SYNTHESIS REPORT

Five partner countries and eight donor countries

Burkina Faso
Cameroon
Mozambique
Uganda
Zambia

Canada
Denmark
Ireland
the Netherlands
Norway
Sweden
Switzerland
United Kingdom

Alignment and Harmonization in Health Research

AHA Study

Council on Health Research for Development (COHRED)

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This report was prepared by COHRED as a part of its Alignment and Harmonization Study (AHA), under the **Health Research Web** Programme.

The AHA study involves five African countries (Burkina Faso, Cameroon, Mozambique, Uganda and Zambia) and eight donor countries (Canada, Denmark, Ireland, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom).

The study aims to:

1) Provide information on National Health Research Systems (NHRS) of the five African countries; outline strategies for health research funding of the eight donor countries; and discuss alignment and harmonization in relation to health research support.
2) Facilitate debate between partners on improving health research support towards national priorities.

The information collected is also published on the **AHA webpage** (http://www.cohred.org/AHA/) and **Health Research Web** (www.cohred.org/healthresearchweb).

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List of abbreviations

ABSP:	Association Burkinabaise de Santé Publique (Burkinabé Public Health Association), Burkina Faso
ADB:	African Development Bank
AHA study:	Alignment and Harmonization study
AHSPR:	Annual Health Sector Performance Report
ANRS:	Agence Nationale de Recherche sur le SIDA (National Agency for Research on AIDS), France
ANVAR:	Agence Nationale pour la Valorisation des Résultats de la Recherche (National Agency for Research Utilization), Burkina Faso
AU:	African Union
CAMES:	Conseil Africain et Malgache pour l'Enseignement Supèrieur, (African and Malagasy Council for Higher Education), Burkina Faso
CCGHR:	Canadian Coalition for Global Health Research
CCRS:	Conseil des Centres de Recherche en Santé (Council of Health Research Centres), Burkina Faso
CDC:	Centers for Diseases Control and Prevention, USA
CHESSORE:	Centre for Health Science and Social Research, Zambia
CIDA:	Canadian International Development Agency, Canada
CIFRA:	Centre International de Formation en Recherche-Action (International Centre for Training and Action Research), Burkina Faso
CIRCB:	Centre International de Recherche Chantal Biya sur le VIH / SIDA (International Research Center Chantal Biya on HIV / AIDS), Cameroon
CNLAT:	Centre National de Lutte Anti-Tuberculeux (National Centre for the fight against Tuberculosis), Burkina Faso
CNRFP:	Centre National de Recherche et de Formation sur le Paludisme (National Centre for Research and Training for Malaria), Burkina Faso
CNRST:	Centre National de Recherche Scientifique et Technique (National Centre for Scientific and Technological Research), Burkina Faso
COHRED:	Council on Health Research for Development, Switzerland
CSLP:	Cadre Stratégique de Lutte contre la Pauvreté (National Strategic Framework for the fight against Poverty), Burkina Faso
CSO:	Civil Society Organization
CSSM:	Civil Society Support Mechanism, Mozambique
DAC:	Development Assistance Committee
Danida:	Danish International Development Agency, Denmark
DDHS:	Director District Health Services, Uganda
DEP:	Direction des Etudes et de la Planification (Department for Studies and Planning), Burkina Faso
DFID:	Department for International Development, United Kingdom
DGIS:	Directorate General for International Cooperation, Ministry of Foreign Affairs, the Netherlands
DROS:	Division de la Recherche Opérationnelle en Santé (Division for Health Operations Research), Cameroon
DSF:	Direction de la Santé de la Famille (Department of Family Health), Burkina Faso
EAC:	East African Community
EDCTP:	European and Developing Countries Clinical Trials Partnership, the Netherlands
ENHR:	Essential National Health Research
EQUINET:	Regional Network on Equity in Health in Southern Africa, Zimbabwe

EU:	European Union
EVIPNet:	Evidence-Informed Policy Network, WHO
FARES:	Fonds d'Appui à la Recherche en Santé (Fund for Health Research Support), Burkina Faso
FESADE:	Femmes, Santé et Développement (Women, Health and Development), Cameroon
FPAE:	Fondation Paul Ango Ela pour la Géopolitique en Afrique Centrale (Foundation Paul Ango Ela for Geopolitics, Central Africa)
FRSIT:	Forum sur la Recherche Scientifique et les Innovations Technologiques (Forum for Scientific Research and Technological Innovations), Burkina Faso
GAVI:	Global Alliance for Vaccines and Immunization
GEGA:	Global Equity Gauge Alliance
GLOBVAC:	Global Health and Vaccination Research, Norway
GTZ:	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation), Germany
HDPs:	Health Development Partners, Uganda
HIPC:	Heavily Indebted Poor Countries Initiative
HIV /AIDS:	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HPAC:	Health Policy Advisory Committee, Uganda
HR-HR:	Human Resources for Health Research
HSSP:	Health Sector Strategic Plan, Uganda
IAVI:	International AIDS Vaccine Initiative
IDRC:	International Development Research Centre, Canada
IMF:	International Monetary Fund
IMPM:	Institut National de Recherche Médicale et d'Etude des Plantes Médicinales (Institute of Medical Research and Studies on Medicinal Plants), Cameroon
INASP:	International Network for the Availability of Scientific Publications, United Kingdom
INDEPTH:	International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries
INE:	Instituto Nacional de Estatística (National Institute of Statistics), Mozambique
INERA:	Institut National d'Etude et de Recherche Agricole (National Institute for Agricultural Research), Burkina Faso
INESOR:	Institute of Economic and Social Research, Zambia
INS:	Instituto Nacional de Saúde (National Institute of Health), Mozambique
INSS:	Institut National des Sciences de la Société (National Institute for Society Sciences), Burkina Faso
ITNs:	Insecticide treated bednets
IRD:	Institut de Recherche pour le Développement (Research Institute for Development), France
IRESCO:	Institut pour la Recherche, le Développement Socio-Economique et la Communication (Institute for Research, Socio-Economic Development and Communication), Cameroon
IRSAT:	Institut de Recherches en Sciences Appliquées et Technologies (Institute for Applied Research and Technologies), Burkina Faso
IRSS:	Institut de Recherche en Sciences de la Santé (Institute for Health Sciences), Burkina Faso
ISSP:	Institut Supérieur des Sciences de la Population (Higher Institute for Population Sciences), Burkina Faso
JASZ:	Joint Country Assistance Strategy for Zambia
JRM:	Joint Review Mission, Uganda
JSSB:	Journées des Sciences de la Santé de Bobo-Dioulasso (Health Sciences days of Bobo-Dioulasso), Burkina Faso
MACHA:	Malaria Research Institute, Zambia

MCT:	Ministry of Science and Technology, Mozambique
MDGs:	Millennium Development Goals
MESSRS:	Ministère des Enseignements Secondaire, Supérieur et de la Recherche Scientifique (Ministry of Secondary and Higher Education and Scientific Research), Burkina Faso
MFPED:	Ministry of Finance, Planning and Economic Development, Uganda
MINEFI:	Ministère de l'Economie et des Finances (Ministry of Economie and Finances), Cameroon
MINESUP:	Ministère de l'Enseignement Supérieur (Ministry of Higher Education), Cameroon
MINRESI:	Ministère pour la Recherche Scientifique et l'Innovation (Ministry for Scientific Research and Innovation), Cameroon
MINSANTE:	Ministère de la Santé Publique (Ministry of Public Health), Cameroon
MISAU:	Ministerio da Saúde (Ministry of Health), Mozambique
MMV:	Medicines for Malaria Venture. Switzerland
MoA:	Memorandum of Agreement
MoES:	Ministry of Education and Sports, Uganda
MoH:	Ministry of Health
MoU:	Memorandum of Understanding
MRC:	Medical Research Council, United Kingdom
MS:	Ministère de la Santé (Ministry of Health), Burkina Faso
MSTVT:	Ministry of Science, Technology and Vocational Training, Zambia
MTEF:	Medium Term Expenditure Framework
NAC:	National AIDS Council, Mozambique
NACCAP:	The Netherlands-African partnership for capacity development and clinical interventions against poverty-related diseases
NARO:	National Agricultural Research Organization, Uganda
NCSR:	National Council for Scientific Research, Zambia
NCST:	National Council of Science and Technology, Zambia
NDA:	National Drug Authority, Uganda
NEPAD:	New Partnership for Africa's Development
NGO:	Non Governmental Organization
NHA:	National Health Assembly, Uganda
NHRAC:	National Health Research Advisory Committee, Zambia
NHRS:	National Health Research System
NHSP:	National Health Strategic Plan, Zambia
NIH:	National Institutes of Health, United States of America
Norad:	Norwegian Agency for Development Cooperation, Norway
NUFU:	Norwegian Programme for Development, Research and Education, Norway
OCEAC:	Organisation de Coordination pour la Lutte contre les Endemies en Afrique Centrale (Organization for the Coordination of the fight against Endemics in Central Africa), Cameroon
OECD:	Organization for Economic Cooperation and Development
PADS:	Programme d'Appui au Développement Sanitaire (Programme for Health Development), Burkina Faso
PARPA:	Plano de Acção para a Redução da Probeza Absoluta (Plan for the Reduction of Absolute Poverty), Mozambique
PC:	Population Council, USA
PESS:	Strategic Plan for the Health Sector, Mozambique
PMCTC:	Prevention of Mother to Child Transmission of HIV/AIDS
PNDS:	Plan National de Développement Sanitaire (National Plan for Health Sector Development), Burkina Faso
PROSAUDE:	National Research Fund, Mozambique
PRSP:	Poverty Reduction Strategy Paper

PSN:	Politique Sanitaire Nationale (National Health Policy), Burkina Faso
PSRS:	Plan Stratégique de Recherche Scientifique (Strategic Plan for Scientific Research), Burkina Faso
REACH:	Regional East African Community Research
REACT:	Strengthening fairness and accountability in priority setting for improving equity and access to quality health care at district level in Tanzania, Kenya and Zambia
REDS:	Network for Ethics, Rights and HIV/AIDS, Cameroon
SAG:	Sector Advisory Group, Zambia
SDC:	Swiss Agency for Development and Cooperation, Switzerland
SERSAP:	Société d'Etude et de la Recherche en Santé Publique (Society for Studies and Public Health Research), Burkina Faso
Sida/SAREC:	Swedish International Development Agency / Department for Research Cooperation, Sweden
SOMANET:	Social Science and Africa Medicine Network, Kenya
STDs:	Sexually Transmitted Diseases
STELA:	Secrétariat Technique pour l'Efficacité de l'Aide (Technical Secretariat for Aid Effectiveness), Burkina Faso
SWAp:	Sector Wide Approach
SWG:	Sector Working Group, Uganda
TB:	Tuberculosis
TDRC:	Tropical Diseases Research Centre, Zambia
TORCH:	Tororo Community Health, Uganda
TWG:	Technical Working Group, Uganda
UCRI:	Uganda Cancer Research Institute, Uganda
UCSF:	University of California, San Francisco, United States of America
UEM:	Universidade Eduardo Mondlane (Eduardo Mondlane University), Mozambique
UFR / SDS:	Unité de Formation / Recherche en Sciences de la Santé (Training Unit / Research in Health Sciences), Burkina Faso
UFR / SEG:	Unité de Formation / Sciences Economiques et de Gestion (Training Unit / Economy and Management Sciencies, Burkina Faso
UFR / SVT:	Unité de Formation / Recherche en Sciences de la Vie et de la Terre (Training Unit / Life and Earth Sciences), Burkina Faso
UNAIDS:	Joint United Nations Programme on HIV / AIDS, Switzerland
UNCRL:	Uganda Natural Chemotherapeutics Research Laboratories, Uganda
UNCST:	Uganda National Council for Science and Technology, Uganda
UNDP:	United Nations Development Programme
UNESCO:	United Nations Educational, Scientific and Cultural Organization
UNHRO:	Uganda National Health Research Organization, Uganda
UNFPA:	United Nations Population Fund, USA
UNICEF:	The United Nations Children's Fund
USAID:	United States Agency for International Development
UTRO:	Uganda Trypanasomiasis Research Organization, Uganda
UVRI:	Uganda Virus Research Institute, Uganda
WB:	World Bank
WHIP:	Wider Harmonization in Practice, Zambia
WHO:	World Health Organization
WHO/TDR:	UNICEF-UNDP-World Bank-WHO Special Programme for Research and Training in Tropical Diseases, Switzerland
WHO/HRP:	UNDP-UNFPA-WHO-World Bank Special Programme of Research, Development, and Research Training in Human Reproduction, Switzerland
ZAMPHOR:	The Zambian Forum for Health Research

Executive summary

Alignment and harmonization of donor support to low and middle income countries are essential to improving the effectiveness of development aid and may be useful in improving impact of health research support. Alignment refers to the donor commitment to base development assistance on partner countries' strategies, institutions and processes. Harmonization is the commitment by donors to rationalize their multiple activities in ways that maximize the collective efficacy of aid under country ownership. The Alignment and Harmonization Study (AHA Study) studied the practices and potentials of alignment and harmonization in health research, using the principles of the Paris Declaration on Aid Effectiveness[1]. The study involved five African countries (Burkina Faso, Cameroon, Mozambique, Uganda and Zambia) and eight donor countries (Canada, Denmark, Ireland, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom), and was conducted between May 2007 and June 2008. Health research system mapping, document reviews, web searchers and key informant interviews were used to collect data.

National Health Research Systems in the five African countries

All five countries have externally supported health research that is conducted in parallel or in consonance with national health research organizations, with great differences between countries in the amount of research done. The governance of health research in all countries is weak or absent, and key elements such as health research priorities or a health research directorate are sometimes missing. Most countries are aware of this and are in the process of developing policies, setting priorities and so on.

When governance and management of health research is existing, it is often fragmented between two or three different ministries. The Ministry of Health is involved in health research in all five countries. Other ministries involved in the governance and management vary by country and include the Ministry of Science and Technology (Cameroon, Mozambique, and Zambia), the Ministry of Higher Education (Burkina Faso and Cameroon) and the Ministry of Finance (Uganda). In addition, a variety of coordinating bodies are involved in health research management often with overlapping responsibilities. The responsibilities of the various ministries and other bodies in research governance are often not clear and are acknowledged to lead to inefficiencies in national health research governance. Enhancing health research coordination between the different ministries and their coordinating bodies remains a major challenge in all five countries.

Although none of the countries has currently specific legislation and/or a national strategic plan for health research, Burkina Faso, Cameroon and Zambia are developing such plans. Uganda has also drafted a Health Research Policy and a National Health Research Strategic Plan which are to be finalized. Most interviewees referred to other documents that can guide health research, such as poverty reduction strategies (Cameroon), strategic plans in relation to scientific research (Burkina Faso, Cameroon and Zambia) and/or general health plans (all countries).

1 The Paris Declaration on Aid Effectiveness, OCED, 2005, http://www.oecd.org/dataoecd/11/41/34428351.pdf

Three countries have defined national health research priorities (Burkina Faso, Uganda and Zambia). In Uganda these have not yet been formally approved and acted upon by the Ministry of Health. Cameroon has defined priorities within each national priority programme and is in the process of defining a national research agenda. Burkina Faso is in the process of updating its priorities. Mozambique's Ministry of Science and Technology has defined national priorities for HIV / AIDS research through a consultative process with the Ministry of Health, research institutions and NGOs.

Precise data on health research financing was difficult to obtain in all countries. As a general trend, government funding for health research is often very limited and inadequate, with high dependence on external funding. None of the five African countries have a budget for health research that represents 2% of national expenditures as recommended by the Commission on Health Research for Development in 1990[2]. The percentage of external funding for health research is estimated to vary between 67% and 90% but may be higher. In four countries, health research is also supported through Sector Wide Approaches (SWAps) for health (Burkina Faso, Mozambique, Uganda and Zambia).

Only Mozambique has a strategic plan for the development of human resources in research. Zambia adopted an action plan after the Human Resource for Health Research Conference organized by the NHRAC in June 2007. In Burkina Faso, equal opportunities for researchers is a major issue as researchers operating under the auspices of the Ministry of Secondary and Higher Education and Scientific Research do not benefit from the same career opportunities as those attached to the Ministry of Health.

Despite initiatives to disseminate health research findings, major improvements are needed to increase impact of research on policy making. Examples of studies that have successfully influenced policies are rare. Even when research findings are disseminated, follow up to evaluate their translation into action does not occur. Interviewees frequently highlighted the need to improve the dissemination of research findings and to design a monitoring system to evaluate the impact of research on policies.

Donor Alignment and Harmonization in the five African countries

The five African countries and the eight donor countries are all signatories to the Paris Declaration on Aid Effectiveness. Burkina Faso, Mozambique, Zambia and Uganda have some systems in place to facilitate alignment and harmonization of aid. Each donor country has developed specific Action Plans and Programmes for harmonization and alignment. Despite this, many of the African interviewees were unfamiliar with the content of the Paris Declaration and its principles.

All but Canada fund some health research through SWAps in health. This facilitates coordination and harmonization between donors at country level. Availability of specific data on research support as part of development aid is limited both at headquarter and country levels.

Interviewees from the African countries stated that donors do not align with the research priorities at country level and that financing channels favor Northern institutions as primary recipients. A number of factors contribute to this situation. Research institutions and NGOs often apply to open calls, which usually express donors' priorities. Most country interviewees emphasized that harmonization between donors on application requirements and reporting formats would facilitate entry of Southern institutions into the competitive process. At the same time, the lack of a clear strategic plan and/or a national agenda for health research in most countries does not create an enabling environment for alignment.

2 Commission on Health Research for Development, Health Research – Essential link to equity in Development , Oxford University Press, 1990

Some interviewees in countries who were well informed about the Paris Declaration expressed concerns regarding its application. Harmonization between research donors could reduce the autonomy of countries to establish and pursue a national research agenda even further. Also, some interviewees cautioned that "ownership" should not be interpreted by donors as way of leaving countries and pull out their support.

The donors also expressed concerns about alignment and harmonization, specifically questioning whether alignment and harmonization would result in agencies having less flexibility in identifying research support priorities and programmes and thus loose their own identities or not being able to follow their institutional mandates. In as far as 'harmonization' focuses on reducing administrative and other transaction costs to countries, there is more willingness to agree to implement the Paris Declaration. Interviewees agree that donors should first harmonize at institutional level, before addressing the challenge of harmonizing at the country level.

Research sponsors other than bilateral and multilateral development agencies that participated in one AHA meeting (the Wellcome Trust and the Fogarty International Center of the NIH expressed the same concerns. They consider themselves primarily supporters of health research with the focus on knowledge generation and not part of the 'development aid' domain. Their funding mechanisms and priorities are not set at national level seeking to solve national health research problems per se. Nevertheless, they expressed the wish to explore closer links with bilateral development agencies to seek complementarity in support of national health research system development, especially around institutional capacity strengthening and the need for joint learning on how best to develop institutional capacity. It is important to expand a discussion on alignment and harmonization to other funders (such as private foundations and other private sector funders) as these contribute most research funding available to sub-Saharan Africa.

Partner and donor countries questioned the level at which harmonization should happen. It is not clear whether 'harmonization' at global level (i.e. in terms of funding provided to the 'Global Health Partnerships / Initiative) supports national health research system development, contributes to alignment at the national level, and, in general, is in line with the intentions of the Paris Declaration on Aid Effectiveness. Even though several interviewees among donor countries would prefer to fund health research through a common fund such as a SWAp for health, some would request to have a specific budget line for research within the SWAp to ensure that the funding for research does not disappear within the overall support for the health sector as well as to ensure that other disciplines necessary to address health issues, e.g. social and basic sciences are receiving attention.

Both African countries and donor countries can undertake some key actions to facilitate and support alignment and harmonization:

- African countries should strengthen their national health research systems by:
  - Improving coordination between the different governance and management structures at the country level to increase the efficiency and effectiveness of health research management and governance.
  - Defining clear health research strategies, policies and priorities that are credibly set and regularly updated to help guide health research at the country level and facilitate donor alignment. Agenda setting will be facilitated by good reporting systems on ongoing health research projects and programmes in the country.
  - Defining strategic plans specifically for long term human resources for health research development and for a stable research financing environment that will increase the quality and extent of research in countries and expand career opportunities for researchers.
  - Stimulating the establishment of units for harmonization at research institutions.

- Donor countries can:
  - Support the strengthening of national health research systems, for example by encouraging the development national research priorities and strategies if these are not yet in place.
  - Develop a good recording system for all research funded by the donor country.
  - Delegate higher level of responsibility to their local offices, facilitating a more flexible and rapid interaction with the Government, and other donors in the country.
  - Develop, jointly with partner countries, an agenda for harmonization and a framework for dialogue.

1. Introduction

Low and middle income countries face a serious under-investment in health research relevant to their needs. Factors contributing to this problem include inadequate funding for health research – both in and by these countries – limited participation of developing country scientists in international research and in the global research policy arena, and a general lack of funding for health research priorities at local or country level. The situation in health research is, in this respect, not much different from the overall health sector and, indeed, general development support.

As a multilateral initiative to improve aid effectiveness, more than 100 wealthy and developing countries and organizations signed the Paris Declaration on Aid Effectiveness in 2005, building on the Rome Declaration on Harmonization of 2003. Signatories to the 'Paris Declaration' committed to adhere to and increase harmonization, alignment and aid management efforts through a set of monitorable actions.

The partnership commitments are organized around five key principles:

- *Ownership*: Partner countries exercise effective leadership over their development policies and strategies, and co-ordinate development actions.
- *Alignment*: Donors base their support on partner countries' national development strategies, institutions and procedures.
- *Harmonization*: Donors actions are more harmonized, transparent and collectively effective.
- *Managing for results*: Donors and partner countries manage resources and improve decision-making for results.
- *Mutual accountability*: Donors and partners are accountable for development results.

The Paris Declaration is aimed at improving the impact of development aid in general and was not specifically designed for health research support. It is within this context, that a group of donors met with COHRED in Cairo in November 2006. The discussion focused on understanding the potentials, limitations and implementation of the Paris Declaration principles in the domain of health research support and resulted in this Alignment and Harmonization ('AHA') study, for which financial support was provided by Sida/SAREC.

The purpose of the AHA study is to understand how the Paris Declaration can be fruitfully employed in the field of health research support , including institutional or project-based research collaboration, as well as other support that is not normally seen as part of 'development aid'.

The AHA includes five African countries: Burkina Faso, Cameroon, Mozambique, Uganda and Zambia, and development cooperation agencies and eight donor countries: Canada, Denmark, Ireland, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom.

This report presents the final results of the AHA study, which are presented in three main chapters: Chapter 3 provides an overview of the national health research systems in the five African countries included in the AHA study, their policies, institutions and regional collaborations. Chapter 4 provides an overview of the health research support strategies adopted by the eight donor countries including their policies, objectives, and budgets for health research support when available. And chapter 5 provides an overview of donor countries' and partner countries' compliance with the Paris Declaration on Aid Effectiveness in relation to health research support in the five African countries.

2. Methods

Study objective and methods

The primary objective of the AHA study was to examine national health research systems and priorities in the five African countries, as well as the policies and activities of eight donor countries as they relate to the funding and the alignment and harmonization of health research.

The methodology for data collection consisted of:

1 Telephone and personal interviews of key informants among the eight donors and among the following constituencies in the five countries:
   - Government
   - research institutions
   - NGOs
   - donor representatives in the countries.

   Representatives from different constituencies were interviewed to provide an objective overview of the NHRS and donors' alignment and harmonization in the countries. In addition, interviews were designed to collect data that would better integrate the diverse perspectives of the different sectors charged with coordinating, undertaking and funding health research at the country level.
2 Desk review of key documents obtained from donors and stakeholders in countries, and general literature on alignment and harmonization of donor aid.
3 Internet searches of relevant donor agency, government department and institutional research sites, and of websites dealing with alignment and harmonization in other contexts.

Data collection

In Burkina Faso nineteen persons were interviewed between July 19 to July 27, 2007, including four representatives from the Government (Ministry of Health), nine representatives from research institutions, two representatives from NGOs, one representative from a donor country (the Netherlands), one representative from a project funded by a donor country (Canada), and two representatives from the World Health Organization. Interviews took place in Ouagadougou, in Bobo Dioulasso and in Nouna.

In Cameroon twenty seven persons were interviewed from September 1st to September 8, 2007, including two representatives from the Government (Ministry of Public Health), four representatives from national priority programmes attached to the Ministry of Public Health, nine representatives from research institutes, eight representatives from NGOs, two representatives from multilateral agencies, one representative from a technical cooperation agency and a representative from the Dutch Embassy. All interviews took place in Yaoundé.

In Mozambique twenty six persons were interviewed from September 13 to September 20, 2007, and from June 9 to June 15, 2008. Interviewees include ten representatives from the Government (Ministry of Health, Ministry of Science and Technology), four representatives from research institutions, five representatives from NGOs, and seven representatives from donor countries (the Netherlands and Ireland). All interviews took place in Maputo.

In Uganda eighteen persons were interviewed from August 1st to August 4, 2007, and from March 3 to March 7, 2008, including five representatives from the Government (Ministry of Health, the Ministry of Finance, Planning and Economic Development and the Uganda Council for Science and Technology), five representatives from research institutions, one representative from a network involved in health research, one representative from a NGO, five representatives from donor countries and one representative from a multilateral agency. The interviews took place in Nairobi, Kenya and in Kampala, Uganda. A feedback meeting for Uganda was requested by the Ministry of Health and is planned for July 2008.

In Zambia twelve persons were interviewed from August 5 to August 8, 2007, including three representatives from the Government (Ministry of Health, National Council of Science and Technology and the National Health Research Advisory Committee), two representatives from research institutions, four representatives from NGOs and three representatives from donor countries. The interviews took place in Nairobi, Kenya and in Lusaka, Zambia.

In addition to the interviews in the African countries, donor information was obtained through telephone interviews with donor representatives at headquarters in the eight donor countries.

See also Annex 1 for a complete list of stakeholders interviewed.

Data analysis and review

Two opportunities were built in to review data, identify gaps and inaccuracies, and to add information not obtained in the first assessments:

- The draft country reports were sent to all key informants in the countries for review. The comments received were reviewed and, where appropriate, included in the final country reports.
- The preliminary analysis and results were discussed during a meeting on "Alignment and Harmonization in Relation to Health Research – current situation, opportunities and challenges" on 31st October 2007, in Beijing, China. The meeting involved 39 representatives of all the five African countries, eight donors and two major sponsor agencies that were not part of the AHA study (the Fogarty International Center of the US National Institutes of Health and the Wellcome Trust), and COHRED staff. The meeting informed the final conclusions and recommendations of the AHA study.

Study limitations

There is a dearth of routine information reporting, and much information had to be obtained through interviews. However, most of the interviewees were unable to provide precise financial data regarding either the national budget allocations to health research or the bi-lateral and multi-lateral funding for health research. Some donors also had difficulties providing a clear picture of their organization's health research funding strategy. Data on human resources, especially details regarding age and gender distribution, were also difficult to collect. Obtaining reports presenting the full details of interviewees' health research projects often proved impossible.

During the study it became clear that of the eight donors involved in the AHA study, only Canada currently has active ongoing projects in Cameroon. Therefore, in the case of Cameroon alignment and harmonization have been reviewed in general terms without a specific focus on the eight donors.

In spite of these limitations, this report provides the most up-to-date view of key potentials, limitations and application of the 'alignment and harmonization' principles to health research support in Africa.

3. Overview of the National Health Research Systems in five African countries: Burkina Faso, Cameroon, Mozambique, Uganda and Zambia

3.1. NHRS Framework

For low and middle income countries (LMICs) the objective of health research is to improve the health status of their population, improve equity and work toward sustainable development. To encourage research to reach this objective, LMICs should not only focus on individual and institutional capacities but should also strengthen their National Health Research System (NHRS). To manage the research system and strengthen the capacity to conduct and use research, COHRED defines the NHRS as "*the people and institutions that govern, manage, demand, generate, communicate or use research evidence to promote, restore, improve, or maintain the state of health and development of the population*".

COHRED developed a framework to support NHRS development according to national needs (see Annex 2). To provide a first assessment of the level of development of the NHRS in the five participating, this study used COHRED's NHRS assessment framework.

3.2. Level of development of the NHRS in the five African countries

3.2.1. Socio-political environment

For optimal development of National Health Research Systems that aim to improve health and equity, there needs to be a basic political commitment to health research.

In different ways, all five African countries recognize the importance of research for health.

In **Burkina Faso**, the Strategic Plan for Scientific Research[3] (Plan Stratégique de Recherche Scientifique - PSRS), adopted by the Government on October 18th 1995, states:

- "*Scientific research is indispensable for the social and economic development of Burkina Faso*";

In **Uganda**, the Government recognizes health research as a critical tool for evidence-based policy and decision-making. The Health Sector report for 2005/06 states, with regard to health research:

- "*Health research is a vital element for evolving rational approaches for solving specific health problems many of which have multi-factorial causes embracing social, behavioral and economic determinants. Evidence-based management of health reforms is essential to the improvement of healthcare delivery*".

3 CNRST, *Plan Stratégique de Recherche Scientifique*, MESSRS, Ouagadougou, 1995.

In **Zambia**, The National Health Sector Strategic Plan (NHSP) explicitly addresses the need for interventions to be evidence-based. It states:

- "*Integration and institutionalization of research as an integral routine component of the health policy development and program implementation process is of critical importance*", and
- "*Institutionalization of the use of research outcomes for health planning, policy and decision-making and program implementation at program level, as well as, the Central and Provincial levels of Ministry of Health (MoH) is currently unsatisfactory. Mobilization of resources for conducting relevant health research is therefore important. The development of effective mechanisms and systems in setting out MoH and national program health research priorities is almost non-existent. Therefore, it is important to develop and strengthen existing health research systems at all levels that define priorities for health research, influence national, regional and global health agendas and lobby for a more equitable allocation of resources*"[4].

Cameroon's Poverty Reduction Strategy Paper (PRSP)[5] recognizes the role of research and innovation in the fight against poverty. The Health Sector Strategy (2007 – 2015) also makes health research a strategic and operational priority.

In **Mozambique**, the Health Sector Policy, approved in 2007, dedicates a chapter to research.

3.2.2. Research conducive environment

To develop a research conducive environment, the COHRED framework identifies the following critical components:

- having 'credibly set and regularly update' **national health research priorities**;
- having a **health research policy framework** that provides the legislative and regulatory structure to guide all actors in health research;
- establishment of **governance and management structures** that provide vision, leadership and increase countries' ability to link short-term research objectives with longer-term health and development aims.

Health Research Priorities: three out of the five African countries have defined national health research priorities (see table 1).

Table 1: National health research priorities

Do countries define clear national health research priorities?

	YES	NO	In Progress
Burkina Faso	X (currently being updated)		
Cameroon			X
Mozambique		X	
Uganda	X		
Zambia	X		

4 Government of the Republic of Zambia. Ministry of Health. National Health Strategic Plan 2006 – 2010. December 2005. Pg 58.

5 Cameroon: Poverty Reduction Strategy Paper, International Monetary Fund, 2003, https://www.imf.org/external/pubs/ft/scr/2003/cr03249.pdf

In **Burkina Faso**, the Strategic Plan for Scientific Research of 1995 set strategic orientations for research, including health research. In 1997, stakeholders involved in health research attended a symposium on Essential National Health Research (ENHR) organized by the Ministry of Health in collaboration with COHRED. Its purpose was to formulate a list of priority health problems. The list consisted of twenty "horizontal" problems and twenty "vertical" problems aimed at orienting health research priorities. During the year 2007, the Ministry of Health (MS) through the Department for Studies and Planning (DEP) updated the priority health problems and defined health research themes in relation to those problems. The objective of this effort is to elaborate a National Plan for the Development of Health Research.

In **Uganda**, the Ugandan National Health Research Organization (UNHRO) employed a widely consultative process to define health research priorities in 2005; however, these still need to be formally endorsed by the Ministry of Health[6]. The health research priorities identified were:

1. Water, sanitation and environment
2. Maternal, child health and nutrition
3. HIV/AIDS
4. Malaria
5. Tuberculosis
6. Other communicable diseases
7. Non-communicable diseases
8. Health policy and health systems
9. Drug use studies

Zambia organized a priority-setting consultative process in 1998. National health research priorities were defined and disseminated through hard copies and e-mails in 1999. Few people interviewed, however, are aware of the priorities. The seven national health research priority areas are[7]:

1. Malaria
2. Child health
3. Nutrition
4. Diarrhoeal diseases
5. Reproductive health
6. STD/HIV/AIDS/TB/leprosy
7. Water and sanitation

6 UNHRO. Research Priorities 2005 – 2010. Health Research and Development. http://www.cohred.org/HealthResearchWeb/insidepages/africa/pdf/Uganda_HealthResearchPriorities(2005-2010).pdf

7 Report on the Zambian Consultative Process for the International Conference on Health Research for Development. April 2000
http://www.cohred.org/main/CommonCategories/LibraryandArchive.php?DocumentId=2156&catId=1333&subCatId=1368

In **Cameroon** health research priorities exist only within each national priority programme related to the major public health problems in the country. Through the Division for Health Operations Research (Division pour la Recherche Opérationnelle en Santé – DROS), the government is currently developing a national health research agenda. The current health (research) priorities are:

1. HIV / AIDS
2. Malaria
3. Schistosomiasis and helminthiasis
4. Tuberculosis
5. Onchocerciasis
6. Lymphatic filariasis
7. Guinea worm
8. Leprosy
9. Human African trypanosomiasis
10. Integrated care of child diseases
11. Cancer
12. Diabetes and hypertension
13. Blindness
14. Drugs and toxicomania

In **Mozambique**, there is a national list of health research priorities for HIV/AIDS defined by the Ministry of Science and Technology (MCT) through a consultative process with the Ministry of Health (MISAU), research institutions and NGOs. An essential national health research priority-setting process has not yet taken place in Mozambique.

Health Research Policy or Strategy: none of the five countries has specific legislation for health research nor a national health research strategic plan or policy. However, Burkina Faso, Cameroon, Uganda and Zambia are currently working on strategic plans for health research. Table 2 summarizes research and health related legislation, policies and strategies currently available in the countries[8].

Health Research Governance and Management: in each country, health research is governed or managed by two or three different ministries, with or without a specific division for health research within ministries. The Ministry of Health and the Ministry of Science and Technology were involved in all countries.

In **Burkina Faso**, scientific research is the responsibility of the Ministry of Secondary and Higher Education and Scientific Research (Ministère des Enseignements Secondaire, Supèrieur et de la Recherche Scientifique - MESSRS). Within the MESSRS, the National Centre for Scientific and Technological Research (Centre National de Recherche Scientifique et Technique - CNRST) is in charge of coordinating research at the national level[9]. The Institute for Health Sciences (IRSS) is the structure in charge of coordinating research for health within the CNRST.

8 Full references and further details of theses documents are available in the individual AHA country reports

9 Direction des Etudes et de la Planification, Profil pays de la recherche en santé du Burkina (PPRS), Ministère de la Santé, Ouagadougou, 2005

Table 2: Health research related documents in five African countries

Burkina Faso

- Strategic Plan for Scientific Research (Plan Stratégique de Recherche Scientifique - PSRS), October 18th 1995
- National Health Policy (Politique Sanitaire Nationale - PSN), 2000
- National Plan for Health Sector Development (2001-2010) (Plan National de Développement Sanitaire – PNDS)
- National Priority Programmes (i.e.: HIV/ AIDS, malaria, tuberculosis)

Cameroon

- Poverty Reduction Strategy Paper (PRSP), 2001
- Health sector strategy, 2007-2015, 2007
- Sectorial strategy for research and innovation, 2004
- National Priority Programmes

Mozambique

- Strategic Plan for the Health Sector, 2001
- Ministry of Science and Technology , National Science, Technology and Innovation Strategy 2005-2015
- National Development Plan (2005-2009)
- Action Plan for the Reduction of Absolute Poverty (PARPA II) 2006-2009

Uganda

- National Health Sector Policy for 1999 to 2009
- Health Sector Strategic Plan, 2005 to 2010.

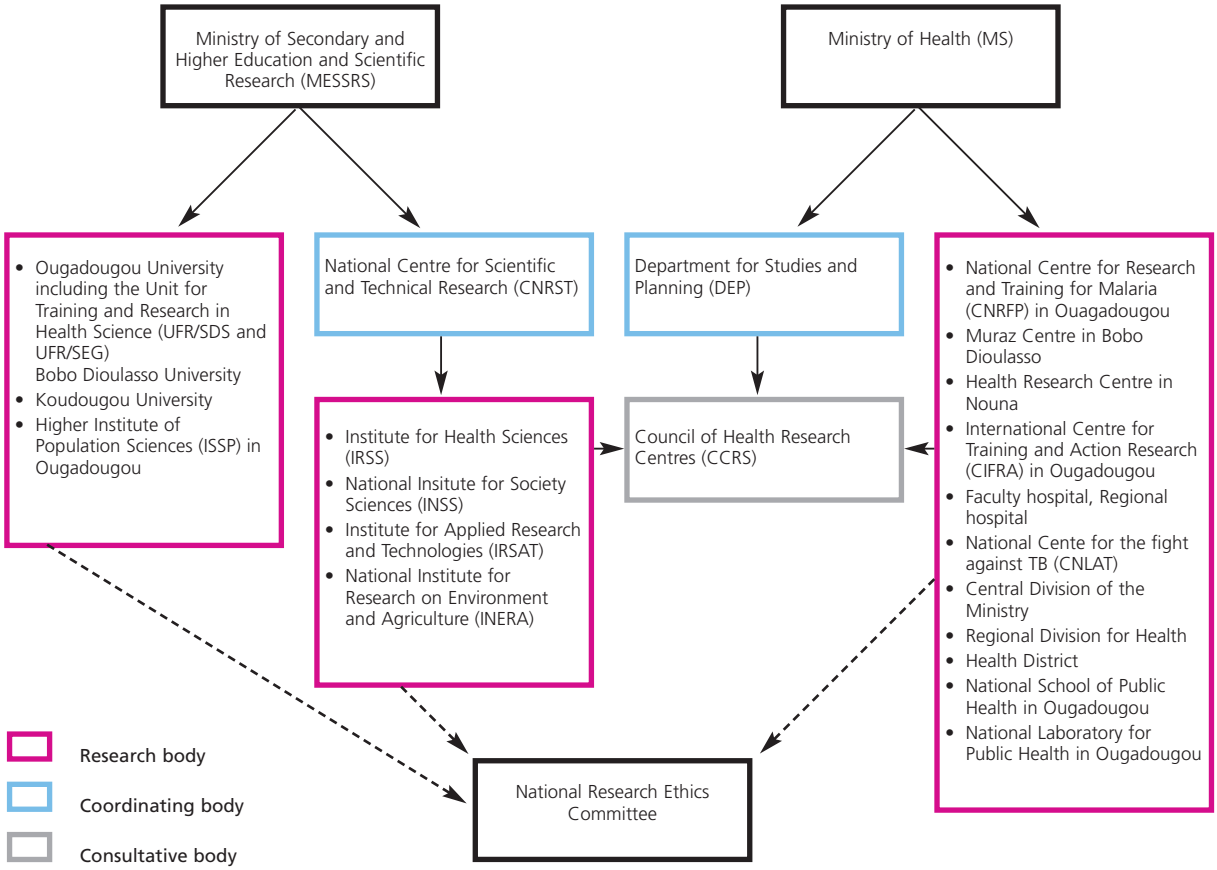
Zambia

- Science and Technology Act, 1997
- National Health Strategic Plan 2006-2010

Within the Ministry of Health (MS), the Department for Studies and Planning (Direction des Etudes et de la Planification - DEP) is responsible for coordinating health research activities that fall under its auspices. Any health research project undertaken by a health zy a research institute attached to the MS, must be submitted to the DEP for approval. Since the adoption of the Plan Stratégique de Recherche Scientifique (PSRS) in 1995, the institutional capacity for health research has been strengthened through the establishment of research institutions attached either to the MESSRS or to the MS.

All interviewees, including representatives from the DEP, indicated that coordination between the CNRST / IRSS and the DEP is the major challenge facing the research sector, including the health research sector. One interviewee stated "*There is health research in Burkina Faso but there is no health research system*". Figure 1 presents the national health research system in Burkina Faso.

Figure 1: The National Health Research System in Burkina Faso

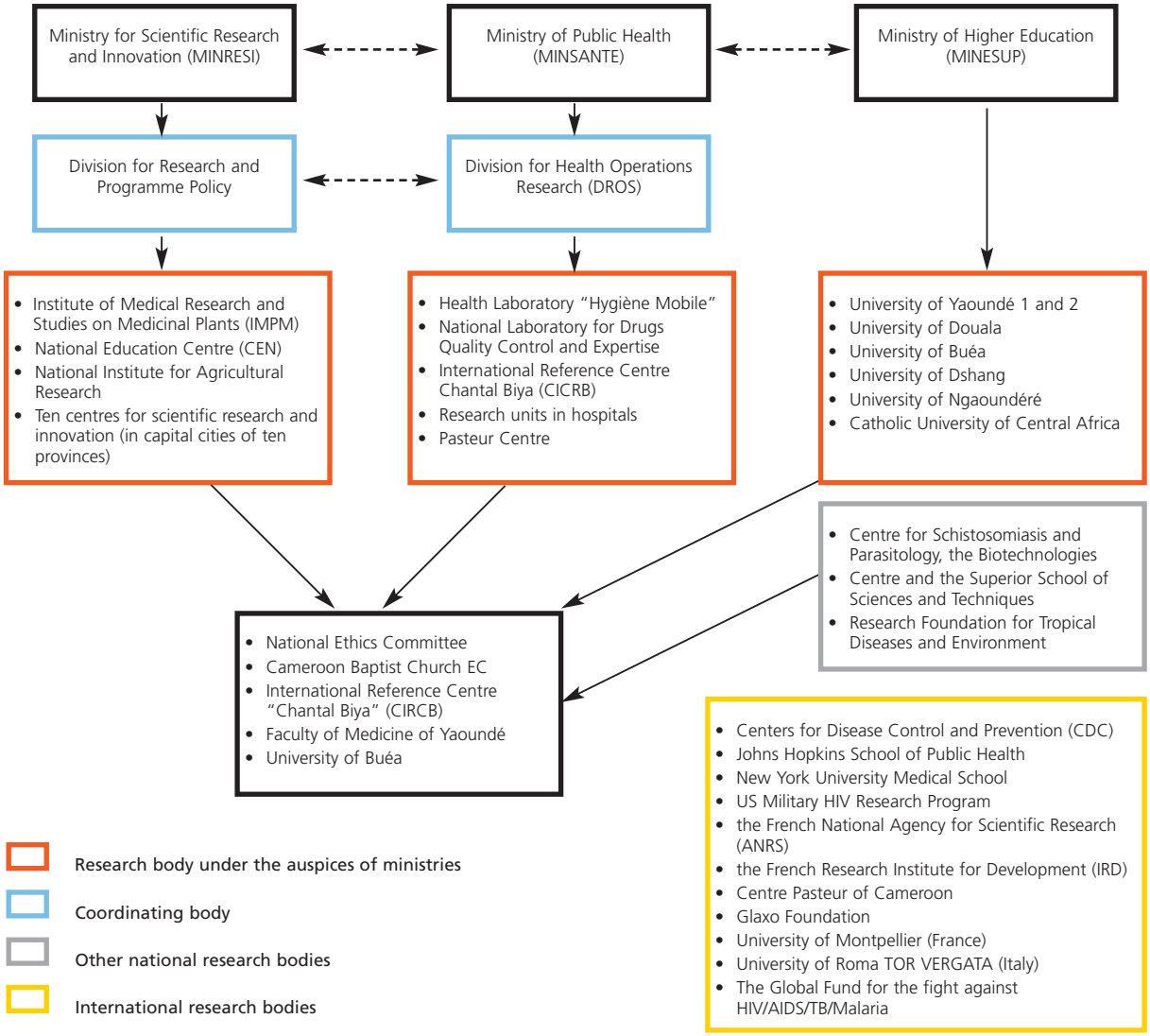


In **Cameroon**, three ministries are involved in the governance and management of health research: the Ministry of Public Health (Ministère de la Santé Publique – MINSANTE), the Ministry for Scientific Research and Innovation (Ministère pour la Recherche Scientifique et l'Innovation – MINRESI) and the Ministry of Higher Education (Ministère de l'Enseignement Supèrieur – MINESUP).

Academic research is coordinated by the MINESUP. Operational research, on the other hand, is coordinated by the MINRESI through the Division for Research and Programme Policy (Division de la Politique de la Recherche et de la Programmation) and by the MINSANTE through the Division for Health Operations Research (Division pour la Recherche Opérationnelle en Santé – DROS[10]), which was established in 2003. Health research is carried out by research institutions that come under the auspices of the three ministries. All

health research projects must obtain administrative approval from the DROS, in addition to an ethical clearance. Having been established just a few years ago, the DROS is still in the process of developing the coordination of health research. Therefore, the exact division of responsibilities between the MINRESI and the MINSANTE is not yet clearly defined. Figure 2 presents the national health research system in Cameroon.

FIgure 2: The National Health Research System in Cameroon



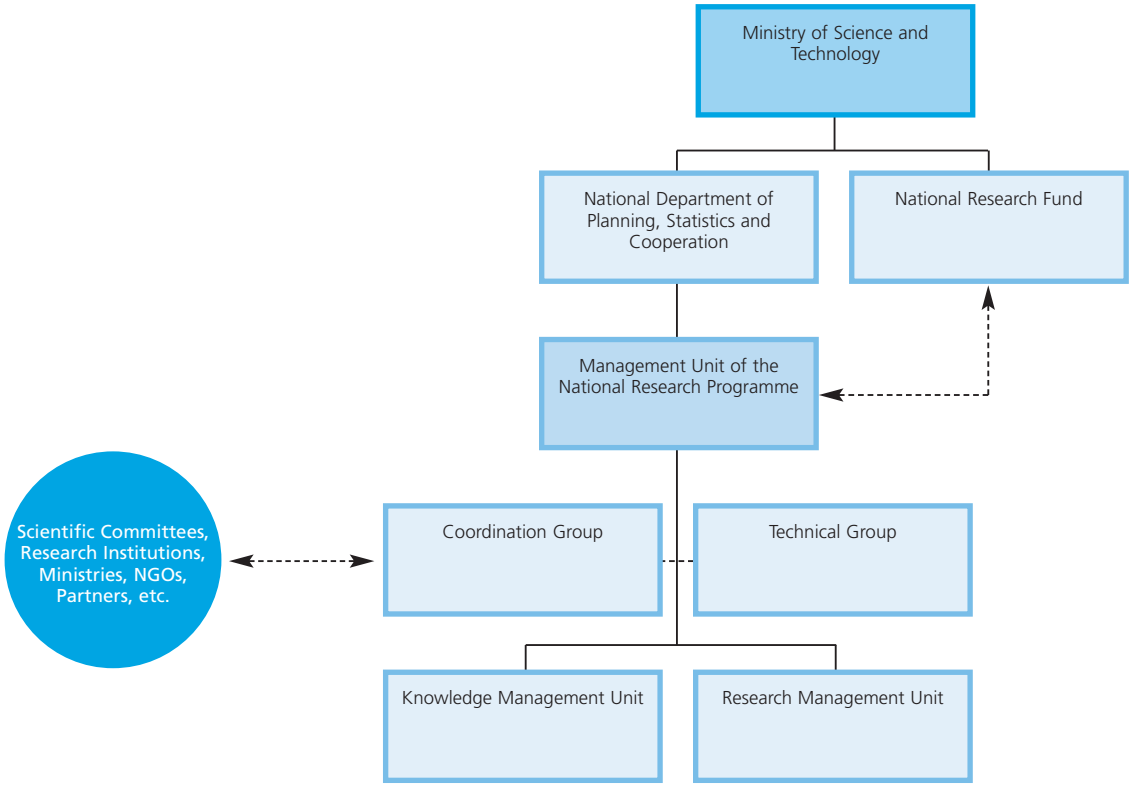
10 DROS' mission is:

- The coordination of health research actors and activities
- The definition of priorities through a consultative process with all the actors
- The conduct of clinical research studies
- The promotion of research within the hospitals and operations research in the domains of disease control, reproductive health and food and nutrition
- The dissemination of research results

In **Mozambique** the Ministry of Science and Technology (MCT) is the institution responsible for overseeing all scientific research in the country. Its mandate is to develop legal and normative mechanisms and to coordinate science and technology-related activities in the public sector. The Ministry of Health (MISAU), through its National Institute of Health (INS), coordinates research for the health sector.

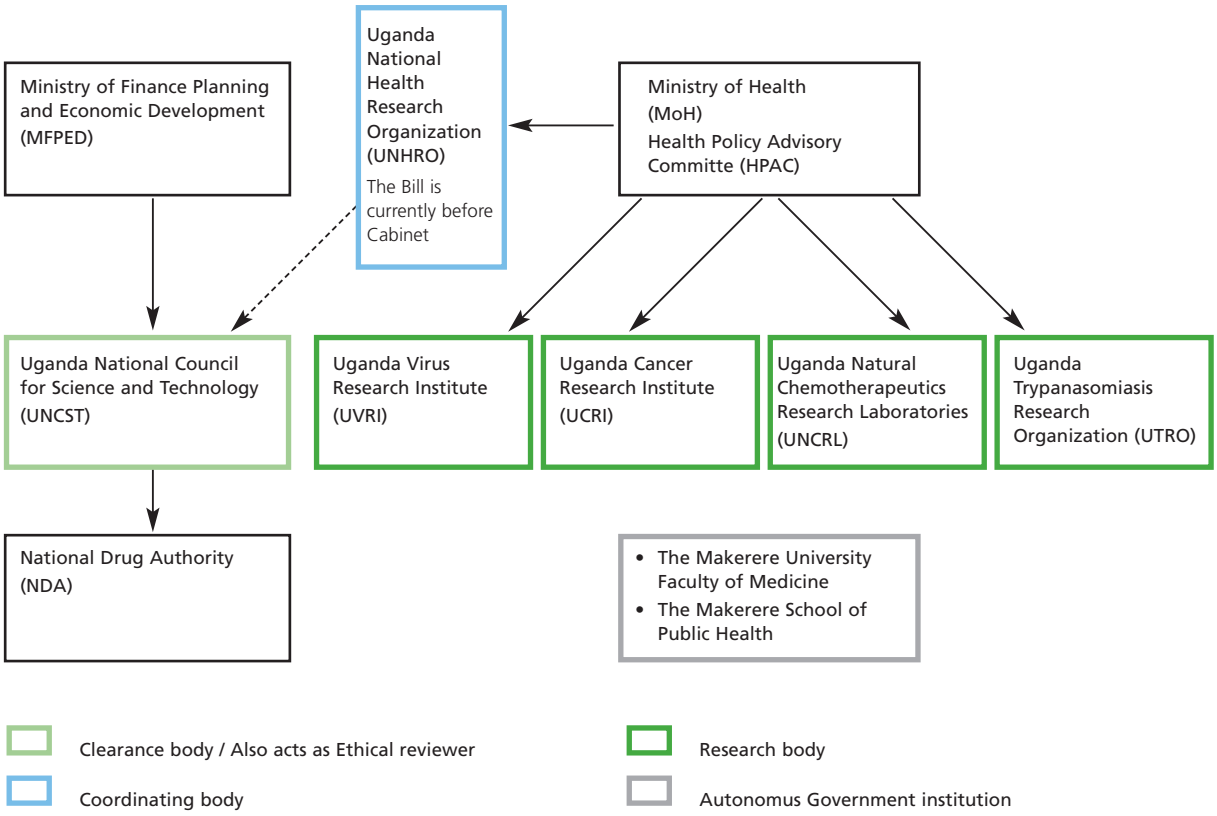
The MCT established an overall research coordination system and mechanism for HIV/AIDS research, aiming to align the research agenda and priorities for this particular field of health research. The structure of this system is illustrated in figure 3.

Figure 3: Mozambique National HIV/AIDS Research System
Source: Ministry of Science and Technology (2008)



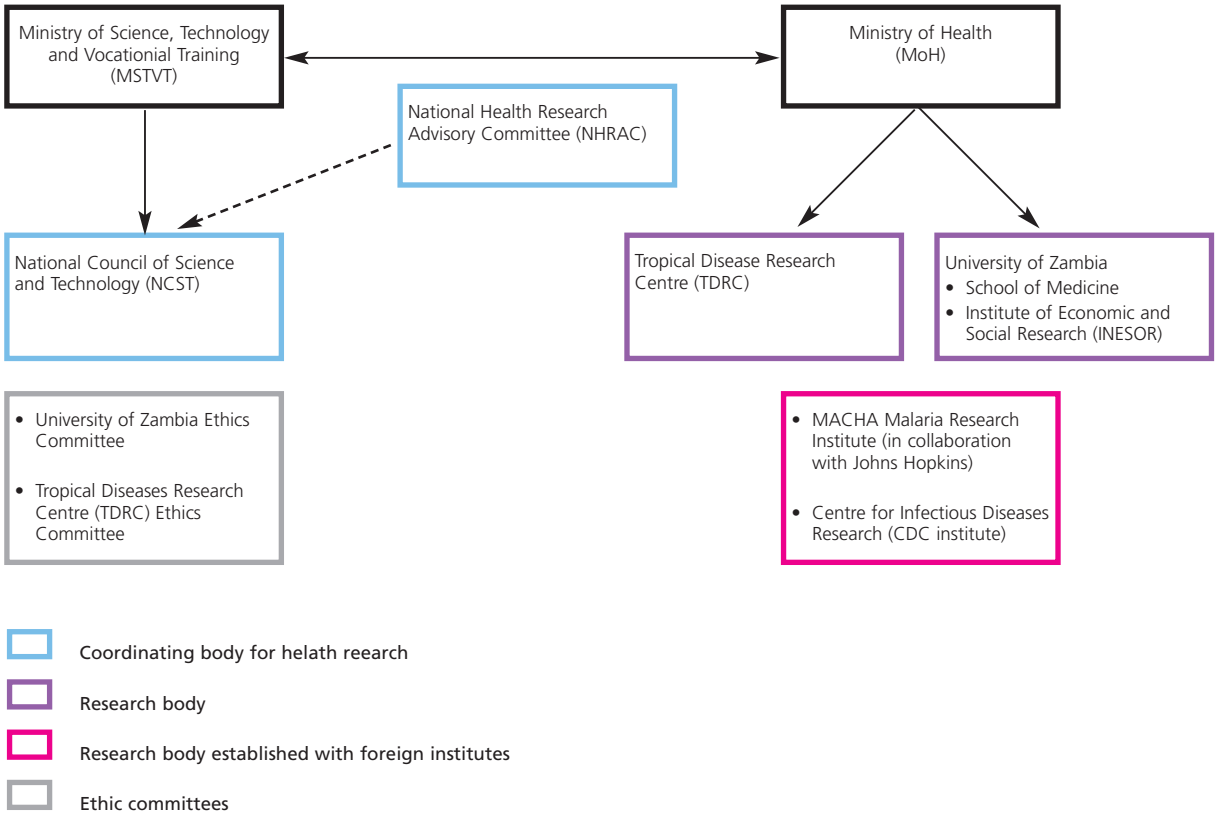
In **Uganda**, the Uganda National Council for Science and Technology (UNCST), which falls under the Ministry of Finance, Planning and Economic Development, is the key body that oversees research in the country. The formulation and management of sectoral research, however, is the responsibility of the relevant ministries. An effort to coordinate health research in Uganda was made by creating the Uganda National Health Research Organisation (UNHRO) through the Ministry of Health (MoH). However, the 'UNHRO Bill' has not yet passed to Cabinet and the status of UNHRO is unclear. It was envisaged that UNHRO should have a formal mandate to develop a coordination framework for health research in the country. Figure 4 presents the national health research system in Uganda.

Figure 4: The National Health Research System in Uganda



In **Zambia,** the National Council of Science and Technology (NCST) which operates under the auspices of the Ministry Ministry of Science, Technology and Vocationial Training (MSTVT), is the statutory body that oversees all research in the country. The National Health Research Advisory Committee (NHRAC) is supposed to coordinate health research but is not yet fully functional. The current draft health research strategic plan proposes the creation of an organizational entity – like a national health research agency. This is still to be discussed in a national consultation process. Figure 5 presents the national health research system in Zambia.

Figure 5: The National Health Research System in Zambia



3.2.3. Research implementation

Following the essentials of commitment and governance, shifting to research implementation involves having strategies for research financing and human resources for health research. Ideally, countries should have:

- a strategy for human resources for health research (HR-HR) to respond to countries' priorities and needs in terms of research but also in terms of research management, and
- stable and predictable research financing mechanisms that are aligned with national priorities and capacity needs.

Only three countries deal pro-actively with human resources for health research, interviewees in all countries listed research capacity building as a key requirement.

Mozambique has a strategic plan for the development of human resources for Sciences and Technologies and Innovation that has been approved by the Council of Ministers (29 March 2006). Intended to address the need for well trained researchers, the plan calls for a stepped approach to meeting its full target of 6595 researchers by 2025 (there were 470 researchers in 2002).

Zambia organized a Human Resource for Health Research (HR-HR) Conference in June 2007[11]. The Conference was supported by Canada (CIDA), Sweden (Sida), the World Bank and other partners, and organized by the NHRAC of the MoH. An action plan for HR-HR is expected to be developed following this conference.

In **Burkina Faso**, the presence of two governing bodies (the MESSRS and the MS) presents challenges in terms of equitable access to career development opportunities. Currently, researchers attached to MESSRS are provided career development opportunities within the CAMES (Conseil Africain et Malgache pour l'Enseignement Supèrieur) framework, whereas researchers attached to the MS do not have access to this framework.

Government funding for health research is very limited or non-existent and generally inadequate, thus causing health research activities in the five countries to be highly dependent on external funding. In all countries, the government budget is directed towards salaries in public universities and research institutes, and towards infrastructure maintenance while no direct funding for research may be provided.

As shown in table 3, three countries do not reach the 2% of the national expenditures as recommended by the Commission on Health Research for Development in 1990[12], while no data was available for the other two countries.

Table 3: Percentage of the national health budget dedicated to health research

Country	% of the national health budget dedicated to health research
Burkina Faso	0.43[13]
Cameroon	0.7[14]
Mozambique	No data
Uganda	Less than 1%[15]
Zambia	No data

11 The theme of the conference was "Transforming Research into Action: Providing Evidence for HRH Policy development, Program Design and Implementation. The overall objective of this conference was to gather evidence that would contribute towards moving the National HRH Agenda forward by informing policy development and implementation of the HRH Strategic Plan in Zambia.
http://www.moh.gov.zm/JM%20Rese/Research%20for%20HR%20for%20Health/HRH%20Research.htm has details on the conference including presentations made.

12 Commission on *Health Research for Development, Health Research* – Essential link to equity in Development , Oxford University Press, 1990

International donor funding accounts for a very large part of the expenditures on health research in the five African countries as shown in table 4.

Table 4: Percentage of international donor funding of health research expenditure

Country	% of international donor funding of health research expenditure
Burkina Faso	67 to 70[16,17]
Cameroon	82[18]
Mozambique	No data
Uganda	90[19]
Zambia	90[20]

In four of the five countries (**Burkina Faso, Mozambique, Uganda** and **Zambia**), the health sector is supported through a SWAp[21], and part of the health research carried out by health institutions (hospitals, health centres) is financed through this mechanism. It was not possible to obtain estimates on how much of this funding was spent on health research as it is not provided as a line item in the budget.

In **Cameroon**, the overall health budget was 71,4 billion FCFA (154,5 million USD) in 2006. The Ministry of Public Health directed 200,000,000 FCFA (400,000 USD) towards health research through subventions to research institutes and the Faculties of Medicine. The overall budget of the Ministry of Scientific Research and Innovation was 5,826,069,414 FCFA (12 million USD), of which approximately 300 million FCFA (600,000 USD) was dedicated to health research.

In **Uganda**, a total estimated approved budget of USD 40,854,995 for research projects was registered that year, of which USD 24,176,281 was in the health sciences[22]. Of these funds, money from AHA study donors represented a total of USD 395,192, of which USD 203,785 was from Sweden (Sida/SAREC), and USD 191,407 was from the United Kingdom (MRC and DFID)[23].

13 Dr. Celestin Traore and Dr. Alain D. Zougba, *Tracking resources flow for health research and development in Burkina Faso* (1999 – 2000), Ouagadougou, 2003

14 Dr. G. N. Mbanga, Dr. M. T. Sama, *Tracking resource flows for health research and development (R&D) in Cameroon*, COHRED, 2002

15 The Uganda National Health Research Organization (UNHRO)'s analysis in the year 2000 indicated that less than 1% of health research funds were from the Uganda Government. In 2001, Uganda spent 0.81% of GDP on Research and Development.

16 Dr. Celestin TRAORE and Dr. Alain D. Zougba, *Tracking resources flow for health research and development in Burkina Faso* (1999 – 2000), Ouagadougou, 2003

17 Estimates made by interviewees

18 Dr. G. N. Mbanga, Dr. M. T. Sama, *Tracking resource flows for health research and development (R&D) in Cameroon*, COHRED, 2002

19 Estimates made by interviewees

20 Estimates made by interviewees

21 The core elements of a SWAp:

1. All significant funding agencies support a shared, sector wide policy and strategy
2. A medium term expenditure framework or budget which supports this policy
3. Government leadership in a sustained partnership
4. Shared processes and approaches for implementing and managing the sector strategy and work programme, including reviewing sectoral performance against jointly agreed milestones and targets
5. Commitment to move to greater reliance on Government financial management and accountability systems

22 These figures indicate the total budgets of the research projects registered that year, and not their budget for that one year. Ref: UNCST registration status report for 2005 (January 01 to December 31 2005).

23 Source UNCST

3.3. Optimizing the system

There are numerous aspects of national health research that can be improved for efficiency gains or for enhanced impact on policy or practice. This study looked at two components of the national health research system only: i) dissemination of research findings and ii) research ethics review capacity.

Despite the existence of **systematic dissemination of health research findings** in some countries, interviewees in all countries expressed that there was a lack of effective dialogue and exchange of information between the different constituencies involved in health research. Research institutes were all keen to obtain more information about the research of the other institutes. Governments are not routinely informed about research produced in their own countries.

Nevertheless, all countries try to undertake innovative initiatives to face this challenge. **Cameroon** serves as a good example on how to improve dissemination, as shown in table 5.

Table 5: Cameroon's initiatives for dissemination of results

For each project that has been approved, the DROS requests monthly progress reports and a final report of the activities, as well as dissemination of the findings at the local and central levels. The DROS is currently working on the definition of a more systematic dissemination. It already initiated the implementation of networks for information sharing between actors involved in health research in Cameroon. The network is built around specific themes related to major health problems or concerns in the country:

- HIV / AIDS
- Reproductive health
- Social Sciences
- Tuberculosis
- Non communicable diseases

The networks consist of interactive platforms where the participants can exchange their research findings and any information of interest. The participants are identified by the DROS and include health researchers operating in research institutes or NGOs, and donors. Each platform is animated by an employee of the DROS who sends a monthly newsletter to keep the members informed of the latest news in their field of interest.

In **Burkina Faso**, dissemination mechanisms exist (Forum for Scientific Research and Technological Innovations, Health Sciences days of Bobo, Scientific Days of Nouna), but most of the interviewees agreed that they are not used in the most efficient manner.

In **Zambia**, the NHRAC created a website to share research information (www.mohresearch.zm) within the main Ministry of Health website (http://www.moh.gov.zm/). The NHRAC also instituted bi-annual National Health Research Scientific Conferences, which attract district and province ministry of health representatives, academia, civil society and other researchers. Stakeholders interviewed said that these have been very successful. The first one was held in 1998. In subsequent years it has been held in 2000, 2004, and 2007. The intention of these conferences is to assess what research has been done, determine what else needs to be done, and share information among different health research stakeholders. These conferences are used to collect information, which is then synthesized. Recommendations as to what needs to be done are then drawn up and given to government. The government is now taking ownership of the recommendations made at the conferences.

In **Uganda** there are no formal requirements for dissemination of research findings. However, forums do exist where scientists share their results and disseminate their findings. Nevertheless, even when research findings are disseminated, there is no follow up to evaluate their translation into action. Most interviewees would like to see issues related to the need for improved dissemination of research findings and design of a monitoring system to evaluate their impact on policies addressed.

Concerning **research ethics review requirements and capacity**, all five countries have institutional Research Ethics Committees, and four of them have national Research Ethics Committees (Burkina Faso, Cameroon, Mozambique and Uganda) as shown below. Some interviewees mentioned a frequent lack of coordination between the two.

In **Burkina Faso**, a National Ethics Committee was established by Decree in 2005 but currently there is no Ethical Code for Health Research. Each project is supposed to be submitted to the National Ethics Committee for approval. This does not occur systematically, however, as most research institutes have their own Ethics Committee.

In **Cameroon**, each health research project needs to obtain an ethical clearance from either the National Ethics Committee (implemented in 1987) or from four other Research Ethics Committees that have been approved and registered at the Health Operations Research Division (DROS).[24] The Ministry for Scientific Research and Innovation is currently in the process of creating an Ethics Committee. Most interviewees agreed that the functioning of the National Ethics Committee should be improved. According to the Ministry of Public Health, many health research projects are still undertaken without any ethical and/or administrative clearance.

The active participation of civil society in ethics issues is an interesting phenomenon in Cameroon. The network for Ethics, Rights and HIV/AIDS - REDS[25] is a working group on ethics composed of representatives from eight community based associations working in the field of HIV/AIDS. Through its GTIA (Groupe de Travail Inter Associatif sur la recherche biomédicale), the REDS provides recommendations regarding ethics on the projects that researchers submit to the group. The REDS also looks at the extent to which the projects are linked to the population's preoccupations and needs. It ensures that study findings are disseminated among the people who participated in the studies. It also has the ability to inform or to get information from the DROS about projects that it considers unethical.

In **Mozambique**, the Ministry of Health hosts the National Bioethics Committee.

For HIV/AIDS research, the Ministry of Science and Technology intends to use this committee, thus empowering existing ethics structures and strengthening the multi-sectoral approach adopted for the HIV/AIDS research coordinating mechanism.

In **Uganda** a Health Ethics Committee and National Guidelines for Research involving Humans as Research Participants are in place.

Zambia currently has two research Research Ethics Committees, one at the University of Zambia and the other at the Tropical Diseases Research Centre (TDRC). A National Research Ethics Committee is in the process of being established.

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24 The four insitutional Research Ethics Committees are:

- The Cameroon Baptist Church (CBC)
- The International Centre "Chantal Byia" (CIRCB)
- The Faculty of Medicine of Yaoundé
- The University of Buéa.

25 The REDS is an association grouping community based associations working in the field of HIV / AIDS. Its activities have four components: 1. Advocacy for considering HIV / AIDS patients in public policies 2. Legal assistance to HIV / AIDS infected people 3. Emergency aid 4. Programme and ethic and research

4. Overview of the eight donor countries health research support strategies: Canada, Denmark, Ireland, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom

4.1. Presence of the eight donor countries in the five African countries

Table 6 shows the donor countries which provide health and health research support in the five African countries.

Table 6: Donor countries' presence in the five African countries

Country	Health research funding	Health funding
Burkina Faso	Canada, the Netherlands, Sweden, United Kingdom	Netherlands, Sweden, Switzerland, United Kingdom
Cameroon	Canada	Canada
Mozambique	Canada, Denmark, Ireland, the Netherlands, Norway, Sweden	Denmark, Ireland, Netherlands, Sweden, Switzerland, United Kingdom
Uganda	Canada, the Netherlands, Norway, Sweden, United Kingdom	Denmark, Ireland, Sweden, United Kingdom
Zambia	Canada, Norway, Sweden, United Kingdom	Ireland, Netherlands, Sweden, United Kingdom

4.2. Donors' policy and objectives for health research support

The information for this section has been obtained through the review of documents provided by the donors, from their websites and through telephone interviews with donor representatives. For some of the donor agencies clear information regarding their health research funding strategy was not available. Generally, information on health research funding is not easily accessible.

Canada (IDRC – International Development Research Centre)[26]

IDRC's mission is to initiate, encourage, support and conduct research into the problems of the developing regions of the world, and into the means for applying and adapting scientific, technical, and other knowledge to the economic and social development of those regions.

26 http://www.idrc.ca/en/ev-8513-201-1-DO_TOPIC.html#1

IDRC's strategic plan 2005 – 2010[27] identifies three corporate objectives:

1) To strengthen and help mobilize the local research capacity of developing countries;
2) To foster and support the production, dissemination, and application of research results that lead to changed practices, technologies, policies, and laws that promote sustainable and equitable development and poverty reduction;
3) To leverage additional Canadian resources for research for development by creating, reinforcing, and participating in partnerships between Canadian institutions and institutions in the developing world.

To achieve these objectives, IDRC:

- Funds researchers in the developing world to carry out their work in their own institutions, with particular attention to supporting research projects and partnerships proposed by developing-country institutions, or by Canadian institutions in collaboration with developing-country partners;
- Provides expert advice to those researchers;
- Funds regional research networks and institutions in those countries.

IDRC focuses its funding on four themes:

- Environment
- Innovation
- Information and Communication Technologies
- Social and economic policy

Within these themes, IDRC offers support for health systems research and for ecosystem approaches to human health.

One IDRC initiative is the Governance, Equity, and Health Programme that examines health systems through a governance lens and, conversely, uses health as an entry point to approach challenges of governance[28].

As stated by an IDRC staff member: "*Our main focus is to fund research developed and submitted by southern researchers based on their own realities and needs. But realities from the field show that there is a great need to intervene upstream (by building technical and scientific capacity) and also downstream (by supporting knowledge sharing and, practice and policy influence)*".

The project financing model is related to criteria such as administrative risk of the institution. Primary recipients are usually research teams or research institutions from the South. In particular cases, the recipients are institutions from the North that are working in close collaboration with southern institutions (upon their agreement). A monitoring and evaluation system is in place to assist the partners in meeting IDRC's administrative requirements and a reporting mechanism is set up accordingly.

IDRC expended CAD$ 160.6 million (156.1 million USD) in 2006-07, of which CAD$ 101.3 (99.8 million USD) was spent on research programmes, CAD$32.6 million (31.9 million USD) on research support—including technical support for researchers in

27 IDRC, Corporate Strategy and Program Framework 2005–2010, 2004
http://www.idrc.ca/uploads/user-S/11250758901CSPF_2005_e.pdf

28 The GEH programme supports research to:

- Strengthen and monitor the capacity of governments to ensure equitable financing and delivery of priority public health and health care services, especially to marginalized and underserved populations
- Support informed and effective citizen demand and participation throughout the policy-to-practice process; and
- Increase the effectiveness of research-to-policy linkages in promoting the dual goals of health and social equity

http://www.idrc.ca/en/ev-3073-201-1-DO_TOPIC.html

developing countries—and CAD$ 26.7 million (26.1 million USD) on administration. The Centre's primary source of revenue is an appropriation from Canadian Parliament (80% of total revenues) through an allocation from Canada's International Assistance Envelope (IAE) that counts as Official Development Assistance (ODA).

The Canadian International Development Agency (CIDA) also funds international networks related to health research such as SciDevNet[29] and Equinet[30].

Denmark (Danida)[31]

Danida supports research in developing countries to advance science and to foster development.[32] The research supported must generate knowledge that will promote the overall objective of Danish development assistance to reduce poverty and contribute to the achievement of the Millennium Development Goals.

Danida's policy for health research was first formulated in 1995 and focuses on[33]:

1) The production of knowledge on health issues, which is "*a critical means of empowerment… and (the) search for solutions to unresolved problems*."
2) The strengthening of research capacity in the partner countries by "*establishing strong linkages between research and action agencies*".

Danida's strategy when funding health research is three-pronged:

- Danish development research
  Support for development research is provided through the Consultative Research Committee (FFU) to research centres and knowledge networks in Denmark. The FFU provides support for both major research projects and individual research projects and research networks. Attention is given to:
  - Prevention and control of communicable diseases affecting the poor (e.g., malaria, tuberculosis and HIV/AIDS);
  - Effectiveness of health care systems, enhancing equity;
  - Improving reproductive and sexual health;
  - Improving child and adolescent health;
  - Broader determinants of health should cut across all themes. Health research should be concerned with the consequences of environmental degradation, globalization, urbanization, migration and violent conflicts.
- Research capacity in developing countries
  Based on the needs of partners in developing countries, Danida's objective is to build and maintain capacity for research relevant to development assistance in the partner countries and in Denmark. In addition, Danida aims to promote production of sought-after and development-related knowledge. The greatest possible proportion of the supported research is to take place in the developing countries and be carried out by these countries' own researchers.
  From the early 1990s, research on health issues has been concentrated more and more in Danida's programme for Enhancement of Research Capacity in Developing Countries (ENRECA), which supports the long-term development of research capacity of selected institutions in developing countries through pairing

29 http://www.scidev.net/index.cfm
30 http://www.equinetafrica.org/partners.php
31 http://www.um.dk/en
32 Danida, *HERA, Final Report*, March 2007
33 Danida, *Evaluation of Danish Bilateral Assistance to health*, 2000/4, 2000

arrangements with Danish institutions. According to the Review of Danida-supported health research in developing countries[34], in North-South collaboration, the ENRECA research agenda tended to be determined more by the Northern research partners than by the Southern partners.

- International research

  Some international institutions, such as the European Malaria Vaccine Initiative and the African Malaria Network Trust, receive funding from the Ministry of Foreighn Affairs. Danida also supports research networks that aim to strengthen the dissemination of research, and increase communication and collaboration between researchers and providers of development assistance: the Danish Development Research Network, the Danish Research Network for International Health, the Danish Water Forum Research, and INASP.[35]

  The funding allocated to research support through Danida in 2005 was on the order of DKK 200 million (38 000 000 USD), and it is expected to remain at the same level for 2006-2010.

  As regards the Paris Declaration on Aid Effectiveness, Danida carried out in 2007 an evaluation of the implementation of the Declaration at headquarter level. The evaluation is focusing on commitment, capacity and incentives in the Danish Aid delivery system towards the implementation of the Declaration. Aspects related to health research support were not included.

Ireland (Irish Aid)[36]

The Irish Aid programme sets the reduction of poverty, inequality and exclusion in developing countries by contributing to the achievement of the Millennium Development Goals as its absolute priority. Health is a key priority of the official aid programme. At approximately 20% of the total budget, Irish Aid's spending on health represents one of the highest levels among donor countries. Support for the sector increased to approximately Euro 150 million in 2006 and Ireland may double its funding for efforts to combat HIV/AIDS and other communicable diseases to Euro 100 million (155 million USD) per annum.

Irish Aid's research and health research strategy consists of:

- Promoting evidence-based policy making at international and national levels;
- Increasing capacity of national systems for health research;
- Encouraging international partnerships in global health research, with particular emphasis on collaborative projects involving Irish research institutions;
- Supporting organizations with a strategic leadership role in global health research.

In July 2007, the Ministry for Overseas Development announced funding of over Euro 7 million (9.8 million USD) to higher education institutions in Ireland for research into development issues. This is the first round of funding announced under Irish Aid's Programme of Strategic Cooperation with Higher Education and Research Institutes, which was launched in 2006. The Programme of Strategic Cooperation between Irish Aid and Higher Education and Research Institutes 2007-2011 was launched in December 2006, with a budget of Euro 12.5 million (19.4 million USD).

34 HERA, *Review of Danida-supported health research in developing countries*, Main Report, Volume I and II, March 2007

35 international network for the availability of scientific publications http://www.inasp.info/

36 http://www.irishaid.gov.ie/

The Health Research Board[37] and the Department of Foreign Affairs, through its official development assistance programme, recently signed a Memorandum of Understanding to work collaboratively to support global health research and to increase research capacity in developing countries. This scheme aims to generate high quality research evidence directly related to the policy areas of the Irish Aid programme and to build research capacity in developing countries.

Thus, mixed modalities are used to support health research in developing countries. Primary recipients are either government institutions and/or national and international research institutions. Irish Aid is also an important contributor of global initiatives such as the Global Forum for Health Research and the Council on Health Research for Development (COHRED)

The Netherlands (DGIS)[38]

Efforts to achieve sustainable poverty reduction in relation to the Millennium Development Goals represent the central goal of Dutch development policy.

The main goal of research policy is to use knowledge and research effectively in efforts to fight poverty and bring about sustainable development. Therefore, the Dutch government accorded priority to four themes:

- Education
- Reproductive health
- Environment/water
- HIV/AIDS

DGIS's research strategy consists of i) promoting demand-driven approaches, and ii) strengthening research capacity to improve developing countries' ability to carry out research and higher education on the basis of their own needs and their ability to make use of existing research results to develop in a sustainable way.

Research, including health research, is supported through Health SWAp funding and bilateral programmes. Under the responsibility of the embassies, research is integrated into the bilateral programmes on the basis of a system approach, which involves focusing not only on the individuals who are part of the system but also on their interaction. The point of departure is not the need for research in its own right, nor strengthening research capacity per se, but the need for knowledge in an area where the embassy, national authorities, other actors, including research institutes, and other donors work together. Within the framework of bilateral programme priorities, embassies can deploy resources to:

- Support the partner in establishing or implementing a national knowledge and research policy;
- Support research and local research capacity using the principles of the system approach;
- Carry out or commission strategic research to improve or assess the poverty reduction strategy or the effectiveness of development efforts in the partner country; and
- Invest in links between policymakers and researchers, with a view to joint agenda setting.

37 The Health Research Board (HRB) is the lead agency in Ireland supporting and funding health research in Ireland. It provides funding, maintains health information systems and conducts research linked to national health priorities. Its aim is to improve people's health, build health research capacity and make a significant contribution to Ireland's knowledge economy. http://www.hrb.ie/

38 http://www.minbuza.nl

A second form of integration takes place in the theme-based or regional programmes set up by ministry departments through public-private partnerships and cooperation with multilateral agencies—European Union, Special Programme for Research and Training in Tropical Diseases (WHO/TDR); European & Developing Countries Clinical Trials (EDCTP); World Health Organization (WHO); Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Population Fund (UNFPA).

The Ministry of Foreign Affairs' Research and Communications Division's 'Central Research Programme' is being converted into a research and innovation programme that is geared to reforming cooperation in research, research methods, and the use of knowledge for poverty reduction and sustainable development. The central research programme had a budget of Euro 25.6 million (39.7 million USD) available in 2006. A part of this budget (Euro 3 million – 4.6 million USD) was allocated to the IS-Academy programme which is a new partnership scheme involving the Ministry of Foreign Affairs and academic institutions in the Netherlands and, potentially, in partner countries. The Ministry hopes that the scheme will foster partnerships between policymakers and researchers in the field of International Cooperation.

The Dutch organization for scientific research (NWO)[39] also has funds available for health research programs between Dutch institutions and those in developing countries.

Norway (Norad / NUFU / Research Council of Norway)

Norad[40]

Norad's overarching aim is to contribute towards lasting improvements in economic, social and political conditions for the populations of developing countries, with particular emphasis on ensuring that development aid benefits the poorest people. Norad supports global health research through several collaboration programs, including the NUFU programme, the Fellowship Programme, and a new initiative in partnership with the Research Council of Norway.

Norad's activities in the field of research and higher education are:

- Capacity-building in research and higher education in developing countries;
- Norwegian development research;
- Formative research and the use of research in development cooperation;
- Assistance in Norway's partner countries.

Norad Fellowship Programme

The Norad Fellowship Programme provides scholarships for students from the South to study in Master and Diploma programmes in Norway, as well as in South Africa, Mozambique, Tanzania and Malawi. It is based on the premise that good educational opportunities at Norwegian universities and university colleges can contribute to increased competence in the South. Fieldwork is performed in the student's country or region.

39 http://www.nwo.nl/

40 http://www.norad.no

NUFU programme

The Norwegian Programme for Development, Research and Education (NUFU)[41] is a programme for academic research and educational cooperation based on equal partnerships between institutions in the South and in Norway.

NUFU supports institutional cooperation and projects between Norwegian universities, specialized universities, university colleges and their partner institutions in the South, directed towards building sustainable capacity and competence in research and research-based education in Southern universities.

Project activities include joint research projects, Master and PhD programmes, development of Master or PhD programmes in the South, training of technical and administrative staff, and publication and dissemination of research results. NUFU supports bilateral projects, regional network projects and supportive activities with an aim to contribute to the development of the institutions in the South.

Eight health-related research projects are currently supported, which account for 14% of the NUFU budget 2007 – 2011. The total amount allocated to the NUFU programme by Norad for the period 2007 - 2011 is NOK 300 million (55.5 million USD) or NOK 60 million (11.1 million USD) per year.

Research Council of Norway[42]

The Research Council, with financial contributions from the development cooperation budget (Norad) and the health budget (Ministry of Health), initiated the programme for Global Health Research in 2004. In 2006 this became the programme for Global Health and Vaccination Research (GLOBVAC). GLOBVAC now consists of two sub-programmes: one on global health research (2004 – 2010) and one on vaccination research (2006 – 2011). These sub-programmes maintain separate budgets and separate calls for proposals but share a joint programme board.

The Research Council's aims are i) to strengthen global health research and contribute to Norway's obligations in the field of global health, and ii) to strengthen current knowledge in the field of vaccination research and contribute to the development of new vaccines.

The Research Council prioritizes:

- Diseases that account for the largest part of the disease burden and mortality among marginalized population groups and the health systems for these groups;
- Thematic areas where Norway is strongly involved in health programmes and global health research;
- Thematic areas where Norway has capacity and competence to be in the international forefront.

Currently, the Research Council funds 10 research projects on HIV prevention and treatment, tuberculosis epidemiology and vaccine, health workers, nutrition and child health, and diabetes under its global health research initiative. The total amount of funding for these projects is 55.2 million NOK (8.8 million USD).[43]

41 NUFU, Programme Document 2007 - 2011 http://www2.siu.no/vev.nsf/d48a0ecf27ae054dc1256f630063e8d7/f7b7d8b4dd4d737bc12571080045edeb/USDFILE/NUFU_pd_2007_2011.pdf

42 The Research Council of Norway, GLOBVAC Programme for Global Health and Vaccination Research, Ann-Mari Svennerholm, 2007, http://www.forskningsradet.no/servlet/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1175177849659&ssbinary=true

43 Information provided by Norad representative

Sweden (Sida / SAREC)[44]

The primary goal of the Swedish Policy for Global Development is to contribute to an environment supportive of poor people's own efforts to improve their quality of life.

The Sida / SAREC research strategy consists of:

- Enhancing capacity building through bilateral research cooperation agreements with universities;
- Producing new relevant knowledge and utilization of this knowledge;
- Supporting Swedish researchers.

Swedish development cooperation has identified the need to strengthen national universities through the transfer of research management and financial responsibility to partner universities. Public universities are part of existing national structures and investment in these structures contributes to the national capability and responsibility to up-hold the independent training of expertise, which is crucial for economic and social development.

The point of departure for Sida / SAREC's strategy is that each country should establish at least one research university that could 1) cater to the needs of the country; 2) eventually become a resource for the creation of a more extended university system and for the development of national innovation systems;[45] and, 3) gain credibility for managing governmental funds for basic research facilities, and be able to attract external funding from the private sector, foreign donors and foundations.

One of the main principles guiding research support from Sida / SAREC is to reinforce ownership on the part of the universities. The support is designed to allow for partner countries to identify research topics; plan, implement and report on the research; and take administrative responsibility for the associated financial resources. This implies that funds should be channeled through the university system, which enables the university to get an overview of the external resources made available. Likewise, financial reporting to Sida should occur through the accounting system at the university. Sida / SAREC encourages 'alignment' as support is supposed to be in line with the university policies and institutional strategies for research and research management.

Sida/SAREC supports capacity development through research training comprising training of PhD students in research projects and in production and dissemination of scientific knowledge. Sweden has chosen to contribute as a part of the university's strategy rather than individual scholarship programmes which detach the student from the home university. This approach to research training is known as the "*sandwich model*".[46] Themes for research projects are set by the local researchers in dialogue with national stakeholders and via a selection process within the university management or a research council.

The support to the development of local research capacity also consists of building laboratories and modern library facilities, setting up local research funds and mechanisms for allocating priority among research proposals, and engaging in dialogue on reform of universities and national research systems. Sida also supports thematic research addressing issues of key concern to meeting the challenge of poverty alleviation including health research. Support is directed to some 30 international organizations and 35 networks and groups that act as nodes for regional collaboration. The main areas of health research

44 http://www.sida.se/sida/jsp/sida.jsp?d=667&language=en_US

45 *Support to national research development*, Sida/SAREC, 2006

46 In sandwich training, research students are recruited and tested for admission to, mainly, Swedish PhD programmes. Research students maintain their position at the home university, define their research project in that context and spend periods in Swedish universities/institutions for course work, analysis and write up. A Swedish supervisor collaborates with a co-supervisor from the home university. Groups of students may be admitted within the same programme. Supervisors from both sides make exchange visits and follow up the students closely.

funded by Sida are biomedical research and social science studies investigating the classic poverty-related health problems:

- Infectious diseases
- Tropical parasite diseases
- Malnutrition
- Sexual and reproductive health
- HIV/AIDS
- Malaria
- Tuberculosis

Sweden also funds regional organizations such as NEPAD[47] and international networks related to health research such as SciDevNet, Equinet and INASP[48].

In 2006, Sida / SAREC's budget was 132 million USD, 20% of which was allocated to health related research. One third of the budget went to bilateral research cooperation.

The Swedish Research Council[49] also funds collaborative projects with developing countries (5 projects in 2006).

Switzerland (SDC)[50]

SDC's cooperation in health aims to contribute to the achievement of the Millennium Development Goals by improving the health of the poor and most vulnerable populations through the reduction of inequities and the promotion of sustainable development[51].

SDC has five strategic priorities in health:

- Strengthen good governance of health systems;
- Develop 'pro-poor' health services;
- Empower communities and users of health services;
- Control major communicable diseases;
- Improve reproductive health.

To address those priorities, SDC has defined operational strategies including the promotion of health research and evidence-based policy making.

SDC's health research strategy consists of:

- Giving priority to Essential National Health Research (ENHR) and to operations research;
- Supporting institutional and individual capacity building. Individual capacity building consists of investments in training and funding of inter-disciplinary research through research partnerships. Examples are "Echanges Universitaires" (University Exchanges) and "Jeunes Chercheurs" (Young Researchers). Each programme provides 300,000 CHF (286,700 USD) per year. Institutional capacity building support includes grants and scholarship schemes as well as facilities for seminars, conferences and workshops. SDC makes also capacity building investments through its funding for some large grants at the global level (WHO TDR, HRP, EDCTP);
- Promoting better dissemination and use of research results.

47 Sida/SAREC support consists of assisting in the development of indicators assessing the research system as a tool for country comparisons in Africa.

48 The Swedish contribution has been directed to PERI (programme for the enhancement of research information) that provides technical assistance to libraries receiving university support.

49 http://www.vr.se/responsibilities/researchpolicy.4.69f66a93108e85f68d48000223.html

50 http://www.sdc-health.ch

51 SDC, SDC health policy 2003 – 2010, http://www.sdc-health.ch/health_policy/SDC-health_policy%20EN

The Swiss Government is also an important contributor and is among the founders of global initiatives such as the Global Forum for Health Research, the Council on Health Research for Development (COHRED) and Medicines for Malaria Venture (MMV), and to international networks related to health research such as Equinet.

SDC provides approximately 12 – 15 million CHF (11.5 - 14.5 million USD) for health research per year, an amount that is projected to remain constant in the near future.

United Kingdom (DFID)[52]

The mission of the Department for International Development (DFID) is to fight against world poverty and to contribute to the achievement of the Millennium Development Goals.

DFID has just developed a new research strategy framework for 2008 – 2013. This five year strategy is the result of a worldwide consultative process.

The current DFID health strategy underlines the importance of generating new knowledge to deliver health services more effectively and efficiently and supporting scientific breakthroughs to provide new medicines and vaccines for tropical diseases and HIV and AIDS. In 2006/7 DFID invested around £45 million (88.6 million USD) in health research.

The four main areas of health research for which DIFD provides funds are:

- Communicable diseases (i.e. Tuberculosis, malaria, HIV/AIDS, neglected tropical diseases and diarrhoea);
- Non-communicable diseases (i.e. research into tobacco control, mental health);
- Maternal and child health;
- Health systems.

DFID also funds capacity development programmes. Its central research department is funding one capacity development programme jointly with Wellcome Trust and IDRC in Kenya and Malawi. All bilaterally funded research includes elements of capacity development, and DFID aims to include research capacity building as a central component of the new research strategy that is currently under way.

To date, health research programmes have been undertaken through:

- Public – private partnerships;
- International collaborations (multi-donor funding);
- Health research programme consortia (previously through Knowledge Programmes);
- Agreements with United Kingdom Research Councils (MRC Concordat).

The research programmes are based on open calls. Proposals can come from the North and the South. In the last period, most of the lead institutions were United Kingdom based with partners in the South.

Each DFID office has its own sets of priorities which depend on the country and the priorities of the country's government. Not all offices fund research activities. Currently there is not a system for recording what research each office is funding.

The new DFID research strategy for health will focus on three inter-dependent priorities[53]:

- Operational and implementation research to make health programmes more effective;
- Research on health systems;
- Global health innovation systems.

52 http://www.dfid.gov.uk / Research for Development: http://www.research4development.info/

53 DFID, Research Strategy 2008 – 2013, http://www.dfid.gov.uk/research/Research-Strategy-08.pdf

Additionally, and as part of a systems approach to health, DFID will focus on building health research capacity, especially in Africa.

DFID also funds international networks related to health research such as SciDevNet, Equinet and INASP.

The total spending on knowledge and research is currently 4% of the development budget, placing DFID in the top three bilateral research agencies. Traditionally, health has accounted for around 40% of investment. The DFID budget for research is set to double from £116 million (228 million USD) in 2006/07 to £220 million (432 million USD) by 2010.

5. Adherence to the Paris Declaration on Aid Effectiveness in relation to health research support by donors and by countries

5.1. The Paris Declaration on Aid Effectiveness

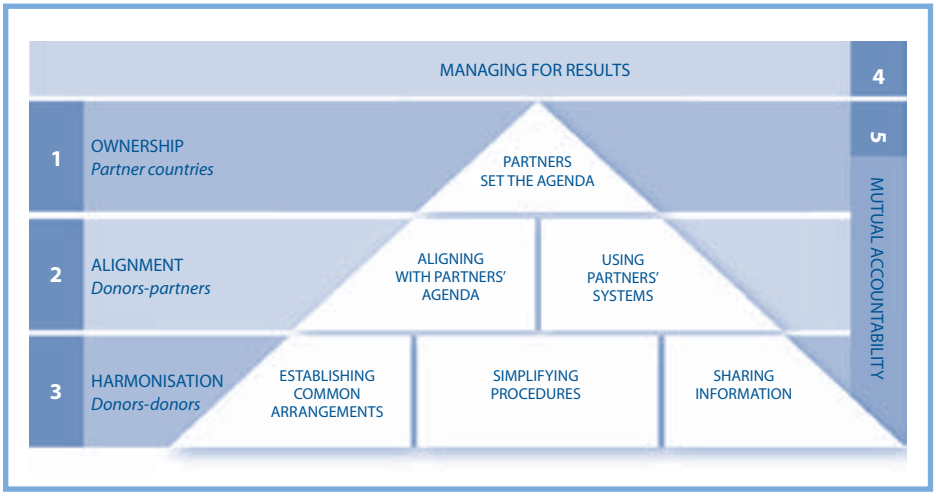
The increased commitment to international development in recent years has led to the involvement of growing number of organizations – and to difficulties for the developing country governments that must manage them. Currently, there are more than 40 bilateral agencies, 26 UN agencies, 20 global and regional financial institutions, and more than 90 global health initiatives[54]. As a result, governments are increasingly overwhelmed by the management and administration costs of dealing with myriad partners.

Such challenges led to the second High-Level Forum on Aid Effectiveness, held in Paris on 2 March 2005, which brought together development officials and ministers from 91 countries and 26 multilateral organizations, as well as representatives of civil society and the private sector[55]. The main outcome was the **Paris Declaration on Aid Effectiveness**. The Declaration was the culmination of various events including Monterrey (2002), the first High-Level Forum in Rome (2003), and the Marrakech Round Table on Managing for Results (2004)[56].

The four broad areas of the Rome and Marrakech commitments can be schematically depicted in a pyramid (see Figure 6). The Paris Declaration added the principle of mutual accountability.

Various indicators exist to measure the progress made in aid effectiveness. Twelve indicators from the Paris Declaration[57] and some of the indicators used by the Development Assistance Committee (DAC) Task Team on Harmonization and Alignment in various surveys[58,59] were adapted to health research support for the AHA study.

Figure 6: The Aid Effectiveness Pyramid



54 DFID,Working together for better health, London, 2007, http://www.dfid.gov.uk/pubs/files/health-strategy07.pdf

55 OECD, http://www.oecd.org/dac

56 Aid and Harmonization website, http://www.aidharmonization.com/

5.2. Donor countries' and partner countries' commitment to alignment and harmonization

All the donor countries and partner countries included in the AHA study have signed the Paris Declaration on Aid Effectiveness. In addition, some of them have developed specific Action Plans and Programmes for harmonization and alignment as shown in table 7.

Table 7: Harmonization Action Plans & Programs[60]

Nordic Plus Group : Denmark / Finland / Ireland / the Netherlands / Norway / Sweden / United Kingdom

The Nordic Plus Group adopted a Joint Action Plan for Effective Aid Delivery through Harmonization and Alignment of Donor Practices (2003)[61] that was updated November 2005 and March 2006. Its overall objective is to ensure more effective implementation of development assistance at the recipient country level. To this end, actions have been defined. A Practical Guide including Principles for Delegated Cooperation[62], and a Template for Arrangements on Delegated Cooperation[63] have been produced to facilitate the initiatives of the Group.

Canada

The Canadian International Development Agency (CIDA) is developing an Aid Effectiveness Agenda to strengthen the effectiveness, accountability and results of the CIDA aid programme.[64]

Denmark

Aid effectiveness is one of the five key areas in the 2005 version of the annual "Priorities for the Danish Government for Danish Development Assistance"[65]. In addition, Danish Embassies in developing countries prepare their own internal harmonization and alignment action plans.

Ireland

Ireland is in the process of preparing a White Paper on Development Cooperation which will be tabled for adoption by Cabinet and the Dail (Parliament) in 2007.

The Netherlands

The Paris Declaration has become a central point of reference for political statements and reports to Parliament vis a vis the Dutch Development Cooperation. In the Explanatory Note to the 2006 and 2007 budget, for example, the targets of the Paris Declaration are used as benchmarks for the Dutch performance. In 2006, before the Senate, the Minister for Developing Cooperation reconfirmed that the aid effectiveness agenda is well integrated in the Netherlands Development Cooperation policy.

Sweden

Sweden adopted an Action Plan on Harmonization and Coordination in Development Cooperation in 2005.[66]

Switzerland

Switzerland developed the Swiss Implementation Plan in 2005.[67]

United Kingdom

After the Rome Declaration on Harmonization in 2003, the United Kingdom adopted the DFID Action Plan to promote harmonization.[68]

When launching a new international partnership in September 2007, Douglas Alexander, Secretary of State for International Development stated: "*The donor community needs to work together better and smarter in order to deliver for the very countries we're trying to help, whilst supporting poor countries' own priorities. This is not about launching a health initiative but is about building health services*"[69].

DFID is part of a United Kingdom funders forum with The Wellcome Trust / MRC / Department of Health.

57 Indicators of Progress, Paris Declaration on Aid Effectiveness, http://www.oecd.org/dataoecd/57/60/36080258.pdf

58 DAC / OECD, Survey on Alignment and Harmonization, , Paris, 2004, http://www.oecd.org/document/61/0,3343,en_2649_3236398_31659517_1_1_1_1,00.html. The findings of the survey were used to report progress to the Second High-Level Forum on Harmonization and Alignment of Aid Effectiveness (early 2005) where the Paris Declaration on Aid Effectiveness was signed.

59 OECD / DAC, Aid Effectiveness, 2006 Survey on Monitoring the Paris Declaration, Overview of the Results, Paris, 2006 http://www.oecd.org/dataoecd/58/28/39112140.pdf

60 DAC/OECD, Compendium of donors reports on disseminating the Paris Declaration, 2007 http://www.oecd.org/dataoecd/55/29/37597465.pdf

A recent World Bank working paper links quality and impact of aid efforts not only to the quality of governance and accountability in the partner government, but also to the incentive system that prevails in the aid agency. Aid agencies could improve their capacity to direct good aid by adopting an incentive system that only rewards good projects. They lean instead towards a culture of 'pushing money', where only the number of accepted projects matters without regard to their quality[70].

The DAC Guidelines on Harmonization[71] outline a series of good practices which could lead to a shift in the incentives available to aid agency staff. These include:

- Create top level advocates of harmonization;
- Encourage initiatives in partnership and joint working by country offices;
- Decentralize decision-making;
- Ensure programme managers' awareness of the degree of flexibility;
- Manage staff to create an environment that encourages them to behave collaboratively and flexibly;
- Set transparent performance standards;
- Be open to assessments of aid management performance;
- Review procedural requirements regularly;
- Review legal frameworks;
- Ensure coherence between the various agencies of an individual donor.

5.3. Ownership

'Ownership' is considered critical to achieving successful implementation of the Paris Declaration. It is defined as a country's ability to exercise effective leadership over its development policies and strategies. In compliance with the indicators developed by OECD – DAC, this report uses six criteria adapted for health research support to assess the degree of ownership (see table 8).

Table 8: Criteria to assess country ownership of health research

1. Does the partner country have well defined priorities and an operational health research strategy to guide the aid coordination?
2. Does the partner country have a significant and operational budget for health research?
3. Does the partner country have adequate human resources to conduct health research?
4. Does the partner country have an agenda on harmonization and a process for coordinating aid in relation to health research support?
5. Does the partner country have a framework for encouraging dialogue between Government and donors in health research?
6. Does the partner country have the capacity for managing financial support for health research?

61 http://www.oecd.org/dataoecd/30/10/30216580.pdf

62 http://www.univie.ac.at/bim/php/bim/get.php?id=495

63 http://www.amg.um.dk/NR/rdonlyres/FEE04319-729E-4F1F-A3CC-D2C5F3A3471D/0/TemplateForArrangementsOnDelegatedCooperation.doc

64 DAC/OECD, Compendium of donors reports on disseminating the Paris Declaration, 2007

65 DAC/OECD, Compendium of donors reports on disseminating the Paris Declaration, 2007

66 http://www1.worldbank.org/harmonization/romehlf/IPlans/Sweden%20-%20SIDA.pdf

67 http://www.oecd.org/dataoecd/30/57/30215777.pdf

68 http://www2.dfid.gov.uk/pubs/files/Harmonization-Action-Plan.pdf

69 http://www.dfid.gov.uk/news/files/pressreleases/ihp.asp

70 W. Waly, T*he quality of foreign aid: Country selectivity or donor incentives?*, World Bank Policy Research Working Paper 3325. World Bank, Washington DC, 2004

71 *Harmonising donor practices for effective aid delivery*, DAC Guidelines and References Series, OECD, Paris, 2003

None of the five countries has currently specific legislation for health research or a National Health Research Strategic Plan or Policy in place. However, **Burkina Faso, Cameroon, Uganda and Zambia** are currently working on strategic plans for health research.

As mentioned by an IDRC staff: "*Our main rule is to have research done by Southern or local researchers for their own need in accordance with the national research agenda. Unfortunately, many African countries don't have a clear and explicit agenda*".

Government funding for health research is often very limited and inadequate, with high dependence on external funding. None of the five African countries have a budget for health research that represents 2% of the national expenditures as recommended by the Commission on Health Research for Development in 1990[72] (see also tables 3 and 4).

National budget appropriations for health research are essentially allocated to salaries of public sector staff and for infrastructure maintenance. In some countries there is a political will to increase the Government's contribution to health research although it remains very limited.

In **Burkina Faso**, in June 2007, a new line for health research in the budget of the Ministry of Health – called "fond d'appui pour la recherche santé" – FARES (Fund for health research support) was approved. The amount should be around 40 000 000 CFAF (82 000 USD) and should be allocated to:

- Support projects that are in line with the national health research priorities;
- Strengthen the coordination of health research at the national level;
- Capacity development.

None of the five countries in this study have an agenda on harmonization in relation to health research support. However, some countries have developed an agenda for the coordination of aid in general or for the coordination of aid related to health support. As a result, some frameworks for dialogue between Governments and donors do exist but have not been used for health research in specific.

In 2004, **Zambia** formalized a Memorandum of Understanding (MoU)[73] on Coordination and Harmonization of Government / Donor Practices for Aid Effectiveness in Zambia, often referred to as the Wider Harmonization in Practice (WHIP) Agreement. To date, almost all external partners[74] have signed the agreement[75]. Table 9 presents the conditions making the WHIP possible.

Table 9: Pre-conditions for establishing the WHIP in Zambia[76]

- An action matrix and regular progress reports
- Improved division of labour between donors
- Provision of support to strengthen capacities
- Delegated responsibility

72 Commission on Health Research for Development, *Health Research – Essential link to equity in Development*, Oxford University Press, 1990

73 *Memorandum of Understanding, Co-ordination and Harmonization of GRZ/Donor Practices for Aid Effectiveness in Zambia*
http://www.aidharmonization.org/download/247117/04-04-01MoUv2.pdf

74 Canada, Denmark, European Union, Finland, Germany, Ireland, Japan, Netherlands, Norway, Sweden, United Kingdom, United Nations ans Agencies, Unites States and the World Bank

75 The agreement includes increased use of direct budget support, establishment of more SWAps, increased reliance on government systems for procurement, fund management and auditing, preparation and implementation of the Joint Assistance Strategy for Zambia (JASZ) with an improved division of labor among the donors

76 M. Van den Boogaard, "*Innovative donor practicies in support of PRSPs*", Module 4, Joint donor training, Lusaka, Zambia, September 2004, World Bank Insitute
http://info.worldbank.org/etools/docs/library/103095/MarksPresentationmodule4Zambia.pdf

A Joint Assistance Strategy for Zambia (JASZ) has been developed and should be finalized this year (2007). The JASZ outlines the way that donors work together in compliance with the Paris Declaration. All partners who are signatories commit to aligning to national priorities.

Bilateral donors and the World Bank are also currently collaborating with the Government to develop and implement an aid policy. This aid policy would focus on guidelines and procedures governing Official Development Assistance agreements technical assistance debt, and disbursement modalities in line with Zambia's Poverty reduction Strategy. Donors are committed to moving towards improved aid predictability through multiyear projections and the use of appropriate aid modalities, and common planning procedures.

In 2003, **Uganda**'s Ministry of Finance, Planning and Economic Development authored the Partnership Principles between the Government of Uganda and its Development Partners[77,78]. A MoU between the Government of Uganda and the health development partners that pertains to health support is presented in table 10.

In **Mozambique**, the Government is taking action to strengthen its leadership role in coordinating HIV/AIDS research. In 2008, the Ministry of Science and Technology established a mechanism to fund HIV/AIDS research through a common fund.

More generally, the Government of Mozambique intends to strengthen its leadership role in development assistance. For example, it is developing an External Aid and Cooperation Policy. While the Ministry of Foreign Affairs and International Coordination is formally in charge of coordinating development assistance, the Ministry of Planning and Development is responsible for day-to-day coordination through its role in the formulation and implementation of the Action Plan for the Reduction of Absolute Poverty (PARPA) and the Economic and Social Plan (PES). An Official Development Assistance database which was originally developed by the European Commission and the United Nations and was adopted by most external partners in 2006, is being handed over to the Government to become its official database. The Ministry of Health and its partners signed a Code of Conduct in May 2000 and revised it in 2003, setting out the principles and guidelines for collaboration and defining the leadership role of the government through the increased use of and attention to national management mechanisms, planning structures, cycles and priorities.

In **Cameroon**, at the sectoral level, the Government has started playing a more active role in coordinating external partners. For example, there is a "Comission mixte de suivi", chaired by the Ministry of Health, which coordinates all external partner support in the fight against HIV/AIDS.

5.4. Alignment

Alignment is the term used to describe donor commitment to base development assistance on the national strategies, institutions and priorities of partner countries. This report uses three criteria to assess the degree of alignment of the donors (see table 11).

Three out of the five countries (**Burkina Faso, Uganda** and **Zambia**) have defined national health research priorities. **Cameroon** has also defined priorities but only within each national priority programme.

77 Ref: Partnership Principles between Government of Uganda and its Development Partners. Ministry of Finance, Planning and Economic Development. September 2003.

78 The principles have eight sections that detail general principles for the partnership, the government's preferred modalities of support from the development partners, undertakings by the Government of Uganda, reflecting development assistance in the budget, global funds, working more effectively at the sector level, joint sector reviews/missions, consultative group meeting. It also includes a calendar of major processes and missions

Table 10: MoU between the Government of Uganda and its health development partners

The MoU spells out the obligations of the main parties and describes the structures and procedures established to facilitate the functioning of the partnership. The following are key structures and processes[79]:

- The Health Policy Advisory Committee (HPAC) provides overall policy guidance to the sector. The HPAC Working Groups carry out functions assigned by HPAC. The HPAC meets every month and consists of government officials, donors, civil society representatives and the private sector. Details of the terms of reference for the HPAC are available[80].
- The annual Government of Uganda / Development Partners Joint Review Missions (JRM) enable the joint monitoring of the sector performance. The JRM receives the Annual Health Sector Performance Report and determines whether overall performance has been satisfactory. JRM also sets the priorities for the following year at the strategic level, through the identification of priority technical programmes, agreeing upon undertakings (or key process outputs) and determining broad allocations for the budget cycle. The HPAC Secretariat ensures that the participants receive, in a timely manner, electronic copies of the relevant documents for each Joint Review Mission.
- The Health Sector Working Group (SWG), established under the auspices of the Ministry of Finance, Planning and Economic Development, is the structure focused on the budget cycle and managing the approval and alignment of project inputs to the sector. New projects should follow Government of Uganda standards, guidelines and systems, be fully aligned with HSSP II priorities and minimize overheads as project resources are now counted as part of the total allocation to the sector and can displace budget resources.
- The National Health Assembly (NHA) was created to provide an annual forum for the broader health partnership (central and local governments, civil society, and development partners) to review sector policy, plans and performance. It provides an effective medium for wider consultation, political mobilization for health, and for consensus development among the stakeholders. The NHA was first convened in 2003. As part of HSSP II, the scope and mandate of the NHA will be clearly defined and its organization improved so as to derive maximum benefit from the effort. The Assembly is consultative and advisory. The NHA convenes once a year, with the MoH providing the secretariat.

The health development partners (HDP) are responsible for their own co-ordination through the HDP group, which provides a forum for information sharing, consensus building and collating and coordinating responses to government. It is intended to reduce transaction costs for all parties, but especially for government partners. The lead agency role is rotated on an annual basis. The nine Technical Working Groups provide input into the technical review meetings, which provide input to HPAC, and focus on:

1. Human resources for health
2. Health infrastructure
3. Drugs
4. Basic package of services
5. Finance and procurement
6. Public partnerships
7. Decentralization
8. Supervision and monitoring
9. Research and development

79 Health Sector Strategic Plan II, Volume I, pages 21 and 22

80 Danida Health Sector Programme Support Phase. Annex 3 of Terms o Reference for the HPAC. Pg 100, 101.

Table 11: Criteria to assess 'alignment' of donor support in health research

- Do donors align on the partner country' national health research priorities?
- Do donors align on the partner country's systems and procedures?
- Do donors align in their support for capacity development?

In **Burkina Faso**, most of the interviewees estimate that donors, except for Canada, do not align on the priorities that have been defined. Instead, researchers adapt their proposals to donors' priorities and "open calls". They suggest that Burkina Faso should initiate a new internal harmonization to define a common agenda for health research on which the donors could then align.

In **Cameroon**, although many donors fund research on HIV/AIDS, the National Strategic Plan for HIV/AIDS 2006 – 2010 stresses that the priority themes related to HIV/AIDS have not been funded so far.[81]

In all countries, research institutes tend to define their own priorities in line with what they perceive as the country's priorities. Interviewees mentioned, however, that the research is strongly influenced by funding opportunities so that it is really 'donor-driven'. Most NGOs that apply to "open calls" also tend to consider health research to be donor-driven. However, this is not necessarily the case. In Cameroon, for instance, NGO representatives mentioned that their projects remain within the research priorities fixed in the national priority programmes. They indicated that donors tend to involve them in project design to ensure that projects are adapted to the local context and needs. They often consider donors' criteria for financing eligibility restrictive, as these do often not allow NGOs to have optimal and sustainable access to funds. Interviewees also stressed that the financial management of the projects tends to be assured by the North.

In countries where the health sector is supported through a SWAp (**Burkina Faso, Mozambique, Uganda** and **Zambia**), the donors make use of national procurement systems and of common progress monitoring, and align aid disbursements with the annual budget of the partner countries.

In **Zambia**, there have been efforts to provide more coherent capacity building support. Increased coordination in capacity support is expected as a result of the JASZ. In addition, the WHIP agreement specifically calls for joint support in strengthening the Office of the Auditor General, and external partners are providing coordinated capacity support in the context of their assistance to public expenditure and financial accountability reforms. External partners including the World Bank are jointly offering support for the Public Sector Reform Program, which has included a significant capacity building component particularly in the context of the public expenditure and financial accountability reforms. External partners participating in the health sector SWAp are providing coordinated capacity building support. Several external partners, including Ireland, Norway, Sweden and the Netherlands, participate in a Joint Financing Agreement to support capacity building for the National AIDS Council.

A contributing factor to the improved aid harmonization and alignment has been the delegation of a higher level of responsibility from headquarters to local offices of aid agencies facilitating a more flexible and rapid interaction with the Government and among donor agencies.

81 Comité National de Lutte contre le Sida, *Plan Stratégique National de Lutte contre le VIH / SIDA* 2006 – 2010, 2006, Ministère de la Santé Publique

5.5. Harmonization

Harmonization is the term used to describe a commitment by donors to rationalize their multiple activities in ways that maximize the collective efficacy of aid under country ownership. This report used four criteria to assess the degree of harmonization of the donors in the five African countries (see table 12).

Table 12: Criteria to assess 'harmonization' of donor support in health research

- Do donors use common arrangements?
- Do donors have delegated cooperation?[82]
- Do donors conduct joint missions?
- Do donors share information and analysis?

Activities for harmonization among donors for health research support are not in place in any of the five countries except in the field of research related to HIV/AIDS in Uganda where DIFD is in the process of initiating a pooled fund. In addition, in the countries where health is supported through a SWAp (**Burkina Faso, Mozambique, Uganda** and **Zambia**), the use of common arrangement, delegated cooperation, joint missions and information sharing is facilitated.

Relationships with Partner Governments also provide key incentives for aid agencies to engage in harmonization. A proactive government taking a leadership role in coordinating donor activities will inevitably create an enabling environment for harmonization.

Burkina Faso, Mozambique, Uganda and **Zambia** are good examples of an increased harmonization among donors. The SWAp there has resulted in significant progress in donors' use of common arrangements and procedures. It also has a strong potential to reduce transaction costs in the long run, although the processes linked to these modalities may increase costs in the short-term[83].

In **Burkina Faso,** the SWAp for health also called "Programme d'Appui pour le Développement Sanitaire" (PADS), has proven to facilitate the coordination and harmonization between the donors who contribute to this fund (France, Germany, Sweden, the Netherlands, the World Bank and UNFPA). The Netherlands acts as leader of the PADS, thereby reducing the transaction costs for the Government and reinforcing transparency of the relations. Additionally, the Netherlands also has a delegated cooperation with Sweden, which means that Sweden is fully represented by the Netherlands. Donors are involved in the process of monitoring and evaluation of the PADS through the Monitoring Committee (Comité de Suivi), which is also composed of the Ministry of Health, other Ministries and civil society organizations. Its activities consist of:

- Bi-annual meetings;
- Field visits followed by meetings to share comments and come up with recommendations;
- Meetings with the central divisions and the health districts that are the primary recipients of the PADS;
- Joint reporting;
- Joint and global audits.

82 Donors make full use of their respective comparative advantage at sector or country level by delegating, where appropriate, authority to lead donors for the execution of programs, activities and tasks.

83 Dr Joao Costa, Sector Wide Approach (SWAp) and Project Support in Health - A brief comparison, Swiss Centre for International Health (SCIF), 2006

Donors participate in the Directory Committee (Comité Directeur) of the National Plan for Health Sector Development5 (2001-2010) (Plan National de Développement Sanitaire - PNDS) and in its six sub-commissions (Sectorial approach / Monitoring indicators / Human capacity / Institutional capacity / Decentralisation / Private sector).

A Technical Secretariat for Aid Effectiveness (Secretariat technique de l'efficacité de l'aide - STELA) was established in 2005. It consists of one full time person financed by the Netherlands, a half time person financed by the United Nations, and half time person financed by the World Bank (this position was still vacant in July 2007). STELA's mission is to identify obstacles to a better harmonization and to work in close collaboration with the Government National Coordinator who is attached to the Ministry of Finance.

In **Mozambique**, key areas of collaboration following the adoption of the SWAp have included:

- Regular meetings of the Ministry of health and its partners to reach consensus on key priorities and strategies;
- The establishment of mechanisms for channeling external funds through a common fund;
- The establishment of the annual performance appraisal of the health sector as a joint exercise and annual joint audits.

The experiences from baskets of labour sharing between donors, including the lead donor and joint secretariat concept, are positive and are useful instruments to reduce transaction costs on the donor side. They facilitate involvement with both government and the Bretton Woods Institutions and also make it possible for smaller countries to be more effective partners in those relations[84].

In **Cameroon**, where setting up a SWAp for health is currently under discussion, a Multi Donor Committee (Comité Multi-Bailleurs – CMB) was set up in 2003 to follow the Enhanced Heavily Indebted Poor Countries Initiative (HIPC)[85]. Since the Paris Declaration on Aid Effectiveness, this Committee has been evolving to become a structure for discussions on donors' coordination. It is composed of France, Germany, the Netherlands, Canada, USA, Japan, Belgium (until 2008), the World Bank, the International Monetary Fund, the European Union and the United Nations Development Programme (UNDP) which has a delegated cooperation with the rest of the United Nations in Cameroon.

The Committee meets twice a month with a rotating presidency to discuss matters related to the fields of intervention of donors: education, forest and environment, infrastructure, public finances, health etc. The partners share information, organize joint missions and fund some common activities through basket funds. In 2006, an order from the Prime Minister initiated an evaluation of all the support provided by the donor countries. Once this is complete, the CMB plans to start a dialogue with the Government to gain a better understanding of the roles and missions of Government structures involved in aid management with the aim of improving aid coordination. Donors expect

84 DFID,*Working together for better health*, London, 2007, http://www.dfid.gov.uk/pubs/files/health-strategy07.pdf

85 The Heavily In-debt Poor Countries (HIPC) initiative set up in 1996 by the rich nations through the IMF and World Bank calls for the reduction of external debt through write-offs by official donors. It was set up for the poorest of nations, for whom, according to the World Bank, the debt of the HIPC countries was, on average, more than four times their annual export earnings, and 120 percent of GNP

that this process will strengthen Government's involvement and leadership in the coordination of aid. Following a retreat in April 2006, the CMB decided to map all of the themes discussed in the meetings, to create a Permanent Secretariat with a President who would be the focal point for discussions with the Government, and to implement a communication system between the partners through the Internet.

In the field of HIV / AIDS, a group composed of all the partners involved in the financing of HIV / AIDS activities meets every three months in order to improve coordination amongst themselves and of their activities.

In summary, although there is general intent to develop mechanisms to implement harmonization, and although these could be of use for harmonization in health research as well, there is little evidence that harmonization of health research support actually occurs.

5.6. Managing for results

The Paris Declaration requires partner countries and donors to work together to manage resources on the basis of desired results, and to use information to improve decision making. This report uses a single criterion to assess this principle (see table 13).

Table 13: Criterion to assess 'management for results'

Has the partner country established a cost-effective results-oriented reporting and assessment system?

As far as we could ascertain, none of the five countries have implemented a 'cost-effective, results-oriented' reporting and assessment system in general, nor for health research support. However, some countries have set up or are progressing in setting up such systems for the management of aid in general.

In **Burkina Faso**, the Government is improving its data collection system, including a national statistical development strategy supported by the World Bank through a Statistical Capacity Building Project, even though this project is not yet fully funded[86]. Apart from this, a monitoring and evaluation system is associated with the National Strategic Framework for the fight against Poverty (Cadre Stratégique de Lutte contre la Pauvreté – CSLP).

In **Uganda**, a National Statistical Development Strategy has been prepared. Stakeholders have direct access to information about Government policies, data on poverty and information about budget process. In terms of monitoring and evaluation, the National Integrated Monitoring and Evaluation Strategy aims at establishing a single system for both Government and external partners' needs[87].

In **Mozambique**, the Government has prepared a national statistical development strategy that is ready for implementation[88].

86 OECD, 2006 Survey on Monitoring The Paris Declaration, Country Chapters, Burkina Faso, 2007 http://www.oecd.org/document/20/0,3343,en_2649_3236398_38521876_1_1_1_1,00.html

87 OECD, 2006 Survey on Monitoring The Paris Declaration, Country Chapters, Uganda, 2007 http://www.oecd.org/document/20/0,3343,en_2649_3236398_38521876_1_1_1_1,00.html

88 OECD, 2006 *Survey on Monitoring* The Paris Declaration, Country Chapters, Mozambique, 2007 http://www.oecd.org/document/20/0,3343,en_2649_3236398_38521876_1_1_1_1,00.html

5.7. Mutual accountability

'Mutual accountability' implies that donors and partner countries are accountable to each other for the use of development resources. This requires Governments to improve their accountability systems and donors to be transparent about their contributions. This report uses one criterion to assess this principle (see table 14).

Table 14: Criterion to assess 'management for results'

Does the partner country have a mechanism permitting joint assessment of progress in implementing agreed commitments on aid?

None of the five countries has such a system in place. However, some of them do have frameworks for mutual accountability in relation to aid for health or for aid in general.

In **Uganda**, a mutual accountability mechanism is in place for aid to the health sector in general, but not to health research in particular. The Annual Health Sector Performance Report (AHSPR) was institutionalized during the Health Sector Strategic Plan (HSSP) I, and has been very useful in highlighting areas of progress and challenge in the health sector[89]. During the HSSP II, the Report is expected to continue playing an important role in health sector monitoring. The different levels of health services delivery are expected to compile their reports, which should be used by these levels to critique their own performance, and then submitted to the national level for compilation of the AHSPR by the end of August every year. The AHSPR is the agreed document for monitoring HSSP II and should be used by all stakeholders for this purpose. The AHPSR is presented by the MoH to health sector stakeholders and discussed at the Joint Review Mission held October-November every year. The AHSPR will include an assessment of performance at and within the different levels, and will utilize the following for this purpose: District League Table, Hospital League Table or other objective assessment of performance, and mechanisms to compare Central level programmes performance (to be developed).

In the HSSP II Volume I, the Government of Uganda states that[90] '*The different roles and responsibilities of the government (at various levels) and the development partners will be further elaborated in the MoU for HSSP II implementation, which will be built on the MoU of the HSSP I and lessons learnt during HSSP I implementation' and that 'Regular assessment of performance against these roles and functions will be carried out – quarterly, by HPAC and the Inter-agency Coordination Committees, and annually by the Joint Review Mission. It is particularly required that expenditure information by the Donor Projects and Global Initiatives (where, how much, alignment with HSSP and annual priorities) should be made regularly available*'.

In **Zambia**, the Wider Harmonization in Practice (WHIP) Agreement commits the Government and external partners to the implementation of a development effectiveness framework and regular assessments of progress. The WHIP includes an annex that spells out a plan of specific actions, timelines and responsible parties, both in the Government and among external partners. Biannual meetings to assess progress of the implementation of the agreement have taken place as agreed. The Government and three partners, on a rotating basis, are in charge of coordinating the meetings and monitoring progress. The monitoring and evaluation of WHIP achievements is likely to be integrated with the implementation of the Joint Assistance Strategy for Zambia (JASZ).

89 Health Sector Strategic Plan II, Volume I, page 99

90 Health Sector Strategic Plan II, Volume I, page 89

6. Conclusion

Even though the Paris Declaration on Aid Effectiveness was only signed in 2005, it has received a broadly positive response from the donor community and from low and middle income country governments. Development sectors such as agriculture and health are exploring mechanisms to give effect to the challenge of increasing aid effectiveness through alignment and harmonization, for example through financing approaches like 'sector wide approaches' (SWAp) and other basket funding mechanisms. However, in the context of health research support to low and middle income countries, the Paris Declaration principles have not been specifically applied nor evaluated. The AHA study is the first effort to assess the application of the Paris Declaration to health research support and the first attempt to look at its potentials and limitations in this area of development.

Despite the generally strong commitment of both donor and 'partner' countries to implementing the Paris Declaration principles in their relationships, the full potential of alignment and harmonization in health research support is still to be realized. The AHA study found that:

- None of the five African countries had a fully operational national health research systems (NHRS) with clear research agendas, research priorities and policies, effective national research management mechanisms, stable research financing strategies nor plans for the systematic development of human resources for health research. As a result, the basis to guide and enable alignment is missing and 'donor alignment to national health research priorities and policies' will be hard to achieve and evaluate. At the same time, all countries in this study have components of national health research systems in place, and more capacity is being developed. Lack of alignment and harmonization in health research support is therefore no longer justifiable on the basis of 'lack of partner-country systems'. On the other hand, to enhance the enabling environment needed for alignment and harmonization, partner countries should continue to make explicit investments in strengthening their national health research system.
- Donor countries and research sponsors need to take note of national health research priorities and policies where these are in place and make explicit why or why not they will respond to these priorities and policies. If it is decided not to align, this should preferably be done in consultation with and with assent of the host country's government as in the case of the IDRC approach. On the other hand, if donors feel that health research priorities and policies or other parts of the health system are not sufficiently developed, then building such key components should become a funding and harmonization priority in itself. Lastly, some donors stated to 'harmonize' at global level, e.g. through the provision of funding to Global Health Initiatives. While this may go some way towards rationalizing health funding for specific conditions, it still leaves national authorities in a funding environment that is highly fragmented and inefficient.

The AHA study and the discussions following the presentation of interim results showed clearly that there remains a largely unresolved tension related to both alignment and harmonization: representatives from all five African countries expressed a wish for a more direct governance of the research being conducted within their own countries, while the need for 'flexibility' and 'creativity' in funding non-priority research and the limitations imposed by funding mandates made donors and research sponsors hesitant to embrace the principle of alignment and harmonization. Specifically, the donors and research sponsors in this study were sympathetic to the concept of trying to reduce administration costs by collaboration but fell far short of agreeing on a harmonized agenda for research funding, for example. Similarly, the five African countries expressed fears that harmonization of research funding may easily turn into inflexibility, lack of individualized approaches for countries and may actually reduce their ability to exercise governance and provide leadership in health research in their own countries.

The recent nature of the Paris Declaration and the lack of evidence around its positive and negative impacts on health research are – at least to some extent – at the heart of this tension. Monitoring and evaluation is therefore needed to provide a much better understanding of the potentials and limitations of alignment and harmonization in health research.

Lack of credibility in research priority setting through selective involvement of national constituencies, for examples, was cited as another reason for this tension. Finally, in the hypothetical case of governments that are not legitimate – how could one base a funding strategy on priorities set by such a government?

Through effective harmonization, donor countries can substantially reduce transaction costs of health research support for recipients and rationalize their own activities. However, the AHA study found no evidence that donors and research sponsors systematically attempt to harmonize their support for health research. An essential pre-requisite for monitoring and understanding harmonization is a good registration system providing detailed data on support provided to health research. Such systems are currently almost non-existing. The web-based and paper-based records of bilateral donor agencies are not particularly clear about research project funding nor are they very accessible – especially not if one takes the perspective of an African research institution manager with slow internet access – the very person one would want to have access to this information. On the other hand, none of the African countries registered its own contributions to health research in any detail nor made this easily available, making it difficult for donors to find the data needed to encourage harmonization. A key to successful alignment and harmonization is, therefore, easier accessible and updated health research funding information organized by country. Both governments and research institutions of recipient countries and research donors and sponsors need to develop and strengthen their health research reporting systems in order to facilitate harmonization. A facility like 'Health Research Web[91] could be an ideal vehicle to bring this information together and provide a simple but crucial way of empowering the alignment and harmonization processes, and building the system needed for good research production and utilization.

The Paris Declaration was designed for improving the effectiveness of development aid and not of health research sponsorship per se. In addition, because the declaration was signed by governments rather than institutions, it has – in the context of high income countries – primary application to their development agencies not to their research sponsoring organizations nor to their private sectors involved in health research. Research

91 see: www.cohred.org/healthresearchweb

sponsoring organizations, including foundations, are therefore less inclined to consider the Declaration's principles or may not have the freedom to do so given their own funding guidelines and mandates. However, discussions resulting from the interim data presentation also made it clear that there was a sincere interest of research sponsors to find areas of complementarity in donor agencies supporting research to be able to deliver more comprehensive health research support. We want to add this 'principle of complementarity' as a specific addition to the other principles in the Paris Declaration – at least for the field of health research. It is thus important to expand the discussion on alignment and harmonization to other funders beyond the confines of aid agencies and to engage research sponsors in debates around health research system strengthening and the need to focus (some of) their support to national health research priorities.

The Paris Declaration on Aid Effectiveness presents serious opportunities for increasing the effectiveness of health research support to low and middle income countries. At the same time, it is clear that much needs to be learned still about appropriate implementation and that the application of alignment and harmonization to health research is not an event or decision but will require medium- to long-term processes instead – and these have just started. It will be important to create mechanisms or 'platforms' for debate, learning and monitoring and evaluation on alignment and harmonization at country level as well as at institutional levels. Lessons will need to be documented and made easily available. Finally, the alignment and harmonization agenda in health research should be brought within the alignment and harmonization agenda that applies to general development to facilitate the understanding of the role of health research for better health, equity and development, and to make sure that 'AHA' in research remains in view.

Alignment and Harmonization in Health Research – Lessons, Issues, Next Steps

Although the AHA study is limited in scope and depth and can not make definitive recommendations, the following actions seem self-evident and will contribute to a better understanding of ways to operationalize AHA in health research:

1. For countries receiving health research support
   - 1.1. all countries should seek to put in place a minimum of conditions needed to enable or facilitate alignment and harmonization and, where needed, get help to do this. The basic NHRS framework (see Annex 2) would be an excellent guide to achieve this, but every country should have at least: i) credibly set and regularly updated health research priorities, ii) a research management directorate (in government or in a research council) to provide a mechanism for interaction with donors and research sponsors, and iii) ways to communicate national priorities and policies clearly to all who need to know – inside and outside the country. An example can be found in the 'health research web' which is one such vehicle that can be used (see: www.cohred.org/healthresearchweb).
   - 1.2. Although 'harmonization' in the context of the Paris Declaration was aimed at donors, countries receiving health research support can greatly enhance their influence on donor alignment if they would 'harmonize internally' – ensure that there are 'national' health research priorities rather than health research priorities that differ from ministry to ministry.

2. Donor countries and agencies, and research sponsors

2.1. Ease of access and transparency of funding information will greatly enhance the ability of research managers in countries dependent for large parts of their research budget on foreign grants to exercise effective governance. All research grants – whether through aid or through competitive granting, whether directly to countries or via 'northern' institutions – should be captured in formats that are easily accessible to research managers in low bandwidth environments.

2.2. Support efforts to strengthen National Health Research System governance to enable an environment in which alignment and harmonization can take place. Not only support for items listed in 1 above, but also the active support of national consultation mechanisms is essential.

2.3. Donors and research sponsors, including private sector, should seek creative ways of increasing the complementarity of their grants to deliver a more comprehensive support that builds research systems rather than funds projects.

3. Alignment and Harmonization in international health research support

3.1. Although the intention behind the Paris Declaration is the increased effectiveness of international aid for development, the field of health research is sufficiently different in key aspects that it should not automatically be assumed that the principles of alignment and harmonization will also improve effectiveness of national or global health research. The AHA study dealt only with bilateral aid for national health research and more understanding about potentials and limitations of alignment and harmonization in health research support in general is needed.

3.2. To keep the AHA agenda alive and let it reach its optimal potential, there needs to be some investment in a platform, ongoing documentation, studies or web-based resources – probably for a period of some years.

Bibliography and websites

Bibliography

Boogaard van den M. (2004). *Innovative donor practices in support of PRSPs*. Module 4, Joint donor training, Lusaka, Zambia, September 2004, World Bank Institute http://info.worldbank.org/etools/docs/library/103095/MarksPresentationmodule4Zambia.pdf

Centre National de Recherche Scientifique et Technique (CNRST) (1995). *Plan Stratégique de Recherche Scientifique*. Ministère des Enseignements Secondaire, Supèrieur et de la Recherche Scientifique, Ouagadougou

Commission on Health Research for Development (1990). *Health Research – Essential link to equity in Development*, Oxford University Press

DAC/OECD (2003). *Harmonising donor practices for effective aid delivery*, DAC Guidelines and References Series, Paris

DAC/OECD (2004). *Survey on Alignment and Harmonization*, Paris. http://www.oecd.org/document/61/0,3343,en_2649_3236398_31659517_1_1_1_1,00.html

DAC/OECD (2006). *Aid Effectiveness, 2006 Survey on Monitoring the Paris Declaration, Overview of the Results*. Paris http://www.oecd.org/dataoecd/58/28/39112140.pdf

DAC/OECD (2007). 2006 *Survey on Monitoring The Paris Declaration, Country Chapters, Burkina Faso, Mozambique, Uganda*. Paris http://www.oecd.org/document/20/0,3343,en_2649_3236398_38521876_1_1_1_1,00.html

Danida (2000). *Evaluation of Danish Bilateral Assistance to health*, 2000/4

DFID (2003). *Action Plan to promote harmonization* http://www2.dfid.gov.uk/pubs/files/Harmonization-Action-Plan.pdf

DFID (2007). *Working together for better health*, Policy document http://www.dfid.gov.uk/pubs/files/health-strategy07-evidence.pdf

Direction des Etudes et de la Planification (2005). *Profil pays de la recherche en santé du Burkina (PPRS)*. Ministère de la Santé, Ouagadougou. Burkina Faso

Foster M. (2000). *Experience with implementing Sector Wide Approaches*. Overseas Development Institute

Government of Zambia (2004). *Coordination and harmonization of GRZ/Donor Practices for Aid Effectiveness in Zambia* http://www.aidharmonization.org/dg-contribute/item-detail?item_id=404515&version_id=247117&return_url=%2fnode%2f547720%2fsearch%2findex%3fsearchtext%3dzambia

HERA (2007). *Review of Danida-supported health research in developing countries*, Main Report, Volume I and II, March 2007

International Monetary Fund (2003). *Cameroon: Poverty Reduction Strategy Paper*. https://www.imf.org/external/pubs/ft/scr/2003/cr03249.pdf

Mbanga G.N. and. Sama M. T. (2002). *Tracking resource flows for health research and development (R&D) in Cameroon*. COHRED, Geneva

Ministère de la Santé (2001), *Plan National de Développement Sanitaire. Ouagadougou*. Burkina Faso. http://www.sante.gov.bf/SiteSante/plans/pnds.html http://www.un.org/millenniumgoals/

Ministry of Public Health (2006). National AIDS Control Committee, *Strategic Plan for the fight against HIV/AIDS 2006 – 2010*. Cameroon

Ministry of Health. Health Sector Strategic Plan II 2005/06 – 2009/2010. Volume I. Uganda

Mulligan J. (2007). *DFID Central Research Department, Expert meeting on Capacity strengthening* in African institutions for endemic disease research, 22 – 24 April 2007, Wellcome Trust

Ndubani P. et al (2000). *Report on the Zambian Consultative Process for the International Conference on Health Research for Development*. April 2000.

Norad / Sida (2003). *Tanzania, new aid modalities and donor harmonization*, Report 8/2003

Norad (2006). *Practical Guide to delegated cooperation*, Nordic Plus Group http://www.univie.ac.at/bim/php/bim/get.php?id=495

NUFU. *Programme Document 2007 - 2011* http://www2.siu.no/vev.nsf/d48a0ecf27ae054dc1256f630063e8d7/f7b7d8b4dd4d737bc12571080045edeb/USDFILE/NUFU_pd_2007_2011.pdf

Pang, T., et al. (2003). *Knowledge for better health: a conceptual framework and foundation for health research systems*. Bull World Health Organ, 2003. 81(11): p. 815-20

Renzio de P. et al. (2005). *Incentives for harmonization and alignment in aid agencies*, Overseas Development Institute. http://www.odi.org.uk/publications/working_papers/wp248.pdf

SDC. *SDC health policy 2003 – 2010*. http://www.sdc-health.ch/health_policy/SDC-health_policy%20EN

SDC (2005). *Paris Declaration on Aid Effectiveness, Swiss Implementation Plan*. http://www.oecd.org/dataoecd/30/57/30215777.pdf

Sida/SAREC (2006). *Support to national research development*

Svennerholm A.M. (2007). *LOBVAC Programme for Global Health and Vaccination Research*. Research Council of Norway http://www.forskningsradet.no/servlet/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1175177849659&ssbinary=true

Traore C. and Zougba A.D. (2003). *Tracking resources flow for health research and development in Burkina Faso* (1999 – 2000), Ouagadougou

Uganda National Health Research Organization (UNHRO) (2005). *Research Priorities 2005 – 2010. Health Research and Development*. http://www.cohred.org/HealthResearchWeb/insidepages/africa/pdf/Uganda_HealthResearchPriorities(2005-2010).pdf

Waly W. (2004). *The quality of foreign aid: Country selectivity or donor incentives?*, World Bank Policy Research Working Paper 3325. World Bank, Washington DC

World Bank (2006). *Aid Effectiveness Review* http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/STRATEGIES/CDF/0,,contentMDK:20919987~menuPK:2540090~pagePK:139301~piPK:139306~theSitePK:140576,00.html

Websites

Aid and Harmonization website http://www.aidharmonization.com/

Danish Ministry of Foreign Affairs (Danida) http://www.um.dk/en

Department for International Development (DFID) http://www.dfid.gov.uk

Development Assistance Committee (DAC) / Organization for Economic Cooperation and Development (OECD) http://www.oecd.org/dac

Dutch Ministry of Foreign Affairs (DGIS) http://www.minbuza.nl/

East African Community
http://www.eachealthconf.org/general_info.asp

EVIPNet – Evidence-Informed Policy Network
http://www.who.int/rpc/evipnet/en/

EVIPNet Africa
http://www.who.int/rpc/evipnet/africa/en/index.html

INDEPTH Network
http://www.indepth-network.org/

Indicators of Progress, Paris Declaration on Aid Effectiveness,
http://www.oecd.org/dataoecd/57/60/36080258.pdf

International Development Research Centre (IDRC)
http://www.idrc.ca/index_en.html

Irish Aid
http://www.irishaid.gov.ie/

Netherlands Organization for Scientific Research
http://www.nwo.nl/nwohome.nsf/pages/index

New Partnership for Africa's Development (NEPAD)
http://www.nepad.org/

Norwegian Agency for Development Cooperation
http://www.norad.no/

The Norwegian Programme for Development, Research and Education (NUFU)
http://www2.siu.no/vev.nsf/O/NUFU

Organization for Economic Cooperation and Development (OECD)
http://www.oecd.org

Regional Network on Equity in Health in Southern Africa
http://www.equinetafrica.org/

Research for Development / Department for International Development (DFID)
http://www.research4development.info/

Social and Development Network (SciDev.Net)
http://www.scidev.net/index.cfm

Social Science and Medecine Africa Network (SOMANET)
http://www.somanet.org/home/index.php

Swedish International Development Agency (Sida) / Department for Research Cooperation (SAREC)
http://www.sida.se/

Sweden's Action Plan on Harmonization and Coordination in Development Cooperation
http://www1.worldbank.org/harmonization/romehlf/IPlans/Sweden%20-%20SIDA.pdf

Swiss Agency for Development and Cooperation (SCD)
http://www.sdc.admin.ch/

The United Nations Millennium Development Goals (MDGs)
http://www.un.org/millenniumgoals/

The World Bank (WB)
http://www.worldbank.org

World Health Organizations (WHO)
http://www.who.org

Annex 1

List of stakeholders Interviewed

Burkina Faso

Structure	Name and Position
Government	
Secétariat Général / Ministère de la Santé	Jean Gabriel OUANGO Secretary General
Direction des Etudes et de la Planification	Sié Roger HIEN Director Salimata KI Chief of the Health Research Department P. Aboulaye NITIEMA Chief of the Secretariat of « le Plan National de Développement Sanitaire » (PNDS)
Research Institutions	
INSD (Institut National de la Statistique et de la Démographie)	Bamory OUATTARA Director General
ISSP (Institut Supérieur des Sciences de la Population)	Banza Baya Co-Director
Centre Muraz (Bobo-Dioulasso)	Potiandi Serge DIAGBOUGA Director General Seydou OUATTARA Researcher
Centre de Recherche de Nouna	Ali SIE Director General
IRSS (Institut de Recherche en Sciences de la Santé)	Jean-Noel PODA Sub-Director
IRSS / Département Médecine Pharmacopée traditionnelles / Ouagadougou University	Pierre GUISSOU Director
UFR / SDS (Unité de Formation / Recherche en Sciences de la Santé)	Laurent OUEDRAOGO University Professor
CNRFP (Centre National de Recherche et de Formation sur le Paludisme)	S. Bienvenu SIRIMA Researcher Co-Director
NGOs	
Population Council	Gisèle KABORE Research Coordinator
Axios	Rosine K. SAMA Project Officer

Structure	Name and Position
Donors	
Embassy of The Netherlands	Renet Van der Waals Chief of the Department for Cooperation
Canada	Abel BICABA SER SAP Director of the "Société d'Etude et de Recherche en Santé Publique"
WHO	
	Youssouf GAMATIE Medical Officer Inter Country Support Team for West Africa
	David KIELEM Project Officer

Cameroon

Structure	Name and Position
Government	
Division of Health Operations Research Ministry of Public Health	Pierre ONGOLO ZOGO Director
	Jean-Marie FOUDA Research Officer
Research Institutions	
IMPM (Institut de Recherches Médicales et d'Etudes des Plantes Médicinales)	Tom AGBOR EGBE Deputy Director General
CIRCB (Centre International de Référence 'Chantal Biya')	Marcel MONNY LOBE Director
	Odile OUWE MISSI OUKEM Deputy Director
	Judith TORIMIRO Researcher
CRESEAR (Centre de Recherche pour la Santé des Armées)	Eitel MPOUDI NGOLE Director
LSHM (Laboratoire de Santé Hygiène Mobile)	Francois Xavier MBOPI KEOU Administrator and Head
Biotechnologies Centre	Wilfred NBACHAM Director
	Jude BIGOGA Researcher
IRD (Institut de recherche pour le Développement)	Jean-Loup BOEGLIN Researcher

Structure	Name and Position
NGOs	
FPAE (Fondation Paul ANGO ELA)	Kalliopi ANGO ELA Administrator and Head Marie-José M. ESSI Researcher Joseph OWONA NTSAMA Researcher Fred EBOKO Researcher (IRD Researcher)
IRESCO (Institut pour la Recherche, le Développement Socio-Economique et la Communication)	Gédéon YOMI Deputy Coordinator
The Shemka Foundation	Jean Calvin NAMA NTSE Delegated Administrator
FESADE (Femmes Santé et Développement)	Damaris MOUNLOM Administrator and Head
RECAP+ (Réseau Camerounais des Associations des Personnes Vivant avec le VIH / SIDA)	MACHOUSSI Executive Secretary
National Priority Programmes	
PNLP (Programme National de Lutte contre le Paludisme)	Etienne FONDJO Chief of the Department "Operational Research" Celestin KOUAMBENG Chief of the Department "Training and Research" Simon Fozo KWAKE Chief of the Department "Control, monitoring and evaluation"
PNLS (Programme National de Lutte contre le Sida)	Louis MENYENG Chief of the Department "Acces to drugs"
Network	
REDS (Réseau sur l'Ethique, le Droit et le Sida)	Calice TALOM YOMGNE Ethics and Research Programme Officer
Multi-lateral agencies	
UNDP UNFPA	Mathilde SANZONE TRAORE UNFPA representant
Technical Cooperation Agency	
GTZ	Gerd EPPEL Head Technical Advisor

Mozambique

Structure	Name and Position
Government	
Ministry of Health	Martin DJEDJE Director of Human Resources
	Ercilia ALMEIDA Director of Informatics
National Health Institute Ministry of Health	João Manuel Carvalho FUMANE Director of National Institute of Health
	Ricardo THOMPSON Scientific Director
Health Systems Research Unit	Bernaditta FERNANDES Senior Researcher
Centre Muraz (Bobo-Dioulasso)	Carlos BOTAO Junior Researcher
	Moosagy MOHAMED Junior Researcher
	Mercia ABELEO Junior Researcher
Ministry of Science and Technology (MCT) Division for Statistics Plan and Cooperation	Marcelino LUCAS Director
National Aids Council	Diogo MILAGRE Director
NGOs	
Médecins sans Frontières (MSF)	Alian KASSA Director MSF Luxemburg
	Corinne BENAZECH Coordenadora de Projecto MSF. Projecto HIV/SIDA Mavalane Centro de Saúde : Primeiro de Maio
	Fernando Maldonado Epidemiologist
NAIMA+	Claudia M.V. BULHA Administrator
Dream	Paola ROLETTA Director

Mozambique

Structure	Name and Position
Academic institutions	
Eduardo Mondlane University Faculty of Medicine Department of Community Health	Ricardo BARRADAS Dean of Faculty of Medicine Baltazar Goncalo CHILINDO
Unit for Donor Coordination	Maria da Conceição L. DIAS
Library and Document Centre	Albertino DEMASCHENE
Donors	
Ireland	Jonas CHAMBULE Health Advisor Caroline FORKIN
Sweden	Sandra DIESEL
Denmark	Berit GADE Coordinator HIV/AIDS and Health Sector
The Netherlands	Annie VESTJENS First Secretary for Health and HIV/AIDS
European Commission	Douglas HAMILTON Health and HIV/AIDS Adviser
The Ford Foundation	Paula MIMPUNO Programme Officer For Southern Africa

Uganda

Structure	Name and Position
Government	
Ministry of Health	Francis Runumi Commissioner Health Services and Planning Grace Mulindwa Principle Medical Officer in Planning
Uganda National Health Research Council (UNHRO)	Raphael Owor
Uganda National Council of Science and Technology (UNCST)	Julius Ecuru Secretary Leah Nawegulo Senior Officer in charge of Research Registration

Structure	Name and Position
Research Institutions	
Makerere University, Medical School	Nelson Sewankambo Dean E. T. Katabira Deputy Dean, Research
Uganda Institute of Virus Research	Julius Luthwama Also Secretary to UNHRO
Institute of Public Health	David Serwadda Director
Uganda Cancer Institute	Jackson Orem Director
NGOs	
Center for Basic Research	Ms. JUSTIN Administrator
Network	
Network of Uganda Researchers and Research Users - NURRU	Anthony Turyahebwa
Donors	
Belgium	Marc Denys Current Chair of the Health Development Partners Group
Danida	Peter Ogwal Health Advisor
Ireland	Susan Fraser Project Coordinator, Research Matters
Sweden	Gloria Kempaka Mugambe Health Economist
United Kingdom	Alastair Robb DFID Representative
WHO	
	William Mbabazi NPO/Surveillance

Zambia

Structure	Name and Position
Government	
Ministry of Health	Godfrey BIEMBA
National Science and Technology Council	Dennis M. WANCHINGA Executive Secretary
National Health Research Advisory Committee (NHRAC)	Mubiana MACWAN'GI Secretary
Research Institutions	
University of Zambia School of Medicine	Yakub F. MULLA Dean
Tropical Diseases Research Center	Emmanuel KAFWEMBE Director
NGOs	
Foundation 50	Sekelan BANDA Founding President
The Zambia Forum for Health Research	Joe KASONDE Director
CHESSORE	T. J. NGULUMBE Director
	Mary TTUBA Acting Director, Social Science Department
Donors	
Canada	Sandy CAMPBELL Project Coordinator, Research Matters
Sweden	Jane MILLER
United Kingdom	Audrey MWENDAPOLE Health, HIV and AIDS Advisor

Donor Agency	Name and Position
Canada (IDRC)	Vic Neufeld (Canadian Coalition for Global Health Research) Ernest Dabiré Senior Program specialist IDRC/WARO (Senegal Office)
Denmark (Danida)	Finn Schleimann Health Advisor Margrethe Holm Andersen Deputy Head / Evaluation Kirsten Havemann Senior Health Advisor
Ireland (Irish Aid)	Dairmuid McClean Senior Health Advisor Annalize Fourie Health Advisor (South Africa Office)
Norway (Norad)	Paul Fife Director Global Health and AIDS Department
Sweden (Sida / SAREC)	Viveka Persson Research Advisor
Switzerland (SDC)	Daniel Mäusezahl Senior Health Advisor
The Netherlands (DGIS)	Harry van Schooten Senior Health Advisor
United Kingdom (DFID)	Sue Kinn Research Manager

Annex 2

NHRS framework

COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT (COHRED)

FRAMEWORK FOR DEVELOPING A NATIONAL HEALTH RESEARCH SYSTEM

USING HEALTH RESEARCH TO IMPROVE POPULATION HEALTH, HEALTH EQUITY, AND DEVELOPMENT.

- The starting point for strengthening a country's health research system is to have **a clear picture of the current state of health research** – and the areas where development should be targeted.
- Using this view, countries can apply various approaches, tools and methods to start **a strategy of system strengthening.**

Stage of development	Actions needed
Basic requirements - socio-political environment	
0. Political commitment to health research	Advocacy, awareness, data and discussion.
0. Political & socio-economic climate human rights	human rights respect & investment friendly.
Level 1 needs – a research-conducive environment	
COHRED's framework, developed in work with many developing countries.	
1. Credibly set and regularly updated health research priorities	Priority setting and updating
2. Health research policy framework	Developing policies/policy framework for research and health research
3. Research management office/mechanism	Exploring mechanisms and structures appropriate to countries' existing structures and aspirations for research.
Level 2 needs - Research implementation	
4. Human Resources for Health Research	Developing a medium and long-term HR-HR strategy and plan.
5. Stable, predictable research financing	Developing medium-long term health (health) research financing mechanisms, including donor alignment and harmonization.
Level 3 needs – Optimizing the system	
6. Improving health research system components	for example: - Research ethics. - Research communication, including evidence to policy & practice. - Peer review vs committee review. - Merit-based promotion system. - Community demands for research. - Monitoring & evaluation of impact . - Health systems research needs. - Good research contracting . - Technology transfer arrangements. - Intellectual property rights. - Institution building.
Level 4 needs – Integrating the national system internationally	
7. Collaborative arrangements	- bilateral - regional - international - organisations - donors / research sponsors

COHRED www.HealthResearchForDevelopment.org

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