Council on Health Research for Development

COHRED supports countries to optimise research and innovation capacity for health, equity and socioeconomic development. *International Innovation* speaks to Executive Director **Carel IJsselmuiden** about the changing global context in which they are working and how they are responding

Why was the Council on Health Research for Development (COHRED) originally set up?

COHRED was established in 1993 out of a concern at the end of the 1980s that health research was not playing its proper role in development in low- and middle-income countries (LMICs). A commission was put together which functioned between 1987 and 1990 and consisted of five Global North and five Global South commissioners. It produced a landmark report, *Health Research: Essential Link to Equity and Development* that found there was a hugely skewed distribution of resources for health research in the world between where it was needed and where it was actually done. This became known as the 10/90 gap in health research – only 10 per cent of the world's resources in health research were spent on diseases that cause 90 per cent of mortality and morbidity. A task force was set up to decide how to act on the report, resulting in the establishment of COHRED. The report made four major recommendations to address the 10/90 gap:

- Every country, no matter how poor, should invest in a strategy for essential national health research to help health departments focus on where they could get most gains and equity, even with very small budgets
- There should be a massive increase in funding for research in global health
- There should be large research partnerships between North and South
- A mechanism should be put in place to assess whether or not the 10/90 gap is closing

Last year, COHRED celebrated its 20th anniversary. How has the organisation's role evolved since its initiation?

In 2011, COHRED and the Global Forum for Health Research merged. In the 1990s, when the organisations were first set up, developing countries were seen to have low capabilities in terms of research and required assistance with expertise and financial transfer. Real research was seen as being conducted in the North and questions of its applicability in the countries where it was going to be implemented were at the forefront. The world is different now; there has been a major increase in the research and innovation capability of the South, so there is now much less need for an organisation that sets research priorities for countries. Across Africa, in spite of the brain drain, most research institutions are now headed by highly competent Africans who have been a part of capacity building for the last 20 years. Of course, there is still a need for money, partnerships and integration, but the role of COHRED is now less about research capacity building and more about optimisation of systems. It is also about creating an environment in which research and innovation can flourish, not only to improve the health of a country's citizens and increase social and economic development, but to become a global player in a competitive market.

Your central goal is for all LMICs to have the basis of well-functioning national health research and innovation systems in place by 2025. How do you hope to achieve this?

We will need to get countries to see this as a development effort. Part of our role is to get governments interested and looking at what others are doing to generate peer competition. Tanzania will be more interested in what Kenya is doing than what the UK is doing, and getting groups together that matter to each other is part of the art of our colloquia and forum meetings. At the global level we have a joint effort with the International AIDS Vaccine Initiative (IAVI), Drugs for Neglected Diseases initiative (DNDi), the Global Health Technology Coalition (GHTC) and others, through which we are bringing together a network to make the case that in the post-millennium development goals (MDGs) and post-2015 development agenda, research should have a far stronger emphasis and there should be significantly increased funding for it. In the lead up to the formulation and acceptance of the MDGs there was a strong drive from the people setting up the health goals, particularly Jeffrey Sachs, for dedicated funds of around US $3.5 billion for research towards the achievement of the health MDGs. However, as is often the case when there is limited funding, research was dropped off the agenda. There's lots of discussion around why the MDGs were not achieved, and part of it was that there was insufficient investment in research and innovation. We are trying to make sure this does not happen again by raising awareness and gathering support.

NATIONAL RESEARCH AND INNOVATION SYSTEMS

Providing country-specific technical support to optimise systems and help develop national research and innovation agendas is one of COHRED's main activities

We carry out studies on what national funds for research are available and what is currently being funded, to get an idea of the local input in health research. We also analyse research and innovation systems to identify strong and weak points. Meaningful country participation in assessments is very important; we don't just do it for them and then hand over a report. Many countries don't have a research agenda which outlines where investment is necessary or where to convince donors to start funding in line with national priorities; so priority setting and research system analysis are our two big competencies in the country support system.

If you have these elements in place the ball starts rolling; countries start forming their own partnerships and deciding where they want to invest their money. For COHRED, the last three or four years have been a learning process in designing national system support, and we are now looking at how to scale up in the most efficient way. To provide an example, Tanzania's Minister of Communication, Science and Technology, Professor Makame Mbarawa, was one of the opening panellists of the first Global Forum for Health Research after the merger, which was held in Cape Town, South Africa, in 2012. He said that Tanzania intended to be a middle-income country by 2025 and that science and technology would help them do that. The President supported this by committing 1 per cent of GDP to be spent on science. However, they face a huge problem with the distribution and monitoring of research funding as the sudden inflow of funds overwhelms the system. So COHRED's country support work is helping them to set up a research information management system: to make calls for proposals, manage the processes, monitor progress and get good quality data on the payback of that research investment.

CRUCIAL COLLABORATION

IJsselmuiden highlights the importance of regional and continental partnerships to accelerate progress and enable LMICs to compete at the global level

Supporting and encouraging global action and regional work across national barriers is an important part of COHRED. This kind of collaboration is key to reach a level where you can start creating systems which have excellence and potential for exports. In general this isn't happening yet and we have set up our new science for health diplomacy arm, which tries to bring people together to find solutions across continents and between different players to deal with the big issues such as drug research and production and health research. Many countries are too internally focused; if you're poor your first aim is to improve your own situation; helping others becomes secondary. So research for global health is seen as a luxury when funds and researchers from high-income countries are involved in collaborations, it is not so prominent in regional collaborations across Latin America, Asia or Africa. There, collaborations focused on socioeconomic impact are more important. However, if you want to get large-scale research or medicine, you have to think about regional or continental approaches. There are tough political barriers to overcome.

As an example, we have been partnering with the West African Health Organisation (WAHO) for several years to develop a dashboard of research system indicators in the 15 countries of the region. Through this they have improved their capability to manage research efforts from a regional level and to encourage participation of the countries that are at the bottom of the income pyramid, such as Liberia and Sierra Leone.

RESEARCH ETHICS

Speeding up the ethical approval time for clinical trials could be a relatively simple intervention with a significant impact

Any health research for drug development needs clinical trials, and these need to be reviewed and approved by research ethics committees. The European and Developing Countries Clinical Trials Partnership (EDCTP) is a flagship European initiative which supports COHRED in mapping research ethics committees across the African continent. COHRED has developed a cloud-based, low bandwidth programme called RHInnO Ethics, which is a management information system for research ethics committees. If implemented properly, RHinnO Ethics could cut 12 months or more out of an average 18-24 month approval review procedure. This could translate into bringing products to market sooner, which would be beneficial for both the company producing the drug and the people who receive it. This package was tried out with support from EDCTP, Pfizer and others. It is now being scaled up and by the end of June 2014 we will have packages in place in Mozambique, Tanzania, Senegal, Botswana and Nigeria (which will be the biggest user by the end of this year). Through a relatively simple intervention like RHInnO Ethics, COHRED can make a very meaningful contribution to improving quality and speed of development of new technologies and drugs, and get them to where they are needed sooner.

FORUM2015: PEOPLE AT THE CENTER OF RESEARCH AND INNOVATION FOR HEALTH

MANILA, THE PHILIPPINES, 25-27 AUGUST 2015

GLOBAL FORUM FOR RESEARCH AND INNOVATION FOR HEALTH

The Forum has transformed from a high- to a low- and middle-income country-driven agenda. IJsselmuiden elaborates on what this will mean for Forum2015

Originally called the Global Forum for Health Research, this organisation was set up in response to one of the recommendations by the original commission and its mandate was to measure whether or not the 10/90 gap was closing by holding an annual meeting and producing a report. The Forum was largely funded by donors, which meant a high-income country perspective, and the drive was to motivate high-income counties to spend more of their money on problems of the South. So the model was still very much one of technology and money transfer from high- to low-income countries. Since we have merged, the forum has been transformed into something quite different; we are aiming for a platform where low- and middle-income countries (LMICs) that are interested in research can help establish the global health research agenda and start becoming active partners in addressing the issues being identified.

The next meeting will be held in the Philippines in 2015. It will be co-hosted and co-funded by the Philippines, who have put up a substantial part of the cost themselves. So it is no longer just a high-income country driven agenda; the agenda will be jointly determined. It is very opportune because 2015 will be the year in which the members of the Association of Southeast Asian Nations will formalise their harmonisation agreement. In those 10 countries we have Singapore, Malaysia and Brunei on one end of the income and research capability spectrum, and Myanmar, Laos, Cambodia and Vietnam on the other – the Philippines, Indonesia and Thailand fall between the two. So it is a really interesting microcosm of low-, middle- and high-income countries. The Philippines will also host the Asia-Pacific Economic Cooperation meeting that year, so we hope to get political mileage for research, industry and collaborations in the region.

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