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The Newsletter of the Council on Health Research for Development

Research into Action

Welcome to the first issue of *Research Into Action* for the year 2000! In this issue, we continue with our focus on equity, with a feature article on the paper by Davidson Gwatkin, Michel Guillot and Patrick Heuveline on the *Burden of disease among the global poor*, published in *The Lancet* in 1999. The article explores the idea that inferences about health status among the global poor cannot be drawn from global average figures.

Evidence for the importance of equity in health is inherent in the ENHR strategy. Of the "Three Key Features of Effective Health Research - *Put countries first, work for equity in health,* and *make research an active part of development"* – work for equity in health is uppermost in importance. However, recognising the importance of equity is not something unique to COHRED and its main messages. Our feature article further illustrates just how many equity studies are currently taking place around the world.

Also on the topic of equity, we announce a number of new publications recently released by COHRED, including a paper that looks critically at the power of health research as an advocate for equity-based health and development.

Our section on **ENHR in Action** focuses on Research to Action, with an article on the COHRED *Working Group on Research to Action and Policy.* The Working Group has recently completed a number of case studies from various global regions. We also feature an article by the Malawi National TB Programme, illustrating how research benefits their programme.

The **Conference Update** section takes a further look at some activities leading up to the International Conference on Health Research for Development in October 2000. In this issue, we review the activities of the Regional Consultation Processes, critical to the preparation of the regional 'voices' for the conference. Summaries from each of the regions involved are included. Also in this section, our second 'Opinion Piece' leading up to the international conference features Dr Adetokunbo O. Lucas and Dr Izzy Gerstenbluth – opinions from two interviews with different realms of experience.

Finally, we wish to thank you all for your responses to the Reader Survey so far - please keep them coming! In the following issue, we will publish some comments and results from this survey. You may notice that we have already begun implementing some of the suggestions we have received. Other suggestions will take longer to implement, but we will endeavour to meet as many expectations as possible.

Enjoy the New Year!

*The **Research Into Action** Team*

Inside this Issue

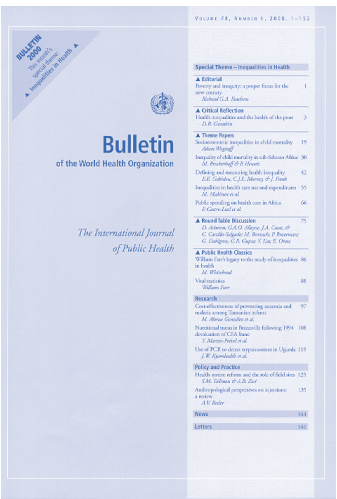
Equity Issues Back on the Global Agenda

It has been a concern amongst researchers of late that equity in health is being left off the research agendas in favour of efficiency based health reforms, and other financially-based reforms of the health system.

Dr John Evans, Chairman of the Commission on Health Research for Development was recently interviewed by COHRED about his views on health research, and his position on equity in the global agenda for health research. His answer was a striking blow to those who insist that equity has never been lost from this agenda.

"…equity is getting lost amongst other issues such as using health research as a means of improving decision-making or achieving efficiency in health …. The current analysis of how equity is achieved recognises that the supply side is important (eg. access to services), but one has to look also at how people view their own lives and how they can be mobilised to pursue equity rather than think of it as a passive concept".

The latest edition of the *Bulletin* from the World Health Organization features a special theme – Inequalities in Health. The publication highlights the health gaps that still exist between different sectors of society (particularly between rich and poor), despite the "tremendous progress in improving human health over the past half century". In the main paper from the WHO *Bulletin*, Davidson Gwatkin[1] draws attention to "a new generation of research" which provides new insight into the questions of poverty, equity and health. This research shows a renewed concern for issues related to equity – reduction of inequalities, poverty alleviation and equity enhancement.



The special issue of the WHO Bulletin focusing on Inequalities in health.

The number of recent (or upcoming) conferences with an equity focus is a further indicator that the world is beginning to act on inequality in their regions. In June, a conference to be held in Cuba, organised by the International Society for Equity in Health (ISeqH) will focus on encouraging advances in knowledge about the importance of equity in the improvement of the health of all people and to promote the application of knowledge to activities directed toward this goal.

A further conference, to be convened by the Regional Network on Equity in Health in Southern Africa (EQUINET) is to be held in South Africa from the 13 to 15 of September. The *International Conference on Health Research for Development*, organised jointly by the World Bank, the Global Forum for Health Research, the World Health Organization, and COHRED will have equity high on its agenda.

In addition to this, according to Gwatkin et al. (1999)[2] there are over 100 countries around the world presently participating in various equity studies. Despite these efforts in many parts of the world, inequalities are worsening rather than improving.

The Global Forum for Health Research's 1999 *10/90 Report on Health Research* provided a number of startling facts, including the statistical reasoning for the so-called "10/90 gap"[3]:

> At present, of the US$ 60 billion spent worldwide annually on health research by both the public and the private sectors, only about 10 percent is devoted to 90 percent of the world's health problems (as measured by DALYs - Disability Adjusted Life Years - or similar indicators).

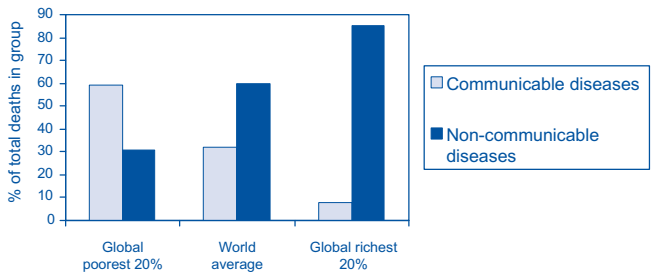
The 10/90 gap is attributed, at least in part, to the fact that decision-makers do not have enough information – particularly that relating to patterns of diseases from which the poor suffer the most. The Global Forumpublication states that "not until we have this information can we be certain that our efforts to deal with diseases are focused correctly on those ailments that are most important among those most in need".

The objective of another more recent report representing a coordinated effort from the Global Forum for Health Research and the Health, Nutrition, and Population Division of the World Bank, is "to contribute to shedding more light on this key topic so that decisions can be based on more and better information". The report takes the leap forward from estimates based on geographical region to the provision of an estimate of the burden of disease among the world's poor wherever they live.[4]

An earlier paper by Gwatkin, Guillot and Heuveline[5] which was published in The Lancet in 1999 first highlighted the issue of the poor-rich gap, and the statistics to support the belief that health research is at a crossroads. In the near future, if the world decides to go one way, and emphasise the universal eradication of non-communicable diseases, the poor-rich gap could be widened. Whereas a decrease in the prevalence of communicable diseases would significantly raise the life expectancy of the poorest 20% of the world's population.

Gwatkin et al. (1999) show that recently, there has been a rise in the importance of non-communicable diseases in the elderly (as the population ages). Medical advances in other diseases affecting young people have also been achieved. However, these apparently good population health statistics do not reflect the conditions amongst the poor, because the estimates were based on societal averages that include data for the rich and the poor. Gwatkin et al. argue that inferences about health status among the global poor cannot be drawn from global average figures (see Figure 1).

Figure 1: Causes of death amongst rich and poor, 1990



Note: figures for deaths due to injury were omitted, as they were very similar amongst all groups.

The paper also reveals that in 1990, communicable diseases caused approximately 60% of deaths and disabilities amongst the poorest 20% of the world's population. Conversely, only approximately 15% of the richest 20% of the global population were affected by the same communicable diseases. Thus, the authors conclude that a decrease in communicable diseases would raise the life expectancy of the world's poorest 20% drastically, but would have little effect on the richest 20%. However, should the medical research community decide to concentrate on decreasing non-communicable diseases, the richest 20% of the world population would greatly benefit, but there would be less effect for the poorest 20%.

From these facts, the authors further conclude that an accelerated decrease in communicable diseases would significantly decrease the poor-rich gap in future.

Whilst this may be an oversimplification of the issues associated with medical research, and decreasing the burden of disease among the global poor, it is often the act of stripping away the advanced statistical measures that bares the cold, hard facts - the needs of the poor cannot be balanced, averaged, or argued away any longer.

Table 1: Extra life expectancy gain attributable to doubled rate of decline in specified diseases, 1990-2020

Life expectancy gain (years)	Doubled rate of decline in:	
	Communicable diseases	Non-communicable diseases
Global richest 20%	0.4	**5.3**
Global poorest 20%	**4.1**	1.4

Note: Figure 1 and Table 1 reproduced from Gwatkin DR, Guillot M and Heuveline P (1999) 'The burden of disease among the global poor', The *Lancet*, **354**: 586-89.

References:

1. Gwatkin DR (2000) *Health Inequalities and the health of the poor: What do we know? What can we do?* Bulletin of the World Health Organization, 2000, **78** (1).

2. Carr D, Gwatkin DR, Fragueiro D, and Pande R (1999) *A guide to country-level information about equity, poverty, and health available from multi-country research programs*. Health, Nutrition, and Population Department; The World Bank, Washington DC.

3. Global Forum for Health Research (1999) *The 10/90 Report on Health Research, 1999*. The Global Forum for Health Research, Geneva.

4. Gwatkin DR, Guillot M (2000) *The Burden of Disease among the Global Poor: Current Situation, Future Trends, and Implications for Strategy*. The Global Forum for Health Research and the Health, Nutrition, and Population Department; The World Bank, Washington DC.

5. Gwatkin DR, Guillot M, and Heuveline P (1999) 'The burden of disease among the global poor'. *The Lancet*, 1999; **354**: 586-89.

For more information on this equity study, please contact:

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Research/Policy Nexus Examined by Working Group

*COHRED's Working Group on **Research to Action and Policy** tries to make a specific contribution to the global discussions on the research/policy nexus by commissioning studies which highlight country experiences in this regard.*

Most initiatives around this topic have focused on research linked to macro-policy, such as health sector reforms. The working group works on the hypothesis that a wider policy framework can be used. Hence, the case studies that are conducted are intended to reflect a broad range of research activities which have relevance to policy.

The working group met in Bangkok from February 21-23 to discuss the outcome of the five case studies which were recently completed, and to extract the lessons learned. A short summary of each of the case studies is included.

Some initial lessons learned can be summarised in three main categories:

To successfully link research to action and policy at least three major issues are important. First of all the **environment** must be supportive and receptive of the research recommendations. Under a political or economic crisis a government will become more receptive to research recommendations (of both old and new research) as it will feel the need to perform better and will seek opportunities and advice to do so. Newly formed democracies will also feel an increased pressure to fulfil demands, to seek advice, and to perform well.

Members of the Working Group on Research to Action and Policy

A **mechanism** is needed to link research to decision making. The main tasks of this co-ordinating mechanism is to monitor the research to policy process, to ensure that priority research is conducted and to monitor the move towards equity in health by conducting and using this priority research. The mechanism facilitates networking between the various actors (eg. researchers - both national and international - decision-makers, private sector, NGO's) and can ensure that the actors are aware of research conducted. It can also ensure that the policies developed are embedded in the existing context

A third major issue is the need for the researchers and the decision-makers to develop specific **skills** to improve the linkage of research to policy. This includes, among others:

- Partnership building by including the relevant stakeholders in an early stage of the research (as early as the definition of the research question)
- Communication, advocacy and social marketing skills
- A feeling for timing of the research, which should be in line with the development of policies.

The five case studies

The **Brazilian** case study aimed to contribute to conceptualising the thinking around the links between research and health policy in the light of Brazil's experience in vaccine research development, production and utilisation by the Brazilian health system.

The case study conducted in **Burkina Faso** focused on the concept of 'Shared Care'. This concept, introduced by a group of researchers approximately ten years ago, is based on the idea that mothers and health workers can jointly take the responsibility for care giving and treatment seeking for childhood illnesses. The case of 'Shared Care' is an example of a research driven policy development.

The case study from **Indonesia** focused on the research conducted in relation to the programme of the Social Safety Network in the Health Sector. This programme was launched by the Government of Indonesia as an attempt to maintain the community health status during the recent economic and political crises. The aim was to learn more about how research had improved the programme, and how that research was then used to determine and implement the programme policies.

The study team in **South Africa** selected the issue of vitamin A: the research conducted in this field and how research results were used for policy making. The case study aimed at illustrating the levels of policy that surround decisions regarding vitamin A interventions - impacting on individual children. The whole case study was embedded in the major political changes of the last decade in South Africa and its influences on policy making.

In **Uruguay**, the research to action and policy case study focused on two major diseases, Chagas disease and Foot & Mouth disease, both of which have been successfully eradicated in Uruguay. The case of Foot & Mouth disease, although it concerns animal health, was selected due to its major economic impact on the country. Both cases show a very long history of research before a major impact was noted in policy making. The political circumstances in the country played a major role in the history of this process.

Further activities of the working group:

The working group will compile the case studies in an overall paper, including a conceptual framework for linking policy to research. This paper will be published around October. It will also try to translate the findings and lessons into a learning manual. COHRED will share these tools with you as soon as they are available.

For more information about COHRED's working group on Research to Action and Policy please contact the chair of the working group, Dr Somsak Chunharas (somsak@health.moph.go.th) or the COHRED Secretariat.

Getting Research into Policy and Practice in Malawi: The experience of the National TB Control Programme

Malawi has a strong National Tuberculosis Control Programme (NTP), which is supported by the Government of Malawi as well as international donors such as the Department for International Development, UK (DFID), the Royal Dutch TB Association (KNCV) and the Norwegian Agency for Development Cooperation (NORAD). All aspects of TB control are supported - including operational research. The NTP attempts to conduct research that is relevant to the needs of the programme, feeding the results of this research back into policy and practice.

What are the necessary ingredients to make this work? First, the NTP has a well-defined goal and several clearly identified objectives, and research projects are based around these objectives. For example, one objective is to improve and sustain equity in the process of TB care. The NTP has put a lot of effort into conducting research into tuberculosis in prisons, and as a result of good collaboration with prison authorities has been able to incorporate its system of TB care into the prison system in Malawi. Another objective is to improve the delivery of effective treatment. For the last 3 years the NTP has been conducting studies in urban and rural districts on decentralizing anti-TB treatment to peripheral health centres and to guardians using a fully oral ambulatory treatment regimen. Results of this research will determine whether or not decentralization is expanded to national implementation.

A second important component is the full integration of the research programme into the management structure of the NTP. A programme management group for the NTP meets on an almost monthly basis. The group consists of the central unit of the NTP and advisors from district hospitals, the medical school and other relevant stakeholders. The group reviews all aspects of TB control in Malawi, including new ideas for operational research and the progress of on-going research. With its executive powers, the group is able to discuss the results of research, and make decisions about whether there is enough evidence to change policy or practice, or whether more evidence (i.e. more research) is required. The management group is answerable to a Programme Steering Group, consisting of senior staff from the Malawi Ministry of Health and Population as well as donors. This Steering group works together to review NTP plans, reports and the progress of operational research, and acts both as a review body and an advisory body.

Thirdly, the entire TB programme is involved, one way or another, in research. Many district TB officers assist with research data collection. The NTP runs an annual two-day operational research training workshop for district TB officers at which a research protocol is developed, which is then carried out. Every year there is a two-day annual review meeting with donors, international experts, TB programme staff and other public health programme staff at which programme activities and research progress are presented. This is an excellent opportunity for TB programme staff to present papers and to learn presentation skills. Donors also provide funding for the research studies published in international journals to be written-up in a locally made document and distributed throughout the country, thereby ensuring that the research findings are more accessible.

Finally, there is strong advocacy for operational research from senior Malawian personnel in the Ministry of Health and Population. Research is recognised as an important and established part of TB control efforts. This strong support allows the NTP to request donor funds for programme support and also for operational research. The success of the research is judged, not so much on how many papers have been written, but on whether NTP performance has improved.

Reference:

TB Research: Putting research into policy and practice; the experience of the Malawi National Tuberculosis Programme; WHO/CDS/CPC/TB/99.268

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"Old problems, new opportunities" the complementarity of SHARED and COHRED

A further case in point for the power of networking is the news that COHRED anticipates working closely in future with an innovative initiative known as SHARED (**S**cientists for **H**ealth **a**nd **Re**search for **D**evelopment). SHARED aims to make high quality information on health research for development available to scientists worldwide via both the Internet, and a gradually developing network of well connected "focal points" in the North and South. The SHAREDinitiative has developed state of the art technology to drive the Internet information system, while the technology has been designed to function in resource- and communication-deprived regions.

Why 'information management' in this field of interest?

The problems are known:

- Traditional 'donors' frequently work along their own priorities for research and intervention, and implement their projects in isolation from one another.
- Energy and investments are wasted because of duplication and gaps.
- In many developing countries, health policy development is often not promoted or is not applicable because of the top-down priority setting and the isolated, donor-driven projects.
- As new initiatives (such as networking) try to overcome some of the barriers, the need for a place to share information across frontiers and divisions became apparent.

SHARED tries to address these problems by enabling more effective networking and coordination in the field of international health relevant to developing countries. SHARED offers a meeting place on the Internet. Its online databases are fed with information about ongoing research and development projects in the field of health, which in turn, allows scientists and policy makers to analyse and compare information, look at relevance, opportunities and gaps, find new partners and, overall, make better, more informed decisions.

SHARED and COHRED share the same concerns

Namely that it is unacceptable from a social equity point of view to once again doom the developing regions of our world to miss out, possibly for a full generation, on a technical revolution that has its roots in the North. The open character of the World Wide Web (www), with its open-source technology and wide scope for utilisation presents an excellent opportunity for optimal sharing of knowledge in a global setting.

Such sharing of information is crucial, particularly in a resource-poor setting where knowledge on the optimal use of existing funds, awareness of best practices, transparency in decision-making and priority-setting would allow recipients to influence and therefore optimise the impact of development funds provided by industrialised countries. This would also serve to minimise the well-documented lack of donor coordination, resulting in erratic and donor-driven policies in recipient countries as well as in severe under-funding of such highly relevant sectors of human development as health care and food provision.

If information and communication technologies (ICTs) can succeed in not only giving stakeholders in developing countries access to the best and latest information in their areas of interest, but also providing a conduit for their voices to be heard by both their governments and the rest of the world, then [ICTs] could become a major democratising force.

The SHARED approach pursues a vision of providing the developing world with this democratising force through equipping people with state of the art technology to allow data-driven communication. The SHARED approach seeks to increase connectivity via a growing network of "knowledge nodes" in developing countries, not only contributing information, but also playing the role of disseminators of information within their district, sector, province or even country.

What is the aim of COHRED's collaboration with SHARED?

COHRED's main objective is to promote and advocate for strong, national research networks that are able to guarantee *priority-driven research* in countries from which *good decision making for equitable health* can take place. COHRED sees the technology made available by SHARED as an extremely useful tool to strengthen these national research coordinating mechanisms. Although this tool is very valuable it will not work on its own. There is a need to strengthen national networking, to disseminate information to stakeholders without access to modern technology, and, more generally, to promote and advocate for health research as tool for stronger decision-making. This is where COHRED and SHARED can reinforce each other.

In particular, the combination of the SHARED and ENHR strategies will provide powerful potential to strengthen health research in a country. SHARED will facilitate the collection of

information about research, research to policy, and research to action that will assist the national research coordinating body in its ability to promote essential research in the country. The optimal linkage of the two strategies would see the SHARED national focal point closely linked to the national research coordinating mechanism, or even located within this mechanism.

Common Ground

The common ground between SHARED and COHRED's ENHR strategy is obvious.

COHRED's main messages could just as well be those of SHARED:

- Put Countries First
- Link Research to Action for Development
- Work Towards Equity in Health

And indeed, the principles driving the ENHR strategy reflect and reinforce those of SHARED:

- Make health research a valuable tool for decision-making
- Set national and sub-national research priorities
- Broaden the diversity of groups that have a say in setting the national research agenda
- Achieve far greater public involvement
- Develop country mechanisms that facilitate effective health research
- Build the capacity of researchers, coordinators and users of research
- Expand interaction between researchers and users of research
- Promote communication and networking
- Extend networks with researchers in other countries
- Mobilise resources for research.

This common ground leads us in one direction - collaboration is the obvious path to take.

For further information about the SHARED initiative, please contact Dr Barend Mons at: MONS@NWO.NL

Web address: http://www.shared.de

International Conference on Health Research for Development Update

In previous issues, we have provided information on some of COHRED's contributions to the **International Conference on Health Research for Development**. *In this issue, we take a closer look at the analytical and consultative work being undertaken by the various regions in preparation for the Conference – otherwise known as Regional Consultations. Coordinators of the regions (or consultants appointed by the Coordinators) have been asked to analyse past research efforts of selected countries, and to compile information on anticipated agendas for research in the future.*

The consultations are intended to inform discussions on:

- A new paradigm for health research
- The new architecture for cooperation amongst national and international actors in health research
- New tools and methodologies to realise the new paradigm for health research
- New approaches to ethics in health research

Although the ultimate goal is to answer these 4 objectives, each region has developed a slightly different way of reaching the objectives, relating to the specific needs and situation.

The deadline for collection of this information is July, when a **global synthesis meeting** will take place.

This article provides a brief summary of activities for each of the global regions, including a special focus on Asia.

Regional Consultative Process

Focus on Asia

The Asian region has taken an innovative approach to the Consultative Process for the international conference, with the introduction of an electronic dialogue tool. Coordinated by Professor Chitr Sitthi-amorn, the dialogue tool has seen some 350 respondents actively participate in, and contribute to, the consultation process to date. A regional Forum (the Asian Forum) was held in Manila from February 17 to 19 in order to address the main objectives of the consultations, and action to be taken. The Forum attracted some 100 stakeholders from a variety of fields related to health and health research, and focused on three basic concepts around health research: **a New Paradigm, architecture, and required action**.

A New Paradigm for Health Research

Defined by the Forum as a set of assumptions, incorporating many of the previous ideas that have dominated health research, but with the introduction of new processes that have emerged in health research, encompassing among other things:

- An emphasis on vision and equity
- Consumer orientation
- Greater use of layman's language over technical jargon
- Movement away from parochial to regional and global needs

An Architecture for Health Research

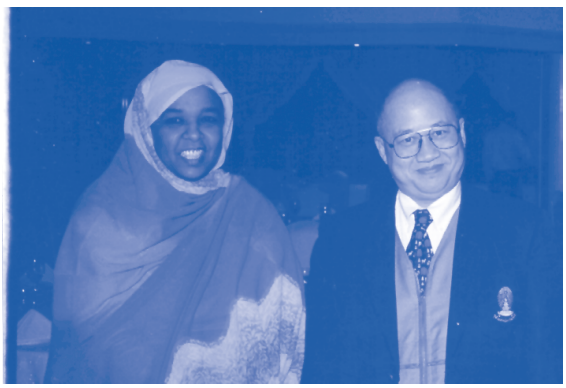
The Asian Forum developed a framework around which the Asian regional architecture for health research co-operation may be considered. This included the recommendation that the architecture be considered at the global, regional, and national level.

Some of the major recommendations for architecture at the national level included:

- Political commitment to equity
- Research priority setting
- Commitment to transparency and accountability

At the regional level, some of the suggestions included:

- Clear statement and vision
- Political commitment
- Supportive organisational structure to assist implementation of national research plan.



Participants at the Asian Forum, Dr Samia Habbani and Professor Chitr Sitthi-amorn

At a global level, results from the Forum suggest that equity-oriented action can place a greater emphasis on research which is designed to respond to the health problems of developing countries. At the same time, the global architecture must pursue strategies that empower national research communities and make processes available to all.

At all levels, there are pitfalls such as bureaucracy, centralised decision-making, and excessively profit- or market-driven factors that should be avoided. In general, efforts should concentrate on adapting existing structures before creating new ones. Throughout the exercise there is an ongoing need for periodic and independent evaluation. However, the Forum also identified that a newly emerging architecture also brings a number of assets to the health research community, including:

- clearer policy-making and priority-setting
- capacity building for research management and implementation
- setting generally acceptable standards and norms

Required Action for Health Research

A number of specific lines of action were identified by the Forum:

1. Action for leadership - a new cadre of equity-oriented, high performance research managers.
2. Action tools and methodologies, including effective promotion and advocacy activities.
3. Empowering tools for research action - including better use of information and communication technologies.
4. Tools and methodologies for Equity watch - in order to measure the progress towards equity goals, good tools must be made widely available.
5. Action to implement new information and communication technologies (including the creation of a *Centre for the Asian Voice on Health Research,* to be launched in March).

The electronic dialogue tool - or *Distance Dialogue,* as it is known - provided a communications network linking a large number of protagonists in the field in the lead-up to the Asian Forum. This dialogue has evolved into the Asian Voice, serving as a vehicle to keep the people of the region abreast of developments leading up to the international conference in October 2000, and beyond.

For further information about the Asian consultative process, contact Professor Chitr Sitthi-amorn at:
chitr@md2.md.chula.ac.th

Latin America

The Latin American Consultative Process was initially launched at a meeting in Mexico on November 24 and 25. It now encompasses representatives of the research community in at least 7 countries and two health research networks within the region.

While the initial entry points for national activities have been through existing contact persons in INCLEN, COHRED, REDSALUD and others, the process has now become more inclusive and encompasses a broader range of stakeholders, such as representatives of research councils, universities and government entities. PAHO has been equally involved and WHO country representatives have been asked to support national efforts.

A meeting in Havana from 9-11 May will provide the first opportunity to exchange preliminary results. The meeting represents the culmination of a Cuban assessment of the past decade in health research. This comprehensive assessment fits perfectly into the preparatory phase for the international conference on health research for development. The Government of Cuba has offered the Havana meeting as a platform to concretise Latin America's participation in the preparatory process of the international conference. Other countries in the Caribbean region have announced their participation.

The regional synthesis meeting will tentatively take place at the end of May.

For further information, please contact Dr Matthias Kerker at: kerker@cohred.ch

Eastern Europe and the Newly Independent States (NIS)

The results of the regional consultative process in several countries of Eastern Europe and the Newly Independent States (NIS) will fulfil a number of needs at national, regional and international levels. Despite inheriting similar research structures across the region, incorporating homogeneity, abundance of data, high government priorities and clear channels, the state of health research in the countries of the Eastern European region and the NIS is in a period of transition and crisis.

Whilst consultations will both inform and be enhanced by the work of the Health Research Profile Project (HRP) in 3 countries in the region (Kazakhstan, Lithuania and Hungary), a further 6 countries will be involved in looking at past and future challenges for health research in the region.

The consultations are being coordinated by Dr Peter Makara from Hungary. For further information, Dr Makara can be contacted at: BHA@who.dk

The Caribbean

Developing a Caribbean plan of action that encompasses sustainable partnerships with members from every region of this culturally diverse area is the goal of the Caribbean consultative process, headed-up by the Caribbean Health Research Council (CHRC). Coordinated by Dr David Picou (Director of Research, CHRC), the consultative process aims to gather information for the global synthesis meeting at various levels:

- Regional governments and Ministries of Health
- Regional health and research organisations
- National health and research-oriented organisations
- Individual researchers
- Publications relating to health and health research emanating from the region

A draft report will be presented to a regional forum in mid-April.

For further information contact Dr David Picou at: chrc.tt@trinidad.net

Africa

The primary objective of the African consultative process is to allow 15 African countries to compile and provide their own data, to formulate specific recommendations for action, and to retain ownership of the outcome of the data to the endpoint (i.e. the international conference). **Lead Consultant** for this project is Professor Mutuma Mugambi of Kenya (Meru University), who, along with assistant researcher Ms Griet Onsea (Kenya), was appointed by the African Mentoring Team, to undertake the analysis of the information received from the countries. The outcome will be comprehensive evidence-based information on health research and development in Africa.

The process is essentially country-based, leading to a regional view through in-depth analysis of 15 countries and abridged analysis in a number of other countries. The work will be carried out through:

- close scrutiny of documents
- questionnaires
- focus group discussions and interviews
- regional synthesis

Countries involved in the project are currently completing reports on the situational analyses of national health research.

A conference will be held at the end of May to review the reports from each of the regions, and approve final text for submission to the global synthesis meeting in July.

For further information about the African Consultative Process contact Professor Mutuma Mugambi at the following address: mugambi@net2000ke.com

Other News:

The task of undertaking a central analysis of research has been embraced by a 3-person team headed-up by Dr Joe Kasonde of Zambia. Dr Kasonde and his team have been contracted by the Organising Committee of the *International Conference on Health Research for Development* to undertake an analysis of all international organisations that have been driving the agenda for health research over the last decade. Specific objectives were outlined by Dr Kasonde as:

- To conduct a review of the existing 'architecture' for international cooperation in health research
- To derive and draw attention to the lessons learnt from the experience of the initiatives that have been taking place in the last decade at global, regional and country level
- To provide options for the future 'governance architecture' of international health research

Dr Mary Ann Lansang (Philippines) and Dr Steve Tollman (South Africa) complete the analytical team.

For further information, please contact Dr Joe Kasonde at: kasonde@cohred.ch

Meetings to be Held in Conjunction with the International Conference

Of interest to members of INCLEN, SEA-CLEN and Thai-Clen will be the news that the XVII Global Meeting is to be held in Bangkok just 2 days after the close of the *International Conference on Health Research for Development*. The meeting will review the contribution of research conducted by investigators in developing countries to the advancement of global knowledge; the value of research collaboration and research networks in solving health problems in developing countries and beyond; and the strategies for incorporation of research results into health care practice. Deadline for submitting abstracts is June 1, 2000. Further information about the October INCLEN meeting is included in the **Notices** section of this newsletter. Other parallel meetings are listed on the international conference website at: http://www.conference2000.ch

One Decade of ENHR

In the issues leading up to the International Conference on Health Research for Development to be held in October this year, the Research into Action team plans to feature a number of 'Opinion Pieces'. This is the second of these articles, contrasting a global picture of the direction health research is taking, and an ENHR country-specific perspective. Lucinda Franklin talks to ***Dr Adetokunbo Lucas and Dr Izzy Gerstenbluth*** *about their views on health research from two different worlds.*

Talking with Ade Lucas...

Dr Adetokunbo Lucas has been part of the wider health research for development community for many years. His experience with COHRED goes back a long way. He was a member of the Commission on Health Research for Development, and was Chairman of the editorial committee which developed the Task Force on Health Research for Development's 1991 monograph, *ENHR: A Strategy for Action in Health and Human Development* – a publication which further refined the recommendations of the 1990 Commission Report. Following his retirement from the Tropical Diseases Research (TDR) Programme of WHO, Dr Lucas was involved in a variety of activities, ranging from capacity strengthening activities to teaching international health at Harvard University. He currently holds the position of Chairman of the Foundation Council of the Global Forum for Health Research, and is based in the UK.

What has been the most important impact of the Independent Commission on Health Research for Development and its 1990 Report?

One of the major impacts I saw from the Commission Report was that it awakened interest in the need for research at the country level. This, tied-in with the idea that we must not undertake health research solely for the sake of research as such, but in order to *promote health, and equity in health*, was the first time I had seen research being actively promoted as the *key* to equity in health and development. It was successful in establishing a number of targets, which at the very least provided us with benchmarks with which to measure progress towards attaining equity in health.

Your interest in capacity strengthening for HR is apparent in a number of COHRED/ENHR-related documents you have either written, or contributed to. How successful has the ENHR strategy been over the last 10 years with strengthening capacity for health research?

I am not close enough to ENHR to be able to answer that question specifically, but it has definitely stirred up the winds of change, although there is still a very long way to go.

Some developing country governments seem to have changed their perception of the role of research. Instead of regarding research as a luxury to be funded by external donors and private foundations, they now recognise it as an integral part of their function in health development. The ultimate goal for countries is to have knowledge-based decision-making at *every* level of the health system, and so this is the type of capacity that must be strengthened. Countries must have capacity for gathering and analysing information, and for doing appropriate research at every level. For example, if a government decides to start immunising children against measles at the age of 7 months, and someone can ask 'why not at 6 or 10 months?', the decision makers are able to present the evidence as a basis of their decision. One does not often see that kind of evidence-based decision-making occurring, where policy makers ask for more information to use as a basis for their decisions.

My view of capacity strengthening and ENHR is that it should be made the primary responsibility of national governments. That would achieve a number of things; one is to show the people in the country that their government is interested in promoting training for local research capacity, and the other is that when results from the expanded research capacity start to show, governments would sit up and take notice, because they invested money in the venture. A further spin-off is that it would reassure external donors that governments are committed to strengthening local research capacity, and there would be less of a need to import foreign researchers to tackle the basic needs of the health sector. It's a win-win situation.

One of the recommendations of the 1990 Commission Report states that:

"Governments should invest at least 2% of their national health expenditure in research and research capacity strengthening"

Adetokunbo O. Lucas receiving the Prince Mahidol Medal from Her Royal Majesty, the Queen of Thailand, 31 January 2000.

Do you think that the recommendations for this kind of resource mobilisation have fallen on deaf ears?

Well, we also recommended that for large, externally funded health programmes 5% of that money should be earmarked for capacity strengthening and I do not know if anyone is monitoring the progress of either of these initiatives. A message we could send to the organisers of the *International Conference on Health Research for Development* is that we would like to see where we are in relation to these two recommendations. I would ask that a graph be prepared that shows 70 developing countries and the proportion of their budget that is specifically set aside for health research – now, compared with 10 years ago.

How have the challenges facing the international health research community changed over the past ten years?

The challenges have changed quite a lot. In one way, the whole atmosphere of international health and public health has changed. At the time when the Alma Ata declaration was made, the world was moving more in the direction of a welfare state, where people felt that it was the responsibility of governments and the state to look after the health of the population from 'womb to the tomb'. The world has now moved in the opposite direction where, due to market directions, it's every man for himself. It's not that one can't achieve equity and good health under this system, it just means that you will be swimming against the tide, and it becomes doubly important that public health arguments be made more forcibly - and that is the real importance and value of health research for us today.

Another thing that has changed is the idea that health inequalities only exist in developing countries. A recent study in the US showed us quite clearly that this is not the case. Health inequalities exist even in the wealthiest of societies, and there is clearly more to inequity than a lack of funding. Chris Murray's study[1] presented a number of health indicators in the US on a county by county basis – with the use of a series of colour coded maps of the country. Looking at these maps, you begin to realise why many people are lobbying for a health policy change in the USA – the under five mortality rate in the US is higher than all the Western European countries, higher than in Canada, and even higher than in Singapore and Hong Kong. The life expectancy figures by county show that in the best counties, the highest life expectancy is amongst women (with an average life expectancy of 90), and in the worst counties, the life expectancy for the black population, particularly males, is only 55 years or so - almost three to four decades difference in the same country!

It is when you bring such evidence on the table that people can actually see the enormous discrepancies. It is not possible though to blame countries for their inequities in health. There is no nation free of it – even in Scandinavia and other welfare states – it is clear – the poor die young. It seems to be a universal law of nature. How governments deal with this – especially in developing countries - will be the make or break factor. The more governments use evidence from research to identify the optimal and most cost effective interventions, the more they will be able to monitor the impact of these interventions, and the better they will do in diminishing the inequalities in health.

In the September 1998 issue of *Research Into Action*[2], you highlighted the complementarity between the Global Forum for Health Research and COHRED. How do you think this relationship has evolved in the 2 years since you wrote that article, and what kind of collaboration do you envisage for the future?

Two of the major recommendations that came out of the Commission's 1990 report were to strengthen health research at the country level and to create a global entity that would monitor and analyse priorities for health research on a global plane. After 1990, the second objective was not addressed properly. It was then that the Ad Hoc Committee on Health Research[3] was set up to look at this question again. That is how the Global Forum for Health Research (GFHR) was born - working closely with, but independent of, WHO so that it would not be perceived as undermining the work of WHO. The second objective was that it complements, but does not compete with, the work of COHRED. The final objective was that since Dr Brundtland took up office as the Director-General of WHO, a further strengthening of the relationship between COHRED and the GFHR was possible, and should be encouraged. An attractive option was then, and is now, to design mechanisms that would enable COHRED, the GFHR, and other international bodies involved in health research to assess their respective roles and to work more closely with WHO, effectively providing the WHO with independent mechanisms for reviewing and implementing its constitutional mandate.

What are the future directions for health research and development?

There are some critical issues that still need to be dealt with. The next stage that I would like to see is an increase in policy maker demand for information and scientific knowledge on which to base their decisions. At present, I do not see much evidence of that. For example, why is it that the child mortality rate in Nigeria is worse than in Kenya? It can only be that the policies do not exist or are not effectively implemented to deal with the problem in Nigeria.

I am also concerned that most of the questions relate to what the scientists are doing – policy and decision-makers are not being challenged as to the basis of their decisions and plans.

The point is that quite often researchers are being blamed for not doing research on the relevant issues, and for not publishing their results in a way that policy makers can understand – yet even when they do attempt to bring the results to the attention of the policy makers, they don't always take notice. I am contrasting this scenario with that of a clinician. Who told the clinicians treating diabetic patients that insulin is effective? Surely it was the clinician's responsibility to find out what drug can help diabetic patients? We do not sufficiently challenge the policy makers – to ask *them* what evidence they have on which to base their judgments and decisions.

It's a question of persuading governments to implement the policies that are based on good science. We have some way to go, but I remain optimistic.

...and Izzy Gerstenbluth.

Dr Izzy Gerstenbluth is a man who wears many hats. He lives on the island of Curaçao, in the Netherlands Antilles - a small group of islands in the Caribbean. The Netherlands Antilles is comprised of 5 islands - the largest of which is Curaçao, with a population of approximately 150,000. Due to a number of factors, including size, and geographical isolation, there is a lack of much needed research capacity in the region. As a result, Dr Gerstenbluth heads up a number of initiatives in his region. To date, he holds the positions of Head of the Epidemiological Research Unit, Head of the Communicable Diseases Unit of the Public Health Service in Curaçao, and National Epidemiologist for the Netherlands Antilles. He also heads up the Disaster Response Unit for the region. In addition to this, he is a recently appointed member of the COHRED Board. Dr Gerstenbluth was kind enough to give up some of his much-needed time to talk with Lucinda Franklin about ENHR in the Caribbean, and specifically, what it means for Curaçao.

What in your opinion, is the most important impact that COHRED has with regards to ENHR?

For Curaçao specifically, Essential National Health Research has helped us move forward on a number of levels. The first relates to our Curaçao Health Study. We were always concerned that policy was only ever developed on an ad-hoc basis, and more often than not, it was financially geared. So,

we decided to try and change this trend. We wanted policy to be based on research, hard facts, and real information.

First implemented in 1993-4, this population-based health survey provided both a comprehensive look at the level of access to health services, and helped answer a number of epidemiological questions we had about the island. What was most important was that we did not carry out this study for academic purposes - it was intended as a practical indicator for the purpose of influencing policy change. This was purely an exercise in getting research into action, so that we might see a measurable change in people's health, and access to health services. On this level, ENHR and COHRED provided practical examples from other countries and other regions where they had already been able to change the way that policy makers viewed research. This not only encouraged us, but also guided us to a number of useful strategies for bringing about that change.

The most important achievement was that, with the help of ENHR, and the support of COHRED, we were able to make that step from a once-off project, to taking this very successful health study to a point where it is now a process that will happen every 5 years.

COHRED's way of working has been undergoing a lot of evolution lately, particularly with the development of some clear messages about putting countries first, linking research to action for development, and working for equity in health. Where do you see this leading to 10 years from now?

I am concerned that whilst the whole idea of ENHR is about coordination, it is not really happening in the Caribbean. It's not anyone's fault - there are groups who are trying to foster regional collaboration, but the Caribbean is such a diverse group of countries, with many, many different cultures, languages, and ways of doing things, that coordination is not an easy task. How do you foster collaboration whilst preserving a country's uniqueness? Differences are inherent in the Caribbean - there is the English-speaking Caribbean, the French, the Spanish, and then the Dutch-speaking. How do you get these regions to collaborate? There will obviously be tensions.

In relation to the first COHRED message (put countries first) there has been some impetus for fostering inter-regional collaboration (bounded usually by culture). The Caribbean Health Research Council (CHRC) has been instrumental in leading that initiative. What concerns me about the Caribbean in particular is that amongst the push for collaboration, there must be room for a country to define its own priorities, not simply tack onto the agenda set by another, larger country in the region. I think it's important to recognise and embrace each individual country's unique situation - because even within the 5 islands of the Netherlands Antilles, every island has a very different health situation. I am not saying that there are no similarities, but there are always problems which are unique to that country which need to be dealt with effectively and efficiently, and this cannot be achieved by borrowing a research agenda from another country.

ENHR has not yet fully matured in the Caribbean. There is still a lot to be done, and I think we should ask ourselves why. Why hasn't anything been happening? When ENHR first came to the Caribbean, we knew about the recommendations from the 1990 Commission report. The most striking was the recommendation that *at least 2% of countries national budget for health should be directed to health research*. As far as I am aware, not one country in this region has ever achieved that, and Curaçao in particular has not achieved that. This then highlights another major problem that Curaçao in particular has, but also many of the other small islands, which is that we have a critical lack of capacity for undertaking research. At present, the human resources we do have available to us are badly overloaded with responsibilities. The time that anyone has to spend on health research is so limited, that it is almost impossible to get anything done. How do you divide your time between the practicalities of life, the tasks at hand, and the desperate need for health research which will shore-up the country's future? Because that is what health research is. A future. We literally can't find time to ensure the country's long-term future. It is a very frustrating situation to be in. We are desperate for a critical mass of researchers.

Do you think that the Commission's optimism about health research being a tool for achieving equity in health is still with us today, 10 years on?

Actually, I don't think so. At a meeting I attended recently someone said: *"we keep talking about equity, but it seems to me that there are more and more inequalities around. What does that mean for us?"*

And it is true. Look at the studies that are taking place. There are hundreds of them happening, all over the world, and they are all uncovering major inequalities. Particularly, and surprisingly, in *developed* countries - inequity is worsening rather than improving.

So, to me the idea of ENHR is great: good research, leads to good action, leads to good policy, but a breakdown has occurred

somewhere. We haven't been able to stimulate the imagination of the policy makers - in the sense that they are still not using our research to influence their policies. We seem to have failed at that critical stage. And again, this is partially exacerbated by our situation. On such a small island, with a limited amount of people, everybody knows the politicians. There is no distance between the two. And when there are immediate problems to be addressed, and long term problems that could start to be addressed by the politicians, of course they will go for the first option. They have a 4-year term in which to make some perceptible difference (in the eyes of the general voting population). What can they achieve in that time? It's pretty rare that you will find a politician who is willing to transcend his own political career - to look past the 4-year term - and see that putting money into health research will make a difference in the long term. Trying to convince them to see into the future, rather than focus on their careers is our job. We need to look at another way of making the results useable, so that they can see the inherent need/reason for research. Not only this, but there is also the problem (again) of capacity for doing research. Even if the politicians are convinced about what you are telling them, they want to see results. And you are the same people on this small island who are carrying out the research, analysing the results, translating those results into something the policy makers can use, and then, when they are finally convinced, they come back to you and say: "Well? What are you doing about it?" Or, "Go ahead and carry it out". With what though? We are so busy identifying research questions and carrying out the research, and undertaking our usual daily duties, who is going to have time to carry out the findings? We literally have no capacity to carry out the recommendations we ourselves made. It is a terrible bind to be in.

Despite these problems and concerns, ENHR as a strategy has certainly helped us move forward on a number of levels. It has provided us with an assurance that the emphasis we are placing on health research is correct, which in turn reassures our government.

References:

1. Murray CJ, Michaud CM, McKenna and Marks JS (1998) *US Patterns of Mortality by County and race: 1965-94*. CDC, Atlanta.

2. Lucas, A (1998) *Fulfilling the Promise of Health Research: A Two-Pronged Approach*. In, Research Into Action. The Newsletter of the Council on Health Research for Development, Issue 14, July-September, 1998. COHRED, Geneva.

3. The Ad Hoc Committee on Health Research Relating to Future Intervention Options (1996) Investing in Health Research and Development: Report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options. The World Health Organization (WHO), Geneva. (Document TDR/Gen/96.1)

Notices

New Publications from COHRED

For copies of any of these publications, please contact the COHRED secretariat.

Essential National Health Research in Bangladesh: An ENHR country monograph. COHRED Document 2000.1

Prepared by Md. Monjur Hossain, this document is another in the COHRED Country Monograph series. The monograph details the introduction of ENHR in Bangladesh, and provides an overview of the health status, and health research situation in the country. It reveals that the critical capacity of human resources for health research is one of the major impediments to the application of ENHR in Bangladesh. However, the creation of a positive environment for health research, based on a new generation of researchers, is underway. The researchers are actively being trained in the ENHR approach, and are showing their enthusiasm for the strategy.

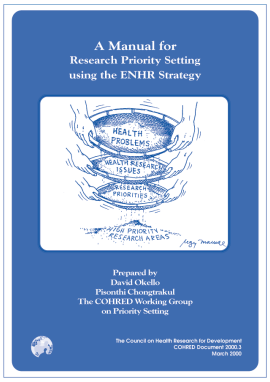
The following two publications are part of an effort by COHRED to document experiences and insights from - and for - countries implementing ENHR.

Health Research: Powerful Advocate for Health and Development, based on Equity COHRED Document 2000.2

Health research can be a powerful advocate for equity-based health and development. But left to market forces and curiosity alone, health research will tend to mirror the interests and health problems of the rich. Instead of helping to narrow the gap between rich and poor - it will simply widen disparities. This issues paper is intended to assist people within countries who advocate a different approach to health research - one that has as its central aim, the improvement of health, fostering development and reducing inequity. Through this publication, the *COHRED Working Group on building country competencies in*

Promotion, Advocacy and Mechanisms for ENHR has tried - in simple terms - to address some of the major debates and issues around the process of health research. The working group argues that health research needs clear leadership and direction if it is to really improve health.

A Manual for Research Priority Setting using the ENHR Strategy COHRED Document 2000.3



Prepared by Pisonthi Chongtrakul (Thailand), David Okello (Uganda) and the members of COHRED's Working Group on Priority Setting, this manual is a practical guide to one of the core competencies of the ENHR strategy, namely priority setting for research. The manual covers the following specific aspects of priority setting:

- Preparatory work by the team convening the priority setting exercise;
- Elements of priority setting;
- Criteria for priority setting;
- Follow-up activities after identifying broad priority areas;
- Implementation.

Throughout the manual the core principles of putting local/ country concerns first, working towards equity, and linking research to action are emphasised as a basis for priority setting.

Conferences:

INCLEN Global Meeting XVII

'Research Networks in the New Millennium: Developing Countries Contribution to Global Knowledge'
Bangkok, Thailand October 15-18, 2000
Organised by: Thai Clinical Epidemiology Network (Thai-CLEN)
In collaboration with: Southeast Asian Clinical Epidemiology Network (SEA-CLEN)
Supported by: International Clinical Epidemiology Network (INCLEN)

The meeting will review the contribution of research conducted by investigators in developing countries to the advancement of global knowledge; the value of research collaboration and research networks in solving health problems in developing countries and beyond; and the strategies for incorporation of research results into health care practice.

For more information contact:

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Deadline for submitting abstracts: June 1, 2000

Resources:

Global Health Council - Free 'Career Network'

The Global Health Council has just launched their new website. As part of the site, the GHC provides a free service called 'Career Network', which lists jobs in the broad area of health, as well as internship advertisements, volunteer positions for students, health professionals and concerned citizens who are looking for opportunities to participate in international health projects. The 'Career Network' site also includes links to other job banks.

http://www.globalhealth.org/jobs

Employers wishing to list positions available may post them directly onto the site at the same address.

Do you have an article or a story

from your country that would make interesting reading for the rest of the development community?

Here's your chance to have it aired in the international arena.

Send all contributions to:

The Editor, Research into Action, c/o COHRED Secretariat.

The Cochrane Collaboration Kenneth Warren Prize

Ken Warren was a larger-than-life man who was a source of encouragement and support for many young people, particularly those living in developing countries. He was very influential in drawing attention to the 'great neglected diseases', like schistosomiasis, which plague people in the poorer parts of the world. He was also one of the first people to draw attention to the potential offered by electronic media for assembling and disseminating the results of health research relevant to people in developing countries.

To celebrate his contributions, the Kenneth Warren Prize has been created. In the light of his interests both in diseases prevalent in poor countries and in electronic assembly and dissemination of health research, the Prize will be awarded annually for whichever systematic review, published electronically in *The Cochrane Database of Systematic Reviews* and authored by a national living in a developing country, is judged to be most relevant to health problems in the third world.

The Kenneth Warren Prize will be presented to the winner each year at the annual Cochrane Colloquium, beginning with the 8th Cochrane Colloquium, which will take place in Cape Town, South Africa, 25-29 October 2000. The criteria for selecting the winner, and the selection itself, will be made by a panel consisting of members drawn only from developing countries. The first panel is composed of Tessa Tan-Torres Edejer, as chair, currently at WHO's Global Programme on Evidence, Karla Soares-Weiser, currently UK Cochrane Center Visiting Fellow, and Patrice Machaba of the South African Cochrane Centre constitute the first panel.

The Kenneth Warren Prize will be awarded to the first or contact author of the winning review or update respectively. All reviews published in the April 2000 volume of the Cochrane Database will be eligible for consideration in the first round. In the subsequent rounds, all new reviews and updates for the year will be eligible for consideration. All eligible reviews will be passed through a quality screen and relevance will be judged primarily in terms of the potential impact on the burden of disease. The Prize will be awarded based on a consensus of the three panel members.

The Warren family has already pledged $5,000 annually, to cover the costs of successive winners attending Colloquia to receive their prizes. Other recurrent donations, as well as one-off donations made to mark Ken Warren's memory, will be gratefully received by the Cochrane Collaboration, which is registered as a charity in the UK (No: 1045921) Standing orders or other contributions should be made payable to:

The Cochrane Collaboration Kenneth Warren Prize

Account Number: 84254203, National Westminster Bank plc (Sort code 60-70-03),
21 High Street, Oxford OX1 4DD, UK.
If more detail is needed contact : tantorrest@who.ch

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RESEARCH INTO ACTION is issued complimentary upon request.

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