem. However, while COHRED has faced organizational problems since the retirement of its first coordinator, the outcome and results appear to have been relatively stable during this period, most likely due to a stable core staff of COHRED and an efficient and effective interim coordinator. The stories of Lao PDR, Indonesia, Ghana and Uganda, thus, amply illustrate the legacy of COHRED involvement which has led to the steady evolution of the respective NHRS. The perception of slackened COHRED activities, lack of follow-up and continuity is much more likely to have been due to an attempt by COHRED to reach out to the entire globe, its wish to respond to all requests, while being totally unable to do so. It was a problem compounded by dwindling funds, a down-sized budget at a time when global competition for steadily decreasing development funds for the poorest of the poor is becoming ever tougher. A period when increased global coordination and target-setting slowly push country based ownership and priority-setting aside, if not by intention, then by default. Comparable large amounts of globally

earmarked funds for country-based activities that aim at global targets serve to distort local priority-setting and make it even more difficult to achieve a nationally integrated and coherent NHRS that can address the health problems of the truly disadvantaged, poor minorities of countries around the globe.

In 1990, we did not talk about ENHR. The advocacy of ENHR before and after 1996 was very successful. COHRED succeeded in introducing it to a large number of low income countries, but there are many more to be reached. COHRED has kept the spirit of Alma Ata alive, reminded us of the importance of primary health care (PHC) and poverty alleviation not for but with the poor. Enabling them and ensuring that their voices are heard by the WHA and other key partners at global, regional and country levels has been one of COHRED's major achievements. It has introduced a new way of research priority-setting "with the poor - for the poor".

There is no doubt that COHRED has done an excellent job, especially in the preparation for and immediate follow-up to Bangkok, 2000. But since then, it has become increasingly difficult for COHRED and similar organizations to operate effectively. The world has changed. Resources for "traditional development aid" have steadily decreased, while the demand for accountability and cost-effectiveness has been on the rise, as have the number of globally set priorities. The target-based outcome-oriented approach has become increasingly popular. Since 2000 COHRED has been spreading its dwindling resources thinner and thinner in an attempt to respond to the growing demands from more and more countries. The focus has been on local ownership and research capacity building, the strategy process-oriented towards the facilitation of locally owned outputs and outcomes. COHRED has had no clearly defined indicators of its own to measure performance and success. The consequence is that, with more and more partners in the field, it has become increasingly difficult to see what COHRED is doing.

The extensive output of documents and publications from 1996 to 2000 is very impressive. Some of these are of an excellent quality and of major relevance for use at the country level. COHRED has, amongst other things, produced some outstanding "tool kits" for the implementation of ENHR and has documented the lessons learnt. The advocacy and actual distribution of these items, could, however, be improved upon to enhance the effectiveness of the outcomes delivered just as there is a need for a quantity and quality control of the impact of these publications.

At times COHRED's inputs appear to be rather *ad hoc* and few and far between with too much focus on individuals and less on strategic institutional development and organizational strengthening. COHRED has continuously had a core group of dedicated proactive individuals capable of making things happen. Over and over again the same people have been engaged in COHRED activities. Some of these have joined international agencies and thereby contributed to the 'brain drain'. Some have been personally and institutionally well connected, while others have been of less good standing with only limited capacity to influence their local environment. The comparative advantage gained by linking up with partners and resources outside the traditional government sector is of limited value if government personnel are marginalized. COHRED needs to develop a more systematic strategic approach with the focus on institutional development and organizational strengthening to ensure the sustainable development of a critical mass of human resources and the institutional capacity necessary to support a longer term strengthening of ENHR and the NHRS.

It is very difficult, if not impossible, to measure COHRED's effectiveness in translating research into policy. It is often assumed that the main reason why policy makers do not make use of research is the lack of communication. Research translated and delivered in a simple form that policy makers can understand and use would facilitate the use of research for policy. But unfortunately this is not always enough. Research has to be relevant for policy makers. Often they want results here and now. What is relevant today might be of less or no relevance tomorrow. The bottom line is that policy making is a political process, and hence not necessarily rational. Even in knowledge-based countries, politicians do not necessarily use research or evidence for decision making.

COHRED has improved co-operation and communication between researchers and policy makers, in an attempt to ensure that the areas researched were of relevance for decision makers. But policy makers are not very patient people and have often taken decisions before the result of the research is out. COHRED has a few examples of research that have been used for policy (see Ghana COHRED Doc 99.3, 1999), but there is a need for more and better documentation within this area. The present perception is, however, that COHRED still needs to assist countries in reaching the phase where the planned prioritized research really is being funded and implemented, before we can judge the effectiveness of COHRED in ensuring that research is being used for policy.

4.3 Analysis of COHRED from a global perspective: a reflection on relevance

The relevance of COHRED to the African region is widely acknowledged both in the literature and by the various interviewees. For most countries in this region COHRED represents the much-needed facilitator to strengthen the interpersonal and institutional arrangements necessary to move the research agenda forward. COHRED is perceived as efficient and effective in providing support to countries wishing to improve upon their ENHR competencies and give a boost to their operational research. COHRED has provided funds for situational analysis and strategy development, supported the undertaking of selected studies, and created fora for sharing country experiences, provided tool kits and leadership training. It has promoted equity and fostered the creation of national networks for Health Research, in which organizations such as the WHO, INCLEN, Global Forum and the Alliance can work together to reinforce the NHRS at the country level.

COHRED has supported the call for using health research to improve health equity and development. Many countries, however, still need to internalise the ENHR framework and draw its full benefit. The adaptation of knowledge, technologies and health interventions to make them more efficient and effective is still an area that requires more local and global attention.

Some interviewees were less clear about the purpose of COHRED or not sure what COHRED is currently doing. Some from the developing countries were uncomfortable with the idea of COHRED assuming a donor profile or operating as a "*global institution for research* "or "*an engine of research*". They felt that it would do better to continue advocacy with a focus on promoting experience sharing and demand for research into policy and implementation. For them *"The challenge is how to strengthen national leadership so the research for action penetrates to the district and community level. This will require a certain level of adaptation of complex research tools based on partnership and co-operation."*

Strengthening national leadership for a country-led approach to priority agenda-setting must go beyond training and recognize the fundamentally political agenda of resource allocation. Greater efficiency and effectiveness can be achieved if COHRED takes its stance in support of an agenda

for greater advocacy of country-based strategies and coordinated plans for funding research, training local researchers with clear career paths, appropriate incentives and international recognition.

Some suggested making COHRED more effective in advocating the sharing of knowledge, technological adaptation and securing the intellectual property rights of researchers in the developing countries. COHRED should consider paving the way for better collaboration between policy makers and researchers in countries with somewhat similar health problems and socio-cultural backgrounds so as to establish a "regional" coordinated and shared research agenda with joint knowledge management. This would prevent duplication of research, minimize the knowledge gap, discover new ways of dealing with priority research questions and facilitate the multi-country studies called for.

At present the demand for research does not appear to reflect the context of the global priorities for policy makers. One possible explanation could be that research is still considered to be too rigidly academic and remote from the needs of the "real" world, unable to communicate with ordinary people and policy makers. Most policy makers find research rigid and a less popular item to support. COHRED should promote a more user-friendly, dynamic and interactive parallel between research and policy through, among other things, promoting more and better interaction between national research coordinators, decision makers and user groups.

COHRED's advocacy role should extend to international research funding organizations with a view to decreasing the present funding of academic "desk-top reviews" and enhancing investments in more locally customized operational and basic research. This would strengthen local capacity building, ensure more and better research of real use to decision makers and the local population, broaden the formation of knowledge and sharing beyond the "Western world" and most likely increase the health benefits accrued for the limited global resources invested in health research for health equity.

During the last couple of years, country requests for COHRED support have steadily increased and it has become increasingly difficult for COHRED to meet the many new demands while sustaining ongoing activities. At times requests for support have gone unanswered creating a sense of frustration among local enthusiasts. Many of the countries in which COHRED has facilitated the introduction and implementation of ENHR have not been adequately developed to sustain the planned activities. In some cases this is due to a lack of "national ownership", but more often the owners of the ENHR or NHRS agenda have become dependent upon external COHRED funding and have, therefore, not planned to a sufficient extent for their own funding of NHRS through national budgets. COHRED needs to strengthen its efforts in encouraging stronger national ownership and willingness to address the issue of sustainable funding for health research activities through the use of internal or external resources at the country level. It could choose to play more the role of a broker at international and national level, and use its own limited funds in a more strategically selective manner. This could prevent future dependency on COHRED funding, but would not eliminate dependency on other external *ad hoc* funding. The use of less *ad hoc* 'experts' from developed countries and more local specialists would build local ownership and research capacity, while making the limited funds go further.

COHRED has developed some good and very useful tools for research priority-setting, planning and capacity building, but most funds have been spent on process rather than outcome. To be more

donor-attractive, COHRED could consider ensuring more outcome-based results with demonstrable impacts. On the other hand, the process-oriented approach has enhanced local capacity building and the value thereof should not be underestimated. Instead COHRED could consider developing and using valid and reliable process indicators, while assisting countries to develop outcome and impact indicators, leaving the ownership of the outcome to the countries. There is no doubt, however, that the development and use of more reliable, valid and timely indicators at various levels would enable a better assessment of COHRED's efficiency, effectiveness and equity orientation as an example, the investments in workshops and seminars could benefit from being better justified and documented if, say, a clear action plan with indicators for follow-up was among the required outputs.

Some interviewees were of the opinion that COHRED had been spreading itself too thinly over too many countries, and that it would have been more efficient and effective to have focused on fewer countries, built capacity and produced some demonstrable products, for example, carried out research that resulted in new knowledge, papers and policy interventions. The use of international networking and the exchange of experiences have, however, proved highly valuable globally and have made COHRED highly relevant from a country and regional as well as global perspective.

In recent years COHRED, WHO and Global Forum have increased their collaboration. Naturally, it is essential for global success that these key partners and others work more in synergy, building upon each other's comparative advantages. Here COHRED plays an important role as a body that promotes ENHR and NHRS too outside the MoH, thus enabling broader participation in health research. COHRED has to further define and build upon its comparative advantages in relation to other global and local partners for example, making its tools and methodologies or its expertise readily available. Currently global interest in strengthening NHRS rarely includes the local needs to reinforce tertiary education and sectoral support for tertiary education. This is an area where UNESCO, the WB, bilateral donors and others could play an important role. As a knowledge-based organization it is important for WHO to intensify its professional involvement in the promotion and strengthening of NHRS to enhance local production and use of health research for equity and evidence-based policy making. COHRED's extensive experience and qualifications as an organization owned by developing countries devoted to the promotion of ENHR and the upgrading of NHRS at the country level would certainly be a comparative advantage likely to have a synergetic effect.

COHRED and Global Forum were once described as 'the two legs of a body'. Today it could be said that while the Global Forum leg is thriving in its niche area, COHRED seems to be limping. COHRED has a visibility problem. Not many people outside of the related areas in countries have heard of COHRED, although many more have heard of ENHR. COHRED needs to be revitalized to be able to play its unique role as a global "southern owned" networker and country catalyst for the promotion of ENHR and the strengthening of NHRS. Additional resources are a must. An optimal strategy for synergy between COHRED and Global Forum would be for the latter to use its current influence, reputation and clout as a convener of the annual 'market place' for improving global behaviour, *inter alia*, among development agencies, in favour of reversing the 10/90 gap. Meanwhile, COHRED should continue to ensure that the voices of the poorest and less developed countries carry as far as the Global Forum, WHA and other entities at the global level, while preparing the ground in these countries for enabling and strengthening local capacity for setting priorities, ensuring equity and absorbing additional global resources for health research. This would contribute to global equity in health research. In other words, COHRED should continue to be an

organization promoting ENHR while moving more into the area of facilitating more holistic management of nationally owned broader-based NHRS. This might mean that COHRED needs to break away somewhat from the present limited parameters of its ENHR elements.

There is definitely a continuing need for a COHRED-like organization in the global health research landscape, albeit a 'reinvented' one based upon its country focus and its ability to operate outside traditional government channels. A good strong NHRS is based on a broader range of stakeholders, that goes beyond the traditional government health sector and includes academia, the private sector, civil society and the end-users of research, as well as local communities. It focuses on the national and local levels, and on building capacity that can lead to research that has a real impact on equity. COHRED has an added value, even in countries that already have NHRS. The promotion of ENHR links research to society, to the people in greatest need and the policy makers. Another asset of COHRED is the quality of the technical assistance it provides for more effective country-based priority-setting, methodologies for monitoring research, disseminating and sharing research results and knowledge between countries.

Today there is an increasing number of global "initiatives" that are in fashion, for example, the MDGs, the Global Fund, '3 by 5', GAVI and others. Most of the recipient countries do not have the human resources and infrastructure to absorb these initiatives, most of which require substantial investment in research to ensure that global knowledge of cost-effective interventions are translated into local action. There is a pressing need to bridge the gap between what is common knowledge and what is really being done to ensure an improvement in local public health. All global initiatives should support the strengthening of NHRS with strong local leadership and effective management. COHRED could play a significant and meaningful role in this by virtue of its experience in, and emphasis on, reinforcing NHRS, an opportunity that could be better taken with an increase in present resources.

Efficiency, effectiveness and relevance can best be achieved by plugging into existing systems and by COHRED providing, for example, the tools and methodologies, by boosting local research capacity building or playing the role of a broker . This would require COHRED to operate on demand, understand the status of each country's current NHRS and identify possible gaps (for example, countries not requesting assistance despite dire needs or perhaps due to lack of information about the importance of health research). COHRED could then, either through its own resources or as a 'broker', try to assist these countries. A decentralised COHRED with regional or country offices or a network of locally engaged representatives would be more likely to know about local needs and opportunities and, therefore, be in a better position to obtain the right local assistance in a more timely fashion and at a lower cost, than would a centralized global organization.

COHRED is at present undergoing major change in its attempt to adapt to a changing environment. What COHRED was set up to do in 1993 remains relevant. However, while much of the advocacy has been so successful that most people now know of ENHR, there is still a long way to go before countries are empowered to manage their own health research in an equitable way. The roles and functions of COHRED have changed, but we still need a COHRED-like organization, owned and operated by the developing countries themselves. The Board needs to be strengthened. The role and functions as outlined in the statutes, the rules and procedures for the COHRED Board need to be updated and adapted to the new structure, thus enabling the Board to play a more active and clearly defined role. The procedures need to be more specific and detailed. For example, the Board

currently adopts, approves and decides upon the secretariat and selects the Director. It reviews progress reports and budgets, but it would be reasonable to request the Board also to provide technical and strategic advice and guidance, critical readjustments and perhaps even to reject proposed plans, projects and budgets. The Board should play a role in strengthening COHRED's administrative and monitoring systems. While the Executive Board might hire and fire, it would probably be a good idea to have the non-executive board approve these decisions, just as the Board should be able to 'hire and fire' the Director and Deputy Director. Whether Board members should be involved in advocacy and facilitate fund-raising for COHRED is a more complicated question. Naturally, all Board members should support COHRED, but their participation in active advocacy might create a conflict of interests with their supervisory and audit functions. There is a clear need to update and delineate the executive and non-executive roles and functions of the Board to ensure that it plays a more proactive and timely role in enhancing the performance of COHRED.

5. CONCLUSION

Disparities and inequities in health remain major development challenges in reaching the MDGs. Effectively managed NHRS is essential in translating knowledge into action and ensuring a more equitable and efficient resource allocation for public health. Advanced academic knowledge and new and better health interventions are important for global public health, but there is also a dire need to apply existing knowledge and interventions in a more locally-adapted, effective and equitable way. Despite the broad endorsement of the MDGs, certain regions and countries are making little progress towards them. Most of the least developed countries, which to a large degree are found in sub-Saharan Africa and Southern Asia, will need special support to accelerate enough progress to catch up. Indeed many of these countries are caught in a poverty trap where limited availability of domestic resources and high population growth restricts public and private investments and public expenditures on social services and development administration necessary to eradicate extreme poverty. Almost half the population in sub-Saharan Africa is struggling to survive on one USD a day or less. Food production is barely keeping up with population growth. Primary school enrolment rates have increased, but substantial additional efforts are required. Women continue to be vastly underrepresented in parliament and the ratio of girls to boys in secondary and tertiary education is considerably less than one. Sub-Saharan Africa continues to have the highest child mortality in the world, nearly twice that of the next highest region, Southern Asia. Uncertainty about maternal mortality estimates does not allow any definitive assessment of trends, but it appears to follow the pattern of child mortality. HIV/AIDs continues to be a potential serious threat to the entire world. Environmental sustainability shows a generally poor record globally. There has been some progress in the development of global partnerships, but the scale of aid flows continues to fall short. Most developing countries are rarely seen as equal partners, but more often as passive recipients of aid. While the MDGs are still considered technically feasible even in the poorest countries, the political will is largely absent. To seize the opportunity there is a need to strengthen the local ownership of the global development agenda through nationally-owned policies and strategies, stronger institutions, wider participatory involvement, focused investment in economic and social infrastructure and more domestic and external resources. Progress towards the MDGs requires local willingness and capacity .

Research and tertiary education need to be higher up the agenda of international development partners and the local public expenditure agenda.

Health research is essential for sustainable development. The foundation for development rests upon a high level of literacy, good quality education at all levels, local expertise, new technology and applied research. Self-reliance in research and development is key to sustainability. Developing countries should not be seen as recipients of charitable handouts, but as partners in producing health research that is of high quality and tackles major health problems, such as health inequalities, infectious diseases and changes in the environment. Strengthening governance for global health research is in dire need of redirection. The countries most in need of health research should have a bigger say in what is funded and how. Multi-partner investments in nationally owned coordinated and strategically deployed “research sector programmes” with sustainable national training programmes for researchers in the developing countries and investments in national well managed institutions would represent a serious commitment to local RCB. Effective long-term country strategies and investments in human resources are essential to retain skilled expertise, prevent poverty and secure a more even economic growth and political stability. Improvement of knowledge management is crucial for sustainable development.

The environment has changed since the Commission created COHRED in 1993 out of a vacuum and an urgent need for advocacy of health research funding and ENHR. Twenty years later the funds for research have increased considerably, but the 1990 recommendations of the Commission on Health Research for Development still remain to be fully realized. About 55 countries have implemented and used components of the ENHR strategy and the number of international programmes and networks concerned with health research for development have mushroomed. A continuously growing number of partners and an increased significance of the private sector, especially industry and philanthropic foundations, presently characterize the sector. The complexity of the arrangements between the different players has grown, exemplified by the large number of initiatives, networks groups and coalitions. Many of these were initially developed to draw the pharmaceutical industry towards neglected areas of health research. Nevertheless, it is a cause for concern that many of the recent initiatives are vertical programmes, not fully integrated in the NHR, and, hence, not contributing optimally to the development of strong and self-reliant NHRS.

The rapid growth in the number of players at the international level and their limited capacity to develop effective linkages and communicate with each other is likely to result in a number of weakly aligned initiatives competing for limited resources, which consequently weakens and fragments international health research efforts.

The role of the governing bodies in NHRS needs to be strengthened to ensure that public interests remain at the core. Country work should be guided by national policies and long-term plans and budgets. The focus on ENHR has been steadily shifting towards strengthening NHRS. WHO has embarked on an analysis of NHRS, but it is confined to the Health Sector and the MoH. The Alliance is focused on Health Delivery Systems; TDR on neglected diseases; and Global Forum on the 10/90 gap, priority-setting and health equity at the global level. The annual market place has been a success, but Global Forum, like most other global organizations, lacks the necessary country knowledge of local community needs and the governance mechanisms to ensure health research for health equity at the country level in the less developed countries.

We need an international organization like COHRED, which:

a. is capable of promoting ENHR and strengthening the NHRS;
b. represents the South at all levels;
c. abounds in the knowledge of countries;
d. has the capacity to work across public & private sectors;
e. has experience in health research for health equity and development.

A COHRED which is even more**:**

a. decentralised, with enhanced ownership by the developing countries operating in a participatory, democratic and equitable fashion;
b. focused on Research Capacity Building for sustainable development of NR(H)S;
c. efficient in its advocacy, communication and knowledge management;
d. skilled in linking individuals within institutional set-ups, across sectors and geographical areas;
e. efficient in coalition building and ‘brokering’ for sufficient resources.

6. KEY FINDINGS AND RECOMMENDATIONS

6.1 Relevance of COHRED in the global setting for health research for development

In many developing countries the efforts for poverty alleviation have been undermined by deterioration in the population's health. The achievement of the MDGs will require increased research into the health needs of those living in absolute poverty, while addressing health and its determinants in a more comprehensive way and intensifying the efforts to close the 10/90 gap. Most governments and donors still need to increase their expenditures on health research for equity in line with the recommendation of the Commission on Health Research for Development. Comprehensive coordinated long-term national policies, strategies, plans and budgets for strengthening of local research capacity building and NHRS (including human resources and institutional development, as well as knowledge management) are essential for sustainable development throughout the world.

Since Bangkok, 2000 the world has changed substantially, embarking to an increasing extent upon a more global and outcome-oriented approach to health and development. The ENHR concept has become widely recognized and COHRED has slowly expanded its original narrow focus on ENHR to a more broadly oriented approach with its focus on strengthening equitable NHRS. The ENHR concept is still of major relevance for the development of NHRS addressing the issues essential for health equity, global development and reaching the MDGs. COHRED is a key partner and an important representative of the less developed and smaller countries at the national, regional and global level.

COHRED's advocacy of, and contribution to, progress in ENHR has been successful and is well appreciated by all. COHRED has left its "footprints along the evolutionary path of NHRS" in countries within its sphere of influence. But since Bangkok, 2000, its visibility has slowly decreased due, among other things, to increased competition for limited funds, combined with increased demand for country support. COHRED has spread itself thinly in responding to the demands, which is largely the outcome of its own successful advocacy of ENHR and the need for NHRS.

COHRED is a "knowledge bank" of information on health research for health equity at the country level, ENHR and NHRS. Largely owned and operated by the less developed and smaller countries throughout the world, COHRED promotes ENHR and strengthens NHRS through enhanced co-operation between a wide range of partners and sectors, public as well as private, all of whom are active in health research and development for health equity at the global, regional or local level. COHRED is unique. Its comparative advantages are of paramount importance for achieving a reduction in the 10/90 gap and reaching the MDGs.

Recommendations:

1. In recognising the large number of players in health research at the global, regional and national level, COHRED should enhance general awareness of the organization's comparative advantages and relevance. It should position itself to support an agenda of greater advocacy of, and technical support for, country-based policies and strategies enhancing the development of coordinated national plans and budgets for integrated NHRS. It should thus mobilize and support networks and offer a platform for countries and regions to exchange experiences and voice their opinions as equal partners in international fora.

2. To decrease the administrative and managerial cost and increase the efficiency, effectiveness and synergy COHRED should explore and pursue possibilities for enhanced co-operation, especially with Global Forum, WHO, TDR, INCLEN and the Alliance. It should seek to enhance the communication between the global, regional and national levels, communicating the voice of the South to the Global Forum, WHA and others. COHRED, Global Forum and WHO are important partners, who should seek to strengthen their collaboration for example, through the sharing of information, databases, training courses and tools.

3. In co-operation with Global Forum, COHRED should continuously support the analysis of research needs and the flow of funds, identifying national opportunities for research and potential funding, and referring opportunities that are in need of regional or global support.

4. COHRED should develop ethical guidelines and investigate options for cooperating with the private sector in support of Corporate Social Responsibilities.

5. COHRED should remain process- and equity-oriented, continuing its advocacy of ENHR in strengthening NHRS, while moving on to enable countries to actually implement and use research for improved health equity and development.

6. COHRED should seize the 'window of opportunity' provided by current emphasis on National health sector reforms, PRSPs, SWAPs, the MDGs, GAVI, the Global Fund, "3 by 5" and other global initiatives. Exploiting the opportunity to increase the prominence and funding of research as a key factor in the management of change, agenda setting and achieving the MDGs.

7. COHRED should take on a broker role of facilitating a more coordinated, equity-oriented, efficient and effective use of the multiple sources of funding already available at the country level. As a more decentralised network organization COHRED could assist countries in gaining access to, and make good use of, locally available resources, for example, bilateral, multilateral and global funds and initiatives engaged at the country level.

8. COHRED should continue to focus on the less developed countries, based on a systematically prioritized agenda for "investments" in selected countries, sub-regions, regions and even, cross-continental networks, based on added value.

6.2 Strengthening National Health Research Systems

Most international development agencies and other partners have an interest in health research for development, an interest which often results in narrowly defined investments in health research. While these interests might be in agreement with national health priorities, they often contribute to a further fragmentation and duplication of the already weak and at times non-existent NHRS in the developing countries. While some partners can agree upon the need for a more systemic strengthening of NHRS, the lack of an overall national strategy, plan and budget does not facilitate progress. To contribute to the confusion, there is no uniform understanding of health research and what contributes a NHRS. The conceptualisation of a NHRS ranges from; (i) a well managed multi-sectoral country-owned approach including human resources and institutional development, (ii) a research approach via a health system including socio-economic and behavioural science to (iii) a narrow, more "curative" approach with the focus on strengthening health systems delivery and not health research or NHRS. There is a need to reach a global consensus on the concepts and the importance of a more coordinated approach to strengthening of NHRS.

Recommendations:

1. COHRED should clarify its conceptualisation of health research and NHRS and the strategically approach to implementation. To enhance the efficiency, effectiveness and sustainability it is recommended that COHRED aim to facilitate the development of well-managed multi-sectoral country owned "Sector Wide Approaches" including long-term national policies, strategies, plans and budgets integrating all stakeholders in a systematic and coordinated fashion.

2. COHRED should negotiate mutually acceptable country "entry" and "exit" strategies with clear action plans, and indicators for expected outputs, outcomes and impacts of the support to country level. This would ensure clear expectations on both sites and facilitate the monitoring of progress.

3. COHRED should strengthen communication and knowledge management. The COHRED website could be used as an interactive forum for exchange of views, experiences and others.

6.3 Human Resource development for health research

COHRED has developed networks of committed individuals. By engaging in individuals attached to key institutions in the individual countries' NHRS COHRED might decrease the internal and external brain drain in its' co-operation countries. Recognising the reverse effect of internal and external brain drain on strengthening sustainable NHRS

Recommendations

1. COHRED should examine its potential impact on internal and external brain drain in various scenarios to develop a strategic model for optimising the retention of qualified human resources within the NHRS.

2. Based on the principles of ENHR, COHRED should actively facilitate the development and strengthening of national plans for human resource development and institutional strengthening for NHRS. In this regard, COHRED could consider collaborating with the World Bank, the EU and others with an interest in strengthening tertiary education systems and research.

3. COHRED should pave the way for the development of South-South collaboration (including possible investments in medium-level income countries), to make national or regional training of highly capable local researchers possible, appointed by well equipped high quality institutions and retained by attractive working conditions.

4. COHRED should encourage the enhancement of skills for research management, methodology, proposal writing and publishing in internationally recognized journals.

6.4 COHRED's administration, management and organizational set-up

In recent years COHRED has taken steps to strengthen the institutional set-up and improve strategies, plans and budgets, to ensure a critical mass and greater efficiency. COHRED has been efficient in converting available resources into outputs, but there has been a lack of follow-up and follow-through of strategies and plans, amongst other things, due to competing requests and limited funding. To reinforce the continuity of activities and enhance efficiency and sustainability COHRED needs to make certain strategic choices. Its present institutional set-up with a small core secretariat and a Board, both of which were recently converted into an executive and non-executive

Board respectively, was originally created for advocacy of the ENHR concept. COHRED has a highly capable, motivated and committed Board, with due consideration for gender, geographical equity and Southern ownership in the non-executive Board. The present organizational set-up of COHRED supports the notion of ownership by the less developed, small countries in the world. It is essential to retain this organizational strength and, if possible, even boost it further. However, for COHRED to move beyond advocacy and enable countries to strengthen their NHRS, there is a need for change in the institutional set-up and the composition of the Boards.

1. To enable the non-executive Board to take a more proactive role; COHRED needs to update its Statue to adapt to the new institutional set-up, as well as its vision and mission, and to specify the roles and responsibilities, so that it may assume a clearly defined and more active role.

2. COHRED should consider constituting a shareholder association for developing countries, where membership of the Board is based upon weighted contributions, not only in the form of donated funds, but also in terms of the value of personal and institutional investments in ENHR and NHRS.

3. The donors on the Board could consider replacing their present 'Northern" representatives with a partner from the South.

4. COHRED's critical mass of human and financial resources needs to be increased to enable optimal efficiency. It should explore and evaluate the pros and cons of the various scenarios for a possible decentralisation of COHRED to determine the optimal future organizational set up. A more demand-based, decentralised and focused approach with sustained country-links to selected countries and regions seems desirable. Increased involvement and facilitation[1] of local health research specialists in key positions or institutions could enhance efficiency, effectiveness and continuity through local RCB.

5. COHRED should streamline its administrative, managerial and monitoring procedures to improve supervision and enhance transparency and accountability in a future, more complex, decentralised organization that links financial allocations to outputs, outcomes and impact indicators at the various levels.

6. COHRED should budget for regular in-service training to ensure actively engaged, qualified and innovative staff and Board members, able to handle new developments (for example, the commission of research and the functions of non-executive Board members).

7. COHRED should devise a marketing strategy to improve its visibility and increase financial contributions

8. The Tools and other guidelines developed by COHRED should be quality assured

Next step:

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[1] Facilitation could consist of individual or institutional support e.g., computers, training, teaching materials, publications and participation in international meetings.

The ideas, experience and expertise of COHRED remain relevant for achieving improved health equity and development through health research capacity building. The analysis and deliberations presented in this document should assist in providing the basis for a more intensive institutional analysis. COHRED is in the process of generating an Action Plan for 2005 that aims at optimizing the opportunities and minimizing the impact of the threats.

Recommendation:
COHRED should establish a temporary "think-thank" consisting mainly of researchers, decision makers and representatives of civil society in the developing countries, with extensive knowledge and practical experience in improving health equity and enhance development by giving additional impulse to NHRS, in elaborating upon COHRED's added value, contributing to a long-term development strategy, plan and budget, and the updating of the Statutes.

"Health research is only effective if it expands knowledge about how to improve health & if that knowledge is used".

ANNEX A

COHRED External Evaluation 2004

For: Swiss Agency for Development and Cooperation (SDC)
Terms of Reference for Evaluators / Abbreviated

Short Version : 30 June 2004

Background

The SDC requires that COHRED be externally evaluated before 2004 grant allocation can be made. As the SDC grant to COHRED and the Global Forum for Health Research (GFHR) is provided as one grant (with equal partition), the timely completion of this evaluation also affects the income of the GFHR.

Expected Deliverables

The date for submission of the evaluation report (pre-final draft) to the SDC is 30 September 2004 at the latest, in order to fit into the SDC funding cycle. A final report can be handed in on 31 October 2004, provided it will not be significantly different in findings and conclusions than the pre-final report. This extension is allowed to add-on evaluative items not needed for SDC per se but that could be useful for COHRED or other donors.

The report should be structured in the form of a normal consultancy report, using international standards. Besides findings, it should report on recommendations in view of the new mission and the new global research environment in which COHRED operates.

The report can / should list the realistic limitations under which it was prepared, due to time – resources, etc and a make a statement on the consequences of these limitations on the interpretation. It should also make recommendations on further evaluation work that could benefit COHRED.

Purpose and Scope

This evaluation will take the form of a review of COHRED's work (efficiency and effectiveness, in global terms only) and of continued relevance of its mission and functional structure given major changes in the global research environment since COHRED's inception in 1993 (again, in global terms only).

The review must take note of the original report of the Commission on Health Research for Development (1990), and the Task Force on Research for Development's report to establish COHRED in 1993. The review should start with the prior evaluations that were done in 1996(external).

The review should investigate and conclude on:

- Continued relevance of COHRED, given the end of its mandate – officially in 2003 (10 years after its inception), changes in its vision – mission – strategies, and changes in the external health research and development environment. A broad approach is required for this, not a focus on COHRED's detailed operations.
- Continued relevance of COHRED's operations, outputs, and staffing – without consideration of its resource base and with consideration of its resource base. We expect a 'global' view relating its operations, outputs, and staffing to its mission, the external environment, and resource base.
- Efficiency and effectiveness of COHRED operations: in particular, to consider use of its materials, changes it may have achieved globally – and in countries, times COHRED is quoted, people who know – use – understand COHRED or ENHR, and its contribution to equity in health through research. Has COHRED had an impact on re-distribution of global health resources to the south, or on the "5/95" gap? If not listed here, what have been COHRED's key contributions?
- Specifically, the resource base for COHRED in view of its (old and new) mission needs to be considered: to make a qualified statement about appropriateness of size and budget. Reference is made to the mandate given in the 1993 report of the Task Force (a 'small secretariat' is required).

- What are key changes in the environment to which COHRED has failed to respond, if any?
- Finally, after reviewing GFHR (known to the team leader), the potentials and limitations of the alliance between COHRED and GFHR should be listed, the actual relationship characterized, and recommendations made to improve / enhance the utility.

Methods

The team should use document reviews, personal and telephonic interviews with key informants (staff, board, GFHR, users/consumers of COHRED services and materials), possibly a short questionnaire mailed to the COHRED database (6000 persons … even with a response rate of 20% this will entail substantial work). A list of key informants will be prepared by COHRED on the basis of previous involvement with COHRED work. The evaluation team is encouraged to use a 'snowballing' technique to obtain the names of further persons who could be interviewed, if needed.

Documents should be of 3 kinds: COHRED publications, work on COHRED (annual reports, internal reviews, board minutes, other), and publications using COHRED work.

The team can call on the COHRED Executive and the External Evaluation Task Team (EETT) at any time for assistance, and the COHRED Executive will be able to do all logistical support work.

Annex B

List of People Interviewed

Ministry of Health and related Research Institutions

- **Data Dr. Narimah Awin,** Director for Communicable Diseases, Ministry of Health, Malaysia
- **Boungnong Bhoupa,** President of Council for Medical Sciences; Director of National Institute of Public Health, Ministry of Health, Vientiane, Lao PDR
- **Somsak Chunharas**, Director National Health Research Foundation, Bangkok, Thailand and COHRED Board member
- **Robert Eiss**, Acting Director, International relations, Fogarty International Center, National Institutes of Health, USA
- **Peter Figueroa,** MD and Public Health Specialist, Jamaica
- **Izzy Gerstenbluth**, Head of Epidemiology and Research Unit, Medical and Public Health Services, Netherlands Antilles and COHRED Board member
- **John Gyapong,** Head of Health Research Unit, Ministry of Health, Ghana
- **Ten Siew Keoh,** Senior Research Officer, Institute for Medical Research, Kuala Lumpur, Malaysia
- **Andrew Y. Kitua**, Director-General, National Institute for Medical Research, Tanzania
- **Delia Sanchez**, Ministry of Health, Uruguay and COHRED Board member
- **Donald T. Simeon**, Director of Research, Caribbean Health Research Council, Trinidad & Tobago
- **Agus Suwandono**, Director, Research and Programme Development, Ministry of Health, Indonesia
- **Suwit Wibulpolprasaert**, Senior Advisor Health Economics, Ministry of Health, Thailand

Universities, Schools of Public Health and Research Institutes

- **Harun Al Rashid**, Director, Medical Research Council, Dhaka, Bangladesh
- **Eric Amuah**, Field Coordinator, School of Public Health, Ghana
- **Fred Binka**, School of Public Health, Ghana, and Director: IN-DEPTH network
- **Ib Bygbjerg**, Professor, Dept. for International Health, Copenhagen University, Denmark
- **Lincoln C. Chen**, Harvard University, Boston, USA
- **Marian E. Jacobs**, Director, School of Child and Adolescent Health, University of Cape Town, South Africa and COHRED Board member
- **Jessica Jitta**, Director: Institute of Child Health, Makerere University, Kampala Uganda
- **Ernesto Medina Sandina**, Rector, University of Léon, Nicaragua and COHRED Board member
- **Carlos Morel**, Scientific Coordinator, Center for Technological Development in Health, Oswaldo Cruz Foundation, Brazil and member of the Foundation Council of the Global Forum for Health Research
- **Gloria Palma**, Department of Microbiology, School of Health, Valle University, Cali, Colombia
- **Susan Reynolds Whyte**, Department of Anthropology, University of Copenhagen, Denmark

- **Chitr Sitti-amorn**, School of Public Health, Chulalongkorn University, Thailand
- **Marcel Tanner**, Director: Swiss Tropical Institute, Basel, Switzerland.
- **Lea Velho**, InTECH University and University of Campinas, Brazil

International Development Organisations

- **Harriet Burungi**, Population Council, Africa
- **Barbro Carlsson**, Head of Division, Human Sciences for Social Development, SAREC, Sweden
- **Julius Court**, ODI, IDRC, TEHIP Project, Canada
- **Andres de Francisco**, Deputy Executive Director, Global Forum for Health Research, Geneva, Switzerland
- **Sylvia de Haan**, Deputy Director, COHRED, Geneva, Switzerland
- **Rebecca de Los Rios**, PAHO, Washington, USA
- **Fatumata Diallo**, WHO Country Representative designate, Angola
- **Carel IJsselmuiden**, Director: COHRED, Geneva, Switzerland
- **Bente Ilsøe**, Department for Policy, Ministry of Foreign Affairs, DANIDA, Denmark
- **Jens Kastberg**, WHO/TDR, Geneva, Switzerland
- **Mary Ann Lansang**, Executive Director, INCLEN Trust, Philippines.
- **Stephen A. Matlin**, Executive Director, Global Forum for Health Research, Geneva, Switzerland
- **Daniel Mäusezahl**, Senior Health Advisor, Social Development, SDC, Switzerland
- **Cheikh Mbacke**, Deputy Director: Rockefeller Foundation, USA
- **David Okello**, WHO Country Representative, Swaziland
- **Peter O'Neil**, DFID, UK
- **Ok Pannenborg**, Senior Health Advisor, World Bank, Washington, USA
- **Tikki Pang**, Director Research Policy and Cooperation, WHO, Geneva, Switzerland
- **Michelle Pletschette**, European Commission, Brussels
- **Reijo Salmela**, Responsible Officer for Health Research, WPRO, Manila, Philippines
- **Than Sein**, Responsible Officer for Health Research, SEARO, New Delhi, India
- **Christina Zarowsky**, Senior Scientific Advisor, IDRC, Canada

Others

- **Tasleem Akthar**, former director, Medical Research Council, Pakistan
- **Martine Berger**, International Consultant, Geneva, Switzerland
- **Lennart Freij**, International Consultant, Sweden
- **Adnan Hyder**, International Consultant, USA.
- **Mathias Kerker**, former SDC, Switzerland
- **Oyestein Evjen Olsen**, Senior Advisor, Research & Capacity Development, DBL, Tanzania
- **Raphael Owor**, Chairman of the African Health Research Forum, Uganda
- **Britt Tersbol**, Research Coordinator, Danish Network for International Health Research, Denmark

Others who were consulted, but not interviewed in-depth:

- **Jens Aagaard Hansen**, Danish Bilharziasis Laboratory (DBL), Denmark
- **Martin Allilio**, Fogarty International Center, NIH, USA, and Tanzania
- **Erik Blas**, Deputy Director, TDR, Switzerland
- **Anders Bjorkman**, consultant, Sweden
- **Gunnar Bjune**, Consultant, Norway
- **Louis J. Currat**, former Ex. Secretary, Global Forum for Health, Switzerland
- **Phyllis Freeman**, Co-editor, Journal of Public Health Policy, USA
- **Gerald T. Keusch**, Dean for Global Health, Medical Campus, Boston University, USA
- **Turid Kongsvik**, NORAD, Norway
- **Rolf Korte**, Senior Health Policy Advisor, GTZ, Germany
- **Maksut Kulzhanov**, Dean, Kazakhstan School of Public Health, Kazakhstan and COHRED Board member
- **Jean Lariviere**, CIDA, Canada
- **Jacques Laruelle**, Programme Officer, Multilatral Cooperation Office, MOFA, Belgium
- **Martha Medina**, International Consultant, Denmark and Nicaragua
- **Mark A Miller**, Director, DIEPS, NIH, USA
- **Berit Olsson**, Director, Research Cooperation, SIDA, Sweden
- **Aagje Papinau Salm**, DGIS, Ministry of Foreign Affairs, the Netherlands
- **Nancy Saravia**, Colombia University, New York, USA
- **Finn Schleimann**, MOFA, DANIDA, Denmark
- **Stewart Tyson**, DFID, UK and Members of the Board of COHRED

ANNEX C

The Interview Tools

The evaluation will provide one global, three regional and four in-dept country studies. The regional assessments will cover 1) Asia Pacific and Central Asia, 2) Africa, and 3) the Americas. The in-dept country studies will cover Laos, Indonesia, Uganda and Ghana. The assessments will focus on; 1) what COHRED has done, 2) what COHRED could have done and 3) what COHRED should be doing in the future to enhance essential health research for equity.

Tool for the literature review:

Based on the two countries selected for in-dept studies in the Asian and African Region (respective Laos & Indonesia, and Uganda & Ghana)

1. Make an inventory of progress (strengths), constrains (weaknesses) opportunities and treats in building up a national health research system, and the use of research been for health and equity for development.
2. Try to clarify COHRED's direct and indirect contributions and impact; perhaps ask the question: 'what could have been done if …..'
3. Identify and describe possible pointers to what difference COHRED has made, (or could have made if …. (see above).
4. Identify the added value of COHRED

Tool for the Phone interviews:

1. Position of the respondent:
2. Name of the organisation for which s/he works:
3. Current association with COHRED:
4. How familiar are you with COHRED? /Have you heard of COHRED? Do you know what it does?
5. What is Health Research?
6. What is Essential National Health Research?
7. What is the status of health research in your country?
8. Do you have a health research system? If yes, please describe! How does the system contribute towards equity in development? How is research translated into action?
9. How does COHRED do capacity development at country level?
10. How did COHRED ensure ownership and contribute to the ENHR in your country; in terms of advocacy, technical support and financial assistance?
11. What is the impact of COHRED in your country? What are the strengths and what are the weaknesses?
12. What role can COHRED play in the future to assist you to achieve equity in health and development through research?
13. Has COHRED's advocacy and communication strategies been engaging and empowering the widest range of society? If yes, how?

Efficiency

14. Is COHRED efficient? Justify your answer!
15. Does COHRED have adequate resources to achieve its objectives? Does COHRED use its resources efficiently?

Effectiveness

16. Is COHRED effective? Justify your answer!
17. What has been the contribution of COHRED's direct country support in enhancing effective health research at country level?
18. What has been the contribution of COHRED's communication in disseminating knowledge on health research management issues? Has this addressed the needs of the developing countries?
19. How effective has COHRED's collaboration been with key partners at global, regional and national level? What are the opportunities for broadening partnerships?

Relevance

20. Is COHRED still relevant? Justify your answer!
21. What has been the contribution of COHRED's analytical work to expanding the knowledge on health research management issues? To which extend has this analytical work been relevant to the needs of the developing countries? And to which extend has it been relevant to the need of the partners supporting developing countries in their attempts to strengthen ENHR?
22. Are there any health research areas at country level to which COHRED could pay more attention? Are there areas of work to which that should receive less emphasis?
23. Has COHRED adequately prioritised its programme of work in response to country needs?
24. Does COHRED's governance reflect the voices from the South and ensure good and fair practices, as well as equity?
25. Has COHRED mechanisms to identify and respond to changes in the global terrain of health research, and if so, has it provided adequate responses? If not, what structural changes could be made?
26. In relation to other local and international organisations that focus on strengthening of health research for development: What are the Strengths, weaknesses, opportunities and treats of COHRED? What are the comparative advantages of COHRED?
27. Has COHRED responded adequately to the changes in the international environment, and especially to the challenges discussed during the IC2000? How could COHRED improve its performance?
28. What are the key short-, medium- and long-term changes that COHRED should effect in its vision and operations that make the biggest difference in achieving equity, health and development through health research?
29. What are the relationship and potential synergies between COHRED and other international organisations especially, the Global Forum for Health Research, the Alliance, and WHO?

Other Questions

1. What is the process for initiating and developing partnership with COHRED
2. When does COHRED enter and when does it withdraw its support to a country?
3. Should COHRED promote ENHR in all countries or does COHRED have a mandate to support developing countries in particular? If yes how does it do that the most effective and efficient way?
4. Should COHRED ensure a greater geographical balance between countries implementing ENHR? If yes – then how can COHRED do that?
5. What concrete steps have COHRED taken to strengthen national, regional and global networking and partnerships?
6. How has COHRED contributed in enduring equity within health research systems, as well as activities that promote research in equity for health?
7. Is the objectives of COHRED realistic compared to the currently available resources?
8. To what degree have country-level partners been involved in design, governance, implementation, monitoring and evaluation of COHRED?

Analysis of COHRED from a global perspective

1. Analyse COHRED's vision, mission and mandate at the inception. Have these changed with time and what influenced the changes (e.g., epidemiological, global development trends)? How have the changes affected COHRED organisationally, strategically and financially?
2. How has COHRED's strategic direction evolved since 1996, with specific emphasis on a) country level (priority setting, conduct of research, capacity building, community participation, financing), b) analytically (areas, taskforces, working groups) and c) within advocacy and communication (mobilisation of financial and human resources)
3. What are the challenges facing COHRED
4. Organisational and management structures within COHRED (incl. annual plans and budgets)

    Monitoring and evaluation (incl. indicators for measuring the efficiency, effectiveness and relevance of ENHR)

ANNEX D

Literature list

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5. The International Conference on Health Research for Development, 1993.
6. COHRED Document 96.1. The Next Step: An Interim Assessment of ENHR and COHRED.
7. Annual Report 1997, COHRED
8. COHRED Document 97.3. Essential National Health Research and Priority Setting: Lessons Learned.
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20. COHRED Document 2000.7. The Council on Health Research for Development. Report of activities 1998-2000
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4. **Concept papers meeting for ENHR in Kenya**, *Executive Summary, Nairobi safari club 23-24 April 1997*
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7. **Proceedings of the first ENHR Congress on Priority Setting,** *Edelweiss Functions Centre, November 14-15 1996, Pretoria, South Africa,* Directorate Research Coordination and Management, Department of Health, Pretoria
8. **Directory of Health Research Groups in Jamaica,** ENHR Task Force, Jamaica, 1996
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15. **Report of the Fourth African Essential National Health Research Network Meeting**, *5-7 October, Arusha, Tanzania*, African ENHR Network and COHRED, 1997
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22. **Sachetana,** *Journal of Essential National Health Research Nepal,* Prof Mathura P Shrestha (editor) Nepal Health Research Council, Kathmandu, 1998
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ANNEX E Budget – see Excel sheet
ANNEX F Country Activities – see Excel sheet

ANNEX G

SWOT ANALYSIS

Strengths	Global knowledge base on ENHR systems at country level; Useful tools and methodologies for ENHR; Broad interaction beyond the traditional governmental Health Sector, e.g., other ministries, NGOs, private sector and civil society; Inclusive approach towards Health Systems; Equity, poverty and human rights focus; Networking South-North and South-South; Intraregional co-operation and mentoring; Network of committed and interested persons; COHRED is the voice of the South; Centralised administration and management; Gender sensitive approach;
Weaknesses	Lack of sufficient funds and human resources; Centralized administration and management; Mainly using consultants from developed countries; Spreading limited resources too thin; Networks of people with limited ad hoc institutional attachments; Sporadic irregular country links; Long period with poor leadership; Low visibility; Limited advocacy and distribution of available printed materials; Lack of clear strategies and plans; Passive Board; Preponderance of medical doctors in ENHR environment;
Opportunities	Perceived need for COHRED-like organization in the global and local health research scenario; A small but sustainable core of ENHR advocates and donors; The ready availability of efficient and tested tools and methodologies in the COHRED armamentarium; Existing networks with many mainly South partners; Strong country focus with links to local people in key-positions; Private sector seeking to make visible contributions in enhancing their social responsibilities; The continuous emergence of new players and initiatives in global funding of health-related activities; Untapped funds for health research and evaluations locked into development funds; The need to strengthen the management and administration of aid funds at country level to balance the distortion due to influx of massive vertical funding; The need to strengthen the coordination of monitoring, evaluation and research at country level; The increasing use of Sector Wide Approach and PRSPs; Enunciation and global acceptance of the MDGs; Multiple countries and partners have been sensitized to the benefits of ENHR; Development partners see the need for operational research to enhance the efficiency of development aid; The potential for the Board to be more proactive; Recognition of the value and contribution of social science to enhance

health and development;

Threats	COHRED's budget is diminishing; Competition from similar organizations and initiatives; Poor coordination of existing efforts to strengthen Health Research; The inappropriate application at country level of funding initiatives for vertical programmes, MDGs and PRSPs; Internal and external "Brain drain"; Insufficient interest, support and investment in development of tertiary education, Science and Technology; Donor fatigue; Civil unrest and war;

58.

ANNEX I

Summary of the 1996 Interim Assessment of COHRED

In 1996 an external evaluation team conducted a four months interim assessment of COHRED based on literature reviews, interviews and site visits to seven countries (Caribbean, Kenya, Mozambique, Nepal, Nicaragua, South Africa and the Philippines). The primary intent of the interim assessment was to facilitate the future planning. The core objectives were; 1) to access the implementation effectiveness of the ENHR strategy, 2) to assess COHRED's effectiveness in promoting EHNR at country, regional and global levels and to elicit the views of a wide range of stakeholders at country regional and global levels.

The key findings and recommendations of the interim assessment were;

1. ENHR remained a strong and timely idea and that several countries had made a good start on creating a sustainable ENHR system, but; there is a need to demonstrate that the basic goal underlying implementation of the ENHR approach has been achieved.
2. Some efforts have been made to identify a small numbers of indicators which could clearly demonstrate the added value of the ENHR approach, but; there is a need to move beyond activity indicators to include qualitative and quantitative indicators of success.
3. COHRED was found to be an important and distinctive vehicle for facilitating health research within developing countries and for bringing the voice of "the South" to the international discussion table.
4. Organisationally the Council appeared inactive and the Board could be more dynamically engaged in problem solving. The Secretariat was, however, well regarded, particularly for its recent emphasis on dissemination of well-prepared materials, but it could strengthen its analytical capacity.

The evaluation team proposed;

1. A special initiative preparing strategies and materials ("toolkits") and training country ENHR groups.
2. The creation of regional "ENHR mentoring teams" to assist countries with coalition building, especially in the early stages when political mapping is most important. The mentoring teams should where possible include researchers, policy makers and community groups, and at times donors, NGOs or the private sector could be added.
3. COHRED's relation ship with WHO and the World Bank should be strengthened.
4. A task force initiated by COHRED and including WHO and the World Bank, should explore how to link national and global initiatives
5. The scope of research training should be broadened beyond researchers to policy makers, community members and NGOs. COHRED should identify countries, which already have embarked on "broader" research training, to strengthen and disseminate the experiences.
6. In many countries the potentially available research capacity is not contributing to the ENHR.COHRED should initiate one or more country studies to describe, analyse, provide and implement solutions to this problem of "internal brain drain".
7. COHRED should facilitate special initiatives to introduce the ENHR concept into the curricula of the basic training of health professionals, incl. the opportunities for students to participate in ENHR.
8. COHRED's board should become more problem oriented and efficient. Small task force groups should be formed to deal with specific issues and the board's size should be reduced or an executive committee be formed. The Secretariat should be strengthened to increase its analytic capacity within ENHR.

Over all the international community was found to be increasingly aware of the ENHR and COHRED could therefore move from general advocacy and promotion to in-dept analysis of the ENHR. The regional networks could play an important role in promotion, monitoring and assisting countries new to with ENHR

The evaluation team emphasized the need to capture and share country experiences with ENHR. These competencies included the original seven element of ENHR plus two new ones; "community participation" and research into policy

and action”. The evaluation team also suggested that the “definition, elaboration and use of this technology represents COHRED’s niche, its value added contribution to the global health and development endeavour”.

Finally the evaluation team recommended a comprehensive approach to capacity development for ENHR with attention to the roles of the multiple stakeholders.