The Next Step: An Interim Assessment of ENHR and COHRED

— Executive Summary —

Council on Health Research for Development
(COHRED)

The Next Step: An Interim Assessment of ENHR and COHRED

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CONTENTS

FOREWORD

EXECUTIVE SUMMARY

A. INTRODUCTION *1*

B. MANDATE & METHODS *2*

C. FINDINGS: 6

1. ENHR IMPLEMENTATION EFFECTIVENESS 7
2. COHRED'S CONTRIBUTION TO ENHR 22

D. RECOMMENDATIONS: 29

1. PRODUCT: TRAINING IN "ENHR TECHNOLOGY" 29
2. PARTNERSHIPS: PURPOSE-SPECIFIC COALITION BUILDING 31
3. PEOPLE: COMPREHENSIVE RESEARCH CAPACITY STRENGTHENING 32
4. PERFORMANCE: A STRONGER COHRED 33

E. OTHER CONSIDERATIONS *39*

F. CONCLUSION *41*

ACKNOWLEDGEMENTS

APPENDICES:

1. COUNTRY SITE VISIT REPORTS:
   - A) CARIBBEAN (JAMAICA; BARBADOS; TRINIDAD & TOBAGO)
   - B) KENYA
   - C) MOZAMBIQUE
   - D) NEPAL
   - E) NICARAGUA
   - F) REPUBLIC OF SOUTH AFRICA
   - G) THE PHILIPPINES
2. DONORS AND ORGANISATIONS
3. KEY INFORMANTS
4. RESEARCH NETWORKS
5. DOCUMENTS REVIEWED
6. EVALUATION TEAM

BOXES AND FIGURES

- BOX 1: PRIME MOVER SYNDROME..... *9*
- BOX 2: POLITICAL MAPPING *11*
- BOX 3: INTERNAL BRAIN DRAIN *14*
- BOX 4: NETWORKING FOR CAPACITY..... *18*
- BOX 5: THE EXPECTATION GAP *20*
- FIG. 1: COHRED MEMBERSHIP STRUCTURE..... *23*
- BOX 6: ENHR TECHNOLOGY AND SOURCES *30*

FOREWORD

More than three years have passed since the Council on Health Research for Development (COHRED) was created in March 1993 on the occasion of the Second International Conference on Health Research for Development. At the time, COHRED was seen as a third phase of health research for development. As such it was mandated to carry on the work of the Commission on Health Research for Development—the originator of the concept of Essential National Health Research ENHR)—and of its successor, the Task Force, which further developed the concept and helped to devise the ENHR strategy. COHRED was established as a long-term mechanism for implementing ENHR and the other recommendations of the Commission. From its inception, COHRED has been assisting an ever growing number of countries in strengthening their research capacity, in identifying their major health problems and in finding through research the solutions which are most appropriate for them.

Given these developments, it was most timely that the COHRED Board requested, at its November 1995 session, an interim assessment of the ENHR process globally and of COHRED's contribution to that process.

The Board formulated the terms of reference for the external Evaluation Team as follows:

- *to assess the implementation effectiveness of the ENHR strategy*
- *to assess COHRED's effectiveness in promoting ENHR at country, regional and global levels*
- *in addressing the first two objectives, to elicit the views of a wide range of stakeholders at country, regional and global levels.*

The Evaluation Team carried out its work between June and October 1996, using a variety of evaluation strategies and involving an impressive number of informants.

The present report summarises the team's findings, observations and recommendations. It should be noted that the Evaluation Team ascertained almost universal agreement that ENHR remains a strong and timely idea which is attracting researchers and policy-makers in an increasing number of developing countries. At the same time, the report draws attention to specific areas which call for priority action. These include: the identification of distinctive ENHR competencies, such as priority setting, advocacy skills, donor coordination, and making this knowledge accessible to, and used by, those involved in the ENHR process; creating and sustaining coalitions between partners in ENHR at both country and global level; exploring specific ways in which national and global research initiatives can be linked; and many more challenges to COHRED and its future directions.

At its Seventh Session (Geneva, 30 October – 1 November 1996), the Board discussed and accepted the Evaluation Team Report. With a view to modifying existing approaches to ENHR development and in order to facilitate adoption of future, new strategies, the Board established a number of Special Task Forces which will give effect to the recommendations made by the Evaluation Team and related Board decisions. To do so, these Task Forces will need inputs and contributions from a variety of partners — partners who are interested in, motivated and committed to making "health research an effective link to equity in development," and who, I am confident, will find this Interim Assessment of ENHR and COHRED stimulating reading.

Prof. Dr. Charas Suwanwela, Chairperson of COHRED

EXECUTIVE SUMMARY

THE NEXT STEP:
AN INTERIM ASSESSMENT OF ENHR AND COHRED

COHRED was created in March, 1993, just three years after the Commission on Health Research for Development presented its landmark report: *Health Research: Essential Link to Equity in Development* at the Nobel Conference in Stockholm. Much has happened on the international health scene since 1993, and in these last three years an increasing number of countries have embarked on essential national health research (ENHR) initiatives, facilitated by COHRED. At its November, 1995, meeting, the COHRED Board recommended that an interim evaluation be conducted by an external evaluation team. The objectives of the evaluation were further elaborated at the COHRED Board's June, 1996, meeting; they can be summarised as follows:

- to assess the implementation effectiveness of the ENHR strategy;
- to assess COHRED's effectiveness in promoting ENHR at country, regional and global levels;
- in addressing the first two objectives, to elicit the views of a wide range of stakeholders at the country, regional and global levels.

As recommended by the COHRED Board, the evaluation team considers this report to be an interim assessment, with its primary intent to facilitate future strategic planning.

What We Did:

The evaluation team began its work on June 28th, 1996, immediately after the special meeting of the COHRED Board. We reviewed many relevant documents and interviewed key informants, donors and organisations, and leaders of research networks. We also conducted site visits to seven countries: the Philippines, Nepal, Mozambique, Kenya, South Africa, Nicaragua and the Caribbean (Jamaica, Trinidad/Tobago, and Barbados). A member of the evaluation team was able to attend regional ENHR networking meetings in Asia (Manila in July) and Africa (Kampala in October).

What We Found:

As a general comment, we found virtually universal agreement that ENHR remains a strong and timely idea which has attracted researchers and policy makers in many developing countries. Along with high expectations that the concept can be implemented, it is generally recognised that this is a relatively early stage in the development of what is a complex process. Nevertheless, from most donors and key leaders in the international health field, there is an expectation that by now there

should be four or five "success stories", with a few more to be added to this list in the next three years. *We believe that this expectation has been fulfilled — there are several country examples where significant progress is evident and where a good start has been made on creating a sustainable ENHR system.*

This conclusion is based on the use of indicators developed by the team for the country site visits; these included the following:

- Evidence of a likely sustainable ENHR mechanism, with broad stakeholder involvement;
- Evidence of a change in the profile of research, with more research focused on priority problems;
- Evidence of increased financial commitment within the country to priority research

In our sample of seven countries, the ENHR development in the Philippines is a good example of substantial progress. Other countries with strong potential for successful outputs include South Africa and the Caribbean countries (particularly Jamaica).

Although efforts have been made to define markers of success, these have not been widely promulgated or accepted, and they still appear to be quite general. There is a need to identify a small number of indicators which would clearly demonstrate the "added value" of the ENHR approach; that is, there is a need to move beyond current indicators that are almost exclusively activities-oriented to include qualitative and more rigorously quantitative measures of success. In the longer term, there is a need to demonstrate that the basic goal underlying the implementation of ENHR has been achieved — that health research is indeed an "essential link" which has improved equity in health.

ENHR IMPLEMENTATION EFFECTIVENESS

Regarding the ENHR process which we reviewed in the countries selected for site visits, the range of experience is very broad. In no country did we find that all three key "stakeholders" (researchers, community representatives and decision makers) were involved at every stage of the ENHR process. There were a number of key findings, summarised below and mapped against the seven elements of the ENHR process:

Promotion

- In some places ENHR is occurring, but by other names.
- It is unwise to rely too heavily on one "prime mover".

Mechanism

The different arrangements used for the ENHR mechanism vary considerably in their effectiveness; careful "political mapping" early in the ENHR process is most important.

Priority Setting

- While several countries have conducted research priority setting exercises, in general the resulting research plan has not led to new research groups or projects. In part, this is because of the difficulty in obtaining agreement about what is truly "essential"; also, chronic lack of additional funding tends to lead to stagnation.

- In some countries, with decentralisation as an emerging feature of health system reform, the ENHR process must now be carried on at provincial and even district levels.

Capacity Building

- Research capacity strengthening remains a critically important element which pervades all stages of the ENHR process. The "targets" for research capacity tend to be restricted to researchers, with relatively little attention to the training of policy makers and community groups in the appropriate steps of the research process — primarily in determining the questions for research, as well as in the use of research results for making decisions.

- Initial training in research is just the first step; equally important are the factors which determine retention of researchers in the roles for which they were prepared, and the alignment of existing research capacity with national priorities.

Networking

- Intra-country ENHR networking is an important but demanding activity; there are some excellent examples of the imaginative use of different communication modalities. The "people component" of networking — creating arrangements where actual collaboration exists among a range of stakeholders — continues to be a major challenge. For example, there are relatively few examples where representatives of the international research networks actually work together within a country.

Financing

- In several countries, progress appears to have stopped with the completion of a research priority setting exercise and writing up a plan; the "next step" of obtaining funding to implement the plan, particularly external funding, seems to be difficult to achieve. There still exists an "expectation gap" where countries expect donors to support the implementation of ENHR plans, and donors expect more specific evidence of progress. Coupled with this is the

challenge of obtaining optimal coordination of input from various external donors.

- There are some encouraging examples where substantial national funding for health research has been allocated. Even here, the actual amount appears to be considerably less that the 2 percent (of national health expenditures) recommended in the Commission report. Furthermore, it has not been easy to track resource flows to determine whether available funds are targeted at priority research issues.

Evaluation

- Evaluation of the ENHR process has begun in several countries, exhibited in various progress reports which have been disseminated. More work is needed on defining clear and specific indicators of success which will be useful both within the country and externally.

COHRED'S CONTRIBUTION TO ENHR

When considering the contribution of COHRED to the ENHR process, we examined the various components of the COHRED mechanism: the Council itself, the Board, the Secretariat and the regional ENHR networks. We also considered the contribution of the international research networks (primarily the members of the Puebla Group) to the ENHR process within countries. We began with the question, "Why COHRED at all?", and found widespread consensus that COHRED is fulfilling a crucial role, to some extent because of a vacuum left by other agencies. COHRED is an important and distinctive vehicle for facilitating health research within developing countries and for bringing the voice of "the South" to the international discussion table.

The Council as such appears to be inactive, with membership criteria uncertain and with no mechanism for reconfirming interest and involvement. The COHRED Board, after a somewhat uncertain start-up period, is now more active and involved. Questions were raised about the process for nominating individuals to the Board, and about the Board's composition — primarily with regard to the representativeness of the three key ENHR stakeholders. There were several suggestions that the Board could be more dynamically engaged in problem solving, with small short term task force groups working between meetings.

The Secretariat is well regarded, particularly for its recent emphasis on dissemination of well prepared materials. From several sources came the suggestion that the Secretariat should strengthen its analytic capacity, to work on issues that are distinctive to the ENHR process; this should be coupled with decreased attention to general advocacy and promotion.

The regional networks are seen as useful, though this view was not unanimous, keeping in mind how differently they are configured from region to region. The Asia network in particular has developed some useful strategies, such as rotating the location of the "focal point" from one country to another, and involving teams (rather than single individuals) in regional ENHR activities. In general, it was thought that

the regional networks can play a particularly important role in promotion, monitoring and in assisting countries new to the ENHR process with the first few steps of ENHR development.

What We Propose:

The evaluation team strongly believes that the objective of COHRED, as stated in the March, 1993, statutes, is more important than ever: *"... for all people of each country to achieve health and quality of life on the basis of equity and social justice".* ENHR continues to have enormous potential as a strategy for ensuring that research serves as a "powerful tool for health and development" (Commission report, page xviii). And considerable experience with this strategy is accumulating in an increasing number of countries. However, there is a sense across the international community that much of the promise remains unfulfilled and undemonstrated. We offer four general recommendations, highlighted below, that we believe represent a "next step" for COHRED and its many partners.

1. PRODUCT: TRAINING IN "ENHR TECHNOLOGY"

The ENHR process represents an approach to the design, production and use of research that is distinctive; it is COHRED's niche, its "added value" product. Furthermore, most of its components have a strong "science" and experience base, much of it to be found within the research networks that have indicated their intent to contribute to ENHR. The challenge is to make this available knowledge and experience accessible to, and used by, those involved in the ENHR process. Examples of these component competencies include: political mapping; advocacy skills; strategies for community participation; the methodology of priority setting; donor coordination and fund solicitation; networking skills — and several others.

1.1 We recommend a special initiative to capture the available expertise regarding these competencies, prepare strategies and materials ("toolkits"), and provide training to country ENHR groups.

2. PARTNERSHIPS: PURPOSE-SPECIFIC COALITION BUILDING

At the heart of the ENHR process, in the work to date, are three partner groups: researchers, policy makers, and community representatives — each of whom shares the goal of having health research used to improve the health and quality of life of the people. Ideally, it is a partnership of equals, where each respects the others' points of view. In some countries, depending on the specific objectives, other partners should be added. These can include donors, non-government organisations (NGOs) and elements of the private sector. Creating these purpose-specific coalitions and sustaining them so that they function in a dynamic and effective fashion, represent complex challenges; however, relevant expertise is becoming available in several countries.

2.1 *We recommend the creation of regional "ENHR mentoring teams", to assist countries with coalition building, particularly in the early stages of the ENHR process when political mapping is most important. Where possible, these mentoring teams should include representatives of the three core partners — researchers, policy makers, and community groups; in some situations, a donor representative could be added.*

The principles of purpose-specific coalition building, with mutual respect among partners, also apply at the global level. COHRED and the various country ENHR groups have important contributions to make to the global health research agenda. In particular, COHRED's relationships with the World Health Organization (WHO) and the World Bank should be strengthened, since it is critical to link the national and global health research processes; these two components are not only complementary but interdependent.

2.2 *We recommend establishing a task force to explore specific ways in which national and global research initiatives can be linked. The task force should be initiated by COHRED and include representatives of the WHO and the World Bank, aiming to develop exemplary collaborative projects at a country level.*

3. PEOPLE: COMPREHENSIVE RESEARCH CAPACITY STRENGTHENING

For ENHR to be successful, all the people involved must be adequately prepared. Research training cannot be restricted to just researchers. Other partner groups must receive training in selected components of the research process, including policy makers, community and NGO representatives. Donors too can be learners regarding aspects of the ENHR process, which will make their contribution more relevant and effective.

3.1 *We recommend that the scope of research training be broadened beyond the usual researcher community; COHRED should identify countries where there may already be experience with a broader scope of research training, with the aim of strengthening and disseminating this experience.*

In many countries the potentially available research capacity to contribute to the ENHR agenda is not actually involved. There are many reasons for what might be called "internal brain drain". This complex situation is not well understood, and solutions are not readily available.

3.2 *We recommend that COHRED initiate one or more country case studies focused on this issue; these studies would not be only analytic and descriptive, but would proactively propose and implement solutions to ensure that potentially available research expertise is contributing to the ENHR process.*

ENHR represents a paradigm shift regarding the production and use of research, and thus requires a long term commitment of vision and resources.

It will be particularly important to prepare the next generation of health leadership to join the ENHR enterprise.

3.3 We recommend that COHRED facilitate special initiatives with appropriate networks and institutions to introduce ENHR concepts and skills to the curricula which prepare future health professionals. This initiative should feature opportunities for students to participate directly in all aspects of the ENHR plan.

4. ***PERFORMANCE:* A STRONGER COHRED**

With the international community increasingly aware of the existence of the ENHR initiative, COHRED can shift its energies and resources from promotion and advocacy activities to more in-depth analyses of aspects of the ENHR process, and to actions which will effectively link national and global research. Adjustments can be made at each level of the COHRED mechanism: the Council, the Board, the Secretariat and the regional networks.

4.1 We recommend that the COHRED Board become more "problem-oriented" in the way it functions. This could be achieved by forming small short term task force groups to deal with specific relevant issues. Also, the COHRED Board could be more efficient either by creating a small executive committee where each member has a specific responsibility or by reducing its size.

4.2 We recommend that the COHRED Secretariat be strengthened to increase its capacity for specific analytic projects. This could be done either by adding a professional officer to the Geneva-based unit, or by engaging regionally based professionals on a part time basis.

In addition to these four major recommendations, there are several other issues for the COHRED Board to consider in its plans for the future. These include the need for COHRED to think about its own "phase-out" strategy; the need for a major follow-up review of the recommendations of the original Commission, to occur perhaps at the ten year anniversary of the Commission's report; and the opportunity for the ENHR process to link up more specifically with the health professions, particularly in relation to the evidence-based health care component of health sector reform.

We believe that these recommendations and considerations, taken together, represent a strategic "next step" opportunity for COHRED and the various ENHR country-based initiatives to build strongly on the excellent base that has already been established. The challenge is to ensure that the ENHR process achieves its original intent, well described in the Commission report, to *"... strengthen the ability — and the resolve — 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"*.

A. INTRODUCTION

More than three years have passed since the Council on Health Research for Development (COHRED) was created in March 1993. At the time, COHRED was seen as the third phase of health research for development, following the work of the original Commission which conceived of the concept of essential national health research (ENHR), and the successor Task Force which further evolved the concept and facilitated an ENHR strategy. It was said at the time that "the ENHR movement has come of age". COHRED was thought to be "a unique non-governmental organisation situated within the United Nations and guided by a Board comprised primarily of individuals from the countries using the ENHR strategy". By March 1993, it was stated that eighteen countries had begun to apply ENHR.

Much has happened in the global health for development field since COHRED was established. Here are some examples:

- For the first time in its history, the World Bank devoted one of its annual World Development Reports (WDR) to the topic of health. WDR '93, *Investing in Health*, was released in July 1993. It introduced the use of disability-adjusted life years (DALYs) as an indicator of the global burden of illness. The report has contributed significantly to a worldwide debate about priorities in health, and has signalled the commitment of the World Bank to increase its investments in health projects.

- Many countries in both the industrialised and developing world have undertaken major health sector reforms, almost without exception featuring a decreased role for the government public sector and an increased dependence on a mix of pubic and private health services. Decentralisation and an increased attention to the cost-effectiveness of interventions ("evidence-based health care") are other characteristics of this movement.

- The World Health Organization (WHO) has begun a restructuring process and has launched a new initiative elaborated in the publication Renewing the Health-for-all Strategy: Elaboration of a Policy for Equity, Solidarity and Health (WHO, Geneva, 1995).

- In June 1996, after more than two years of work, the Ad Hoc Committee on Health Research Relating to Future Intervention Options released its report Investing in Health Research and Development (WHO, Geneva, 1996). The report is intended to "... contribute to an agenda for international action in which individual nation's agendas inform global priorities, and global needs and experience influence national agendas". The report highlights four key challenges: improving maternal and child health; the changing threat of infectious disease; noncommunicable disease and injuries; and research to inform health policy.

Within this global context of health reform, research and action, COHRED has a remarkable opportunity to contribute its special area of experience — the process at a national level whereby health research is used as a tool to solve the most important problems determined by that country in order to achieve equity in health. COHRED has facilitated the use of the ENHR strategy by countries who choose to use it, and has brought country representatives together through regional networks to share their experiences with the strategy. It is a most important and worthy mission as the dawn of the twenty-first century approaches.

Given the importance of COHRED's task, it is most timely that the COHRED Board has requested an interim assessment of the ENHR process globally and of COHRED's contribution to that process. The request is consistent with one of COHRED's functions, stated in the March 1993 statutes: *"COHRED will .... analyze the global effectiveness of the (ENHR) Strategy and assist countries in national analyses and assessments"*.

B. MANDATE AND METHODS

At its Sixth Session in November 1995, the COHRED Board recommended that an interim assessment be conducted by an external evaluation team and then approved a document outlining the objectives. These were elaborated at the June 1996 special session of the Board, and further clarified in discussions between members of the evaluation team and the COHRED leadership (chairman, vice-chairman, coordinator, and some other members of the Board). In particular, it was clear that this was an interim assessment, and that the team's report should "provide guidance for the future directions of COHRED" (quote taken from minutes of the Board's special session). In addition, it was hoped that the report could provide donors with evidence of past success and the value of activities going forward.

In a working document, prepared with the help COHRED's Board chairman and the COHRED coordinator, the evaluation team summarised its responsibility as follows:

1. *To assess the implementation effectiveness, value and use of the ENHR strategy by countries and to make corresponding recommendations for improvement.*

2. *To assess COHRED's effectiveness in promoting ENHR at country, regional and global levels, indicating specific changes facilitated and the appropriateness of the balance of activities at all three levels. This is to involve an evaluation of all of COHRED's activities and the functioning of the Board, Secretariat and working groups/special projects, with corresponding recommendations for improvement.*

3. *In addressing the first two objectives, to elicit the views, experiences and expectations of ENHR stakeholders at the country level (policy makers, researchers and community members), of the donor community, and of international health (research) programs concerning the role of COHRED at the country, regional and global levels.*

The evaluation team began its work on June 28, 1996, immediately after the Special Session of the Board. Since an earlier assessment commissioned by the predecessor Task Force had been done (see the August 1992 report Assessment of Progress prepared by Dr. David Rowe), we chose to restrict the scope of our analysis to work done from March 1993 onward — the date when COHRED was established. We identified several evaluation strategies that are described below.

1. Review of Documents:

The documents reviewed are listed in Appendix 5. Additional documents were reviewed in relation to each of the country site visits; these are included as appendices in each of the site visit reports (see Appendix 1).

2. In-depth Interviews:

These were conducted by members of the evaluation team, sometimes during special visits and sometimes as opportunities presented themselves (for example, at regional ENHR meetings). Most interviews took place in person, but a few were conducted by telephone where visits were not possible. Those interviewed can be grouped as follows:

- Donors and organisations, selected on the basis of current support of COHRED or specific ENHR initiatives, or because of the relevance of a given organisation's mandate to the work of COHRED. (See Appendix 2).

- Key informants: these are individuals who were members of the Commission or Task Force, or who are knowledgeable about the international health research scene and the work of COHRED specifically. (See Appendix 3).

- Leaders of international research networks, associated with the Puebla Group of networks. (See Appendix 4).

3. Site Visits:

The evaluation team decided to visit countries in each major region where ENHR activities are in progress: Asia, Africa and the Americas. Somewhat arbitrarily, we selected two prototypes: countries where there appeared to be well documented progress; and countries where there was questionable progress. Thus the following countries were selected:

REGION	POSITIVE PROGRESS	QUESTIONABLE PROGRESS
ASIA:	Philippines	Nepal
AFRICA:	South Africa	Mozambique
AMERICAS:	Commonwealth Caribbean	Nicaragua

In addition, a special request was received from local ENHR planners in Kenya for the evaluation team to include Kenya in its scope of work; a site visit to Kenya was therefore included.

Efforts were made to add a second person from a given region to assist an evaluation team with a site visit. For a variety of logistic reasons, this strategy was possible only for the Kenya site visit, where Dr. David Okello from Uganda joined Dr. Tessa Tan Torres. Arrangements for site visits were made directly with the "focal point" person or group for a given country; in each case, the arrangements were excellent and the evaluation team member was given every assistance to facilitate the site visit.

The purpose of the site visits was not primarily to evaluate the progress of ENHR in the countries; this would have been inappropriate since, other than Kenya, an evaluation by an

external site visit was not specifically requested by them. Rather, it was to learn about the ENHR story, identify key features that could contribute to an overall global analysis of the progress of ENHR, and provide guidance to COHRED for its future work. The site visits also provided an opportunity to learn about COHRED's contribution to the ENHR process in a given country. The country site visit reports are therefore organised to highlight these elements (see Appendix 1).

4. Analysis and Synthesis:

From October 6–8, 1996, after most of the information had been obtained from the above sources, the evaluation team met in Geneva to analyse its findings, synthesise the main conclusions and prepare recommendations.

Limitations of Our Work:

As with any evaluation of a complex and wide-ranging enterprise such as ENHR, there are some limitations and confounders in this assessment exercise. We wish to identify the following in particular:

- COHRED by its nature and mandate has to work through countries, but assessing the contributions of COHRED to the ENHR process in a given country is highly influenced by a range of factors in that country. It is therefore difficult to make a general assessment of COHRED's overall contribution.

- In each country there are entities other than COHRED that are facilitating the health research endeavour; thus, it was sometimes difficult to identify the distinctive contributions of COHRED.

- Because of time limitations, it was only possible to visit seven countries. We recognise that there are several other important examples of ENHR progress — in countries such as Thailand, Bangladesh, Benin, Uganda, Mexico and others.

  Given these and other limitations, we see our work as an interim "rapid assessment" exercise — interim because the original plan of work and budget approved by the Third Session of the COHRED Board (on August 28, 1993) was for approximately a five year period (April 1, 1993, to December 31, 1997). As stated earlier, our main goal is to make a contribution to COHRED's strategic planning process as it considers its next steps. The title of our report, *The Next Step: an Interim Assessment of ENHR and COHRED*, attempts to capture this idea.

C. FINDINGS

We found widespread agreement that ENHR remains a timely and critically important concept that has attracted researchers, policy makers and community representatives in many developing countries. It has been endorsed by an impressive number of donor agencies and other organisations. Balanced with high expectations that the concept can be implemented is the recognition that the evolution of this complex process is at a relatively early stage. Nevertheless, many donors and leaders in the field of international health hold the view that there should by now be four or five "success stories", with more to be added in the coming few years.

We believe that this expectation has been fulfilled — there are several examples where countries have made significant progress and are well on the way to creating a sustainable ENHR mechanism.

This conclusion is based on the use of indicators developed by the team for the country site visits; these included the following:

- Evidence of a likely sustainable ENHR mechanism, with broad stakeholder involvement;
- Evidence of a change in the profile of research, with more research focused on
- priority problems;
- Evidence of increased financial commitment within the country to priority research

In our sample of seven countries, the ENHR development in the Philippines is a good example of substantial progress. Other countries with strong potential for successful outputs include South Africa and the Caribbean countries (particularly Jamaica).

We also had the opportunity to read draft monographs from Uganda and Thailand describing their ENHR process; these countries too have made significant progress. We understand from other observers that the same could probably be said of Mexico, Bangladesh and probably one or two other countries.

With respect to defining markers of success, several initiatives have been undertaken. Examples include the "Evaluation Framework" in the 1991 document, *ENHR: A Strategy for Action in Health and Human Development* (Box 2.31), and the working document *Evaluation of ENHR* discussed at the Second African ENHR Networking Meeting in Harare in August 1995. These are good beginnings, but the markers to date are either too general or they consist mostly of lists of activities. Sufficient experience has accumulated in the various countries that COHRED could now identify a small number of indicators that would clearly demonstrate the added value of the ENHR approach. These should include some qualitative and more rigorously quantitative measures of success.

Of course, over the longer term there will be the challenge to demonstrate that the basic goal underlying the implementation of ENHR has been achieved — that health research is indeed an "essential link" that has improved equity in health.

The findings will be elaborated under two general headings: “ENHR Implementation Effectiveness”; and “COHRED's Contribution to ENHR”.

1. ENHR IMPLEMENTATION EFFECTIVENESS

We defined our task with regard to country ENHR activities in the following way:

> ***To assess the implementation effectiveness, value and use of the ENHR strategy by countries and to make corresponding recommendations for improvement.***

In conducting this analysis, we relied primarily on the findings from our country site visits and regional network meeting participation. It should be noted at the outset that the primary objective of these site visits was the identification of factors that have either favoured or constrained the progress of various ENHR initiatives, with the further aim of arriving at informed strategies that COHRED might pursue in its facilitation of ENHR globally. The purpose, therefore, was *not* in and of itself to judge the extent of any one country's progress; however, the selected anecdotes presented below do reflect stories of relative success or difficulty that should serve as useful lessons for COHRED. At the same time, it should be made clear that no generalised conclusions should be drawn with respect to ENHR activities in these countries based on this section of the report (see Appendix I for detailed accounts of each site visit). Meanwhile, comprehensive country ENHR evaluations can only be completed after much more rigorous analysis takes place — something that we believe might now be an appropriate undertaking in several countries in the form of formal self-evaluation, perhaps followed later in any country so requesting by an external evaluation.

In presenting our ENHR findings, we feel it worthwhile to use the familiar seven element evaluation framework that was proposed in the 1991 Task Force on Health Research for Development report (pp. 46-7). For each of these elements — Promotion, ENHR Mechanism, Priority Setting, Capacity Building, Networking, Financing and Evaluation — we will recall the stated objectives from the report and then present commentaries that may lead, where appropriate, to the modification of existing approaches to ENHR development and, perhaps more important, to the adoption of new strategies for the future.

1. Promotion

Objectives:

- Convince policy makers, health care givers and researchers about the value of ENHR
- Obtain political commitment of government and academic commitment of researchers to support ENHR

A number of countries have built significant momentum through ENHR workshops; the drafting and publication of national ENHR plans; and the institutionalisation of the ENHR process. The Republic of South Africa, for example, has come to promote ENHR at the highest levels: it is listed as a guiding principle behind health research policy in the ANC government's 1993 Reconstruction and Development Program (RDP). In 1995, the country's ENHR initiative was housed at the newly created Chief Directorate of Health Information, Evaluation and Research (HIE&R) within the national Department of Health. In its efforts to ultimately arrive at a national health research policy, the HIE&R has taken on the task of involving a number of stakeholders (ranging from other powerful health sector entities to groups previously marginalised under the apartheid regime). Meanwhile, the country's Medical Research Council (MRC) has created an ENHR Web site, which provides up to date information on ENHR activities across the country. South Africa is, in short, a country in which ENHR has enjoyed a strong institutional support base from its inception.

An immediate neighbour of South Africa, Mozambique, reflects an altogether different ENHR experience. Prior to our visit to the country, it was believed that ENHR in Mozambique had been stopped in its tracks by mid-1993. It was at that time that the prime mover behind ENHR left the country; since then, little had been heard from the coalition of three institutions, led by the National Institute of Health (INS), that had been formed to oversee ENHR. However, what we found was that the prime mover's successor in Mozambique, the director of the INS, had decided on a creative integrative approach in response to the country's chronic lack of research capacity and financial resources. Given that the INS had served as the institutional focal point for the country's Health Systems Research (HSR) project since 1992, he took the decision with the support of the Minister of Health to incorporate ENHR activities into the already existing HSR framework. There is, in fact, much evidence within Mozambique, despite the hardships imposed in the post-war period, that ENHR is alive and well in all but name. Here, it is important to highlight the role played by the succession of two individuals who have managed to promote ENHR successfully despite great odds. However, it should be noted that, as we have learned from other country visits, too great a reliance on a single prime mover can reduce the chances of successfully sustaining a country's ENHR momentum (see "Box 1: Prime Mover Syndrome").

Box 1: Prime Mover Syndrome

In the short history of ENHR, a number of passionate advocates in positions of influence within their national health policy arenas have emerged to promote and pursue the guiding principles behind ENHR. No doubt, these prime movers have contributed significantly to the gathering momentum needed to support the ENHR movement. However, remaining indispensable to any given ENHR initiative, or, put another way, failure to create a self-sustaining institutional mechanism to formally support its development, can put such an initiative in a precarious position. For example, a working hypothesis for the apparent derailing of ENHR in Nicaragua — after a tremendously auspicious start that culminated in a widely supported national ENHR plan in 1993 — is that little priority was given to providing ENHR a viable institutional home. This despite the strong initial involvement of representatives from the Ministry of Health (MOH), the universities and the community, as well as the creation of a National ENHR Commission to coordinate their ENHR activities. But with the move of Nicaragua's ENHR prime mover into a more demanding position at the MOH, coupled with the disappointment of not having received donor support for the national plan, ENHR momentum has slowed significantly.

Nepal provides another good example of the impact that reliance on a single prime mover can have as a country experiences significant political change. Nepal's National Health Research Council (NHRC) was founded in 1991 as an autonomous, MOH-funded body directed by an influential prime mover of ENHR. A new government elected to replace him upon the completion of his term with a former health minister. However, this government's stay in power was short lived and a tripartite coalition subsequently took over. The NHRC's budget was then slashed by 80% and it received no funding this year whatsoever. The current ENHR leader has been kept busy consolidating his forces within the NHRC and finding resources for it to function. This may have led, directly or indirectly, to a failure to actively promote ENHR among other stakeholders, particularly NGOs, and to engage them as partners in the ENHR process. The NHRC will need to expand its base among supporters in the NGO sector and in academia, thereby increasing its credibility and influence in order to achieve a sustainable mechanism that involves several stakeholders.

Although the existence of an effective prime mover confers significant advantage to the country first adopting the principles of ENHR, and is probably even essential in the early stages, it is critical to invest the effort required to develop a *de facto* institutional mechanism, including broadly-based teams, that will survive the unforeseen departure of any one individual. *Promotion alone by individual advocates is inadequate where it is not followed up by the creation of a formal and sustainable ENHR mechanism.*

2. ENHR Mechanism

Objective:

- Create a system to ensure the effectiveness and sustainability of ENHR

Of the countries we visited, the Philippines represents perhaps the most creative model for an ENHR mechanism that has been successful in maintaining continuity and inclusivity in expanding its reach — despite a succession of leaders. By 1991, ENHR was a formally established initiative at the Philippines Department of Health (DOH) under the enthusiastic guidance of the then Secretary of Health. His commitment to involve other stakeholders at this time led to the inclusion of non-DOH representatives in an ENHR Advisory Council and Steering Committee; by 1993, a detailed five year National ENHR agenda had been formulated through extensive consultations with a great number of interested stakeholders in the country, including various community groups and NGOs. This early forging of formal national linkages was pursued out of a desire to build on the institutional strength of the long-standing research tradition in the Philippines. It has also fostered a climate of cooperation, rather than competition, whereby the most powerful health sector entities are supportive of ENHR as a valid coordinating and research priority setting mechanism in the country. For example, the Philippine Council for Health Research and Development (PCHRD) — the most powerful policy making body in the health research sector — has been actively involved alongside the DOH in the implementation of ENHR, and there is mutual representation in the governing/advisory bodies of both entities. A major strength of this ENHR mechanism has been the bolstering of so-called "research-policy-action" linkages through the direct interaction of policy makers and health research program managers.

A further development in the Philippines was the establishment in 1993 of a private sector NGO, the ENHR Foundation, to serve as an autonomous support mechanism for the ENHR program at the DOH. Its membership includes representatives from academia, NGOs and other non-DOH government agencies. Its current president was, significantly, formerly the head of another important health sector institution, the Health Research Network. The Foundation's independence and flexibility make it an effective research program management body with close ties to the research community; this complements well the DOH program's advantage of direct access to policy makers mentioned above. With the incorporation of the ENHR Foundation in the Philippines, a public-private sector interface has been institutionalised that is so far unique in the history of ENHR.

As a general comment it should be noted that, depending on the unique circumstances in a given country, it is not imperative that an ENHR mechanism be housed in a newly created independent entity; it may be better placed in the hands of an existing governmental or non-governmental body.

In particular, careful political mapping is required in the early stages of ENHR development to ensure that the eventual mechanism for a given country is effective and sustainable (see Box 2: Political Mapping").

Box 2: Political Mapping

Although it is a given that the timely establishment of an institutional ENHR mechanism is critical to its effective implementation, it is very important that the appropriate national actors be identified and involved in the design of such a mechanism. Initial contacts and subsequent commitments made to certain individuals and their institutions, leading them to take responsibility for the implementation of ENHR, have profound implications for its future course. If care is not taken early on to invite the participation of identified powerful national institutions and their leaders — ultimately best placed to either help or hinder the development of ENHR — then even the establishment of seemingly effective ENHR planning mechanisms might fail to negotiate the political landscape in their quest for implementation support. Formal political mapping exercises are thus a critical step in the initial approach to introducing ENHR in any country.

An example of this lesson is currently playing out in Kenya. Capitalising on the momentum that had been building since the 1991 national ENHR convention organised by the Kenya Task Force on ENHR, the National Health Research and Development Centre (NHRDC) was established in 1994 as an NGO with responsibility for the implementation of ENHR. The NHRDC has since released a national health research plan (1994–1997), incorporating three independent health research initiatives — Health Systems Research, Clinical Epidemiology and Biomedical Sciences — each tailored for implementation by one of three health research bodies. However, although the government has committed to ENHR by integrating it into its National Development Plan, devoting a national budget line item to the NHRDC, and allocating to it K$100,000 in funds for 1995/96, the NHRDC has not yet been able to obtain sufficient national funding and institutional support necessary to implement its ENHR plan. A key institution, the Kenya Medical Research Institute (KEMRI), established in 1979, receives approximately 75% of the health sector budget of the Ministry of Research (representing approximately 30% of all health research funding in the country). Despite the fact that several individuals associated with KEMRI are also involved with the NHRDC, there is considerable variation among KEMRI scientists with respect to their enthusiasm for Kenya's ENHR activities.

A conclusion that might be drawn from Kenya's experience to date is that the political mapping exercise integral to the successful introduction of ENHR in a country was not sufficiently thorough. Had this been done initially as a formal exercise, it may have been determined that KEMRI, as the most powerful entity in the health research arena, should have been a focus of early and then on-going involvement as an important stakeholder of Kenyan ENHR. *Even with the express endorsement of ENHR by government policy makers in any given country, it is important for ENHR planners to consider the potentially transient influence of politicians as compared to the often powerful influence enjoyed by the country's existing institutions.*

3. Priority Setting

Objective:

- Set forth an interactive process for identifying research topics and issues relating to the research infrastructure

Defining the "essential" in national health research — the principle behind ENHR itself — has proved to be a very difficult challenge even in the most advanced ENHR countries. Without a truly interactive and dynamic process that brings together, *in a consultation of equals,* representatives of all relevant stakeholders, the objective cannot be properly met. In contrast with national health research institutions which have usually been able to more quickly determine their research priorities by internal discussions, the democratic multiple partner mechanism espoused by ENHR is much more time consuming and complex. Many of the national research agendas published under the banner of ENHR do not reflect the results of such a process: even where there has been dutiful, ongoing consultation with multiple stakeholders, there has often been insufficient rigour in the effective prioritisation of research.

Such rigour is of clear benefit: the more that national research plans come to embody realistic and actionable project proposals that are crafted through the joint efforts of appropriate stakeholders, the more likely they will garner the support of potential national and foreign donors. Some ENHR advocates have prematurely tried to solicit funding for national health research plans deemed too general to warrant the interest of donors. Such was the case, for example, after the ENHR spearheading body in the Caribbean, the Commonwealth Caribbean Medical Research Council (CCMRC), completed its five year ENHR plan in 1993. This plan laid out regional health research priorities that corresponded to the Caribbean Cooperation in Health Initiative's Goals and Targets, with each country's priorities set in the context of a regional consultative process. The CCMRC's hope at the time was that donor funding would become available to implement its ENHR plan; however, it was unsuccessful in obtaining such support because the plan, regionally conceived, did not go far enough to rigorously define and delineate each Caribbean country's distinctive research priorities.

A compounding challenge to the process of national priority setting is the general trend toward political decentralisation. National governments everywhere are beginning to devolve their powers in matters of health policy to increasingly autonomous regions or districts. In South Africa, for example, beginning in 1997 the nine provincial health authorities will be given responsibility for their own health care budgets, thereby gaining real responsibility for health research policy making. Later this year a national congress will be held for the purpose of ENHR priority setting; the challenge for the participants in the context of decentralisation will be to arrive at agreement on what might best be described as essential *provincial* health research priorities. That these priorities might vary between provinces and even districts in South Africa is to be expected, as is the likelihood that their determination will take quite some time. After all, the orientation of an entirely new layer of provincial health policy makers to the

ENHR process will be required and these individuals will have to devise effective consultation and coalition building mechanisms for the realisation of their ENHR goals. Meanwhile, a similar challenge is emerging in other countries like Mozambique, which may be able to benefit from consultations on this issue with its neighbour; and, an Asian example, in the Philippines the involvement of regional health authorities in research priority setting has already begun.

4. Capacity Building

Objective:

- Develop the critical mass of researchers and the institutional infrastructures for implementing ENHR

Capacity building is a critical element of ENHR and it remains the most difficult long term challenge faced by ENHR planners. Although all recognise the need for it, it is difficult to identify strong examples of capacity building success stories. It should be said that, with the exception of looking for evidence of investments in ENHR research infrastructure, it would be currently premature to stringently apply the output measures proposed by the Task Force, which focus on the goal of increasing the number of trained and employed research scientists, the publication of the results of their completed projects, and the policy shifts that should follow from such results.

Meanwhile, in the shorter run, it is important to remember that capacity building is not just a quantitative question of increasing the size and training of national research communities. In a world of severe resource constraints, there is a critical qualitative aspect to capacity building that makes it also a question of ensuring that scientists receive the *right kind* of training, appropriate in the context of a country's prioritised national health research objectives; that new generations of young scientists not be overlooked in the ongoing competition for scarce training and positions; that the factors compromising the effectiveness of a country's researchers once trained — those leading to "internal brain drain" (see "Box 3: Internal Brain Drain") — be understood and addressed; and, perhaps most important, that the concept of capacity building be applied not just to researchers, but also to policy makers, community groups and other ENHR stakeholders.

This last point speaks to the notion that *capacity building should be a broadly applied imperative that pervades each element of the ENHR process*. Effectiveness in the implementation of ENHR is the result of a combination of hard work and competence at each step of the way. Competence is itself the product of experience and expertise gained in the course of promoting, establishing institutional mechanisms, research priority setting, intra- and international networking, obtaining financing and objectively evaluating this entire process. As such, the knowledge base it depends on can, and should be, captured in ways that serve to build the capacity of all ENHR stakeholders.

Box 3: Internal Brain Drain

Skilled researchers in developing countries are few and very much in demand. They are appreciated not only for their research skills, but also for their analytic, writing and computing skills which can be applied in administration, policy making and teaching. These competing needs result in what might be termed "internal brain drain". The traditional concept of brain drain has been used to describe the phenomenon whereby highly skilled individuals opt to leave their own home environment because of better opportunities abroad. In developing countries this "external" brain drain is still a major problem; it is created when those researchers who have finished their training abroad refuse to come back home to their country and when on-site researchers decide to move away to an environment more conducive to research.

Internal brain drain is more insidious and difficult to detect. Researchers in developing countries frequently have to work without secretarial staffs or administrative support. They have to perform these tasks themselves if they want work to be done, even when it is clearly inefficient for these researchers to spend their time on such activities. Even in countries where there is a strong ENHR program, research is still viewed as a luxury which should be conducted only after office hours. Consequently, researchers take on the same administrative and teaching responsibilities as their colleagues do, even as they try to focus on their research as well.

Meanwhile, within the research field, there is stiff competition for highly skilled researchers. "Pirating" sometimes occurs and, in such cases, programs can be left without the researcher capacity to manage them. In other cases, researchers might not abandon a project but just agree to take on several different projects; however, in the end they come to realise that, being quite overextended, they simply do not have enough time and therefore have to submit pieces of work that may be substandard simply in order to meet their deadlines.

Internal brain drain has been attributed to the failure to realise that "the important is the enemy of the essential". It is a complex phenomenon which will be both difficult and challenging to identify when it occurs and, further, to resolve.

5. Networking

Objective:

- Strengthen linkages and support between ENHR groups at national, regional and global levels

National Networking

The extent to which ENHR groups have developed national networks is highly variable from country to country. As has been highlighted above, the early establishment of strong linkages between relevant stakeholders within a country is virtually indispensable to the successful promotion and institutionalisation of ENHR. *In order to create value in the domain of health research, ENHR planners must be careful to pursue activities that facilitate coordination and not duplication.* This conceptual underpinning should serve to guide such planners in the design of inclusive mechanisms that involve the representative participation of all those who might have a stake in health research — including university researchers, community representatives, policy makers, as well as other research institutions, professional associations, NGOs and donors that become the basis of a truly interdisciplinary, multisectoral approach. In this way the coordinating mechanism behind ENHR can only be effective if it is considered practically synonymous with the normalisation of an extended national network. Otherwise, as has happened in some countries, the ENHR process comes to be viewed by entrenched health sector organisations as yet another vertically oriented, *de novo* program deserving to be ignored at best, or to be considered a competitor for finite resources at worst.

There are several different examples of effective national networking in the context of different inter-related country attributes that collectively present certain logistical challenges to the ENHR process. These attributes include country size, wealth, existing health research base, actual number of possible stakeholders (individual and institutional), and so on. (For an illustration of how these have influenced the character of relatively successful networking efforts, see, for example, the site visit reports for the Philippines, Mozambique and South Africa in Annex I). It should be remarked that there are two aspects to successful networking. These are, first, the "people" aspect whereby ENHR planners identify the appropriate mix of individuals and the institutions they represent for relationship building purposes; and, second, the "technology" aspect whereby a range of communications media is employed to create and sustain the network. It is in the domain of this second aspect that modern information technology is generating considerable opportunity for cost effective innovation. So, in addition to regular newsletters and publications, there is now the possibility, for example, of constant electronic communication via the Internet, both nationally and internationally. There is no reason that the ENHR process should not take advantage of the opportunity to create and link up Internet Web sites (as has recently been done in South Africa, for example) in order to provide stakeholders worldwide access to useful information.

Regional Networking

At the regional level there is also a significant amount of variability in the degree of ENHR networking. In the Caribbean, the ENHR process was uniquely initiated at a regional level and its subsequent progress in the individual island nations has been due in no small part to the strong regional networking support provided by the CCMRC (see "Box 4: Networking for Capacity"). Meanwhile, there is no Latin American network as yet, leaving ENHR planners in Nicaragua feeling quite isolated. Although there has been some contact between Nicaragua and the Caribbean network, the language barrier does pose a challenge; this said, for reasons of language and geography, it does appear to be sensible to focus on building and maintaining networks that are regionally based, while also advocating appropriate inter-regional and global networking opportunities.

The African network has so far been somewhat loosely structured with no real institutional basis for the coordination of any ongoing regional initiatives in-between yearly networking meetings. In the absence of such a regional mechanism, the single regional focal point, who is also heavily involved in his own country, cannot alone provide the fifteen country members of the network with the kind of support they require. In fact, most of these countries rely on their direct links with the COHRED Secretariat in Geneva, communicating only rarely through their regional network. This network must be strengthened to support the urgent needs of the many ENHR countries on the African continent. In addition, again for reasons of language and geography, it may be necessary to establish another regional network for the ENHR-active, French speaking West African countries.

Finally, serving perhaps as the best model for an effective country-driven networking mechanism, there is the Asian regional network. In the last two years this network has institutionalised itself through the creation of a regional task force consisting of representatives from the three leading Asian ENHR countries: Bangladesh, the Philippines and Thailand. Official responsibility for the management of task force activities passed at a recent task force meeting from Bangladesh to the Philippines, making it the Asian ENHR focal point for the next two years. The task force supports a network (that has grown in its membership from eight to twelve ENHR countries) by facilitating the exchange of information and expertise between these countries, as well as linkages to other networks and organisations where appropriate (e.g., the International Health Policy Program (IHPP); it has organised several ENHR planning meetings and a workshop on "Research Management for ENHR" at the end of 1995; and, perhaps most important, it provides a permanent organisational infrastructure for the execution of the tasks mandated in its two year regional work plans. A new initiative that the task force has decided to undertake is the promotion and conduct of inter-country collaborative research on issues relevant to the ENHR process. These growing commitments reflect the collegiality, shared values and mutual respect of the various members of the task force who, together, make up a very dedicated team. Meanwhile, a significant implication of the Asian regional network's evolution is that it has developed the capacity and mandate to take over much of the role that has so far been played by the COHRED Secretariat, freeing the latter to take on a different role.

Global Networking

At the global level, with a couple of notable exceptions, there has been a relatively disappointing lack of ENHR group collaboration with international research networks and other organisations that might prove beneficial to ENHR initiatives. These include the Puebla Group, the International Clinical Epidemiology Network (INCLEN),the International Health Policy Program (IHPP), the World Health Organization (WHO), selected UN agencies, the World Bank, the US Agency for International Development (USAID), various regional development banks, and several others.

With specific regard to the WHO, its recent Ad Hoc Committee report, *Investing in Health Research and Development*, and the follow-up to it, should be perceived by COHRED as an opportunity rather than as a threat. There might be great synergy between COHRED's ENHR activities, which are by definition focused on *national* action agendas with respect to health research and its outcomes, and potential WHO health research activities initiated by the impetus of its recent work, which is focused on contributing to an *international* action agenda in which "individual nation's agendas inform global priorities, and global needs and experience influence national agendas".

Meanwhile, the World Bank and some of the UN agencies such as the UNDP are increasingly committing to cooperating and participating more in the area of national health research. There are unexplored opportunities for ENHR planners to tap into these bodies as sources of funding for well designed health research proposals, which field representatives of these same organisations can contribute to significantly themselves. In fact, these individuals may be involved early on in the ENHR process as stakeholders who may valuably contribute to the establishment of a prioritised national health research agenda.

Box 4: Networking for Capacity

Networking can be used as an effective capacity building tool. An interesting model to illustrate this is the capacity building networking effort that has been undertaken in the Caribbean. After the CCMRC failed to gain donor support for its regional ENHR plan, it organised a 1995 workshop on priority setting that involved a variety of stakeholders from Barbados, Curaçao, Jamaica and Trinidad & Tobago, as well as experienced ENHR planners from Kenya, Thailand and South Africa. This formalised a process of cross-fertilisation across the region, whereby the participation of those well versed in certain aspects of the ENHR process has been deliberately sought by those countries serious about ENHR. The CCMRC itself, as the regional ENHR networking body, has created a dedicated position for an ENHR coordinator whose task is the organisation of research skills workshops in the region (of which twelve have so far been conducted), as well as the support of research proposal drafting and prioritisation.

This approach has been further reflected by the invited participation of Curaçao (a country that is not a member of the Commonwealth Caribbean group of nations) in the CCMRC's regional ENHR development efforts. This occurred in the wake of Curaçao's completion of a comprehensive national health study and it has resulted in a joint research proposal to the EC for funding to apply the Curaçao health study model in the region. In this way, it would appear that the CCMRC and the countries under its regional ENHR umbrella are actively tapping into, and sharing, their respective expertise in areas relevant to the development of ENHR.

This networking model could be formally extended to become a needs-based consultation mechanism for ENHR initiatives globally. For example, South Africa's ENHR planners will be among the first, through an upcoming November 1996 congress and the planned follow-up to it, to gain specific expertise in the area of province level priority setting (the Philippines is also engaged in a similar exercise). That is, with the ANC government's devolution of health policy planning authority to South Africa's nine provinces effective next year, it will only be possible to reach agreement on national health research priorities by creating a mechanism for the effective support and coordination of provincial ENHR agendas. Given the number of other countries that have also started to undergo decentralisation, the sharing of South Africa's experiences with priority setting could be of great value for ENHR planners elsewhere. Again, *the value of knowledge capture and dissemination in the form of expert "product" must be emphasised going forward as a means of ENHR capacity building.*

6. Financing

Objective:

- Increase national and international financial support to all phases of the development of ENHR

The general experience of many ENHR countries has been one of frustration when it comes to the question of financing. Even some of those countries that have progressed to the point of drafting a national health research plan with tripartite stakeholder input (i.e., researchers, community representatives and policy makers) have been unable to implement their plans for lack of government financial support, let alone support from the international donor community. In fact, even in those countries where ENHR activities have enjoyed some degree of financial commitment, a lack of *sufficient* funding for new health research has had the tendency of generating a certain amount of cynicism amongst researchers hopeful that policy maker and international donor community buy-in to ENHR would result in a flood of fresh funding. In other countries where far less, or no, financing has been forthcoming, unmet expectations on the part of all those stakeholders involved have gone on to significantly compromise the momentum generated by ENHR planners (see "Box 5: The Expectation Gap").

There are, of course, some success stories in the area of national funding for ENHR. The Philippines, for example, has been able to sustain its growing ENHR movement by relying mostly on government funding. Granted, after a strong commitment in fiscal 1993, government ENHR funding dipped substantially in the following two years; however, in 1995, ENHR became a line item in the Department of Health (DOH) budget and its 1996 allocation rose almost to previous levels. At the same time, an administrative order was issued for the allocation of research funds by the country's regional health offices. With this renewed national commitment, ENHR planners in the Philippines no longer have to depend heavily on foreign funding, which almost matched or exceeded national funding in 1994 and 1995 respectively, but then fell to zero in 1996.

The national funding target that is being aimed for in the Philippines and in all other countries, for that matter, is a health research budget that corresponds to 2% of health care expenditures (as recommended in the original Commission report and further endorsed in the Task Force report). Some countries manage to track health research spending and can therefore assess their performance against the 2% target — South Africa's Health Systems Trust (HST), for example, has been able to estimate that in 1992/93 the country's health research expenditures accounted for only just over 1% of total health care expenditures. The ability to keep track of resource flows in such a way as to make the level of national commitment to health research transparent is of great value as a quantitative measure — it can be correlated with a country's progress in addressing its priority health concerns, while being used as well to induce ongoing government financial support.

Box 5: The Expectation Gap

Perhaps most disappointing to ENHR planners has been a relative lack of support from the international donor community, which, in some instances, has severely impacted the forward momentum of the initiative. The story of ENHR in Nicaragua is a good example of this. A strong early advocate of ENHR, Nicaragua decided to establish a National Commission on ENHR at its first national workshop in mid-1991. The Commission worked with the support of an executive Secretariat and working groups; it organised a series of workshops that led to the drafting of a national ENHR plan for 1994–1998. In a subsequent workshop on health development, Nicaragua's ENHR planners brought stakeholders and donors together to discuss the implementation of the plan; 102 national delegates from the MOH, both of the country's university health sciences schools, the Nicaraguan Community Movement, research centres and others met with representatives from eight different donor agencies. A series of meetings took place on site at the MOH, the universities in Managua and Leon and in the community — an exemplary reflection of stakeholder involvement. The outcome of the workshop was the adoption of the Nicaraguan Declaration on ENHR with the stated purpose of implementing the ENHR plan. Funding was to come from national and foreign sources and, with the aim of soliciting the support of the latter, the plan was sent out to approximately 40 donors. No commitments were made in response and, for the last two years, there has been little, if any, effort made to continue implementation efforts. The ENHR Commission itself has been inactive in this period, leaving Nicaragua's ENHR stakeholders without an effective mechanism to move things forward.

The unfortunate train of events in Nicaragua points to an urgent need to address what might be termed the "expectation gap". This can be defined as the difference in expectations held by ENHR stakeholders and by donors, each of the other, and it is characterised by a lack of transparency that can lead to the premature conclusion that ENHR is a non-viable proposition. On the part of ENHR stakeholders, as in Nicaragua, there appears to have been a perception that the international donor community would be a panacea — sufficient funding for ENHR plan implementation would quickly flood in from foreign sources, obviating the need to pursue difficult to obtain national commitments.

In this there appears to have been relatively little understanding of the many different members of the donor community, of their different areas of interest, new project selection criteria, and the length of time required to evaluate and decide on the merits of such projects. In a time when foreign donor resource pools are shrinking and cynicism regarding vaguely defined development projects is growing, it is not enough to have an ENHR plan. Donors are increasingly only considering the merits of proposals that, in the case of ENHR, present health research priorities in the form of clearly actionable projects that serve an analytically sound purpose. Meanwhile, given how long it can take even a genuinely interested donor to approve new program funding, ENHR planners should not place themselves in a position of exclusive reliance on foreign support for plan implementation; *national commitments are critical to the continuity and development of ENHR.*

In the meantime, donors themselves harbour expectations of the ENHR movement that need to be addressed. At this point in the history of ENHR, most donors would like to see real evidence of initial success in at least some countries. This might include evidence that ENHR is resulting in the more efficient use of existing health research funding in a given country; that it is also generating increasing national government commitments to health research; and, perhaps more significantly, that ENHR is being driven by national prime movers who themselves can take the initiative to form formal bilateral relationships with donors.

These expectations can be met in several ways: ENHR planners might consider involving donors early on in the process of ENHR planning as collaborative stakeholders; they might begin to formally track health research expenditure and utility data to keep donors informed of ENHR progress on an ongoing basis; and they might, through an increasing degree of transparency in their donor relations and the additional background support of COHRED, improve their chances of success in the solicitation of funding for ENHR plan implementation. A key notion here is that *the proactive coordination of donor involvement at the various stages of ENHR development could be a valuable tool for ENHR planners.*

7. Evaluation

Objectives:

- Develop and strengthen mechanisms for relevance and quality of research projects
- Ensure rapid translation of research results into effective programs

Several countries have begun the process, or have announced their intentions, of evaluating their progress in ENHR implementation — at this point more an evaluation of intermediate process steps rather than of the whole process *per se* as an instrument for health policy modification, let alone for the improvement of a nation's health status. But there remains the challenge, first, of identifying and applying an appropriate set of indicators that can lead to informed interventions in different aspects of the ENHR process; and, second, of actually creating and implementing an evaluation mechanism that can itself be dynamically integrated into the ENHR process. In answer to at least the first part of the challenge, a starting point is the detailed set of indicators developed, with COHRED Board input, by Professor M. Mugambi in the 1995 working document "Evaluation of ENHR". However, although many of the activities listed in this document are more or less integral to the success of ENHR, they are presented somewhat as a checklist without the qualitative distinctions that must be elaborated to make such indicators useful to countries with an elaborate ENHR process.

The lessons described above under the six previous ENHR process headings can perhaps serve as a stimulus to thinking about such qualitative measures that might be applied in the evaluation of ENHR. For example, it is fairly clear that a given country's ENHR program can reach a significant number of the milestones signalled by some of the major output indicators highlighted in the Task Force report and in subsequent documentation. These include such items as the institutionalisation of an ENHR mechanism; health research plan drafting through tripartite stakeholder collaboration, sharing of information through newsletters and workshops, ENHR integration in national policy plans, line item budgetary status, receipt of funding, and so on.

But in each case a more fundamental question needs to be asked: has the ENHR mechanism been housed in an institutional framework appropriate to the country's political landscape or has it predisposed itself to marginalisation by not securing the endorsement of other existing institutional power brokers?; have all the right stakeholders been identified and involved in plan drafting, participating together as equal partners in the process?; has there been sufficient rigour applied in health research priority setting such that ENHR plans might appeal to potential sources of funding?; does the existence of newsletters and workshops mean that there is real and ongoing collaboration taking place between growing numbers of stakeholders?; is the stated commitment of government backed up by a significant enough and consistent financial resource allocation to allow for substantive implementation of ENHR plans? *These questions are meant to get at the quality of the result of each activity undertaken in the name of ENHR; in answering them, ENHR planners should be identifying ways to modify their strategic process inputs in order to maximise the quality of the outputs.*

2. COHRED'S CONTRIBUTION TO ENHR

We saw the following as our task regarding COHRED itself:

> ***To assess COHRED's effectiveness in promoting ENHR at country, regional and global levels, indicating specific changes facilitated and the appropriateness of the balance of activities at all three levels. This is to involve an evaluation of all of COHRED's activities and the functioning of the Board, secretariat and working groups or special projects, with corresponding recommendations for improvement.***

While carrying out this assessment, it was useful to review the documents describing the origins of COHRED, contained in the proceedings of the March 1993 International Conference on Health Research for Development. Of most relevance were the statutes, implementing regulations and the schematic showing the COHRED membership structure.

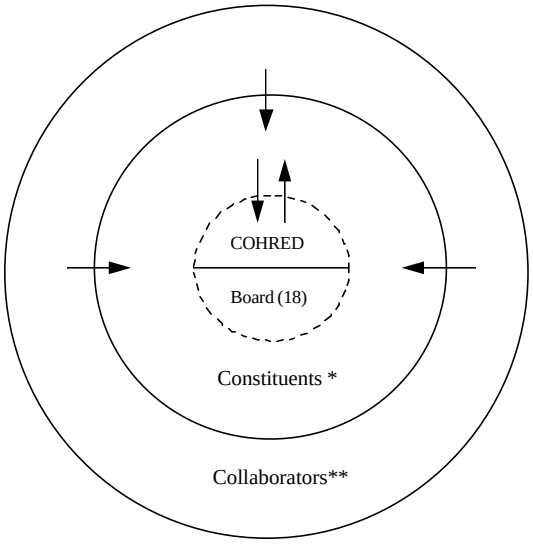
We considered the components of COHRED to include: the Council itself, the Board, the Secretariat, any working groups or special projects, and the regional networks. We also reviewed the links between COHRED and a group of international research networks identified as the Puebla Group, since this group was created in 1990 with an intent to support ENHR. We will present our findings and analysis concerning each of the component parts, then make some comments on the overall contribution of COHRED to the ENHR process, including some observations about the balance of the COHRED's efforts at the national, regional and global levels.

The Council

The 1993 schematic (see Figure 1) illustrating COHRED's membership structure shows three concentric circles with the COHRED Board at the centre, interacting with the next circle which comprises the "Constituents"; these are defined as countries, agencies and organisations accepted by the Board and comprising COHRED. The outer circle shows "Collaborators", defined as countries, agencies and organisations working with COHRED but without formal constituent status. An October 7, 1996, list shows 47 COHRED constituents, of which 27 are countries (represented by a variety of ministries and institutes); 18 are donor agencies; and 7 are organisations, including three UN organisations: UNDP, UNICEF and UNFPA. It should be noted that only one of the Puebla Group research networks is identified as a COHRED constituent.

We understand that after a potential constituent contacts the COHRED Secretariat, assuming that general criteria are met, the potential constituent is then presented at the next COHRED Board meeting for acceptance. Constituents regularly receive information, are invited (as observers) to Board meetings, and are asked to contribute to the nomination process for new Board members.

Figure 1



COHRED MEMBERSHIP STRUCTURE

* Countries, Agencies and Organisations accepted by the Board as comprising COHRED

** Countries, Agencies and Organisations working with COHRED but without formal constituent status

It was suggested by several informants that the Council (that is, the constituent members as a group) could be more dynamically involved in the work of COHRED. This could take the form of involvement in regional activities (for countries), or participation in problem-oriented working groups (for agencies and organisations). The Council *per se* has not met since 1993, leading to the suggestion that it may be timely to convene another Council meeting, perhaps in conjunction with the World Health Assembly.

On reviewing the current constituent list, some other observations can be made. There are some constituent member countries that are not receiving significant attention from COHRED and perhaps they should be. Also, it is noteworthy that there are several organisations and agencies that are associated with the Puebla Group that should logically be constituents but are not. This observation leads to the suggestion that some form of proactive recruitment might be considered.

In general, it is our assessment that the Council as such represents an important resource and could receive more careful attention from the Board, in terms of criteria for membership, involvement in COHRED activities and possibly recruitment of desirable new constituents.

The Board

As the "supreme policy making body of COHRED", the Board is responsible for the direction and functioning of COHRED. We were able to speak to more than half of the current Board members, as well as some former members. Overall, we found a high level of interest in, and commitment to, the work of COHRED among these individuals. Some additional observations concerning the Board were made by other key informants. Several specific issues emerged:

The Selection Process: Currently, nominations for Board positions are submitted by ministries of health from COHRED's country constituents and from other constituents. Several sources suggested that ministry officials often do not understand some of the fundamentals of COHRED's origins and mission, and that other sources of nominations should be accessed. These would include individuals who were members of the Commission and the Task Force, as well as former Board members.

Representation Issues: It was observed that the Board consists mostly of researchers and donor agency representatives. There was a sense that two of the prime ENHR stakeholder groups were not well represented — decision makers (government policy makers) and community representatives. On another theme, a few individuals questioned the somewhat unusual arrangement whereby representatives of donor agencies are members of a working Board, although no one suggested that this was inappropriate. More importantly, it was reinforced that these individuals should serve on the Board both as representatives of their agency, and in their own right as development specialists.

Effectiveness and Efficiency: There were some comments that in its first two years the Board could have been more dynamically engaged in the work of COHRED, that it was too passive and that, therefore, bringing people together for two or three days seemed not to be cost effective. This pattern seems to be

changing, for example, with the recent preparation and presentation of working papers by Board members; the special session in June included a modified Delphi exercise regarding COHRED's priorities.

Two general suggestions emerged in our discussions. The first concerned the size of the Board, with the suggestion that a smaller executive committee of the Board be created with perhaps five or six members, each of whom would have a specific area of responsibility. An alternative suggestion was that the COHRED Board itself should be reduced in size — this was a less frequent view.

Secondly, there were several suggestions that Board members could be more actively engaged in specific problems or issues, through participation in issue-specific working groups or short term task forces. This would mean a commitment to do some work between Board meetings, a suggestion that is now much more feasible given the increased use of modern communication technology.

Role-Modelling and Values: Over the years, a few key values have been recognised as characterising the ENHR process. They include inclusiveness, transparency (accountability), multi-sectorality, and equity. Several observers remarked that these values should be reflected in the way the Board functions, adding that to a large extent this was happening. The Board must "practice what it preaches" by role-modelling ENHR values in its work. It may be that some kind of manual of operations would be helpful, particularly for new Board members joining COHRED.

The Secretariat

There was a general agreement that the Secretariat was functioning well and serving the needs of COHRED. Particularly appreciated was the preparation and dissemination of information materials, such as the regular newsletters. The new Web page will be a welcome addition. The coordinator plays a multi-faceted role and his many contributions are generally well regarded.

However, with the ENHR movement now gaining momentum and with the emergence of some new challenges, there is a growing sense that more analytic work is needed. Examples of issues requiring more in-depth analysis include:

- The analysis of financial resource flows for ENHR in countries by documenting both internal sources and external sources of funding; the task might be to develop an analytic model in one or two countries, to be used subsequently by other countries.

- The methodology of research priority setting; (it is recognised that some work has already begun on this issue).

- The further elaboration of the various skills needed at different stages of the ENHR process, with the aim of creating training packages for use at the country level.

These observations lead to the suggestion that the Secretariat needs to strengthen its analytic capacity; at the same time, some of the advocacy and promotion functions could be taken on by Board members, and certainly by the regional ENHR network groups.

The Regional Networks

Two regional network meetings were held during the time that the evaluation team was carrying out its task. One team member participated in a task force meeting of the Asian network held in Manila in July; another team member was able to attend the African network meeting in Kampala in early October. In addition, we heard views about the role of the regional networks from several key informants and from some of the agency representatives.

The Asian network group appears to be functioning well, with three countries playing a lead role: Bangladesh, the Philippines and Thailand. At the July meeting the "focal point" for the Asian network moved from Bangladesh (after two years) to the Philippines. This network's goals are to monitor ENHR progress in the countries of the region, with special attention given to helping new countries get started; to learn about the ENHR process in more depth (based on country experience in the region); and to facilitate links regarding ENHR with appropriate regional networks and organisations. In addition, some inter-country collaborative research is being developed. There is a clear two year plan of work. Of particular note was the functioning of "focal point teams" — several individuals in Bangladesh, and now in the Philippines, working as a team to carry out the focal point tasks.

The African network meeting was held in conjunction with a regional meeting of the International Clinical Epidemiology Network (INCLEN), with planned overlap of participants in both meetings. Our observation is that the African ENHR network, though it has had several meetings, is not functioning optimally. Too much of the work falls on the shoulders of the single focal point for the region. Some progress is being made on the use of a regional electronic listserve, moderated by GTZ in Harare. Although there is a general regional plan, it was our impression that this needs to be more focused in order to make a real difference in a small number of countries.

In the Caribbean region, the introduction and development of ENHR has been strongly facilitated by an existing organisation, the Commonwealth Caribbean Medical Research Council (CCMRC). The document, A *Proposal for ENHR for the Caribbean*, prepared by the CCMRC, was endorsed by the Conference of Ministers Responsible for Health in 1994. At a November 1995 joint CCMRC–COHRED workshop in Jamaica, teams from five countries discussed issues regarding priority setting for health research and prepared country ENHR plans. Four of the five countries presented progress reports at an April 1996 meeting of the CCMRC in Trinidad. Thus, the Caribbean experience represents an interesting example of a previously existing network taking on the function of facilitating the development of ENHR at a regional level.

Several general observations can be made about the role of ENHR regional networks:

- Much of the general promotion and advocacy function for ENHR can be taken up as the responsibility of the regional networks, thus freeing up the Board and Secretariat for other priority activities. These groups have a distinctive knowledge

of the region's social and political trends and of other existing regional networks and organisations. Thus the nature and style of the regional expression of COHRED can and must be adapted to particular regions by ENHR planners from those regions.

- At the same time, it would be useful for the COHRED Board, given the experience to date, to think more specifically about the role of the regional networks: what are their distinctive functions; how are they complementary to the work of the Board and Secretariat; how can the objectives be achieved most efficiently? Having two years of accumulated experience with the regional networks, it may be timely to reflect on some of these questions, and propose specific guidelines.

- We have encountered situations where inter-country links across regions might be useful with respect to specific issues or problems. An example is the question of applying the ENHR process at a provincial and even a district level — an issue raised as a result of increasing decentralisation as a part of health system reform. This issue is just now being confronted by South Africa. ENHR experience at the regional level is available in the Philippines (and probably in some other countries as well). A topic-specific exchange between these countries might represent an example of inter-regional networking.

- The African region presents a special challenge to COHRED for several well known reasons: there are many pre-existing health networks, often the creation of large, externally funded projects and programs; the pool of qualified researchers and policy makers is much smaller, resulting in extraordinary demands on these few individuals; many of the countries are poor in economic terms; there is unpredictable regional instability because of natural disasters and armed conflict. Given this regional reality, what can COHRED do, in the process of facilitating ENHR, to make a constructive value added contribution to this complex of regional activities? Certainly, the COHRED sponsored "Networking the Networks" January 1996 meeting at Victoria Falls, Zimbabwe, was a useful contribution. However, the intended follow-up from this meeting has lagged somewhat, in part due to the general "African situation". These issues require more analysis and discussion.

Working Groups and Special Projects

Although "carry out special projects" is listed in the March 1993 statutes document as one of COHRED's functions, this has not been a prominent feature to date. A small working group met in Mexico to consider "COHRED — Why, What and How?". Another sub-group of the COHRED Board met earlier in 1996 before the Ad Hoc Committee conference to consider COHRED's position. To an extent, some of the tasks given to individual consultants in the past one or two years could be considered special projects — for example, the work that led to the June 1996 report by Professor M. Mugambi, *ENHR Networking of Networks*. We anticipate that the "special projects" function will be added to the mix of COHRED's activities, given a re-emphasis on Board-initiated task force groups and a re-alignment of Secretariat functions to focus on specified analytic projects.

Links with International Health Research Networks

Although not a specific component of the COHRED mechanism, the group of international health research networks represents a very important resource for the work of COHRED. Representatives of several networks were interviewed and we received some further written submissions from others (see Appendix 4).

In January 1990, during the course of the annual INCLEN meeting held in Puebla, Mexico, the emerging ideas and recommendations of the Commission were presented and discussed. Representatives of various networks attending this meeting felt strongly that ENHR was a powerful idea, and they proceeded to prepare a joint *Puebla Declaration* endorsing the Commission's proposals and pledging a re-alignment of their individual and collective activities to enhance ENHR. Since 1990, representatives of these networks have met from time to time, and they have engaged in some collaborative activities in support of ENHR. The most visible product has been the *Puebla Group Information Handbook* published in 1992 and again in 1995, facilitated by one of the members, the International Health Policy Program (IHPP), based in Washington, D.C. Two of the networks (INCLEN and IHPP), in collaboration with COHRED, have cooperated with the Uganda National Council for Science and Technology by assisting with a July 1995 workshop. The goal of this workshop was to review concept papers on potential research projects, with a view to developing these into fundable proposals. By mid-1996, about half of the original concept papers had become full proposals.

For the most part, however, the promise of the Puebla Group remains unfulfilled. Only one of the current members is a constituent of COHRED — this is the International Forum for Social Sciences in Health (IFSSH). Many more examples of intra-country collaborative activities are needed, initiated (or at least supported) by country representatives of the international networks and integrated into national ENHR plans. In addition, the evaluation team believes that the research networks have specific areas of expertise (knowledge and skills) that relate quite directly to the various stages of the ENHR process. This expertise could be more effectively accessed and disseminated to strengthen the ENHR process globally.

Balance across National, Regional and Global Activities

The central contribution to be made by COHRED as it contributes to the "health research for development" effort relates to its work at the country level. Facilitating ENHR development at the country level must remain COHRED's priority activity. No other organisation has taken on this specific area of work. It follows that COHRED's energies and resources should be deployed accordingly. Taken together, the various components of COHRED — the Council, the Board, the Secretariat and the regional networks — are all means to the priority goal of strengthening national ENHR initiatives.

In analysing the range of COHRED's activities at the three levels, we find that the balance is quite appropriate. For example, the regional networks have not become independent mini-organisations, whose activities are unrelated to the work at the country level. The global activities of COHRED (for example, participating in the Ad Hoc Committee meetings) are principally geared to promoting the national perspective, as links between global and national research priorities and programs are developed.

D. RECOMMENDATIONS

ENHR continues to have enormous potential as a strategy for ensuring that research serves as a "powerful tool for health and development" (Commission report, page xviii). Considerable experience with this strategy is accumulating in an increasing number of countries. However, there is a sense across the international community that much of the promise remains unfulfilled and undemonstrated.

The evaluation team believes that in order for COHRED and its partners to make further progress in achieving its objective, "... for all people of each country to achieve health and quality of life on the basis of equity and social justice", some specific next steps must be taken. These are offered as four general recommendations, some of which have sub-components.

RECOMMENDATION # 1

PRODUCT: TRAINING IN ENHR TECHNOLOGY

With the launching of ENHR and the identification of its seven key elements, it was assumed that people would see the need for these elements and undertake them on their own. In fact, the country ENHR groups have accomplished these with varying success. It is important to recognise that, in order to ensure success, the seven elements must be carried out through the systematic application of a knowledge and skills base. Some examples of the competencies are: political mapping, advocacy skills, priority setting, strategies for community participation, preparation of research proposals for funding, and others. We are calling this group of competencies "ENHR technology" and suggest strongly that the definition, elaboration and use of this technology represents COHRED's niche, its value added contribution to the global health and development endeavour.

COHRED should now proceed with the identification of the requisite knowledge and skills for each element, incorporate them into modules or "tool kits" (materials and events), and offer them as training for ENHR planners in various countries, based on specific needs and interest assessments. We believe that much of the expertise related to these competencies can be found within the research networks and institutions that have indicated their intent to contribute to the ENHR process (see "Box 6: ENHR Technology and Sources"). Training in ENHR technology should involve not only researchers but also the other ENHR stakeholders in any given country.

1.1 We recommend a special initiative to capture the available expertise regarding the competencies which comprise "ENHR technology", prepare strategies and materials ("toolkits"), and provide training to country ENHR groups.

BOX 6: ENHR TECHNOLOGY AND SOURCES

Competency	***Possible Resource***
1. Promotion and Advocacy:	
• Advocacy skills	Many non-government organisations
• Political mapping	Harvard University; London School of Hygiene and Tropical Medicine
2. ENHR Mechanism:	
• Skills for facilitating community participation	International Forum for Social Sciences in Health (IFSSH)
3. Priority Setting:	
• Methodology of priority setting	Several networks and institutions for research
4. Capacity Building & Strengthening:	
• Preparation of research protocols	INCLEN and others
• Translating research into policy	International Health Policy Program
• Curriculum reform (to incorporate research training, ENHR skills	Network of Community-Oriented Educational Institutions
• Leadership development	University Partnerships Project (UPP)*
5. Networking:	
• Networking skills (both "people" and "technological aspects")	Several Puebla Group networks
6. Financing:	
• Donor coordination and fund solicitation	Donor agency development specialists and others
7. Evaluation:	
• Skills for evaluating projects and programs	Several Puebla Group networks and other institutions

Notes:

* UPP is a demonstration project of the Network of Community-Oriented Educational Institutions

RECOMMENDATION # 2

PARTNERSHIPS: PURPOSE-SPECIFIC COALITION BUILDING

By the time that the 1991 "green book" was published, three key participant groups (later known as ENHR stakeholders) had been clearly identified. They were researchers, communities and policy makers — all sharing the goal of ensuring that health research results in the improved health of the people. The thinking was that each stakeholder has distinctive contributions to make to the ENHR process, and that in a "partnership of equals" each partner would respect the others' point of view and value the different contributions.

We have found in the various country analyses that there is considerable variation in the extent to which all three partners are involved. In addition, at least in some countries, additional partners have been or should be added. These include donors, the private sector, NGOs and UN agency programmers. We have also found that the process of appropriately involving the various groups requires considerable sensitivity, wisdom, persistence and skill. This kind of expertise is now becoming available in countries with several years of experience with the ENHR process; however, this resource is not readily accessible to countries involved in earlier stages. As a step to solving this problem:

2.1 We recommend the creation of regional "ENHR mentoring teams" to assist countries with coalition building, particularly in the early stages of the ENHR process where "political mapping" is most important. Where possible, these mentoring teams should include representatives of the three core partners — researchers, policy makers, and community groups; in some situations, a donor representative could be added.

These same principles of purpose-specific coalition building, with mutual respect among partners, also apply at the global level. COHRED and the various country partners have critically important contributions to make to the global health research agenda. In particular, COHRED's working relationships with the World Health Organization (WHO), with other UN agencies and with the World Bank should be strengthened. The national and global health research processes and agendas are not only complementary — they are inter-dependent. Special opportunities exist at the country level for collaborative efforts between national ENHR groups and the global agencies — the WHO, other UN agencies and the World Bank. Examples include the following:

- Initiated by Davidson Gwatkin of IHPP, and with the strong encouragement of Richard Feachem of the World Bank and Tim Rothermel of UNDP, a cooperative UNDP-World Bank proposal is under active consideration to mobilise country-level resources for Bank-supported national health policy research. The focus would be on issues regarded by policy makers in these countries to be of the highest priority; the resulting research would be linked to the international community. Dr. Feachem has expressed his interest in exploring the possibility of having this

experiment based in one or more countries where there is a strong ENHR process in place.

- In reading the Report of the Ad Hoc Committee, *Investing in Health Research and Development*, (WHO, Geneva, 1996), there appear to be several issues which direct links between an international research group and a country-based research consortium could address. An example might be to link the analysis of global resource flows (see Annex 5 of the WHO publication) with a strengthened model for monitoring internal and external resource flows for national health research, paying particular attention to whether these funds are targeted at the priority issues identified in national ENHR research plans.

- In recent discussions with UNICEF officers based in New York great interest was expressed in the prospect of having country-based UNICEF program officers more involved in the ENHR process. It was suggested that these programmers often have important research questions to suggest based on considerable experience; they may themselves have research skills to contribute; they can assist with national networking; and UNICEF could contribute to the funding of research (focused on projects related to children and adolescents).

2.2 We recommend establishing a task force to explore specific ways in which national and global research initiatives can be linked. The task force should be initiated by COHRED, and include representatives of the WHO and other UN agencies, and the World Bank, aiming to develop exemplary collaborative projects and programs at the country level.

RECOMMENDATION # 3

PEOPLE: COMPREHENSIVE RESEARCH CAPACITY STRENGTHENING

As with any complex endeavour, it is critical that there are the right kind of people — in adequate numbers, trained appropriately and supported adequately — to do the work for which they have been prepared. ENHR is indeed a complex adventure, requiring that all stakeholder groups possess sufficient expertise. Research training must not be restricted to just researchers. Other stakeholders must receive appropriate preparation for selected elements of the ENHR process; these include the policy makers themselves, community members, and NGO representatives. Donors too can be learners regarding aspects of the ENHR process, leading to the prospect that their contributions might become more relevant and effective.

3.1 We recommend that the scope of research training be broadened beyond the usual researcher community; COHRED should identify countries where there may already be experience with a broader scope of research training, with the aim of strengthening and disseminating this experience.

In many countries the potentially available research capacity to contribute to the ENHR program is not actually involved. There are many reasons for what might be termed

internal brain drain (see Box 3). This complex situation is not well understood and solutions are not readily available.

3.2 We recommend that COHRED initiate one or more country case studies focused on this issue; these studies would be not only analytic and descriptive, but would pro-actively propose and implement solutions to ensure that potentially available research expertise is contributing to the ENHR process.

ENHR represents a paradigm shift with respect to the initiation, design and implementation of health research, and the subsequent use of research findings. It therefore requires a long term commitment of vision and resources. It will be particularly important to prepare the next generation of health leadership, today's health professional students, to understand and join the ENHR enterprise.

3.3 We recommend that COHRED facilitate special initiatives with appropriate networks and institutions to introduce ENHR concepts and skills to the curricula that prepare future health professionals. This initiative should feature opportunities for students to participate directly in all aspects of the ENHR plan.

A promising approach to the preparation of future health researchers is the "University Partnerships Project" (UPP) — a demonstration project within the Network of Community-Oriented Educational Institutions for Health Sciences. Over the past five years, the UPP has worked with more than 12 universities in various parts of the world, assisting them to develop the institutional capacities to promote student research in communities, whereby the questions for student research are derived from intensive dialogue between the university (including students), local government and community leaders. The aim is to provide training and experience for students in the process of partnership development, as well as in the conduct of community-based, partnership-driven research.

RECOMMENDATION # 4

PERFORMANCE: A STRONGER COHRED

The successful implementation of the above recommendations will depend on the performance of a COHRED whose *modus operandi* will be to proactively and efficiently tap the great range of resources at its disposal. We have arrived at the following recommendations for the strategic restructuring COHRED (including the Council, the Board, the Secretariat and the regional networks) that will help make it a stronger, more effective organisation over the coming years.

The Council

There are currently 47 constituent members of COHRED's Council, a body that is not formally called on as a whole to participate in any ENHR initiatives. Beyond the initial interest shown by those who have joined the Council, many either have not been given an opportunity to become more actively involved or they have themselves chosen to remain only passively involved. *We feel that the Council represents a potentially*

valuable source of consultant expertise for ongoing projects, whether at the national, regional or global level. As such, the acceptance of constituents should be subject to a more rigorously defined set of guidelines (based on the expected contributions of the Council), and its current membership should be accordingly revisited and reconfirmed. In addition, the active recruitment of new Council members should also be considered; for example, it would be sensible to include members of the Puebla Group network as Council constituents.

The Board

4.1 We recommend that the COHRED Board become more "problem-oriented" in the way it functions. This could be achieved by forming small short term task force groups to deal with specific relevant issues. Also, the COHRED Board could be more efficient either by creating a small executive committee where each member has a specific responsibility or by reducing its size.

It is COHRED's Board that will have the responsibility to develop and disseminate the *product* that brings scientific method and new competencies to ENHR; to build and maintain purpose-specific *partnerships* to foster consensual attitude change and mutual commitment; and to focus special attention and resources on *people* to effectively strengthen the research capacity of developing nations. Ultimately, the successful coordination of these three thrusts will be necessary to facilitate the continuing evolution of ENHR initiatives worldwide. We feel, however, that in its current configuration the Board will not be able to be maximally effective in achieving this aim.

A traditional problem in the governance and management of an international organisation is the unwieldy size of its Board and the general lack of accountability of its membership (with the possible exception of donor representatives). These two factors, together with a strong adherence to consensus-based decision making, make it difficult for such organisations to define their strategic focus, to adopt problem-based workplanning techniques, and to then work efficiently to realise their operating goals. We believe that COHRED's Board itself is hampered by such a governance model and should therefore restructure itself, taking into consideration the following options:

- **Create an *Executive Committee* made up of 5-6 directors**, including the chairperson. As a body accountable to the rest of the Board, its role would be to formulate COHRED's strategy, devise the operational means to realise its objectives, and to take individual leadership of task forces commissioned to address COHRED's capability gaps. The Executive Committee might meet relatively frequently (perhaps quarterly), but in making the serious commitment commensurate with their responsibilities, its members would collaborate with one another, as well as with other task force members, on a regular basis. A rigorous set of selection criteria would have to be established to ensure that the individuals selected for Executive Committee positions would make the appropriate commitment.

  Meanwhile, the Board itself will have the authority and obligation to ratify, amend or reject any proposal put to it by its Executive Committee members. Matters falling within the ambit of COHRED's statutes might be decided by

majority vote; matters relating to the amendment of these statutes might require a special majority vote (e.g., by regional representation, two thirds majority, etc.). At the same time, Board members would be expected to participate as members of the task forces led by Executive Committee members and to become actively involved in their own capacities outside of Board meetings as strong ENHR advocates. Therefore, the criteria by which they themselves are selected should also be tightened to ensure that all directors be willing and able to take on the significant responsibilities accompanying their positions.

- **Reduce the size of the Board by a third** to approximately a dozen members (the COHRED coordinator, a chairperson and vice-chairperson, four or five representatives from the regions, a donor representative from North America and Europe, and a couple representatives from international research network partners). Again, with the aggressive problem-oriented mandate of the Board and the concomitant level of commitment required of the Board members, rigorous selection criteria for directors would have to be adhered to.

- **Modify the representative mix of the Board's membership.** As COHRED strives to initiate and institutionalise partnerships with donors, health research networks and other international organisations, its Board membership should come to reflect this thrust. Similarly, as progress is made at the national level in the promotion of researchers, community representatives and policy makers as equal stakeholders in the ENHR process, the Board member selection process should be expanded with the aim of effecting a better representative balance (achieved by identifying suitable candidates from the under-represented ranks of community and policy maker stakeholders).

The Secretariat and Regional Networks

4.2 We recommend that the COHRED Secretariat be strengthened to increase its capacity for specific analytic projects. This could be done either by adding a professional officer to the Geneva based unit, or by engaging regionally based professionals on a part-time basis.

Until now COHRED's Secretariat has been very effective in expanding the sphere of interest in ENHR adoption; engaging informally in political mapping and facilitation; supporting the development of the regional networks and the planning of networking workshops; acting as an ENHR information repository and disseminator; involving and soliciting funding from donors; and beginning to build working relationships with other institutions. In sum, the Secretariat has successfully played a strong ENHR promotion and advocacy role that has led to the generation of significant momentum in a number of countries.

Meanwhile, we feel that the regional networks in Asia and in the Caribbean have sufficient capabilities to formally take on much of the role that the Secretariat has played in Geneva. That is, as these networks have developed an increasingly institutionalised presence in their regions, they have placed themselves in the best position to carry out ENHR advocacy and promotion. Specifically, the ongoing networking of regional expertise, the provision of various kinds of support for ENHR initiatives, and the monitoring of developments at the national level, including formal

political mapping, should all be the responsibility of the regional networks; moreover, the above proposed ENHR mentoring teams that would take on these tasks in selected countries would best be appointed and coordinated at a regional level.

It would be timely for the Board to consider how to optimise the sharing of responsibility amongst the regional networks, the Secretariat and itself. Meanwhile, special consideration should be given to the challenges faced by the African network. It must be strengthened to support the urgent needs of the many ENHR countries on the continent. In addition, for reasons of language and geography, it may be necessary to establish another regional network for the ENHR-active, French speaking West African countries.

Given these developments, we feel that the Secretariat, working closely with the regional networks, should now focus on becoming an analytic body, with the aim of being less the advocate and more a "behind the scenes" funding broker, enabling ENHR planners to become more effective at each step of the process and to obtain increased financial support for the implementation of ENHR initiatives. In this capacity, the Secretariat's primary role would be, first, to gather and publish both quantitative and qualitative evidence of ENHR progress worldwide and, second, to provide ENHR stakeholders nationally and regionally with the tools (developed, for example, through the work of the Board-commissioned task forces) that may aid such stakeholders in pushing ahead with their initiatives. These two mutually reinforcing areas of focus could specifically involve the following:

- ***Tracking internal and external resource flows*** *as a transparent, quantitative measure of ENHR progress in various countries. The challenges posed by inexact definitions of ENHR and health research in general, by ENHR projects pursued under other names, and by the shear difficulty in getting good data would all have to be overcome. The extent to which ENHR results in both the more efficient use of existing resources and the allocation of more funding for health research could serve as an intermediate quantitative indicator of success that might, among other things, maintain the commitment of national governments and external donors alike. Initially, a resource tracking model could be developed through a case study in one or two countries, to then be applied across the ENHR world.*

- ***Designing and deploying generic information tools*** *for the optimisation of ENHR plan drafting and implementation. This might include guidelines on the process of effective stakeholder collaboration, on research prioritisation exercises, and on means of outlining actionable research proposals that may be attractive to potential donors. Especially significant might be information on specific donors that would lead ENHR stakeholders to approach, involve and coordinate the inputs of various donors at appropriate times in the pursuit of their projects. It is hoped that long term bilateral relationships might be facilitated in this way, an auspicious development in light of the current trend towards an increasingly exclusive focus on bilateral funding in the international donor community.*

We believe that the successful implementation of these initiatives might serve to close the "expectation gap" that exists between ENHR stakeholders and donors. It is this gap that leads the former to lose hope of implementing their health research plans when initially unsuccessful in obtaining funding support and the latter to lose interest in ENHR after failing to see real evidence of results. The greater the transparency that exists in the relationships between national stakeholders and donors, the more likely that ENHR momentum might be sustained.

- *Whether at the level of the Secretariat or the regional networks, COHRED does not have the human resource availability to take on the work that would allow it to successfully realise the above proposed objectives.*

OTHER CONSIDERATIONS

In addition to the four major recommendations, several other issues were identified in our analysis, many of them derived from discussions with key informants. Several of these considerations are described below. We believe that they are also important for the COHRED Board to consider in its planning process.

A Major Review in Three Years

The year 2000 will mark the tenth anniversary of the release of the Commission Report, *Health Research: Essential Link to Equity in Development.* It has been suggested that this represents an opportunity to conduct a major, comprehensive review of the state of health research for development, to coincide with this date. From COHRED's point of view, this idea would be timely in that it will follow this report by three years — enough time to determine whether some "next step" strategies have been useful. Such a review would also offer an opportunity to examine the realities of the interaction between national and global research initiatives. Both IDRC and SIDA-SAREC have indicated preliminary interest in facilitating such a review.

A "Phase-Out" Plan for COHRED

In the view of some the contribution of COHRED fills a vacuum left by other agencies, principally the World Health Organization. It may be useful for the COHRED Board to think strategically about whether it should have a "sunset clause" — that is, the specific goal of working itself out of a job — systematically transferring its experience, networks, conceptual models and tools to other hands. The WHO, perhaps principally at the regional and country level, would be one potential recipient or partner in this process. From the WHO perspective, this may be timely both because of the recent effort to renew its Health-for-All strategy and because of the view from some WHO headquarters staff members that WHO's own analytic capacity is weak. Another recipient would be the World Bank, since some observers see the publication of *Investing in Health* as a shift whereby the World Bank has become "the principal leader on international health" (quote from an editorial, The Lancet, Vol 342, July 10, 1993, pp. 63-64).

From another perspective, an implicit goal in COHRED's work is that the ENHR mechanism within countries should eventually become self-sustaining, no longer requiring input from COHRED. There are already some countries that are nearing this stage. Our intent at this point is simply to raise the idea that the COHRED Board may wish think about whether it sees itself as eventually completing its work, and, if so, what the target phase-out date and the operational indicators might be.

COHRED and the North-South Balance

The Commission report stated: *" Our most striking finding is the stark contrast between the global distribution of sickness and death, and the allocation of health research funding. An estimated 93 percent of the world's burden of preventable mortality ... occurs in the developing world. Yet, of the $30 billion global investment in health research in 1986, only 5 percent or $1.6 billion was devoted specifically to health problems of developing countries".* In the study by Michaud and Murray,

recently published in the Ad Hoc committee's report (Annex 5, pages 213-236), it was concluded that this gap has not narrowed but widened from 1986 to 1992, so that now only 4.4% of global R & D investment is expended in low and middle-income countries. Furthermore, this trend is accentuated by the overall stagnation in overseas development assistance (ODA), with the resulting decline in financial resources for health through this mechanism. Some informants expressed the view that COHRED should become more involved in addressing this alarming situation, which essentially is an expression of inequity on an international scale. This may be an area where COHRED's donor agency constituents can play a special leadership role.

Engaging the Professional Community

There is a general worldwide trend of increasing private sector health expenditure, with a concomitant decrease in public sector spending. Much of the private sector spending is initiated by physicians in private clinics and hospitals, targeted at investigations and treatments (medications and procedures). Several recent studies indicate that much of this spending is on interventions that are not effective; in some instances, money is spent on interventions which do more harm than good (for example, the wanton use of steroids and the use of ineffective antibiotics that increase community drug resistance levels). An important player in this scenario is the global pharmaceutical industry. Some informants emphasised that this is a growing problem in many developing countries, requiring research which involves the professional community (physicians, pharmacists, etc.). A specific suggestion was that COHRED should initiate a dialogue with the "Cochrane Collaboration" — a well organised global initiative designed to evaluate the cost effectiveness of therapeutic interventions by conducting meta-analyses of all available randomised trials for a given condition. Included in this collaboration are developing country clinician-scientists, many of whom are associated with INCLEN. It was also suggested that COHRED should be presenting its work at international gatherings of clinicians, such as the International Pediatrics Society.

ENHR For All — Including Industrialised Countries

A few informants reminded us that the ENHR strategy could be important for industrialised as well as for developing countries. In fact, there are some examples of industrialised countries where ENHR-like activities are in progress. They include Great Britain, where there has been a major reorientation of the National Health Service (NHS) towards "Evidence-Based Care" — the theme of a major conference last October. Sweden has just hosted a conference on priorities in health. Some limited examples can be found in Canada; for example, the Medical Research Council (MRC) of Canada recently completed a national participatory strategic planning exercise resulting in some shifts in health research funding. (In this regard, it is interesting that Canada is a constituent country member of COHRED — the only industrialised country on the list!). These are, however, isolated and unrelated examples. There may therefore be a role for COHRED to facilitate a dialogue between industrialised and developing countries regarding ENHR values and strategies; a likely finding would be that the South has much to teach the North.

F. CONCLUSION

This has been a rapid assessment, by an external evaluation team, of the progress of the ENHR process that has been made over a relatively short time — no more than five years — and of COHRED's contribution to this most important endeavour. We conclude that impressive progress has been made and that COHRED remains an important mechanism for the further development of ENHR. We believe that it is now time to explore the ENHR process in more depth — to elaborate and disseminate the competencies that are part of the ENHR process; to more systematically facilitate the complex process of coalition building, both nationally and globally; and to examine in more detail the difficult issues involved in engaging a country's research capacity with its most important health and development problems. To facilitate this "next step", we urge COHRED to strengthen its own analytic capacity; and to mobilise all of its people assets, through the use of problem-oriented working groups and special projects, to tackle the important challenges ahead in a dynamic and creative fashion.

Acknowledgements

First of all, the evaluation team wishes to thank the COHRED Board for the opportunity to conduct this assessment. It has been a thoroughly enjoyable and challenging learning experience for all of us.

We wish, in particular, to thank all those in the countries we visited who made the necessary arrangements and gave generously of their time and energy to assist us with our work. We also thank the many individuals — key informants, donor agency representatives and leaders of research networks — who gave us their candid and helpful views about progress to date and, in particular, about what might be done in the future.

The COHRED Secretariat was most helpful in providing a space for us to think and work, making all documents available, and helping us with the actual arrangements for most of the site visits.

We also wish to acknowledge the patience, understanding and help of the support staff in each of our "home base" locations — in London, Manila and Hamilton (Canada).

Vic Neufeld (team leader), Canada

Qhing Qhing Dlamini, Swaziland and the United Kingdom

Mark Pruzanski, Canada

Tessa Tan Torres, the Philippines

APPENDIX 1: COUNTRY SITE VISIT REPORTS

	Country	Site Visitor(s)
1 (a)	Caribbean (including Jamaica, Trinidad & Tobago, Barbados)	Qhing Qhing Dlamini
1 (b)	Kenya	Tessa Tan Torres David Okello
1 (c)	Mozambique	Vic Neufeld
1 (d)	Nepal	Tessa Tan Torres
1 (e)	Nicaragua	Qhing Qhing Dlamini
1 (f)	Republic of South Africa	Vic Neufeld
1 (g)	The Philippines	Vic Neufeld

APPENDIX 1(a)

JAMAICA ENHR SITE VISIT — SUMMARY
August 19 – 20, 1996
Prepared by Qhing Qhing Dlamini

FOREWORD:

The COHRED/ENHR external evaluation team wishes to thank the Ministry of Health and the University of West Indies (Jamaica), for their participation in the evaluation. A special word of thanks goes to Dr J Peter Figueroa, Principal Medical Officer(Epidemiology) for arranging and co-ordinating the visit of the evaluation team.

Purpose of Site Visit:

The visit to Jamaica was to collect information on the progress made in ENHR in the country, and to assess COHRED's effectiveness in promoting the ENHR process. With the relevant information obtained, to make recommendations to the country and to COHRED on how to enhance the ENHR process.

Methods:

The visit was conducted from 19-20 August by Dr Qhing Qhing Dlamini from the Commonwealth Secretariat, London, one of three members of the external evaluation team. The places visited, individuals met and documents reviewed are in Appendices 1,2 and 3.

Limitations:

The country visit was short. Initially it had been intended that a member of the COHRED Board from that region would join the evaluation team member. However, that did not happen because of other commitments.

Because of time constraint, given the number of people whom the evaluation team member met, discussions were not in-depth and only key issues could be addressed.

Background:

General data and health situation: Jamaica has a population of 2,447,000 (est 1995) life expectancy at birth in 1990 was 73.1; years of schooling 5.3 (1990) the GDP per capita in 1990 was $2,979.

Access to safe water and sanitation is 72% and 91% respectively (1988-90). Maternal Mortality rate is 120 per 100,000 live births (1988). Public expenditure on health (as % of GNP) is 2.9% (1988-90).

Summary of ENHR events:

April 1992:	Workshop on ENHR for the Caribbean, held in Curaçao following the 37th Annual Meeting of the CCMRC.
November 1995:	Regional Workshop on ENHR and Priority Setting in Health Research, Ocho Rios, Jamaica.
January 1996 to August 1996:	Jamaican research team met and received commitment from Planning Institute Jamaica (PIOJ) and ISER to prepare a questionnaire for institutions and researchers engaged in health research. Research commenced. Data entry and analysis progressed. A research assistant was employed to ensure that data collection is completed before September 1996.
April 1996:	Workshop on ENHR, Port of Spain, Trinidad and Tobago. Representative from Jamaica reported on progress in implementing ENHR since the Regional Workshop in November 1995.
May 1996:	Meeting of the Jamaica research team.
September 1996:	National workshop on ENHR, Jamaica, 12 September 1996.

Special Features of the ENHR story in the Caribbean (including Jamaica):

The Task Force on Research and Development based in Geneva provided the Commonwealth Caribbean Medical Research Council (CCMRC) with a grant to organise a preparatory meeting to arrange for a workshop on ENHR for the Caribbean which was held in Curaçao in April 1992 following the 37th Annual Meeting of the CCMRC.

The workshop was attended by representatives of CCMRC, Caribbean Health Ministries, Caribbean Women's groups, representatives of the University of West Indies (UWI) and its Institute of Social and Economic Research (ISER), PAHO and Chief Medical Officers in the region.

The proposal on ENHR for the Caribbean was one of the outcomes of the ENHR Workshop held in Curaçao. It is based on concepts and approaches to health issues which have been reached after a long process of national and regional consultation. Activities include strengthening the research capability in the Caribbean, developing and implementing national and regional collaborative research projects on priority health issues, and establishing within CCMRC an ENHR Secretariat.

The CCMRC Research Secretariat (ENHR Coordinator) has been in office since October 1995. He has been responsible for organising and conducting the Research skills workshops. About a dozen have been conducted so far. He also supports researchers who need assistance in project proposal development and data analysis. Thus among his role is that of interacting with and supporting researchers.

APPENDIX 1 — PLACES VISITED

1. Ministry of Health
2. University of West Indies (Jamaica)

APPENDIX 2 — INDIVIDUALS MET

1. Dr J Peter Figueroa – Principal Medical Officer (Epidemiology), Ministry of Health
2. Dr Deanna Ashley – Acting Chief Medical Officer, Ministry of Health
3. Dr Affette McCaw-Binns – Lecturer/Researcher, Department of Community Health, University of West Indies
4. Dr Nigel Gibbs – Dean, Faculty of Medical Sciences, University of West Indies
5. Dr Satmarine Maharaj – Lecturer, Department of Sociology and Preventive Medicine, University of West Indies
6. Dr Tomlin Paul – Lecturer, Department of Sociology and Preventive Medicine, University of West Indies
7. Ms Jean Tulloch-Reed – Lecturer/Health Education Specialist, University of West Indies
8. Dr Brendan Bain – Acting Head, Department of Community Health and Psychiatry, University of West Indies
9. Dr Alderie Henry-Lee – Research Fellow, Institute of Social and Economic Research, University of West Indies
10. Hon. Dr. Peter Phillips – Ministry of Health
11. Dr. Terrence Forrester – Director, Tropical Metabolism Research Unit, University of West Indies

APPENDIX 3 — DOCUMENTS REVIEWED

1. Proposal for ENHR for the Caribbean prepared by the CCMRC for the Commonwealth Caribbean. Undated.
2. J Peter Figueroa — Is serious research possible in the Caribbean? Ethnicity and Disease – Vol 1, Fall 1991
3. CCMRC Research Skills Workshop, 28–30 October 1994, Port of Spain, Trinidad & Tobago
4. CCMRC/COHRED Regional Workshop on ENHR and Priority Setting in Health Research, Ochos Rios, Jamaica, 6–8 November 1995.
5. Programme (including objectives and agenda) for the National Workshop on ENHR, Jamaica Pegasus Hotel, 12 September 1996.
6. Evaluation Briefing Document by M Pruzanski, July 1996

APPENDIX 1 (a)

BARBADOS ENHR SITE VISIT — SUMMARY REPORT
August 21, 1996
Prepared by Qhing Qhing Dlamini

FOREWORD

The COHRED/ENHR external evaluation team wishes to thank the Ministry of Health and the University of West Indies (Barbados) for their participation in the evaluation. A special word of thanks goes to Dr Ronald C Knight, Senior Medical Officer (N), Ministry of Health, for arranging and coordinating the visit.

Purpose of Site Visit:

The purpose of the visit to Barbados was to gather information on the progress made in ENHR in the country, and to assess COHRED's effectiveness in promoting the ENHR process. With the relevant information obtained, to make recommendations to the country and to COHRED on how to enhance the process.

Methods:

The visit was conducted on the 21st August 1996 by Dr Qhing Qhing Dlamini from the Commonwealth Secretariat, one of three members of the external evaluation team. The places visited, individuals met and documents reviewed are in Appendices 1, 2 and 3.

Limitations:

The country visit was short, only one day. Initially it had been intended that a member of the COHRED Board from that region would join the evaluation team member, but due to other commitments, was unable to do so. Because of a rather tight schedule which involved meeting with a number of people from the Ministry of Health and University of West Indies according to the programme arranged, the visit allowed only for a glimpse of ENHR activities in the country.

Background:

General data and Health Situation: Barbados has a population of 262,000 (1995 est). The per capita GNP (1992) is US$6,540. Life expectancy at birth (1995 ets) is 74 years for males and 79 years for females. Literacy rate is 99% for both males and females. Access to safe water and sanitation is 100%. The Maternal Mortality rate is 35 per 100,000 live births, and the Infant Mortality Rate (1988) is 9 per 1000 live birth (1995 est).

Summary of ENHR events in Barbados:

April 1992:	Workshop on ENHR for the Caribbean, held in Curaçao following the 37th Annual Meeting of the CCMRC.
November 1995:	Regional Workshop on ENHR and Priority Setting in Health Research, Ochos Rios, Jamaica
April 1996:	Workshop on ENHR, Port of Spain, Trinidad & Tobago. Barbados representative reported on progress in implementing ENHR since the November 1995 regional meeting in Jamaica. The delegate stated that anticipated progress in implementing the ENHR plan of action was not realised due to slowness in compiling the necessary procedural matters. However, he assured the meeting that there was growing support for ENHR within the Ministry of Health and that a national ENHR workshop would be held in 1996.

Special Features of the ENHR Story in the Caribbean (including Barbados):

The Task Force on Research and Development based in Geneva provided the Commonwealth Caribbean Medical Research Council (CCMRC) with a grant to organise a preparatory meeting to arrange for a workshop on ENHR for the Caribbean which was held in Curaçao in April 1992 following the 37th Annual Meeting of the CCMRC.

The workshop was attended by representatives of CCMRC, Caribbean Health Ministries, Caribbean Women's groups, representatives of the University of West Indies (UWI) and its Institute of Social and Economic Research (ISER), PAHO and Chief Medical Officers in the region.

The proposal on ENHR for the Caribbean was one of the outcomes of the ENHR Workshop held in Curaçao. It is based on concepts and approaches to health issues which have been reached after a long process of national and regional consultation. Activities include strengthening the research capability in the Caribbean, developing and implementing national and regional collaborative research projects on priority health issues, and establishing within CCMRC an ENHR Secretariat.

The CCMRC Research Scientist (ENHR Co-ordinator) has been in office since October 1995. He has been responsible for organising and conducting the Research Skills Workshops. About a dozen have been conducted so far. He also supports researchers who need assistance in project proposal development and data analysis. Thus among his role is that of interacting with and supporting researchers.

APPENDIX 1 — PLACES VISITED

1. Ministry of Health
2. University of West Indies (Barbados)
3. Chronic Disease Research Centre

APPENDIX 2 — INDIVIDUALS MET

1. Dr Ronald C Knight – Senior Medical Officer of Health (N), Ministry of Health
2. Dr E Ferdinand – Acting Chief Medical Officer, Ministry of Health
3. Mrs Clora Tudor – Chief Project Officer (Ag), i/c Planning Unit, Ministry of Health
4. Ms Reeshemah Cheltenham – Health Planning Officer II (Ag), Ministry of Health
5. Prof. E R Walrond – Dean, Faculty of Medical Sciences, UWI
6. Dr Harold White – Consultant Pathologist, Ministry of Health
7. Dr Colin Alert – Chronic Disease Research Centre

APPENDIX 3 — DOCUMENTS REVIEWED

1. Proposal for ENHR for the Caribbean prepared by the CCMRC for the Commonwealth Caribbean, Undated
2. CCMRC Research Skills Workshop, 28 – 30 October 1994, Port-of-Spain, Trinidad & Tobago
3. CCMRC/COHRED Regional Workshop on ENHR and Priority Setting in Health Research, Ocho Rios, Jamaica, 6–8 November 1995
4. J Peter Figueroa: Is Serious Research Possible in the Caribbean? Ethnicity and Disease – Vol. 1 Fall 1991
5. Evaluation Briefing Document by M Pruzanski, 5 July 1996

TRINIDAD AND TOBAGO ENHR SITE VISIT — SUMMARY REPORT
August 22 – 23, 1996
Prepared by Qhing Qhing Dlamini

FOREWORD:

The COHRED/ENHR external evaluation team wishes to thank the Ministry of Health, University of the West Indies (UWI), Trinidad Public Health Laboratory, Caribbean Epidemiology Centre (CAREC), Non-Government Organisations and Community Groups for their participation in the evaluation. A special work of thank goes to Dr Donald T Simeon, Research Scientist, CCMRC, for arranging and co-ordinating the visit of the evaluation Team.

Purpose of Site visit:

The visit to Trinidad and Tobago (T&T) was to gather information on the progress made in ENHR in the country, and to assess COHRED's effectiveness in promoting the ENHR process. With the relevant information obtained, to make recommendations to the country and to COHRED on how to enhance the ENHR process.

Methods:

The visit was conducted from 22-23 August 1996 by Dr Qhing Qhing Dlamini from the Commonwealth Secretariat, London, one of three members of the external evaluation team. The places visited, individuals met and documents reviewed are in Appendices 1,2 and 3.

Limitations:

The country visit was short. Initially it had been intended that a member of the COHRED Board from that region would joint the evaluation team member. However, that did not happen because of other commitments. Because of time constraints, given the number of people whom the evaluation team member met with, discussions were not in-depth and only key issues could be addressed.

Background:

General data and health situation: Trinidad and Tobago has a population of 1,306,000 (est 1995). Annual population growth rate is 1.1%. Life expectancy at birth is 70 for males and 75 for females (1994). Adult literacy rate (1980) is 96% for males and 93% for females. Per Capita GNP (1992) is US$3,940. The infant mortality rate (est 1995) is 16 per 1,000 live births. The Maternal Mortality Rate (1998) is 120 per 100,000 live births. Access to safe water (1988–90) is 96% and for sanitation (1988–90) 99%.

Health Reform: The Health Sector Reforms in Trinidad and Tobago started around January 1994 when a situation analysis (health sector study) was conducted with grant from the Inter-American Development Bank (IDB). One and half years later reform recommendations from the study were being implemented ranging from decentralisation (not just devolution) to alternative financing options; exploring public-private mix;

certain aspects of civil service reform which call for strong political commitment to the reform process e.g. health workers ceasing to become civil servants but recruited and employed by a Regional Health Authority on contract basis.

The level of political will to implement health reforms in Trinidad and Tobago is high. This is probably a result of the social mobilisation efforts Trinidad and Tobago has undertaken by involving everybody at all levels in all sectors, (public, private, NGOs) down to grassroots for the inception of the reform process.

Summary of ENHR events in Trinidad and Tobago:

April 1992:	Workshop on ENHR for the Caribbean, held in Curaçao following the 37th Annual Meeting of the CCMRC.
November 1995:	Regional Workshop on ENHR and Priority Setting in Health Research, Ocho Rios, Jamaica.
April 1996:	Workshop on ENHR, Port of Spain, Trinidad and Tobago. The T&T representative reported on progress in implementing ENHR since the November 1995 regional meeting in Jamaica. The report indicated that after the Jamaica workshop, the country team met with and gave a report to the Chief Medical Officer and other key officials at the Ministry of Health. There was full acceptance and support to the convening of this April 1996 workshop, where the Hon Minister of Health gave the feature address. Invitations were issued to a wide range of representatives from Government, the UWI, NGOs and other interested groups.

<u>Special Features of the ENHR Story in the Caribbean (including Trinidad and Tobago)</u>:

The Task Force on Research and Development based in Geneva provided the Commonwealth Caribbean Medical Research Council (CCMRC) with a grant to organise a preparatory meeting to arrange for a workshop on ENHR for the Caribbean which was held in Curaçao in April 1992 following the 37th Annual Meeting of the CCMRC.

The workshop was attended by representatives of CCMRC, Caribbean Health Ministries, Caribbean Women's Groups, representatives of the University of the West Indies (UWI) and its Institute of Social and Economic Research (ISER), PAHO and Chief Medical Officers in the region.

The proposal on ENHR for the Caribbean was one of the outcomes of the ENHR workshop held in Curaçao. It is based on concepts and approaches to health issues which have been reached after long process of national and regional consultation Activities include strengthening the research capability in the Caribbean, developing and implementing national and regional collaborative research projects on priority health issues and establishing within CCMRC an ENHR Secretariat.

The CCMRC Research Scientist (ENHR Co-ordinator) has been in office since October 1995. He has been responsible for organising and conducting the Research Skills workshops. About a dozen have been conducted so far. He also supports researchers who need assistance in project proposal development and data analysis. Thus among his role is that of interacting with and supporting researchers.

APPENDIX 1 — PLACES VISITED

1. Ministry of Health
2. Trinidad Public Health Laboratory
3. Caribbean Epidemiology Centre
4. University of the West Indies

APPENDIX 2 — INDIVIDUALS MET

1. Dr Donald T Simeon – Research Scientist, CCMRC
2. Dr Angela Patrick – Epidemiologist, General Manager, MOH
3. Dr Joan Rawlins – Lecturer (Health Sociology), Department of Community Health, UWI; also representing Caribbean Association of Feminists Research and Action (CAFRA)
4. Ms Carol-Ann Senah – Acting Director, Health Education
5. Dr Rahaman – Acting Head of the Trinidad Public Health Laboratory
6. Dr S Blount – Director, Caribbean Epidemiology Centre
7. Dr Rosemarie Paul – Manager, Policy Planning and Health Promotion, MOH
8. Ms Muriel Douglas – Acting Co-ordinator, National AIDS Programme, MOH
9. Dr Dan Ramdath – Lecturer, Health Sociology , UWI
10. Ms Althea La Foucade – Senior Technical Officer, Health Economics Unit, UWI
11. Dr Karl Theodore – Co-ordinator, Health Economics Unit, UWI
12. Dr Heather Cateau – Lecturer, Department of History, UWI
13. Dr Roland Marshall – Lecturer, Behavioural Sciences, Department of Sociology, UWI
14. Mr Gregory Milers – Graduate Student, Behavioural Sciences, Department of Sociology, UWI
15. Ms Cynthia J Rennie – T&T Association of Nutritionists and Dieticians (TTANDI)
16. Ms Myrna Branch – TTANDI
17. Ms Bernice Dyer-Regis – Northwest Regional Health Authority, MOH
18. Dr Elizabeth S M Quamina – National Cancer Registry, T&T Cancer Society; Population Council of T&T

APPENDIX 3 — DOCUMENTS REVIEWED

1. Proposal for ENHR for the Caribbean prepared by the CCMRC for the Commonwealth Caribbean. Undated
2. CCMRC Research Skills Workshop 28–30 October 1994, Port of Spain, Trinidad and Tobago
3. CCMRC/COHRED Regional Workshop on ENHR and Priority Setting in Health Research, Ocho Rios, Jamaica 6–8 November 1995.
4. J Peter Figueroa: Is Serious Research possible in the Caribbean? Ethnicity and Disease – Vol 1 Fall 1991.
5. Evaluation Briefing Document by M Pruzanski July 1996

KEY LESSONS FROM THE CARIBBEAN SITE VISITS

1. The CCMRC, a regional body, has played the role of a prime mover in introducing the Commonwealth Caribbean countries, including Jamaica, to the ENHR process. The proposal on ENHR for the Caribbean was prepared by CCMRC. However, ENHR should now be established as an ongoing and self-sustaining activity.

2. Through the regional ENHR plan, a regional training programme has been developed in order to strengthen national and regional research capacities.

3. The initiation of ENHR at the regional level through CCMRC seems to have first hampered progress in ENHR implementation at country level, but then to have facilitated it. The Commonwealth Caribbean countries are a good example of ENHR networking on a regional basis through regional co-operation and co-ordination.

OTHER CONSIDERATIONS FOR COHRED

1. COHRED should play a brokerage role by identifying agencies which are interested in supporting developing country ENHR efforts since lack of financial resources is a draw back to countries moving forward the ENHR process.

2. COHRED should support national capacity building and strengthening.

3. COHRED should support regional collaboration and exchange of information on ENHR.

4. COHRED should consolidate ENHR in countries which have started the ENHR process before thinking of expanding to new countries.

APPENDIX 1(b)

KENYA ENHR SITE VISIT — SUMMARY REPORT
September 25 – 27, 1996
Prepared by Tessa Tan Torres

Purpose of Site Visit:

The site visit was conducted to gather information on the progress of ENHR in the country and to make concrete recommendations to the country and to COHRED to further enhance this progress.

Methods:

The visit was conducted in September 25–27, 1996, by Drs. Tessa Tan-Torres from the Philippines and Dr. David Okello from Uganda. The individuals met and the documents reviewed are in Appendices 1 and 2.

Limitations:

1. The country visit was very short and limited. Although background material on the activities in Kenya had been provided beforehand and one person (Dr. Okello) of the evaluation team was from the region and familiar with the Kenya ENHR work, the visit itself allowed only a superficial glimpse of the work done and clarification of a few issues.

2. The schedule and the persons to be met during the country visit were arranged by the National Health Research and Development Centre (NHRDC) of Kenya. Most of the individuals met were from research and academic institutes with a few NGOs. There was only one person from the MOH and no one outside Nairobi or from the community interviewed.

Background:

General Data: Kenya has an area of 582,646 square kilometres and is bordered by Tanzania, Uganda, Sudan, Ethiopia and Somalia. Per capita GNP in 1992 was US$310. The adult literacy rate in 1993 was 75.7%. Estimated population is 26.4 million with an annual population growth rate of 3.1%. Life expectancy at birth in 1993 was 55.5 years. The Human Development Index rank for Kenya in 1996 was number 128 out of 174 countries.

Health Situation: The Infant Mortality Rate is 69 and the Under-five mortality rate is 90/1,000 live births. The Maternal Mortality Rate is 650/100,000 live births (1993-4). Malaria is one of the ten leading diseases with six million individuals reported malaria cases treated annually (1994). The number of reported AIDS cases is 24.8/100,000 pop. There are 20,000 persons per doctor and 9,091 persons per nurse in 1991. Public expenditure on health is 2.7% of the Gross Domestic Product in 1994. 77% of the population had access to health services, 53% to safe water and 77% to sanitation (1).

Health Research: Overall, there are 1.3 R&D scientists and technicians per 1,000 people (1992). Kenya is distinguished by a considerable infrastructure for health research. It was active as a member of the East African Community and with the break-up in 1977, research programmes were continued through establishment of research institutes (Kenya Medical Research Institute and Kenya Trypanosomiasis Research Institute among others) by the Science and Technology Act, 1977, amended 1979. The budget allocations for the operations of both research institutes amount to 5% of the entire health budget. The Ministry of Research, Science and Technology was created in 1987 to better facilitate research. A National Council for Science and Technology was also established as an advisory body to the Ministry (2).

ENHR Activities:

January, 1991: A few enthusiasts got together and brainstormed on the concept and then agreed on a plan of action.

April, 1991: Situational analysis of ENHR was commissioned and funded by UNICEF, Kenya office.

June, 1991: First convention on ENHR took place in Nyeri and brought together all key players in health research. A Task Force on ENHR was subsequently formed and charged with the following: create a national mechanism to coordinate health research; include ENHR in the National Development Plan; create a budget line within the government system; identify priorities for health research in Kenya.

January, 1992: Community survey was done in five poorest areas to help prioritise health research issues.

February, 1992: Research Agenda was set up with a priority short list which included maternal and child health/family planning, water and sanitation, health care delivery systems, STDs and AIDS, Training and related activities.

April, 1992: Inventory of health researches in the last 50 years was done (3).

December, 1993: The National Health Research and Development Centre was incorporated as an NGO set up by the government as the mechanism for implementing ENHR. A board of Management was convened to consist of heads of 20 stakeholder-institutes.

June, 1994: Secretariat of NHRDC was organised within NCST. Three major research divisions: Biomedical (under KEMRI), Clinical/Epidemiologic (under the CEU, University of Nairobi) and Health Systems (under AMREF/Ministry of Health) were set-up. An implementation plan developed for each of the divisions included a complete proposal for capacity strengthening. Quarterly newsletter starts to be published. Advocacy done among heads of stakeholder-institutions. ENHR is successfully included in the National Development Plan for

1994–7. A line item for K$ 100,000 for NHRDC was provided starting 1995-96.

December, 1995: First networking meeting was convened, followed by a second one with broader participation in July 1996.

August, 1996: Grant for improving NHRDC's Health Information Network was provided by Carnegie Foundation.

November, 1996: There is a planned presentation of research proposals (around 20 received at the time of writing of this report) to donors.

Special Features of ENHR in the Country:

1. There has been expression of total commitment from the Government of Kenya on ENHR. Support is manifested in inclusion of ENHR in the National Development Plan and provision of a line item in the budget, as well as resources in kind from the NCST.

2. The rich infrastructure of health research has been accommodated by establishment of an NGO as the ENHR mechanism. This is non-threatening and all the major players are included in the Board of Management. The responsibility of the three research divisions have been assigned to the three strong research institutes. An NGO as the ENHR mechanism was also decided upon to meet the perceived reluctance of some donors to deal with government bureaucracy and to capitalise on the trend of donors to increase funding to NGO work.

3. The prime mover is an advocate who is credible in the medical, academic and government circles. The Secretariat can count on a few dedicated individuals to help them implement advocacy and networking and other tasks.

Key Lessons:

1. The process of introducing ENHR is a political process. ENHR is never introduced into a vacuum. There are stakeholders with their own agendas. A successful ENHR process is one which accommodates as many of these stakeholders and gets their cooperation to change the status quo. The prime mover who is acceptable to all stakeholders is essential. It is clear, however, that not all stakeholders will be won over and although they do not oppose ENHR actively, their mere lack of active participation (only lip service) can hinder the ENHR process.

2. The process of introducing ENHR cannot be hurried and can only be done in stages. At the early stages, the process is as important as, or perhaps more important, than the outcomes. Part of the ENHR philosophy is that ownership be given to all stakeholders and that the process be made as inclusive as possible. It is particularly challenging to continuously keep the other partners (community and policy-makers) actively involved. Advocacy has to be continuously done. The infrastructure and support system have to be set-up. The research agenda has to be

crafted with broad-based participation. A research implementation plan arising from all the consultations must be made and must be implemented. However, although this elements are necessary and can only be a product of consultative and consensus-building processes, there is a real danger that the stakeholders will only see this movement as all talk and no concrete action.

3. The main stumbling block is lack of funding in developing countries. This is where the ENHR process is in danger of stalling. Innovative strategies for resource mobilisation will have to be sought. If not, momentum cannot be sustained and the stakeholders will be frustrated and ENHR will lose its credibility.

4. Regular internal evaluation of ENHR is crucial. At the early stages, operational measures (e.g. mechanism set-up, research agenda crafted, line item institutionalised in budget, etc.) are acceptable. The challenge in the immediate future in Kenya is to carry out the research in the priority list with the participation of the partners (community, researchers and implementors).

Other Considerations for COHRED:

1. Assistance to the national ENHR efforts should be prioritised over regional activities. The regional and international activities will only be in support of the national activities.

2. Brokering should be a major activity as lack of funds is recognised as a major stumbling block in the national activities.

3. COHRED should synthesise the country experiences and come out with a manual of "guidelines" on the most appropriate way of doing things (selecting an ENHR mechanism, research agenda setting, planning for capacity strengthening) so that the countries starting on ENHR will learn from the experiences of the other countries.

Country Report on ENHR in Kenya:

(Revised after presentation to NHRDC Chairman Dr. Abdullah and Secretariat on the final session of the country visit)

1. Since its inception in December 1993, the NHRDC has put up the secretariat and the board, made a brochure, published newsletters and provided extensive documentation of its major activities. These were national meetings to launch ENHR, craft a research agenda with priority list, develop an implementation plan and networking. They have also made an inventory of health research in Kenya in the past 50 years and developed proposals for capacity development. It has also been able to harness some financial support from the Kenyan government, UNICEF, Carnegie Foundation, COHRED and the Barclays Bank. Resources in kind have been provided by the National Council on Science and Technology and from the other stakeholders (CEU, etc.). Official government commitment has been evident in the incorporation of ENHR in the National Development Plan and the presence of a line item in the national budget for NHRDC.

2. The above has been achieved with limited resources. Effectively, the secretariat is Dr. Oduwo with her secretarial staff. The prime mover for ENHR is Prof. M. Abdullah, who with his credibility in the academic and government circles has been able to create NHRDC.

3. The NHRDC is organised according to types of research: biomedical under KEMRI, clinical/epidemiologic under University of Nairobi (CEU) and health systems research under the MOH/AMREF. Each division has made its own implementation plans independently which when implemented, may result in inefficiency (e.g. each division has an advocacy plan).

4. Current funding is not enough to expand their current activities, much less to fund studies to ensure that the priority list in the research agenda gets addressed.

5. After the initial flurry of activity, progress has slowed. There have been expressions of frustration from some sectors, particularly the young researchers. "There s a lot of talk, a lot of documents and no action." "Where is the output?" "You can come here and have meetings and then go home. If there's no money, nothing will happen." The coming year will be critical for NHRDC in maintaining its credibility in the Kenyan Research Community.

6. There has been rapid turnover within the Ministry of Health. It has been difficult to sustain gains in advocacy because of this.

Recommendations:

1. Research in the priority list has been identified and should be carried out. Funding is urgently needed to get the research agenda tackled. The board may be broadened to include representatives of donor agencies and private sector as partners. Brokering should be more active and should tap into opportunities (HSR, ARCH).

2. Research agenda-setting should be a formalised and documented process. Transparency is essential. An appeal or updating mechanism should also be put in place to take into account new developments in the health field. Regular in-house review of extent of accomplishment of agenda should be done.

3. The implementation plans of each division must be merged or coordinated and a new budget made based on the merged plan. There may be economies of scale achieved in the new budget. Continuous advocacy is needed in the Ministry of Health, particularly with the staff at the research desk. Coordination should also be formalised if the partners are to work together in research. Responsibilities should be clearly outlined, perhaps in the form of memorandum of agreement or understanding.

4. The roles of the policy-makers and the community should be strengthened in board representation by increasing their numbers and by encouraging active participation. In addition, conscious effort can be given to involving them while the research is being carried out.

APPENDIX 1 — DOCUMENTS REVIEWED

1. Country Updates: Kenya, in COHRED, Research into Action, Issue 6, July–September 1996, pp 5-6

2. Proceedings of the Convention on the National Health Research Plan, May 1994.

3. Abdullah MS. ENHR in Kenya. In Science in Africa, Report of a symposium organised by the AAAS Sub-Saharan Africa Program at AMSIE 95.

4. Newsletters (3) and brochure of NHRDC

5. The National Health Research Plan (1994–97), Nairobi, Kenya, November 1994.

6. Proceedings of the Second National Health Research Network Meeting, Nyeri, July 1996 (Includes reports of the First Network Meeting in Nairobi, December 1995 and the Networking of Networks Meeting in Victoria Falls, January, 1996)

7. Country Report on Kenya in the Report of the Africa and "ENHR" International Conference, April 13–16, 1992.

8. Country Report on Kenya in Second African ENHR Networking Meeting, August 27–29, 1995, Harare, Zimbabwe.

9. Evaluation Briefing Document by M. Pruzanski, Aug. 30, 1996, including response from Kenya.

10. Evaluation of ENHR, draft working document, COHRED, 1995. (A first draft was discussed by participants attending the second African ENHR Networking Meeting in Harare, in August, 1995).

11. Annual Report (1993/94 and 1994/95) and Brochure of the Kenya Medical Research Institute.

APPENDIX 2 — INDIVIDUALS INTERVIEWED

NHRDC Board:

1. Dr. M. S. Abdullah – Chair
2. Mr. David Andere – Secretary, NCST
3. Prof. Joseph Mungai – Secretary, Commission on Higher Education
4. Prof. E. Wofula – Programme Officer of the clinical/epidemiological research, NHRDC
5. Dr. Davy Koech – Director, KEMRI
6. Representatives of KETRI

• Dr. Omolo	Senior Deputy Director for Research, Health Standards and Inspectorate, Ministry of Health
• Ms. Margaret Mathai	Consultant, Health Information, NHRDC
• Prof. Pamba	Dean, Faculty of Medicine, Nairobi College of Health Sciences
• Prof. Peter Odhiambo	Past Dean, Faculty of Medicine, Nairobi College of Health Sciences
• Dr. Macharia	Director, Clinical Epidemiology Unit, Nairobi University
• Dr. Njeru	Deputy Director, Clinical Epidemiology Unit, Nairobi University
• Prof. J. Wang'ombe	IHPP and SOMA-NET
• Dr. Muthoni Kairuki	AMREF
• Dr. Paul Chuke	WHO Country Representative
• Dr. Kirumbi	(Reproductive Health), KEMRI Programme Official
• Dr. Githure	(KEMRI-JICA), KEMRI Programme Official
• Dr. Odhiambo	(ARI), KEMRI Programme Official
• Violet Kimani	Interfaculty Collaboration Programme, University of Nairobi
• Dr. Bambrah	Director of Primate Research

APPENDIX 1 (c)

MOZAMBIQUE ENHR SITE VISIT — SUMMARY REPORT
September 17–20, 1996
Prepared by Vic Neufeld

Purpose and Methods:

The aims of the site visit were:

- to learn about the ENHR situation and experience in Mozambique, particularly since there had been little news over the past two years;
- to identify "lessons" that will be useful to COHRED for its strategic planning;
- to obtain views about the contributions of COHRED to the ENHR process in Mozambique.

The visit was very well arranged by Drs. Rui Gama Vaz and Martinho Dgedge of the National Institute of Health (INS). I met with quite a number individuals (listed in Appendix 1) all in the city of Maputo. I also reviewed a number of relevant documents (see Appendix 2). Later in September, during a visit to Sweden, I obtained some further documents from SIDA-SAREC related to health sector projects in Mozambique funded by this agency; and I discussed these projects with SIDA-SAREC project officers.

Background:

Following a prolonged battle for independence which was finally won in 1975, the RENAMO guerrilla movement and the FRELIMO government engaged in a civil war for another sixteen years. A new constitution was adopted in 1990, leading to a general peace agreement signed in Rome in October, 1992. After repeated delays, an election took place in October, 1994 with 86% of eligible voters participating. The incumbent government was elected, though RENAMO won in five major provinces, and gained a strong minority in parliament. As a result of the prolonged conflict, approximately 1.5 million people, of a population of 16 million (1992 estimate), became refugees in neighbouring countries, while a further 3.8 million people were internally displaced. Most of the refugees have now been repatriated, and internally displaced individuals have returned to their homes.

With this recent history, it is not surprising that Mozambique remains an impoverished country. Estimates from 1993 reveal an infant mortality rate (per 1000) of 147, life expectancy at birth of 47 years, an adult literacy rate of 40%, a GNP per capita of less than US$100, leading to a score of 0.261 on UNDP's Human Development Index (HDI), and a ranking of 167th (of 174 countries). Public health expenditure per capita is well under $US5.00 or 1.5% of GNP, while public military expenditure is 8.3% of GNP. Mozambique is a country still struggling with a range of issues: a ravaged infrastructure, unruly excombatants, ongoing banditry, a legacy of land mines, and a lagging economy. However, there are many rehabilitation initiatives underway

supported by a great number of NGOs, and with an increasing interest by bilateral donors and recently by the World Bank (for example, the Mozambique Health Sector Recovery Programme project, Report No. 14373, July, 1995).

The ENHR Story:

Dr. Jorge Cabral, then national director of health, presented the Mozambique health situation to a Commission meeting in Harare in January, 1988, indicating the urgent need for strengthening the country's health research capacity (see Box 2.10 on p.21 of the Commission report). Mozambique was included as one (of four) ENHR case studies in the 1991 Task Force document: *ENHR: A Strategy for Action in Health and Human Development*, with a particular emphasis on a proposed 10-year plan for research capacity strengthening. Dr. Abdul Noormahomed, then National Director for Planning and International Cooperation in the Ministry of Health, attended the March, 1993 international conference which inaugurated COHRED, and made a brief presentation about the health and health research situation in Mozambique. Since then, there has been little systematic information about further developments in this country; for example, Mozambique was not represented at any of the Africa ENHR networking meetings.

An important feature was the initiation in March 1991 of a project jointly supported by IDRC and SAREC called: "Integrated Support for Research Institutions: Strengthened Capacity for Essential Health Research" (ISRI). The project involved support to three institutions: the National Institute for Health (INS), the Faculty of Medicine at University Eduardo Mondale (UEM), and the Regional Centre for Health Development (CRDS). Three components are identified: documentation, training and research. The documentation component seems to have been quite successful with the strengthening of the medical school library (including a well-used computer laboratory), and the creation of a documentation centre at the INS. The research component has supported a small grants programme, and a major national research conference in October, 1992. The grant was originally designed to extend for ten years, but funding for the second five year phase seems quite uncertain (in part due to shifts in IDRC's priorities).

Mozambique has been part of the Joint WHO/RTI/DGIS Health Systems Research (HSR) project for Southern African countries since 1987. With the return to Mozambique in 1992 of Dr. Rui Gama Vaz (with an MPH from the University of Washington, Seattle), the "focal point" for HSR was changed, by order of the Minister of Health, from the Ministry's planning department to the INS where Dr. Gama Vaz became the Director. With the departure of Dr. Jorge Cabral for South Africa, Dr. Gama Vaz also assumed responsibilities for carrying on with the ENHR process and integrated ENHR and HSR into a single set of activities. An ENHR/HSR board involves staff members from different institutions. A 5-year plan of work for HSR has been prepared, the first two years of which will likely be funded by the Dutch government. Mozambique remains an active member of the regional joint HSR project.

The INS has become the de facto "ENHR mechanism" for Mozambique. Created in 1980, its mandate is to provide technical and scientific assistance for disease control and prevention activities carried out by the National Directorate of Health. With a staff of 20 national researchers and 3 expatriates, it undertakes epidemiological, biomedical and social research on communicable diseases and traditional medicine. It serves as a reference laboratory, provides consultations, and contributes to research training at the

Faculty of Medicine and the CRDS. The INS serves an important dissemination role through its Documentation Centre, publishing newsletters and collecting documents about health in Mozambique. The Mozambique Medical Journal (Revista Medica de Mocambique — RMM) is an important vehicle for disseminating research findings. It is published quarterly by the INS, and is funded by WHO. The editorial board includes individuals from all the relevant institutions in the country. Also important are periodic National Research Conferences; the next one is planned for 1997.

Special Features and Lessons:

Among the many aspects of health research development in Mozambique, four features are singled out for special comment.

1. ENHR Progress — though by another name:

When looking for the various elements of the ENHR, they are in fact observable in Mozambique, though not under the specific term ENHR. There is promotion and advocacy for health research which is relevant to the important health needs of the country. There is relatively little internal funding for health research —approximately US$40,000 is allocated to the INS from the MOH budget; in addition, some specific MOH programs include research activities. All other health research funding comes from external sources; an example is the DANIDA supported "Mozambican Foundation for Health Research" (FUMIS) which provides small grants to young researchers, particularly outside of Maputo. There is not yet a national health research policy (or statement of priorities), but this issue will be included in the upcoming national research conference. There has been relatively little experience with community participation in determining health and health research priorities; again, this has been identified as a need and a "demonstration district" proposal has been submitted for the Bagamoyo district on the edge of Maputo city.

2. Links between researchers and policy makers:

Although Mozambican colleagues would be the first to say that much more could be done, I was impressed by the degree of interaction between Ministry of Health planners and the researchers from the INS and UEM. In part this is attributable to the small numbers of professionally trained researchers and planners. It was not uncommon to discover that the same researcher was involved as an educator in the university and an advisor to the Ministry of Health; for example, there is only one indigenous fully trained psychiatrist for the whole country. Nevertheless, there are specific mechanisms in place for this researcher-policy maker interaction. The director of the INS is a member of the weekly planning group of the MOH. There have been several completed research projects where the question has derived directly from these meetings. An example is a public opinion study, requested by the Minister of Health, to evaluate the functioning of "special clinics" in the four main hospitals of Maputo city; the study results were presented at the national Parliament and led directly to changes in policy regarding the private/public mix of health services. The National Research Conference (mentioned above) provides another forum for involving policy decision makers and discussing health policies based on research. Several of the national health programs within the MOH, as part of the annual plans of action, allocate funds to carry out commissioned studies, some of which are conducted by the ENHR/HSR unit.

With decentralisation as a feature of health system reform in the country, steps are being taken to create similar links at the provincial level with provincial health planners.

3. Realities of research capacity strengthening:

In the 1991 Task Force report: *ENHR: A Strategy for Action in Health and Human Development*, research capacity strengthening was identified as an important priority for Mozambique, and indeed some progress has been made with young researchers having gone abroad for training (some of whom have returned), and with a variety of other research training activities occurring in the country. However, when taking a closer look at whether researchers are actually engaged in research on priority health issues, a sobering picture emerges. Several well-trained individuals have left the country (some for South Africa). Most researchers are heavily involved in "other than research" activities, such as clinical and public health service (including private practice for clinicians), planning, meeting with external delegations (donors, NGOs, etc.), training activities, involvement as consultants in various projects, participation at regional conferences, and so on. Involvement in some of these activities are simply a response by individuals to the need for finances—because government salaries are low in relation to rapidly rising costs of living. In addition, several researchers have been attracted to higher salaries offered by NGOs and other organisations. Some research and evaluation opportunities required by external agencies were awarded to external consultants, when in fact they could have been satisfactorily done by nationals. In addition, health researchers leaders were also involved in the more general process of science and technology policy development, both at a national and regional level. The net result is there is relatively little actual research being done on priority health issues. This is a complex situation which requires further in-depth analysis, and more importantly, some innovative solutions.

4. Contributing to a national research policy:

In addition to trying to establish a health research system, health researchers in Mozambique are involved at a national level in establishing a general policy for science and technology. Preparing this policy is a research board consisting of the heads of all the nation's research institutions, as well as the Rector of the university; it is coordinated by the Ministry of Education. While progress has been slow, the Mozambique government will soon be presented with a Science and Technology policy for its approval.

The Role of COHRED:

As indicated earlier, there has been relatively little contact between Mozambique and COHRED since the March 1993 International Conference in Geneva. The main reason is that Mozambicans felt they were already involved in "like-minded" networks, principally the joint HSR project, and were in fact involved in ENHR. Mozambicans do agree that involvement in the early stages of the Commission's work and in the Geneva conference, helped the country with the "ENHR concept". The links also contributed fairly directly to the development of the IDRC/SAREC supported ISRI project. There now is an expressed desire to be more closely linked to COHRED (for example, the Africa ENHR network), to receive the publications, and so on.

Some Special Considerations for COHRED:

1. ENHR can happen under other names, as illustrated in Mozambique. COHRED should be careful to focus on the underlying goal, and realise that there are various ways (and various names) to achieve it. On the other hand, the Mozambique story illustrates that there might have been some important advantages to the country by having kept more "in touch" with the evolution of ENHR, particularly in Africa.

2. There are important lessons to be learned from the Mozambique story about coordination of effort. At the national level, it was my impression that donor coordination was still a major problem, with various donors not communicating with each other about their explorations, plans and current activities. Given the small number of busy health planners, it is too much to expect Mozambican nationals themselves to take major responsibility for the needed coordination of effort. This function likely needs to be taken on by one of the external donor or agency groups, or possibly by the WHO representative (though he too was heavily involved in many issues other than health research).

   At the Africa regional level, there are several health research and health development networks and projects. Frequently the same people from a given country or institution are involved in several different research initiatives, with result that much of their time is spent at meetings and travelling, and not on actual research and training at home. It is a situation that is well known to members of the COHRED board, but seems to be particularly evident in Africa. Recently, there have been some important efforts to coordinate activities — for example, the linking in Harare of some GTZ information dissemination activities with the joint HSR project, and with the African ENHR network group. But more could be done, and perhaps COHRED (through its Africa network group) could play a special role. An example might be to link national ENHR groups with the recent "Better Health in Africa" initiative and its expressions at the country level.

3. Mozambique is one of five African states where Portuguese is the national language, and is playing a lead role in training for health research (through the joint HSR project) and management (through the CRDS); Spanish-speaking Equatorial Guinea has also received help from Mozambican researchers. There may be opportunities to further strengthen the Lusophone health research network by facilitating the additional involvement of Brazil in a more specific way, through the ENHR process.

CONCLUSION

Despite very extenuating circumstances, health research in Mozambique has become stronger over the last three years. Even though the collective research capacity is small and stretched, there are some good examples of "ENHR-like" activities. A major challenge is to strengthen the functional research capacity by altering the context in which the research is done. It is encouraging to note that researchers in Mozambique wish to be reconnected with the African and global ENHR community.

APPENDIX MOZ 1 — INDIVIDUALS INTERVIEWED

National Institute of Health (INS):

Dr. Rui Gama Vaz	Director
Dr. Martinho Dgedge	Deputy-director
Dra. Rassul Nala	Dental health
Dr. Fernanda Fahrina	Social scientist
Mr. Nelson Cuamba	Entomologist
Sr. Antonio Nguenha	Librarian, Documentation Centre
Dra. Angela Fernandes	Director, National Reference Laboratory
Dr. Yoao Lucas Massingarela	Head, Traditional Medicine Group
Dra. Adelaide Bela Agustinho	Ph.D. Biochemist
Sr. Lucas L. Gulube	Historian
Sra. Felizbela Gaspar	Biology student

Ministry of Health:

Dr. Abdul R. Noormahomed	Vice Minister of Health
Dra. Custodia Mandlhate	Advisor, Mental Health
Dra. Maria da Luz Vaz	Advisor, Maternal & Child Health

Centro Regional de Desenvolvimento Sanitario (CRDS):

Dra. Maria Angelica Salomao	Director
Dr. Helder Martens	Advisor, Training Programme

Universidade Eduardo Mondlane (UEM):

Dr. Brazao Mazula	Rector of the University
Sra. Sandra Lopes	Department of International Cooperation
Dr. Joao F. L. Schwalbach	Director, Faculty of Medicine (FM)
Dra. Julie Cliff	Community Medicine

Other:

Dr. Arnaldo Nhavoto	Minister of Education
Dr. Carlos Tiny	WHO Representative
Mr. Roberto Carr-Ribeiro	Consultate, Government of Canada

APPENDIX MOZ 2 — DOCUMENTS REVIEWED

ENHR: A Strategy for Action in Health and Human Development (Task Force on Health Research for Development, Geneva, 1991)

- *Special section on Mozambique (pp. 49-51); and other references*

Second Progress Report:
"Integrated Support for Research Institutes: Strengthening Capability for Essential Health Research", March 1992 – October 1993 – submitted to IDRC and SAREC

Revista Medica de Mozambique: (Medical Journal):

- Vol. 5, No. 4, December 1994
- Vol. 5, No. 4, (Supplement 1), December, 1994
- Vol. 5, No. 4, (Supplement 2), December, 1994
- Vol. 6, No. 1 & 2, March – June, 1995

INS Newsletter, Vol. 5, No. 1, March, 1995

Unpublished Report:

"Health Sector Review: The Role of Health Systems Research in Mozambique" Humberto Cossa, Rui Gama Vaz, Ella Visser (Presented in the inter-country meeting, HSR Joint Project Arusha, Tanzania, November, 1995)

The National Health Systems Research Plan Documents:

- for 1996–2000 (dated May 1995)
- for 1997–1998 (dated July 1996)

Other Information Documents:

- from Centro Regional de Desenvolvimento Sanitario (CRDS)
- from Laboratorio Nacional de Higiene de Agua E Alimentos
- from The African Foundation for Research and Development (AFRAND)

Documents obtained from SIDA-SAREC (Stockholm):

1. Health Research in Faculties of Medicine in Addis Ababa, Dar Es Salaam, Maputo: A Review by M. Mugambi, SAREC Documentation, Research Surveys 1995:2
2. Report of a Seminar held on the above Report, held in Arusha, Tanzania May, 1995. Report edited by: M. Mugambi, J. Mtabaji, A. Swai
   Conference Reports: 1996: X, SIDA, Department for Research Cooperation

NEPAL ENHR SITE VISIT — SUMMARY REPORT

October 9 – 11, 1996
Prepared by Dr. Tessa Tan Torres

Purpose:

To assess the development of ENHR in the country and to determine the factors facilitating or hindering its development.

Methodology:

The site visit was conducted by Dr. Tessa Tan-Torres of the Philippines, on behalf of COHRED, from October 9-11 to 11, 1996. Review of relevant documents and interviews (face-to-face and telephone) with key informants were the major methods used to collect information. The schedule for meetings with the key informants was made by the National Health Research Council (NHRC) and in the actual interviews, Dr. Tan-Torres was accompanied by Dr. Indira Shrestha and Mr. Majendra Kumar of the NHRC. There were a few key informants who were not available for interview (see Appendix A for sources of information).

Brief Background on Nepal:

Health Situation:

The estimated population in 1993 was 20.8 million with an annual growth rate of 2.6%. Life expectancy at birth is 53.8 years. The infant mortality rate is 98/1,000 live births while the maternal mortality rate is 1,500/100,000 live births.

Adult literacy rate is 53.8%. There is limited access to health professionals. The population per doctor ratio (1991) is 1:16,667 and per nurse ratio is 1:33,333. The Human Development Index is 151 out of 174 countries.

Health Research:

There is no funding for health research provided by the government. However, major research projects and survey have been and are being carried out with funding from UN agencies, WHO and other developed country institutions, including National Institutes of Health, etc. The more recent surveys have been carried out by expatriate consultants in collaboration with Nepali private consulting firms like New Era.

The ENHR focal point is the NHRC, now headed by Dr. Mathura Prasad Shrestha, head of the Department of Community Medicine in the Institute of Medicine, Tribhuvan University and former Minister of Health. It was established by an Act of Parliament, in 1991, as an autonomous body with its own board and officials with fixed terms of 4 years. However, funding for the NHRC is coursed through the Ministry of Health. NHRC's functions are to:

1. Provide information and consultancy services to make study and research related to health more useful; and 2. brief the government from time to time on these issues. All proposed research projects on health involving "examination" is required to be registered at the NHRC where the proposal will undergo technical and ethical review.

In December, 1993, Dr. Mrigendra Raj Pandey, then director, wrote COHRED regarding the intentions of NHRC to introduce the ENHR process in Nepal through a series of workshops. In May, 1995, Dr. Shrestha was appointed as the new director by the Communist Party which was then in power. Dr. Shrestha reconfirmed Nepal's intentions to pursue the ENHR process. In July, 1995, Dr. Yvo Nuyens and Dr. Sadia Chowdhury made a visit to Nepal. A five-person country team then attended the Kanchanaburi workshop where they drafted a one-year plan for ENHR.

Subsequently, advocacy for ENHR was done through lectures in different venues and workshops in Kathmandu. Most of the sessions were done on a volunteer basis by Dr. Indira Shrestha, the wife of the NHRC chairman. The audience included people from the Ministry of Health, the University, a few NGOs and the Nepali Medical Association. Dr. Shrestha, himself, has participated in the discussions on the long-range health plan where research will be one of the components.

There were only two consultative sessions explicitly convened to discuss ENHR. The first one was held in January and the second in October, 1996. Mostly people from the NHRC, MOH and funding agencies participated in these sessions. There has been little participation from the NGOs or the university (although Dr. Shrestha and the member-secretary Dr. Upreti are both faculty members, they did not represent the university officially). The last meeting discussed a concept paper on ENHR (appendix B) and the possible mechanisms (working groups plus a steering committee with broad representation and chaired by the Minister of Health) for disseminating ENHR. A meeting with wider participation to decide the future mechanism and activities for ENHR will be held in November 22, 1996.

<u>Key Features/Lessons of ENHR</u>:

1. NHRC appears to be in the best position to promote ENHR, based on its legal mandate. However, because its funds come from the Ministry of Health, its autonomy (which is mandated by law) is easily threatened. NHRC had 80% of its budget slashed last year and this year, it has no operating budget. NHRC has been able to continue to carry out a few activities using funds from various sources: projects (e.g. WHO country office provides some money to upgrade the library facilities and to provide seed funding to young investigators), overhead fees and charges for services provided.

   A major political stalemate also recently occurred when the tri-partite (excluding the party which appointed Dr. Shrestha) cabinet replaced the member-secretary with a person whom Dr. Shrestha has refused to accept, saying that there was no cause to replace Dr. Upreti who was performing well.

   Considering its precarious position, it is remarkable that NHRC was still able to do some advocacy aside from carrying out some of its mandated functions. It is possible that it was in the Kanchanaburi conference, where a country plan was

produced and publicly declared, that commitment was forged to carry out at least a few ENHR activities in the plan.

2. The democratic government has only been recently installed since 6 years ago. Prior to that, there was a one-party government led by the King. Thus, Nepal is still experiencing the growing pains of a young democracy with many political groupings, enthusiastic to participate in the government but not with very well-delineated guiding frameworks and corresponding platforms of action. Mechanisms for transparency and accountability are also not yet fully developed. Under this situation, it is difficult to ensure stability of programs. It will require concerted support from outside the government (e.g. credible NGOs and the academe).

It is interesting to note that ENHR has flourished in two other countries which also underwent drastic changes in government (Philippines and South Africa) but had more advanced infrastructure and economies.

ASSESSMENT:

Nepal is a country which could greatly benefit from the ENHR philosophy. NHRC and the Ministry of Health have identified two major areas of research, health services and policy research, which are needed to improve the availability and quality of health services. At the same time, there is a significant amount of externally-funded research going on.

For ENHR to steadily progress and to wield influence over and above party politics, the NHRC should become truly autonomous and financially independent. It must be credible to gain the trust and to gather solid support from the NGOs and the academe. These are major requirements and will require a lot of work over time. To its credit, NHRC has been able to raise funds to carry out a few activities and has started hiring a few professionals, but these are not sufficient to propel ENHR forward.

RECOMMENDATIONS:

1. The leadership in NHRC must be consensual, while actively advocating ENHR, to encourage the alliance of sympathetic individuals within the government and to attract support from the NGOs and academe. In particular, a political solution is needed to address the problem of appointment of the member-secretary.

2. A major infusion of donor funds is needed to make NHRC financially independent until it can negotiate a commitment of assured funding from the government.

3. Externally funded research should be coordinated ("one national survey after another; people have to go to the fields") and donor agencies need to be asked to consider capacity building in research ("involve other groups") as one of their objectives when carrying out these major studies.

4. The chances of success of ENHR can be better assessed after the November 22, 1996 meeting.

APPENDIX A — SOURCES OF INFORMATION

Face-to-face Interviews:

1. Dr. Mathura Prasad Shrestha – Chairman, NHRC
2. Dr. Ram Upreti – Member-Secretary, NHRC
3. Dr. Indira Shrestha – Volunteer, NHRC
4. Mr. Majendra Kumar – Research Officer, NHRC
5. Ms. Manjeela Malla – (Information and Documentation Officer)
6. Mr. Shanta Lal Mulmi – Executive director, Resource Centre for Primary Health Care (NGO)
7. Mr. Gouri Pradhan – Executive Coordinator, Child Workers in Nepal (NGO)
8. Mrs. Uma Pandey – Mrigendra Medical Trust
9. Dr. B.D. Chattaut – Chief, Planning Division, MOH
10. Dr. Harry Feirman – WHO/HSR
11. Mr. Ghana Nath Ojha – Secretary, MOH
12. Dr. Durga Manandhar – Acting Secretary, MOH

Telephone Interview:

1. Dr. Bill Pigott – WHO Country Representative
2. Dr. Bruce Campbell – UNFPA

Not Available for Interview:

1. Dr. Mrigendra Raj Pandey (out of the country)
2. Dr. Kalyan Pandey, Director-General of Health Services (originally scheduled but meeting did not push through)
3. Minister of Health, (out of the country)
4. Dean, Institute of Medicine (busy)

APPENDIX B — DOCUMENTS REVIEWED

1. Evaluation Team, briefing document on Nepal
2. NHRC. NHRC and Health Research Priorities in Nepal, 1995
3. Shrestha M. Status of Health Services Research in Nepal – Paper delivered in Kanchanaburi, Thailand, December 1995
4. Work Plan Towards ENHR developed by Nepal Team at the Kanchanaburi Conference, Thailand, December 1995
5. NHRC Newsletters (2)
6. Excerpts from Bojer B. Report from a Regional Workshop on Research Management for ENHR, Kanchanaburi, Thailand.
7. Excerpt from the Proceedings of the 1st Asian ENHR Network Meetings, May 1994 at Ologapo City, The Philippines
8. Mrigendra Medical Trust, An Introduction, Nepal 1992
9. Brochures and Materials from RECPHEC and Child Workers in Nepal
10. Relevant Data on Nepal from Human Development Report 1996, UNDP

APPENDIX 1 (e)

NICARAGUA ENHR SITE VISIT — SUMMARY REPORT
August 14 – 16, 1996
Prepared by Qhing Qhing Dlamini

FOREWORD

The COHRED/ENHR external evaluation team wishes to thank the Ministry of Health at national and local level, the National University of Nicaragua, both in Leon and Managua and the National Community Movements for participating in the evaluation. A special word of thanks goes to Dr Fabio Salamanca, Director General of Research and Training in the Ministry of Health, for arranging and co-ordinating the visit of the evaluation team.

Purpose of Site Visit:

The purpose of the visit to Nicaragua was to collect information on the progress made in ENHR in the country, and to assess COHRED's effectiveness in promoting the ENHR process. With the relevant information obtained, to make recommendations to the country and to COHRED on how to enhance the process.

Methods:

The visit was conducted from 14–16 August, 1996 by Dr Qhing Qhing Dlamini from the Commonwealth Secretariat, London, one of the three members of the external evaluation team. The places visited, individual met and documents reviewed are in Appendices 1,2 and 3.

Limitations:

The country visit was short. Initially it had been intended that a member of the COHRED Board from that region joins the evaluation team members, but that did not happen because of other engagements of the Board Member/s. The language spoken in Nicaragua is Spanish, such that an interpreter had to be used. Some of the documents were in Spanish.

The visit was arranged by Dr F Salamanca from the Ministry of Health, also a COHRED Board Member. Interviews were conducted individually for persons met from the Ministry of Health and the Universities of Leon and Managua, and in groups for the UNI Project, Nicaraguan Community Movement and the Ministry of Health at local level (System of Leon). It was not possible to meet with actual Community Members because of time limitations.

Background:

General data and health situation: Nicaragua has a population of 5.2 million (1993). The adult literacy rate (1990) is 81%, and the GNP per capita US$420 (1990). Life expectancy at birth in 1990 was 64.8 years. Maternal Mortality is 200/100,000

live births (1988) and infant mortality is 58/1,000 live births (1991). Access to safe water supply is 53%.

Health Research:

Before 1990, Nicaragua lacked a national strategy to co-ordinate, fund and implement health research which addresses the health problems of the people and of the health system. The country also lacked a framework to disseminate and utilise research results for health development.

The National Health Plan in 1987 had recognised the weak scientific and technical capacity of the health sector, particularly of human resources.

Summary of ENHR events

December 1990:	Preparatory meeting on ENHR to introduce the ENHR strategy and to discuss development.
May 1991:	Policy workshop on the development of the ENHR strategy.
February 1992:	First Meeting of the National Commission on ENHR.
February – December 1992:	Development of the ENHR strategy. • Establishment of an Executive Secretariat for ENHR • Production and Dissemination of an ENHR Bulletin • Organisation of local ENHR workshops
December 1992:	First National ENHR Workshop
February – May 1993:	Drawing up a "Strategic Plan for ENHR in Nicaragua, 1993-97 by a team.
May 1993:	Nicaragua proposed for membership on to the COHRED Board
June 1993:	Special session of the National Commission for adoption of the Strategic Plan on ENHR and to agree on holding National ENHR Workshops II in August.
June 1993:	Executive Secretary of the National Commission on ENHR attended Second Session of COHRED Board.
July 1993:	Executive Secretary discussed first version of the Strategic Plan with COHRED Co-ordinator who made recommendations for improvement of the Plan, stating that financing for implementation would probably be forthcoming.
July 1993:	National ENHR Workshop II.
August 1993:	Priority tasks decided upon for later 1993 and early 1994.

September 1993:	Support was sought from COHRED to continue the ENHR process. COHRED Co-ordinator proposed a national workshop involving agency representatives to introduce the plan and seek technical and financial support.
November 1993:	Commencement of national inventory of researchers and institutions with GTZ support.
December 1993:	National Commission adopted the Five-Year ENHR Development Plan, Nicaragua, 1994–98.
April 1994:	Workshop on Health Development and ENHR in Nicaragua involving Donors. No significant commitment generated from donors. Outcome of workshop was acceptance of the Nicaragua Declaration on ENHR with focus on implementing the National Plan.

Special Features of ENHR in the Country:

A study was carried out from August to November 1992 in 7 of 17 SILAIS (Sistemas Locale de Atencion Integral en Salud) which are local health systems in Nicaragua. The results of the study were used to formulate a national essential health research agenda. In each SILAIS every effort was made to involve policy makers, researchers and representatives of local communities.

In April 1994 the National Commission on ENHR organised a workshop on Health Development and ENHR in Nicaragua, whose objective was to review ENHR experiences and discuss implementation of the national plan. Outcomes of the workshop was acceptance of the Nicaraguan Declaration on ENHR with focus on implementing the National Plan.

There is strong commitment to ENHR among the three ENHR constituencies in Nicaragua (MOH, Universities and Nicaraguan Community Movement). There is a culture of research particularly at the University of Leon where right from the first year, students are introduced to research methodology.

The National Commission on ENHR which was formed in 1992 has been inactive since 1994 when the last meeting was held. This is of deep concern to all three constituencies, since the inactivity of the Commission has resulted in slowing down, in fact cessation of efforts to implement the national plan on ENHR.

ENHR activities in Nicaragua have been stimulated and propagated by the presence of a prime mover (Dr F Salamanca) who has credibility among all three constituencies. The danger here is that in the absence of the single prime mover, activities tend to stall, as evidenced in Nicaragua.

Key Lessons:

1. In order for the ENHR process to succeed, all stakeholders should be involved from the very beginning, to arrive at a consensus from that early stage since each stakeholder will initially have its own agenda. A prime mover who has confidence of all stakeholders is essential.

2. The process of introducing ENHR in countries cannot be rushed and experience shows that it is even more important than the outcome since the process takes a long time with lots of experiences gained then. Thus it is important to develop process indicators.

3. An infrastructure and system for local co-ordination of local ENHR efforts should be set up. The co-ordinating mechanism should be agreed upon by all stakeholders and should preferably be outside government structure.

4. The development of a National ENHR Plan through the appropriate consultative stages of involvement of all stakeholders is only the beginning of the ENHR process. The real challenge is in the implementation of the plan, which is where the problem really starts. Unavailability of funds at this stage is the main problem. This might slow down the process as stakeholders with expectations for funding gradually get frustrated and demotivated. Eventually the ENHR process might "die out" if financial resources are not identified.

5. Reliance predominantly on external funding for moving the ENHR process in countries is risky since it may lead to a complete halt of the ENHR process if such resources are not forthcoming. Efforts should made to mobilise resources internally, however little they are.

Other Considerations for COHRED:

1. More attention should be given to support national ENHR efforts as opposed to regional and global support. COHRED should consolidate ENHR efforts in countries which have started the ENHR process, before thinking of expanding to new counties.

2. COHRED should play a brokerage role by identifying agencies which are interested in supporting country ENHR efforts since lack of financial resources seems to be a drawback in countries, particularly when it comes to implementation of National ENHR Plan.

3. COHRED should support national capacity building and strengthening in countries, possibly again through its brokerage role.

4. In addition to global monitoring of ENHR efforts, COHRED should be involved in monitoring of ENHR in countries, gather country experiences and disseminate these widely to facilitate exchange of experiences among countries.

APPENDIX 1 — PLACES VISITED

1. Ministry of Health (Central), Managua
2. Ministry of Health, Local System of Leon

3. Autonomous National University of Nicaragua, Leon
4. Autonomous National University of Nicaragua, Managua
5. Nicaraguan Community Movement, Managua

APPENDIX 2 — INDIVIDUALS MET

1. Dr Fabio Salamanca – Director General of Research and Training, Ministry of Health (MOH)
2. Dr Julius Espinoza – Director of Health Research, MOH
3. Dr Argentina Parajon Alejos - Deputy Director of Health, Local System of Leon, MOH
4. Pedro Cruz Molina – External Co-operation, Local System of Leon, MOH
5. Dr Scarlett Moreada – Trainer, Local System of Leon, MOH
6. Lic Teresa Rivera – Vice Dean, School of Medicine, University of Leon
7. Dr Ernesto Medina Sandino – Rector (President), University of Leon
8. Dr Rene Mèlendez – Director, UNI Project, Former Vice-President, University of Leon
9. Dr Francisco Bustamente Ramirez – Executive Co-ordinator, UNI Project, University of Leon
10. Dr Julio Pinra – Director, School of Public Health, University of Managua
11. Dr Alfonso Matus – Vice Director, Children's Hospital of Nicaragua
12. Dr Gustavo Sequeira – Dean, School of Medicine, University of Managua
13. Lic Yadira Medrano – Professor of Health Research, School of Medicine, University of Managua
14. Ms Maxima Bermudes – National Vice-Coordinator, National Community Movement (NCM) Nicaragua
15. Ms Nora Mejia – In charge of health projects, NCM, Nicaragua

APPENDIX 3 — DOCUMENTS REVIEWED

1. Workshop on Health Development and ENHR in Nicaragua, 20-22 April 1994, Executive Summary
2. Declaration of Nicaragua on Essential National Health Research, 22 April 1994
3. National Commission on ENHR, Nicaragua. Final Report, August 1994
4. ENHR in Nicaragua. Summary of Progress, Plans and Budget 1993–97. Draft. March 1994
5. ENHR Development Plan, Nicaragua 1994–98, Managua, Nicaragua, December 1993
6. Evaluation Briefing Document by M Pruzanski, July 1996
7. Commission on ENHR, Nicaragua Five-Year Essential Health Research Development Plan, Nicaragua 1994–98. Summary, Managua, Nicaragua, January 1994
8. Priorities of ENHR and the Potential of Human Resources, November 1992, Executive Report
9. Strategic Plan for Development of ENHR, Nicaragua 1993-1997 Managua, Nicaragua, June 1993
10. Comision Nacional Investigaciones Esenciales En Salud (INES-Nicaragua).
    - vol 2 num 2 Noviembre 1992
    - Junio 1993

- Septiembre 1993

11. Boletin Nacional Investigaciones Esenciales En Salud, INES-Nicaragua
    - Año 3 No 1 Febrero 1994
    - Año No 2 Mayo 1994
12. Task Force on Health Research for Development. Report on Future Mechanisms, 26 June 1992

APPENDIX 1(f)

SOUTH AFRICA ENHR SITE VISIT — SUMMARY REPORT
September 11–16 and 22–23, 1996
Prepared by Vic Neufeld

Purpose and Methods:

The aims of the site visit were:

- to learn about the ENHR experience in the Republic of South Africa (RSA), and identify "lessons" that will be useful to COHRED in its future planning; and

- to obtain views about the contributions of COHRED to the ENHR process in the RSA.

The first part of this visit was arranged by Dr. Mohamed Jeenah and Ms. Yasmin Dada of the Chief Directorate: Health Information, Evaluation and Research (HIE&R), National Department of Health (DOH), Pretoria. I met with a large number of individuals and groups in Durban, Pretoria, Bloemfontein and Cape Town. As it happened, I also was able to attend part of a symposium on health professions education in Durban (September 22,23) and used the opportunity to meet with several more individuals. Sometime later, I also spoke to two of the "prime movers" of the ENHR in the RSA: Dr. Derek Yach (now with WHO in Geneva) and Dr. Steve Tollman (by telephone—now on sabbatical in London). The individuals interviewed are shown in Appendix RSA-1, while Appendix RSA-2 lists the relevant documents which were reviewed.

Background:

It is now more than two years since the "South Africa miracle" began, with the inauguration of President Nelson Mandela as the first democratically elected leader of a united nation. The dynamism of this re-energised country is very palpable, coupled with a strong determination to make the miracle work. Still there are enormous challenges which are becoming apparent in this "post-honeymoon" period. Health and other social indicators continue to show huge disparities explained mainly on racial grounds. In 1990, infant mortality rates (IMR) among Africans (blacks) was 48.3 and among whites was 7.4, with coloured at 28.6 and Indian 15.9 for an overall IMR of 40.2. In the "new South Africa", traditional analyses where race and class variables dominated the measurement of inequality and access to health care, are now augmented by the inclusion of other determinants of health such as gender, the environment and living space.

The ENHR Story:

The development of ENHR in the Republic of South Africa (RSA) is well documented in several sources (see in particular South Africa Health Review 1995, pp. 131-138). It is interesting to note that in the 1940s and early 1950s, there was a significant tradition of community-based research targeted on issues of equity in health. With the

advent of apartheid policies in the next two decades, the character of health research reverted to predominantly laboratory-based research . The term ENHR appeared as early as 1991 in the study conducted by the Medical Research Council (MRC) for the Henry J. Kaiser Family Foundation, Changing Health in South Africa: Towards New Perspectives in Research. Somewhat later, a five-person South African team participated in the March, 1993 meetings in Geneva which resulted in the birth of COHRED. In the landmark 1994 publication of the Africa National Congress (ANC) The Reconstruction and Development Programme (RDP), one of paragraphs (2.12.9.8) begins with the sentence: *" A programme of Essential National Health Research must be initiated. . . . ."*

In December 1994, the Minister of Health, Dr. Nkosazana Zuma, hosted a national workshop on ENHR. This was followed by the appointment of a national technical committee on ENHR which submitted its report in November, 1995. The report was the subject of an intensive national workshop in February 1996, to some extent reflecting the constructive tension that existed between the reformers of the MRC, and research groups that were more community-based in their orientation. Though the consequence seems to have been a modest convergence of each position, the overall result has been the founding of a truly "national" ENHR movement.

The recommendations which emerged from the combination of the committee report and the national workshop were turned over to a newly created office within the national Department of Health, the Chief Directorate of Health Information, Evaluation and Research (HIE&R). This office now has the task of coordinating and managing national health research. At the time of the COHRED evaluation project site visit, intensive efforts were underway by the HIE&R staff to involve a wide range of "stakeholders" in the planning and implementation of next steps; these will include:

- conducting a major Congress on November 14–15, 1996, the aim of which is to prioritise health research needs based on disease burden; this Congress will be the first in a series of annual ENHR congresses;
- strengthening the links with funders of health research (other than the Department of Health), such as the funding committees of the Departments of Education (DNE) and the Department of Arts, Culture, Science and Technology (DACST);
- electing a Health Research Advisory Committee/ENHR Committee;
- creating an information data base and dissemination mechanism for ENHR; this may include the commissioning of research articles and reviews;
- preparing ethics guidelines, and the setting up of national ethics committees;
- preparing a health research policy (which will incorporate ENHR).

Special Features of the South African ENHR Experience:

1. A match of values:

There has been a remarkable coming together of the basic principles which characterise both ENHR (captured in the title of the Commission Report: "Health Research: Essential Tool for Equity in Development"), and the Reconstruction and Development Programme (RDP) of the current government. The timing of the introduction of the ENHR concept was most propitious coming as it did when there was a ready climate for its adoption and implementation. That there has been strong

"political will" is obvious; evidence of this is the appointment of a high level Technical Committee on ENHR specifically (not on health research more generally) within less than a year of the new government assuming its mandate. The "windows of opportunity" within this context are still open. Thus, it will be important for the international community to support this endeavour, and to observe and learn from the South African ENHR story in the years to come.

2. Strong players:

In addition to the Department of Health, there are other strong players in the health research community in RSA. These include in particular the Medical Research Council (MRC) and the Health Systems Trust (HST). Others are the Department of Education which channels funds for health research directly to universities and technikons, and the private sector--for example, Glaxo (a pharmaceutical company) is contributing substantially to a major research project aimed at the prevention and control of tuberculosis.

The Medical Research Council (MRC) was created as a statutory body in 1969, and continues to represent the major conduit of government-funded health research. The MRC adopted the principles of ENHR in 1993, and somewhat later introduced the term "Integrated National Health Research" (INHR) to illustrate the need for all kinds of research to be linked and targeted on important health problems. In 1988, the MRC created a Centre for Epidemiological Research of Southern Africa (CERSA)—this unit developed a strong research internal research group and is also collaborating with other university-based groups in the country. The MRC continues to struggle with the best balance between basic, clinical and "applied" research—particularly in relation to an increasing consensus that all (or most) research must relate in some way to the country's health priorities. Also, the MRC has a long history and is a large organisation, therefore rapid adaptation to change is not easy.

The Health Systems Trust (HST) was established in 1992 to shape health systems reform by supporting health systems research. It is an independent non-government organisation (NGO) which disburses funds received from the government, as well as from external agencies such as the Henry J Kaiser Family Foundation and the European Union. The HST has a reputation for responsiveness and flexibility, with a particular interest in linking researchers and health planners. It has also recognised the need to strengthen research capacity, particularly of young black researchers.

The lead role taken by the Department of Health raises the question whether the public sector leadership can capitalise on the special opportunity which this situation creates. For the whole "alliance" to succeed might require special strategic support, both from within and from outside the country.

3. The role of basic scientists:

There is a strong basic (primarily biological) science research tradition in the country. However, with the steady and significant shift to research targeted on the country's health needs, there is considerable uncertainty among basic scientists

about their future in the new scenario. It is proving very difficult to achieve a balance between maintaining support to current research institutes, and increasing support to new researchers and research groups. Renewed efforts are underway to create coalitions of researchers from different disciplines and methodologies along the continuum of research, working together on common research themes or problems. Again, the rapid change in the RSA research scene offers special opportunities for multi-disciplinary and transdisciplinary approaches to problem-oriented research (along with training and action).

4. Available analysis of resource flows:

Although not entirely complete, there is considerable information available about how much funding is available for health research, and how that funding is used. The HST document South African Health Review 1995, estimated that just over 300 million rand (about US$ 75 million) was spent on health research in the 1992/93 financial year; this represents just over 1.0% of total health care expenditures — substantially short of the 2% recommended by the Commission. Professor Jairam Reddy, who chairs the Health Systems Trust (HST) and also chairs the highly influential National Commission on Higher Education (NCHE), is a strong advocate of increased government investment in health research.

It was difficult to judge the degree to which research expenditures are targeted on priority health problems. It seems clear that most of the funding goes to basic and clinical research (as judged for example by the distribution of publications by South African researchers), and that research capacity needs to be strengthened in disciplines such as health systems research, community-based epidemiology and inter-sectoral studies. In addition, there are large disparities in the distribution of research funds to institutions of higher learning, with "historically black universities" receiving a small percentage of all research funding to universities. This presents special challenges regarding the allocation and nature of health research capacity strengthening in RSA. When the upcoming Congress (to determine health research priorities) is completed, the re-allocation of funding will be an important issue for the South African health research community to consider.

5. Adapting ENHR to the decentralisation strategy:

Like several other countries, the RSA is moving rapidly to a decentralised health system. Beginning next year, provincial health authorities will become the major decision-makers about the allocation of health system funds. It follows that time and attention will have to be paid to "essential regional (and even district) health research". This is now being recognised, but the actual process has hardly begun of orienting provincial health planners to the ENHR concept, establishing local health research priorities, building provincial and district coalitions, and so on. It is likely that individual local institutions (universities, technikons, and other research units) will become more important players at the regional and district levels. This will provide opportunities for innovation and "demonstration projects" particularly at a district level, that might not otherwise have occurred.

The Role of COHRED:

From several interviews, it was clear that the participation by a five person South African team in the March, 1993 Geneva meeting was an important milestone in the evolution of the ENHR process in the RSA. Also, RSA delegates have attended the African ENHR meetings in Harare and Kampala. However, there was some sense that the "state of play" in South Africa was substantially different from that of other African countries; there may be more similarities between the RSA and the ENHR process of some Asian countries. At the same time, other researchers felt that it was very important for RSA to be both "in" and "out of" Africa. The role of the COHRED coordinator on his several visits, playing a supportive but restrained facilitating role, has been much appreciated.

Some Special Considerations for COHRED:

1. The MRC (based in Cape Town) has recently created an ENHR Web page for South Africa, which includes a display of current and completed research projects, research news, information about funding for researchers, and other relevant information. This Web page is, of course, accessible internationally. It may be timely and useful for COHRED to consider using "Web information technology" as a key vehicle for sharing information about ENHR across countries. For example, COHRED's own Web page could serve as a bridge to ENHR Web pages in specific countries.

   COHRED could serve as a bridge to bring together countries that have distinctive challenges not necessarily shared within a given region. For example, South Africa is just coming to terms with the application of ENHR to provincial and district levels; there is some experience about this in the Philippines. It may be quite useful for COHRED to arrange a purpose-specific exchange between these two countries. There may be other examples of exchanges between countries which share specific problems and experiences.

CONCLUSION

A key lesson from the South African ENHR story is that the ENHR process can serve as an empowering tool to promote the fundamental thrust of the Commission report—that health research should serve as an "essential link for equity in development." Another lesson is that ENHR is a powerful strategy in major transitional situations—such as macro-political transition, health sector reform, decentralisation and so on. The story also illustrates that the process of integrating ENHR principles into an evolving health system is prolonged and difficult. One individual remarked: "most of the story is yet to be written"; another said: "come back and talk to me again in five years". There is also some scepticism to see whether there will be action "beyond lip service" to see, for example, whether available research funds will actually be redistributed to national health research priorities. The ENHR mechanism is still evolving, and it remains to be seen whether a sustainable arrangement can be put in place which will keep the momentum going, particular in a context where there are enormous pressures on capable and hard-working colleagues to "make the miracle work". In this high-energy climate, it may be difficult to create an appropriate balance between action and stock-

taking. Overall, the ENHR story in South Africa is most encouraging and deserving of the attention and support of the international health community.

APPENDIX RSA-1 — INDIVIDUALS INTERVIEWED

Department of Health:

National:

Dr. Nkosazana Zuma	Minister of Health
Dr. Mohamed Jeenah	Chief Directorate: Health Information, Evaluation and Research (HIE&R)
Ms. Yasmin Dada	Deputy Director: Research Coordination and Management
Dr. Rachel Gumbi	Chief Directorate: Health Resource Planning
• and team members:	
• Patrick Masobe	Health Financing & Policy
• Khanyisa Nevhutalu	Deputy Director: Human Resource Policy & Planning
• Brenda Ntombela-Motapanyane	Deputy-Director: Health Professional Liaison
• Steven Hendriks	Director, Human Resource Development
Dr. Lindiwe Makubalo	Director: Health Systems Research
Ms. Pakiso Nethshadzivhani	Assistant Director: Research Coordination and Management
Dr. J.H.O. Pretorius	Deputy Director-General
Ms. Glaudina Loots	Health Information Service
Dr. S.H. Khotu	Director: National Health Information Systems

Provincial:

Dr. Laetitia Rispel	Guateng Health Department
Dr. Antonio Fernandes	Guateng Health Department
Mr. Gerrie van der Merwe	Head: Health Informatics Department of Health, Kwazulu-Natal

Agencies / Organisations:

Medical Research Council (MRC):

Dr. Walter Prozesky	President
Dr. Anthony Mbewu	Research Thrust Coordinator
Dr. J. A. (Koos) Louw	Research Systems Support
Dr. Romilla Maharaj	Research Capacity Development
Dr. Salim S. Abdool Karim	Director, Centre for Epidemiological Research for South Africa (CERSA)
Mr. O. Groenewald	Finance & Operations
Dr. B.R. Kuhbert	Human Resources
Ms. Mieke Faber	National Research Programme Nutrition Initiative

Health Systems Trust (HST)

Dr. David Harrison	Executive Director

Universities:

University of Pretoria	
Dr. Somaire Grey	Vice-dean, Research, Faculty of Medicine
University of Stellenbosch	
Prof. J. Lochner	Dean, Faculty of Medicine
Prof. D. Labadarios	Head: Dept. of Human Nutrition
University of Cape Town	
Dr. R. Millar	Vice-dean, Research, Faculty of Medicine (Director, MRC Regulatory Peptides Research Unit)
Dr. Gregory Hussey	Child Health Unit
University of the Western Cape	
Prof. Tyrone B. Pretorius	Dean, Fac. of Community & Health Sciences
Prof. David Sanders	Faculty of Community & Health Sciences
University of Free State	
Prof. H.C.J. van Rensburg	Director, Centre for HSR & Dev't (CHSRD)
Dr. Nic van Zyl	Research, Health Management, CHSRD
University of Durban-Westville	
Dr. Mahomed A. Seedat	Dean, Faculty of Health Sciences
Jennifer Smit	Department of Pharmacy
Anil Bhagwanjee	Department of Psychology Director: Interdisciplinary Health Group (IDHIG)
University of Natal	
Prof. J.R. van Dellen	Dean, Faculty of Medicine
Dr. C.C. Jinabhai	Head, Department of Community Health
Witwatersrand University	
Dr. Max Price	Dean, Faculty of Medicine
Dr. Steve Tollman	Department of Community Health (now on sabbatical in London, U.K.)
University of Transkei	
Prof. E.L. Mazwai	Dean, Faculty of Medicine and Health Sciences

Other:

Dr. Derek Yach, WHO, Geneva (formerly an MRC staff member who was actively involved in the early development of ENHR in the RSA)

APPENDIX RSA-2 — DOCUMENTS REVIEWED

1. The Reconstruction and Development Programme (RDP)
   ANC 1994, Johannesburg, Umanyano Publications

2. White Paper on Science and Technology: "Preparing for the 21st Century"
   Department of Arts, Culture, Science and Technology (DACST), 1996

3. ENHR – RSA documents:

   - Report of the National Technical Committee, November, 1995
   - Report of the February/96 ENHR workshop (consolidated)
   - Planning documents of the Directorate of the Department of Health: Directorate of Health Information, Evaluation & Research

4. Medical Research Council (MRC) Documents:

   - Changing Health in South Africa: Towards New Perspectives in Research, Henry J. Kaiser Family Foundation; MRC
   - MRC Update, 1996
   - Annual Report, 1995–1996
   - Corporate Strategic Plan: 1995–1997
   - MRC Newsletters

5. Health Systems Trust:

   - South African Health Review 1995. HST & Kaiser Foundation
   - HST Annual Report, 1995
   - Directory of Health Systems Research in South Africa 1995
   - HST Update (Newsletter)
   - Health Expenditure and Finance in South Africa, 1996

6. From Universities:

   Various project reports, newsletters and other materials from:

   - University of Durban-Westville (UDW)
   - University of the Free State (UOFS)
   - University of the Western Cape (UWC)
   - University of Transkei (UNITRA)

7. Other Department of Health documents:

   - Towards a National Health System (Draft, November 1995)
   - Human Resources Audit Report (July, 1996)
   - National Human Resource Development Policy for RSA (August 1996)

PHILIPPINES ENHR SITE VISIT — SUMMARY REPORT

July 29 – August 2, 1996
by Vic Neufeld

Purpose and Methods:

1. To make some observations about ENHR in the Philippines, comparing the information available in a variety of documents with information obtained directly from on-site discussions.

2. To identify special features ("success factors") in the Philippine experience which can assist with the overall assessment of the ENHR process, and of the role of COHRED.

I attended a meeting of the Asia ENHR network task force in Manila, July 29 – August 2, 1996. Given the location of this meeting, I took the additional opportunity to learn what I could about the "ENHR story" in the Philippines. This country was selected by the evaluation team as a place where things seemed to be going well, and where there was good documentation (to allow a comparison between what was documented, and what was observable directly). More importantly, it has been the intention of the evaluation team to identify those features (in the countries selected for site visits) which demonstrate "real" progress, which may be applicable to other countries, and which may assist COHRED in its future programming.

There is considerable documentation available, some of which I read (see Appendix Phil-2). Also, I was able to spend an extra day (July 30) meeting some key individuals; in addition, I spoke with several Filipino colleagues during the course of the task force meeting (see list of persons interviewed — Appendix Phil-1).

This report will be quite brief and will be limited to a few key observations, since there already considerable documentation available. Furthermore, the Philippines group is preparing a more detailed account of the ENHR story, which will include a self-appraisal of achievements to date. (This is one of the group of monographs commissioned by the COHRED board scheduled for completion by late 1996).

Background:

The ENHR process in the Philippines began in 1990 as a direct initiative of the Secretary of Health, Dr. A. Bengzon, who had attended the Nobel conference where the Commission presented its report. By April 1991, an ENHR unit had been established within the Ministry of Health. There followed a series of consultations, workshops and conferences, leading to the preparation (by November, 1993) of a detailed five-year plan (1993–1997). The plan included a requested budget of $US 10.5 million over 5 years, of which $5 million would be required from external sources. In the fiscal year 1996, the ENHR programme budget received 23 million pesos (about $US 950,000) from the DOH. The plan includes a fairly detailed listing of research priorities

clustered under four headings: health care; product research and utilisation; health sector organisation and management; and economics of health care.

Also in 1993, the ENHR Foundation was established as a "private sector" NGO to handle some of the funding for the national ENHR programme, and to serve as a resource group to the ENHR unit within the Department of Health (DOH), as well as to other organisations. In fact, the Foundation serves as a "quality control" influence to ensure that the underlying principles of ENHR are maintained. There are currently 22 "members" of the Foundation. A small number of officers are elected to serve in an executive capacity.

Special Features:

1. **Government commitment**: Beginning with the strong leadership of Secretary Bengzon in 1990, who created an ENHR unit within the Department of Health (DOH), there has been an on-going commitment to an ENHR programme. This has included both personnel and research project funding. However, the pattern of financial support has varied considerably, with sharp rises (to almost US$ 1 million in 1993, and again in 1996) but with deep decreases in the interim years. From 1995, ENHR became a line item in the DOH budget; also in the same year, an order was issued to the regional health offices to allocate some funds for research from their own budgets.

2. **Leadership & teamwork:** It is clear that Secretary Bengzon was a visionary and persuasive leader, initiating ENHR in the Philippines. Since then, the leadership of the DOH has varied depending on the interest of particular individuals at any given time; over the course of the past five years, there have been six Secretaries of Health—this explains the degree of variation in support which the ENHR unit/programme has received. However, the complementary ENHR foundation has been a source of continuity and vigilance (over the ENHR concept). It brings together a team of professionals who are well respected in the country.

3. **Building on a strong research tradition**: The ENHR programme is successful in part because it builds on a strong research tradition in the country. Examples of research organisations include:

   - the Philippine Council on Health and Development (PCHRD)—a council of the Department of Science and Technology; it deals primarily with biomedical and "product" research;

   - the Health Research Network (HRN) — created by the Philippine Population Council to facilitate community-based social science research;

   - the Department of Economics (University of the Philippines — Diliman campus), which has a group of health economists and policy analysts who have been working for several years on a variety of issues related to health system reform. This group is associated with the International Health Policy Program (IHPP).

Given this strong tradition, there was some sense initially that ENHR is a "top down newcomer" to the health research system, with some resentment (or at least scepticism) about the ENHR programme's fairly high profile, and perhaps its exaggerated expectations of achievement.

4. **Communication and advocacy:** Several different communication strategies are used by the ENHR unit, including a monthly research forum; several different publications; and an annual celebration ("Tuklas Lunas Week"). Electronic communication is now being introduced.

5. **Research capacity strengthening:** the annual programme includes a series of training workshops, particularly for "R & D regional coordinators". Materials related to a training modules have been developed. Some funding is available for thesis support grants for projects which are related to the national and regional research agenda.

Other observations:

1. **The ENHR mechanism—a public-private link:**

   The Philippines experience with ENHR provides an instructive example of combining a government-supported ENHR structure with a non-government organisation—the ENHR Foundation. The functions of these two elements appear to be quite complementary, bringing together the official commitment of government (profile, funding, personnel, official recognition) with the flexibility and stability of a group of respected professionals who care deeply about the values embodied in the ENHR process, and are dedicated to ensure that ENHR will achieve its intended goals.

2. **Integration and prioritisation of health research:**

   While steady progress is being made within the government about the integration of research with health programming, more remains to be done. In addition, it was my impression that there were quite large health research projects funded by bilateral agencies (e.g.: USAID) and the World Bank, where the research focus did not necessarily fall within the research priorities identified in the 1993 five-year plan. Although this plan does indicate four general research priority areas, the descriptors are still quite broad and general, and do not really come to grips with what is truly "essential" (I understand that the recent September 1996 conference to review health research priorities again stated these in fairly broad terms).

3. Use of research results:

There are several good examples of the use by decision-makers and planners of the results of health research. However, there is not yet a consistent system for this. Some of the successful examples were simply the consequence of individuals (researchers and policy makers) knowing each other on a personal basis.

CONCLUSION

The development of ENHR in the Philippines is a very encouraging story. It illustrates the importance of the role of a highly-placed "prime mover" who demonstrated the necessary political will to initiate the process. The ENHR process was complementary to several pre-existing research agencies, organisations and projects; though not without some difficulty, this complementary and facilitating role seems to have been quite well accepted. Also of special interest is the unusual "public-private" combination which represents the ENHR mechanism, combining the ENHR unit in the Department of Health, with a free-standing non-government organisation, the ENHR Foundation. The ENHR group in the Philippines has had considerable experience with setting national research priorities, though they feel they still need to become more focused on what truly is "essential" health research.

A challenge for this strong ENHR consortium will be to see whether the coordinated research effort can lead to improved equity and health of the people. Is it likely that in a few years, the situation below will have changed as a result of the ENHR effort in the Philippines?

> *"Little progress in mortality reduction occurred in the 1980s compared to previous decades ..... Recent data for 1990 show that little progress occurred in reducing the high rates of malnutrition among pre-schoolers and school children".*
>
> - *Health Sector Review : Philippines 1993*

APPENDIX PHIL-1 — INDIVIDUALS INTERVIEWED

Department of Health:

Ms. Remedios V.S. Paulino	Programme Manager, ENHR ("Tuklas Lunas")
Dr. Jovenicia Quintong	ENHR Service Chief (former)
Dr. Carmencita N. Reodica	Secretary of Health
Dr. Manuel Dayrit	Assistant Secretary of Health
Dr. Leda Laya Danao	Deputy Programme Manager, ENHR Philippine Nurses Association)

ENHR Foundation:

Dr. Corazon Raymundo	University of the Philippines, Diliman (President, ENHR Foundation)
Dr. Antonio Perlas	University of the Philippines, Manila
Dr. Mary Ann Lansang	University of the Philippines, Manila
Prof. Nina Castillo Carandang	University of the Philippines
Dr. Ernesto Domingo	University of the Philippines, Manila

Other:

Dr. Pacita Zara	Executive Director, PCHRD
Professor Alejandro Herrin	University of the Philippines, School of Economics
Dr. Tomas P. Maramba, Jr.	University of the Philippines, College of Public Health

APPENDIX PHIL-2 — DOCUMENTS REVIEWED

1. Summary of Progress, Plans and Budget 1993–1997
   (Draft, November 1993)
   The Philippines: Essential National Health Research
   ENHR Unit, The Philippines and COHRED

2. "Tuklas Lunas" ENHR Newsletters
   (several issues)

3. Brochure: An investment for a better Philippines: ENHR

4. Health Sector Review: Philippines 1993
   (Department of Economics, University of the Philippines)

5. Towards Health Policy Development in the Philippines
   (Department of Economics, University of the Philippines)

6. ENHR: A Strategy for Action in Health and Human Development
   (1991, Task Force on Health Research for Development)

   - pages 51–54, case study on the Philippines
   - also, other references and boxes in this document

APPENDIX 2: DONORS AND ORGANISATIONS

Carnegie Foundation	Patricia Rosenfield, Programme Chair, Strengthening Human Resources in Developing Countries, (Telephone interview, 15 September – VN)
Dutch Ministry of Foreign Affairs (DGIS)	Martin de la Bey (Telephone interview, 6 August – QQD, MP)
The Edna McConnel Clark Foundation	Joseph Cook, Director (Interview in New York, 24 October – VN)
German Ministry for Economic Cooperation & Development	Herbert Krumbein, Director (plus staff), Rolf Korte, GTZ (Interviewed in Bonn, 31 July – QQD, MP)
International Development Research Centre (IDRC)	Enis Baris, Senior Programme Specialist (Interview in Ottawa, 18 July – VN) Maureen Law, former head, Health Sciences (Interview in Ottawa, 4 September – VN)
Overseas Development Administration (ODA)	David Nabarro, Director Health and Population Division (plus staff) (Interviewed in London, 16 October – QQD

	Matthias Kerker, SDC)
SIDA-SAREC	Group interview (VN, QQD) in Stockholm, 24 September, which included: • Lennart Freij, Senior Research Advisor • Prof. Jan Holmgren, Goteborg University (SIDA Research Council) • Hellen Ohlin, Senior Research Officer • Barbro Carlsson, Senior Research Officer • Prof. Göran Sterky, Karolinska Institute (SIDA Research Council)
Swiss Agency for Development and Cooperation (SDC)	Matthias Kerker, Scientific Advisor (Interviewed in Geneva, 25 September – QQD)
United Nations Development Programme (UNDP)	Tim Rothermel, Director, Science, Technology and Private Sector Division (Interview in New York, 24 October – VN)
United Nations Children's Fund (UNICEF)	Bruce Dick, Health Sector group (Interview in New York, 24 October – VN) Ian Hopwood, Joseph Foumbi (Evaluation Unit) (Telephone interview, 29 October – VN)
World Bank	Richard Feachem, Senior Health Advisor (Interview in Washington, 30 August – VN) Olikoye Ransome-Kuti, Director, Task Force on "Better Health in Africa" (Interviewed in Washington, 10 July – VN)
World Health Organization (WHO)	Hu Ching-Li, Interim Deputy Director General (Interviewed in Geneva, 27 September – QQD) Tore Godal, Director, TDR (Interviewed in Geneva, 27 September – QQD) Andrei Issakov, Programme Manager, HSR (Interviewed in Geneva, 10 October – QQD) B.G. Mansourian, Director, Office of Research and Strategy Coordination (Interviewed in Geneva, 27 September – QQD) N.P. Napalkov, Assistant Director General (Interviewed in Geneva, 27 September – QQD) E. Tarimo, Director, ARA (Interviewed in Geneva, 27 September – QQD) Derek Yach, Director, Division of Policy, Programme and Evaluation (PPE) (Interviewed in Geneva, 9 October – VN)

APPENDIX 3: KEY INFORMANTS*

Eusebi Alihonou (L)	Task Force (Benin)
Enis Baris (VN)	COHRED Board (IDRC, Canada)
Sune Bergström (VN) (T)	Commissioner (Sweden)
Gelia Castillo (L)	Vice-Chair, Commission; (Philippines)
Steve Chandiwana (TTT)	COHRED Board (Zimbabwe)
Lincoln Chen (L)	Commission Secretariat; Task Force (U.S.A.)
Sadia Chowdhury (VN)	COHRED Board (Bangladesh)
John Evans (VN)	Chair, Commission (Canada)
Esmat Ezzat (VN)	Commissioner; Task Force; Board (Egypt)
Peter Figueroa (QQD)	COHRED Board (Jamaica)
Lennart Freij (VN, QQD)	COHRED Board (SIDA-SAREC, Sweden)
Matthias Kerker (QQD)	COHRED Board (SDC; Switzerland)
W. Kilama (TTT)	COHRED Board (Tanzania)
Mary Ann Lansang (VN)	COHRED Board (Philippines)
Maureen Law (VN)	COHRED Board (Canada)
Adetokunbo Lucas (VN)	Commissioner (Nigeria)
J.M. Mugambi (TTT)	International Health Consultant (Kenya)
V. Ramalingswamy (VN)	Commissioner; Chair, Task Force (India)
Olikoye Ransome-Kuti (VN)	COHRED Board (World Bank; U.S.A.; Nigeria)
Raphael Owor (TTT)	COHRED Board (Uganda)
Patricia Rosenfield (VN) (T)	COHRED Board (Carnegie Fnd; U.S.A.)
Tim Rothermel (VN)	COHRED Board (UNDP; U.S.A.)
Fabio Salamanca (QQD)	COHRED Board (Nicaragua)
Göran Sterky (VN)	International Health Consultant (Sweden)
Charas Suwanwela (VN, TTT)	Chair, COHRED Board (Thailand)
S.P. Tripathy (VN)	COHRED Board (India)

* Interviewer(s): Vic Neufeld (VN); Tessa Tan Torres (TTT); Qhing Qhing Dlamini (QQD)

Interview method: by face-to-face discussion, unless indicated otherwise, such as Telephone (T) or Letter (L).

APPENDIX 4: RESEARCH NETWORKS

International forum for Social Sciences in Health (IFSSH):

Letter (3 October 1996) from Santhat Sermsri, Secretary (Thailand)

International Health Policy Program (IHPP)

Several discussion (VN) with Dr. Davidson Gwatkin, Director

(Also July 25, 1996, letter with document: "Toward a More Analytical COHRED")

International Clinical Epidemiology Network (INCLEN):

Correspondence (18 September 1996) with Shelley Kessler, Acting Executive

Director.

Additional Notes:

Dr. Tessa Tan Torres is on INCLEN's Programme Committee

Dr. Charas Suwanwela is a member of the INCLEN Advisory Board

Network of Community-Oriented Educational Institutions for Health Sciences:

Interviews (VN) with Professor Esmat Ezzat, Secretary-General

Also discussions (VN) with members of the Network Executive Committee:

- Dr. Rogayah Jaafar (Malaysia)
- Dr. Abraham Joseph (India) — Dr. Joseph is chair of the Network Executive Committee

Additional Notes:

Dr. Vic Neufeld is a past chairman of the Network Executive Committee

Drs Ezzat, Jaafar, Joseph, Neufeld, Nuyens and Owor are all associated with the Network's demonstration project: "University Partnerships in Essential Health Research" (UPP)

APPENDIX 5: DOCUMENTS REVIEWED

The following set of documents was reviewed by the evaluation team as important background material:

General Background Documentation

- Health Research: Essential Link to Equity in Development *(Blue 1990 Commission Report)*
- Nobel Conference – No 15: Health Research for Development *(Grey/White Feb. 1990 SAREC Booklet)*
- ENHR: A Strategy for Action in Health and Human Development *(Green 1991 Task Force Report)*
- Report of the Africa and ENHR International Conference *(Unbound April 1992 Uganda MOH Report)*
- Essential National Health Research: Assessment of Progress *(Unbound Aug. 1992 Consultant Report)*
- Report on Future Mechanisms *(Yellow June 1992 Task Force Report)*
- International Conference on Health Research for Development *(Black March 1993 COHRED Booklet)*
- COHRED: Why, What and How? *(Unbound Dec. 1993 COHRED Report)*
- Research Capacity Strengthening for Essential National Health Research *(Brown COHRED Booklet)*
- ENHR: Challenge For Developing Countries *(Unbound 1995 Commonwealth Health Research Interregional Consultation)*
- Working Papers submitted by the COHRED directors at the June 25–27, 1996 Special Session

Regional Documentation

- Science in Africa: Essential National Health Research *(Brown 1995 AAAS Booklet)*
- First Asian ENHR Networking Meeting *(Unbound May 1994 COHRED, IHPP, IDRC Report)*
- First African ENHR Networking Meeting *(Unbound May 1994 COHRED Report)*
- Second African ENHR Networking Meeting *(Unbound Aug. 1995 COHRED Report)*
- Mission to West Africa: Benin, Mali, Guinea, Burkina Faso *(Unbound Sept. 1995 COHRED Report)*
- ENHR Networking the Networks Meeting *(Unbound Jan. 1996 COHRED Report)*

ENHR Evaluation Documentation

- Evaluation of ENHR: Draft Working Document *(Unbound Oct. 1995 Mugambi Document)*
- Evaluation of ENHR/COHRED: Updating *(Unbound June 1996 COHRED Board Document)*

National ENHR Documentation

- National ENHR Plans for Benin, Commonwealth Caribbean countries, Guinea, Kenya, Nicaragua, the Philippines, South Africa and Zimbabwe
- Essential National Health Research *(Unbound Nov. 1995 S. Africa National Technical Committee Report)*
- Draft ENHR monographs for the Philippines, Thailand, South Africa and Uganda
- ENHR Newsletters from Bangladesh, Kenya and the Philippines
- Reports of national and intercountry meetings

Miscellaneous Documentation

- Communications Audit and Strategic Plan for the COHRED *(Unbound 1994 Eurosciences Report)*
- Eurosciences Communication fax of Jan. 19, 1994, proposing a COHRED communications strategy
- COHRED Reference Manual table of contents *(Contents available upon request)*
- Strengthen Health Research Capacity: A review and Major Policy Directions in Tropical Disease Research, Edited by E. M. Pearce. UNDP/WORLD BANK/WHO Special Programme for Research and Training in Tropical Diseases 9 TDR), 1992.
  (And the follow-up document: Research Capacity Strengthening (RCS): Updating the strategy, June 1996)

APPENDIX 6: EVALUATION TEAM

Vic Neufeld is a physician and educator at McMaster University, in Hamilton, Ontario, Canada. He is a Professor of Medicine and Clinical Epidemiology, and director of the Centre for International Health. He is closely associated with several international networks, including the Network of Community-Oriented Educational Institutions for Health Sciences. Dr. Neufeld has been a consultant with several agencies, including the World Bank and the World Health Organization.

Qhing Qhing Dlamini (originally from Swaziland) is a physician with post-graduate training in public health. She is Health Advisor and head of the Health Department, Commonwealth Secretariat, London. She was former Deputy Director of Health Services, Ministry of Health, Swaziland. She was until recently a member of the Executive Board of the World Health Organization.

Tessa Tan Torres is an infectious diseases clinician and researcher with training in clinical epidemiology and economics. She is a member of the International Clinical Epidemiology Network (INCLEN) and is currently the director of the Clinical Epidemiology Unit of the University of the Philippines, College of Medicine, Manila, the Philippines.

Mark Pruzanski is currently a medical student at McMaster University, in Hamilton, Ontario, Canada. His background includes post-graduate training in international affairs at the Johns Hopkins School of Advanced International Studies, and several years as a private and public sector management consultant.