COHRED

RESEARCH INTO ACTION

The Newsletter of the Council on Health Research for Development / Issue 15 / 1998

COHRED, the Council on Health Research for Devel-opment, is a non-governmental organisation. It was established in March 1993, and is located in the European Office of the United Nations Development Programme in Geneva, Switzerland.

The Council consists of member countries, agencies, organisations and an 18-member board, the majority of whom are from developing countries.

Its objectives are to promote the concept of Essential National Health Research (ENHR), which aims to assist countries in identifying their health and research priorities as well as strengthening their research capacities, and encourages multi-disciplinary and multi-sectoral collaboration to ensure that health policies and decisions on important health issues respond to the actual needs of the public and will translate into

IN THIS ISSUE

International Cooperation in Health

By CHARAS SUWANWELA, MD

OVER THE PAST SEVERAL DECADES, the health of people living on this planet has markedly improved due, to a large extent, to the advancement of knowledge and its applications. The average life expectancy throughout the world has increased from 55 years in the early 1960s to over 65 years in 1997. At the same time, demographic, socio-economic and technological changes have exponentially accelerated. Differences between various parts of the world are rapidly increasing and the gaps between countries and among different groups within a country have widened.

While global averages suggest that our health status in general is improving, some countries and some groups of people are facing a deterioration in their health status. New health risks such as violence and injuries, diseases stemming from the degradation of the environment, the AIDS pandemic and the re-emergence of infectious diseases all demand new knowledge which goes beyond the normal determinants of health. In addition, knowledge which was perceived as a common property of mankind through the ages has increasingly become a commodity or product that can bring benefit as well as monetary return.

Health is in general a concern within the confines of a nation, but both positive and negative externalities demand various forms of global cooperation. Knowledge is needed for sound public policies and for the solution of health problems. Yet the resources for health research appear to be shrinking and the management of those limited resources is not being maintained at the optimal level. Gaps, fragmentation and imbalance are common features in both the global and national pictures. Many research results are not utilised and those results that are usable are not well distributed.

On the other hand, misinformation, usually for commercial benefit, is seriously affecting developing countries. The efficacy and safety of new health technologies such as new drugs and medical equipment depend by nature on their selective uses, and should be subjected to continuous monitoring. Overstatements, claims and over-enthusiastic promotion can lead to misuse or wrong public policy, especially where critical appraisal is inadequate. Wrong advocacy and exploitation may occur within a country or across national

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boundaries. International cooperation can serve many purposes of mutual benefit to all, and can reduce these negative externalities.

Health knowledge involves three broad steps: the generation of knowledge through research, the optimisation of knowledge, and the mobility and utility of knowledge. In managing health research for the generation of knowledge, there is a need for health research intelligence, including information and visionary analysis. In order to address the gaps and imbalances, the development of health research capacity is needed in many countries and in many aspects of the problems, as well as appropriate allocation of limited resources.

HEALTH KNOWLEDGE

Prioritisation of health research at both the national and global levels is undoubtedly an essential part of research management. Health research is at present undertaken in both public and private institutions. In industry, research and development is extensively funded, and the resulting products are patented, some of them being manufactured and marketed. The monopoly of products permits high pricing. In the public sector, health research efforts can fill the gaps and create a counterbalance with the aim of achieving equity in health care. A public/private mix in this field is a challenging but promising form of collaboration.

In this age of information explosion, there has to be consistency as well as validity and acceptability in extrapolating and utilising research results. Synthesis requires proper weighting and multidisciplinary and cross-cultural considerations as well as a balanced and often holistic view. Consensus, controversies and options must be recognised in making recommendations for the use of knowledge. Indeed the process of optimisation of health knowledge has become so sophisticated that it approaches becoming a research in its own right.

As for the dissemination of health knowledge, many gaps and barriers remain, especially for developing countries with inadequate infrastructures, and high operating costs often exceed the capacity of developing countries' resources. On the other hand, for knowledge to be used in policy-making, in programme execution and in service provision, the receptive capacity of those involved must be appropriately tuned. In the long-term perspective, future health professionals must be prepared to accept a world with more 'knowledge mobility.'

NATIONAL AGENDA FOR HEALTH RESEARCH

In many developing countries, health research is a new venture. Formerly, the higher education system concentrated on the transfer and application of existing knowledge, and research was considered too luxurious for the limited human and financial resources. Many health problems therefore remain with no or ineffective solution because the necessary research was not done either locally or elsewhere. The inadequate development of health research can also be blamed for the inability to critically assess new information and technologies. Inappropriate uses of technologies and the shift towards Western medicine and values have created gaps, inequity and wasteful practices in health care.

Medical and health research in developing countries usually started out of personal interest or in response to donors' initiatives. It is often fragmented and may not address national problems. Yet that health research has now increasingly been recognised to be essential. Development of health research capacity has been intensified in many countries through international cooperation. The World Health Organization (WHO), multilateral and bilateral agencies, foundations and international networks such as INCLEN, IHPP and FETP have been active in the process. The Special Programmes of WHO in human reproduction and in tropical diseases include capacity development as a strong component.

Promotion, coordination and management of health research have also been recognised, and many countries have had medical research councils for many years. WHO's system of advisory councils on health research (ACHR) has contributed to the planning and support of relevant health research. The launching of the Essential National Health Research concept by the Commission on Health Research for Development in 1990 marked an important step forward, and the Council on Health Research for Development (COHRED) is active in encouraging and assisting countries to redirect their efforts and resource allocation to the kind of research considered to be essential for each country. It is hoped that this will lead to better health policy and practice aiming at better quality and equity. In-country mechanisms are being developed, coupled with know-how and experiences compiled from other countries, while two-way collaboration among countries has proved of mutual benefit. Synthesis of these country experiences and competencies could be an essential component of the global health research picture.

By optimising the use of health knowledge, for instance by drawing up a national drug list, formulating practice guidelines and a health policy and plan, the health research manpower can greatly contribute to assessing state-of-the-art knowledge. Already, involving health policy-makers in the research process has increased the willingness to accept research results — all the more so when former health researchers become policy-makers.

A SHRINKING WORLD

Disease has no respect for national boundaries and actions, or lack of actions, or the lack of actions on the part of one country can affect others. This phenomenon is increasing with the globalisation process and greater ease of transportation and communication. While health research to solve a problem should be carried out wherever it has the best likelihood of producing effective results at lowest cost and in line with local conditions, for wider application of the research results different settings for their use must also be considered. In view of the existing imbalance of health research capacity and efforts in various parts of the world, capacity development and strengthening have to be taken into account. Since health is value-loaded and culture-bound, the estimation of a health problem, its consequences and burdens as well as the goals and objectives of interventions, can vary. A global average based on one standard as a top-down global view may not reflect the true picture and can be misleading, especially when it is used in prioritising and allocating resources. If the approach is complemented by a view from below with synthesis at the various levels upward, it can reflect a truer picture.

While any analysis should be as quantitative as possible, health is a human affair with a social and spiritual overlay. Holistic vision and judgement must be added on top of the analysis based on evidence. In the past few decades, the health research agenda at the global level has evolved to a great extent. The positive efforts being made in many directions will, let us hope, lead to a better formulation for a more balanced, beneficial and equitable health research system.

INTERNATIONAL COOPERATION OPTIONS

As an intergovernmental organisation with 191 member countries, WHO with its technical programmes, special programmes and the ACHR system has greatly contributed to health research development throughout the world, particularly in developing countries. The current reform within WHO is eagerly awaited by all concerned, in the hope that the Organization will serve as the mainstream partner in health research efforts.

Bridging the Gaps : A Tale of Two Countries

by S. Adjei and I. Wolffers*

DURING THE CONSULTATIVE meeting of the National Health Research Unit held in Accra, Ghana, on 8 and 9 October 1998, one of the participants said: 'Our Ministry of Health has a clear agenda for the future. It has agreed on health reforms and we have to know how this is best done and how the people for whom it is all meant can be involved. Research plays an important role in these plans. What should we do about a researcher from the North who comes here and wants to do research into the acidity of crocodiles' bile? If researchers from the North want to do research together with us, that is wonderful — but let them adapt themselves to the priority needs that we, the Ghanaians, have formulated. Ghana is a free country and they can do their research if they want to, but it is a pity if Northern donors tempt our researchers into research that may be interesting for academic reasons or because it satisfies the needs of the donor, while we would lack funding and researchers for our own programmes.'

This was one of the many remarks made during this meeting which reflected the attitude of Ghanaian researchers and policy-makers. For a few years now there has been a continuous process of consultation between policy-makers, service providers, researchers and NGOs aimed at coming to understand what is really needed to improve health in Ghana. This has changed views on how they want to cooperate with donors and researchers from the North.

> **"If researchers from the North want to do research together with us, that is wonderful — but let them adapt themselves to the priority needs that we, the Ghanaians, have formulated."**

Because of the existing relationship of dependency between the North and the South, research cooperation often has negative or adverse effects on the development of a genuine national research agenda in developing countries, and on building up capacity for research for health and development. Research agendas are frequently produced in the North or at international academic fora. Therefore they too often reflect academic criteria instead of development criteria. While agendas produced in the South will reflect the conditions of scarcity that overshadow the research environment and will focus, for instance, on malnutrition or the malfunctioning of the health care system, academic agendas often reflect the agendas formulated by donors or simply become shopping lists of diseases. Researchers in the South rarely have the opportunity to devote all their time to research and they are continually reminded of the lack of funding. Too often, the researchers from the North run the show and take the major decisions.

Development of an essential national health research agenda is already one step in the direction of equity in research cooperation because it will strengthen the Southern researchers' arm in their negotiations about research topics. However, this does not lead automatically to better research partnerships, because funding mechanisms are often still based on the idea that this cooperation between North and South is a matter of technical assistance

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Cooperation ... continued from page 2

Many actors are today entering the health research scene. Governments can no longer be the sole body responsible for the health of the people, so community, nongovernmental groupings, non-profit foundations and enterprises are all playing important roles. Since health is the prime responsibility of each country itself, health research should also be a part of that responsibility. We believe that the Essential National Health Research principle and approach is most suitable, and that research capacity to solve important health problems in each country must be developed. COHRED is assisting countries in their efforts to make health research and the use of resources responsive to needs, with the active involvement of all partners. Countries are learning from each other, and workable ways and means are being identified as ENHR competencies.

The Global Forum for Health Research was established two years ago to provide a forum for all those involved or interested in health research to talk to each other, to think together, and to work together in some selected areas. This annual forum should serve as a marketplace for people to meet and exchange ideas and experiences, as well as further developing the global health research agenda. Analytical works to improve the formulation of that agenda would be topics of common interest, while many initiatives and alliances can also be started at the forum.

Financing of health research is an important element, and the involvement of financial institutions such as the World Bank and Regional Development Banks is crucial not only for the support and management of research but also to link health research with broader development activities. A public/private mix with the involvement of industries is also vital, and academics, educational institutions, training bodies and networks are playing a big role in the long-term development of health research capacity. Good practice in international cooperation and ethics in health research are continuing interests for many agencies, including the Council for International Organizations of Medical Sciences (CIOMS).

Essential National Health Research and Priority Setting in Nepal: Another Lesson Learned

THE 'CONFERENCE ON Prioritisation of Essential National Health Research Agenda' was held in Nagarkot, Nepal, in August 1998 as part of a series of exercises planned by ENHR Nepal in collaboration with the Nepal Health Research Council (NHRC). Earlier this year, a high-level consultative meeting on prioritisation of health research, organised by NHRC and the World Health Organization (WHO), had recommended a participatory continuation of the prioritisation process. Such a process should forge 'strategic alliances in developing priority research areas by identifying key research needs, [following a] critical analysis of [the] present situation so that [the] interests and needs of [the] different health and [health-]related sectors will be reflected along with the people's needs.' As a result, the Nagarkot Conference mobilised representatives from the major stakeholders in health research, together with ENHR colleagues from Indonesia, the Philippines and Thailand.

The participants were called upon by the Rt. Honourable Prime Minister of Nepal, Girija Prasad Koirala, in his opening address, to recommend areas of research amenable to bringing health to all, but first and foremost to Nepal's poorest and most vulnerable people. 'The cost of health care,' Mr Koirala said, 'has been going up in Nepal as well. In this situation the question of prioritisation in national health research becomes evident. It is a special challenge for us to provide primary health care to the majority of the poor people in Nepal.'

The Conference participants identified for four major fields of research areas that should receive high priority. (See below.)

In addition, the Conference formulated a series of recommendations to guide the process into its next phase. These recommendations include : '...ENHR Nepal will develop special committees, representing the four major fields of research, by involving task force members and other experts, to develop research proposals by participatory methods...; ...ENHR Nepal will continue to develop actively a network of networks for ENHR, which will network information and act as a clearing house for an effective dissemination.' The Conference further recommended that the ENHR office's location rotate from research institutes to universities to NGOs to academia in order to prevent ENHR Nepal from getting caught in organisational pitfalls and to enable it to uphold its good characteristics as a forum or network.

Photo: NHRC

The priority-setting exercise as well as the recommendations of the Nagarkot Conference illustrate — once again — that the ENHR strategy provides a unique learning environment in which all

Research Priorities

Health policy and health systems research
- Resource allocation for meeting objectives of national health policy
- Health policy implementation research

Behavioural and social research
- Child labour, street children, child abuse
- Early marriage and child marriage
- Sexual violence/abuse, prostitution, human trafficking
- Workplace environment and safety
- Environmental and social degradation

Basic health and clinical research
- Injuries and accidents
- Determination of standard health parameters in the Nepalese population

Technology and product assessment
- Biotechnology
- Food safety
- Development of standards for rational drug use and technologies
- Monitoring of adverse reactions to drugs
- Cost-effectiveness analysis of high-tech equipment
- Conservation of biodiversity and identification of useful medicinal plants
- Country-specific laboratory-based research
- Vaccine assessment

Photo centre: Opening the Conference at Nagarkot, from left to right, Girija Prasad Koirala, Prime Minister of Nepal; and Indira Shrestha, Honorary Secretary of ENHR Nepal.

For a full account of the deliberations and the priority areas identified, see 'Sachetana,' Journal of Essential National Health Research Nepal, Vol. 1 No. 1, September 1998, available from: ENHR Nepal, Nepal Health Research Council (NHRC) Building, Ramshahpath, PO Box 7626, Kathmandu, Nepal. E-mail <nhrc@npl.healthnet.org>

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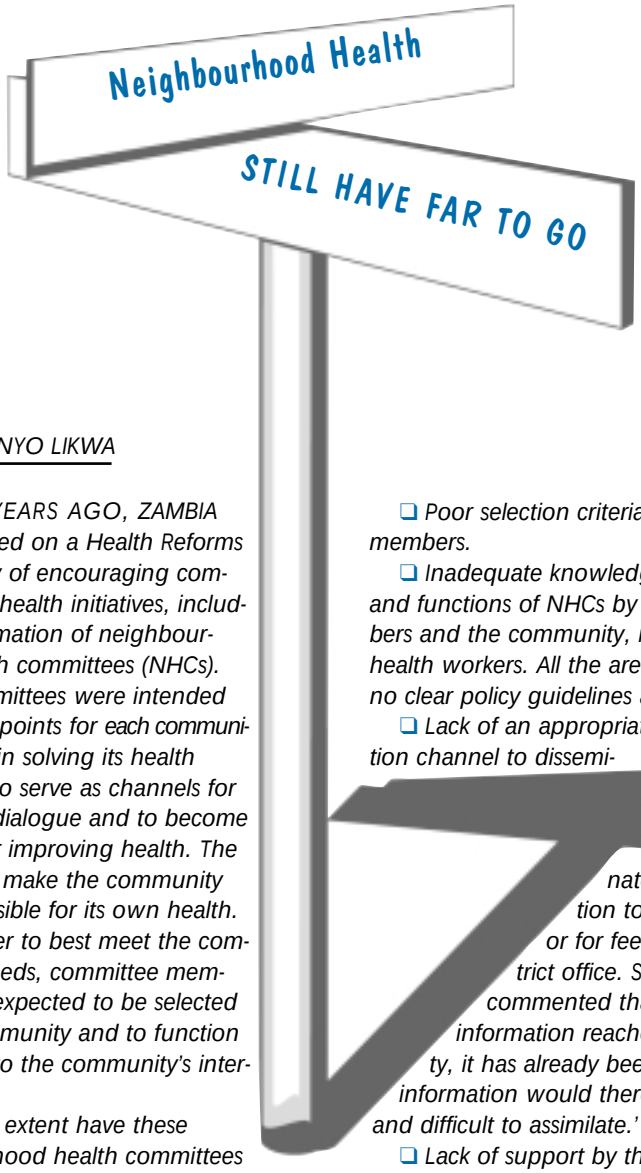

Lessons Learnt in Zambia

BY R. NDONYO LIKWA

THREE YEARS AGO, ZAMBIA embarked on a Health Reforms strategy of encouraging community health initiatives, including the formation of neighbourhood health committees (NHCs). These committees were intended to be focal points for each community's interest in solving its health problems, to serve as channels for consumer dialogue and to become catalysts for improving health. The aim was to make the community feel responsible for its own health. And in order to best meet the community's needs, committee members were expected to be selected by the community and to function according to the community's interests.

To what extent have these neighbourhood health committees succeeded in meeting the basic health requirements of the communities? Are people satisfied with their performance? Have they contributed to changes in the community's health development? Realistic answers to such questions can be regarded as driving forces for effective monitoring and evaluation of community health initiatives.

When judged against the intentions of the community strategy as laid down by the Health Reforms since 1995, the NHCs have not so far fulfilled the community health needs in the districts that have been surveyed. Whether those districts reflect the true situation in all districts still needs to be further explored. Certainly, several factors have contributed to disappointing results.

A study carried out in 1997, through a qualitative approach, shed some light on the current status of the performance of NHCs in a few selected districts and communities. Among the reasons for their ineffective impact were:

- ❑ Inadequate consultation of NHC members by the community, resulting from the community's negative perception of NHCs.
- ❑ Poor selection criteria of the NHC members.
- ❑ Inadequate knowledge of the roles and functions of NHCs by both NHC members and the community, including the health workers. All the areas studied had no clear policy guidelines at the site.
- ❑ Lack of an appropriate communication channel to disseminate health information to the community or for feedback to the district office. Some respondents commented that 'by the time information reaches the community, it has already been diluted. The information would therefore be valueless and difficult to assimilate.'
- ❑ Lack of support by the health workers to provide both moral and technical competence to community health services and to the management of NHCs. One comment was that 'health workers visit the communities to immunize children — as if men do not fall sick.'

All these points indicate that the comprehensive community health service is not being supported by the health providers, whether at the health centre level or at the district health office. This lack of community support is to a large extent responsible for the poor performance of the NHCs, and there has been poor community participation as a direct consequence. Indeed, current data suggest that community participation in Zambia stands at a low 6% to 10%, which compares unfavourably with countries such as Kenya, Nepal, Tanzania and Zimbabwe.

Other factors include uneven distribution among the membership of NHCs, poor collaboration with other sectors besides health, and inadequate resources for managing the committees or other community initiatives.

Three distinct lessons emerge from the study.

1. There is a direct association between what the community knows about the roles and functions of the NHC and how that community perceives the performance of the NHC. That is to say, people who do not understand what the NHC is trying to do will take a negative view of what the NHC actually does. It follows that knowledge is a basic requirement for a community if community initiatives are to be strengthened and sustained. Equally, NHC members should have education, experience and exposure to health issues if the committee is to achieve its goals and aspirations. By the same token, health workers should be fully acquainted with the roles and functions of NHCs.

2. Community involvement in the formation of NHCs has a positive influence on whether the community will participate in the decision-making process. Even in a community with an established NHC, if the selection of the committee members did not involve ordinary people, there will be only reluctant participation in health initiatives.

3. The level of collaboration and of community participation directly influences the performance of NHCs. The study revealed that little or no link exists between health workers and the community, indeed, effective collaboration is more evident with NGOs than with the health workers who are supposed to be key partners in community health service promotion. Furthermore, communities which collaborated with the NGOs proved to be quite actively involved in community participation, whether or not there was an NHC in place.

Finally, the study in Zambia has only been able to convey a tentative feel of what community health initiatives might achieve and of what improvements in community health services can reasonably be expected. ❑

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TANZANIA

ESSENTIAL NATIONAL HEALTH RESEARCH (ENHR) is a strategy which ensures that evidence-based information is utilised correctly in the policy- and decision-making process, enhancing the provision of better and equitable health to a population. This is all well said and ambitious, but can it be done?

An analysis of the Tanzanian situation shows that the process has started, that some steps have been made, but that there still is a long way to go to better and equitable health.

Since its inception in 1991, the Tanzania ENHR Mechanism has established the National Health Research Users Trust Fund (HRUTF) (1997), has been bringing out a HRUTF-funded national health research bulletin, and it has realised that the ENHR mechanism is not the monopoly of any single institution but a partnership involving all stakeholders. As to the HRUTF, this Fund awards grants for national research which are competition-based and open to all Tanzanian researchers. Currently under review by the Fund are 13 proposals for the October 1998 award. Applicants are required to write and submit a proposal for operational research on one of the priority national health problems listed in the HRUTF's calls for proposals. Originally provided by the Ministry of Health (MoH), this list is being updated to include regional and district health priorities, based on the district medical officers' feedback to the HRUTF Secretariat's request to list the ten priority diseases, the ten leading health-services problems, and the five social and/or cultural aspects that hinder health development in their respective district. Plans are under way to use focus-group discussions, key informants and nongovernmental organisations to gather information from the communities on what they see as their priority health problems. The vehicle for making research results known — in easy-to-understand terms — to policy- and decision-makers and to the population at large, is a twice yearly newsletter entitled Health Research Bulletin.

Establishing ENHR means overcoming a number of stumbling blocks, such as the question of 'Who is going to own the ENHR Mechanism?' In Tanzania, the institution the Government mandated through an act of parliament to coordinate all health research activities in the country is the National Institute for Medical Research (NIMR) — a decision resented by other health institutions in the country for fear of the mechanism becoming a property of NIMR. As a result, ENHR is poorly coordinated; the individual research institutions do not communicate with each other, which obfuscates relations between the individual partners in the ENHR Mechanism; added to this, Tanzania has had problems formulating strategies for building national research capacities, unclear plans for ENHR, and no resources to fund ENHR activities.

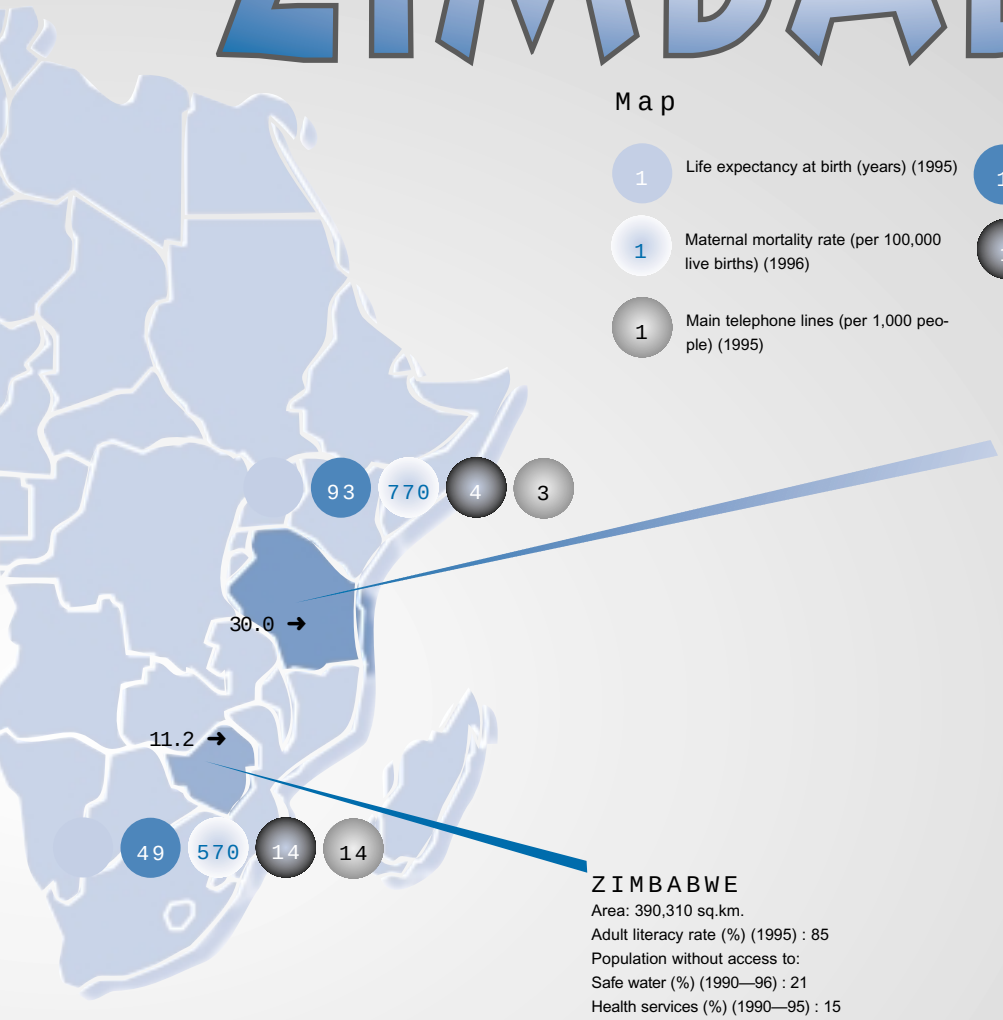
A recent repositioning of the ENHR Mechanism in combination with a clear definition of each partner institution's role is hoped to help to surmount those constraints. (See Schematic, page 9.)

The new set-up makes the National ENHR Forum, which is composed of the partner institutions and their representatives, the central body — the ENHR Mechanism. The authority to coordinate research remains in the hands of one institution, the National Institute for Medical Research, which also functions as the Mechanism's secretariat and as its custodian on behalf of all partner institutions, who are members of the Forum and have voting rights to the coordinating body. Thus, the Mechanism is not the monopoly of one single institution but a responsibility- and role-sharing partnership.

This set-up has many advantages over institution-based mechanisms. It ensures that each partner has a clearly defined role, is considered an asset and hence, tends to be highly motivated; it precludes institutional monopoly of the mechanism, creates confidence in partner institutions, promotes accountability, and cuts down on red tape. It further allows for efficient use of available resources, as there is no need to create a new body or a special infrastructure. It enhances sustainable development by virtue of its non-allegiance to any religion or political group.

Once the proposed mechanism has been approved by all the partners, a National Essential Health Research Forum is expected to be in place in Tanzania by December 1998. An updating of the country's research priori-

ZIMBABWE



TANZANIA

Area : 945,035 sq.km.
Adult literacy rate (%) (1995) : 68
Population without access to:
Safe water (%) (1990—96) : 62
Health services (%) (1990—95) : 58
Sanitation (%) (1990—96) : 14
Gross Domestic Product (US$billions) (1995) : 4
GDP per capita (1987 US$) (1995) : 155
Public expenditure on health (as % of GDP) (1990) : 3.2
Defence expenditure (as % of GDP) (1996) : 2.5
Total net ODA* received 1996 (US$ millions) : 894
Human Development Index** (HDI) rank 1998: 150

ZIMBABWE

Area: 390,310 sq.km.
Adult literacy rate (%) (1995) : 85
Population without access to:
Safe water (%) (1990—96) : 21
Health services (%) (1990—95) : 15
Sanitation (%) (1990—96) : 48
Gross Domestic Product (US$billions) (1995) : 7
GDP per capita (1987 US$) (1995) : 604
Public expenditure on health (as % of GDP) (1990) : 3.2
Defence expenditure (as % of GDP) (1996) : 3.9
Total net official development assistance (ODA) received 1996 (US$ millions) : 374
Human Development Index (HDI) rank 1998: 130

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ties is planned for late January 1999. Two capacity-building workshops — one on research methodoloy and one on health management and financing — are slated for August and November 1999 respectively.

Planning for the longer term will start once the ENHR Forum has been set up.

Summarising, one can say that 'ownership' is both the biggest problem in setting up an ENHR mechanism and a prime motivating factor for active participation. As long as the mechanism is institution-based, partner institutions will regard it with suspicion and, consequently, resist participating in it. This is why we opted for this novel arrangement, which we believe is conducive to partnership and active participation. Relying on existing institutions and requiring no

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* An EGDI-commissioned aid-dependency study (*see below for full title*) found Tanzania an aid-dependent, aid-devastated country that has backslid from its World Bank 1970s upper-level low-income countries ranking to become one of the poorest nations, which the study authors attribute, among other factors, to the donor-supported Tanzanian institutions lack of financial sustainability. The authors recommend that donors address the underlying causes of ineffective aid, aid-dependency and poor sustainability by shifting away from a supply-driven, disbursement-oriented policy to a demand-driven, performance-oriented and knowledge-based service. For details regarding the study entitled *The Sustainability Enigma Aid Dependency and the Phasing Out of Projects. The Case of Swedish Aid to Tanzania* by Julie Catterson and Claes Lindahl, Management Perspectives International, Stockholm, 1998, contact : Elisabeth Brolin, phone 46-8-405 5776, E-mail <Elisabet.Brolin@foreign.ministry.se>
EGDI = Expert Group on Development Issues, appointed by the Swedish Government in 1995.

** This index, worked out for 174 countries having comparable data, measures a country s overall progress along three dimensions of human development health, knowledge and a decent standard of living.

whereby the Northern partner supports and trains while the Southern partner is the recipient. Funding mechanisms then put the Northern researchers in a position of dominance.

A lot of attention has been paid recently to so-called 'demand-driven research.' The idea behind this is that the Southern partner sets the agenda, based on currently existing problems. Some of these 'demand-driven research programmes' are really innovative, but they beg certain questions. Does a group of Northern and Southern researchers make a short list of topics and present this to a meeting of stakeholders in order to receive applause and start the research? What will the chances be that the results of such research will really be used?

The involvement of policy-makers (in this case the Ministry of Health of Ghana) and the community is essential to develop a health research agenda which will produce results that may be utilised. This will require from the researchers in the South other skills and a different role. The Northern research partners will have to wait until this process is finalised. The donor will have to understand that investments must be made in setting the agenda, but also in strengthening the research environment to ensure there is a maximum chance of the capacity building at different levels in the health care system and at universities being sustainable. This implies other criteria for agreeing about funding. Donors will have to pay more attention to verifying that the agenda-setting was a genuine Southern process, and they will have to give priority to societal as well as scientific criteria. In this context, obscure peer review mechanisms are not useful.

In 1995, the Dutch Ministry of International Cooperation asked the Dutch Council on Research and Development, RAWOO, to develop a programme on demand-driven health research for development. In cooperation with several Dutch research councils, this challenge was accepted and Ghana was asked if it would be interested in a research partnership based on such ideas. Since 1996, this process has gradually moved towards the final formulation of policy principles. The programme intends to bridge the gaps between Southern and Northern researchers, between bio-medical, social and cultural sciences and health system research, between needs of the people at grass-roots level and research institutes, and between the different stakeholders in the health research process. It sounds ambitious, but is quite feasible.

In the programme there is not only focus on the research itself but also on:
•research training (and better use of existing, often under-utilised, capacity);
•methodologies for assessing needs and setting priorities (through workshops, participatory approaches and networking);
•strengthening health research institutes and other research infrastructure (libraries and information and communication facilities); *•a mechanism for linking research, policy and practice;* *•creation of an institutional and policy environment that will enable Southern countries to design, implement and manage policies and programmes for health research.*

As Ghana had already developed a strong policy on Health Reforms and wanted it to be steered by health research, it was an ideal partner in this Dutch pilot programme. In Ghana, attention had already been given to developing mechanisms to steer the research process. Ghanaian and Dutch researchers met during a workshop in Amsterdam in May 1997 and began drawing up a framework for the Ghanaian-Dutch partnership. By means of a questionnaire Dutch researchers were asked whether they were willing to be partners in this programme, and the results were summarised in a report distributed during the Consultative Meeting on Health Research in Accra (October 1998).

While development of this programme has not always been easy, all the key players in this process gradually learned what is at stake and how their experiences may slot into the partnership process. Initially, there seems to be an important role for partnership in the fields of health system research, community assessments and participatory research approaches to more detailed agenda-setting at community level.

The Dutch Ministry of Development Cooperation is following the process with interest, and other donors have shown their interest. The initiative also met with enthusiasm during a meeting of 20 African countries convened to exchange views on Essential National Health Research (Accra, Ghana, October 1998). ❑

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rawoo

ADVISORY COUNCIL FOR SCIENTIFIC RESEARCH IN DEVELOPMENT PROBLEMS, RAWOO

RAWOO s mission is to advise the Dutch Government on matters of policy related to development problems research. Its joint Ghanaian—Dutch programme (*see main article*) is guided by the following policy principles.

Steering health research through a society-driven or demand-driven approach. In practice, this principle means that the proposed research programme will give priority to the health problems of the poor and to the policy and institutional constraints related thereto.

Developing a comprehensive approach aimed at integrating support for collaborative research and support for building and strengthening national health research capacity. This principle makes it the Programme s central concern to develop a strong and sustainable national capacity for health research in developing countries.

Research cooperation on an equal footing, which principle implies that Southern researchers participate as equal partners in designing and implementing the collaborative Programme, and that they have an equal say in the policy- and decision-making process as well as in the governance and management structure.

Coordinating programmes of health research for development. This principle reflects RAWOO s stance that the Southern countries themselves are best placed to coordinate donors efforts, particularly if they have a national health research policy that reflects the country s relevant needs and priorities.

Source : Framework for a Ghanaian–Dutch Programme of Health Research for Development, Publication No. 15, RAWOO, 1998. ISBN 90–71367–24–x. Available from: RAWOO, Kortenaerkade 11, PO Box 29777, 2502 LT The Hague, The Netherlands. Fax 31–70–426 0329 • E-mail <rawoosec@nufficcs.nl>

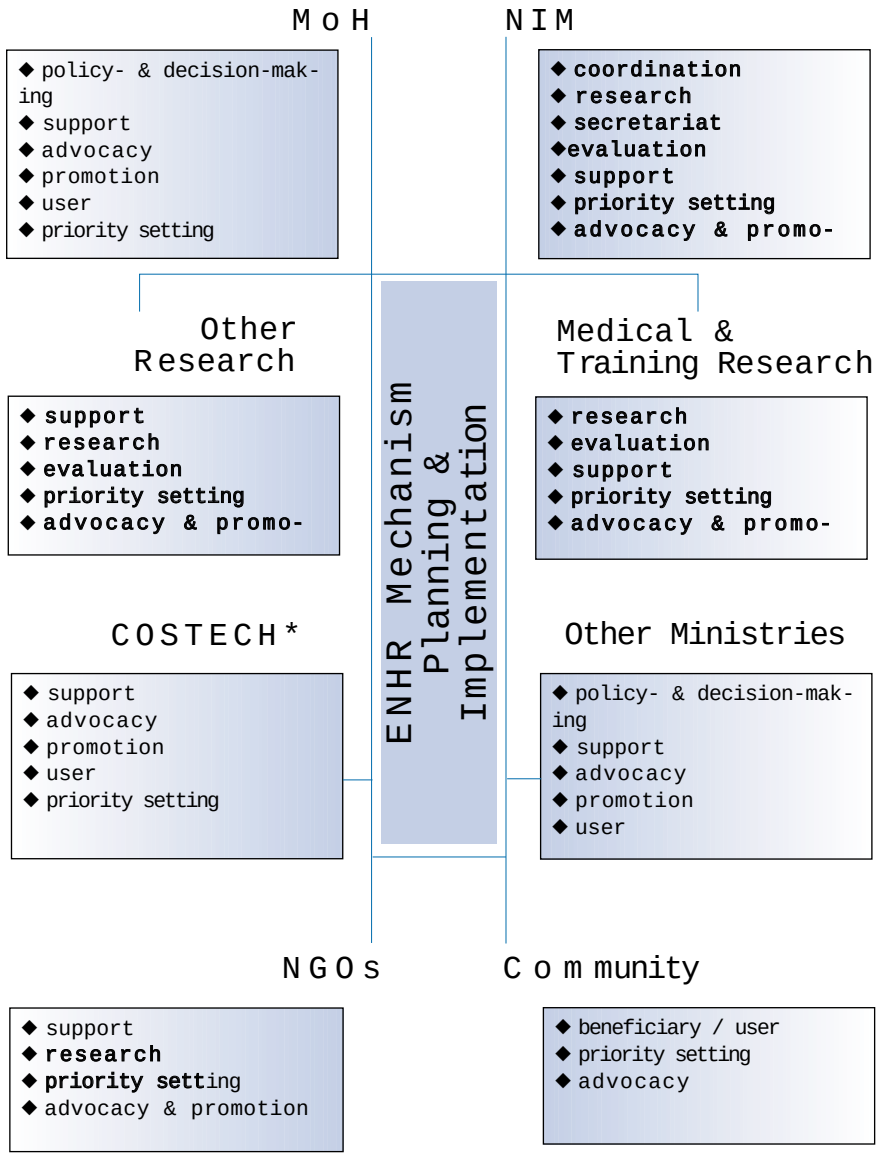
Zimbabwe

CREATED IN 1974 AS A BODY of volunteers chosen by the Minister of Health and Child Welfare, the Medical Research Council of Zimbabwe, MRCZ (Secretary: S. Chandiwana, member of the COHRED Board) — the health sector arm of the Research Council — has been the prime mover for the country's ENHR agenda. Within the MRCZ, an ENHR task force was established to maximise dissemination of research for the benefit of institutions involved in conducting research, in addition to the community and the country at large. In addition, the task force apprises the Minister of Health and Child Welfare of areas to which resources should be channelled.

Recently, the MRCZ introduced the concept of Institutional Ethical Review Committees (IERCs) — a concept in line with the Council's mandate 'to ensure that research proposals take ethical considerations into account' that is currently being put into practice, as recommended by the 1994 Ethics and the 1995 ENHR Workshop. All major institutions (research institutes, medical schools, provincial medical directors' offices, hospitals) are expected to form such a Committee, which would be tasked to monitor projects approved by the MRCZ. At the same time, the ENHR facilitator — the Blair Research Institute — is promoting ENHR by providing a small operational research grant of US$30,000 for setting up focal points. The amount is earmarked, among others, for procuring computers and e-mail software, and recipients are required to report to the Institute within four months of grant receipt. ❑

Source: Newsletter, published by the Medical Research Council of Zimbabwe, Vol.7, No.1, March 1998.

Roles of Key Partners in ENHR



**COSTECH – Commission for Science and Technology*
*** incl. MUCHS – Muhimbili University College for Health Sciences*
KCMC – Kilimanjaro Christian Medical Centre

additional outlays for infrastructure and personnel, this mechanism is expected to prove efficient and economical, to reduce bureaucracy and, most importantly, to strengthen institutional links and collaboration and, hopefully, it will enable us to bring better and equitable health to our people sooner. ❑

PUBLICATIONS

Human Development Report 1998. *United Nations Development Programme. 1998. New York: Oxford University Press. ISBN 0–19–512459–6 (paper), 228 pages.*

The ninth in an annual series, the Human Development Report (HDR) 1998 explores the complex issues behind the dramatic surge in global consumption and sets out an agenda to bring about consumption that is shared, strengthening, socially responsible and sustainable. The main features of this year's Report are: an overview of changing consumption levels and patterns; the inequalities between the rich who benefit from the consumption boom and the poor on whom the impacts of pollution, degradation and scarcity fall the hardest; practical examples of innovative policies and technologies that are enabling developing countries to leapfrog into environmentally-friendly consumption patterns; the 'HPI–2' index — a new measure of human poverty in industrial countries, focused on deprivation in longevity, functional literacy and economic provisioning as well as social exclusion.

To order copies of the HDR 1998, please contact:
ARABIC: Please contact your local UNDP office.
CATALAN: Centre UNESCO de Catalunya, Majorca 285, Barcelona 08037 Spain. Fax 34-3-457 5851
ENGLISH: Oxford University Press, Cary, NC 27513, USA. Fax 919-677 1303. Fax orders from outside the US and Canada: 212-726 6453;
Oxford University Press, Oxford, OX2 6DP, UK. Fax 44-1865-556 646
FRENCH: Editions Economica, Paris, France. Fax 33-1-45-750 567
GERMAN: UNO-Verig GmbH, Bonn, Germany. Fax 49-228-217 492
ITALIAN: Rosenberg & Sellier, Torino, Italy. Fax 39-11-812 7808
JAPANESE: UNDP Liaison Office/Japan, Tokyo 150, Japan. Fax 81-35-467 4753
PORTUGUESE: Trinova Editora. Lda, Lisboa, Portugal. Fax 351-1-342 0751
RUSSIAN: Forssan Kirjapalno Oy, Forssa, Finland. Fax 358-3-4155 737
SPANISH: Mundi-Prensa Libros, sa, Madrid, Spain. Fax 34-1-575 3998

Also available: Human Development 1998 Database (database diskettes and user's guide); Background Papers 1998. Order from: UN Publications, Room DC2-853, Dept. 1004, New York, NY 10017 USA. Fax 1–212-963 3489.

Rx for Global Health Cooperation Beyond 2000. *Report on the Conference on Global Health Cooperation Beyond 2000, Mexico City, April 1998. Overseas Development Council, ODC, Washington, 1998. 20 pages.*

This Report takes a hard look at what should be the work of international organisations — within the context of an increasing number of public and private players in global health — in meeting the challenges and opportunities beyond 2000.

It presents the results of a year-long analytical work and deliberations of four collaborating institutions: The Chulalongkorn University School of Public Health in Bangkok; the Mexican Health Foundation in Mexico City; the London School of Hygiene and Tropical Medicine in London; and the Overseas Development Council in Washington, DC.

Supported, among other organisations, by the Council on Health Research for Development, COHRED, the effort culminated in the above Conference, which brought together a group of individuals from different regions — among them the Chairperson of COHRED's Board, Professor Charas Suwanwela, and COHRED's Coordinator, Dr Yvo Nuyens — who reflected the wide array of global health stakeholders from international organisations, governments, civil society, and business.

For the Report in its entirety, please contact the Overseas Development Council, Washington, DC, phone 1–202–234 8701, or go to <http://www.odc.org>

Health Systems Assessment and Planning Manual: Transforming Reproductive Health Services. *Published by the Women's Health Project, Department of Community Health, University of the Witwatersrand, Johannesburg, South Africa. ISBN 1–86838–213–3. 1998. 80 pages.*

This manual is designed to provide health service planners and researchers with some basic tools for identifying barriers to quality of care in health services and ascertaining means of addressing these; for improving micro-management tools to strengthen clinic-based health services and their linkages to other levels, in particular strengthening district health systems; for mainstreaming gender equality in health services and related policies, and for increasing capacity for, and improving delivery of, sexual and reproductive health services. The methodologies presented in this publication can be used in different settings, across different types and levels of health services, and in different cultures. Contact details: Women's Health Project, PO Box 1038, Johannesburg, 2000, South Africa. Fax 27–11–489 9922 • E-mail <womenhp@sn.apc.org>

La Recherche Nationale Essentielle en Santé et la définition des priorités : les leçons de l'expérience. *COHRED Document 98.3, 1998. 66 pages.*

Les thèmes principaux de ce guide sont: l'information et la définition de priorités dans la RNES; les participants à la définition des priorités; les critères pour la définition des priorités; galvaniser les participants; l'articulation entre le niveau national et le niveau mondial dans la définition des priorités de recherche. Cette publication est aussi disponible en anglais (COHRED Document 97.3). Pour obtenir des exemplaires à titre gracieux, veuillez contacter le Secrétariat du COHRED.

The Asian Regional Network has released the ***Proceedings of the 2nd Regional Meeting*** *in September 1998. It is distributed to the members of the Asian Essential National Health Research Network, Member of the Council on Health Research for Development, COHRED, and other interested parties.*

The Proceedings summarise the discussions and activities which took place during the meeting. It includes the presentations and discussions on the four ENHR competencies: Promotion, Advocacy and ENHR Mechanism, Priority Setting, and Translating Research to Policy; the concepts and guidelines presented by the working group leaders; the experiences, lessons and challenges shared by the delegates from selected countries; key components and issues identified by the participants during the workshop; initial findings and discussion of case studies on Health Research Resource Flow presented by the resource persons from the Philippines, Thailand and Malaysia; the role of NGOs in generating funds; and the plenary discussions on capacity building and future directions for the ENHR Asian Network.

Programme, directory of participants and a guide for small group discussions on ENHR competencies are also included. For copies of the Proceedings, contact Dr Corazon M. Raymundo, President, Tuklas Pangkalusugan Foundation, Inc., and Focal Point for Asian ENHR Network, c/o Department of Health, Bldg 12, Ground Fl., San Lazaro Compound, Rizal St., Sta. Cruz, Manila

Please note, COHRED cannot supply the publications reviewed on this page. Please write to the appropriate address.

MARCH 1 – 5, 1999
Bangkok / Thailand

Creative Partnerships for Securing Health
The INCLEN XVI Global Meeting will highlight the challenge of meeting the basic health needs of all people, with particular emphasis on collaborations that have used innovative ways to tackle the problem of health security and of coordinating the interests of the various partners — general population, health practitioners, policy-makers, scientists, governments, nongovernmental organisations, and donors. INCLEN XVI will feature success stories and lessons learned.
For details, contact INCLEN Inc., 3600 Market Street, Suite 380, Philadelphia, PA 19104–2644, USA. Fax 1–215-222 7741 • E-mail <inclen@inclen.org>

AUGUST 10 – 13, 1999
Ko-Phuket / Thailand

Towards Unity for Health
Expected to bring together about 200 representatives of the principal partners in health — health policy-makers, health-care organisers, health professionals — this international conference will focus on: challenges for health systems to respond adequately to societies' needs; cases demonstrating endeavours to create unity for health and their implications for the reorientation of health professions practice and education; identification of priority areas for research and development, recommendations for future action, presentation of an Oath and setting up of a global collaborative network.
For specific information, please contact: Dr B. Salafsky, USA. Phone 1–815–395 5600 • Fax 1–815–395 5887 • E-mail <BuzS@uic.edu> or <cbs4601@uicvmc.aiss.uic.edu>

JULY 11 – 15, 1999
Tucson, Arizona / USA

Universities and the health of the disadvantaged: Building coalitions with the health professions, local governments and their communities
Co-organised by the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organisation (UNESCO), and the University of Arizona, this global conference will have the format of plenary presentations, group discussions and poster sessions around the following main themes: Knowing the health care of the disadvantaged; Optimising universities' potential for improving the health of the disadvantaged and underserved; Creating coalitions for sustained, effective and efficient action; Weaving global links for health care for the disadvantaged and underserved.
For further information, please contact the 1999 Global Conference Committee, University Arizona Rural Health Office, 2501 East Elm St, Tucson, Arizona 85716, USA. Fax 1–520–321 7763 • E-mail <anichols@ahsc.arizona.edu> or Dr Charles Boelen, WHO, HDP/HRB, 1211 Geneva 27, Switzerland. Fax 41–22–791 4382 • E-mail <boelenc@who.ch>

COURSES

Boston University School of Public Health Center for International Health Certificate Course Field Research Techniques for Developing Countries

The International Health Department is considering a new course that focuses on practical skills in biostatistics, epidemiology, operations research, survey methodology, and qualitative methods directly applicable to developing country environments. The first course offering is expected in autumn of 1999. For details, contact: Boston University School of Public Health, Center for International Health, 715 Albany Street, T4W, Boston, MA 02118, USA. Fax 617–638 4476 • E-mail <cih@bu.edu> or go to <http://www–busph.bu.edu/depts/ih>

Season's Greetings To All Our Readers

COHRED

COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

This newsletter of the Council on Health Research for Development is published four times a year.
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- *latest country developments*
- *COHRED's working groups*
- *regional developments in the field of ENHR*

New Faces at COHRED

MEDICAL ADVISOR
'DATUK' DR. M. JEGATHESAN
brings to COHRED over 30 years of experience in medical and health research, research management and health administration. His most recent position was that of Deputy Director General (Research and Technical Support) in the Ministry of Health in Malaysia. As a medical doctor, he specialised in pathology, microbiology and infectious diseases and gained wide experience in international health, having close associations with relevant programmes of the World Health Organization and the Southeast Asia Minister's of Education–Tropical Medicine (SEAMEO-TROPMED) programme. For the last few years he has also been the focal point for ENHR-type activities in his country.

RESEARCH OFFICER
SYLVIA DE HAAN
joined the COHRED Secretariat recently. Sylvia graduated from Nijmegen University (The Netherlands) with a degree in Health Sciences in 1992 and since that time has gathered considerable experience carrying out research projects in the field of urban health in Dar es Salaam, Tanzania. In Geneva, she is the liaison officer for COHRED's working groups and task forces.