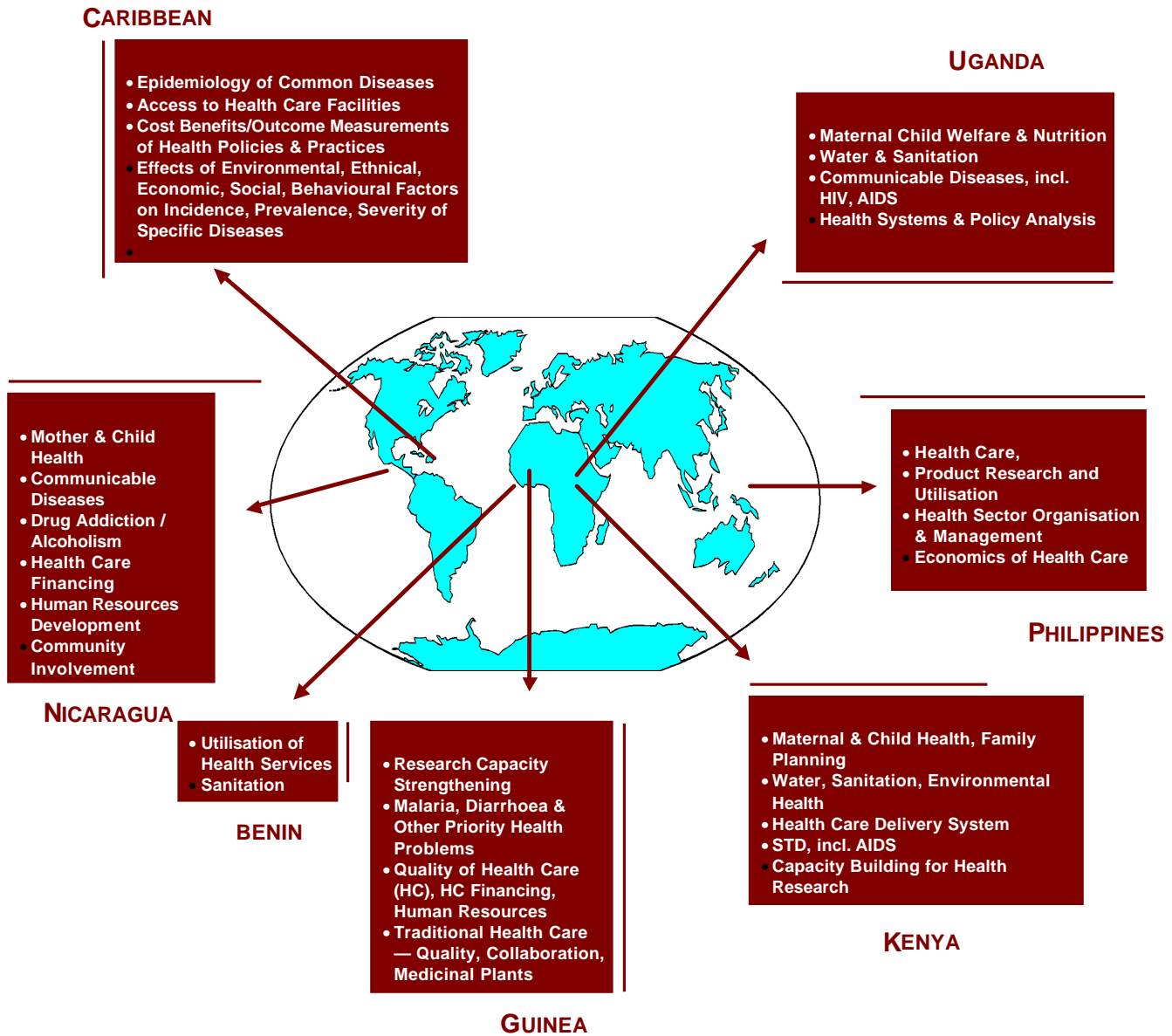


COUNTRY EXPERIENCES WITH PRIORITY SETTING FOR ESSENTIAL NATIONAL HEALTH RESEARCH (ENHR)

A WORKING DOCUMENT



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Annex 1 Synoptic Overview of Country Developments in ENHR

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1. EXECUTIVE SUMMARY

- 1.1 *The Commission on Health Research for Development (1990) demonstrated the low investment in health research in developing countries and a gross mismatch between health research needs and dedicated resources. It was recommended that each country, no matter how poor, should have a health research base, which will enable it to understand its own problems and enhance the impact of limited resources. The process of setting priorities for national health research must be inclusive and involve scientists, decision makers and representatives of the people as equal partners. The resulting national research agendas should serve as a starting point for global research efforts. The Commission called this concept Essential National Health Research (ENHR).*
- 1.2 *The Task Force on Health Research for Development and, since 1993, the Council on Health Research for Development have been working with some forty countries to promote, facilitate and support the implementation of ENHR and to strengthen their research capacities accordingly.*
- 1.3 *The document reviews country experiences in implementing the ENHR strategy, with a particular emphasis on priority setting for research. It looks at processes, mechanisms and outcomes as outlined in plans and based on experiences of seven countries (or groups of countries), namely Benin, Commonwealth Caribbean, Guinea, Kenya, Nicaragua, Philippines and Uganda.*

The review reaches the following general conclusions:

- *The importance of nationally based and essential health research in developing countries and related research capacity strengthening.*
- *The promising experiences of the ENHR strategy in a number of countries. Political support, managerial mechanisms and intra/inter-country collaboration are increasingly being noticed, but there is need to concretise the process now by intensifying research, and developing systems for result dissemination and utilisation.*
- *The importance but also the complexity of setting national health and health research priorities: this should be considered and respected in any process of global health research priority setting.*
- *Most developing countries still have to develop a sound health data base, for which support from the donor community is required.*
- *The importance of considering national needs in setting global health research priorities and of considering the need of enabling countries to develop capacities to contribute to this process.*

- 1.4 *For the ENHR strategy to mature, more and targeted country-specific support will be needed from the donor community. Donors need to appreciate the value of coordinated country activities, a process emerging from the ENHR strategy.*
- 1.5 *A more expanded and detailed study of ENHR experiences and developments, including the institutional arrangements for health research in each country would be valuable for the future to provide in-depth understanding of this new approach.*
- 1.6 *The importance of involving communities and decision-makers in priority setting, and indeed the whole research process, needs greater appreciation. To this end, methodologies for appropriate consultations/participation need to be refined.*
- 1.7 *International initiatives in support of health research in developing countries need to take cognisance of emerging national initiatives and, whenever possible, make country-specific arrangements for the desirable points of collaboration. ENHR seems to offer hope for a novel way of conducting business.*

2. INTRODUCTION

- 2.1 The health of a nation is the responsibility of its people. It is for individual countries therefore to determine their key health problems and action programme. This includes the setting of a health research agenda based on priorities in support of health development. A starting point for the latter process is elaboration of national plans that outline strategies for health research and health sector objectives. National health research provides a knowledge base on which national strategies seeking to improve public health and quality of life are based. International initiatives in health research and in health reform should be supportive of such expressed country needs. Most of the existing international health research programmes, although directed to important health issues, tend to be narrowly focused and are usually expected to have quick outcomes to avoid risk of losing support of their donor agencies. Although some of these initiatives have had positive impacts in disease control, health promotion and capacity building, it remains arguable, however, if they are mobilising sufficient resources and creating the necessary self-reliance in recipient countries.
- 2.2 The Commission on Health Research for Development demonstrated the low level of investment in health research in developing countries and a gross mismatch between health research needs and dedicated resources. It was also observed that research efforts in these countries were fragmented. Further the demand for, and utilisation of, research products was low. Therefore, the Commission concluded that each country however poor needed to develop an integrated health research strategy, to intensify research and the development of research capacity as a means to achieving equity in development since there exists no standard prescription for this. The Commission named this integrated response Essential National Health Research (ENHR).
- 2.3 Much of the research in the past has been determined by needs of individual researchers or their institutions and therefore has tended to be "ivory tower" in nature. ENHR, on the other hand, views the community as central to the whole process of conduct of research. Communities are therefore involved at all stages (participatory research) including priority setting, research and utilisation of products.

- 2.4 The report of the Commission has had a major impact in developing countries. Since its publication in 1990 over thirty countries have so far adopted the ENHR strategy and many more are considering operationalisation of the process. The Task Force on Health Research for Development (TFHRD), the successor to the Commission, in consultation with a number of countries, outlined elements considered important in implementing ENHR at country level and the Council on Health Research for Development (COHRED) continued to work with an increasing number of countries to promote, facilitate and support ENHR. By 1994, some 35 countries are implementing ENHR. One of the elements which will be further examined in this report is the setting of research priorities as a means for guiding action.

3. SCOPE OF THE REVIEW

- 3.1 The point of departure is that ENHR is a sound and potentially sustainable strategy for health research and development at country level. This review examines the element of priority setting by looking at processes, mechanisms and outcomes as outlined in plans and based on experiences of seven countries (or groups of countries) namely Benin, Commonwealth Caribbean, Guinea, Kenya, Nicaragua, Philippines and Uganda. These countries represent developing nations at different stages of development and provide a range of similarities and diversities that could explain a number of common approaches and differences in progress. Their approaches may vary on account of health problems, economic status, institutional and human resources and political backgrounds. The analysis is not an attempt to judge the degree of success or failure of the country ENHR plan. Such an attempt would be premature since the described action programmes are the start of a gradual development process whose impacts on health are only likely to be realised in the years to come. Notwithstanding this there are a number of factors which appear to increase the probability of success. Some of these which can be used as indicators for progress include political, professional and public acceptability; dynamic leadership; establishment of operational and management frameworks; recruitment and networking of national expertise; elaboration of inter-institutional collaboration and coordination; mobilisation of additional resources; promotion of confidence between decision-makers, the public and researchers.

3.2 Benin, Guinea and Uganda are in the grouping of Least Developed Countries (LDC). The Commonwealth Caribbean and Philippines, on the other hand, are relatively more developed with higher per capita incomes, high literacy rates and better health indices. The Caribbean consist of a group of 18 island countries of diverse races, cultures and religions dispersed in a vast area of the Caribbean sea while the Philippines is one nation comprising over 7000 scattered islands. The smallest of the countries under review have populations of around five million (Benin, Caribbean, Guinea, Nicaragua). Politically the countries range from relatively stable to those emerging from prolonged civil strife with destroyed public and private investments (Benin, Uganda). A number of countries have a reasonable research tradition (Philippines, Caribbean, Kenya) while others are at the very beginning of organising their research systems (Benin, Guinea).

Despite the diversities all the countries have taken action to use the ENHR strategy with the belief that the approach is a sound way of addressing inequalities in health, using health research to direct health policy and action.

4. PRIORITY SETTING

4.1 Determining key health issues and eventually setting research priorities are important steps in guiding the country ENHR plan. However, achieving the above is a complex process. Priority setting is not just a technical issue but involves philosophical, political and ethical considerations as well. The fact that there are many interested parties in health development further demands that related decisions should be balanced to avoid imposition from a particular constituency. Having determined research priorities the challenge remains to translate these into tangible projects, activities and other measurable outcomes.

4.2 A basic problem in deciding on key health problems and research priorities arises from definition. Unfortunately there are no universally agreed criteria for determining the main elements in the setting of health priorities. One approach may be to consider disease as the major determinant. An alternative is to focus on people's expressed (and non-expressed) needs. The latter approach, for instance, may lay emphasis on groups at risk (slum dwellers, minority populations) as opposed to the former where diseases are ranked on the basis of negative health indices. Notwithstanding the above there are a

number of ways in which priorities are presently considered. For example, mortality and morbidity data are major determinants in ranking health problems. Burden of disease measures (e.g. DALYS) have recently been used. Economic indicators (productivity loss, cost effectiveness analysis) are also commonly applied measures. Apart from these measures priority determination may be influenced by ethical considerations (e.g. value of life). Finally, political decisions may weigh heavily in influencing determinants of health or health research priorities.

- 4.3 At a subjective level, research priorities could be influenced by informed judgement of health professionals and researchers. Other biasing factors include institutional traditions, allocation of financial resources, donor mission statements and international opinion.
- 4.4 Even after deciding the key health problems, setting of research priorities still requires considerable thought. In the first instance not all health issues need research. Secondly, research for the most part is driven by individual initiative. It could be argued, therefore, that the scientists are the best qualified to identify research themes. On the other hand, the public as consumers and funders of research have rights and expectations that must have a bearing on the choice of research topics.
- 4.5 The basic raw materials for ranking health problems are the country health statistics. That information is usually scattered and may be found in health ministries, peripheral health institutions, universities, research institutes and with other interested groups. Available health data in many developing countries are for the most part lacking in quality which makes it problematic to make conclusive assessments. There is great need, therefore, for countries to build capacities for data collection and analysis to provide disease-specific information and indicate social preferences. Research conducted by multidisciplinary teams increases the value of data. Whatever the type or nature of research, data generated must be of the highest quality so that only valid and scientifically credible findings guide action. Moreover, equal importance should be given to relevance and cost-effectiveness in selecting and producing these high quality data.
- 4.6 As indicated earlier, prioritisation of health problems and the formulation of health research agendas have a number of stake-holders, the main three constituents being the

policy/decision-makers, the community and the researchers. Thus wide participation and broad based consultation or inclusiveness in decision making is absolutely essential in setting of priorities. The constituency with a major stake in health research is the community. As the ultimate beneficiaries of health initiatives, communities not only need to understand the value of research but should also actively participate in expressing their perceived needs and research priorities. Involving communities in the different phases of the research process, including priority setting, is a relatively new approach. In view of its very culturally specific character, there are no standard procedures or specific guidelines for involving communities in research and therefore, countries are learning by doing. Different methods such as public meetings, cross-sectional themes, focus group discussions, interview of community representatives (e.g. NGOs) etc. have been used. Despite this lingering problem it remains vital that community participation be encouraged from the grass-roots and all the way to the national conference on priority setting. Collection of field research data starts at the community and there also ends implementation and action. There is therefore benefit in involving communities as active partners.

- 4.7 Ministries of health are key agencies for making health related decisions and for implementing options and are also the principal consumers of health information. Thus, health ministries should be actively involved in the process of setting priorities and in creating demand for relevant research. The problem, however, has been that of linkages. In particular, the gap between health officials and researchers needs to be bridged. Researchers usually produce piecemeal information and release it in small doses while decision-makers are often faced with broad issues whose solutions require wide ranging information. Therefore, there is a need for convincing policy-makers on the value of applying relevant findings while at the same time making health researchers aware of the importance of being credible and being acutely conscious of the difficulties that the former face in utilising results of research. Several ways of narrowing the gap between the two constituents have been suggested. For instance, J. Frenk identified the following means to supersede potential barriers between researchers and decision makers (Soc. Sci. Med., Vol. 35, 1992) : presence of decision makers in governing or consulting bodies of research centres, collaboration between researchers and decision makers since the early planning stages of a project, identification of intermediate products of research,

executive syntheses, translators of research into policy, joint seminars for analysis of results, meta-analysis, mission-oriented research, definition of utilisation objectives in addition to scientific objectives, greater weight to relevance in evaluation of researchers.

- 4.8 In deciding priorities, consideration of the urgency of issues needing research is important. In some cases problems requiring research only present themselves on certain occasions. Timeliness is, therefore, of essence when this occurs. Priorities have to be flexible to accommodate such demands.
- 4.9 Feasibility and expected cost-effectiveness are very important considerations in setting priorities. Financial resources, available technology, cost and institutional capacities should always be taken into account when selecting research projects. It is vital that countries should recognise their abilities and constraints and model their response to capitalise on their existing research capacity. At the same time they should take into account limitations of implementation, be they political, cost-related, service constraints, etc.
- 4.10 As priority research is conducted there is need to consider the potential impact that expected results are likely to have on health. The greater the probable impact the more value should be given to the research.
- 4.11 International dimensions of health and health research cannot be ignored in country programmes. Rapidly changing health scenes and changing life-styles create challenging global health dynamics. Thus, national research priorities are influenced by global health issues. On the other hand, country priorities are the basis for global priorities. Thus these two aspects constitute a two-way feedback system. However, as earlier indicated, quality of developing country health information required to be improved. Therefore, building of appropriate national capacities, standardisation of methodologies and establishment of criteria should be an important objective of international research initiatives so as to give meaning to global priority determination.

5. **COUNTRY SUMMARIES** (See also Annex 1)

5.1 Introduction

The country documents under review are 5-year ENHR plans. Some provide more detailed two year programmes. In a way the plans could be viewed as medium term. In a few cases they could also be seen as early efforts to develop national health research systems. Criteria used by individual countries to determine their research priorities were dependent on measures available at national or regional levels and combination of these with perceptions of different groups.

5.2 **BENIN**

The ENHR strategy was launched in 1991 at a national conference. This national event had been preceded by a number of other related activities. For instance, a situation analysis showed that research in health was minimal, research institutions were few, human capacities for health research remained unclear and the national financial allocation for research was insignificant. It also came to light that the country lacked mechanisms for setting health and health research priorities. Further, prior to the national conference a series of promotional seminars at district and provincial level conducted to create broad-based support for health research. During the national conference the serious shortage of human resources for research was recognised and a recommendation made to enhance skills through training in research methodology at district level. The meeting saw the need to have a legalised framework to guide the ENHR strategy and also thought it fit to decentralise research activities to promote networking from the grassroots. The national conference further agreed on broad health priorities which were to guide research. Prioritisation was based on available mortality and morbidity data, disease incidence returns, expressed needs of the health system and policy decisions on health reform. At the meeting a number of other important needs such as better collection of health data, strengthening of multidisciplinary research teams and documentation of on-going research were expressed.

A number of outcomes have resulted from the above process. Very significantly ENHR as well as the national research plan were accepted by the Council of Ministers, thus creating an enabling political environment. Mechanisms for research have also been

established since 1992 by formation of central and peripheral ENHR units to implement and monitor activities.

A research plan identifying local collaboration, training requirements, financial needs, and existing constraints emerged. The plan also identified priorities for research. Research has been initiated in a limited number of areas. To improve quality of research skills training workshops have been conducted.

5.3 CARIBBEAN

In 1992 a preparatory meeting for ENHR was held in Curaçao. Participants included researchers, ministry of health officials, women's groups, academia, PAHO and Chief Medical Officers from the region. The meeting acknowledged that most of the research in the past was investigator-driven and, therefore, the ENHR strategy was adopted as a way of redirecting research to meet health service needs and to benefit the most disadvantaged in society.

In 1986 the Caribbean health ministers adopted the Caribbean Cooperation for Health (CCH) initiative which identified six broad areas of priority in health: environmental protection, human resource development, chronic non-communicable diseases and accidents, the health system, food and nutrition, maternal and child health and population (AIDS has later been added). Five years later, goals and targets based on the initiatives were set. The current ENHR plan is based on the CCH initiative although each constituent nation is expected to determine country-specific objectives. The major thrust of the ENHR plan is to develop a coherent regional plan. To achieve this goal a number of seminars and study groups involving researchers, community groups and decision makers are to be organised. Other aspects of the programme are to include research training, institutional coordination, protocol standardisation, promotion of multi-disciplinary teams, project implementation and monitoring. Community participation will be stressed by involving women's groups, NGOs, informal sector workers, teachers, etc.

There have been a number of positive outcomes resulting from recent activities. For example, ENHR has been adopted by regional health ministers as a suitable strategy and an action plan accepted. The Commonwealth Caribbean Medical Research Council (CCMRC) has been identified as a focal point and regional secretariat for ENHR

activities to provide leadership, organise training, coordinate research and mobilise resources. Finally, university medical faculties and health-related institutions have agreed to be partners in conducting essential health research.

5.4 GUINEA

Part of the health policy of the government aims to promote health of the people with special emphasis on vulnerable groups. The policy also stresses population management. The ENHR strategy was introduced to the Ministry of Health and Social Affairs (MPHSA) in 1991 through collaboration between the Task Force on Health Research for Development and WHO-TDR. Prior to 1991 the country had no research policy and grossly insignificant resources were allocated for health research. Further, health research institutions remain weak and lack sufficiently trained manpower. A small Planning Bureau within the MPHSA was established in 1988 to stimulate operational research in support of Primary Health Care (PHC), Essential Drugs Programme (EDP) and Expanded Programme on Immunization (EPI). In 1989 with assistance from IDRC-Canada, this unit initiated modest additional research on malaria and safe motherhood.

The ENHR strategy was officially adopted by a multi-sectoral team from the MPHSA during an international conference on ENHR which was held in Kampala in April 1992. Following this, an intersectoral and multidisciplinary working group (GTI) comprising policy-makers, researchers, medical practitioners and traditional healers was appointed by the health minister to recommend ways of establishing ENHR in the country. The group was charged with the responsibility for identifying major health concerns of communities and those of the health services. The group was also to identify operational constraints and consider all relevant aspects in preparing an ENHR plan. The group prepared a draft report based on reflections of regional meetings, formal and informal group discussions, consultations with public and private health care providers, traditional healers and users of health services.

In September 1992 the health minister formed a "Groupe de Reflexion", comprising scientists, decision makers, academia and allied government ministries to guide development of ENHR. Later in the year a national conference was organised to develop a national agenda based on the GTI report. One of the four groups at the conference

formulated research priorities which were debated and adopted. Subsequently eight specific research projects have been developed. In early 1993 a 5-year ENHR plan, identifying the key health issues, was compiled and approved by a national seminar.

A number of outcomes of the above processes can be identified. A national management structure to guide ENHR activities has been established. Constraints to research which include lack of human research resources and infra-structural weaknesses are now better understood. A national ethical review committee has been established for the first time. Notably, modest research based on identified priorities has been initiated. Finally, a series of activities dealing with a number of related issues such as advocacy, resource mobilisation, networking and information dissemination have been started.

5.5 KENYA

In 1983, the Kenya Medical Research Institute (KEMRI) set its priority research agenda by convening a national conference with representation from the Ministry of Health, other relevant ministries, regional development authorities, interested NGOs and the academia. This guided the research agenda of the institute for the next decade. Community views were not sought. Influenced by recommendations of the Commission on Health Research for Development, a national convention on ENHR took place in June 1991. The basic guiding document for the conference was a situation analysis that was commissioned to examine priority health needs. Views were solicited from health research organisations, individuals, Ministry of Health and national universities. Ten health priorities were identified. One of the four groups at the convention deliberated on health research priorities based on the ten themes. ENHR strategy was adopted at the conference and a task force was established to follow up the recommendations.

As a result of recommendations of the task force, an autonomous National Health Research Development Centre (NHRDC) was incorporated with its secretariat at the National Council for Science and Technology (NCST). In June 1994, NHRDC convened a national conference whose participants included researchers, policy-makers, community representative groups (NGOs) and community members. The conference re-examined research priorities and considered related issues such as capacity building, promotion of ENHR, networking, resource mobilisation and institutional arrangements.

Priority determination was guided by available health statistics, researcher experience and informed individual views. Four broad research themes were identified. Specific research projects were left to be developed by networks of appropriate research groups. In Kenya health research is built on a tradition of health research institutes and medical faculties, some dating back decades from the defunct East African Community. There have also been a number of research oriented NGOs on the scene. In general, research has been individual or institution-driven. Views of communities and decision-makers have not in the past guided prioritisation for research to any significant degree.

Some outcome can be identified as a result of the country ENHR movement. These include critical review of research priorities, greater involvement of policy-makers, establishment of a national mechanism for essential health research development and the bringing closer of researchers from different institutions and disciplines. Specific research protocols are yet to emerge from the identified themes.

5.6 NICARAGUA

Primary Health Care (PHC) remains the basic health strategy in Nicaragua. It had been recognised that one of the main constraints of health development was the weak scientific and technical capacity of the health sector. The ENHR strategy was, therefore, to be used to guide the research development process, increase and widen participation of professionals and communities, establish solid mechanisms for linking research to policy and action and facilitate interaction and cooperation between researchers, policy-makers, providers and users of health care services.

In December 1990 a meeting took place to introduce ENHR. In mid-1991 a policy workshop on ENHR adopted the strategy and proposed a management structure consisting of a national Commission and a Secretariat. The Commission, whose responsibility is to provide overall guidelines, is made up of representatives from the Ministry of Health, academia, research institutions and community organisations. In its meeting of February 1992 the Commission prepared an ENHR work-plan and appointed a Working Group to implement the plan. The commissions met several times to consider proposals emanating from the Working Group.

The Working Group produced widely circulated bulletins which highlighted national and international ENHR experiences. Local workshops at the level of SILAIS, which brought together officials of the health ministry, community groups, research and academic representatives, were conducted aiming to identify the major health problems and also to examine the status of health research at the local level. These workshops discussed perceived priorities and constraints of the health system and of research.

At the end of 1992 the first National ENHR Workshop was convened to develop a national plan. One of the four working groups was mandated to produce priorities for research. A list of twenty key health issues was first produced. In 1993 these were further ranked into six categories of research themes in order of priority, (mother and child, communicable diseases, financing, personnel development, community participation, others, e.g. violence and drug addiction). Specific research protocols were to be developed based on the issues identified. To this end questions needing answers have been posed. A second major workshop on health development and ENHR was organised in April 1994 where important resolutions were passed.

Important developments have included the establishment of a national strategy to implement and coordinate health research which was hitherto absent. A national management mechanism, comprising a non-profit-making body, the Nicaraguan Council of Health Research for Development (NCHRD), has been proposed for the purposes of coordination, advocacy and resource mobilisation. A Secretariat has also been established for programme implementation and monitoring. Priorities for research have been set and plans have been outlined for strengthening human and institutional resources, networking, research documentation and dissemination of results.

5.7 PHILIPPINES

The Department of Health (DOH) believes that health research can contribute to improvement of health and equitable distribution of health care by improving problem definition, health policy formulation and health action and through maximisation of the limited resources. Although the Philippines has a large number of health-related research institutions and a reasonable number of researchers, a survey recently carried out showed that the larger number of health researchers had medical backgrounds and fewer than

10% were trained to doctorate level. Very few researchers had training in epidemiology and social sciences. Also revealed was that most of the ongoing research was biomedical in type.

In February 1990 an ad hoc ENHR committee was formed. This led a few months later to a workshop in the Department of Health where ENHR was introduced to senior representatives in the health sector, including decision makers, health providers and researchers. Towards the end of 1990, the Philippines presented its ENHR provisional plan at an ENHR international conference in Thailand. In early 1991 a consultative meeting of senior DOH officials was organised to plan preparation of an ENHR programme and soon after an ENHR Unit was established in the Ministry. In mid-1991 five ad hoc committees of experts were appointed to develop health priority research agendas on the basis of each of the five main areas of responsibility of the DOH, viz. health sector organisation, disease control and public health, personal health care, health care financing and health product development. Each of the committees was multidisciplinary and represented diverse interests including those of policy-makers, health professionals, and researchers in clinical, biomedical and social sciences. In early 1992, perceptions of health needs of the community were assessed in seven of the fourteen regions through consultations with NGOs, people's organisations and multi-sectoral focus group discussions. Findings of the consultations were compiled into a "people's health agenda" and later incorporated into reports of the ad hoc committees which provided background information for the national conference on ENHR which was convened in April 1992. Proposed priority research was further refined by considering potential benefits to be derived and feasibility. This was done in realisation of the prevailing limited human and financial resources in the country. More specific research areas were further prioritised into short-term (2 year) and long-term programmes. In the final analysis study disciplines and topics covered epidemiological surveys, socio-behavioural studies, health systems, clinical trials, economics, policy and management and basic sciences. Also considered were other supportive areas such as programme management, capacity building, national/regional/international networking and resource generation.

Follow-up meetings between ENHR programme management and donors were held in 1993 and 1994 to highlight ENHR activities and seek donor support for the plan.

Several important outcomes can be identified. For instance, ENHR was accepted as a sound strategy leading to the establishment of a unit in DOH reporting to the Under-Secretary for health. An ENHR Foundation Inc., was established in late 1992 as an efficient means of mobilising financial resources. In early 1993 DOH granted the Foundation US\$ 400,000 as seed money. A management structure for ENHR was established consisting of an Advisory Board, Steering Committee and Programme Managers with a Secretariat housed in the DOH. Other outcomes include networking of local researchers and recruitment of multi-disciplinary teams into health research. Recently at a meeting which was attended by foreign government representatives and donor agencies the Philippines plan was highly regarded.

5.8 UGANDA

The major aim of ENHR in Uganda is to create a science culture in which research plays a major role in policy formulation and action leading to efficient utilisation of the scarce resources available to health and in ensuring that health development is directed by people's needs. As a result of past civil strife in the country the number of health researchers is low. A situation analysis by an ad hoc ENHR committee demonstrated that most current and planned research was either biomedical or clinical and that there was a shortage of epidemiologists, social scientists, health economists, statisticians, information scientists and field researchers.

In February 1991 a national ENHR workshop with representation from government, health care providers, researchers and community groups was hosted by both the Health Ministry and the Uganda National Council for Science and Technology (UNSCT) with support from IHPP. The workshop established an ad hoc committee to look into advocacy for ENHR, facilitation of the process for setting research priorities and improved ways of gathering health information. Membership of the ad hoc committee was derived from researchers, government officials and the community. In preparing its report the ad hoc group consulted researchers, relevant government departments and a variety of communities.

Available health statistical data and information on mortality and morbidity were obtained from the Ministry of Health (MOH) and district health services. Focus group discussions with community representatives were conducted in three of the thirty-nine districts. Five broad health priority areas (maternal and child health welfare, water and sanitation, communicable diseases, nutrition and health systems) were identified. In 1992, UNCST adopted the report of the ad hoc committee including the plan of action. Consequent to this a 3-year National ENHR plan was prepared in 1993. The ENHR Secretariat is housed at the UNCST. Research projects are expected to be based on the above themes and are planned to be conducted at national, district and subdistrict levels and the community will be involved in the entire research process. In the ENHR development process very high priority is given to capacity building and management. The latter includes establishment of an administrative unit, creation of linkages at home between researchers, policy-makers and the people and internationally with donors and research institutions. Finally, documentation is seen to be most important.

Some of the outcomes include establishment of an efficient Secretariat for programme implementation and monitoring. The MOH is very supportive of the ENHR plan and has supported its inclusion in the coming World Bank Health Financial Plan. Some modest funding has also been obtained from donors. Finally several research institutions have shown their approval of the programme and this is significant in terms of networking at the national level.

6. OBSERVATIONS AND COMMENTS

- 6.1 As summarised earlier in paragraph 2.2 the seven countries have very different backgrounds and face challenges that are unique unto themselves. Despite the differences all the seven have resolved to adopt the ENHR strategy as a process through which researchers, decision-makers and community representatives use scientific methods to analyse health situations, identify problems and solve them. To effect this each country has prepared a three of five year plan which details ways it intends to promote, conduct, manage, utilise and evaluate programmes of research. At this stage, it is premature to assess impacts of the ENHR process on health status, health care organisation and health policy, since capacity strengthening, research production and its translation into decisions and actions will take time to emerge. Naturally, the period of time until this point is reached, will depend on the types of projects and the level of research development in a given country.
- 6.2 It is probably true that a crucial step in the plan is to translate intentions into concrete research action. It is important, therefore, for the plans to receive tangible support to enable transformation of ideas into projects and in this way participants can learn practically by doing. With shortage of national funds for research in the poorer countries some assistance from committed donors would be a great morale booster. All the seven countries are implementing a number of projects. Research could be intensified if more funding were available.
- 6.3 In the countries above the first steps in the adoption of the ENHR strategy were realised through seed grants that enabled nationals to organise brain-storming and planning meetings. In the present cases either the Task Force/Council on Health Research for Development alone or in collaboration with other programmes (for instance, WHO-TDR and IHPP) and/or (bilateral or multilateral) donor agencies were instrumental in enabling this first step.
- 6.4 A unique aspect of the in-country processes described above was that policy decision makers, researchers, academia, health care providers, interested NGOs, women's groups and individual community members were assembled together to review the national

status of health and to describe from their own perspectives and perceptions what actions were needed.

- 6.5 The three main stake holders have knowledge on health issues or health research that is derived from their different backgrounds. Communities were invited to express their perceived health needs. Since they remain the ultimate beneficiaries of health action and are also often subjects of research, communities need to have inputs into the processes of priority setting and must stay active partners in research and action. The practical difficulty has been how best to obtain the most valuable contributions from them especially in situations where levels of education are low. The seven countries have used an array of methods to involve communities. In a few instances cross-sectional surveys were undertaken. In others discussions with community representatives (e.g. NGOs, women's groups, field administrators etc.) were used to generate information. Focus discussion groups were also conducted. Individuals or community representatives were always invited to participate in discussions at district, provincial and national levels. Finally, most working and policy-guiding committees have lay participation to ensure community representation. To further enrich community involvement some programmes considered holding seminars to enlighten the public on research. Communication techniques that reach the public and convey information in a form that is understandable to them have been tried as a way of narrowing the gap between the researcher and the consumer.

Decision makers often see broad issues that are based on existing or intended policy decisions or change and may also be privy to pressing problems in health care delivery. The researcher is expected to understand these concerns and in consultation with others to determine whether research is applicable and, if so, which type. The necessity to bridge the gap between researchers and bureaucrats is the key to success of health research strategies if products of research are to influence action. In the cases under review visits to ministries of health, discussions at peripheral health centres, seminars, bulletins, conferences, etc., were used to narrow the communication barriers that have traditionally existed between the researcher and the policy maker.

- 6.6 All ENHR plans have gone through several steps to determine the key health problems and active dialogue generated excellent cooperation between the three constituencies.

Based on these consultations, which also served as filtering processes, research priority areas were narrowed and agreed.

In two of the countries health priorities had been set in the past (Caribbean, Philippines). In these countries some of the actions required through ENHR were to establish new organisational and management frameworks to include participation of communities to reorient decision-making and to encourage researchers to focus their investigations on areas of public demand. From a more general point of view, ways of institutionalising or maintaining an interactive process between the three constituencies to bond them to remain active partners in health research require more thought. Lessons can already be learned from the variety of experiences in the countries under review.

6.7 Where no clear health priorities had been set, actions included search for existing data on disease profiles especially information on morbidity, mortality and incidences. Information on government health plans and policy decisions on health was also sought. To supplement these statistics and policy guidelines, surveys and discussions were conducted where appropriate. Ministries of health, other relevant sectors, research centres, individuals, interested groups and organisations were approached to give their views. What is admitted as fact by countries is that health information and statistics remain incomplete, scattered and of inferior quality. To give more accuracy to the setting of priorities there is need to increase national capacities to conduct appropriate research using better standardised methods, document accurately, and analyse and disseminate the data in professional ways. Good and accurate information at country level will give meaning to the setting of regional and global health priorities and consequently health research agendas and, therefore, help to channel both national and international resources better. Global priority setting is likely to remain somewhat moribund unless it can rely on the complementarity of a priority setting mechanism based on the perceived needs of the population.

6.8 There are a number of important developments arising out of the ENHR country activities that need to be exploited to enhance research development. Political and governmental backing of the strategy is a crucial step in mobilising local country resources for research. In all the cited countries that step has been attained. In a few of the countries the process has gone further with governments devoting extra funds, incorporating ENHR

plans into national development plans and even including health research in government briefs prepared for major donors and funding agencies. The other significant advances include establishment of research managerial systems and creation of local research groups recruited from different institutions. These perspectives are essential for performance and sustainability of programmes.

- 6.9 Finally the need to harmonise research activities at country level, whoever the donor happens to be, seems vital for logical development of research and its applications. It is fundamental that the point of focus for donor support should be the country's identified needs and yet this principle is often not respected. ENHR programmes have a responsibility to include existing international research agencies and programmes into their equation. There is every likelihood that both national programmes and those of donors will benefit from the ensuing collaboration.

UGANDA

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<p>⇒ Consultations with</p> <ul style="list-style-type: none"> ◆ Decision Makers (Meetings) ◆ Researchers (Questionnaire, Interviews, Meetings) ◆ Communities (District Seminars, Focus Group Discussions) <p>⇒ National ENHR Workshop (1991)</p> <p>⇒ ENHR Donor Workshop (1994)</p>	<p>Health Committee — Uganda National Council for Science & Technology</p>	<p>⇒ Maternal Child Welfare & Nutrition</p> <p>⇒ Water & Sanitation</p> <p>⇒ Communicable Diseases, incl. HIV/AIDS</p> <p>⇒ Health Systems & Policy Analysis</p>	<p>Report on the Uganda National ENHR Workshop (18–20/02/91), MoH and Uganda National Council for Science & Technology, 1991</p> <p>Report of the Africa and ENHR International Conference (13–16/09/92), MoH and Uganda National Council for Science & Technology, 1992</p> <p>ENHR: Summary of Progress, Plans and Budget 1993–1995, MoH, Uganda National Council for Science & Technology and COHRED, 1993</p> <p>Report on a workshop to mobilise resources to support ENHR for Uganda, (14–15/02/94), MoH and Uganda Council for Science & Technology, 1994</p>

NICARAGUA

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<ul style="list-style-type: none"> ⇒ Meetings of National Commission for ENHR ⇒ Local ENHR Workshops in Seven Silais (local systems of integrated health services) 	<p>National Commission for ENHR, incl. (at present) Executive Secretariat</p>	<ul style="list-style-type: none"> ⇒ (First group of priorities only) ⇒ Mother and Child Health ⇒ Communicable Diseases 	<p>Prioridades de investigaciones esenciales en salud y potencial de recursos humanos, Comision Nacional Investigaciones Nacionales Esenciales en Salud, 1992</p>
<ul style="list-style-type: none"> ⇒ National ENHR Workshop (1992) 	<p>(in future) Nicaraguan Council for Health Research for Development</p>	<ul style="list-style-type: none"> ⇒ Drug Addiction/Alcoholism ⇒ Health Care Financing ⇒ Human Resources Development 	<p>Comision Nacional Investigaciones Esenciales en Salud (ENHR Newsletters 1992—1994)</p>
<ul style="list-style-type: none"> ⇒ ENHR Donor Workshop (1994) 		<ul style="list-style-type: none"> ⇒ Community Involvement 	<p>Essential National Health Research Development Plan 1994—1998, National Commission for ENHR and COHRED, 1994</p> <p>Workshop on Health Development and ENHR, Executive Summary. (20–22/09/94), National Commission for ENHR, 1994</p>

BENIN

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<p>⇒ Departmental Seminars and Search Conferences to Identify Priority Health Problems (1991)</p> <p>⇒ National ENHR Seminar to Identify Health Research Priorities (1991)</p>	<p>Cellule Nationale Décentralisée de la Recherche Nationale Essentielle en Santé, with Secretariat within the Centre Béninois de la Recherche Scientifique et Technique</p>	<p>⇒ National</p> <ul style="list-style-type: none"> ◆ Utilisation of Health Services ◆ Sanitation 	<p>Rapport général — Séminaire sur les problèmes prioritaires nationaux dans le domaine de la santé et les stratégies de recherche, Ministère de la Santé, 1991</p>
<p>⇒ Establishment of National, Departmental (6) and Local Units for ENHR (1992)</p>		<p>⇒ Departmental</p> <ul style="list-style-type: none"> ◆ Malnutrition ◆ Illiteracy ◆ Conversion of agricultural products 	
<p>⇒ Departmental Training Seminars in Research Methods (1993)</p>		<p>⇒ Local,</p> <p>for example,</p> <ul style="list-style-type: none"> ◆ Community Participation in Health ◆ Anaemia ◆ Water and Sanitation 	<p>ENHR Five Year Plan 1993–1997 (also available in French), Cellule Béninoise Décentralisée de la Recherche Nationale Essentielle en Santé, 1993</p>

CARIBBEAN

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<ul style="list-style-type: none"> ⇒ Two ENHR Workshops (1992) ⇒ National & Regional Consultations with MoH, Universities & Community Groups ⇒ Networking with other Commonwealth Health Secretariats (1994) ⇒ ENHR on Agenda of Conference of CARICOM Ministers Responsible for Health (1994) 	<p style="text-align: center;">Commonwealth Medical Research Council</p>	<ul style="list-style-type: none"> ⇒ Epidemiology of Common Diseases Within and Between Racial Groups ⇒ Access To Health Care Facilities ⇒ Cost Benefits and Outcome Measurements of Health Policies and Practices ⇒ Effects of Environmental, Racial, Economic, Social and Behavioural Factors on Incidence, Prevalence, Severity of Specific Diseases 	<p style="text-align: center;">Picou, D. & Stuart, K., <i>Caribbean Cooperation in Health Research Perspectives</i>, Commonwealth Medical Research Council, 1991</p> <p style="text-align: center;">Report of the Workshop on ENHR for the Caribbean (27–29/09/92), Commonwealth Medical Research Council, 1992</p> <p style="text-align: center;">Proposal: Essential National Health Research for the Caribbean, Commonwealth Medical Research Council, 1994</p>

GUINEA

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<ul style="list-style-type: none"> ⇒ ENHR Working Group of Policy Makers, Researchers, Traditional Healers (1992) ⇒ Round Tables with Health Care Workers and Users of Health Services in Five Regions (1992) ⇒ National ENHR Conferences to Develop National Health Research Agenda (1992, 1993) ⇒ National Ethical Committee for Health Research (1993) 	<ul style="list-style-type: none"> ◆ ENHR Consultative Committee ◆ Technical Service for Coordination of ENHR ◆ National Ethical Committee for Health Research within the Ministry of Science and Technology 	<ul style="list-style-type: none"> ⇒ Research Capacity Strengthening ⇒ Priority Health Problems, incl. Malaria, Diarrhoea, etc. ⇒ Priority Problems Related to Modern Health Care, incl. Quality of Care, Health Care Financing, Human Resources, etc. ⇒ Priority Problems Related to Traditional Health Care, incl. Collaboration, Medicinal Plants, Quality, etc. 	<p>Document de réflexion pour l'atelier national sur la Recherche Nationale Essentielle en Santé, Groupe Technique Intersectoriel, 1992</p> <p>Recherche Nationale Essentielle en Santé en Guinée: politique et stratégies, Ministère de la Santé Publique et des Affaires Sociales, 1992</p> <p>ENHR: Summary of Progress, Plans and Budget 1993–1997, Ministry of Health and Social Affairs and COHRED, 1993</p> <p>Code d’Ethique pour la Recherche en Santé, Ministère de la Santé Publique et des Affaires Sociales, 1993</p>

KENYA

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<ul style="list-style-type: none"> ⇒ Two National ENHR Conventions (1991, 1992) ⇒ ENHR Task Force ⇒ Community Survey (1992) ⇒ Workshops in Three Rural and Two Urban Districts (1993) ⇒ Workshop, incl. Policy Makers, Researchers, Community Leaders to Prioritise Research Areas (1993) ⇒ ENHR Donor Workshop (1994) 	<p>National Health Research & Development Center with Secretariat within the National Council for Science and Technology</p>	<ul style="list-style-type: none"> ⇒ Maternal and Child Health incl. Family Planning ⇒ Water, Sanitation and Environmental Health ⇒ Health Care Delivery Systems ⇒ Sexually Transmitted Diseases incl. Aids ⇒ Capacity Building for Health Research 	<p>Proceedings of the Convention on Essential Health Research in Kenya (3–6/06/91), Task Force on Essential National Health Research, May, Kenya, 1991</p> <p>The National Health Research Plan 1994–1997, National Health Research and Development Centre, 1994</p> <p>Report of the Convention on National Health Research Plan (26–28/05/94), National Health Research and Development Centre, 1994</p>

PHILIPPINES

PROCESS	MECHANISM	PRIORITIES	SELECTED DOCUMENTS
<ul style="list-style-type: none"> ⇒ Workshops and Consultative Meetings (1990, 1991) ⇒ ENHR Unit within MoH (1991) ⇒ Ad-hoc Committees of Experts To Develop Health Research Programmes (1991) ⇒ Consultations with NGOs, People's Organisations, and Multi-sectoral Focus Group Discussions in Seven Regions (1992) ⇒ National ENHR Conference (1992) ⇒ Two ENHR Donor Workshops (1993, 1994) 	<p>ENHR Unit under the Office of the Chief of Staff and the Under-secretary of Health</p> <p>Philippine ENHR Foundation, Inc.</p>	<ul style="list-style-type: none"> ⇒ Health Care <ul style="list-style-type: none"> ◆ Infectious Diseases ◆ Non-infectious Diseases ◆ Special Groups & Programmes ⇒ Product Research and Utilisation <ul style="list-style-type: none"> ◆ Rational Drug Use ◆ Vaccines ◆ Diagnostic Reagents ◆ Pharmaceuticals ⇒ Health Sector Organisation and Management <ul style="list-style-type: none"> ◆ Policy Studies ◆ Health & Management Information Systems ◆ Human Resources ⇒ Economics of Health Care <ul style="list-style-type: none"> ◆ Impact of Macro-economic Policy ◆ Cost-effectiveness ◆ Community Health Care Financing ◆ Community-based Health Insurance 	<p>Report of the National Conference on Formulation of Research Agenda for ENHR (24–25/09/92), Department of Health, 1992</p> <p>Executive Summary of People's Consultation on Health Concerns, Department of Health, 1992</p> <p>ENHR: Summary of Progress, Plans and Budget 1993–1997, ENHR Unit, Department of Health and COHRED, 1993</p> <p>Tuklas Lunas: Essential National Health Research, Philippines, 1994</p> <p>Conference Report Phase II of ENHR, Donors Meeting (20–21/04/94), Department of Health, 1994</p>

ANNEX 2 — COMMISSION, TASK FORCE AND COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT, SELECTED DOCUMENTS

- Health Research — Essential Link to Equity in Development, Commission on Health Research for Development, Oxford University Press, 1990.
- Karolinska Institute Nobel Conference No. 15 — Health Research for Development, SAREC Documentation, Conference Report, 1990:1.
- A Strategy for Action in Health and Human Development, Task Force on Health Research for Development, Geneva, 1991.
- Report of the Africa and ENHR International Conference, Ministry of Health and National Council for Science and Technology, Uganda, 1992.
- International Conference on Health Research for Development, Council on Health Research for Development. Geneva, 1993.
- Report of the First Asian ENHR Networking Meeting, Philippines, 1994.
- Report of the First African ENHR Networking Meeting, Kenya, 1994.
- Science for Health, Council on Health Research for Development, Geneva, 1994.
- Research Capacity Strengthening for Essential National Health Research, Geneva, 1994.