

R Research into Action

Winds of change sweep across the COHRED landscape

December 2000 finds COHRED in a state of transformation. It heralds the end of a COHRED journey for our Board Chair of the past 4 years, Professor Charas Suwanwela from Thailand. Professor Suwanwela has provided great leadership and valuable experience to all those who were fortunate enough to work with him. We wish to thank him for his commitment and enthusiasm towards ensuring COHRED's progress during his time as Chair. The new Chair of the COHRED Board was elected at the recent Board Meeting in November. Professor Marian Jacobs, from South Africa takes on this challenging task - welcome Marian! This issue's section on **The COHRED Board** features interviews with both of these individuals. We also welcome Dr Delia Sánchez from Uruguay as the newest member of the COHRED Board.

Since the close of the International Conference on Health Research for Development on October 13th, there has been a whirlwind of planning and other activities occurring around the globe. In our **Conference Update** section, we feature interviews with each of the coordinators who were involved in the regional consultative processes prior to the Conference, and ask them to describe the activities that have been spurred on by the International Conference, and, for those of you who were unable to attend the International Conference, we present the Conference Declaration.

In keeping with our focus on equity, our **Feature Article** was contributed by Davidson Gwatkin of the World Bank. Dr Gwatkin's programme recently released a series of country reports on Socio-economic Differences in Health, Nutrition and Population. This article looks at the methodological issues behind this exercise, the benefits and limitations, and invites readers who are convinced of the importance of these studies to participate in further work.

Our **ENHR in Action** section features three articles. The first is a report of a workshop on "Communicating Health Research Results" which took place recently in Uganda. The workshop focused on scientific writing in the broader context of research utilisation and dissemination. Continuing with the focus on communication, the second article - another from Uganda - looks at one research centre's experience in developing a proactive information dissemination system. The third article is an issues brief from the Working Group on Research to Action and Policy, announcing the release of their new publication.

Finally, Merry Christmas and a Happy New Year from the **Research into Action Team**.

See you next year!

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Socio-Economic Differences in Health Status and Service Use within Developing Countries

Report on an Initial Effort to Obtain Better Information about Conditions Prevailing among the Poor

Introduction

Traditionally, health planners have stated objectives and measured progress in terms of population averages. Examples include the widespread use of a country's or province's average infant mortality or immunisation rate for program planning and assessment purposes.

This use of averages is obviously appropriate when the objective is to improve conditions in society as a whole, without regard to how the improvements are distributed among different groups within the society. However, this is not suitable when one is concerned with a particular segment of the population, such as the poor, and when significant differences exist among different population segments within society.

The misleading impression produced by averages in such a situation can be illustrated with respect to the standard practice of setting health objectives in terms of reductions in a country's overall average infant mortality rate, and interpreting declines in the average as beneficial for the poor. This is not necessarily the case. In many settings as widely varied as Bolivia, Côte d'Ivoire, and India, the average infant mortality rate could be reduced by as much as two-thirds through a pattern featuring very large declines in upper- and middle-income and minimal improvements lower-income groups. The result would be a significant worsening in poor-rich inequalities, and in some cases a largely unchanged infant mortality rate in the poorest 15-20% of the population.

An important reason for failing to use health information specific to the poor is the absence of such information when poverty is measured in terms of socio-economic status, the aspect of human well-being that most frequently comes to mind when poverty is discussed. Recognition of this has given rise to several efforts to fill the void.¹ The most recent has been a series of reports on forty-four countries of Africa, Asia, and Latin America published by the World Bank.² The purpose in producing the reports is to provide basic information about

health conditions and health service use among people of different socio-economic levels, as an initial step toward identifying the magnitude and challenges involved in improving the health of the poor and in reducing poor-rich disparities.

Method

The information in the World Bank reports is drawn from household data collected through the Demographic and Health Survey (DHS) program sponsored by the U.S. Agency for International Development. This well-known program of comparative country studies, typically covering 5-10,000 households in each country studied, is oriented especially to the collection of information about vital events and maternal/child health. It is considerably less strong with respect to information about socio-economic status, since it contains no questions about income or consumption. However, its standard individual and household survey instruments include a number of questions about household assets – availability of electricity; possession of consumer goods like a bicycle, radio, etc.; flooring material; source of drinking water, etc. Using principal components analysis, these can be combined into a single index of household assets or wealth that is of interest in its own right and that approximates reasonably well the consumption measures that economists tend to prefer.³

In preparing an information sheet, a country's population is divided into quintiles on the basis of the asset index; and the value of each health, nutrition, or population indicator is tabulated for each population quintile. The approximately thirty status indicators covered in each report are of two types: health status and health service use. Examples of the former include infant and under-five mortality rates; total and adolescent fertility rates; and such commonly-used indices of malnutrition as stunting and low weight-for-age. Typical of the service indicators are immunisation rates, medical treatment for diarrhea and acute respiratory infections among children, use of antenatal and professional delivery care, and contraceptive prevalence.

1 In addition to the project covered in this report see also the data on poor-nonpoor health status appearing in annex table seven, p. 114, of World Health Organization, *World Health Report 1999: Making a Difference* (Geneva: World Health Organization, 1999); and the information about infant and child mortality by economic status in Adam Wagstaff, "Socio-Economic Inequalities in Child Mortality: Comparisons Across Nine Developing Countries," *Bulletin of the World Health Organization*, vol. 78, no. 1 (January 2000), pp. 19-29.

2 Davidson R. Gwatkin, Shea Rutstein, Kiersten Johnson, Rohini Pande, and Adam Wagstaff. *Socio-Economic Differences in Health, Nutrition, and Population* (Washington, D.C.: HNP/Poverty Thematic Group of the World Bank, 2000) The full text of each country report is available in the "Country Data – Country Information Sheets" section of the World Bank's poverty and health website: www.worldbank.org/poverty/health/index.htm.

3 Deon Filmer and Lant Pritchett, "Estimating Wealth Effects without Expenditure Data – or Tears" World Bank Policy Research Working Paper no. 1994 (1998).

Each report features three tables: one covering the entire population; the second presenting findings separately by gender; the third providing data separately for urban and rural areas. Each table provides the value of each indicator for each population quintile: for example, the infant mortality or contraceptive prevalence rate for the poorest twenty percent of the population, for the next-poorest twenty percent, for the middle twenty percent, and so on. In addition, the table covering the entire population provides, for each of the status and service indicators, the values of two disparity indices. One is the easily-understood ratio between the value of the indicator under consideration in the poorest quintile and in the richest quintile. The second is the concentration index, a more sophisticated indicator often preferred by economists that is analogous to the well-known Gini Coefficient used in measuring income inequalities.

Illustrative Findings

In light of the number of countries and indicators covered, it is not surprising that the findings defy easy summary. However, it is possible to provide a few illustrations of some of the more striking disparities found. If one defines a “rich” individual as belonging to the wealthiest twenty percent of a country’s population and a “poor” person as being in the least wealthy twenty percent:

- A poor Ghanaian child is over five times as likely to be severely malnourished as a rich one.
- A rich Bangladeshi woman is over fifteen more times more likely than a poor woman to have a medically-trained person (nurse, nurse-midwife or doctor) present when she delivers her baby
- In the course of her lifetime, an average poor Nicaraguan woman will have more than six children, while an average rich woman will have fewer than two.
- In Madagascar, a rich woman is ten times as likely as a poor woman to be using a modern contraceptive method
- A poor child in Côte d’Ivoire suffering from an acute respiratory infection is one-quarter as likely to receive medical treatment as a rich child suffering from the same illness
- A poor Indonesian teenage girl is five times as likely to bear a child as a rich teenage girl
- A poor child born in Bolivia is over four times as likely to die before her/his first birthday as a rich child

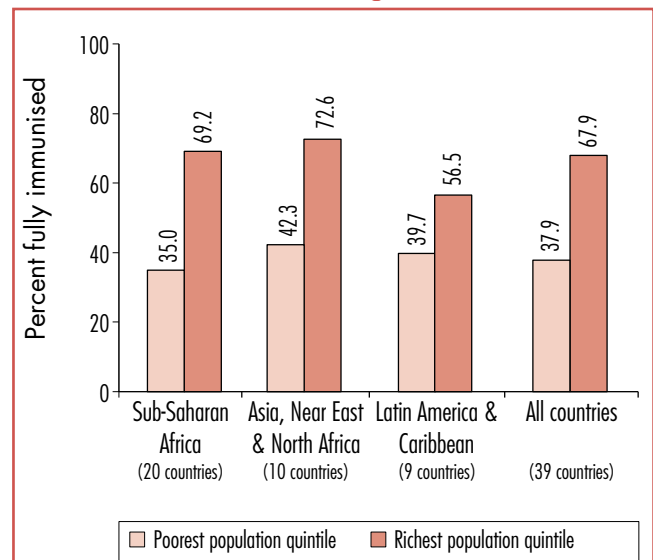
In some cases, inter-country comparisons with respect to specific indicators are also instructive. An example is the information for full immunisation coverage presented in the accompanying figure. The information shows that, in an

average country covered by the country reports, about 65-70% of rich (highest quintile) children are immunised, compared with 35-40% of poor (lowest quintile) children; and that the average immunisation rate within each region is considerably lower for poor than for rich children. This suggests that, in countries where most immunisations are provided through public programs, those programs are not reaching the poor children who suffer most from the diseases countered by immunisations nearly so well as they are covering the richest children who need immunisations least (See Figure 1).

Having said this, it is also important to note that there is a great deal of diversity among countries with respect to all of the indicators covered in the reports, so that one must look beyond the averages. For example, even within Africa, where intra-country poor-rich differences in immunisation coverage are particularly large on average, there are countries like Malawi, Zambia, and Zimbabwe, where poor-rich coverage differences are quite small. There is even one instance among the forty-four countries covered (Uzbekistan) where the full immunisation rate is slightly higher among the poor than among the rich.

Similar diversity appears with respect to other indicators, as well. For instance, in Namibia the infant mortality rate is only around ten percent higher in the poorest quintile as in the richest, compared with the overall regional average of around 65-70%. In the average Latin American and Caribbean country, infant mortality is over two and a half times as high in the

Figure 1
Immunisation Rates among the Poor and Rich



Full immunisation refers to the percent of living children 12-23 months who had received BCG, 3 doses each of DPT & OPV and measles vaccination by the time of the survey. Figures are unweighted country averages.

poorest population quintile as in the richest one; but in Haiti, it is only about twenty-five percent higher. Also, there are a number of countries, especially in Africa, where infant and child mortality appear to be slightly to somewhat higher in middle-income groups than in either the lowest or highest quintiles, for reasons that remain to be understood.

Limitations

It is hoped that the reports and findings just described will contribute to improved health equity by providing the kind of group-specific data that policy makers need in order to develop and implement health strategies that benefit the poor. Any such contribution can be no more than an initial one, however. For the data presented in the reports suffer from numerous limitations.

A flavor of these limitations can be gained from reading the extensive technical notes contained in the reports, which point to several difficult choices that must be made in constructing the report tables. For example, one must choose which asset indicators to include and exclude in constructing the asset index; whether to apply a household's total asset score to all individuals in the household, or to divide the total household score by the number of individuals in it; and whether to prepare estimates for quintiles of households, or for quintiles of individuals. There are no established conventions or guidelines for these or the many other choices that must be made; and the results appear to be quite sensitive to decisions with respect to the rather arcane technical matters involved. It is also quite possible that similar computations using different data sets and/or different definitions of socio-economic status – such as income rather than wealth – could produce different results. A further limitation is the general nature of the data presented, and the resulting difficulty in dealing as directly as desirable with an issue of particular importance to policy makers: how well, or poorly, the specific programs they administer are reaching and benefiting the poor.

Next Steps

So further work is clearly needed. Any readers of this who are persuaded of the importance of measuring and tracking socio-economic difference in health status and service use are warmly invited to participate in such work. Here are some examples of what can be done:

- Evaluations of Intervention Projects. Each country report contains a wealth questionnaire, based on the asset index developed in preparing the report tables, which can be used in assessing how well any given health facility is reaching the poor. This involves administering the wealth questionnaire through exit interviews, requiring five minutes

or less, with people who have just received treatment. The responses can be compiled to form a socio-economic profile of facility patients, which can be compared with socio-economic profiles for the population of the country as a whole that are available from the report. The reports also provide guidelines for using the asset questions, plus a question about the use of a particular health service, as an instrument in a simple household survey that can measure the socio-economic status of people using the service and compare it with the status of the entire population surveyed.

- Analysis of additional data sets. Tables such as those appearing in the country reports described here can be constructed from any household data set that contains information about health and about socio-economic status, by a data analyst with standard, commonly-available statistical skills. The more comprehensive the asset or other socio-economic information, the better; but even comparisons based on very simple indices – say, comparisons between the X% of families with four people in each room of a dwelling to the Y% living one person to a room – can be useful under many circumstances. So too can tabulations of data from sources often not considered in the health context. For example, the household expenditure surveys used to estimate inflation rates often contain information about things like tobacco consumption and payment for health services.
- Development of better data sets. More complete health information in socio-economic household surveys, and fuller socio-economic information in household health surveys could greatly increase the scope for health equity analysis. A case in point concerns the myriad of careful disease-specific epidemiological surveys undertaken over the years. These typically fail to collect information about the socio-economic status of the individuals covered; and as a result, it has only rarely been possible to estimate from them the poor-rich distribution of the diseases with which they deal. Assuming an adequately large sample size, this shortcoming can easily be overcome by adding to the survey instrument a set of asset questions like those used by the DHS, which take under five additional minutes to administer, as noted above.

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News From The COHRED BOARD

*A meeting of the COHRED Board was convened in November, one of the purposes of which was to elect a new Chair and Vice-Chair of the Board. We are pleased to announce that Professor Marian Jacobs (South Africa) and Doctor Peter Makara of Hungary have accepted their nominations as Chair and Vice-Chair respectively, and commence their duties immediately. Also at this meeting, Board Members bid a fond farewell to the present Chair, Professor Charas Suwanwela (Thailand) and Vice-Chair, Professor Owor (Uganda). On behalf of the COHRED family, we wish them luck in their future endeavours. The **Research into Action** Team spoke with Professors Suwanwela and Jacobs following the meeting.*



Raphael Owor, Charas Suwanwela, Marian Jacobs and Yvo Nuyens at the November Board Meeting. Professors Suwanwela and Owor are outgoing members of the Board.

Interview with Professor Charas Suwanwela, Chair of the COHRED Board 1996 - December 2000

The November Board Meeting was Professor Charas Suwanwela's final appearance as Chairman of the COHRED Board. It is a momentous occasion for Professor Suwanwela - a time to reflect on past achievements and future challenges. He holds a position which is unique to himself and only one other member of the current Board, Professor Raphael Owor (Uganda). Having served on the COHRED Board since its inception in 1993, Professor Suwanwela has seen ENHR grow from an idea to a movement. This time has not been without its share of high and low moments. With such a unique story to tell, the **Research into Action** Team asked Professor Suwanwela to provide some insight into his experience with COHRED, and his thoughts on the organisation's course in future.

What do you see as COHRED's main achievements over the last three years?

Well, ten years ago ENHR was an ideal, a principle, and a concept, but not a reality. Since then, we have been trying it out in real-life situations and have found that there is indeed a place for ENHR. During the International Conference on Health Research for Development in Bangkok in October of this year, the country delegations reiterated that ENHR remains a crucial element in achieving equity in health.

In 1990, our main business was to convince people of the value of the ENHR principles. A few years later, it was recognised that ENHR required some practical competencies for it to be of true worth, and that, given this practical application, ENHR might even be perceived as a technology. For this to occur however, it was important that the competencies be coupled with the will and resources to carry them out and be applicable to real life situations. Ensuring applicability of ENHR would manifest itself in the redirection of health research, the reallocation of resources for health research, and the use of research results to modify policies, plans and activities making them more evidence-based. The overall goal is to make positive inroads into stamping out inequities. One indicator of change is the provision of a national budget for health research, demonstrating a government's recognition of the importance of health research. From experiences in many countries, we know that this is a long, multi-faceted process, requiring commitment and effective planning. Nowadays, we talk about the importance of health research management at the country level and of the capacities needed to achieve an effective or appropriate health research system. The competencies are indeed an integral part of ENHR, yet they have also become entities in their own right. For example, the **research to action and policy** competency today advocates a paradigm shift that promotes the utilisation of research in the health policy system. Similarly, **capacity development** for the utilisation of research no longer focuses on researchers only, but also includes capacity building for the various users of research.

I see the Conference in Bangkok as the highlight of COHRED's work over the last few years. Initially, COHRED intended to *simply* organise a COHRED constituent meeting to review the past ten years of work in health research for development (after the Commission's report¹). This evolved into the International Conference, which saw a number of important partners in health research recognising the ENHR ideals and working together. The Conference came forward with a very strong message to **put countries first**. I see this as a recognition of the principles of ENHR at a global level. The ENHR movement has expanded both in depth and in scope since the Conference. This, I feel, is a very positive development for COHRED and ENHR.

What are the challenges facing COHRED now?

We are only at the very beginning of addressing the issues at stake in health research for development. In fact, we have

but scratched the surface. The magnitude of activities must be increased and this has to happen in partnership with other organisations - and not only those in the health sector. Many countries are now embarking on ENHR implementation. But to really see an impact, many more activities must be undertaken. I also feel that despite the ENHR competencies which do exist, we have not found answers to everything yet. We have not yet, for example, evolved far enough in our discussions about national, regional and global level mechanisms for health research coordination. We also need to make greater headway in the field of networking and partnership building.

I think international organisations need to lose their self-interest, and look instead for a common goal and agree to work together towards this goal. This does not necessarily mean that for example COHRED should lose its own identity. During the COHRED constituent's meeting in Bangkok the constituents argued that the functions COHRED has been performing over the last years are still relevant. However, they also discussed that the current structures (or mechanisms) do not need to remain the same, as long as the performance of the functions is guaranteed. For international organisations this might mean that we have to establish more and better collaboration, perhaps in the form of **strategic alliances** to be more effective and efficient as well as of mutual benefit. These alliances would work together to accomplish a goal, and would be more accountable. But each organisation within an alliance can nevertheless have its own functions.

What did you enjoy most during your time as chair of the COHRED Board?

Prior to joining COHRED, I had been working as a researcher, dean and president at Chulalongkorn University in Thailand. However, during my time with COHRED I have been exposed to many different cultures and people from different



Raphael Owor and Yvo Nuyens at the November Board Meeting

backgrounds. Never did I feel this stronger than during the consultative processes in preparation for the Conference in Bangkok. I attended meetings in places as far apart as Cape Town (South Africa), and Balatonlelle (Hungary), yet there was a common feeling of trying to accomplish a noble goal. I have gained a lot of life experience from this.

As outgoing chair what do you wish to be best remembered for?

Nothing! I would like to be humble. We have tried to achieve something, accomplished some things, but there is still a lot to be done.

Do you have a message for Marian Jacobs, the new Chair of the COHRED Board?

COHRED is in a time of transition, and there will be many challenges ahead. The next Chair will need to be innovative and creative to be able to lead COHRED through this period. Marian will fulfil this role admirably. I am not the kind of person who wishes to safeguard the past and to continue to haunt the place in its further work - after all, change is a positive thing, and can only benefit COHRED's development.

Would you like to say anything to the readers of *Research into Action*?

Only that I am more than ever convinced about the ENHR philosophy - particularly of the concept of self-reliance, and of the role that research can play at any level of decision making (national, district and local levels, but perhaps also at the international level). This will fit with the present and future world where evidence-based decision-making and accountability is in more and more demand. Health research by and for developing countries, communities and districts is a means to empowerment which leads to self-reliance, and this should be encouraged. Finally, research is an essential tool, that will allow people to work more effectively, and that is a worthwhile investment.

References

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

New Chair Highlights Challenges and Priorities for the New Millennium

Marian Jacobs is Professor of Child Health at the University of Cape Town, in South Africa. She holds the position of Chair of the Board at both the Medical Research Council in South Africa, and at the Centre for Health Research in Bangladesh. She is a member of the WHO Advisory Committee on Health

COHRED Board

Research (ACHR), and her main research interest is in translating child health policy-related research into action. Recently elected as the new chair of the COHRED Board, the **Research into Action Team** caught up with Professor Jacobs to find out what course she believes COHRED should chart now.

You have been involved in COHRED's work for a number of years now. What do you think COHRED's main achievements have been in that time?

I became involved in the work of COHRED at the beginning of 1999, when asked to join a meeting of the working group: research to action and policy.

On review of the work of COHRED over the years of its existence, I perceive its main achievement as having been a key "political activist" in spearheading the movement of health research for development. Focusing on the goal of utilising health research to promote health equity, COHRED has effectively mobilised interest and involvement of a number of global constituencies around health research for development strategies such as community participation, national capacity development, participatory mechanisms for setting research priorities and – most importantly – advocating strongly for the application of research to policy and action.

What do you think are some of COHRED's unmet challenges?

There are a number of areas which need strengthening in the health research for development movement – which are not the sole responsibility of COHRED!

Notwithstanding this, within the realm of global participants in this movement, I believe that COHRED should continue to play the "political activist" role, but should also move systematically – and with rigour – into tactical support for the implementation of the strategies. Although we have focused on "countries first" in the past, we should now give careful consideration to our contribution to comprehensive interventions which are sustainable.

We have a strategic advantage in this regard in that we have...

- A strong foundation of several years of experience in the Health Research for Development (HRD) movement;
- A network of colleagues working at the coal-face; and
- Experience, and learned lessons about how to do things – but also about how *not* to do things!

This is the foundation on which we will build our future plans.

What do you see as COHRED's main priorities for the next couple of years?

Our main priority will be developing a kind of global alliance for health research for development. By building on our strengths and networks, and collaborating with other global

players, we should continue to focus our efforts at country level. A key strategy for ensuring an effective focus on countries will be to strengthen the regions as mediators of these efforts.

It may well be that the key to the challenge of linking health research to health equity lies in focusing health research efforts in the development of the district. Another strategy would be to explicitly define the areas of national capacity strengthening that COHRED will target (which I think, specifically, will be research systems and their management) This will not only result in a more focused effort on COHRED's part, but will also affirm COHRED's commitment to putting countries' needs first.

A complementary strategy could be to identify those countries with the greatest needs, and target them with support for strategies leading to the achievement of equity in health research development within and between countries.

To ensure success, we will have to secure support of our development and strategic partners. In a climate of funding challenges and opportunities, this will be a major priority.



What do you personally hope/wish to contribute to the work of COHRED?

I am following Professor Charas Suwanwela, a giant in the health research for development movement, on whose shoulders I will have to stand to gain a purview of the task before me.

I have a wonderful team of colleagues on the Board and in COHRED, and though I am a newcomer to this field, have been privileged to make many wonderful friends in the global community. I will rely on my colleagues to guide me, to support me with their insight and experience – as I have no qualms about acknowledging my own limitations – and to stand next to me as we walk into the next decade of HRD together.

On the COHRED Board, I hope to contribute my health research management experience – gained in a rollercoaster fashion by having been appointed to a few South African and international boards of health research institutes in the last few years.

But I also am deeply grateful to the mass democratic movement of the South African struggle for the opportunity to learn the hard lessons about participation, inclusivity/, transparency and accountability – all of which contributed to the attainment of our democracy, and all of which were directed at promoting equity and justice. I believe that my South African experience will help to keep me focused on the real purpose of the Board, viz supporting COHRED to continue to be an effective and efficient contributor to the health research for development movement towards health equity and justice.

Given that our readership includes researchers, decision-makers, community representatives, ENHR country constituents and many more of the stakeholder groups, is there any particular message you wish to convey to the readers of Research into Action?

I believe that ENHR is to health research what PHC is to health care – a philosophy directed at justice and equity, based on democratic principles, and expressed through a number of different strategies. In order to attain the goal of the ENHR philosophy, it is therefore shortsighted – and ineffective – simply to implement the strategies without locating them in the context of the philosophy, and without grounding them in the principles and values.

It is therefore my hope that we will hold the goals, values and principles of health research development for equity and justice before us as we build on the process which led to the Bangkok conference, reflect on our deliberations there, and position ourselves, our countries our institutions to plan for the future.

I wish all our friends and colleagues the strength to continue to advance the revitalised HRD movement in the new millennium.

Finally, on behalf of the COHRED Board, I want to thank Professor Charas Suwanwela and Professor Raphael Owor for their leadership and commitment, not only to COHRED, but also to the global movement for health research for development. Although they both leave COHRED at the end of this year, their continued contributions to the movement will always be welcomed, and highly valued.

COHRED Welcomes New Board Member

Further news related to the COHRED Board is that Dr Delia Sánchez from Uruguay has accepted her nomination to join the Board.

Delia Sánchez (45) is a medical doctor from Uruguay, with a masters in public health and community medicine (Hebrew University of Jerusalem). At present Dr Sánchez holds positions at the Ministry of Health, where she is in charge of the development of clinical guidelines and review of clinical trials, and as Senior Researcher at the Grupo de Estudios en Economía, Organización y Políticas Sociales (GEOPS). Dr Sánchez has also undertaken a number of consultancies for PAHO (Washington). Over the past year she has been an active participant in, and the coordinator of, the Latin American consultative process on health research for development in preparation for the International Conference on Health Research for Development (October 2000, Bangkok).

Welcome to the COHRED Board, Delia!

Communicating the Results of Health Research

*"Most research findings do not reach the population they are intended to benefit. ... The potential users of research findings remain unaware of recommendations. Many researchers tend to work in isolation..."*¹

The title of this newsletter – Research into Action – encapsulates one of the basic competencies of ENHR. Yet more often than not, far from being translated into action, research results are "lost" because they are never made known to anyone beyond the research group itself. The report of the consultative process in Africa,² carried out as part of the preparations for the International Conference on Health Research for Development, commented that health research in Africa has not been very effective and even suggested that researchers are not interested in whether their results are used or not, but only in publishing papers in their own interest. Yet even then, much research never appears in print. The consultative report estimated that the average number of publications per research institution per year in Africa was ten.

In 1991, WHO's Special Programme of Research, Development and Research Training in Human Reproduction (HRP) started a series of workshops for developing country scientists on scientific writing, with a view to increasing the visibility of their research in international journals. While these workshops have had some success, there has been a growing awareness that fostering scientific publication alone is not enough to ensure effective sharing of research results. COHRED's focus on research to action and policy was recognised as an important element in expanding the scope of these workshops to address the broader issue of utilisation of research.

As an experimental expansion of the HRP workshop, and as one element of strengthened collaboration between COHRED and WHO, a joint workshop on scientific writing and utilisation of research results was organised in Kampala, Uganda, in cooperation with representatives of the Ugandan research community.

The objectives of the workshop were:

1. To promote the concept of research as a continuous process, from problem identification to application of results, involving a broad range of stakeholders;
2. To sensitise researchers to the need to communicate with the various stakeholders at all stages of the process, and to explore strategies and mechanisms for doing so; and
3. To identify and practise specific approaches and techniques to facilitate such communication. While the focus in this

regard was publication in academic journals, other approaches for different target audiences were also explored.

The workshop was held over three and a half days in November with 19 participants who were all research scientists from the Faculty of Medicine of Makerere University, Kampala, with links either to HRP or to the Ugandan ENHR process. In addition to the more conventional content relating to preparing a scientific paper for publication, the workshop used presentations, group work and discussions to identify the range of stakeholders who need to be involved in research and to explore mechanisms and tools for communicating with them. Participants used examples of local research projects as the basis for this work, developing strategies that could be considered for application in the real situation. Many of the researchers commented that this was the first time they had been exposed to the notions of working with the community and of involving practitioners and policy-makers in the research process.

Commenting on the workshop, Dr Raphael Owor of the Uganda National Health Research Organisation said that, "Our researchers - who are mainly biomedical - are now able to see the importance of dialogue with all the stakeholders to ensure that research priorities are relevant and research findings are used. Sometimes it takes a long time for research findings to be used for policy formulation. This is because research findings form only part of the decision-making process. Other factors such as economy, politics, etc are taken into consideration. Researchers must be involved in this decision-making process which goes beyond biomedical sciences."

The relevance and interest of this combined workshop for other developing countries will be evaluated, to allow COHRED to decide if this is an activity that should be further developed.

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References:

- 1 Ndeki SS (1997) *A regional assessment of health systems research training in East and Southern Africa*. WHO Regional Office for Africa and Academy for Educational Development, unpublished document.
- 2 *Health research in Africa: past experiences and perspectives for the future*. Unpublished document, 2000.

Developing a Proactive Information Dissemination System: The Uganda Experience

There is a tremendous need for information to guide policy formulation and programme development for better health care delivery, since, in the absence of such information, decisions may not be based on optimal choices. However, the information must also be useful, made available at the right time to those who need it (such as policy makers, programme planners, and health workers), and it must be in the right form.

The Child Health and Development Centre (CHDC), at Makerere University in Uganda aims to promote the use of information generated from research and programme activities in policy formulation and programme development. This activity is funded by the Commonwealth Regional Health Secretariat (CRHS) and the Support for Analysis and Research in Africa (SARA) project (USA). Success is dependent upon a network of partner institutions and individuals.

"Our experiences over the last 4 years have allowed us to explore new areas and raised questions about the most effective use of resources in dissemination", said Fred Kalyowa, who has been responsible for developing the resource centre since 1992. A series of activities have been undertaken, including the development of an organisational Newsletter, "MOCHEDI", which reports the activities of the centre, and the new resources which are available; synthesis of research findings into programme and policy booklets; dissemination seminars and workshops; print and audio-visual materials collection; production of bibliographies; production of technical reports; and working with the mass media to raise awareness on key issues. "The resource centre has become an important source of health-related information", reported Mr Kalyowa, "our aim is to serve the needs of our partners, who have a wide array of interest areas". The CHDC as a unit, maintains strong linkages with government bodies, community groups, non-governmental organisations, and service provider groups.

As the National Focal Point (dissemination centre), for the Commonwealth Regional Health Community Secretariat for East Central and Southern Africa (CRHCS/ECSA), the CHDC serves 13 countries in the African Region. "The project initially focused on reproductive health and nutrition", said Mr Kalyowa "but it was so successful that further funding was provided so that the scope of the dissemination activities could be expanded", he said. Further support was in the form of computer hardware, funding for dissemination workshops and joint partner meetings, and collation and distribution of grey, or unpublished literature.

Exchange of research findings is a well-established tradition within scientific and professional communities. However, the link between researchers and decision-makers is a weak one. "Our experiences so far have demonstrated that using an integrated approach with researchers playing a central role but working in partnership with other players has the potential of bridging this gap in a sustainable way", said Mr Kalyowa, whose goal is to identify organisations and create sustainable programmes, systems, and activities together, which not only satisfy the mandate of both organisations, but are accessible and relevant. "It is my hope that our experiences will stimulate further thoughts and discussions on how these linkages can be developed, and attract both technical and financial support to realise our dream. The ultimate aim is to create a more knowledgeable, enlightened and supportive environment for better health care delivery", he said.

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Addressing the Challenges of Research to Action and Policy

Ten years ago, the Commission on Health Research for Development proclaimed health research an "essential link to equity in development." But health research that is not relevant to local concerns or goes unused holds little value for improving the health and well-being of the peoples of the developing world. Research must be linked to action – policies, programs and community mobilisation – in order for it to have an impact. How can this link between research and action, and in particular policy, be strengthened?

The challenges are significant. By and large, the processes of research generation and decision-making take place in separate institutional "worlds" and are engaged in by two sets of professionals who often have little understanding of the exigencies of other's work and who put different values on research. There is a prevailing understanding within the research community that policymakers often do not make use of research findings in decision-making. In addition, managers of health-care programs are seen to not always use research

results, nor apply scientific methods in planning, monitoring, and evaluating the services that they deliver. By the same token, researchers have been accused of failing to address the health problems that are perceived as top priorities by policymakers, health-care managers, and the public. Moreover, they often do not succeed in communicating their findings and recommendations beyond academia and in readily understandable language nor in a timely fashion.

Entrenched attitudes and ineffective strategies for communicating both research results on the one hand, and research needs on the other, present one group of challenges. Lack of meaningful and sustained interaction among not just researchers and policymakers, but also communities, health-care providers and donors is another. Research will have a greater likelihood of being used in decision-making if all the stakeholders are identified and encouraged to take ownership in defining health problems and seeking solutions.

How international organisations work with decision-makers and researchers in countries as well as the national and sub-national sociopolitical context can also prevent effective links between research and policy development. Overall societal values and practices may not be supportive of evidence or knowledge-based decision-making. Political circumstances within a country may not just be at odds with the notion of dialogue between researchers and decision-makers, but may result in the suppression of research and researchers by governmental powers.

The past decade of developing country experience, however, suggests at least five entry points for addressing these challenges.

The Researchers

Researchers themselves can develop some skills in communication and advocacy. In particular they must understand how resource allocation decisions are made and how policy is developed, implemented, and monitored.

ENHR Mechanism

Countries with a mechanism for promoting and coordinating Essential National Health Research (ENHR) are well positioned to strengthen research-policy linkages. A premier function of the ENHR mechanism should be to act as a mediator to facilitate on-going interaction between the research and policy processes as well as among the various stakeholders.

National Research Managers

There is a need for national research managers, preferably within the context of an ENHR mechanism or system. These leaders could be researchers themselves, research users, or

fundings. They require skills such as: facilitating the process of multi-stakeholder priority setting, building coalitions around specific problems, seizing opportunities to identify relevant research questions or to ensure that available research is used, and nurturing future leadership for national health research and development. In particular, these leaders must learn how to function as "knowledge managers" within the rapidly changing context of the global knowledge economy.

Political leaders

National governments have an important role to play in improving the infrastructure for social communication, both technical and human. Governments set the political climate for listening and responding to the concerns of the people, conducting the affairs of government in an open and transparent fashion, and asking for evidence to support decision-making. Political leaders must also understand that investing in science and technology, for both short- and longer-term purposes, is an investment in enhancing the well-being of the people.

International research community

The international research community has a major responsibility in ensuring stronger links between research and policy in developing countries. International agencies must consider changing the way they have traditionally operated. Examples include: aligning agency agendas with those determined by the recipient countries, providing funding support directly to a multi-stakeholder national research structure,

rethinking the function of "technical assistance" as a condition for funding, making much more use of national consultants (who understand the local context), and using "external experts" only for carefully negotiated distinctive contributions.

Following two years of intense work on this subject, the COHRED Working Group on Research to Action and Policy have recently compiled an issues paper. Please see the **Notices** section of this Newsletter for details.

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The COHRED Working Group on Research to Action and Policy met in Bangkok earlier this year.

Regional Activities post-Conference, Bangkok 2000

It is more than two months since the International Conference on Health Research for Development, and the regions who participated in the consultative process in the lead-up to the Conference have reported various levels of activity since then. This article is a compilation of interviews with each of the regional coordinators. We asked them for their assessment of the Conference outcomes, and if their region had made any plans at this stage to take the proposals from the Conference forward.

Africa

Prof Mutuma Mugambi and Ms Griet Onsea

In principal, we agree with the majority of the statements in the Declaration and support the Action Plan.

Three small comments for the African Region:

- Gender was not considered in this specific consultation
- Centrality of the country focus as a basis for health research initiatives is not recognised in the Declaration
- The absence of adequate political commitment for health research at the national level (resulting in - amongst other problems - brain drain, the absence of a research culture, high dependence on external resources, low financing, and administrative bottlenecks) is one of the main constraints to health research development in Africa. We feel that this is a very important factor to be looked at in the future and would therefore like to see it mentioned somewhere in the Action Plan.

A satellite meeting of African researchers and health leaders in Bangkok discussed the African report and agreed that it was desirable to broaden its ownership and widen its

constituency with a view to establishing an African Health Research Forum. Prior to this, a concept paper detailing the envisioned function of the Forum should be prepared as an adjunct to the African report. To promote debate on the next steps, it is recommended that the report be widely disseminated among key target audiences and an electronic dialogue established.

Activities proposed so far include:

- Support of in-country dissemination seminars by key individuals and hosted by country teams
- Use the summary in the present report to develop and produce a stand-alone summary for policy makers and other influentials
- Prepare a concept paper that actualises the recommendations from the report, including suggestions on functions and operations of an African Forum
- Develop a closed electronic discussion forum moderated by two or three professionals knowledgeable on the issues raised by the concept paper
- Organise a meeting to establish the African Forum
- Preparations are also underway to implement a number of in-depth follow up studies on some critical issues identified during the African consultations in support of national health research and development processes.

Parallel activities will include:

- Documentation of research initiatives (including collaboration and networking) at regional level
- More in-depth analysis of country findings
- Information sharing/active dissemination of parallel activity outcomes, including the publishing of an 'African Book'

It is clear that these plans will challenge the existing African ENHR network's activities and future direction.

For further details on African regional activities, please contact:

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Asia

Professor Chitr Sitthi-amorn

My response reflects my opinion and the opinions of others whom we talked to. I think in general, the Declaration addresses the issues of the Asian consultation. At this stage it is necessary that the declaration speaks in broad terms. I feel the challenge is to transform the broad framework into real concrete actions with participation from all those involved.

As for the second question, I would need to consult the constituents to answer this well. At the moment, my response is that we are currently compiling responses and, at the end of December, all constituents comments will be sent to the secretariat of the International Conference. Following that, we will explore the possibilities of a regional focus to help countries at different stages of development in the region to address the issues of using research for good governance of the health system (not only the health care system). This will include knowledge management, interaction with stakeholders, and some forum mechanisms to enhance the check and balance mechanisms. It would also mean that the knowledge management system will need some governance as well. Research will not stand alone but has to interact with many more actors including the government, the NGOs, the public, the private sectors and the development agencies. COHRED can help by promoting a country focus, upholding the issues of equity, promoting partnership as an honest broker, and eventually should aim at collecting experiences and methods to be tested, used, and refined by countries. This will be done through the Kalayanamitra or "friend-helping-friend" principle.

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Latin America

Dr Delia Sánchez

Although all large Conference Declarations tend to be very vague and end up saying more or less the same thing, I think this Declaration has some specific significance, due to the priority given to ethical issues (to the question of what is the acceptable objective of research, the Conference responds that the main objective is the improvement of the living conditions of the world's disadvantaged), and the emphasis on developing and strengthening the infrastructure for continuing, self-reliant research. An explicit focus on the gender issue was seen as very important in our regional consultation, and it came out very clearly in the final statement, which we're pleased with.

In those terms, the final products of the conference are a far cry from the original program, which was initially in danger of becoming a long list of priority diseases or research subjects.

The question is now how to apply those principles in research. How do we strengthen capacity to develop good quality, socially relevant, continuing lines of research in developing countries with limited budgets? That I think should be the agenda of all involved in research management at all levels for the next 10 years.

As for LA, we are currently trying to reach a consensus on the role of our "post-Bangkok" group. We are receiving a variety of responses, but most of them come down to eliminating the isolation of people working in different fields of "public health research" in our countries. Sometimes this isolation is due to the hegemony of other disciplines in research, sometimes because of alternative theoretical frameworks, and still other times, because of geographical or political reasons, but one way or another, it exists. We are concerned about empowering civil society to determine national research agendas, which is an objective we all adhere to, but I feel that we are even further behind, as many researchers still feel that they do not have control over their possibilities to work as they should or on the issues they should.

So, no matter what structure (if any) comes out of our consultation, we shall have to create a space for interacting, supporting ideas, and advocating together for the inclusion of ENHR in the mainstream of research structures.

There have been some concrete proposals to start some ENHR-related work in Chile, Cuba, and a district in Colombia. Argentina has also officially expressed interest. I see a role for the Latin American network in supporting these efforts and also in identifying new ones.

For further details on Latin American regional activities, please contact:

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Eastern Mediterranean

Dr A Mechbal (Regional coordinator) and Dr J Hashmi (Consultant for Regional Consultations)

Personally, we feel that the conference was a success. It certainly provided a timely opportunity to reflect carefully on the progress achieved since the Commission submitted its report a decade ago. While much has happened and has been talked about at the global level (several new initiatives launched), the preparations for the conference did provide a unique opportunity for groups of researchers in many developing countries to put forward their perceptions about the existing situation of health research and their suggestions for the future in clear terms. It also pinpointed the weaknesses in health research systems at the regional level.

The Bangkok declaration and the conference action plan did address the outcome of the Eastern Mediterranean regional consultation. In retrospect it is perhaps easy to say, but as with other international conferences held during the last decade, the discussion would have been more productive if a draft action plan was elaborated before the conference itself. We did have a well-written and well-presented background document incorporating regional views and this was a big help.

WHO/EMRO is currently developing plans to incorporate some of the proposals emerging from the conference and the recommendations made in the regional consultation held earlier. What is required to implement them are financial resources of a modest order of magnitude which are not available within the current financial constraints in EMRO. Therefore, resources have to be solicited from elsewhere, and we have already submitted a proposal to COHRED for technical and financial support for promoting and implementing ENHR in several countries of the region.

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The Caribbean

Dr David Picou

A report on the Bangkok Conference was presented to the third annual meeting of the ENHR Council of Trinidad & Tobago held on November 24, 2000. Council noted the report with interest and expressed the view that the conference proceedings would be of value in the forthcoming exercise of drafting a strategic plan to implement ENHR in Trinidad and Tobago.

A direct outcome of the Conference is the regional workshop on bioethics, which will be held in February 2001. Much emphasis was placed on the importance of ethics in general, and this workshop aims to elucidate the major issues in research ethics both nationally, and regionally. Participants will include representatives from all English-speaking Caribbean countries, as well as Cuba, Haiti, the Netherlands Antilles, and observers from the Forum for Ethical Review Comittess in Asia and Western Pacific Regions (FERCAP) and some of the Latin American countries. The workshop will examine other research ethics committee models from elsewhere, and discuss their suitability for the Caribbean. It will also serve to formulate an improved system of ethical review - one that will meet the capacity of all states, both small and large. Identifying barriers to implementation is an important exercise which will be undertaken, along with recommendations to overcome them. Finally, the workshop will seek to facilitate the establishment of a Caribbean Ethics Network (CEN) - a proposal first mooted at the International Conference by some of the Caribbean participants.

In January 2001, a preparatory meeting for the "Regional Bangkok Follow-up Meeting" will be held. The meeting will look closely at the outcomes of the Conference, and decide which have most relevance to the Caribbean region. This will have great relevance to the finalisation of the Caribbean Health Research Agenda - a process which began during the regional consultations in early 2000. The Regional Bangkok Follow-up

Meeting is due to be held in the second quarter of 2001. A wide representation from across the region will be invited to attend this meeting, which will be critical to defining a regional ENHR plan for the next five years (2001-2006), and in reviewing national ENHR plans for 2001/2002. Finally, an overall regional response to the International Conference Discussion Paper will be formulated at this meeting.

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

Dr Peter Makara

An immediate outcome of the conference was the establishment of health research and ENHR networks in both Kazakhstan and Russia. In Kazakhstan, the network currently has 20-25 members - most of whom were directly involved with the International Conference in Bangkok - and includes researchers, civil servants, university academics, NGO leaders, programme managers, staff from the Kazakh School of Public Health, and other National Institutes in Kazakhstan.

The network plans initially to assist in developing and reviewing national research priorities and to integrate ENHR plans into Kazakh social and economic development plans. A strategic planning process has been proposed, in the hope that it will stimulate cooperation with international donor agencies. A World Bank loan was recently secured, which will assist in implementation of health services, policy and research development. This initiative offers a favourable environment for the implementation of ENHR.

The proposed activities for 2000-2001 are as follows:

- Distributing key COHRED documentation through the new ENHR network
- Formal launching of the network, signing an agreement of cooperation with COHRED
- Introducing an ENHR training element in the programme of the Kazakhstan School of Public Health
- Organising a consensus-building conference on ENHR

We believe COHRED could particularly assist us with introducing ENHR to the medical education curricula at the Kazakhstan School of Public Health.

For further details on CEE/NIS regional activities, please contact:

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Bangkok Declaration On Health Research for Development

The International Conference on Health Research for Development brought together more than 700 participants representing a wide range of stakeholders in health research from developing and developed countries. Conference participants from over one hundred countries welcomed the interactive and participatory nature of the discussions.

Having reviewed the reports from the various regional and country consultations, and taking into account both the in-depth analysis of progress in health research over the past decade and the discussions before and during the meeting, We the participants make the following Declaration.

The Conference reaffirms that health is a basic human right. Health research is essential for improvements not only in health but also in social and economic development. Rapid globalisation, new understanding of human biology, and the information technology revolution pose new challenges and opportunities. Social and health disparities, both within and between countries, are growing. Given these global trends, a focus on social and gender equity should be central to health research. In addition, health research, including the institutional arrangements, should be based on common underlying values.

There should be:

- A clear and strong ethical basis governing the design, conduct and use of research;
- The inclusion of a gender perspective;
- A commitment that knowledge derived from publicly funded research should be available and accessible to all;
- An understanding that research is an investment in human development; and
- A recognition that research should be inclusive, involving all stakeholders including civil society in partnerships at local, national, regional, and global levels.

An effective health research systems requires:

- Coherent and coordinated health research strategies and actions that are based on mutually beneficial partnerships between and within countries;
- An effective governance system;
- A revitalised effort from all involved in health research to generate new knowledge which addresses the problems of the world's disadvantaged, and increases the use of high quality, relevant evidence in decision-making.

It is the responsibility of an active civil society through their governments and other channels to set the direction for the health research system, nurture and support health research, and ensure that the outcomes of research are used to benefit all their peoples and the global community.

We the participants commit ourselves to ensuring that health research improves the health and quality of life of all peoples.

The work carried out in preparation for, and during, the Conference should continue, through a process that will allow all stakeholders to contribute to debate and decisions on the key issues for the future of health research for development.

Notices

Upcoming Courses

Cours intensif en Recherche sur les Systèmes de Santé (RSS)

2 juillet - 24 août 2001 (8 semaines)
l'Université Libre de Bruxelles, Belgique

L'objectif de ce cours est d'améliorer la capacité des participants dans leur démarche de recherche. Concrètement, ils développeront leurs compétences à imaginer, formaliser, réaliser et évaluer les recherches nécessaires à une meilleure compréhension et performance des systèmes de services de santé. Le nombre de participants est limité à 30. Clôture des demandes d'inscription: le 1er avril 2001. **Frais d'inscription:** L'inscription est de 120.000 FB. Les frais de séjour ne sont pas compris et s'élèvent environ à 35.000 FB/mois.

Renseignements complémentaires et bulletin d'inscription:

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Course in Epidemiology and field research methods - An interdisciplinary research training course

May 28-June 15, 2001 (application before February 26, 2001) Umeå University, Sweden

The overall aims of this three-week course are to discuss epidemiological design, analysis and interpretation, as well as the roles of quantitative and qualitative approaches in public health research. The course is designed to follow the research process from problem identification, planning and data collection through analysis, interpretation and documentation. A number of places in the course are reserved for participants from developing countries involved in public health research.

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New Publications

Funding of Health Research, and Development of the National Institutes of Health in Malaysia

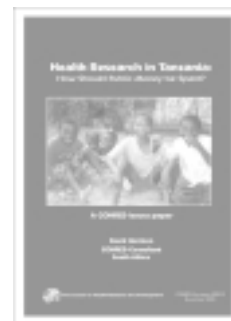
A consultancy report prepared
by Goran Sterky, COHRED
Document 2000.8



The Ministry of Health in Malaysia requested COHRED's support for a consultant who would assist in addressing two areas of concern: funding for health research in the country and the co-ordination of health research. This report is a result of that consultancy, and includes a number of recommendations for action to both the Malaysian government and COHRED.

Health Research in Tanzania: How Should Public Money be Spent?

A COHRED issues paper, by
David Harrison, COHRED
Document 2000.9



Tanzania cannot afford to waste its scarce resources and must ensure that public funds spent on health research lead to better health for its people. In 1999, the National Forum on Health Research conducted a process of priority setting for health research, which established a ranked list of topics regarded as most important for Tanzania. The challenge now is to translate that list into a research agenda expected to realise greatest social benefit.

Essentially, this involves two iterative steps. The first is to define a public investment portfolio of R&D expected to maximise improvements in health. The second is to ensure efficient implementation of the portfolio, so that expected benefits actually materialise. The purpose of this paper is to describe how each step can be carried out.

Please Note:

All publications with a COHRED Document Number can be ordered free of charge from the COHRED Secretariat (contact details on the last page of this issue). Unless otherwise indicated, all other publications must be ordered from the relevant organisations.

Lessons in Research to Action and Policy: Case studies from seven countries

An issues paper prepared by the COHRED Working Group on Research to Action and Policy, COHRED Document 2000.10

How can the link between research and action, and in particular policy, be strengthened?

This question guided the work of the COHRED Working Group on Research to Action and Policy. Formed in 1998, the Working Group strove to better understand the issues behind why there is often a gap between research and its practical implementation, particularly in relation to decision-making. One of the aims of doing this was to try and identify capacity development needs to help countries in their efforts to make research an effective tool for health development. The Working Group's findings and resulting lessons learned have been compiled as a COHRED issues paper on the subject, and will be available for distribution in late December.

The publication includes case studies from seven countries: Brazil, Burkina Faso, Indonesia, Lithuania, Pakistan, South Africa, and Uruguay.



international organisations and major donors have been pushing for more demand-driven research and better identification of capacity building needs in the South. It sounds logical, but reality is more complicated than that. The author of this book has been involved in several demand-driven research programmes, and describes, based on his experience, how the agenda setting process takes place. He discusses methodologies for participatory research in order to involve the end users of research in the learning process of research; capacity building needs; mechanisms to make sure that research results are disseminated and utilised; and especially the resistance of more conventional researchers against the needed changes.

In addition to theoretical reflections on demand-driven research for health in development, three programmes are described in order to see how things are developing in practice."

Tracking Country Resource Flows for Health Research and Development (R&D): A comparative report on Malaysia, the Philippines, and Thailand with a Manual on Tracking Country Resource Flows for Health Research and Development

*Bienvenido P. Alano Jnr and Emelina S. Almario, Centre for Economic Policy Research, the Philippines, 2000
ISBN 971-508-082-0*

This publication is available from COHRED

The result of a two-year multi-country study funded by COHRED, part one of this publication aims to present the data, and subsequent analysis of an intensive study undertaken in three countries: Malaysia, the Philippines and Thailand. The document proposes future strategies for optimising the policy impact of research in this area, and encourages sustained data-gathering efforts.

Part two includes a Manual on Tracking Country Resource Flows for Health Research and Development. It presents the methodology used by the three countries, and explains in detail the steps involved. Addressed to other countries wishing to undertake similar studies, an attempt is made to simplify the steps and make them as straightforward as possible. Where necessary, potential areas of difficulty are identified, and where applicable, solutions identified by the study participants are presented.



The Democratisation of Science: Demand-Driven Health Research for Development

*Ivan Wolffers, VU University Press, Amsterdam 2000.
ISBN 90-5383-962-6*

The following review has been reproduced from the flyleaf of the publication.

"Research can play an important role in development and in improving health of populations in the South. However, conventional research partnerships between researchers from the North and the South are often dominated by research agendas that reflect academic rather than societal needs.

The major consequence is that more than 90% of research results does not go beyond two copies of a report that is subsequently shelved. Since the beginning of the 1990s



The newsletter of the Council on Health Research for Development is published four times a year.

RESEARCH INTO ACTION is issued complimentary upon request.

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

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