International Conference on Health Research for Development

Regional Consultative Process

Asia

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Asian Forum for Health Research

A Progress Report

"The type of essential research carried out in a country depends on its scientific stage of development…. An intervention technology might never be developed at all if left to market forces alone" …**Charas Suwanwela**

This is the Progress Report of the Asian Forum for Health Research, organized in Manila after a five month dialogue process aimed at nurturing collaboration among diverse stakeholders in Asia, who are committed to ensuring that research serves as a crucial element in building equity into health for development.

The sponsors of this dialogue are: COHRED, the Rockefeller Foundation, WHO/SEARO/WPRO, INCLEN Southeast Asia.

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Summary

The Asian region took an innovative approach to the consultative process for the International Conference, with the introduction of an electronic dialogue tool. Coordinated by the College of Public Health, Chulalongkorn University, the dialogue tool has witnessed the active participation of some 350 respondents, who have contributed to the consultation process to date. The Asian Forum was held in Manila on 17–19 February 2000 and addressed the main objectives of the consultations and the necessary follow-up action. The Forum attracted some 100 stakeholders from a variety of fields related to health and health research, and focused on three basic concepts of health research: a new paradigm, the architecture, and follow-up action needed. The action envisaged by the Forum fell into three categories: enhance leadership for innovative health research management; develop and disseminate tools and methodologies to get the job done; and use new information and communication technologies to integrate the process and content of health research into equity in health for development.

The new paradigm for health research was defined by the Forum as a set of assumptions that incorporate many of the previous ideas that dominated health research, but which also introduce newly emerging processes in health research, including an emphasis on vision and equity; consumer orientation; greater use of layman's language instead of technical jargon; and movement away from parochial to regional and global needs.

One of the major objectives of the Bangkok Conference is "the realization...of an action plan for health research for the coming decade, and the future architecture for health research co-operation." Regional analytical work is being encouraged to look at this aspect of health research. The Asian Forum developed a framework, around which the Asian regional architecture for health research co-operation can be considered. This included the recommendation that the architecture be considered at the global, regional, and national level. A set of recommendations were elaborated for each of the three levels.

At all levels, there are pitfalls, such as bureaucracy, centralized 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 brings with it a number of assets to the health research community, including clearer policy-making and priority-setting; capacity-building for research management and implementation; and setting generally acceptable norms and standards.

A number of specific lines of action were also identified in the areas of action for leadership, action tools and methodologies, tools that facilitate the translation of research into action, tools and methodologies for equity watch,

and action to implement new information and communication technologies.

The electronic dialogue tool, the so-called Distance Dialogue, provided a communications network, linking a large number of protagonists during the lead-up to the Forum. This dialogue has evolved into the *Asian Voice*. It has served to keep the people of the region abreast of developments leading up to the International Conference in October 2000 and beyond.

The Forum and the associated Distance Dialogue focused on the basic health issues in the region, namely population structure, migration and control; control of infectious diseases; policy responses to globalization; behaviourial and cultural responses to a changing paradigm; and approach to non-communicable diseases.

The results of the Asian Consultative Process will be used as Asia's input to the Global Synthesis Meeting in July, to the International Conference on Health Research for Development in October.

1 The Asian Forum for Health Research

1.1 The objectives

The primary aims of the Forum were:

- To develop an *Asian Voice*, based on the integration of knowledge and processes, plus leadership, with the appropriate use of new information and communication technology for capturing, generating, validating and using research to support equity in health for development
- To capture significant ideas from the various sessions and organize them under the major categories of the Forum
- To help people reflect on useful follow-up action and focus further on the crucial ideas and recommendations that the Forum groups want to propose as in the *Asian Voice*
- To stimulate additional specific initiatives, which would be seen as helpful follow-up to the Forum
- To inspire people to reaffirm their commitment to the on-going dialogue and the creation of a perceptive *Asian Voice* on health research.

One of the overriding issues is what it would mean to have a new kind of management system, using technology to improve research management for equity in health and development. The approach must attempt to strike a balance between the need to focus and at the same time to be flexible and to maintain an Asian uniqueness and solidarity, while respecting Asian diversity.

1.2 Background

The Forum reviewed the status of health research in Asia and suggested actions to be fed into the International Conference on Health Research for Development. The review was timely, since the year 2000 is witnessing various efforts to support research 10 years after the report of the Commission on Health Research for Development, 22 years after the Alma-Ata Declaration, 10 years after the World Health Assembly's technical discussion of health research, and 4 years after the Ad Hoc Committee recommended the establishment of the Global Forum for Health Research. An important outcome of the International Conference will be the development of a guiding principle for health research. The Alma-Ata Declaration came up with Health for All (HFA) as the guiding principle. ENHR is one of the basic principles for world health research resulting from the Commission's Report. What will we have as the guiding principle for the world after the International Conference 2000 that will have an important impact on research towards equity in health for development?

1.2.1 Preparations to capture the *Asian Voice*

Prior to the Forum, key scientists of the region got together in a consultation, with the support of WHO SEARO, WPRO, INCLEN Southeast Asia, ENHR country focal points, and the Federation for Social Sciences network. The Dialogue was designed to be highly interactive, giving immediate responses to questions and answers, and entertaining diverse viewpoints. The Marketplace and the Technology Centre were designed to demonstrate the possibilities of interaction in an informal way, using both traditional and electronic media. The results of the meeting were technology-based, accessible via websites and printed materials.

The process has been educational for many involved in preparing and participating in the Dialogue and the Forum in terms of collaboration to accomplish specific tasks. The method is believed to have been instrumental in maintaining collaboration between Asian stakeholders on specific issues, and will continue well beyond the 2000 Conference, since the sense of ownership of the *Asian Voice*, as well as the process of collaboration, has proved to be both possible and challenging.

Basic researchers and various types of medical and health scientists, NGOs, policy makers, private enterprises and donors all participated in the Dialogue process, as well as the Forum. The selection of members for the Dialogue, as well as the Forum, was done in an inclusive manner by asking people to suggest more names. Several contacts were made to connect with policy-makers, the National Institute of Health, the Biomedical Institutes and researchers. Mailing lists were also obtained from scientific societies in the Asian countries, since many have direct links with researchers.

1.3 Vision

The vision of the Forum was to serve as a powerful vehicle for inspiring collaborative efforts to identify, document and apply innovative Asian responses to the challenge of ensuring that research serves as a crucial element in building equity in health for development.

1.4 Mission

The Forum is intended to serve as an innovative Open University-type gathering, which inspires people to collaborate in creating, collecting, organizing, and sharing ideas, research findings, contacts, best practices, pilot projects and practical support tools to improve the performance of groups committed to the vision.

1.5 The assumptions

The assumptions on which the Forum was convened can be grouped into six categories. They are:

- Asia wants its voice to echo loud and clear:
  - The Manila Meeting was to collate Asian input to the International Conference and beyond
  - A five-month Challenge Dialogue Process documented important inputs for discussions in the face-to-face meeting in Manila, with a post-Manila Dialogue leading up to the Bangkok Conference in October.
- A new type of regional meeting will be required to capture the ideas and ideals of health research in Asia:
  - The Planning Committee decided that only a meeting that was highly innovative, different, inspiring, collaborative, and which allowed participants to make quick quality team decisions would be conducive to further dialogue
  - The participants in the Manila Meeting were prepared to adopt "out-of-the-box" thinking, take risks, suspend judgement for a period of time and enthusiastically try new approaches.
- The knowledge-based economy and its implications will influence how Asia approaches health research for equity in health for development:
  - Globalization comes with the new knowledge-based economy that is global, fast-changing and highly competitive
  - The impact of the new economy is being felt by organizations, including those in the health sector
  - This competition can affect equity too: we are committed to research towards greater equity in health.
- Asia will need to think about new leaders or the re-orientation of existing leaders:
  - Innovative health and research leaders are required
  - New leaders will need to have thinking skills based on knowledge; doing skills based on the ability to implement; and being skills based on a set of values.
- New thinking, tools and ethics are crucial for research towards equity in health for development:
  - New thinking, tools and ethics for research are needed to drive the concept of equity in health

- We need to clarify our historical assumptions about thinking, tools, and ethics of research in promoting equity in order to determine what shifts might be useful.

• New functions and architecture are needed for new collaboration to make health research as productive as possible in promoting equity:

- New collaboration (or based on new functions) among diverse stakeholders concerned with issues about equity in health for development is no longer just a “nice idea”. It is a crucial aspect of improved performance.

1.6 The organizational process of the Forum

1.6.1 The “challenge dialogue” process

This process was developed and applied as the organizing framework for the Asian Regional Health Research Dialogue. It is an approach that can be used to help people to learn to work well together. It is a framework and a set of activities that can be used to:

• Help diverse stakeholders collaborate in accomplishing a complex task in an effective manner

• Help workshop organizers create an innovative, interactive meeting, in which diverse stakeholders are challenged and assisted to explore collaborative approaches in dealing with a complex topic.

1.6.2 Key steps in the challenge dialogue process

• Determine the strategic intentions of the group: What is their key challenge? What do they want to accomplish?

• Set the scene for collaboration

• Select a documentation vehicle

• Use the alignment process for teaching groups to make quick, quality team decisions

• Identify options, examine consequences, set priorities

• Imagine innovative approaches for implementing the priority option

• Take concrete action to implement the priority option

• Determine the “measures that matter” and select, track and utilize key performance indicators

• Sustain collaboration.

Not all the steps necessarily have to be used in every situation, nor do they have to be followed in this sequence. But these steps, if followed with some discipline and creative use of supporting tools, can lead a group to discover "the magic within", and allow them to achieve significant goals through collaboration.

1.6.3 Key conceptual ideas driving the process

These entail recognizing and developing the ability to:

- Practise leadership innovation, which involves knowledge in action, to make a difference in performance
- Nurture imagination as the foundation of innovation
- Help groups of people collaborate and make quick, quality team decisions
- Spread the concept of strategic thinking, as opposed to the old classical mode of strategic planning, throughout the organization and help everyone function as if they owned the organization
- Function as a systems thinker and view tasks and problems in a holistic, integrated manner
- Nurture trust among people
- Practise out-of-the-box thinking
- Understand the new challenges of knowledge management and the manner in which appropriate information and communication technology can assist in knowledge management in support of high performance.

1.6.4 Using the challenge dialogue process to focus on the issues of research for equity in health for development

The process encompasses the following precepts:

- Knowledge and good information are key to appropriate decisions. For the first time in history, it really matters whether people search, access, process, and share and make decisions based on good information and knowledge
- Globalization of the world economy creates a context that amplifies the impact of all efforts, including those of research towards equity in health for development. The availability of knowledge and information on a global scale means that the old standards of inward looking towards a single organization are no longer adequate
- The horizon for globalization can no longer be limited to particular cultures or nations. Rather, the framework for all decisions and actions must be global in scope, cutting across boundaries of time, space, cultures and nations

- The process, based on trust, can create a sense of ownership in all involved, because all will have an opportunity to voice their ideas and others will be attentive to their ideas
- The dialogue process didl not end when the Asian meeting ended. Rather, we hope to involve the Asian groups in a long-term relationship in promoting research and information-sharing towards equality in health for development
- In the dialogue process, the ideas of participants are highly valued and will be incorporated in the *Asian Voice*
- The dialogue process will help to develop a clear set of objectives and directions of efforts reflecting the views of the participants
- The process will enable the group to capitalize on the strengths and experiences of a wide spectrum of stakeholders in Asia
- The process will help highlight ideas about ways of improving the next steps.

1.7 Description of the basic organizing process of the "Open University" –type Forum

The Forum was organized as if it were a three-day session of an "Open University of Research for Equity in Health Development". The concept allows us to deal more easily with diversity and interaction among the participants. The Open University concept was being used in order to provide an opportunity:

- For the stakeholders (society of learners, decision-makers, the community and others) to freely participate in the thematic debates resulting from the dialogue over the previous several months. This led to a degree of consensus on the important health equity for development issues or the Asia Voice related to each of the themes
- To discuss the availability, usefulness and limitations of existing tools in helping to address the themes
- For researchers, decision-makers, the community and others to define the functions and mechanisms which will use health research as tools in moving society towards equity in health for development
- To offer leadership development workshops that provide training in specific leadership skills supported by tools
- To modify and adopt a declaration on health research towards equity in health for development.

This “Open University” concept also provided the opportunity to be flexible and innovative.

The Forum provided several different ways of treating key topics, as follows:

- Major presentations by keynote speakers
- Leadership workshops
- Table group and collaborative group discussion
- Marketplace
- Forum resource centre.

1.7.1 Major presentations

The major presentations described why, despite recent gains in health development, the world still has a long way to go to achieve equity in health for development. The population of Asia is on the increase. Communicable diseases now exist in a new context and non-communicable diseases and diseases related to social interaction are imposing new constraints on equity. New and emerging diseases are threatening mankind, particularly the underprivileged. Economic prosperity has been followed by economic crisis. Despite new advances in knowledge, science and technology, health inequities between rich and poor nations widen within and between countries, affecting progress in development. Therefore, the world needs a new conceptualization of health research to empower countries; new ways and architecture to enhance international cooperation; new tools and methodologies; and a new look at ethical issues. The assumption is that this new conceptualization, new co-operation, new tools and methodologies and new ethical standards will allow actors to better cope with these challenges, and to promote equity in health for development together. New cooperation among international donors, multilateral and bilateral organisations, in the light of the changing paradigm, will be highlighted.

The presenters were key international personalities with vast experience. All of them come from developing countries in Asia, but have gained international recognition. They are people who do not think within a particular discipline but rather in the research system as a whole. They have shared their experiences in many aspects of research towards equity in health for development (organizational, administrative, technical and procedural). They have shown how to bring government, non-governmental, national and international agencies in line with the corresponding changes in other sectors of the country and the global community, and with developments in research in other countries.

The speakers were given a guideline to what was expected of their session, namely:

- Make a 5-15 minute presentation, structured so as to:
  - Highlight the key challenge or issues
  - Give a brief background of the ideas that led to this challenge
  - Refer to one or two exciting examples of breakthrough innovations already underway or being considered
  - Assign to the group questions for participants to consider in discussing the issues.

The presenters were expected to see themselves as catalysts to stimulate dialogue and focus responses from the participants. As there were many experts in the audiences with possibly different views, the presenters were asked to try to stimulate expressions of these views. The way in which presentations were made greatly influenced the tone of the meeting.

- Invite participants (to be gathered in table groups) to discuss and react to the ideas presented (25 minutes)
- Request participants to summarize their reactions quickly on the flipchart shared with the larger group (2 or 3 key bullets). The flip chart summaries from each table represent the first products of the Forum
- Encourage feedback from the table group (some, not necessarily all, of the table)
- Give a few reactions to the feedback (5 minutes). The total time for the session was 35 - 45 minutes.

1.7.2 Leadership workshops

Two sessions were held with an assignment in between. Thirty people signed up for both sessions. A “leadership action” working group was formed to make comments about what worked well, and what could have been improved. A facilitator group was formed on the spot on the first day and, despite the short notice, they each did very well. The degree of interest, energy and dedication by participants to the tasks they were given, was beyond expectation.

1.7.3 Collaborative team action

The purpose of the collaborative team was not to collaborate people, but rather to integrate ideas about how to solve a problem in a way that will result in equity in health for development. If we want to be integrated in the reality of the changing paradigm, we have to deal with the political reality, human reality, technical reality and resource reality, along with knowledge reality. This can be the expectation or the stretched goal of the dialogue.

Participants were asked to choose to be a member of one of the collaborative teams examining different aspects of public health problems of importance to Asia. The themes for each of the teams were summarized from the five months on-line dialogue on email before the meeting. The subjects were the expressed concerns of the on-line participants, as follows:

- Population, migration and control
- Control of infectious diseases
- Policy responses to globalization
- Cultural responses to the changing paradigm
- Non-communicable diseases.

The teams were instructed not to get too involved in the technical aspects of the subject matter. In the scientific community, as opposed to the political community, technical content of research is usually discussed, while the political people talk about the processes, through which decisions will be made to promote political objectives. The Asian workshop tried to bridge the two communities.

The groups were set specific questions pertaining to the problems and issues at hand. In particular, these questions were:

- What is the status of the problems with respect to equity? What has research contributed so far to solving them?
- Is the new conceptualization of research, which links the problems with utilization, appropriate for changing the status of the problems of equity?
- What aspects may be redundant? What aspects may be missing? How can we make it operational?
- What are the new functions of the health research system? What architectures at the local, regional and global level do we need? How can we make it operational?
- Are the tools and methodology appropriate? What tool is redundant? What tools are missing? How can the tools be developed and applied?
- Are the ethical principles presented appropriate? What is redundant? What is missing? How can these principles be further developed and applied?

The teams' ideas about the changing nature or paradigm affecting public health problems and the role of research, as well as the architecture, structures, functions and the ethics of research and international cooperation were then incorporated into the *Asian Voice*. The summaries, which appear in section 3 of this progress report, have tried to capture the ideas of team members on how to use the new conceptualization of research and develop new architecture to deal with equity in health for development.

1.7.4 Marketplace

The market is where participants buy and sell research products, proposals and ideas, and where donors can display their areas of funding and terms of reference. There was also a corner where people shared information on the existing health research profile of their respective countries. Government Health Ministries, medical schools, Colleges of Public Health also had a chance to display their activities, so too did groups such as COHRED, INCLEN, and WHO. The Marketplace was prepared to receive all participants in an informal, interactive environment. There were opportunities for several activities in the market place such as:

- Information and resource centre
- Enabling technology centre
- Open space for speakers corner.

The Information and Resource Centre was the best place to find answers to questions, such as when and where each session took place; what collaborative team people were in and where it was meeting; how to get in touch with someone with specific experience; how to get the printed notes of the presentations made. The Enabling Technology Centre was a place where participants had a better chance to understand how to use appropriate technologies (ICTs) to support the work of their organization.

2 The SHARED approach to development

The SHARED approach pursues a vision of providing the developing world with a democratizing force by equipping it with state-of-the-art technology for database-driven communications. The SHARED approach seeks solutions through a gradually increasing connectivity through a growing network of "knowledge nodes" in developing countries. The nodes also serve their less connected colleagues in the country through communication channels that are suitable for their situation.

Many of the participants in this workshop will have a chance to attend the International Conference on Health Research in October 2000. Their efforts and deliberations in this regional dialogue and workshop will be fed into the Bangkok Conference. Those who contribute to the Forum and post-Forum dialogue will be able to share their experiences at the global meeting.

2.1 Leadership for making extraordinary things happen

This innovative Challenge Dialogue was intended to help participants sharpen their thinking skills, clarify their knowledge, improve their implementation ability and find the courage to attempt to make extraordinary things happen in the application of research towards equity in health for development.

Jame Kouzes and Barry Posner, in a fascinating book *The Leadership Challenge,* describe their perception of what it takes for high performance individuals to keep extraordinary things happening in organisations. Table 1 summarizes their thinking.

The goal of the Asian Regional Challenge Dialogue on Research towards Health Equity was to make extraordinary things happen. The Dialogue was guided by the five practices listed in Table 1. The goal is to stretch our minds, have fun and take actions that will make a difference to people's lives.

Table 1

Practices	Commitments
Challenging the process	Search out challenging opportunities for change, growth, innovation, and improvemrnt. Experiment, take risks, and learn from the accompanying mistakes.
Inspiring a shared vision	Envision an uplifting and ennobling future.
Enabling others to act	Foster collaboration by promoting cooperative goals and building trust. Strengthen people by giving power away, proving choice, developing competence, assigning crucial tasks, and offering visible support.
Modelling the way	Set the example by behaving in ways that are consistent with shared values. Achieve small wins that promote consistent progress and build commitment.
Encouraging the heart	Recognize individual contributions to the success of every project. Celebrate team accomplishments regularly.

2.2 The paradigm shift

The new paradigm, which is defined as scheme or pattern of things, subsumes many of the older assumptions that have dominated health research. The elements of this new paradigm address key processes that are now emerging as the defining characteristics of a health research framework. These are as follows:

- An emphasis on vision and equity driving research as “keenness of understanding depends on the keenness of vision”
- An emerging consumer orientation with the consumer steering rather than rowing; increasing focus on practice-based prerogatives for guiding research;
- Use of rewards and incentives to promote local use of locally generated information; increasing emphasis on process and interaction between protagonist vis-à-vis outputs and impacts

- Strengthening the ownership of knowledge generated by those that are the source of that knowledge rather than those that elicit samples and analyze the knowledge
- Moving towards a protagonist for development orientation instead of a donor-beneficiary one
- Increasing the use of a lay language in the dissemination and diffusion of information to supplement the technical (jargon) language when dealing with people and policy-makers
- Basing the research agenda increasingly on the respondent, natural or community, rather than the sponsors priorities and concerns
- Moving away from parochial properties to regional and universal ones
- Employing a consultative agenda-setting process, as distinct from submitting to a donor/sponsor/specialist imposed agenda.

The purpose of the new paradigm of research for equity in health for development is to develop a process that deals effectively and positively with an increase in the interdependencies of nations, people and regions. These interdependencies have resulted from the spread of democracy, the dominance of market force, the development of a worldwide market, the transformation of production, technological changes and media revolution. These changes affect legal and illegal cross-border movement, poverty of some sectors, economic prosperity of others, environmental pollution, and international travels with implications for health. International regulations, rules, code of conduct and legal systems are needed to oversee the harmony between nations and protect human rights, environment and acceptable living standards of the people from all walks of life. Nations are calling for political change in the North and the South. Issues like democratic empowerment, local control, environmental sustainability, economic and gender equity, cultural autonomy for diverse people, human rights, strengthening of civil society are being evoked for discussion and action.

The motive for these changes is not the quest for a single identity for all peoples and nations. Rather it seeks cultural identity, harmonization of living standards, rights and environmental protection. It demands that the rules and practices of research systems contribute to increasing equity between nations and regions of the world. The key to research responses to the changing paradigm is that actions can start without having to wait for theoretical clarity. Responses can be an evolving process and more and more clarification takes place after reflection on action in favour of adopting rules and practices to increase equity in health for development, both within and between nations.

2.3 Functions and architecture

With a paradigm shift towards research for equity in health, more cooperation will be needed between national, regional, and global institutions. The architecture for more cooperation can be a range of structures, support systems and networks. Therefore, each country can re-orient existing structures, support systems and networks or develop new architecture to support research for equity in health under the new paradigm. The nature and extent of the evolved architecture will be specific to each country.

There are many operating principles for an effective architecture at the national level. These include a political commitment to support equity; capacity to set research priorities and direct research policies; capacity to identify and mobilize private and public institutions, researchers, and the community for effective networking and partnership; willingness to support decentralized autonomy, with central and multi-sectoral cooperation; willingness to be inclusive and interactive; responsiveness and relevance to needs; collaborative spirit and receptiveness to feedback, including accountability and transparency. In this respect, a transparent national work plan should be developed in consultation with national researchers and other stakeholders. The ability to retain and support qualified manpower must be an important component of the work plan.

At the regional level, a clear mission statement and vision, political commitment, supportive organizational structure, work plan, regional agenda setting, resource mobilization and allocation according to regional priorities, a regional clearing house of institutions and researchers for networking, interaction, collective leadership, and operation in support of national work plans are all necessary.

The global level can enhance support for equity by responding to needs of developing countries that act as a balance to the current emphasis on research that solves health problems in developed countries. In addition, the global architecture must include strategies to empower national research communities in the developing countries, with explicit and clear processes of work accessible to all.

The architectures at all levels should avoid bureaucracy, centralized decisions, prescriptive or donor domination, exclusivity, restrictive networks that lead to isolation and in- breeding, artificial boundaries, collaboration without technology transfer, excessive profit or market-driven, close operation and over-reliance on high technology. The creation of new institutions or structures to coordinate existing institutions should be avoided unless a significant effort to refocus existing mechanisms is ineffective.

Missions and plans at all levels must be subjected to periodic self and independent evaluation, including periodic reviews of the interactions between different levels in support of the status of health research in countries.

A range of functions is considered important in an evolving architecture. These include policy making and priority setting; development of capacities

to implement and manage research, resource mobilization and allocation based on research priorities; promotion and advocacy of a research environment; dissemination and utilization of research results; setting norms and standards; partnership and international cooperation.

This information technology can be optimally capitalized to foster the new collaborative effort. There may be several components to consider. Firstly, the government and local agencies can initially develop the basic infrastructure for communication. Secondly, the collaborative network has to produce high quality content to put in the infrastructure. Finally, the marketplace will be able to invest in areas, activities and quality products that will show a profit. Over the coming years, it is expected that the marketplace can play a major role in the new architecture, because the utilization of high quality products increases based on the basic infrastructure. The organization and infrastructure should not attempt to become the neutral global super-body for health research coordination. Rather, the collaboration that focuses on the ideals of equity in health for development between developed and developing countries, using the new technology to initiate and report on real content and different processes, by which people collaborate. The potential of the evolving information and communication technology in this new architecture needs to be further explored. The group suggested that a website be created and that the summary of the meeting, related ideas and documents be made available. This is not only a new way of doing the same thing but, with sufficient effort, it will produce a different product and help identify the barriers of coordination.

2.4 Development and refinement of tools and methodology

2.4.1 Global burden of disease

The best known indicator for measuring the global burden of disease is the Disability Adjusted Life Year (DALY). However, it is important and advantageous to recognize the burden of disease as a generic field, with a full spectrum of indicators that can be used to estimate the burden. It can be mortality or morbidity and some other sets of indicators such as the HeaLY and DALES. The various sets of indicators need data, which are required to develop the estimate of the burden of diseases. The data can be very demanding and the question is whether the information is available, and if not, can the burden of disease or other proxy indicators still be estimated, or should another search to estimate the Global Burden of Diseases be undertaken. Each of these methods for estimating the burden of diseases has a scientific basis behind its calculation, and a knowledge about the assumption is crucial in order to understand the utility of the measures of the global burden of diseases. The more complex the indicators are, the more demanding will be the information need.

Most of the indicators for measuring the global burden of diseases combine the morbidity and the mortality factors into a single number, based on some rational. The rational is to change the information into a single unit to compare diseases. The mortality effect and the morbidity effect will then be combined. The one-dimensional measure most commonly selected has been time. The time loss on the basis of mortality and that of morbidity can be compared to come to certain decisions. Once the burden of diseases can be compared between diseases, some rationalization of the value of investment can be undertaken. For example, what kind of investment will be needed to bring about a reduction of the burden of disease or what impact investment in health is having on the reduction of the burden of disease, when different interventions are applied.

The combination of morbidity and mortality into a one-dimensional unit has been traced back 40 years. This was highlighted by the World Development Report in 1993. The publication in 1996 of the Global Burden of Disease represents the sixth version of that particular data set. After the publication of those books, there has been remarkable global interest in the measurement of burden of disease, in both the technical and ethical fields with respect to the value of choices associated with the assumption used in the measurements. These started to appear in national literatures. Now more than 40 national studies have been completed. Several others are being planned. The Global Burden of Diseases for the year 2000 is also being done. Disability Adjusted Life Years (DALYs) and Disability Adjusted Life Expectancy (DALE) are going to be a part of the global routine estimate and reporting. The International Burden of Disease Network (IBDN) has been established with the intent of allowing capacity development in countries. The network has an office and secretariat in the United Kingdom, with 45 developing countries as its members. The network allows the use of the indicators and shares experiences between countries for their refinement. Many of the DALY studies have now gone to district level analysis.

There are additional advances in the refinement of the Global Burden of Diseases. WHO is prepared to support the work in countries and help them implement the study at the national and the sub-national levels. These movements represent a challenge as well as an opportunity. The main challenge is to develop capacity in countries and make the best use of the instrument for making decisions. The second challenge is the availability of information to estimate the burden of disease. How can the research community advance our collection of data that would actually feed the development and improvement of methodology?

The Global Burden of Diseases can be projected, but it would require further assumptions. It can be used in several ways, such as:

- Systems evaluation
- Priority setting to identify mismatch between priority problems and resource allocation

- Evaluation of the effect of intervention and the cost-effectiveness of intervention
- End point for equity study.

In evaluating a health care system, the tools can estimate the mismatch between the health problems and reform efforts. More tools, such as the measures of equity, need to be explored. Ideally, measurement should be able to distinguish between inequity and inequality. Some of the inequity or inequalities can be avoided; others cannot. Some inequities are harmful to health, while others are not. The task of decision makers is to tackle inequities, which are avoidable and are harmful to health. Therefore, good equity measures can help policy makers and researchers discover the effectiveness of policy options and interventions, as well as the effectiveness of research.

2.4.2 Priority Setting

Ten years ago, the Commission on Health Research for Development urged countries to undertake essential national health research (ENHR) in order to correct imbalances in global health and development. In 1992, estimated resources for research on health problems of developing countries amounted to only 4.4% of global R&D investment, a marked contrast to the fact that almost 90% of the global disease burden in 1990 was in developing countries. Over the past decade, various strategies to increase the research resources for developing country problems have been attempted by international health bodies and agencies. Yet the latest estimates, according to the Global Forum for Health Research, still stand at an unhealthy disequilibrium “10/90”. These constraints underscore the continuing need to focus on priorities in order to optimise health benefits and the impact of scarce research resources.

Many models have been used to set priorities for health resource allocation, some of which have been applied to research priority setting. These approaches range from qualitative methods of consensus building to the use of quantitative formulations and prioritization matrices. In recent years, composite indicators have gained prominence in the research priority-setting process because these single measures lend themselves to comparisons across a broad range of diseases and are particularly attractive for cost-benefit analysis of interventions. For example, the Disability Adjusted Life Year (DALY), a single measure of the disability, premature mortality and relative values of life at given ages, has been used to assess the global and regional burden of disease. More recently, another formulation, Healthy Life Years (HEALY), has been proposed to similarly reflect disability and premature mortality, but with improved valuations of the stream of life lost due to disability or death, based on the natural history of the disease, and with discounting calculated separately.

Although useful in advancing methods for rational resource allocation, the extended discussions on burden of disease measures have sidelined other important issues in research priority setting. These include the question of

who sets priorities and how. What criteria are used to guide prioritization? These questions become all the more important in the light of the continuing observation that priorities for international health research have seldom been developed with the active participation of developing country research leaders.

Priority setting exercises based on ENHR approaches have been attempted in several developing countries, among them Benin, the Commonwealth Caribbean countries, Guinea, Kenya, Nicaragua, the Philippines, South Africa and Thailand. General research priority areas have been identified and acted upon by some countries.

A framework for priority setting is presented to define the overall approach. Steps and methods that countries can use to bring stakeholders together and to set priorities for health research were also suggested. These processes of self-determination can pave the way for a stronger developing country voice in priority setting at the international level and for increasing the allocation of research resources to the problems of developing countries.

2.4.3 Resource flows

Policy makers control resources and allocate them, based on programme and budget systems. The processes of fund allocation for research differ between national and international agencies. Researchers, on the other hand, work within disciplines and subjects of interest with, at times, tightly controlled parameters. Thus, there is evidence of a mismatch between the frame of reference of donors, governments and researchers. In addition, the classification of resources used is often not based on the value of equity in health for development. Some common language and methods are needed to harmonize the viewpoints of stakeholders and to support the guiding principles based on equity in health for development.

The key challenges are to identify sources and uses of health research and development funds, to estimate the amount and nature of health research and development and to assess whether there is a match between health research expenditure and health research priorities. The methodological issues include the identification of the universe of donors, users and operative funds; the consensus on definitions and classifications; the estimate of under-reporting, over-reporting, and double counting; and the strategies to achieve a consistent monitoring over the years. Many countries have not known about resource flow methodologies. Some have undertaken resource flow studies for development measurement techniques. All felt that the methods can be useful, but none have used them on a routine basis.

Resource flows should be more than tracking funding sources and expenditure for research. The source of resources should include human resources and infrastructures. How to set up an inventory of resources, that includes funding as well as human resources and infrastructure for health research, will be important. The financial department will be an important actor in gathering information about financial resources. How do you set up

a system to best match researchers with donor agencies? The resource flow study group should work on developing strategies and methodologies to monitor resource flow for research and its impact on equity in health for development at the country level. Some simple accounting method might be used as an alternative to sophisticated techniques. There is currently no overriding clearing house to monitor resource flows, although some attempt has been made to collect data on funding for research. These are not systematically done and there is no feedback system about the usefulness of the effort. This is partly due to the fear by authorities of being controlled, and has, thus, lead to a loss of transparency.

Many countries, such as Pakistan, Indonesia and Bangladesh, do not know the methodology of resource flow. Thailand, the Philippines and Korea have had some experience with the techniques. Indonesia is on the verge of implementing the study. Korea is tracking resources from the government budget. All countries think that tracking of resource flows is strongly needed and should be supported, starting with model development and later institutionalized for the health sector.

Rather than having a snapshot of the situation, it is desirable to have a systematized mechanism to capture the resource flow over time and look at the determinants of resources for research. There must be much more input from the countries and many more country studies.

2.4.4 Equity

The key hypothesis of the Commission Report is to suggest that health research, both at the global and country levels, is an essential link to equity in development. The Task Force on ENHR has developed strategies, which countries might use to promote research within countries that would allow selections and implementation of cost-effective interventions for the promotion of equity in health that are acceptable to the unique culture and the affordability of health systems within countries. It is important to see how far the world has gone in achieving equity in development, equity in health status, equity of access to health care, and change in lifestyle ten years after the Commission Report. Furthermore, it is important to know whether the degree of achievement in equity differs between countries that are active and inactive in implementing ENHR strategies.

The definition of equity varies, depending on what aspects of equity are considered. We will examine equity in health, equity in access to health care, equity in some non-health sector indicator, such as literacy rate, equity in some lifestyle indicators, and equality in the human development index. A narrow and practical definition of equity is the equality in access to health care between income classes, races, sex or regions, implying also that equality in access will result in equality in health status between these population groups. Access to health care can be estimated by a set of indicators of health systems, such as the coverage of immunization, antenatal

care and safe delivery. Other indicators include the health expenditure and finances between different population groups, the distribution of health care facilities and human resource for health between various population groups,

However, since it was shown that health services contributed only one quarter of the population's health status, other factors must also be considered in assessing equity, the so-called "non-health sectors inputs" to health. These non-health sectors inputs include population, urban rural distribution, literacy rate, education, income and housing and sanitation.

Unhealthy lifestyles have become a prevalent challenge to public health intervention. Whether these lifestyles differ in the population subgroups deserves to be investigated, since these unhealthy lifestyles are amenable to prevention through the commitment of the state and other stakeholders. The tracer conditions used for the study of these lifestyles include regular smoking, alcohol use, the prevalence of HIVs, the prevalence of prostitutes and other commercial sex workers, and the prevalence of men with multiple sex partners.

There are trade-offs between achieving equity and compromising efficiency, quality and affordability (as a proxy of sustainability) of care. It is therefore important to develop indicators for efficiency and affordability. The indicators for quality will require information on structures, processes and the outcome of health facilities that are unlikely to be readily available. Therefore, in the present study, quality will be addressed using the clients' perspective: i.e. the perception of technical capacity of various facilities, the average waiting time, and the ability to choose health practitioners.

Finally, to empower countries to develop action to reduce inequity in health, it is important to identify whether the current research is addressing equity, either directly or indirectly, and whether countries have research competence and commitment to address the issues related to inequity in health.

An international study on equity was supported by the Council on Health Research for Development in five Asian countries: the Philippines, Thailand, Malaysia, Bangladesh and Indonesia. The objectives of the equity study are:

- To study the change in equity of access to health care, health status, some non-health indicators, and lifestyles between population groups at two points in time;
- To compare equity between countries with particular focus on the levels of development and the duration of adoption of ENHR strategies
- To study the change in efficiency of achieving health status, as defined by the relationship of health expenditures and mortality and life expectancy among various population subgroups

- To study and compare the changes in efficiency, affordability, quality and sustainability of the health care system between various Asian countries
- To identify to what extent the current research is addressing equity, either directly or indirectly
- To identify competence and commitment for information and research for addressing the issues related to inequity in health within or outside the responsible agencies.

Five countries were involved in the study and finalized the data to be collected. Each country started data collection from existing information within the country. The country study was finished by the end of August 1999. The Indonesian experience was presented at the Forum. The study gave rise to many conclusions. Firstly, the health status in Indonesia varied among the provinces, indicating that the inequities still occurred, despite a general improvement of health status. One big methodological problem is the lack of the data and capability of local staff to collect information on health status and access to health services. It is very important to consider not only the need met (the user of the health facilities) in comparing access among the provinces, but also the unmet need (those who cannot afford or never reach modern facilities due to many factors such as education or infrastructures). Secondly, the availability of resources tends to increase, but still does not relate to the need. Provinces, which are poorer and have a greater need (lower health status) as well, do not receive more resources/subsidies. Thirdly, the resource allocation does not correspond to the capability of the region. The richer areas still received as much subsidy as poor areas. Furthermore, the demand for health services in the richer area tended to be private and modern facilities, suggesting that subsidies that go to public facilities would be better reallocated to other poorer areas. Fourthly, equity could be viewed as a continuum, where the goal is equity of outcome (health status, quality of life). Proximate determinants are behaviour of the population, sanitation and water, living conditions, health seeking behaviour, and availability of resources. And, to deal with efforts of reducing inequities, some background variables should be examined, such as socio-economic status. In Indonesia, we realize that the socio-culture varies from area to area, and to reduce inequities this should be carefully considered in planning interventions.

Measurements of avoidable inequities will allow decision makers to compare a match or mismatch between the inequities and reform efforts. Good measures of equity need to be explored to help decision makers define the effectiveness of interventions, as well as the effectiveness of research.

2.4.5 Research into action

Effective research can lead to action when researchers re-direct their focus from publications and career promotion to translation of findings into action. The key factors for translating research into action include:

- Ownership of the relevant questions
- Re-orientation of research and research institutions from the ivory-tower mentality to making research products accessible to potential users
- Research products should be identified both in terms of publications and in terms of translation into action
- Research proposal should be accompanied by a good plan for dissemination of research results.

Capacity building for translating research into action must involve both users and producers of research. The user must have skills to search for essential research and seek appropriate interpretation of results. Producers must be attentive to the potential users when undertaking research and disseminating the findings. Community participation in research can improve the capacity of the researchers, the users and the community to demand and use research. Strategic networking and coalition can improve the production, dissemination and use of research for decision making. Most of the tools presented were known, but not regularly used by the participants in the meetings. The tools are needed. The tools can help highlight the need for basic information to compile the indicators. International cooperation can assist in clarifying assumptions, providing training, and disseminating the results for decision making, both at national and sub-national levels.

2.5 Ethics in international collaboration and utilization of research results

The ethical issues in conducting research in general include priority setting, resource allocation (which is also about value choices, including how much people in different subgroups and at different ages get resources for research), the assessment of the burden of diseases, issues around bio-medical research and international cooperation in clinical research.

The AZT trials in the treatment of vertical transmission of mothers with HIV/AIDS, as well as the HIV/AIDS vaccine trials using viral strains prevailing in countries other than those undertaking the trials, have created a demand for ethical guidelines for conducting research in developing countries. These demands have ranged from the use of placebo control; prevailing standards of care; the recipients of post-trial benefits in terms of individuals and communities; the sero-type composition of vaccine; and issues of informed and voluntary consent. Of special concern are the weaknesses of ethical review capacity in developing countries, as well as the weaknesses of existing

ethical guidelines and mechanisms and procedures of ethical reviews, in terms of the transparencies of potential benefit and harm of studies by widespread distribution, particularly to the vulnerable group; the public and private expressions of medical ethics and law; as well as the protection of the confidentiality of data related to individuals or groups.

The situation of Rotavirus vaccines with some minor side effects is of particular interest. The vaccine was withdrawn from industrialized countries with a very low prevalence of Rotavirus infections. Such a vaccine can be used in developing countries, where the prevalence of the disease is much higher and, therefore, many more people will be protected, and when clinical trials have demonstrated that the benefits from the vaccine outweigh the potential harm.

The meeting strongly endorsed the need for a Code of Conduct for international collaborative research. International organizations, such as the World Health Organization, should have a definite role to develop, harmonize, and standardize guidelines to foster a normative context for scientific investigations. International organizations, such as the WHO, can advocate and monitor such a Code of Conduct to protect developing countries, most of which have no bargaining power.

3. Major themes of the Forum

This section contains summaries of the five themes discussed by the Collaborative Teams (see section 2.7.3) and represent the special issues and action within the themes, which were, in fact, abstracted from the on-line Asian Dialogue Process that preceded the Forum. The Teams' ideas and proposals were incorporated into the *Asian Voice*.

3.1 Population, migration and control

3.1.1 Current and emerging population problems

In recent years, population growth in Asia has declined in some countries such as Thailand and Sri Lanka. However, because of the magnitude of the population, even a declining rate can translate into significant growth.

In addition, some population groups and problems have not had enough attention. For example, there is an increase in the rate of the elderly population. A large proportion of elderly people have been experiencing poor quality of life. The adoption of Western values has led to an increasing number of single parents.

Armed conflict and poverty have led to migration with related cultural changes in health problems of the migrants and the receiving countries they migrated to. International migration is a major problem is Asia. Migrants came from China to Myanmar and from Myanmar to Thailand. The Thais and Burmese move directly to Malaysia and Singapore. From the East, people move from China to Laos and Viet Nam and from Viet Nam to Laos, Cambodia and from Cambodia and Viet Nam to Thailand. Indonesians move to Malaysia, Singapore and Sarawak areas. The Thais and the Filipinos move to Japan, Hong Kong and Taiwan and other parts of the Asia Pacific Region. On the global scale, migration is more to the Middle East, Canada, USA, Australia and New Zealand. Therefore, migration involves at least two regions, SEARO and WPRO. The flows increased drastically in 1990s.

The ILO Convention No.97 and International Convention for the Protection of Migrant Workers and Members of their Families are the two instruments to protect the health of these people, although they do not provide adequate assistance to these people. Migrants suffer from communicable disease (malaria, tuberculosis, filariasis, diarrhoea and HIVs). Many have suffered from SUDS and skin diseases. There is a shortage of vaccination, primary health and medical care and family planning services. Like the poor, migrants do not have access to services, due to poverty. They are difficult to reach, because many are illegal. Communication and language will be difficult because these are foreigners and do not enjoy the full benefit of health care

services. Funds and resources are limited in most destination countries who may not be willing to bear the expenses of caring for these patients. The lack of cooperation among migrants and between adjacent countries for communicable disease control make eradication of diseases, such as malaria, more difficult. Finally, stigmatization of the migrant workers prevails in countries where these people live.

3.1.2 Poverty, illiteracy and cultural norms

Poverty and illiteracy are important reasons why a high birth rate still prevails in some populations. In addition, the local culture itself, such as gender inequality has also played an important role. Poverty in some regions is such that many people cannot afford contraceptive methods for regular use and have to depend on funding for contraception. Alternative methods to conventional contraception are needed to cope with contraceptive dependence. These may include multi-sectoral approaches to population control. In terms of cultural norms, most of the intervention programs have been targeting women. The group felt that men should also be the target of intervention to deal with population problems. There is an interconnection between population increase, poverty and migration. Increased population leads to poverty, which then leads to migration for employment. These migrants live in poor conditions, which lead to bad health. One way to deal with migration is the poverty alleviation programme, including the empowerment of women to work on their premises, in such areas as chicken farming. In addition, concern for reproductive health through empowerment of women can reduce population growth and reduce poverty.

3.1.3 Information, education and communication (IEC) strategies guided by operational research

The IEC techniques targeted at appropriate population groups can contribute to poverty alleviation programmes. The key actions are to:

- Strengthen the *Asian Voice* and put population control and poverty alleviation at the centre of debate
- The population explosion should be considered seriously and measures adopted to proceed with education and campaign strategies to combat it
- Further research is needed to deal with the causes and effects of migration
- Poverty alleviation programmes should be enhanced
- Emphasis should be placed on reproductive health to bring about smaller and healthier families with a better way of life
- A continuous dialogue through E-mail and websites among countries with similar problems might be initiated.

3.1.4 Translation into interventions

The multi-faceted causation of population problems, such as population growth, migration, poverty and problems of the elderly, require a comprehensive translation of multi-disciplinary research into multi-dimensional intervention. For example, the development of community- based care for the problems of the elderly will require an integration between primary health care strategies and social strategies, involving care takers of individuals, families and local communities. Health providers alone will play a more supportive role for other actors in the control equation.

3.1.5 More sensitive delivery approaches

The delivery of multi-dimensional interventions needs a better understanding of the dynamics of population problems. Some actors, such as NGOs, may be a better deliverer of interventions because of the lack of bureaucracy, but their enthusiasm might overlook the objectivity of the evaluation of intervention models. The academics, the Government and the people might be talking different languages, since they come from different organization cultures. The private sector might be efficient, but will require some financial gain to survive and, thus, might not support the ideals of equity and equality. Test for models, which support the value of equity in health for development through the involvement of the Government, the academics, the NGOs and the private sector and industry, will be needed before widespread application.

3.1.6 Research issues

The group felt that the priority areas for research in population control include:

- The effects of donor funding for population control other than a reduction in fertility
- The effects of social security system and primary health care services for the elderly
- The effects of economic transition and globalization on poverty and internal and external migration.

3.1.7 A new architecture and functions of stakeholders

Each country and the international community will need a new coordination mechanism to better understand the needs and demand for population control, to harness political commitment, and to mobilize and formalize resources. As far as possible, the new coordination mechanism will have to be community-driven.

3.2 Control of infectious diseases (Research synergist good governance or the RSGG Group)

In recent years, diseases thought to be under control have reappeared. RSGG Group: Research Synergism Good Governance: The team had 14 participants and was led by Dr. Nelia Salazar from the Philippines to tackle the problems.

3.2.1 The Situation

While the countries of the developing world struggle to control their infectious disease problem, newer diseases emerged and threatened to become epidemics. Diseases, such as malaria and typhoid, which were thought to be under control, reappeared. Concerted action, which can be a part of these countries' research agenda, was needed, and ways of doing this were discussed.

The group recognized the central role that could be played by the Forum in bringing countries together. It could act as a body that would facilitate dialogue among these countries, and facilitate and provide advocacy for policy changes in health research towards the achievement of equity in health and development.

The following problems/barriers towards achieving equity in health development were recognized by the group:

- Most policy decisions were centrally made, and the voice of the grass roots workers, whether in research or in health service provision, were seldom heard
- Most of the research was donor-driven and so of little or doubtful relevance to the countries
- Most researchers felt that publications were the end of the line for research and did little towards making research results influence policy formulation
- There was a strong divide between applied and basic research. Basic/ strategic research was thought to be of secondary importance and it was difficult to find funds for carrying it out
- Even in applied research, most of the laboratory work was done in developed countries. While technology transfer is now becoming more common, there is still uncertainty over intellectual property rights and so, in collaborative research, most developing countries do not enjoy intellectual property rights
- Vaccine research is another area that was thought to be too expensive and was not supported by governments
- The Government's response to emerging diseases was sketchy and delayed; hence the opportunity for control is often lost.

3.2.2 Follow-up action needed

The group made the following recommendations for cooperation to overcome these problems:

- The group strongly endorsed the value of the Asian Health Research Forum as a body that facilitates and supports action to provide the necessary platform for these initiatives and for using research as a tool for achieving equity in health for development
- The general recommendation was to establish cooperation among researchers at the national and regional levels, including a network for sharing knowledge between countries. The education and infectious disease control messages should be incorporated into the curriculum. The Forum can help exchange information about emerging and re-emerging diseases
- Specific recommendations are to organize and support multi-centre study on emerging issues, such as MDR TB
- In addition, ongoing training workshops on risk assessment and impact assessment of infection should be developed and conducted
- Finally, a consortium on infectious diseases should be established with the emphasis on capacity building, poverty alleviation and human resource development for health.

3.3 Policy response to globalization

Globalization has had a multiple effect on equity in health and development. The key issues include the following.

3.3.1 Health manpower

Globalization has affected the quality of education, thanks to easier access to global knowledge. However, globalization also attempts to increase market share through privatization of health services. This leads to a movement of health care personnel from the public to the private sector and from developing countries to developed countries, resulting in brain drain. Many developing countries subsidize the training of health personnel for use in the public sector. Thus, brain drain, through globalization and privatization, can adversely affect the principle of equity in health for development.

3.3.2 Environment

Environmental problems have been the consequences of the impact of factory and pollution on health resulting from globalization.

3.3.3 Traditional and alternative medicine

Increasing drug costs have made many people seek self-reliance by resorting to alternative and traditional practice, including acupuncture and herbal drugs. Many of the practices have been handed down from generation to generation. Many people use unconventional therapies for health problems, but the extent of this use and the costs are not known. Furthermore, many doubt the efficacy, safety and the standardization of traditional preparations. The extent to which these practices have clinical efficacy according to biomedical criteria was in need of ongoing research and debate. As has happened in the developed world, alternative medicine can become a source of concern. The use of alternative medicine may be independent of any evidence of efficacy. Rather, the attraction of alternative medicine may be the common belief in the power of its underlying cultural assumptions, linked to an advocacy of nature, vitalism, the inadequacy of science, and spirituality. These assumptions can give patients a confidence and self-identity when illness threatens their sense of well-being. An open-minded discussion of these themes may help to harmonize the interaction between conventional and unconventional care with the mutual search for the best drive towards equity in health for development.

3.3.4 Equity in Health

The main objective of globalization is to promote individual rights to health care, linked to the ability to pay, and thus increase market share. This contrasts with the equity principle championed by the Health for All ideology, which demands that everyone, regardless of their ability to pay, needs equal access to health care and, thus, more or less equal health status. The World Health Organization concept of Health for All, therefore, supports the notion of equity or common good. Poor health and access to health care is related to poverty. Targeting poverty and inequity in health is definitely a step towards Health for All. The income expenditure criteria for defining poverty in targeting health service to the poor has been challenged and increasingly replaced by a new definition of poverty based on the capacity of the poor to improve their conditions, including their health status and education. Therefore, health appears poised for a significant move toward the centre of thinking about poverty, as a component not as a determinant of it.

Any measures towards achieving common good must incorporate this new thinking. The new definition of poverty and equity in health is complicated. The issues debated must have practical implications. Increasingly, poverty and inequity in health will count in both the policy and the intellectual spheres. Thus, on the one hand, attacking poverty and inequity is becoming a major concern of the World Health Organization. On the other, the idea of entertaining individual rights to get the best care affordable by individuals has been strengthened by economic transition in countries propelled by

globalization. There are fundamental principles in the values between the ideal of Health for All or common good and the recent trend in globalization that drives the socio-economic and health systems. Under the banner of Health for All, governments have been the mainstay of health and social services. The goals and values of governments are to meet the needs of every individual equally. That is the basis of equity. In contrast, the goal of globalization is not about equity, but rather about individual rights, and the emphasis is on the methods to exercise those rights. Equity requires governments to ensure that everyone meets his/her basic needs and, therefore, governments must resort to central planning and allocate resources based on non-price mechanisms. At the same time, globalization strives for private ownership and resorts to the market mechanism to do so.

Therefore, Health for All and globalization support different social values. Public health communities should aim at a compromise between the two different social values. Public health communities can support Health for All by bringing all for health. Balancing common goods and individual rights requires that all partners develop innovative methods to provide more health, despite limited resources, innovative methods (a) to increase resources for health through private and foreign investments, (b) to create incentives for research and provision of quality care, and (c) to develop high quality public health services in response to the changing context created by the market economy, new health problems and challenges associated with a rapid rise in health care cost following globalization. Therefore, balancing common good and individual rights calls for a new system, a new way of doing things with our partners involved.

3.3.5 Trade and the World Trade Organization

Despite recent gains in health development, the world has still a long way to go to achieve Health for All. Nations have focused on economic development, often at the expense of social development. Economic prosperity has been followed by economic crisis. The gap between the rich and the poor nations widens within and between countries, despite economic growth. The world needs international cooperation to cope with these challenges together, so that each country can be more responsive to the health needs of its people. Along with globalization, international trade, including trade in medical and human services, has become more important. Countries with a transitional economy, such as Thailand, Viet Nam, Cambodia, Malaysia and the Lao PDR, are developing ways to balance economic prosperity (by joining and adopting the rules of the World Trade Organization) and equitable health and access to health care. Food products affecting health are readily available without adequate consideration of health effects. New drugs, such as melatonin and Viagra can be obtained without much debate among the authorities involved. Many countries do not yet know about the WTO Committee on Sanitary and Phytosanitary Measures, despite the fact that seven countries in the Southeast Asia Region are members of WTO. Many

are not aware of the details of GATS and TRIPS, despite the fact that trade in services has been growing and now accounts for 20-25% of world trade. These agreements have major implications for the pharmaceutical industry and the governments of developing countries. Patents will be protected with monopoly rights for a certain period of time (20 years from the date of application). Theoretically, developing countries may gain with the increase in health services. However, the attraction of better professionals to foreign-owned enterprises, especially from the government sector, will marginalize the poor and rural people. The effect of trade on equity in health for development needs to be constantly monitored through innovative and multi-disciplinary research.

3.3.6 Aggressive promotion by multinational companies

The possible piracy of biological substances and traditional knowledge of potential market values that resulted from the developing countries' weakness in basic science research highlighted the ethics of international trade and promotion. Although fungus has been a source of useful substances to make beer, bread and antibiotics world-wide, Thailand has only recorded 10% of the 12,000 fungal species registered in Britain. For a tropical country with much greater bio-diversity, the number is clearly highly underestimated and might deprive the country of an opportunity for revenue generation. Basic sciences are also needed to develop the so-called "orphan drugs". These drugs have not been a priority for development by multi-national industries due to low market values. The donor, government and community operate within a very different accountability framework. The donors want to demonstrate value for money. The government is not enforcing the accountability of funds, while the community operates on a different time-frame from the donors and the governments. What should be the ethics of development and promotion of products beneficial to health require some principles for development, implementation, and enforcement of a code of ethics, such as an in depth re-examination of attitudes towards the current materialistic concepts of globalization and development in meeting human needs; balancing the materialistic concepts by some fundamental issues related to basic human rights and social justice; and relieving the suffering of the disadvantaged in an effort to fulfil the attainment of basic human rights and social justice.

3.3.7 Guiding principles

These include:

- *The knowledge base approach:* Studies of the impact of globalization on health have to be reactivated and strengthened. These include the development of a conceptual framework to resist the harmful effects by redefining competitions, evaluating assumptions, with an analysis of governance, resources and information, overcoming the differences that exist among countries, while preserving the diversity

- *Research Capacity Development:* Multidisciplinary health research will be needed to assess the magnitude, causes, impact of globalization and options for intervention, both nationally and internationally
- *Protection against the brain drain:* Health manpower planning at the country level should design innovative approaches to education and training so that the brain drain would not occur by contextualization of training and organizational receptivity, so that human resource planning will reflect the countries' needs
- *Cooperation to cope with environmental problems:* There must be continuing studies of the impact of new industry through collaboration between developed and developing countries, since environmental degradation will affect the global village. More resources will be needed.
- *New approaches to funding:* Funding sources usually decide on the areas of research. Donors should be empowered to allow decisions on the use of funds to reflect the people's needs and the country's decisions
- *Health priority over trade priority*: Health should get precedence over free trade
- *Collective efforts by Asians*: Collective action will be needed by Asian and other third world countries to safeguard health interests.

3.3.8 Follow-up action needed

In the interest of brevity and carrying some weight as an outcome of the Forum, the group considered that globalization has had a multiple effect on national health services and the status of people's health, which each country should assess. The group felt that it was not enough to generalize, and that the country situations are likely to be different. There have been different waves of globalization. The extent of globalization has been restricted in some countries and has been encouraged in others. In Sri Lanka, the global economy started in 1977, whereas in India it started very much later. Therefore, globalization has had a different impact in different countries. In needs assessment, countries will need data that would carry the message across. In order to do that, we have to understand that the globalization process has developed momentum and intensity in the last 15 years. If we make a comparison between health status 15 years ago and today, we will have a useful means of assessing the impact of globalization. Comparisons of status 15 years ago and today can be done in relation to the following:

- Health status of the people
- Depletion of human resources, such as the brain drain
- The status of public health sector, especially primary health care, to see whether public health sector has been adversely affected

- Impact on drug prices and the impact of TRIPS, whether it has given rise to cheaper or more expensive medicine in countries
- The impact of privatization on equity, including the growth of private hospitals, the shift of health personnel to provision of private care and the provision of private care of public personnel paid by public salary.

The information from the findings should be made public through the media to make people aware of the situation. A collective voice from countries in the third world should then be raised. If we start early, we can get some data, even limited, and present the findings to the October meeting. We should also raise a collective voice at the World Trade Organization to show how poor countries are being dominated by powerful ones. Collective voices, backed up with data, can become more effective. Some action must be taken to readjust the balance. For example, compensation from developed countries that benefit from the brain drain might be given to poor countries in return. This can be done in terms of provision of skills training for poorer countries or provision of opportunities for reverse brain drain, even for some period of time. We have to change the mind set, which is a part of the globalization process that overstates the benefit of privatization and the move to cut welfare benefit for people. This mind set not only affects the policy maker but also affects our own professional colleagues. We have to carry on the campaign that would change the mind set and provide measures, which would counteract the process of globalization.

The process of globalization is taking place, whether we like it or not, due to the outcome of advances in science and technology, including communication technology. The process cannot be halted. But it has to be corrected, because it has caused imbalances. The promotion of a free flow of money has led to economic crisis because of currency speculation. If this is to be halted, there must be an international regulatory organization, which oversees finance, to ensure the system survives. The Asian crisis resulted from the unregulated flow of capital within minutes. In the health sector, the process also needs regulation. It must be done in a way that will benefit the people of our countries. We have to do it now, in order not to be drowned in the process. We have to take countermeasures within the context of the existing system, rather than opposing the system.

3.4 Cultural response to a changing paradigm

The changing paradigm resulting from globalization has effected several aspects of the culture of countries in Asia.

3.4.1 The effects of the changing paradigm

The new paradigm has had an impact on cultural norms around gender, ethnicity, geographic migration, social class and the effect of cultural values on the lifestyles of different peoples. Globalization has brought about sophisticated health services, mainly within the reach of those who have the ability to pay for services. There are several different medical cultures in Asia, each with its own ideologies about disease causation and the nature of medical intervention. The choice of healers, practitioners using the western system of medicine as well as others, depends on a variety of conditions such as: the health status of the people, relative proximity of the healer, cost of health care, transportation facilities, gender, attitude of the parents towards different systems of medicine and the past experience of the parents. The choice of healer may be related less to the traditional or modern orientation of the parents and more to the severity of the infant's condition and the expectancy of a cure. The poor made much more use of government facilities than the rich, manned by different types of personnel and practitioners with varying hazard to health. The modern concept of health and disease has a different meaning for the underprivileged. In some rural areas, to teach peasants and the underprivileged about modern medicine, it is important to understand their beliefs and to use them for improving health care. In addition, modern medicine can learn from the traditional concepts of health and disease. In contrast, western cultures, products and lifestyles have invaded the urban centres.

3.4.2 Positive and negative effect of the changing paradigm

Globalization has a positive and negative effect. The positive effect includes the increased visibility of issues, such as women's rights and child's rights. Increasing sophistication of medical technology resulting from globalization has brought new possibilities for care and cure but has hampered equity. Those who gain access to high technology get better and better resources, possibly at the expense of the availability of health services for the needy, because new technologies have invariably been expensive beyond the reach of the poor or the almost poor. Control of pricing, product standardization, and control of advertising have not so far been very effective. Social demand for the right of access to cost-effective services has not been fully promoted and the disadvantaged are losing in the competition for resources.

3.4.3 Cultural invasion

Television, other information technology and franchising of health services have invaded the culture of developing countries with positive and negative effects. The world has moved from the Flexner's report about the crucial power of medicine, from the public health directive top-down administration to a new page of heath systems and care. We are struggling with the question of how the health sector will manage private commercial growth. Increasing

pluralism of health care systems, with the unprecedented growth of private medical services, widens the gap between the privileged and the disadvantaged in accessibility to health services and it affects equity. There has been an increase in social gaps, exploitations by providers and users, and a change in attitudes and values towards health care, such as the move from the doctor-patient relationship to a more market orientation (provider-client relationship). There have been more malpractice lawsuits. Doctors have started acquiring malpractice insurance. Payers and financiers have become new actors on the health system scene.

3.4.4 Research

More research to assess the situation, like an intervention monitoring mechanism, such as the Health Asia Watch will be needed. Health social science perspectives should be incorporated in health research. Participatory action research will be the key to launch appropriate cultural responses to the changing paradigm. Research should be done and co-ownership of the issues and cooperation are the keys to success.

3.4.5 Localization of the problems

Local people do not know how ethnic groups and migrants live. Healthy social environment programmes must be enhanced and cultural sensitivities must become a key to develop such a programme, since many health problems of the different social groups and migrants result from the poor social environment, such as marginalisation, stigmatization and loneliness among others.

3.4.6 Key to action

The following courses of action are recommended:

- Develop capacities for health social science research, including training workshops and seminars, and websites
- Networking, dialogues, exchanges of ideas between participants of the Asia Forum, using E-mail and websites
- Inventories of researchers, research conducted in the area (nationally and regionally)
- Initiate action research on the priority issues identified
- Prioritize areas for further research
- Mobilize support for more resources (technical and funding) for social and cultural research

- Raise awareness among policy and decision makers on the usefulness of this research area
- Increase awareness of local needs and cultural aspects of communities among policy makers and researchers
- Establish forum for social, behavioural scientists to get together nationally and regionally
- Make the theme of a cultural response to the changing paradigm an agenda item for the October meeting.

3.5 Non-communicable diseases (NCD)

3.5.1 The situation

There has been a rising trend in many non-communicable diseases, such as cancer, psychiatric disorders, hypertension, diabetes mellitus and obesity. These diseases are related to behaviour and lifestyles. Smoking is an important public health problem and the cause of premature deaths and disability, such as deaths and disability from chronic obstructive lung diseases, lung cancer and ischemic heart disease. Rising alcohol consumption has been associated with mental infirmity, road traffic accidents, and social problems. Non-rational use of drugs and medicine in communities and hospitals is common. The abuse of illicit drugs such as heroine, amphetamine derivatives, solvent, marijuana, and opium have prevailed in many Asian countries. Rapid changes in economic, social and cultural conditions have resulted in a rising incidence of mental illness, such as psychosis, anxiety, depression and suicides. The proportion of the elderly is increasing in most countries, resulting in changes in patterns of chronic diseases and illnesses related to the aged, such as arthritis, chronic obstructive lung diseases, including asthma, myocardial ischemia, strokes, depression and cancer. To effectively cope with these problems and promoting equity in health for development, a changing conceptual approach to identification of multi-level causation (biological, behavioural, organization and infrastructure, and social policy), as well as multi-dimensional interventions involving various sectors will be needed.

3.5.2 Priority for action in NCD research

- *Assessment of the current situation in NCD burden, risk factors and responses:*
  - There is not enough information on the burden of NCD among countries in Asia in three major aspects: the burden of disease, the risk factors and the responses. The data required to estimate the burden of diseases are the prevalence of NCD.

- There are certain issues which the group felt were important: i.e., the need for standardized criteria for local and international cases, the requirement of local validation and revision of existing tools, especially in mental health, injuries and abuse. In standardization, there is a danger of imposing international definitions and standards on countries. The group suggested the creation of some mechanism to set local standards. The risk factors for NCDs relate to behaviour and lifestyle issues and would need some baseline data about behavioural health risk.

• *The responses:* In terms of the response mechanisms for NCDs, there are issues about:

- *The structures and functions of health systems:* What are the existing policies, legislation for some behaviour, such as smoking, personal safety (seat belt), flow of resources in different localities throughout Asia? What are the current levels of involvement of other sectors, such as education and law enforcement

- *Surveillance or screening system:* Once the current situation is established, we need to set up a surveillance system to track the burden, risk factors and responses overtime and see how the situation is changing for research

- *Evaluation of screening***:** There is a need to develop and evaluate screening activities related to locally valid methods, which are culturally relevant, such as mental illness. There is also a need to develop and evaluate relevant clinical, social and political interventions. These evaluations will give rise to a health system research agenda

- *Social sciences agenda:* Finally, there is a specific call for a social sciences agenda, which would involve a wider cross-sectoral research response. In terms of behaviour of individuals, we have issues around compliance to treatment and prevention, lifestyle changes, as well as the behaviour of providers and clinicians in treating and preventing NCDs. How well they effectively educate the patients, particularly when there is a gap between the burden and the response. Part of this will be related to the way we train clinicians and health care personnel. With respect to the behaviour of communities, we also need to monitor how they respond to intervention. In general, we felt there is a need to promote a change in philosophy and vision of NCD research among research communities, away from following the Western models towards more locally relevant models.

3.6 Documenting health research profile

A set of indicators for measuring the "Health Research Profile" was announced at the Asian Forum. All countries were encouraged to try to obtain information of these variables. The meeting endorsed the idea that even placing on record that the data was not available could still be very useful. The variables for these indicators include:

- Evidence of the amount spent on health research (On any research and on research related to explicit priorities; the government budget line item; the sources of funds and the balance between behavioural, biomedical, and system research)
- Evidence of research capacity at the individual, institutional, government and international agency level; the number of researchers per capita; the profiles of researchers and the topics of research; the number of research institutions; the curriculum and career opportunities of researchers; the nationality of researchers; the capacity for management and coordination; the research networks, culture and environment; and the capacity to mobilize resources
- Evidence: Research on health inequities/equity among population subgroups within countries and the global influence on country specific inequities
- Evidence: Research into policy, action and practice, including the influence of research on policy; the content analysis of policy statements with respect to research; research priority agenda and plan; evidence-based policy; community participation (stakeholders); and dissemination of research results.

3.7 Towards the *Asian Voice*

The purpose of the *Asian Voice* is to summarize and highlight certain fundamental concepts, conclusions, and concrete suggestions built upon the issues from the Distance Dialogue, as well as discussions and revisions at the Asian Forum for Health Research. This *Asian Voice* is a "work in progress", which will evolve further over the coming months with additional inputs from a wider audience. In the meantime, the Voice will serve as a useful resource for many, who are trying to engage others in their country in a dialogue about the Asian response to health research, including larger groups of stakeholders in countries.

4. Observations and conclusions

4.1 Fundamental concepts

The Forum participants engaged in a highly interactive, imaginative dialogue with output that was organized around three fundamental concepts of Principles (values), Architecture and Actions. The Forum affirms the need for new thinking around a new paradigm (set of assumptions) about health research in the light of the new knowledge-based economy that is global, fast changing and highly competitive, with undesirable impacts on equity in health for development. The Forum reaffirmed a strong commitment to uphold the equity goal of health research and the ethics of research cooperation. The Forum participants also advocated that an appropriate architecture, (consisting of structures, support systems, networks) be evolved and developed, based on country needs, to undertake the functions demanded by the changing paradigm and by sustaining the goal of equity. Finally, the Forum suggested that three categories of action be undertaken:

- Action to enhance leadership functions required by innovative health research management
- Actions to develop and disseminate appropriate implementation tools and methodologies to meet the new demands of new functions
- Actions to engage stakeholders in effective interaction, which is highly collaborative, innovative, distinctive and inspiring, and supported by the use of appropriate new information and communication technologies (ICTs) for the development of new architecture to support the principles and values of research.

4.2 Principles of research for equity

The *Asian Voice* reaffirms the commitment to:

- A health research enterprise defined by the values of equity and ethics
- Health research that upholds the principle of equity. This is a reaffirmation of the principle of justice - social justice and distributive justice - in health. Equity in health will be the avowed goal for health research efforts within the Asian region. These efforts will help to create the opportunity for all people in Asia to optimize their health development
- An ethical base for health research. All elements of the health research enterprise - generation, conduct, and utilization - will be consistent with ethical guidelines. These guidelines refer to elements that define ethical health research in the Asian region and developed by Asians for Asian people.

These principles guided the actions and goals of the Forum.

4.3 Principle of a new paradigm

The new paradigm, which is defined as a set of assumptions or a scheme of ideas and principles or a pattern of things, subsumes many of the older assumptions that have dominated health research. The elements of this new paradigm address key processes that are now emerging as the defining characteristics of a health research framework. These are:

- An emphasis on vision and equity-driven research. This element assumes that “keenness of understanding depends on the keenness of vision”
- An emerging consumer orientation, which sees the consumer as steering rather than rowing
- Increasing focus on practice-based prerogatives for guiding research; use of rewards and incentives to promote local use of locally generated information
- Increasing emphasis on process and interaction between protagonists vis-à-vis outputs and impacts
- Strengthening the sense of ownership of knowledge generated by those that are the source of the knowledge, rather than those that elicit the samples and analyze the knowledge; movement towards a protagonists-for-development orientation instead of a donor-beneficiary one
- Increasing the use of lay language in the dissemination and diffusion of information to supplement the technical (jargon) language when dealing with people and policy makers
- Increasingly basing the research agenda on the respondent, natural or community, rather than the sponsors priorities and concerns
- Movement away from parochial properties to regional and universal ones
- Employing a consultative agenda-setting process as distinct from submitting to a donor/sponsor/specialist imposed agenda.

4.4 Architecture (new structures, support systems, networks and functions)

With a paradigm shift towards research for equity in health, more cooperation will be needed between national, regional, and global institutions. The architecture for more cooperation can be a range of structures, support systems and networks. Therefore, each country can re-orient existing structures, support systems and networks or develop new architecture to support research for equity in health under the new paradigm. The nature and extent of the evolved architecture will be specific for individual countries.

4.4.1 National level architecture

Certain operating principles for an effective architecture at the national level include:

- A political commitment to support equity
- Capacity to set research priorities and direct research policies
- Capacity to identify and mobilize private and public institutions, researchers, and community for effective networking and partnership
- Willingness to support decentralized autonomy with central and multi-sectoral cooperation
- Readiness to be inclusive and interactive
- Responsiveness and relevance to needs
- Collaborative spirit and receptiveness to feedback including accountability and transparency.

In this respect, a transparent national work plan should be developed in consultation with national researchers and other stakeholders. The ability to retain and support qualified manpower must be an important component of the work plan.

4.4.2 Regional level architecture

At the regional level, the following elements are required:

- A clear mission statement and vision
- Political commitment
- Supportive organizational structure and work plan
- Regional agenda-setting, resource mobilization and allocation according to regional priorities
- Regional clearing house of institutions and researchers for networking, interaction, collective leadership, and operation in support of national work plans is required.

4.4.3 Global level architecture

The global level can offer enhanced support for equity by responding to the needs of developing countries for a balance to the current emphasis on research into health problems of developed countries. In addition, the global architecture must have strategies to empower national research communities in developing countries, with explicit and clear processes of work accessible to all.

The architectures at all levels should avoid the following pitfalls:

- Bureaucracy
- Centralized decision making
- Prescriptive or donor domination
- Exclusivity
- Restrictive networks that lead to isolation and in-breeding
- Artificial boundaries
- Collaboration without technology transfer
- Excessive profit or market-driven incentives
- Over-reliance on high technology.

The creation of new institutions or structures to coordinate existing institutions should be avoided, unless a significant effort to refocus the existing mechanisms has proved ineffective. Missions and plans at all levels must be subject to periodic self and independent evaluation, including periodic reviews of interaction between different levels that support health research status in the countries.

A range of functions is considered important in an evolving architecture, as follows:

- Policy making and priority setting
- Development of capacities for research implementation and management
- Resource mobilization and allocation based on research priorities
- Promotion and advocacy of the research environment; dissemination and utilization of research findings
- Setting norms and standards
- Partnership and international cooperation.

4.5 Follow-up action to accomplish the new architecture

Priority innovative action that can have the potential to help groups create the evolving architecture in support of Asian values must be inclusive and participatory. Some important first steps include:

4.5.1 Action for leadership

The movement towards the new paradigm for health research has underscored the need for equity-oriented research managers with strong leadership skills. These persons (functioning both individually and in teams) will demonstrate some of the general behaviours of high performance leaders, which include the capacity to articulate a compelling vision, to enable others to share that vision and build purpose-specific coalitions, and the ability to set and follow priorities, that is to do "first things first". In addition, these people will require more specific knowledge and competencies to manage and provide leadership for equity-oriented, priority-driven health research. The following measures are proposed in order to develop and sustain the necessary leadership:

- An on-going electronic dialogue about equity-oriented health research management and leadership
- A series of learning modules on knowledge management and related competencies, to be developed, tested and used by Asian countries
- A workshop on health research leadership, to be conducted at the October 2000 Conference, which would bring together the Asian experience to date, with similar experience elsewhere in the world
- The creation of a working group, which would have the task of creating an on-going programme that incorporates the features described above. Such a programme would assist countries to develop national health research leadership activities including the identification of emerging leaders, access to the use of training modules, opportunities for progressive experience and responsibility, and mentoring by more skilled, senior persons.

4.5.2 Action for tools and methodologies

New and improved tools are needed to create, implement and operate the new architecture of health research. To develop an effective health research system, the following are needed:

- An innovative mechanism for research coordination at the national, regional and global levels
- Effective promotion and advocacy skills
- Research priority setting that is based on sound situational analyses of health status and burden of disease, and involvement of multiple stakeholders with a shared vision and value system
- Resource mobilization tools
- Processes for networking and partnership building.

4.5.3 Empowering tools for research to action

To empower stakeholders to link research to action, we need improved competencies for:

- Policy-oriented and action-oriented research, including crucial appraisal for best evidence and best practice
- Stimulating and engaging community participation; processes for integrating knowledge, processes, leadership with the use of information and communication technologies
- Appropriate behavioral change interventions (change leadership tools including systems thinking tools).

4.5.4 Tools and methodologies for the Equity Watch

To track progress towards the goal of equity in health, there should be good tools for measuring inequity and change over time, and for measuring research resource flows both in countries and globally. These tools and methodologies should be made widely available through a Web-based toolkit, accompanied by an interactive "help" facility. In particular, networks need to be formed around common methodologies for burden of disease estimation, resource flows monitoring and equity tracking. Training for improved communication skills is urgently needed for effective resource mobilization for research priorities and for linking research to policy and action.

4.5.5 Action to utilize appropriate new information and communication technologies (ICTs) as enabling technology

- The Asian Regional Health Forum is endeavouring to support the development of a leadership network, which is working collaboratively to develop a knowledge network (on Equity in Health), and which in turn is supported by a technology network, which serves as a supportive enabling tool
- The Forum operated a pilot Enabling Technology Centre to explore how electronic tools might best be used to support the vision and mission of the Forum. A prototype Electronic Resource Centre gathered all the input from the Forum, and these resources are now in the process of being synthesized, organized and stored electronically so that they can be made available for quick, flexible, inexpensive access by interested stakeholders
- The intention is to launch, at the end of March, an interactive, **E**lectronic **R**esource **C**entre for the *Asian Voice* on health research (ERC *ASIAN VOICE*). Included will be knowledge, processes, leadership development initiatives and tools on research for equity in health. This will include electronic templates for supporting electronic surveys, on-line dialogues,

and the ability to create detailed research reports collaboratively at distance

- These resources will be available by fax, E-mail, and on the web.

This *Asian Voice* was also intended to serve as an exploratory prototype for helping individuals and organizations to understand the elements of building a useful Knowledge Management System, and how appropriate new information and communication technologies (ICTs) might best be used in such a system to support the improvement of an organization's performance.

4.6 The Technology Centre

The purpose of the Technology Centre in the meeting is to collect all the materials and ideas together by synthesizing, organizing and collating discussions in a way that they can be shared. Some of the sharing initially appeared on paper and will later be documented for access on a website.

The Technology Centre attempted to demonstrate the first stage of the websites. It showed people how to "build ideas together electronically" (BITE process). The electronic media was used for taking polls or electronic voting by designing a set of questions and inviting responses to the questions. Ideally, those who made the presentation could survey the responses by the audience to the key ideas or statements in their presentation. Several questions and polls were organized at the meeting. The purpose of these polls was to let people know what is possible and not the actual result, which would require much more preparation.

The College of Public Health will be the initial webmaster, and will work to highlight potentials and barriers, and towards integration.

4.7 On-line dialogue

The on-line dialogue began as two pages of challenge statements about the issues concerned. In particular, the dialogue centred on the process of the meeting and whether it should be recommended for use at the October meeting in Bangkok. There was a moderator, who tried to ensure that the members of the on-line dialogue team stayed on the topic. The team then strove to reach some conclusions. Six individuals were involved and exchanged ideas around a specific topic. The conclusions reached are shared by a wide variety of people. The members of the on-line dialogue team spent five to fifteen minutes each day at the Technology Centre and looked at what other colleagues had discussed on the topic and added a further comment. The method allows members to carry on the dialogue, despite being unavailable at the same time. This could be a powerful tool to encourage bright people to talk to each other on substance, without having to spend money and time to bring them all together.

4.8 Reflections on the workshop

A group was organized during the meeting to reflect on the process of the Asian Dialogue, which began in September 1999 and lasted several months. Everyone agreed that the dialogue process had been useful and should be documented. However, the group advised that the audience be enlarged. This could be achieved in several ways, either through an institutional approach (by locating focal points among various types of institutions including the government, strategists, pressure groups and NGOs) or by making better use of electronic communications, such as establishing a Frequently Asked Questions (FAQ) session. In all forms of networking, it is important that a search for better evidence, with a country focus grouped by subject, discipline and special interest groups, be the basis of discussion and conclusions. The development and refinement of indicators for measuring the contribution of research towards equity in health for development could be among the first steps.