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Regional Consultative Process

Regional Report Summaries

Africa, Asia, Caribbean, Central and Eastern Europe and the Newly Independent States, Eastern Mediterranean, and Latin America

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Summaries of the Regional Consultations

Contents

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Health Research in Africa: Past Experiences and Perspectives for the Future

EXECUTIVE SUMMARY

Introduction

This report attempts to capture the status of health research in Africa in the past with emphasis on development that has taken place in the last decade of the 20th century. The report provides a platform for the African Voice (see below) on health research. Africa is the second largest continent made up of 58 diverse countries in terms of size, population, culture and economic status. Past colonial occupation created linguistic barriers and left complex systems of governments. Occupation by at least six colonial powers fragmented the continent into spheres of economic and political dominance. These spheres have negatively impacted on human development and have generated continuous civil conflicts.

At the threshold of the new millennium, wars and civil conflicts fuelled by ethnic differences reverberate across the continent. Political instability has had a major negative impact on the development of science and technology in the continent. While recent global political and economic changes have given hope to new opportunities, in Africa these changes threaten to marginalise the continent even further. Africa's share of global investments and world markets is extremely low, the external debt burden is crippling and governments are under investing in social sectors, including health. Rising poverty, with 37% of the people of sub-Saharan Africa living below the poverty line undermines health even further.

In spite of these difficulties, the past three decades have witnessed notable gains in health. Education (especially of girls), public health measures, and immunization programmes have contributed to a rising life expectancy and falling child mortality, to take only two indicators of improving health. As we enter the 21st century, changes in the preceeding ten years point to new hope for the future of sub-Saharan Africa. The past decade has witnessed emerging democratic institutions; economies that had hitherto stagnated are now registering positive growth; and levels of literacy are on the rise. The emergence of voices against exploitation of the south by the richer industrialized powers is also encouraging. The poor state of health in African countries and the increasing health inequalities between and within countries however, remain of great concern. Disease burden due to endemic infectious diseases and the rising health burden due to chronic diseases remain a major challenge. To complicate the picture HIV /AIDS now poses the greatest economic, social and health burden which has begun to reverse all past gains. This picture has to be seen in the light of low national support for health, high donor dependency, and the prevailing economic hardships. Health research, an important tool for health development based on equity gets only token support within the health budget considering the low priority given to research and development in Africa.

The international health conference in Alma-Ata in 1978 recognized the inequalities in health that existed in developing countries. The concept of

primary health care was proposed and subsequently adopted by African countries as a practical and affordable approach of providing basic health care to communities and getting the latter to play an important role in advancing their own health. However, due to lack of adequate commitment and shortage of human resources, health for all (HFA) objectives were not attained within the set time frame as anticipated.

In 1990 the Commission on Health Research for Development (CHRD) published a landmark report, *Health Research: Essential link to equity in development*. The report reflected in detail on the status of health and health research in developing countries. It was observed that whereas 80% of the global population living in developing countries shouldered 95% of the global burden of disease, only 5% of the global investments in health research were addressing health problems of these countries. Developing countries invested very little in health research addressing their problems and in general maintained research systems that did not provide sufficiently conducive health research environments. To redress these imbalances the commission envisioned a global research system where researchers in developing countries linked together in networks that addressed both national and global health issues in partnerships. The Commission called on countries to invest at least 2% of their national health expenditures and for internationally funded health programmes to earmark 5% of the budget in support of health research.

The Commission also advocated for the adoption of the concept of Essential National Health Research (ENHR) as a means of generating information to address key health problems. As a follow up to the work of the Commission, a Task Force was formed. In 1993 COHRED was established by countries to promote the concept of ENHR. The report of the Commission has stimulated considerable debate internationally and has resulted in a number of global initiatives, mostly aiming at promoting health research in developing countries.

Among these initiatives, the principal ones are:

1. The Ad-Hoc Committee on Health Research whose findings were published in 1996. The report of this Ad Hoc Committee led to the establishment of the Global Forum for Health Research in 1998 (“The Forum”) and the Alliance for Policy and Health Systems Research in 1999.

2. The production by the WHO global Advisory Committee on Health Research (WHO- ACHR) of a report, *A research Policy Agenda for Science and Technology*, which was published in 1998.

Some key objectives of these initiatives include monitoring the progress of health research in the poorer countries including tracking financial flows to redress the existing disparities.

Ten years after the Commission report, it was considered prudent to take stock of national and international developments in health research. The African consultation was designed to assess the current situation of health research in the continent, to highlight developments over the past ten years and to provide an informed view on the way forward. Sample countries were selected for in-depth studies using instruments that permitted analysis of country situations and institutions and also the collection of views and opinions of different health research stakeholders. Apart from the in-depth studies, other shorter national surveys and extensive literature reviews were conducted. This report therefore has two main sections, the first looking at historical perspectives and the second giving current findings.

Findings

The past

Africa has an ancient record of science and technology. Documented examples include, mathematics and complex numbers used in Nigeria and Congo over 8000 years ago, steel production on the shores of Lake Victoria more than 2000 years ago, architectural and engineering works in Egypt and Zimbabwe and agricultural sciences in the Sudan. In the health field, there are documented records of very developed plant and traditional medicine, anatomical studies and advanced surgical procedures for the treatment of complex pathologies such as cancer.

With the exception of a few regions, the continent was invaded and colonized for several centuries. During that era of occupation, colonial powers fragmented the continent into numerous states and indigenous cultures were systematically dismantled and foreign ones imposed. As the continent was converted into a source of raw materials and slaves, most of the scientific achievements were not developed further. Not surprisingly therefore, health research developments in the pre-independence period are full of examples of very diverse systems that are reflective of the colonial legacies.

The British, French, Belgians, Germans, Portuguese, Spanish and Boers ruled different parts of Africa with an iron fist on racial lines and denied locals scientific education. The Belgians and Portuguese ran their own exclusive research systems and at independence left hardly anything tangible in their former colonies. The French built up relatively strong infrastructures but these continued to be directed by expatriates and capacity building for locals received little attention. The British in contrast left strong research infrastructures, although even in their case, developing local research manpower received low priority. Thus the colonial period can only be seen as a time when local momentum in science and technology was **frustrated** and systems to benefit the colonizers build with hardly any concern for health research development for the benefit of individual countries.

Post-Independence

Emergence of independent states started in the 1950s and the process continued for the next three decades. As each country gained independence, it started to develop its own research, science and technology policies. The post-independence scenarios are very variable, but in nearly all countries universities bacame the main seats of research. Those with medical schools gave impetus to health research, but with emphasis on biomedical and clinical disciplines. In some countries, in addition to universities, governments set up research councils (or commissions) which operationally established health sectoral committees. The degree of activity of these councils and specialist committees depended on the underlying policy frameworks and the extent

of local financing. In a few countries ministries of science and technology were established either as independent bodies or as part of ministries of education. Medical research institutes were formed either under the ministries of education or research councils. In addition to the above the majority of countries established internal research units to respond to operational needs. In a few countries, independent research laboratories, under the sponsorship of external agencies, also exist.

In summary therefore, emerging independent states inherited variable colonial research structures and systems with little research culture and low human resources. Subsequently, with a few exceptions, Africa continued to invest little in research, in the process making local scientists highly dependent on external funding. Most African countries are signatories to the Lomé Convention which, among other things, stipulates that countries should commit 1.5 % of national budgets to research. Few countries have paid attention to this guideline.

Financing

Health research financing in Africa is characterized by low global expenditures (10/90 inequality) and insignificant national investments. Health as a whole remains a low priority sector to which only between 0.1 and 3% of the GDP is allocated. Health research ranks even lower, receiving on the average, less than 0.5% of the health budget. In some African governments budget lines for research are non-existent. Due to the economic hardships of the recent past there has been a trend towards less allocation for research. Involvement of the private sector in health research in Africa is also virtually non-existent. There are exceptions, like South Africa where science budgets have risen significantly in recent years. The consequence of low national investments has been overdependence on donor funding, which in some countries has exceeded 90 % of all research funds available nationally. This type of funding has led to distortion of national priorities, uncertainties of research planning and degradation of research infrastructures. Despite the Commission's recommendations on essential health financing, information collected during the consultation indicates that current levels of financing are nowhere near optimal levels. Deserving record is that documentation of the resource flows for research at country level is rudimentary for lack of appropriate monetary instruments. Development partners who were interviewed believe that part of the underlying problem in the area of financing may be lack of national health research plans. Evidence shows that the problem runs much deeper and calls for more dialogue.

Priorities

Prior to independence, national health research priorities were based on the interest of the colonial governments. In the post-independence period, setting of priorities has at best been a haphazard process. The Commission in its report had stressed the value of priorities directed at essential health research in view of the inadequacy of resources and capacities for research in the poorer countries. Despite this insight, national priority has tended to be determined by institutions or based on the interests of a stakeholder. Until recently national surveys have indicated that priorities have leaned more towards biomedical and clinical research and less on multidisciplinary community-oriented research. Beginning about the mid-1990s, a number of countries, stimulated by the concept of ENHR, moved towards bottom-up national consultations that drew on the wealth of information of a cross-section of stakeholders. In these countries the priority-setting process has been quite elaborate and increasingly has had participation of decision-makers and communities. This approach has been found to be very enriching because of its ability to galvanize national interest in health research. As a result of this process, national mechanisms including ownership and coalition building (networking) have been strengthened. One of the difficulties encountered in the inclusive approach of priority setting has been community participation. But in addition, because of the shortage of research funding

and appropriate mechanism for dialogue with funding agencies, the translation of priorities into research activities has proved difficult. This latter outcome has had a negative impact on emerging national research networks. It is argued that national governments and external funding agencies should increasingly identify with the national priorities.

Research Utilization

In Africa, as a general observation, research has not been an effective tool for health action. The lack of impact has in part been blamed on the low output of appropriate research in most countries. Even more importantly the weak researcher-user interaction has been a major contributory factor. Universities tend to be more detached with users of their information. But even where useful results are available utilization has been low due to lack of sufficient capacities to prepare policy briefs for ill-prepared decision-makers, especially in health ministries. There is increasing concern being expressed in connection with underutilization of findings. As a result some countries have started to address this anomaly through training and by closely involving other stakeholders in the research process, including in the dissemination of results.

Although Africa's global contribution to the published literature is abysmal, there are a few countries with an impressive record. In many countries the poor results are partly blamed on the fact that researchers lack sufficient opportunities and avenues for disseminating their findings. Local journals have an uphill battle to survive while peer-reviewed journals are perceived as discriminatory. It is proposed that capacities for research demand and for utilization are strengthened and ways found to improve and sustain a number of strategic national (regional) health research journals.

Collaboration

Collaboration between health research institutions in the continent has remained weak, as has that between similar institutions of developing countries (South-South linkages). Partnerships with institutions of industrialized countries are better established due to funding channels, project generation and exchanges of expertise and technology. As much as North-South collaboration has been of value the ensuing collaboration is not perceived as between "equal" partners. Often it is perceived as a relationship between donor and recipient where priorities have often been imposed, where institutions have to operate on uncertain funding situations and with shifting rules and lack of trust. In fact some of the collaborative arrangements have been considered plainly unethical because of the subtle exploitation that underlies the arrangement.

Donors (and sometimes their proxies) have been largely blamed for the fragmentation in health research that prevails today in Africa. This arises through funding mechanisms that tend to emphasize individual researchers

or institutions rather than national interest. The identity of the donor, as a way of justifying survival, has at times overridden the national interest. Development partners on the other hand argue that the basic problem is the absence of clear national health research programmes and priorities to provide guidance. Donors also feel that research institutions in Africa have to improve their capacities, work ethics, incentives and management systems if they are to be competitive. But the same donors also admit that their efforts could have been more effective at national level if there was better coordination among them, and if their territorial interests were minimized through contributions to a common national research basket. Two important recommendations were made. The first one would involve developing an international code of practice on the conduct of research and the second would embolden countries to put in place a mechanism to encourage donor coordination at the national level.

The WHO Regional Office for Africa (WHO-AFRO) commands considerable clout on health matters within the continent. Being an intergovernmental agency, with an extensive network of country representatives, it has great potential to influence health and health development. However, the involvement of WHO-AFRO in health research has been limited, in part due to lack of a research focal point. Mechanisms for research coordination have remained weak in comparison with its other programmes on health services and disease control. Although WHO-AFRO has a regional health research agenda, few researchers in its member countries are aware of this agenda. According to the WHO-AFRO Regional Office, health research in the region has remained underdeveloped because countries have given low priority to research. This is made worse by the large gap that exists between consumers and researchers. There is also divergence between research projects and health needs and poor regional collaboration especially between Anglophone and Francophone countries. WHO-AFRO shares the view of the majority of countries that countries should be the focus of health research strengthening initiatives and that equity should be higher on the health agenda than it is at present. There was widespread feeling too that the extensive network of WHO country representatives, could play a greater role in health research developments.

Networking

Although a few countries have effective health research networks, most have difficulties in establishing and coordinating networking among researchers. This problem has its roots in the lack of effective national mechanisms for research coordination. Countries that have adopted the ENHR strategy have given high priority to the establishment of national linkages. Poor communication systems have rendered the exercise a big challenge. Africa has numerous regional health networks that have an interest in research. Most are established by outside donors but indigenous ones also exist. Because most of the networks are not well known in the countries, their effectiveness has been limited. There was widespread opinion that regional

networks could be of great value in catalyzing regional S-S linkages. For this to happen the networks need new approaches to redefine their mandates and modus operandi, including forging better networking between themselves and establishing better communication lines with countries. At the global level, international research networks are seen as being poorly coordinated. The recent research initiatives, as part of these networks, with a few exceptions have not made significant impact in countries. Two networks that were singled out as having been useful are COHRED and INCLEN. Useful but not considered as initiatives are agencies and programmes such as IDRC, Sida-SAREC, WHO-TDR, and WHO-HRP. The multiplicity of global research initiatives was viewed more as self-serving and not addressing the interest of countries. The consultation defined a number of functions that would give more value to regional and global networks (initiatives). The underlying principle is that the networks should focus on country agendas, be based on country needs and ownership, be complementary rather than competing, and be demand rather than supply driven.

Capacity

The term capacity for research is broad and goes well beyond individual skills to encompass institutions, users of research and facilitating networks. Africa has less than 0.5% of the world's scientists and engineers. Most of the countries visited indicated that shortage of capacity was the single most serious constraint in research. The shortage was in terms of quantity, quality, institutional abilities, under-utilization and misallocation of personnel and effective networks. It was acknowledged that steady progress in building capacities for health research by countries has been made in the past ten years but it was also noted that progress has been slower than anticipated. Unfortunately a few countries have less health research capacity today than a decade ago. One of the major drawbacks to capacity building in Africa has been the growing brain drain as qualified people leave in search of better opportunities. Information shows that loss of scientific manpower from Africa has risen tenfold in the past forty years. While this is occurring, Africa's dependence on external experts through consultancies and technical assistance now costs over 32% of the ODA. Even where the external assistance is inferior to local expertise, it is common to find preference given to the former. This undermines the confidence of local experts. The actual extent of the under-capacity in individual countries is difficult to determine due to lack of accurate records. Instruments for this are needed. During the consultations, country teams were clear that capacity building and its viability require a serious approach. Countries should start to document the level of existing capacity and then prepare forward plans for capacity development. A determined effort to create an enabling research environment is a precondition to sustainable capacity development.

Equity

Equity in health has remained a central concern since the Alma-Ata conference. The Commission highlighted the issue of inequalities even further and came to the conclusion that health research was an essential link to equity in health. The extent of inequity in health is still of concern at both global and national levels. Global disparities especially between Africa and the rest of the world continue to widen. Within the continent there are great variations between countries. Within any given country there may exist large differences between rural and urban populations, between ethnic groups and between sexes. Where subsidies have been given to assist the poorer in society, it is the richer who tend to benefit more. Only a few African countries are approaching the health issue seriously. Most countries only have policies and intentions but few practical remedial measures. Research on the subject of equity is low in most countries and the few examples of published information point more to commissioned research using a high proportion of external researchers and institutions. Participants strongly recommended that equity should be brought to the surface and that research should guide the process of not only identifying the disparities but also that of proposing appropriate responses and the monitoring of progress towards equity.

Research Output

Despite the fact that health research output in the continent remains low, researchers from Africa have made a number of significant contributions to science. Examples include basic research done in South Africa, multidisciplinary work on tropical neuropathy done in Nigeria, applied research on malaria control using bednets, and operational research on onchocerciasis control in West Africa. These few select examples, among many others, attest to the potential of research in Africa if capacities were strengthened, enabling environments were created, international partnerships boosted and better financing made available.

Ethics

While research outputs are of paramount importance, there are important concerns regarding ethics. The concern is even greater because of the numerous clinical trials involving human subjects and epidemiological studies involving populations. Lack of adherence to ethical principles has been documented in countries, sometimes out of omission but not infrequently through pressure and collusion between external and local researchers. Institutional and national guidelines, review mechanisms and monitoring systems need to be strengthened. Since ethics may have regional variations due to cultural differences and research needs, it is imperative that guidelines

and training programmes be sensitive to those variations. Another angle to the debate of ethics at the global level touches on collaboration, partnerships, funding mechanisms etc. The issue of good research practices underpins this concern. Some of the past relationships and conduct of research between the Northern and Southern partners have been fundamentally flawed and hence the proposal to establish an acceptable code on research practices.

ENHR

The term ENHR was coined by the Commission to describe a concept that addresses research at country level based on the principle that each country – however poor – should conduct research of priority using available resources while the country continues to build up its capacities, to seek increased funding and to improve organization of research.

ENHR is not a special form of research but a strategy for total health research as we know it. The only difference is the approach. Unfortunately many country researchers and decision-makers have mistakenly taken ENHR as a new programme to the extent that countries have sometimes been labeled as ENHR or non- ENHR. The work of COHRED and its predecessor (TFHRD) has guided the adoption of the ENHR strategy in 22 African countries since 1990. These countries presently constitute the African ENHR network at the regional level.

In many of the 22 countries, ENHR has received priority and been integrated in the national process. In a few countries, however, little progress has been made. One of the most significant achievements of ENHR has been the bringing together of different stakeholders, in particular the involvement of communities and policy makers. The second achievement has been a change in the focus of priorities and the promotion of multidisciplinary research, both of which have strengthened national networking. At the regional level the African ENHR network is one of the widest research networks in the continent, without which the work that has led to this report would have been difficult to organize.

In future, in promoting ENHR, it may be useful to stress health research, describing guiding principles to avoid confusion over terms.

The future

Health research development in Africa faces the following three key challenges:

1. Building appropriate capacities to undertake research;
2. Developing effective national mechanisms; and
3. Creating an enabling environment.

These challenges have principles that apply to all countries and also elements that are country-specific. Arrangements (or architecture) for health research at the national level should consider the following functions among others; critical masses, institution strengthening, efficient networking and coordination, advocacy for research policy and programme, change through informed choice, knowledge management and utilization, and leadership and management for health research.

At the regional level, an African Forum is needed to advocate for more attention to research, to build coalitions and to articulate the African Voice, promote South-South and North-South linkages, promote effective regional and global networking and broker for resources. The forum should also provide analytical information, offer technical assistance to countries and conduct oversight functions on matters such as ethics and good research practices, promote mutually beneficial international cooperation in research and evaluate/monitor progress in research development. Global or international responses should support national efforts through information sharing, promotion of N-S linkages, capacity development, technology sharing and providing a forum to share experiences and to set the global health research agenda.

The African Voice is a composite of twelve key messages which are addressed to national governments and to the international community.

Key Messages from the African Consultation

- The African community increasingly recognises the importance of health research as a tool for health development in the spirit of African renaissance, self-determination and strong desire to be self-reliant in science and technology. Bearing in mind past legacies that have led to increasing intellectual decapitation and human conflict, health research stakeholders with a **loud voice** appeal to the different actors at national, regional, and global levels to invest more in health research to correct current inequities.

- The centrality of the **country focus** as a basis for health research initiatives is recognised, and it is on that basis that all research-building efforts should be approached by the different benefactors to minimise the existing fragmentation of research in Africa.

- A responsible political environment that ensures peace and national stability underpins all science and technology development. Without tranquillity, health research as a long-term investment cannot be sustained. An **appeal** is therefore made to African leaders and their international counterparts to place human development at the forefront of the political process and create solidarity out of the existing diversity.

- Countries are urged to establish national research mechanisms that ensure that national potential is harnessed and exploited effectively for health development. A national **forum** of all stakeholders in health/health research is recommended as an effective way in which external development partners can usefully focus on the funding of priority national health research needs.

- **Capacity** building and retention are central to the a long-term success of health research development efforts and therefore must get the highest attention. In all countries capacity building and strengthening must include both the demand and supply sides, including l**eadership** development, **management** for health research, **negotiating** skills and research **communication.**

- **Advocacy** for health and health research, and their place in human development, should be intensified to ensure higher investments, but also to inculcate a culture for evidence based decision making and production of relevant quality research.

- The nature of health problems in Africa demands more community-based research and interventions. Therefore **ethical** practice has to be assured. Increasing international cooperation in health research also calls for new code of ethical guidelines that are sensitive to national and regional issues.

- Linkages and partnerships with the North (industrialised countries/ development partners) should be guided by the principle of **equality** and should stop the existing paternalistic, exploitative practice and also discourage the brain drain phenomenon.
- The health research process in a country should form the basis of holistic health development involving all national partners/stakeholders and thus create **ownership** that should translate into greater support for research from national resources, including political mainstreaming of health research.
- The development of health research in Africa requires an intense effort in the coming decade. An effective way of guiding this process is to create an **African Regional Forum** (platform) which would constantly address generic issues of the process such as donor dialogue, ethics, promotion and advocacy, analysis, methodology and instruments, networking, South-South and North-South collaboration, technology sharing, and information system, and generally encourage the convergence of national, regional and global efforts in health research.
- **Equity** in health remains a central concern. Health research development in Africa must always take cognisance of that fact. Global inequalities in health research should be addressed to ensure fair and just flow of benefits. At the international level, African experts should have their rightful role in the setting of global agenda.
- The International Conference on Health Research for Develeopment in Bangkok is not an end in itself but the beginning of a long process of building up health research in Africa. That being the case, practical **action** agendas at national, regional and global levels are needed.

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Asian Voice:

The Future of Health Research

Summary report

The Product of a 12 Month Consultation Organized by the College of Public Health, Chulalongkorn University

"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 on a Forum for Health Research organized in Manila following a 5-month Dialogue Process plus seven months of discussions of the outcome of Asia Health Research Forum. The Report is aimed at nurturing collaboration among diverse stakeholders in Asia who have a commitment to ensuring that research serves as a critical element in building equity in health for development.
- The Sponsors of this Dialogue are: COHRED, the Rockefeller Foundation, WHO/SEARO/WPRO, INCLEN Southeast Asia
- Recipients of this Report are invited to engage in this virtual dialogue (by fax and/or email). The Asian Views will be an important input to the group discussions at the International Conference on Health Research for Development in Bangkok, October 2000.

Preface

The Asian Forum for Health Research convened in Manila from 17 to 19 February 2000 to determine how best to create a new paradigm and a new set of assumptions for health research in Asia. The forum was organized as an "Open University of Research for Equity in Health Development" to define the new paradigm and to identify methods for building a dynamic and collaborative architecture to more effectively link the nations and region of Asia with global stakeholders in health research. It was also to determine Asian actions required to enhance leadership functions for innovative health research management, to develop and disseminate tools and methodologies needed to accomplish essential tasks, and to use new information and communication technologies to integrate the process and contents of health research with equity in health development. Results of the forum's review of issues were to create a more productive, cohesive and comprehensive Asian Voice in health research, which would be presented and discussed at the International Conference on Health Research for Development, to be held on 10-13 October 2000 in Bangkok, Thailand. It is expected that the forthcoming conference will establish important new guiding principles for health research address the continuing and growing public health problems presented by contemporary globalization.

Although a decade ago the Commission on Health Research for Development urged countries to undertake essential national health research (ENHR) to correct imbalances in global health and development, since then, various strategies to increase the research resources for developing country problems have been tried. However, a '10/90' disequilibrium persists. Only 10% of global research and development (R + D) investment is dedicated to dealing with the nearly 90% of the global disease burden borne by developing countries. Exacerbating this disequilibrium is replacement of the 'double burden' of disease by the 'triple burden'. Developing countries that are still dealing with old and new infectious diseases, in addition to gradually emerging chronic non-communicable diseases such as stroke, diabetes, cancer and heart disease, must now cope with the impact of globalization on health care systems, budgets, and political decisions.

"The best public health response to contemporary globalization is to develop a cohesive and comprehensive globalization and health research agenda. Strong international leadership is required for this agenda. A new style of cooperative research is required. The first task for the international public health research community is to establish a mechanism for facilitating this research that must extend beyond international boundaries." However, the evolving transnational civil society, political institutions and integrated economy coexist with traditional national and local systems which continue to behave autonomously to deal with perceived and real idiosyncratic needs or demands while simultaneously negotiating for larger roles in and greater benefit from the emerging universal scheme. Therefore, the challenge of strengthening global, and specifically Asian, governance of health research

lies in effectively integrating national, regional and international activities and instituting new technologies and standards without sacrificing equity and the health requirements of all segments of society to the demands of open market capitalism and maximum financial profit.

Introduction

This paper is a review of the issues addressed at the Asian Forum for Health Research held in Manila, the Philippines, on February 17-19, 2000. The Forum attracted 100 stakeholders from myriad health-related fields who focused on three basic health research concepts. The first of these was a new paradigm for health research emphasizing vision and equity, a transition from parochial to regional and global needs, and replacement of technical jargon with layman's language and consumer orientation. The second concept presented a framework around which to build an Asian regional architecture for health research cooperation and meaningful participation in the evolving global system. And the third concept examined required action for more effective health research.

The Forum's focus on these three health research concepts resulted from an innovative approach to the consultative process for international conferences. In the five months prior to the Forum, diverse health research stakeholders in Asia used the Internet as an electronic dialogue tool. Coordinated by the College of Public Health, Chulalongkorn University (Bangkok, Thailand), some 350 respondents actively participated in electronic discussions, nurturing the collaboration needed in Asia to ensure that research serves as a critical element in building equity in "health for development". This electronic dialogue tool – or Distance Dialogue, as it is known – continues to provide a communications network linking a large number of protagonists in the lead-up to the International Conference on Health Research for Development in Bangkok. This dialogue has evolved into the Asian Voice and serves as a vehicle to keep the region's people abreast of developments. It is intended that the Asian consultative process will directly provide Asia's input to the international conference and will capture information relevant to the conference's parallel sessions and distribute this to the conveners of such sessions.

The forthcoming conference is expected to lead to a new vision and responsive health research agenda for the next decade. Participants will examine past health research and explore innovative proposals for cooperation in international health studies and discuss new tools and methodologies. This paper represents significant new Asian perspective to be included in the overall declaration on the future of health research for the next decade.

The International Conference on Health Research for Development is spearheaded by an international organizing committee from the World Health Organization, the World Bank, the Global Forum for Health Research, and the Council on Health Research for Development. Close to 30 other national and international organizations are collaborating in steering the process.

Historical Background

It was at the end of the 19th century that the three preconditions emerged that led to effective action against transmissible diseases, the highest cause of death worldwide: (1) the knowledge of their causes, (2) the identification of appropriate prevention and therapy, and (3) the will for international action.

The decades spanning the late 19th to the early 20th century were the most successful in the fight against epidemic diseases. A number of microbes were discovered, the agents of widespread and lethal infections such as tuberculosis, plague and cholera, as well as their mode of transmission through arthropods or through air or polluted food and water. Sera and vaccines were introduced. Many cities and towns underwent transformations to prevent and counteract epidemics. Bills were enacted to reduce working hours from 10 or 14 to 8 hours a day, to provide protection for pregnant workers, and to limit child labour. Social insurance and various forms of collective protection of health were developed. Nations agreed to cooperate in fighting the transmission of disease across the planet, and the International Epidemics Office was created, the seed of a world health agency.

The creation of the World Health Organization, the public health policies and universal health care systems promoted in many countries, as well as the struggle for national independence and social reforms after World War II, made it possible to extend the benefits of biomedical sciences and economic progress to the majority of humanity. The interplay of a number of factors and the convergence of widely different interests resulted, for the first time in history, in a consistent pushing back of many epidemic diseases.

This paved the way to increasing life expectancy, a phenomenon occurring with large variations in time and space across the planet, thus maintaining or creating substantial inequalities among peoples and social classes. But overall, this was probably the most remarkable social and biological progress in the 20th century. The 20th century also brought two world wars, genocide, violence and local wars beyond number. But the judgment of a historian such as Toynbee holds true: the 20th century will be recalled not so much as an epoch of political conflicts and technical inventions, but rather as the time when human society dared to think about the health care of the entire human species as a practical objective within its reach.

The most recent decades will not be recalled so positively. The growing differences and inequalities in health and safety standards among nations and within nations have led to the surrendering of many hopes. The present sad orientation towards health in relation to globalization can be summed up in three points:

- The notion of health as a cornerstone of economic growth, as a multiplier of human resources, and most importantly as a primary objective of such growth, has been widely replaced by an opposing notion. Public health services and health care for all are now perceived as an obstacle, perhaps the greatest obstacle, hindering public finance and the wealth of nations,

so much so that a reduction in health expenditures (not a rationalization of expenditures, which is an imperative for all fields) has become a top priority for most governments. Owing to its own weakness and to the declining commitment of national governments, the World Health Organization, which is still internationally recognized as the leading scientific and technical health authority, slipped from a position of political leadership in health. Power and influence have shifted to the World Bank, which is becoming the real health leader, especially for developing countries. This shift and vacuum have led to 'health policy by default'.

- The model of primary health care as fundamental to the prevention and treatment of diseases has been hampered by the shift of power, in most nations, from the Ministers of Health to the Ministers of Finance, by the loss of control on social determinants of diseases, and by the priority given, even in countries with minimal resources, to costly technologies, to the exclusive benefit of the happy few. Community services are increasingly being replaced by private insurance – which in the United States turns out to be the most expensive and least equitable system of health delivery in the world – and the state is made responsible only for the poor. This is, in brief, a step back to 19th-century Europe, when health care for the poor was granted by the government or by local authorities as part of poor relief.

- The notion of world health as indivisible – a milestone in the middle of this century, the founding principle of WHO itself – has been supplanted by a widespread belief, in Europe and the United States, that wealthy populations can enjoy the best possible health separate from the suffering of other peoples. The same misconception is largely shared, within each country, by its rich and healthy social groups, often unresponsive to the conditions of the underpriviledged.

The major presentations at the Asian Forum for Health Research in Manila also further described why, despite recent gains in health development, the world is far from achieving equity in "health for development". Among the reasons discussed were population growth in Asia, the changing new context in which communicable diseases are reappearing and spreading, and the demands of non-communicable diseases and diseases related to social interactions which pose new challenges to equity. Also discussed were emerging diseases threatening mankind particularly the underprivileged, the negative consequences to public health of environmental degradation and violence, the psycho-physical and social damage resulting from drug abuse, and last, but not least, economic instability.

Although the reasons are diverse, some common features can be identified.

1. First, damage selectively, if not exclusively, falls upon persons, groups, classes and peoples in inverse ratio to their level of wealth, education, and power, thereby causing or aggravating the conditions of inequality.

2. Second, threats become increasingly global in character, so that new and strong empirical motives link the immediate interests of individuals and peoples to universal rights and to global ethics.

3. Third, not only infections but also environmental pollution, drug addiction, and violence are largely anthropogenic: they are brought about not by natural events or chance but by human choices. As such, they can be modified by voluntary action, dictated by our conscience and our needs alike.

4. Fourth, even more schematically, most of the time there is someone who makes a profit at the root cause of these events, and/or through promoting late remedies to them.

The fact that trade liberalization and trade openness (and specifically the decisions of the WTO) have facilitated the trade in hazardous commodities like 'legal' drugs and weapons, particularly directed to vulnerable groups, highlights major contradictions of a purely market-driven approach to development, health and equity.

In summary, the universe of contemporary world health research problems consists of a dynamic, multidimensional, perpetually evolving and interacting constellation of elements. Among these elements are dominance of a relatively unregulated new form of transnational capitalism over traditional political, institutional and social structures; increasing pressure to compromise local needs and surrender national autonomy without rationalization of how best to integrate national and international interests; exploitation of nations and populations and the diminution of health resources dedicated to the poor; and the appearance of multiple health burdens in developing countries. Nations and even entire regions can no longer operate independently to address the constantly changing nature of problems created by these elements. Innovative and malleable approaches and systems which effectively deal with new and old problems while sensitively and sensibly integrating national, regional and global public and private interests must be developed. The Asian Forum in Manila represented an initial step in responding to these challenges and creating a new health research future.

The Process at the Manila Meeting

The organizing framework for the Asian Forum for Health Research in Manila was a challenge dialogue process. This process was used to help the diverse stakeholders collaborate in accomplishing complex tasks in an effective manner and to help organizers create an innovative, interactive dialogue in which stakeholders were challenged and assisted in exploring cooperative approaches to deal with complex topics. The nine key steps used in the challenge dialogue process comprised:

1. Determining the strategic intention of the group, their key challenge and what they wish to accomplish.
2. Setting the scene for collaboration.
3. Selecting a documentation vehicle.
4. Using the alignment process for teaching groups to make timely, quality decisions.
5. Identifying options, examining consequences, and determining priorities.
6. Imagining innovative approaches for implementing the priority option.
7. Taking concrete action to implement the priority option.
8. Determining the measures that matter and selecting, tracking and utilizing key performance indicators.
9. Sustaining the collaboration.

These steps do not necessarily all have to be used in every situation, nor do they have to be followed in exact linear order. But, if utilized with some discipline and creative application of the supporting tools, the steps can lead a group to discover untapped potential or academic capital and facilitate achievement of significant goals.

The dialogue process is based on trust to create a sense of ownership by all involved, each participant has the opportunity to express ideas and be heard. This process will not end when the International Conference on Health Research for Development ends. Rather, it is expected to be the genesis of involving Asian groups in a long-term relationship for promoting research and information sharing to realize equality in “health for development”. Finally, through the dialogue process, participants’ ideas will be incorporated into the Asian voice and will help create methods for improving the next steps.

The forum was conducted as if it were a three-day session of an Open University of Research for Equity in Health Development. This open university concept provided stakeholders the opportunity to freely discuss the Asia dialogue and consequently to realize consensus on the important health equity for development issues or the Asian voice related to each of the themes. Stakeholders were able to discuss the themes and to define the functions

and mechanisms, which will use health research as an instrument for moving society towards equity in health. In addition, stakeholders were given the opportunity to modify and adopt a declaration on health research.

The forum included major presentations by keynote speakers, table and collaborative group discussions, a marketplace and a Forum Resource Center. The major presentations described why, despite recent gains in health development, the world has yet to go a long way, to achieve equity in "health for development". The presenters were key international personalities with myriad experiences. All of them were from developing countries in Asia and their context was not within a particular discipline but rather in the research system as a whole. They shared organizational, administrative, technical and procedural experiences in many aspects of research and demonstrated how to bring government, nongovernmental, national and international agencies in line with corresponding changes in other sectors and with current research developments. Each speaker was instructed to highlight the key challenge related to the topic, to give a concise background on what led to this challenge, to provide examples of breakthrough innovations, and to assign one or two questions for consideration. In addition, each speaker acted as a catalyst to stimulate collaborative group discussions. The speakers asked each collaborative group to summarize their reactions on a flipchart and encouraged feedback from the larger assembly. The flipchart summaries represented the first products of the forum.

To complement the presentation process, six collaborative teams based on subjects derived from the five-month e-mail or distance dialogue exercise, were created. These subjects were considered as entry points for team members to discuss conceptualization of health research and issues related to health research functions, action plans and architecture. The teams were asked to integrate ideas about solving problems in a manner that would result in equity in "health for development". They were also asked to avoid limiting themselves *to* traditional methods of using scientific evidence for analyzing disease or promoting health. The purpose was to connect scientific approach with political process, to reorient researchers in dealing with and addressing evolving political, technical, resource and human or social realities. Each collaborative team elected a leader who summarized ideas on the new conceptualization of research and developing new architecture, which were then incorporated into the Asian Voice.

As a third component, a physical marketplace was established at the forum to allow participants to share information on the existing countries or on the activities of government health ministries, medical schools, academic institutions, and organizations such as COHRED, INCLEN and WHO. The marketplace served as an informal, interactive environment and comprised an information and general resource center, an enabling technology center and speakers corner. Through the technology center, participants were provided a better understanding of how to use appropriate technologies (ITCs) to support the work of their organizations.

Ultimately, the forum represented an effective application of the SHARED approach, realizing a vision of providing a democratizing force to the developing world by equipping participants with state-of-the-art technology to allow database-driven communication. The process before and during the forum was and remains both an end unto itself and means to an end – an end consisting of a new paradigm, architecture and course of action to ensure equity in “health for development”.

Framework

The New Paradigm

The Asian Consultative Process which evolved from the Distance Dialogue (initiated five months prior to the Forum through support from WHO SEARO, WPRO, INCLEN Southeast Asia, ENHR country focal points, and the Federation for Social Sciences network), established basic concepts, procedures and recommendations upon which to base future work. The results of this "Asian Dialogue" are expected to feed into the International Conference on Health Research for Development the process of organizing that meeting itself. These results emanated from a set of dialogue derived assumptions:

- that Asia wants to make its voice heard loud and clear;
- that a new type of regional meeting will be required to capture the ideas and ideals of health research in Asia;
- that the knowledge-based economy and its implications will influence how Asia approaches health research for equity in "health for development";
- that Asia will need to think about new leaders or re-orientation of existing leaders.
- that new thinking, tools and ethics are critical for research towards equity in "health for development"; and
- that new functions and a new architecture are needed for more meaningful collaboration in effecting health research that efficiently and productively promotes equity.

Participants at the Manila meeting, who included basic researchers and various types of medical and health scientists, NGO representatives, policy makers, and private enterprise and donor representatives, discussed each assumption. They concluded that the Manila meeting would provide Asian input to the international conference and beyond, and that electronic dialogue topics would be the basis of face-to-face deliberations about the Asian Voice. Regarding the new type of regional meeting, it was decided only highly innovative, stimulating and collaborative conferences which allow participants to adopt "out-of-the-box" thinking and to make quick, quality team decisions, would be conducive to further dialogue. The participants recognized that the new knowledge-based economy is global, fast changing, and highly vigorous and significantly affects health and equity. Therefore, Asians must be committed to research towards better equity in health. Participants also resolved to provide understanding and capacity development to produce new, innovative health and research leaders equipped with knowledge-based thinking skills, ability and quality-based execution skills, collaborative and collegial in their orientation and with honorable, ethical values. There was

consensus that new thinking, tools and ethics for research are needed to drive the concept of equity in health, and that Asians need to examine their historic assumptions about thinking, tools and ethics to determine what shifts might be useful. Finally, it was concluded that improved performance is predicated on innovative collaboration based on new functions among diverse stakeholders concerned with issues about equity in "health for development".

These assumptions will guide Asians participating in and contributing to the International Conference on Health Research for Development, directing their renewed emphasis as influential shareholders and actors in the transnational future development of health, and guaranteeing the universal adoption of principles of equity, ethics, and inclusion in that future.

Architecture and Required Action

With a paradigm shift towards research for equity in health, more cooperation among national, regional and global institutions will be needed. The architecture for this increased cooperation can be a range of structures, support systems and networks. Therefore, countries may decide to reorient existing structures, support systems and networks or develop new architecture to support research in equity for health under the new paradigm. The nature and extent of the evolved architecture will be country specific to simultaneously meet idiosyncratic, indigenous needs while coordinating national efforts with regional and international partners.

There are many operating principles for an effective architecture at the national level. These include a political commitment to support equity; a capability for setting research priorities and directing research policies; an ability to identify and mobilize private and public institutions, researchers and the community for effective networking and partnership; a willingness to support decentralized autonomy with central and multisectoral cooperation; a desire to be inclusive and interactive; a responsiveness and relevance to needs; willingness to communicate in simple language research findings to influence policy makers and obtain commitment of various protagonists; and a 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 capable manpower must be an important component of the work plan.

At the regional level, a clear statement of vision, mission, and political commitment is needed. In addition, supportive organizational structure, work plans, regional agenda setting mechanisms including timeframes for such exercises, resource mobilization and allocation according to regional priorities, and a regional clearing house of institutions and researchers for networking, interaction, collective leadership and operation in support of national objectives, is required.

At the global level support for equity can be achieved by responding to developing country needs to balance the current research emphasis on solving health problems of developed countries. Furthermore, the global architecture must contain strategies to empower national research communities in developing countries with explicit and clear work processes accessible to all.

The architecture at all levels should stringently avoid bureaucracy, predominant and excessive centralized decision-making, prescriptive or donor domination of the research agenda, priority setting mechanisms and the research architecture, exclusivity, restrictive networks that lead to isolation and inbreeding, arbitrary setting up of artificial boundaries, exploitative collaboration without technology transfer, excessive profit or market driven forces, closed operations and over reliance on non-transferable and expensive high technology. The creation of new institutions or structures under the guise of coordinating existing institutions should be avoided unless a significant effort to refocus the existing mechanisms is made. Missions and plans at all levels must be subject to periodic self and independent evaluation, including periodic reviews of interactions between different levels in support of the health research status in countries.

A range of functions is considered important in an evolving architecture. These functions include policy making and priority setting; development of capacities for research implementation and management, resource mobilization and allocation based on research priorities; advocacy and promotion of research environments; improving communication skills of the researchers for effective and timely dissemination, creation of ownership and utilization of research results; setting standards and norms; and fostering equal and capacity-building partnerships and international cooperation.

Information technology should be optimally capitalized to nurture the new collaborative effort. First, government and local agencies must, at the outset, develop the basic infrastructure for communication. Second, the collaborative network has to produce high quality content to put in the infrastructure. Finally, the market must be able to invest in areas, activities and quality products, which will make a profit. Over the next few years, it is expected that the market will play a major role in the new architecture because of increased utilization of the high quality products resulting from the new basic infrastructure. The emerging organization and infrastructure should not attempt to become a new neutral global institution for health research coordination. Rather, collaboration should focus on ideals of equity in “health for development” to be achieved by developed and developing countries using the new technology to initiate and report on real content and the different processes by which people collaborate. The potential of the evolving information and communication technology in this new architecture will be further developed with the creation of a new Website and expansion of the Asian dialogue process.

Effective research will lead to action when researchers redirect their focus from publications and career promotion to cooperative translation of findings into action. The key factors for transforming research into action include:

1. Ownership of the relevant questions
2. Reorientation of research and research institutions to make research products accessible to potential users.
3. Identification of research products both in terms of publications and in terms of transformation into action.
4. Inclusion in research proposals of good plans for dissemination and communication of research results.

Capacity building for transformation of research into action must involve both users and producers of research. The former will need to be equipped with skills and aptitudes to examine implications of essential research and to seek appropriate interpretation of results, while the latter must develop the necessary communication and presentation skills and use simple language so as to be attentive to potential users when undertaking research work and disseminating the findings.

The new framework must also include development and agreement on ethical standards in conducting research. It should also include priority setting, resource allocation (based on value choices such as how large a share is dedicated to people in lower-income subgroups and different age groups), the assessment of the burden of diseases, accessibility to biomedical research and international cooperation in clinical research. Of special concern are the weaknesses of the ethical review capacity in developing countries as well as the weaknesses of existing ethical guidelines. Ethical review mechanisms and procedures regarding transparency of the potential benefit and/or harm (particularly to vulnerable groups) resulting from widespread distribution of studies must be examined and strengthened. Furthermore, protection and confidentiality of individual and group data must also be ensured. The forum in Manila strongly endorsed the need for a code of practice for international collaborative research. International organizations such as WHO should have a definite role in developing and standardizing guidelines to foster a normative context for scientific investigations. In addition, these international organizations should advocate and monitor such a code of practice to protect developing countries, most of which have little or no bargaining power.

Outcome

The Asian Forum for Health Research meeting in Manila endorsed the following fundamental principles of research for equity as representing the Asian Voice.

1. The Asian Voice reaffirms the commitment to a health research enterprise defined by the values of equity and ethics.

2. The Asian Voice reaffirms a commitment for health research to uphold the principle of equity. This is a reaffirmation of social and distributive justice in health. Equity in health will be the definitive goal for Asian health research efforts, which will help create the opportunity for all people in Asia to optimize their health development.

3. The Asian Voice also reaffirms a commitment to 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 are developed by Asians for Asian people.

It was agreed these principles would guide the actions and goals of Asian health research.

Questions to be Addressed

The forum recognized that many problems remain to be solved before the Asian Voice principles can be realized. The magnitude of research information available and the multitude of stakeholders participating in cooperative research endeavors made possible by new technology is overwhelming. Global Link (a current, rapidly expanding major Internet platform connecting policy makers, academics and NGOs in all countries) now links over 1200 tobacco control programmes worldwide, demonstrating the power of modern information technologies to close the gap between global and local concerns. However, issues of how such large systems best coordinate their efforts and altruistically share relevant new information and discoveries to benefit all participants equally will dominate efforts to effectively coordinate and direct regional and worldwide partnerships. Furthermore, mechanisms are needed to determine which pieces of the massive amount of information available are relevant and/or useful and which are altogether missing and/or purposefully unavailable.

Other questions include how best to establish multilateral communication and cooperation among technically impoverished communities, grass roots organizations, academic ivory towers, nationalistic politicians, regional and international institutions and far-from-selfless global businesses to begin the equity negotiation.

In addition, another question remains to be answered as to how best to mobilize local, national, regional and international resources and how best to effectively, fairly and equitably allocate such resources; which methods and combinations of monetary, social, political and technical capital utilization are best suited to idiosyncratic, indigenous needs; what mechanism will be employed to reconcile the myriad and perhaps conflicting interests and requirements of Asian stakeholders; and, finally, who will assume leadership in building consensus on ways to ensure sustainability, objective evaluation and meaningful translation of research findings into realistic and optimally beneficial political policies and programs.

To satisfactorily address these and other problems, the Asian Voice community will require formal memoranda of understanding and related regulatory mechanisms to secure agreement on the division of resources and responsibilities among and contributions expected from network members. Although the Asian Voice will strive to avoid bureaucratization, institutionalization and regulatory gridlock, a modicum of coordination, oversight and accountability is a prerequisite, essential condition of success.

Evaluation and Sustainability

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 national and global research resource flows. 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 to ensure effective resource mobilization for research priorities and for linking research to policy and action.

The Asian Regional Health Forum is supporting the development of a Leadership Network, which is working collaboratively to create a Knowledge Network (on Equity in Health). These networks will be supported by a Technology Network to serve as an enabling tool. The forum meeting in Manila operated a pilot Enabling Technology Center to explore how electronic tools might best be utilized to support the vision and mission of the forum. A prototype Electronic Resource Center gathered, synthesized, organized and stored all the input from the forum electronically to make it available for quick, flexible inexpensive access by interested stakeholders. The intention is to launch an interactive Electronic Resource Center for the Asian Voice on Health Research (ERC Asian Voice). The center will provide information about knowledge, processes, leadership development initiatives and tools on research for equity in health. This will involve electronic surveys, on-line dialogues, and the ability to create detailed research reports collaboratively at distance.

The Asian Voice is intended to serve as an exploratory prototype for understanding the elements of building a useful knowledge management system and how appropriate new information and communications technologies (ICTs) might best be used in such a system to support the improvement of an organization's performance. In the final analysis, sustainability of the Asian Voice will be critical if the commitment to health research enterprise defined by the values of equity and ethics, is to be realized; if left to market forces alone, an intervention technology to ensure essential research with these values might never be developed.

Report of the Retreat on the Caribbean Health Research Agenda:

Executive Summary

Prepared by:

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Summary

The Caribbean Health Research Council (CHRC) arranged a retreat for stakeholders in Caribbean health to outline a research agenda for the region as part of the consultative process for the International Conference on Health Research for Development. The meeting was held on 13-15 July 2000 and was attended by representatives of governmental, academic and professional organizations active in the field of health research in the Caribbean. Various persons had been invited to present discussion papers on six of the eight Caribbean Cooperation in Health (Phase II) priority areas, and working groups were designated to identify health research issues within the priority areas.

The debate was structured around the discussion papers on the following key themes: issues in health research: a Caribbean perspective; food and nutrition; chronic non-communicable diseases; mental health; maternal and child health; communicable diseases; and environmental health.

The paper on issues in health research from a Caribbean perspective outlined the characteristics of health research in the region. Research funding comes from a variety of sources with less than 10% coming from governments. A majority of research is done at universities and health research institutions, but there is little collaboration. Constraints include inadequate funding and facilities; problems with data collection and analysis; and lack of supporting staff. In reviewing research in the last 50 years attention was drawn to inadequate linkages between the producers of research information, intermediary organizations, such as ministries and funding agencies, and end users. The neglect of local communities was also cited.

The paper on food and nutrition addressed the major problems of obesity; anaemia and malnutrition; and household food security. The availability, accessibility, consumption and nutritional status of food were cited as key factors. Anaemia continues to be a problem in pregnancy, in children under the age of four, and in school age children.

The presentation on chronic, non-communicable diseases dealt with the epidemiological transition in terms of models applicable to changes in lifestyle and urban–rural differences, including the management of risk factors such as obesity and cholesterol.

In the presentation on mental health the wide range of mental health disorders was underlined. Most so-called mental health services in the Caribbean are still focused on psychiatry, not mental health. Much research is needed on the prevention of mental disorders and substance abuse and there is a need to train people to deal with stress at various stages of the life cycle.

The paper on maternal and child health pointed out problems of data collection and analysis. For example, 91% of stillbirths were not registered in a recent national study. Perinatal mortality is still high.

The paper on communicable diseases referred to the globalization of infectious diseases and the emergence of antibiotic-resistant organisms. Specific areas for research include HIV/AIDS, tuberculosis, food- and water-borne illness, and tropical and vector-borne diseases (VBD), including dengue, yellow fever, and malaria.

The presentation on environmental health considered various aspects of the problem, ranging from the economic and social impact of poor environmental health practices, water supply, solid waste management, waste water management and excreta disposal, pollution control, management of chemicals, occupational health and safety, food safety and coastal water quality. Baseline studies on air pollution (indoor and outdoor) and relationship to health and quality of life were significant.

After presentation of the discussion papers, four groups examined the topics presented and all identified several common issues under two headings of general research issues and cross-cutting issues. General issues included the need for health information systems; a “research culture”; capacity strengthening; staff training, collaboration between ministries, universities and other groups; dissemination of research results, fund-raising mechanisms; and reduction of “brain drain”. Under cross-cutting issues mention was made of social and economic determinants of health: risk factors, equity and gender issues; lifestyle changes; translation of research findings into policy and action.

In the ensuing debate a number of research issues in priority health areas were determined and are listed in detail in the report. In concluding, participants elaborated a series of recommendations on key themes for inclusion in the region’s input to the International Conference on Health Research for Development, which included the following: human capacity development; the “brain drain”; country first (the subsidiarity principle); sustainable funding for development; better networking; links between health and development; health research for greater equity and the alleviation of poverty.

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Regional Consultation on Health Research and Policy Development in Central and Eastern Europe and the Newly Independent States

Balatonlelle, Hungary, 12-13 May 2000

Organised jointly by the Council on Health Research for Development (COHRED) and the World Health Organization Regional Office for Europe (WHO EURO)

SUMMARY

Aims

- Review major health research initiatives in Central and Eastern Europe (CEE) and the Newly Independent States (NIS).
- Assess the use of evidence-based policy making in CEE countries and NIS.
- Set a new health research agenda for the next decade.
- Outline possible linkages between health research and policy making.

Objectives

- Assess the impact of major health research initiatives during the past ten years with focus on health policy development;
- Review the indicators, tools and methodologies used for health research and evidence-based health policy;
- Build partnerships;
- Make recommendations to improve equity in health and for international organisations supporting health research.

Working method

The working method of the consultation was as follows:

1. Presentation of selected country case studies (Kazakhstan, Lithuania, Hungary, Romania, Russian Federation, Uzbekistan).
2. Open discussion of case studies, outlining the similarities and differences in CEEC and NIS.
3. Situation analysis of health research and health policy in CEEC and NIS, based on SWOT-analysis (strengths, weaknesses, opportunities, threats), carried out by the participants.
4. Drawing of conclusions from the outcomes of the analysis, making recommendations for the CEEC, NIS and international organisations on the new health research agenda based on the lessons learnt from the SWOT-analysis.

Outcomes of SWOT-analysis

Strengths

- Strong, competitive human resources in specific areas of health research, fundamental scientific research and scientific schools that are still important.
- Existing organisational structures of health research: universities, academic institutions, education of researchers, academic scientific carrier system.
- Long tradition of health research in most countries.
- Competition-based resource distribution in health research.
- Existing links with international agencies and research institutions.
- Changes in population health of interest for the international research community.
- Rich database; adequate, detailed information system exists for health policy and health research policy formulation;
- There are existing health research priorities for most of the countries.
- Rapid development of information technology.
- Existing experience of involving governments and other state agencies in organising and funding health research.
- Successful survival techniques practised in an economically difficult situation.

Weaknesses

- Insufficient funding of health research.
- Financial allocation does not reflect real priorities.
- Lack of equipment and appropriate technical infrastructure.
- International support insufficient and uncoordinated.
- Lack of experience in fund-raising and research management.
- Lack of coherent strategy or implementation plan for human resource development for health research.
- Declining interest of younger generation in research career.
- Low salaries of researchers.
- Insufficient training in health research in the field of public health.

- Lack of stakeholder involvement in different phases of health research: needs analysis not practised, no community involvement, poor dissemination and communication with broader community, policy makers, media.
- Lack of coordination and cooperation between health researchers in different disciplines.
- Imbalance among biomedical, health system and behavioural science research; behavioural sciences relatively neglected and underfunded;
- Problems with the process of priority setting; priorities are often not based on existing evidence, sometimes no consensus on priorities.
- Lack of clear health policy, health research policy and policy implementation plan.
- Not enough attention devoted to inequalities.

Opportunities

- International and regional cooperation between research institutions and individual researchers.
- Rapid development of information technology, with a chance to improve access to information and knowledge.
- New priorities emerging, new methods of priority-setting.
- General improvement of economy in the region.
- Use of internationally available expertise and knowledge (WHO, etc.).
- Access to funding from international development agencies.
- Better understanding of research as an investment;
- Wider acceptance of new practices of intersectoral thinking.
- New ethical standards of research in international cooperation and at national level.
- Globalisation offers potential for establishing new partnerships and alliances.

Threats

- Political instability in many countries of the region, with frequent change of government.
- Low level of research funding and general economic crisis in many countries.
- Corruption and nepotism widespread in the region.
- Loss of existing or previously functioning networks, structures, scientific schools.
- Migration of researchers, brain-drain to the West.
- Ageing of research community, weak links to the new generation.
- Lack of clear ethical standards in research, commercialisation.
- Persisting lack of coherent health policy.
- Lack of responsiveness to new challenges within research community, lack of flexibility, mental barriers to adaptation to a turbulent environment.
- Continuing neglect of health as an investment, underestimation of health as an input to the national progress.

Recommendations for future health research policy

The participants formulated recommendations for different levels and organisations dealing with health research and health policy.

In-country

- Create sustainable partnerships with politicians and policy-makers, focusing on advocacy aimed at policy makers and enhanced coordination of State resource allocations.
- Improve quality of priority-setting processes.
- Develop interdisciplinary linkages between different branches and areas of health research to increase effectiveness of advocacy and use of resources.
- Develop and strengthen research management, with focus on quality of research and research processes.
- Need for strategic human resource capacity development.
- Increase health research finance.
- Build on existing structures and the rich heritage of the past.

Recommendations for regional cooperation

- Regional networking and cooperation are vital, and should be strengthened and deepened.
- Professional networks and societies of different disciplines should be linked for exchange of experience and joint actions.
- Develop bilateral cooperation and twinning.
- Need for subregional approach with differentiated policies (Central Europe, Eastern Europe, Central Asia).
- Supranational and subregional collaboration, with sustainable organisational background.
- Need for region-wide training of health researchers in local centres of excellence.
- Regional clearing-house of research projects and results.

Recommendations for international level

- Need for worldwide dialogue on health and health research.
- Regular exchange of ideas and opinions.
- Free flow of information.
- CEEC/NIS should be present in world-wide initiatives and activities.

For WHO

- Strengthen collaborative activities,
- Give more attention to human resources development: training for researchers and civil servants, decision makers on the subject of priority-setting, research-to-action.
- Provide forum for regional dialogue, organise regional follow-ups.
- Contribute to formulation of regional health research policy.
- Create and enhance utilisation of research standards and norms (research quality, ethics of co-operation).
- Create health research related glossary for common understanding.
- Contribute to establishing of regional clearing-house of health research know-how.

For COHRED

- Provide more technical and financial support for in-country activities.
- Contribute to regional networking process; provide know-how on networking.
- Develop ENHR regional network.
- Give priority to support for Central Asia.
- Support the voice of countries with poor representation in international forums.
- Involve CEEC/NIS region in COHRED regular activities (task force, research-to-policy initiatives).

For Global Forum for Health Research

- Provide analytical support for CEEC/NIS in priority setting for health research.
- Support regional initiatives.
- Provide information regularly on ongoing Global Forum activities; ensure the “right to ask” for CEEC/NIS.
- Provide forum in GFHR marketplace for regional initiatives.

CEEC/NIS VOICE

Voice of Central and Eastern European Countries and Newly Independent States for the International Conference on Health Research for Development

The new paradigm

- Balance of health research in many aspects
  - balance of basic biomedical-behavioural sciences-health system research
  - balanced stakeholder involvement in research planning and evaluation
  - conscious dissemination of results for different stakeholders
  - balance between quality of research and relevance/timeliness for decision making
- New partnerships in the process of research policy development - deliberate involvement of stakeholders, open-up to the community, NGOs, insurance companies
- Countries with less developed health research must be involved in international and regional cooperation
- Equal partnerships in health research between institutions, professions, countries and regions.
- Great experience of health research in socio-economic transition and economic crisis
- More emphasis on research management, resource mobilisation and effective financing techniques.
- Need for formulation of new research ethics, ethics of inter-institutional and international cooperation, new ethical values in the field of biomedical research, research of communities.
- Re-emphasize the importance of equity in health and the research of equity.

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Report on the Eastern Mediterranean Regional Consultation on Health Research for Development

Sponsored by the Council on Health Research for Development and the WHO Regional Office for the Eastern Mediterranean

Cairo, Egypt, 24–26 June 2000

Executive Summary

A regional consultation on health research for development was held jointly by the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) and the Council on Health Research for Development (COHRED) from 24 to 26 June 2000 in Cairo, Egypt, as part of a broad consultative process in preparation for a global conference on health research for development to be held in Bangkok, Thailand, in October 2000. The consultation, which was attended by 16 experts from 10 countries of the Region as well as by staff from WHO and COHRED, reviewed the current situation of health research in the countries of the Eastern Mediterranean Region and proposed future directions for health research.

The review of the current situation of health research in the Eastern Mediterranean Region revealed the following:

- In most countries there is political commitment for health research, and some sort of health research policy exists.
- Priority-setting is being done through workshops and consultations and based on results of health surveys.
- Stakeholders are mostly limited to staff in the universities and in research institutions.
- Most countries report little utilization of research findings by planners and policy-makers. In fact, there is hardly any demand for research by health service managers and planners, and except for ad hoc contacts no sustained linkages exist between researchers and decision-makers.
- Different models for coordination of research exist in the Region. However, there is considerable room for improving their effectiveness.
- Weaknesses are widely present in defining research problems, use of appropriate research methods, data analysis and interpretation and writing scientific papers.
- Very few functioning networks exist in the Region.
- Some attempts are being made to strengthen research capacities of young researchers, mostly through short-term national training courses. However, no systematic national plans exist for developing research capacities of concerned stakeholders.
- There appears to be an urgent need to demystify research and create a research culture in which research training is integrated early in medical education and planning for research is included as an intrinsic component of national health plans.

Regarding strategic directions for health research during the coming decade, the following recommendations were made.

To countries

1. Health research units should be created/strengthened in ministries of health and encouraged to create a demand for research.
2. National forums should be established to periodically bring together all of the stakeholders involved in heath research, particularly nongovernmental organizations and community representatives.
3. Health research should be promoted as an integral part of health development.
4. Research priorities should be set not only at national levels but also at subnational and district levels, and they should take into account explicit principles and values.
5. Universities and ministries of health have complementary roles in health, and every effort should be made for collaboration between them on health problems of national importance.
6. Broad social objectives should be used as an entry point for promoting multidisciplinary research.
7. All national bodies funding health research services should develop explicit policies and procedures for reviewing proposals as well as for monitoring and evaluating those which are funded.

To WHO and/or COHRED

8. WHO/EMRO and/or COHRED should document and disseminate country experiences in community mobilization in priority-setting and in health research.
9. WHO/EMRO should disseminate information about the strengths and weaknesses of different national mechanisms being used for coordinating health research.
10. WHO/EMRO should facilitate and support research projects among countries on common and priority topics.
11. WHO/EMRO should play a key role in supporting the development of appropriate learning materials for enhancing the research capacities of different target groups of stakeholders, including in areas such as research management, communication skills, advocacy, social marketing, participatory techniques, etc.
12. WHO/EMRO and/or COHRED should support studies on research flows for health research.
13. WHO/EMRO research policies and programmes should reflect regional diversity.

14. The WHO Regional Advisory Committee for Health Research should reconvene and meet regularly. It should be multisectoral and include subcommittees to represent different stakeholders and research themes.

15. WHO/EMRO and COHRED should explore the idea of establishing a regional fund for health research. Possible donors might include the Organization of Islamic Conference and Gulf Cooperation Council, as well as other regional donor organizations.

16. WHO Representatives' Offices should be strengthened to support health research in their respective countries.

17. The presence of COHRED in the Region should be strengthened.

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Latin American Consultative Meeting

Summary

Buenos Aires, June 26 - 28, 2000

Summary

The meeting started with a presentation by Dr. Ernesto Podestá on the situation in Argentina. This showed a history of accumulation of knowledge and creation of critical masses in the 1950s, which reached such levels of excellence as to achieve three Nobel prizes, and later on, its falling apart, and the consequences of this process. The " CONICET researcher's career" was explained, including its shortcomings. This is one of the few cases in Latin America where a salary is assigned to researchers based on the body of their production, not attached to a specific project.

Next, presentations were made by the international agencies attending the meeting.

The Commission on Health Research for Development (COHRED) and the Global Forum for Health Research made brief summaries of their histories, and the situation diagnosis that had led to their creation. The main driving forces in both cases were the observations that health research had not been a priority, had not focused its attention on the most relevant problems of local populations and had not contributed to development.

Dr. Pellegrini, Head of the Research Coordination Unit of the Pan American Health Organization presented a paper, based on a more infrastructural approach and pointing to the fact that although national investment in research and development has increased in the past ten years in most countries of the Region, it is still insufficient, as is the Region's presence in the international scientific literature.

During the discussion that followed, several issues were dealt with:

1. The fact that the diagnosis made in the presentations should also be subject to discussion.

2. The understanding of Latin American processes in most international agencies is very inadequate. This may be because of the Region's complexity, but there is a mismatch between many recommended "solutions" and self-perceived needs.

3. There are important contradictions between international agencies guiding economic models and those in the social area, such as the World Health Organization (WHO). It is hard to ask health research to solve or alleviate the problems created and/or increased by other sectors.

4. Inequity is the main problem within the Latin American context. Much conceptual work is still required on the definition and operationalization of the equity concept, in terms not only of class, but of gender also. This concept should permeate the whole practice of health research .

5. The existing scientific model has its supporters, and there is no consensus about some proposals that are often heard, such as the benefits of a greater private sector participation in the financing of health research.

There is no proof that this would increase equity.

6. Problems related to human resources for research:

   i. There is still a need to discuss and define the type of training required for carrying out research in different disciplines.

   ii. The difficulty of reinserting highly trained scientists who have spent some years abroad, often with scholarships from their own countries.

   iii. The existence of different "corporations" in the field of health research, including at least the groups related to Science and Technology Development, Health Systems and Services, and Technology Assessment (Knowledge dissemination). None of these groups should or could be ignored.

7. There was an agreement regarding the need to create/strengthen structures oriented to:

   i. Priority setting for public expenditure in research and development, improving the participation of public health (broadly defined to include all health research with a population approach) within health research;

   ii. Gathering and distributing research funds;

   iii. Disseminating locally produced knowledge;

   iv. Contributing to the training of researchers in a planned and continuous manner.

Some **false contradictions** came up during the discussion, and they were identified as such:

- **Research vs. action**. The group did not consider it a valid opposition, as action is grounded on knowledge, which needs to be increased and updated.
- **Basic and Clinical research vs. Public Health**. It was clear that nobody means to decrease the funds available for basic science, or endanger the existing centers of excellence, but to strengthen an area of special social relevance that is presently underrepresented. A "research culture" favors all areas of knowledge.
- **Immediate application of results vs. research for the future**. Research that can be applied more or less immediately is nevertheless based on previously accumulated knowledge, and both are valid. In our area of knowledge, public health, an orientation to problem solving is required, be it at the micro or macro levels, and of more or less immediate acceptability.

The following relevant points came up but were left for later discussion:

- There was a consensus on the need for priority setting in health research, but there was still no clarity regarding the most appropriate methodologies

and tools to do it, particularly regarding alternatives to disease-based tools for priority setting.

- The reasons why health research is marginal in Latin America.
- The most appropriate criteria to judge science. Should judgement be based on its contribution to equity, its intrinsic quality, or something else?

On day 2, groups that had been conducting case studies either at country level or within networks made presentations. All of the results presented were preliminary, but they greatly contributed to the understanding of health research in the Region and to the discussion that followed.

The **Chilean group** carried out a survey among a representative group of researchers in order to understand their perception of health research. This showed quite a negative perception, since the most frequent answers were that research has not contributed to change in medical practices, or improved the quality of life of populations, or been useful for monitoring inequity.

The **Network for Latin American and Caribbean Women's Health** made the next presentation. The survey included 130 reports of research projects and 21 interviews. Results showed that with few exceptions, there has been no research with a gender approach. The projects were found not to be very comprehensive, and not to focus on the health problems of women. Most were case studies using a qualitative methodology and considering few cases. The issues most frequently dealt with were sexual and reproductive health (mainly fertility surveys), violence against women, and mental health. The subjects were mainly urban poor adolescents.

The combination of quantitative and qualitative methodologies is quite frequent, as is the use of secondary data. Advances have been made in the development of gender-sensitive health indicators. From the theoretical point of view, some of the papers reviewed showed interesting new approaches, and a complex analysis of power relations. Among the obstacles found, a resistance to using gender as an analytical category was prominent. The lack of a critical mass of researchers on the subject was also noticed. The paper remarked the need to deepen the understanding of the gender concept, the need to include it in all studies, to develop new sensitive indicators and to foster concern for equity in all stages of research.

The **Mexican case study** had three main objectives: to make a situation analysis of health research in Mexico, to understand its relationship with health policies, and to contribute to the process of priority setting in health research. A wide consultative process with the most representative Mexican research institutions is underway. This case study is still in the data collection phase, and results presented at the meeting were mainly about global scientific indicators.

Finally, the **Cuban case study** was presented. Cuba has been carrying out priority-setting exercises for the past ten years. The country has a national scientific policy, and health research priorities fit within it.

The need to give priority to infrastructure was also a concern in this case. Finally, science and technology planning in Cuba is programme-based in the cases of national, branch and territorial programs, while some projects, such as biotechnology or vaccine production are not programme-related.

A discussion followed each presentation, and served as the basis for the group work that followed.

Four groups were formed:

1. Group 1 dealt with the relationship between research and health policies. Its members were Drs. Podestá, Machicao, Medina, Illanez and Pérez
2. Group 2 discussed the subject of financing for health research. It was formed by Drs. Palma, M. Sánchez, Dutihl, Muñoz and Gagliardi
3. This group, dealing with priority setting was formed by Drs. Possas, de Francisco, Gestenbluth, Reyes and D. Sánchez
4. The fourth group concentrated on inequity, and its members were Drs. Cabrera, González, Zeledón, Chapman and Kerker.

On the final day the groups briefly met again and wrote summaries of their conclusions, which were then submitted to the plenary, and constitute the **Consensus Diagnosis and Recommendations of this Latin American consultative meeting**.

Consensus Diagnosis and Recommendations

1. So that health research may contribute to development with equity, it must be based on the following values:

   i. Ethics

   ii. Solidarity

   iii. Social and gender justice

   iv. Human rights.

2. It is therefore necessary to strengthen research oriented to the understanding and solution of social problems and population needs, and aimed at overcoming inequities.

3. The Latin American presence in the international scientific literature is extremely limited: 2.09% of the world production registered in the database of the Institute for Scientific Information (ISI) in the year 1996, and just 1.37% of the articles registered in MEDLINE for the same year. Scientific production is larger than this, and there has been an accumulation of knowledge in some relevant areas, but its translation into publications has been quite limited.

4. Latin-American countries are very diverse in terms of infrastructure, human resources, availability of financing for health research and technological development. This is evident in the uneven concentration of scientific production, with Argentina, Brazil, Chile, Mexico and Venezuela responsible for almost 90% of the Latin American publications registered in MEDLINE and ISI.

5. This diversity is seldom recognized in the diagnosis made about the region by many international agencies.

6. There is a tension between health research and health policies. Health research does not contribute as much as it should to the establishment of new health policies, while the latter do not often favor research. Health policies that allow for the development of research policies focusing on social problems are greatly needed.

7. Ethical intervention mechanisms must be created. These include the democratization of information and knowledge, increased community participation, and the creation of spaces for interaction of the different stakeholders in health research.

8. Despite the growth in science and technology spending that has taken place in recent years, financial resources for research are insufficient, with different situations according to countries, and the use of existing funds could be improved. Research is still considered mainly as an expense instead of an investment, and stable mechanisms for financing it are missing in most countries.

9. The tools generally used for priority setting are different at the national and international levels. While the former show a greater weight of a mix of political will and researchers' lobbying, the latter are mainly disease-based and need to be critically reviewed.

10. This revision should incorporate the theoretical and methodological contributions of the Region, oriented to health determinants and a democratization of decision-making processes.

The participants in the consultative meeting propose therefore:

1. To strengthen health research that has a social approach, whether it is basic, applied or operational, increasing its participation in the total research budget.

2. To speed up the trend of the past ten years, increasing the availability of funds for research.

3. To define mechanisms that facilitate the training of human resources, including researchers, decision-makers and research managers. This includes the creation of regional post-graduate courses and research methods programs, but is not limited to it.

4. To establish appropriate mechanisms to stop the present brain drain process Latin American countries are subject to, facilitating the repatriation of scientists.

5. To create networks, both at the national and international levels, in order to ensure a greater visibility of research in the public health field, the exchange and accumulation of knowledge and the contribution of regional researchers and other stakeholders to priority setting.

6. To strengthen the appropriation of knowledge and decision-making on health research by general society, through the systematic dissemination of information.

7. To consider the possibility of creating a Latin American scientific journal, of high scientific level and with the objective of increasing the region's participation in world publications as well as of favoring the dissemination of knowledge generated in Latin America.

8. To create mechanisms to retrieve much of the existing Latin American production in health research, which is presently of difficult access, and facilitate its dissemination.

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