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The Newsletter of the Council on Health Research for Development

Research into Action

Inside this Issue

By the time this issue of *Research into Action* goes to press, the International Conference on Health Research for Development, to be held in Bangkok in October 2000, will almost be upon us. Around 700 participants are expected to attend the conference, and its associated meetings - the result of a partnership between WHO, the World Bank, Global Forum for Health Research, and COHRED.

Although not all of you will be able to attend, we hope that the articles in this issue will go some way towards painting a picture of the COHRED/ ENHR contribution to the conference. A total of forty parallel sessions will take place, eight of which are either the sole, or joint responsibility of COHRED. A major section of this issue brings you detailed information on those sessions.

We also hope that *Research into Action* readers will join us from the 10-13 October for the 'virtual conference' on the internet, where many of the highlights of the conference will be reported via the official conference website: http://www.conference2000.ch/ .

Also in this issue we provide you with a special preview of the *regional input* to the international conference. Since mid-1999, six regions (Africa, Asia, Caribbean, Latin America, Central and Eastern Europe & the Newly Independent States, and the Eastern Mediterranean) have been engaged in a consultative process which is intended to inform the conference programme on a number of levels. At a country level, the consultations have been an invaluable exercise in evaluating national research capacity, and promoting the role of health research in development.

You will recall that we have, in previous issues, run a series called "Opinion Pieces". The Opinion Pieces were interviews with a variety of personalities from COHRED's past and present. This series was intended as a run-up to the Bangkok conference. Our final interview in this series is with Yvo Nuyens, COHRED's coordinator, who is "looking forward in the mirror" - providing both his personal input to the international conference, and his insights on a future for COHRED.

Finally, we bring you news of a forthcoming publication. In December, IDRC will publish *Forging Links for Health Research: Perspectives from the Council on Health Research for Development*. The book represents the culmination of a major collaborative effort between many individuals – in particular from low- and middle-income countries.

See you in December!

*The **Research into Action** Team*

Countries and regions provide input to International Conference on Health Research for Development

Representing the first time that four leading partners in the field of health research for development have joined forces to draw up a common agenda for health research leading into the next 10 years, the partnership between the World Health Organization (WHO), the World Bank, the Global Forum for Health Research, and the Council on Health Research for Development (COHRED) will ensure that the international conference becomes a landmark meeting in its own right. The conference will provide a forum for international, regional and country institutions and networks to develop an action plan in support of a truly global partnership serving a rapidly changing world.

Since mid-1999, as part of the groundwork to develop this global partnership, a series of consultations have been held with countries and regions. COHRED, in its capacity as executing agency for the International Organising Committee for the conference, facilitated this process of consultations and played an active part in each of the regional meetings. The process was aimed at obtaining background material (including national case studies) which would lay the foundations for a number of interactive sessions at the conference. In particular, these consultations have:

- Obtained information on national and regional experiences in health research
- Solicited country and regional perspectives, including ideas and opinions on the critical issues for health research in the future
- Forged more effective and creative partnerships which should benefit health research in the long term.

At the country level, the process is further intended to provide recommendations related to the strengthening of national research capacities, and to promote the role of health research in development. Background information, a brief summary of the methodology, and some key messages arising from each of the regional consultations are presented here.

Dr Gonzalez, Dr N'Diaye, Dr Nuyens, and Dr Nafo (Minister of Health, Mali) at the francophone West Africa Consultative Meeting in Mali, June 2000.

It is important to note that these country and regional consultations have created important momentum and stimulated renewed interest in regional collaboration in health research for development. As a consequence, most regions have already planned a series of follow up activities, to bring the discussions and recommendations from Bangkok to their region and to start translating them into action.

Regional consultative processes: essential information

Africa

The consultative process for the African region was introduced, reviewed and designed at the African Conference on Health Research for Development (Harare, Zimbabwe), in September 1999. This meeting, organised by COHRED and co-sponsored by the WHO Regional Office for Africa, brought together some 150 stakeholders in health research from over 20 countries and also representatives from a number of leading health research networks in the region. An in-depth analysis of 15 countries (Benin, Burundi, Cameroon, Egypt, Ethiopia, Kenya, Mali, Mauritius, Nigeria, Senegal, South Africa, Sudan, Tanzania, Togo, Zambia), and an abridged analysis in a number of other countries was selected as the overall approach to the consultations in the African region. At least 150 people were involved in these national consultations. The analysis was undertaken using the following sources:

- Literature review
- National surveys
- Focus group discussions and one-on-one interviews
- Selected country visits
- Electronic conferences
- National consensus-building meetings for various stakeholders.

A regional synthesis meeting took place in Cape Town, South Africa 27-30 May 2000. The meeting reviewed the history of health research in Africa and agreement was reached on the basic issues that needed to be considered when charting Africa's future course in health research. The meeting drafted twelve key messages addressed to national governments and to the international community.

For further information, please contact: Mutuma Mugambi
Email: mugambi@net2000ke.com

Asia

An innovative approach to the consultative process was adopted in the Asian region. Coordinated by the College of Public Health at Chulalongkorn University (Thailand), some 350 stakeholders throughout the Asian region participated in electronic discussions through an internet-based "Distance Dialogue". The electronic dialogue evolved into the Asian Voice, including three basic health research concepts:

- A new paradigm for health research emphasising vision and equity, a transition from parochial to regional and global needs, and replacement of technical jargon with layman's language and consumer orientation
- A framework around which to build an Asian regional architecture for health research cooperation and meaningful participation in the evolving global system
- Required action for more effective health research.

These concepts were further elaborated and subsequently concretised during 'The Asian Forum for Health Research' held from 17 to 19 February, 2000 in the Philippines. This meeting was attended by approximately 100 participants, from 17 countries. Specific stakeholders included basic researchers, medical and health scientists from a number of fields, NGOs, policy makers, representatives of private enterprises and donors.

For further information, please contact: Chitr Sitthi-amorn
Email: chitr@chula.ac.th

Caribbean

Consultations in the Caribbean region were held in three stages, using various methodologies and tools (such as: analysis of documents, meetings of stakeholders, country and regional visits, and questionnaires) to collect information. In stage one, key national stakeholders were sensitised to the importance of formulating a Caribbean Health Research Agenda for the next 10 years. A workshop held in Jamaica on February 1, 2000 presented a draft of the Caribbean Health Research Agenda, and the process for refining this was agreed upon. The region's Chief Medical Officers and directors of regional health research institutions attended this initial workshop. Stage two consisted of a brainstorming session held in April to further develop the Health Research Agenda. This session was attended by representatives of the region's Ministries of Health, universities, and health institutions. Representatives from PAHO and UNAIDS also attended the meeting. Stage three of the consultations was a retreat attended by eighteen participants representing Caribbean countries, regional health institutions, various disciplines, and interest groups, held in July, in St Lucia. Commissioned papers on six of the Caribbean region's eight priority research areas were presented at the retreat.

For further information, please contact: David Picou
Email: chrc.tt@trinidad.net

Latin America

Following an initial meeting in Mexico in November 1999, the consultative process in Latin America has expanded and now encompasses representatives of the research community in at least 7 countries, and two health research networks within the region. Stakeholders in the process include representatives of research councils, universities and government entities. A regional consultative meeting was convened in Buenos Aires on 26-28 June, at the invitation of the Argentine Ministry of Health. Discussions focused on the importance of creating greater awareness of the region's complexity at an international level. Issues included the quest for equity, financing of health research, priority setting and human resource training, and better coordination among the various stakeholders in health research. Chile, Mexico and Cuba undertook country case studies. At the network level, a further case study was undertaken by the Network for Latin American and Caribbean Women. This study illustrated the lack of a gender approach in research in the region and highlighted the need to deepen the understanding of the gender concept.

For further information, please contact: Delia Sanchez
Email: geops@chasque.apc.org

The Regional Synthesis Meeting for Latin America was held in Buenos Aires, 26 - 28 June 2000.

Central and Eastern Europe and the Newly Independent States (CEE/NIS)

The countries of Central and Eastern Europe and the Newly Independent States have inherited very similar research structures. Throughout the region, health research is in a state of transition to a more decentralised structure.

A sub-regional meeting in Hungary, November 1999, initiated the regional consultative process for this region. Six countries (Hungary, Kazakhstan, Lithuania, Romania, Russian Federation and Uzbekistan) were selected for case studies.

On 12-13 May 2000 a regional consultative meeting, sponsored by the WHO Regional Office for Europe, was held in Balatonlelle, Hungary to review the analytical work central to the consultative process. Recommendations arising from the consultative process are featured on page 5. Participants included representatives from: the six case-study countries (including members of the ministries of health and other government bodies, and of universities), Belarus, donor agencies, the Global Forum for Health Research, COHRED and WHO. A SWOT (strengths, weaknesses, opportunities and threats) analysis was conducted for the region.

For further information, please contact: Peter Makara
Email: bha@who.dk

Eastern Mediterranean

Ten countries participated in the Eastern Mediterranean consultative process: Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Oman, Pakistan, Sudan, Syrian Arab Republic and Tunisia. Each of these countries conducted a case study to review the national health research situation. A regional synthesis meeting was held from 24 to 26 June 2000 in Cairo, facilitated by the WHO Regional Office for the Eastern Mediterranean, to review the current health research situation in the region and to propose future directions for health research. The meeting was attended by 16 representatives from the 10 participating countries, as well as by COHRED and WHO staff members.

Professor Marian Jacobs at the Regional Synthesis Meeting for the African Consultative Process.

For further information, please contact: A Mechbal
Email: mechbala@who.sci.eg

Key Messages from the Regions

This section provides a general summary of key messages arising from each of the regional consultations. These messages have been fed into the global synthesis, which will in turn, inform specific sessions of the International Conference on Health Research for Development.

Africa - Key Messages

- Invest more in health research in order to correct current inequities
- Focus on countries first
- Place human development at the forefront of the political process: Promote political stability so that health research (as a long-term investment) is sustainable
- Establish national mechanisms for coordination of health research to ensure effective use of resources
- Capacity building and retention are central to the long-term success of health research development and must, therefore, be given the highest priority
- Advocacy of health and health research to create a culture of decision-making based on hard evidence, and of relevant, high quality research
- International collaboration is needed to develop a code of ethics that is sensitive to national and regional issues
- Partnerships with the North should be guided by the principle of equality
- Create a sense of ownership that can be translated into stronger support for research from national resources, including the political mainstreaming of health research
- Create an African Regional Forum: a platform to address common issues and to foster the convergence of national, regional and global inputs to health research in Africa
- Equity in health remains a central concern, which health research development in Africa must always take into account
- Set practical action agendas at the national, regional and global levels as part of a long-term process for building up health research in Africa.

Asia - Key Messages

The Asian Forum for Health Research focused on three basic concepts: a new paradigm for health research; architecture; and required action.

The new paradigm for health research addresses new processes that are emerging in health research that encompass the following:

- An emphasis on vision and equity
- Consumer orientation, with the focus on practical prerogatives
- Emphasis on interaction between the protagonists, and between outputs and impacts
- Stress on the role of the owners of knowledge that leads to action for development instead of the donor/beneficiary relationship
- Greater use of lay language and less technical jargon with the emphasis on the needs of the respondent rather than the sponsor's priorities
- Movement away from parochial to regional and global needs
- Consultative process that replaces an agenda imposed by donors/sponsors.

At the national level, the key messages related to the new architecture for health research were:

- Ensure political commitment to equity
- Set priorities for research
- Identify partners for networking initiatives
- Support inclusive and interactive ways of working
- Be responsive and relevant
- Commit to transparent and accountable ways of working.

A number of specific lines of action are needed to build the new architecture that is designed to support greater equity in health research as follows:

- Action for leadership: The strategy calls for a new cadre of equity-oriented, high performance research managers
- Action tools and methodologies:
  - innovative mechanisms for research co-ordination at all levels
  - effective promotion and advocacy
  - research priority-setting, based on sound situational analysis
  - resource mobilisation tools
  - processes for networking and partnerships
- Empowering tools for research action: For stakeholders to link research to action the following tools are needed:
  - policy and action oriented research
  - more community participation
  - better use of information and communications technologies
- Tools and methodologies for Equity watch: To measure progress towards equity good tools must be made widely available through the Internet and as printed training modules
- Action to use new information and communications technologies.

Caribbean - Key Messages

- Development of a health information system would assist monitoring and evaluation efforts
- Create a "research culture" in the region, particularly in medical education
- Capacity building for health research is essential
- Devise mechanisms for obtaining funding for health research
- Promote intersectoral collaboration between Universities, the public and private sectors, and regional research institutions, and facilitate this process

More than 100 participants representing 17 countries were present at the Asian Health Research Forum.

- Encourage each country to develop National Health Plans to increase coordination of national research activities
- Translate research findings into material that can be used to shape policy, programmes, and action.

Central and Eastern Europe and the Newly Independent States - Key Messages

- Build sustainable partnerships between researchers and politicians/policy-makers
- Improve national process of priority setting
- Forge interdisciplinary links so that scarce resources are utilised more effectively
- Reinforce research management and emphasise quality of research
- Strengthen and intensify regional networking and cooperation
- Create networks of professional societies to promote the exchange of information and experience and for joint action
- Create a regional clearing-house for research projects and findings.

Eastern Mediterranean - Key Messages

- Strengthen health research units in Ministries of Health, create a demand for research
- Establish National Forums to increase interaction between various stakeholders in research
- Promote health research as an integral part of health development
- Set research priorities at subnational and district levels, as well as at the national level
- Develop explicit policies for funding particular types of research, and create mechanisms to monitor this

The Eastern Mediterranean Regional Consultative Meeting, held in Cairo 24 - 26 June 2000.

- Strengthen research capacity by targeting young researchers, and developing their skills in research design, methods, analysis, and writing scientific papers
- Create functioning research networks that serve the region effectively
- Demystify research by creating a 'culture' where research training is integrated into medical education, and planning for research becomes an intrinsic component of national health plans.

Latin America - Key Messages

- Strengthen research that is oriented towards solving social problems and understanding the needs of the population, aimed at overcoming inequities
- Increase publication in international scientific publications, so as to accurately reflect the actual scientific knowledge present in the region
- Recognise region's diversity, embrace and promote this factor to international agencies
- Encourage more research that leads to action and policy
- Create a mechanism to promote partnerships, encourage community participation, and democratise knowledge. This includes creating a mechanism to facilitate health research information dissemination.

Participants at the Latin American Regional Synthesis Meeting in June.

Please note that full reports of each of the consultations including contact details, are available from the Conference Secretariat on request. For further information on the consultative process or the International Conference on Health Research for Development, please contact the Conference Secretariat.

Tel: +41 22 917 8554
Fax: +41 22 917 8015
Email: conference2000@cohred.ch
Conference website: www.conference2000.ch

Looking forward in the mirror

An interview with Dr Yvo Nuyens, Coordinator of COHRED

The issue of health research is getting increasing focus nowadays internationally. Why do you think that is?

I see three major reasons for this increasing focus. First of all, there is a growing recognition that investing in health is critical to economic productivity and human development and that the application of knowledge is central to global development. Thus, research is not only a strategic tool leading to improvements in health – it is a driving force behind all development. Secondly, the publication in 1990 of the report of the Commission on Health Research for Development, followed during the nineties by a number of other prestigious reports, including the World Bank report on health (1993) and the report of the WHO Ad Hoc Committee on health research, definitely created a momentum for health research. And finally, but not least, a number of countries have discovered the strategic value of research in reforming their health system. Having said that, it is however clear that we have a long way to go yet before the aims of the Commission are fully realised.

Why do you say that? Surely the topic of health research gets enough discussion?

Discussion yes. There is plenty of rhetoric. There are many people moving between Washington, Geneva and London, from one meeting to another, including a transit-stop in the capital of a developing country. They produce highly intellectual trend reports about and for the developing world, seldom in dialogue and partnership with developing countries. Many of these people still see health research as an academic exercise, and therefore live, think and act in a kind of solitude, remote from reality, and this despite all the international travel, despite all the wonderful communications we have at our disposal today.

You mean that the international experts are out of touch with reality?

Well I don't want to generalise. But I mean that, for whatever reason, we often forget that what we are supposed to be doing is alleviating misery and easing human suffering. Somehow that seems to get overlooked or just ignored. You can see this solitude that I referred to - call it isolation if you want - at international level, but also at country level too. Even at country level there are people - deans of medical schools,

health planners, heads of NGOs - who seem to be distant from the reality of what ordinary people have to put up with. Not all of them, of course, but there really is too much solitude - isolation from reality - in this world. Things like AIDS and war kill people and destroy families and communities; we can't just go on with our work as if they don't exist.

So what is COHRED's role in this?

> "We see health research as an inclusive process..."

A key role COHRED is trying to play is breaking down the barriers that create this double isolation. Its focus is on the junction between the reality of life for so many ordinary people and families, with all the suffering and inequality they experience, and the various authorities at different levels within countries and, beyond that, internationally. We see health research as an inclusive process, involving the different stakeholders – decision makers,

researchers and communities – in an equal way and therefore paying as much attention to the producers as to the users of research. You know, this void between the people who suffer the consequences of problems and the people who are supposed to be solving those problems really worries me. It should worry all of us. And it's certainly not just in developing countries.

Only last week I was having lunch in a restaurant and I heard a conversation that astounded me. The director of one of the most modern state-of-the-art teaching hospitals in Europe was complaining about the way that patients don't cooperate the way they should, lose their way in the hospital and therefore come too late for appointments, and don't appreciate all the wonderful facilities that they're offered. Then he went on to complain about how medical students made the work of the hospital more difficult than it should be. Well, you can't just build a new teaching hospital and then complain that the patients and students are a nuisance. After all, what's a teaching hospital there for if it's not for the patients and students? Maybe the planners of that wonderful hospital failed to find out what the needs of patients and medical students really are.

"research... is a driving force behind all development."

The same is true for the role of countries in health research. I recall once hearing the head of a UN agency say that countries didn't seem to appreciate what was being done for them. Well maybe what the agency was doing wasn't what the countries really needed in the first place. Maybe a number of agencies should start listening more to countries and then doing things **with** them, not just **for** them. These examples show the difficulty we have sometimes in our work - providing the link between the problem and the solution. That's what COHRED is trying to do.

So COHRED sees itself as an intermediary?

No, not at all. COHRED tries to act as a catalyst. On reviewing the track record of initiatives in health research for development over the past decade, a pervading and serious criticism is that efforts continue to be fragmented, uncoordinated, uneven and unsustained. This situation exists at all levels: global, regional, national, sub-national, and organisational. COHRED's role is therefore to forge links, to facilitate the building of functional coalitions, where one group's activities are informed – and enhanced – by what others are doing. We define this challenge first and foremost at country level, because that could create within countries some countervailing power, some damage control capacity, against any kind of externally imposed regional and global 'architecture'. In this way COHRED is promoting country-driven architectures for health research, based on principles of subsidiarity and equal partnerships. Coalition building and 'forging links' – which by the way is the title of COHRED's new book - means also a direct answer to the vertical programmes, of which we have seen the rise and fall since the Alma Ata declaration on primary health care. It is therefore encouraging for instance that one of WHO's Special Programmes – on Tropical Disease Research – in its recent evaluation called for its capacity development activities to be placed far more clearly within the context of an evolving national health research system.

You often seem to question the conventional wisdom on how things should be done. Some people call you a populist and argue that the ENHR movement suffers from a 'research bashing syndrome'. Any reaction?

If working for equity, emphasising relevance and not just quality in research, arguing for a shift in health research initiatives, including their funding from North to South, and fighting for a stronger voice of the South in the global health research arena, if all this means 'populism', I can live with that label. Although I must say that I personally do not like labelling or dichotomising people into boxes, sects, 'mafias', who almost by definition are going to fight each other, not enter into a constructive dialogue. With regard to the so-called 'research bashing syndrome' let me just say the following. In the past we have been focusing nearly exclusively on the supply-side of research, and not on the demand-side, on the producers of research and not on its (multiple) users, on the research product and not on the research process. Within the broader context of a knowledge society, and recognising the vital role of information technology, we believe that there is a need for a new health research paradigm, which promotes a more balanced approach between demand and supply side, between producers and users, between product and process. This implies a redefining and repositioning of all involved partners, including researchers, but has nothing to do with bashing researchers.

Do you think COHRED's role is changing?

Well, it's evolving; it has to. We all have to evolve if we're to remain relevant. Fortunately we've managed to keep COHRED small so we're not influenced by vested interests. We're driven

by what countries want, not by what some donor or think-tank in the North wants. And it's this country focus that keeps us independent. I believe that one of COHRED's real strengths is that it is a learning organisation. We're as interested in documenting failures in countries as we are in achieving successes, because both situations offer opportunities for learning and sharing.

COHRED changes as the countries change and develop. It's not our style to tell people that COHRED is making a difference, but I do believe that through COHRED the countries are better able to make a difference themselves. In the early 90s we were still trying to find our way. But now, despite all the reservations that I've expressed above, I do believe the situation is changing for the better. The idea in which we believe - that research should focus on the needs of the people rather than on the needs of researchers, or academic interests or donors - is gradually becoming much more accepted than it was. Although there are some disappointing, even shocking exceptions, more agencies are more concerned than ever before that research should be demand-driven, should focus on equity, and should involve all stakeholders.

"COHRED tries to act as a catalyst."

What do you believe is the biggest challenge that the Bangkok Conference will present for COHRED?

To turn all the talking into reality and to start (re)constructing this reality according to the signals and messages we receive. The way to Bangkok has passed through numerous country, regional and institutional consultations. In addition, a lot of analytical work has been done on what has been achieved – and what hasn't – over the past ten years. The challenge for COHRED will be to help ensure that these voices will be heard and taken seriously, not neutralised or, even worse, sidelined in some last minute 'hijacking'. What countries and regions will do after Bangkok is the determining factor for the success of this international gathering and COHRED's role in it.

And what do you believe will be the issues on COHRED's agenda over the next 10 years?

We need to look back in order to see our way forward more clearly. I think of it as looking forward in a mirror. If we try to look ahead in this way over the next 10 years, the first thing I have to say is that there is a definite need for such an agenda. Whether it will be COHRED in its present form that will carry forward this agenda, is a different question. The next decade will require much more investment and synergy in working with countries to create an appropriate environment for an effective national health research system. That means being more politically active than before, in the grey area between government and civil society, to make sure this happens. As an NGO COHRED has the advantage that it is not restricted to working with governments and ministries, but can interact freely with civil society as well.

What about equity?

COHRED will continue to be driven by the quest for equity, of course. We can't do otherwise, since equity is the basic underlying value for essential national health research. Capacity development definitely has to remain on the core agenda. COHRED's specific input will be to further distill lessons and experiences from countries and transform those into tools for the health research system, empowering tools for research to action and new methodologies and instruments for the equity watch. The recent publication of COHRED manuals on priority setting and resource flow monitoring illustrate for me the way to go. Finally, it is clear that this journey should be taken together, not in solitude. Such coalition building requires a process of selective partnership development, not only based on an analysis of costs and benefits, but – more important – guided by shared values.

And have you any wisdom for those who lead COHRED in the future?

One thing that COHRED must try to avoid is what I call the 3-C trap, where the "C"s refer to capital, cabinet and campus. I believe COHRED must avoid becoming too big, for otherwise it will become too dependent on capital and therefore too dependent on those who provide the capital. Although COHRED must work with governments it must avoid becoming too closely associated exclusively with them, for otherwise it runs the risk of alienating the very communities it exists to help. And COHRED must avoid becoming a branch of an academic institution, run by the intelligentsia of the North, or even of the South. Life is more than money, government and academia.

Of course, the main piece of advice to those who lead COHRED must be: "Be learners as much as leaders". The strength of COHRED lies not in its leaders but in the countries, communities and people that get involved in health research and that benefit from it. Unless we listen to them, health research for equity and effective development will remain no more than a dream.

COHRED in Action at Bangkok: Parallel Sessions at the International Conference on Health Research for Development

The Bangkok conference represents an important opportunity to highlight many of COHRED's activities in support of countries. More importantly, it is an opportunity for countries to learn from each other, and provides a forum for presenting experiences and instances where health research has led to development. This section of **Research into Action** *focuses the spotlight on COHRED's contribution to a very specific part of the international conference – the parallel sessions.*

A total of around 40 parallel sessions will be held at the conference, eight of which COHRED has sole, or joint responsibility for conducting. These are:

- Priority setting for health research
- Community involvement in health research
- Research to policy and action
- Resource flows for health research
- District health research
- Information and communication technology in health research
- Capacity development for health research
- Indicators of national health research development

The themes which the sessions reflect, are central to the focus of COHRED's work with countries - directed at improving health research management and its enabling environment at national level. The articles that follow list the problems at stake, the challenges ahead and the key lessons learned and provide COHRED contact addresses for further information. During the conference, the learning process around each of the themes will continue, allowing COHRED to plan its future work with countries in a more effective way.

Capacity Development – creating a demand for equity-oriented research

A national workshop on health research capacity strengthening was held in Beijing, China 28 - 31 August 2000. Pictured are the workshop organisers with the Vice-Minister for Health, Peng Yu.

The problem

Capacity Development has been identified as a key strategy for achieving the goal of promoting equity in development through health research. In its 1990 publication[1], the Commission on Health Research for Development made some very specific recommendations relating to national investment in capacity strengthening for research, and how resources could be mobilised for these activities. Yet, global investments in health research (including capacity strengthening) directed at the problems of the poor and disadvantaged have not increased substantially in the last 10 years[2].

The traditional approach to capacity development has been constrained, however, by its focus on strengthening specific areas, with limited attempts at horizontal integration, so crucial to strengthening the overall enabling environment for health research.

The challenge

There is a major imbalance between the 'supply' and 'demand' side of capacity building. The 'supply' side offers a wide range of projects and programmes (mainly sponsored by international agencies) to increase the 'critical mass' of health researchers in a country. But unless the demand for equity-oriented research is also encouraged, this research capacity will not be put to optimal use. Effective use of research results will improve if the capacity of key consumers (e.g. ministries, media, health service managers, advocacy and action groups, legislators) both to use and commission research is developed at the same time. The capacity of researchers to respond to the increasing demand for research is of equal importance.

Another major challenge for capacity building in health research is to upgrade the communications infrastructure, especially in developing countries. The development of communications networks among researchers in different disciplines, and between them and the users of research, can cut the high costs of current means of communication. Increasing knowledge will also augment the capacity of the research community.

Combating the "10/90 Disequilibrium": Recommendations from the Commission on Health Research for Development

- [that] developing countries should invest at least two percent of their national expenditure in research and research capacity strengthening, and
- at least five percent of project and program aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening.

Source: Commission on Health Research for Development (1990) *Health Research: Essential Link to Equity in Development.* Oxford University Press: New York.

A recent WHO workshop held in Annecy, France, was co-sponsored by, among others, the Global Forum for Health Research, the Alliance for Health Systems and Policy Research and COHRED[3]. The workshop formulated the following key-strategies and principles for research capacity strengthening (RCS):

- The research agenda (including a plan for RCS) is primarily the responsibility of the countries themselves
- More attention must be given to strengthening the "demand" for research by governments (decision-makers), the public (community), non-government organisations, the media, the private sector, and academic institutions (where future producers and users of research are being primed)
- All aspects of the research process (not just technical competence) must be strengthened including: advocacy and promotion, priority-setting, partnership development, facilitating the use of research, networking and leadership
- A "systems view" of RCS is needed, which includes national health research networks and forums, the enabling environment and the "culture" for research
- There is a critical need for more effective collaboration and partnership; the new information and communication technologies can be an important tool for this
- RCS must be more focused on equity-oriented health research.

COHRED took the responsibility to follow-up the recommendations of this meeting by technically facilitating and financially supporting the organisation of two national meetings on capacity development, one in China (August) and one in Kenya (September). At both meetings the various national stakeholders made an assessment of present capacity development needs, using a national health research system as a framework, and recommended specific actions to address those needs.

Results of the two national workshops will be presented at the jointly-organised (WHO, Global Forum for Health Research and COHRED) parallel session on capacity development at the International Conference on Health Research for Development in Bangkok. Other critical issues that will be addressed during this parallel session are capacity development requirements for:

- Leadership skills for health research managers
- Priority setting
- Resource flows monitoring
- Communication & dissemination of research information.

For further information, please contact: Dr Lennart Freij
Phone: +41 22 917 8558
Fax: +41 22 917 8015
Email: freij@cohred.ch

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Community Involvement in Essential National Health Research

The problem

Community participation in health has been a major policy theme since the 1970s and was a fundamental ideal in the Alma Ata Declaration of 1978. Twenty years on, it is still considered an essential part of health development, but there is growing recognition that community participation is not a simple matter. In Essential National Health Research too, community involvement is a declared ideal. The community is considered one of the three major stakeholders in ENHR, and community involvement is an important part of the ENHR strategy for action.

Despite the importance attributed to it, we have little systematic knowledge of how community participation actually functions, or could function, in ENHR. The time has come to critically review community involvement in health research. By exploring its varieties, problems and potentials, we want to try to re-energise the concept of community participation.

The challenge

The task can be framed in terms of six questions:

1. Who is the third stakeholder?

"Community" refers to people who have something in common, whether that is geographic locality or shared interest in a particular issue. We need to rethink what community can mean in different situations.

2. What does community participation in ENHR entail?

Participation may occur in varying degrees of intensity and in different phases of the research process. Effective involvement of community is a matter of reciprocity in which participation takes different forms and influences change in several directions.

3. Who speaks for whom?

Representation is always partial, but it should be meaningful. The pursuit of equity requires that attention be given to the situation of those whose voices are not heard directly because others speak for them.

4. When is community participation in research relevant?

Operational studies and action research have tended to provide the best opportunities for community involvement because they are relevant to immediate problems. Should attempts be made to involve communities in other kinds of research such as epidemiological, clinical, or health systems studies? If so, how?

5. What kinds of relations exist between researchers and communities?

Community involvement rests on the relationship between communities, researchers and health managers, and the expectations that each holds for the research process. There is a need to identify institutions and frameworks to support contacts between these parties and strengthen communities' capacity as users of research.

6. What are the expectations and tradeoffs of community participation?

Community involvement demands resources, especially time, to carry on dialogues and attend to (often conflicting) interests. Community expectations may not correspond to research goals and methods. Realistic assessments of the costs and benefits for both researchers and communities are needed.

Emerging lessons

Recent attempts to reconsider community involvement can be summarised in a set of propositions - call them lessons or call them issues for further work:

- That community involvement in ENHR is fundamentally about the role of people in research - as direct or indirect beneficiaries, users, and subjects. The relationship between research and the public can take many forms
- That community should be understood not just as a neighbourhood but pragmatically as any collection of

people who feel that their interests are at stake in a particular issue. Community is defined for a purpose and in relation to other stakeholders in a particular situation

- That communities are not static but come into play in a dynamic interaction with researchers and policymakers They should be seen as part of reciprocal relationships and processes, rather than as bounded groups with fixed characteristics
- That involvement has to start with communication of research and policy issues in ways that are meaningful to people in the particular realities in which they live. One of the greatest weaknesses of ENHR so far has been the failure to establish dialogue about research findings
- That involvement of researchers with communities is one of the most important forces for linking research and action because communities press for the kind of research they can use
- That there is a need to create windows through which local realities can be viewed from the national level. Establishing a strong ENHR portfolio of community-oriented research projects provides the widest of windows possible
- That national research coordinating mechanisms need to establish guidelines on the use of participatory research methods and policies that encourage community involvement in health research.

The Bangkok agenda

The session on community involvement in health research will focus on the variety of ways in which researchers, community members and policy makers/planners may form coalitions around specific issues. A panel of case presentations will contrast the perspectives and interests of communities with those of researchers and health managers. On the basis of concrete experiences, discussion and debate will move to general questions and possible answers:

- Does community involvement in research foster equity in health and if so how?
- How does community involvement promote research leading to action?
- How can information and communication flows be improved so that mutual learning can be stimulated?
- In what ways can capacity be developed to involve communities in more meaningful ways?

For more information please contact:
Susan Reynolds Whyte
Phone: +45 35 323 464
Fax: +45 35 323 465
Email: susan.reynolds.whyte@anthro.ku.dk

District Health Research

The problem

Recently, there has been concern that the implementation of Essential National Health Research (ENHR) has focused too much on central-level mechanisms and on large national institutions; with only limited attention being paid to the involvement of the sub-national/district level as an integral part of the ENHR process. At the same time, it is known that most countries have embarked on various forms of health sector reform initiatives, including decentralisation. For those countries that have adopted decentralisation as a policy, the district has become the central focus of all development programs. Faced with this kind of situation it is both appropriate and urgent to address the district as the central point in ENHR.

The challenge

The concept of district-focused health research is, in many countries, likely to be confronted with many problems and challenges. There are limited skills and capacity to create and maintain a research culture at the district level. This is compounded by a serious shortage of resources - both human and financial - to conduct research (absence of a research budget, few trained and skilled research personnel). It also is doubtful if the district organs, including the so-called "district health teams" fully appreciate the value of health research in guiding decision-making and its potential to contribute to district development. Research is still considered an issue for the "ivory tower". The challenge is to demystify research, and the value of research at the district level.

Lessons learned

Many countries have recognised the need to re-direct their research efforts at sub-national/district level, and have started addressing some of the problems and challenges identified above, through:

- Advocating for a budget line for district health research as part of the normal funding of national health system
- Encouraging donors to focus on district health research
- Encouraging institutional research and training programs to have a district component
- Acknowledging the role of research in district-level health planning (presupposing key constituencies are made aware of the role of research and its importance as a management tool)
- Creating pilot districts to demonstrate ENHR in practice
- Decentralising research priority-setting process

- Targeting field research towards answering questions and solving problems relevant to the day to day implementation, management and organisation of district health services, as well as the development of appropriate and effective policies relevant to the district level
- Practical commitment to and appreciation of the importance of the conduct of and utilisation of results of district health research among top level health managers (regional and national level), policy makers and politicians. This is essential given the important role they have to play in creating an enabling environment within the country for the conduct of district health research.

Issues tabled for discussion

A parallel session on District Health Research has been organised by COHRED. The organisers have identified a number of important questions that they wish to address in the session. The questions include:

1. What are the conditions for developing an effective health research system at the district level?
2. How can district research priorities best be identified and translated into research agenda?
3. What are the capacities needed to implement the research agenda and to develop essential health research at district level?
4. How can research done at the district level be utilised for policy and decision-making at the district and national level?
5. What is the role of communication and information in developing a good research culture at the district level?

This session should appeal to all those who are involved in, or interested in adopting a policy of decentralisation at the country level.

For further information, please contact:
David Okello
Phone: +1 407 733 9204
Fax: +263 470 0742
Email: dokello@whoafr.org

District Health Workshop, Uganda 1998.

The Health Research Profile project: an index of national health research activities

The problem

In most developing countries, there are limited funds allocated to health research. To make the best use of the available funding, it is essential that research efforts are well-coordinated and directed at the priority health concerns of the country. It is also imperative that international donors have a clear picture of the country's priority health concerns, so that funding can be directed at particular projects, to maximum effect. However, in most countries the actual health research situation is far from clear. Also, it is unclear whether health research has indeed been 'an essential link for equity and development' as the subtitle of the Commission report suggests[1]. It was for this very reason that the Health Research Profile project was initiated by COHRED.

The challenge

The Health Research Profile project represents a step towards determining the extent to which health research has indeed influenced human development. Launched in 1999, the ultimate goal of the project is to develop a model to determine the strength of the relationship between national health research investment and national human development. In so doing, it is intended to develop a tool which countries can use to address key questions such as:

- Are health research efforts directed at the priority health problems of the country?
- Are countries using global and country-specific knowledge effectively?

The specific objectives of the project are:

1. To determine the feasibility and availability of data for the development of indicators for a national health research profile
2. To develop a prototype for a national health research profile tool.

In each of four regions (Africa, Asia, Eastern Europe and Latin America), three countries have been selected which are representative of high, medium and low human development, using the UNDP human development index (HDI) and its refinements. In addition to these 12 countries, three industrialised countries were also selected to participate in the project. The participating countries are: Hungary, Lithuania, Kazakhstan; Uganda, Namibia, Mauritius; Chile, Nicaragua, Ecuador; Bangladesh, Korea, Thailand; Canada, Japan, and the Netherlands.

Five categories of "indicators" have been identified as being "key elements" of the profile. Each of these has several sub-descriptors. The key elements are:

- Amount spent on health research
- Research done on health inequities (equity)
- Quality of research
- Research capacity
- Research to policy, action and practice

Assessing the feasibility of obtaining the data has been an ongoing activity for some time now, and preliminary results are promising.

The project team will be presenting the preliminary findings during a parallel session in Bangkok. The rationale of a health research profile will be explored, particularly the feasibility of a country-specific health research index. The methodological contribution to the equity discussion will also be explored. Country coordinators involved in the project have thus far reported their experience with the project as being a catalyst for strengthening health research for development. Clearly a powerful analytical tool, its potential to support the establishment of an architecture for health research cooperation at country level, although untested, is strong.

For further information, please contact:
Peter Tugwell
Phone: +1 613 737 8755
Fax: +1 613 737 8851
Email: ptugwell@compuserve.com

David Okello
Phone: +1 407 733 9204
Fax: +263 470 0742
Email: okellod@whoafr.org

Dr David Okello will chair two parallel sessions at the international conference.

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Revolutionalising health research: the power of information and communication technology (ICT)

*"In March 2000 an estimated 276 million persons worldwide were users of the Internet with a growth rate of roughly 150,000 persons per **day,** 220 million devices were accessing the worldwide web and almost 200,000 devices were added each **day**. Web pages totalled 1.5 billion with almost 2 million pages being added each **day**...These are astonishing figures, unprecedented by any measure, but they reflect activity [of] less than 5% of the world's population. (http://www.undp.org/info21/new/n-ecosoc.html)."*

In 5-10 years' time, advances in hardware and software coupled with falling prices of this technology will make information and communication technology widely available and accessible. ICT can be democratising and empowering. It has the potential not merely to improve health research incrementally, but to revolutionalise it.

However, the current situation is far from ideal. The North/South divide in information and communication technology is even more inequitable than health research funding. More concretely, in Africa, with a population of 700 million, less than a million had access to the internet in 1998, and of this number, 80% were in South Africa. Just counting the remaining 20%, gives a ratio of 1:5000 internet users in Africa compared to 1:6 in the US or Europe (Lown, 1998).

Where ICT *can* be made available to developing countries, what are the potential implications of ICT advances in health research? Perhaps the greatest transformational change in health research can be facilitated by ICT. This transformational change will occur when researchers drop the belief that policy-making is a rational, problem-driven process and that they will be able to answer policy-relevant questions in their own timeframe and in their ordered worlds where selected variables can be "adjusted for" or held constant. The "interactive model" of policy-making holds sway now and the model views research as only one of the inputs among many in policy-making, with an influence which is more diffuse than direct, such as providing fresh concepts and perspectives, rather than actual data.

In a technologically-enabled environment powered by advances in ICT, the linear model of "production to utilisation" of information is faced with the possibility of instantaneous connectivity from multiple points, with subsequent revision.

Research, while being carried out and documented on-line, can be interactive and continuous inputs can be obtained both from the policy-makers, future beneficiaries and other stakeholders in communities. At the same time, ownership is engendered and the "diffuse" impact of research is maximised through early sensitisation. Such impact can be further maximised by overhauling the paper-on-the-net model of transmitting research and exploiting the opportunities for tailoring the volume and style of presentation of information to the user by using hypertext and multimedia links.

Such a model of research is likely to be less under the (sole) control of the researcher and also requires that work-in-progress be put up for scrutiny, rather than the customary fine tooth-combed, defensible manuscript that is released to the public at the end of the research. This will undoubtedly make traditional researchers uncomfortable. However, the potential benefits of exposing the other stakeholders to the research process and its attendant values, of empowering them by providing real opportunities for providing input, and on the other hand, of increasing the probability of professional and personal fulfilment because of improved relevance of the research makes the model worth testing. The goal of popularising science is still a long way off, but this simple change in the health research model (in a technologically enabled environment) could help leverage the contribution of research in the struggle for health, development, and equity.

The Bangkok conference will address the future architecture for health research. ICT should be the cornerstone on which this future is built. A parallel session will present the potential of ICT to revolutionalise health research, using current and envisioned examples of how ICT has been, and can be used in health research. The second part of that session will be a discussion on how to actively manage ICT and ensure that its benefits are distributed quickly, and equitably in the health research arena.

The specific objectives of the session are to:

1. Describe the advances of ICT and its potential for addressing inequities in access to knowledge sources, and in facilitating communication and the connections between developed-developing country researchers, donor-funders, policymakers-researchers. Part of this is to create a conceptual appreciation of the nature and potential power of the new technology: of how the technology introduces a new culture, brings in new players, changes power structures, and begets new ways of working
2. Demonstrate the actual and envisioned uses of ICT in health research through selected case studies. This objective will demonstrate how ICT has been used in the different stages of research (surveillance and early warning systems, scientific discussion groups, continuing education/ mentoring/capacity, building of human resources, the use of databases in research, electronic publishing, etc)
3. Present a situational analysis on the current status of ICT in developing countries
4. Draft a proposal on how ICT can be used to inform and design the new health research architecture and discuss how the proposal can be transformed from the virtual to the real!

For further information, please contact:
Tessa Tan-Torres
Phone: +41 22 791 3497
Fax: +41 22 791 4328
Email: tantorrest@who.ch

Dr Tessa Tan-Torres will chair the session on ICT at the international conference.

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Priority Setting for health research: lessons from developing countries

The problem

There will never be enough resources to address every person's health needs, especially in developing countries. The central premise of Essential National Health Research (ENHR) is that countries must take stock of what is 'essential', i.e. health research that countries cannot do without if they are to pursue health for their own people. Focusing on essential research leads to better use of available resources for health, and ultimately to more health gains per dollar spent.

The challenge

The methods used for setting priorities have previously been highly technical, while less attention has been placed on who sets priorities and how choices are made. The COHRED Working Group on Priority Setting proposes a strategy of priority setting which is based on lessons learned from approaches attempted in several developing countries. With equity in development as its goal, the proposed model is demand-driven, and involves far greater interaction with multiple stakeholders, including: identifying participants; gathering evidence and information; determining criteria for priority setting; and implementation and evaluation.

Who sets priorities?

Participants should be those who have a major stake in the goal of equity in health and development. Countries implementing the ENHR strategy have identified four general categories of participants: researchers, decision-makers at different levels, health service providers, and communities. Experience suggests that there is a need for stronger representation from the private sector, parliamentarians, and potential donors and international agencies, since participation of a broadened spectrum of stakeholders helps to identify research needs, technical and financial capabilities, information gaps and distortions, the political environment, and the values and ethics of a given society.

What criteria are used to guide prioritisation?

Drawing-up a list of final research priorities will depend on a two-step process of, first, selecting criteria for priority setting and second, selecting research topics from among identified priority problem areas. Countries have generally used one or more criteria from the following categories:

1. Magnitude and urgency of the problem, as suggested from quantitative and qualitative data in the requisite situation analysis
2. Extent of previous research and the potential contribution of research in discovering, developing or evaluating new interventions
3. Feasibility of carrying out the research in terms of the technical, economic, political, socio-cultural and ethical aspects

COHRED workshop on Priority Setting for ENHR, The Philippines 1997.

4. Expected impact of the research, considering both direct and indirect effects, short- and long-term benefits, as well as its implications on issues of affordability, efficacy, equity and coverage.

Implementation of the research agenda

There are intermediate, but critical steps to ensure success: effective advocacy and dissemination of the agenda to all stakeholders, especially decision-makers who hold the key to health policy and research resources; implementation of the agenda by researchers, in partnership with other stakeholders; and periodic review and assessment of priorities. Three important indicators are proposed for evaluation:

1. Utilisation of the research agenda: how extensive was the implementation of the research priorities? How much interest did the research agenda generate among stakeholders?
2. Involvement of multiple stakeholders: how many groups or constituencies were involved and what were their contributions? Who was not involved?
3. Do the research priorities address equity in health? (e.g. The proportion of research that address health problems of the poor, the shift of resource flows towards equity-targeted programmes and the identified research priorities, and 'buy-in' from national and international sources).

The Bangkok agenda

There will be two parallel sessions on research priority setting. The sessions are to be jointly organised by COHRED and the Global Forum for Health Research. The first session will address the following issues:

- What methods and processes may be used for setting research priorities at the district level? national level? global level?
- What frameworks and strategies have been used?
- How can different stakeholders be better involved in setting research priorities?
- What are the critical determinants and criteria for guiding research priorities?

Session two will provide a more focused look at the practical examples of priority setting strategies that have worked at the district, country and global levels.

Examples of how research priorities of countries can be communicated and integrated into priority setting at the international level will also be explored, since the country-global interface in research priority setting must be improved in order to move towards equity in health and development.

For further information, please contact:
Mary Ann Lansang
Phone: +632 525 4098
Fax: +632 526 4265
Email: mlansang@pacific.net.ph

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Resource flows for health research and development

The issue

In the early 1990s, the Commission on Health Research for Development recommended that all countries should vigorously undertake Essential National Health Research (ENHR) to accelerate health action in diverse national and community settings, and to ensure that resources available for the health sector achieve maximum results. The Commission's recommendations related to mobilising research funds included:

- Developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening
- At least 5% of project and program aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening.

In 1996, the WHO report, *Investing in Health*[1] emphasised the need for a mechanism for exchanging ideas about progress and priorities in health R&D, and for tracking flows of funding and identifying important gaps.

COHRED multi-country study sets the scene

A COHRED-commissioned study was a first attempt to track health research and development (R&D) funds in three middle-income countries: Malaysia, the Philippines, and Thailand. Built upon a study funded by the Department of Health of the

Philippines, the overall objective of the study was to develop a basic methodology for tracking and measuring health R&D funds at national level as a tool to streamline and fine tune the allocation of health R&D funds. The study made use of an accounting framework which traces the flow of funds from fund sources to fund users.

The study unearthed interesting patterns. The government sector was consistently the largest contributor to health R&D funding for 1997 and 1998 for all three countries. At the same time, it also emerged as the dominant user. Again for all three countries, applied research and research in the medical sciences received the highest funding levels. Results of the surveys also allowed the development of funds flow diagrams for sectors as well as agencies that were prominent fund sources and users, such as the pharmaceutical sector in Malaysia, the Department of Health in the Philippines, and the non-government sector in Thailand.

Moreover, the study compared the resulting allocation of research funding with national research priorities within the respective priority-setting process of the countries. The original intent of the ENHR process is to strengthen the ability of developing countries to meet the needs of the most disadvantaged and, reinforced by international scientific and financial resources, to accelerate progress toward the fundamental goal of equity in health. This does not necessarily imply that ENHR aims to divert all health R&D funds toward the identified health research needs, especially if the government can subsidise all the funding requirements of priority research areas. If the government cannot do so, the role of the ENHR strategy is to advocate more rigorously among all stakeholders to align health R&D with the national priorities. In the case of the public health sub-sector in the Philippines, research priorities are defined by two government institutions: the Philippine Council for Health Research and Development (PCHRD) of the Department of Science and Technology (DOST), and the Essential National Health Research (ENHR) unit of the Department of Health (DOH). Both institutions formulate their respective health research agendas through similar but distinct consultative processes. However, in spite of the priority setting process being in place, study results showed that the research priorities set by the DOH-ENHR and the PCHRD did not necessarily obtain the most funding. In fact, these research priorities were supported only by funds coursed through PCHRD and DOH-ENHR. The DOH (Philippines) sponsored study showed that for the survey year of 1996, these funds amounted to P24 million, or roughly a third of government-sourced health R&D.

Next steps

Ideally, the research efforts of this multi-country study should serve to encourage key stakeholders to monitor resource flows on a regular basis. Such a task would be best housed in and funded by a government agency; its best linkage would be to the national health accounts of a country.

The results and experiences of the study will go towards developing a manual that can be used by countries to conduct their own R&D funds flow study. The parallel session during the Bangkok conference, which will be jointly organised by the Global Forum for Health Research and COHRED, will provide a forum for further discussion on the study, the feasibility for countries to develop a monitoring system for resource flows and on global efforts to monitor resource flows.

For further information please contact:
Bienvenido Alano
Phone: +632 415 2156
Fax: +632 410 5200
Email: cepr@mozcom.com

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This issue of ***Research into Action*** was compiled by:
Pat Butler, Sylvia Dehaan, Lucinda Franklin and Yvo Nuyens.

Mailing address: COHRED, c/o UNDP, Palais des Nations, CH-1211 Geneva 10, Switzerland

Phone: +41 22 917 8558
Fax: +41 22 917 8015
Email: cohred@cohred.ch
Web site: http://www.cohred.ch

Designed by: The Press Gang, South Africa
Phone: +27 31 307 3240 • Email: pressg@iafrica.com

Printed by: PCL, Switzerland
Phone: +41 21 317 5151 • Email: pcl@worldcom.ch

Forging Links for Health Research: Perspectives from the Council on Health Research for Development

Edited by Victor Neufeld & Nancy Johnson

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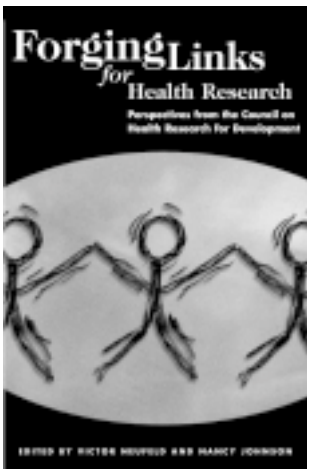

This book looks at the contribution of health research to development and, in particular, to the equity dimension in development. Its title is a reference to the 1990 report of the Commission on Health Research for Development, *Health research: essential link to equity in development,* which asserted that the power of research could "enable developing countries to strengthen health action and to discover new and more effective means to deal with unsolved health problems." It also reflects the need for stronger links between all stakeholders in the health research process if that process is to be truly an integral part of development.

The various contributions to this book focus on pinpointing the key achievements – as well as the setbacks – in the implementation of essential national health research over the past decade, and on outlining the prospects for the coming years. The book is a collaborative effort of many individuals – in particular from low- and middle-income countries. Most chapters are the result of a participatory writing process in which a group of colleagues provided feedback to one or more lead writers. As well, health research leaders in a number of developing countries contributed their views about "the way ahead" through a series of in-depth interviews. The experiences of a number of individuals, groups, and institutions involved in health research in developing countries over the past decade are presented in various "Boxes" throughout the book.

The book is organised in three sections. The first section includes three chapters: an account of the main events of the past decade related to health research for development; an essay concerning the evolving understanding of inequities in health; and an analysis of the contribution of health research to human development. Section two is devoted to the experience of countries with three aspects of the health research process: promoting community participation; translating research into action and policy; and strengthening the capacity of national health research systems. An additional chapter provides "snap shots" of the health research situation in several regions of the world, along with an analysis of the contribution of regional arrangements to national health research efforts.

The final section looks to the future and consists of two chapters. Chapter 8 tells the COHRED story, including its efforts to assess its own contributions to meet future challenges; this chapter also presents the views of national health research leaders from developing countries. The final chapter summarises important "realities" confronting the global health research community at the beginning of the new century. It also presents some key challenges to those responsible for national health research systems, in particular those committed to the goal of ensuring that health research becomes a stronger tool to achieve equitable health development.

The book thus combines a look into the mirror of the past with an attempt to gaze into the crystal ball at what lies ahead – in other words, it uses reflections from the past to take us forward into the uncharted territory of the future. It is hoped that it will contribute to the continuing dialogue between all involved travelers and help steer the journey towards more equitable health development.

Forging Links for Health Research: Perspectives from the Council on Health Research for Development will be available in December. However, a summary of the publication will be distributed at the Bangkok conference.

Do you have an article or a story from your country that would make interesting reading for the rest of the development community?
Here's your chance to have it aired in the international arena.

Send all contributions to: The Editor, Research into Action, c/o COHRED Secretariat.