THE NATIONAL HEALTH RESEARCH FORUM IN ECUADOR

Dr. César Hermida
November 2002.

Background:

During the V Global Forum for Health Research (Geneva 2001) the group of Latin American and Caribbean participants had a meeting in order to start a collective process to share the national experiences and set up national health research policies and system in those countries that do not have these yet.

In October 2002, COHRED supported a formal meeting of such a group during the CITESA (Health Sciences and Technology) Seminar in Habana. The group signed a Declaration about the collective objectives.

Between the V and the VI Global Forum, a national inter-institutional process was developed in Ecuador, which concluded with a successful national meeting organised in Quito in October 2002, with the participation of around 50 delegates from several provinces, signing the constitution of the National Forum for Health Research.

Objectives:

General:

To initiate a process which will establish a national health research policy and corresponding system, as a mechanism of coordination, participation and mutual support among institutions and individuals working on health research in Ecuador.

Specific:

To organise a national meeting of heads of institutions and researchers individually considered, in order to set up the national coordination structure, eventually supported by law, as the scientific community on health.

To produce a national policy and a corresponding system on health research, including the definition of research priorities for the common needs.

Methodology:

The national meeting was organised by the National Foundation on Science and Technology (FUNDACYT), the National Council for Health (CONASA), the National Council of Universities (CONESUP) and the National Association of Faculties of Medicine and Health Sciences (AFEME), in order to listen the PAHO experience on financing health research projects, such as the BIREME´s Scielo network and other projects, and the Cuba´s national experience on health research policy. With this couple of participants a Technical

Cooperation Among Countries (TCAC) Project was proposed in order to support the Ecuadorian national health research process.

During the meeting the network of PUISAL (the University Program on Health Research of the Latin American Union of Universities) was presented.

During the meeting the three main Ecuadorian experiences were presented: one from the National Foundation on Science and Technology (FUNDACYT) in the field of health, other from the Institute of Science and Technology of the Ministry of Health, and other from the Master's Degree Program on Health Research developed by the University of Cuenca.

During the workshop of the meeting four main headlines were established: one "political" for management of the process, other "technical" for setting up the health research priorities, another for financing the process and the last one for development of human resources.

The group decided by consensus:

.- To define the health research as a new way of "learning to think" in a national identity context.

.- To understand health research as an instrument for action that leads to social development.

.- To focus the goals more in the context of health than in the one of disease.

.- To develop a model of complementary efforts instead of one of competitivity.

.- To search beyond the biomedical limits in order to understand the political implications.

.- To facilitate negotiations in order to build a public private partnership.

The group decided to follow recommendations of Global Forums and CORHED documents and constitute the Ecuadorian NATIONAL HEALTH RESEARCH FORUM, which will be responsible of defining the details of the four main headlines of the process for the next meeting to take place in the northern city of Ibarra early in 2003.

A "Declaration" with this contents was signed by all participants at the end of the meeting in October 31, 2002.

THE SITUATION OF HEALTH AND HEALTH RESEARCH IN CENTRAL AMERICA

Dr. Ernesto Medina
Rector
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Introduction

At the beginning of the XXI century social equity is still a pending challenge in the Central American region. The end of the military conflicts that afflicted the region during the 1980s, the democratization of the political regimes and the modernization of the economies have had little impact on the historical social inequities of the region. These inequities or equity gaps are multiple: between urban and rural areas; between rich and poor; between indigenous and non-indigenous population; between men and women. The region is still is still the stage of a social inequity that affects the human development of the majority. Millions of Central Americans do not have at all or have only a very limited access to opportunities for having a job, for having access to education or for covering their health needs.

There are, however, some signs of hope. For the first time in the Central American history the need of more social equity has been recognized by the governments as a fundamental objective of the regional integration. Today, no social or political group justifies social inequity in the name of social or political stability or in the name of national security. Furthermore, social reforms have been put in place in every country in the region, which with different degrees of ambition have brought forward the need for a real social change.

Poverty in Central America

Different kind of studies carried out during the 1990s show that three out of five Central Americans live under the poverty line. Even more worrisome is the fact that two out of five are considered to live in extreme poverty. The rural areas are the most affected by this phenomenon. 71% of the people liven in rural areas are considered to be poor, compared with 56% of the residents of urban areas. Again, the picture is more dramatic when extreme poverty is considered, since more than 50% of the people living in rural areas live under this condition, compared with 25% of the population in urban areas. Guatemala, Honduras, Nicaragua and El Salvador are the countries where the poverty problem is specially grave.

Inequity in the access to drinking water and basic sanitation services is one of the major problems in the region. Moe than 10 million people, do not have access to drinking water. The situation is specially difficult in the rural areas, where more than 50% (72% in Nicaragua) have no access to drinking water.

In general, the indigenous people of Central America experiment a higher degree of exclusion.

The Health Gap.

It is estimated that less than 70% of the population in Central America have access to some kind of health service, including very basic ones. Accessibility is different from country to country, as well as between the rural and urban areas. In the case of countries, Guatemala, Honduras and El Salvador, followed by Nicaraguan show the lowest levels of access. Costa Rica, on the other side, show almost a 100% access.

Two indicators generally used to determine the accessibility to health services are the coverage of birth by qualified personnel and the pre-natal attention. In 1995, these indicators showed results for the regional average of 64% and 70% respectively, which are considered very low. Again, there are differences between countries. As well as between rural and urban areas.

The Central American countries are in a phase of epidemiological transition, in which transmissible diseases are combined with non transmissible diseases in all age groups.

The main cause of mortality among children are affections originated in the perinatal period. However, in Honduras and Nicaragua intestinal infections are the first cause of mortality among children. Infant malnutrition continues to be an important public health problem.

The annual incidence rate of AIDS in the region is increasing. It went from 32.1 per million in 1991 to 80.5 in 1996. In all countries the male population is the more affected and the main mechanism of transmission is heterosexual intercourse (62.5%).

The Health Services

The region has little more than 35,000 doctors, which gives an average of 10.4 for every 10,000 inhabitants. They are not equally distributed among countries and regions. In the case of other health professionals, like nurses and dentists, the proportion in relation to the population is lower than the one for doctors.

In Central America, there are more than 45,000 hospital beds, for a relationship of 1.5 beds for every 1,000 inhabitants. 87% of the beds belong to public institutions, the majority to the Ministries of Health (63% of the total) and 24% of these to the social security systems.

At the regional level, the private sectors owns 11% of the hospital beds.

Problems in the Health Sector

The following problems, which are common to all countries in the region, have been identified:

- Scarce economic resources.
- Deficient planning and organization
- Low social participation
- Low management capacity
- Epidemiologic transition
- Lack of adequate information systems.

Other problems that have been mentioned are the lack of leadership and coordination among the institutions of the sector, the inadequate legal framework and the social inequity in the access to health services. In the administrative area some of the problems mentioned are: centralization, low efficiency. Inadequate policies for cost recovery. Deficient management models and finally, low coverage of the system.

With this identification of problems, all health systems in the region are processes of reform and modernization. The purpose of these processes, in the majority of cases is the search for more efficiency, efficacy and equity with more financial sustainability.

Regional Efforts in the Health Sector

There are several institutions and organization with functions oriented to specific areas of activities in the Health Sector. The Central American Institute of Nutrition (INCAP) and the Central American Commission for Education and Prevention on Natural Disasters are two examples. The governments and ministries of Health of Central America have cr4eated two organizations with a broader character: The Central American Council for Social Integration (CISCA) and the Health Sector Meeting of Central America (RESSCA). Their purpose is the coordination of efforts for the analysis of health problems and the joint mobilization of resources for the development of the health systems.

In the framework of the Alliance for Sustainable Development in Central America, the heath sector presented an Immediate Health Action Program for Central America (PAISCA), which was approved by the Central American Presidents in the XVII Presidential Summit, in December 1995 in San Pedro Sula, Honduras. PAISCA is oriented to the concentration of efforts in areas considered a priority for all countries on the isthmus. The Ministries of Health have agreed to coordinate dates for actions against dengue fever and diseases preventable through vaccination. They have also established responsibilities for each country for the monitoring of specific problems: Belize in food and nutritional security; Costa Rica and Panama in environmental sanitation and Information and Communications System; Guatemala in immunizations; El Salvador in Diarrhea and Cholera; Nicaragua in Dengue Fever and Malaria; Honduras in HIV/AIDS. The priority areas for the mobilization of resources are :a) immunizations; b) cholera and acute diarrheic diseases; c) prevention and control of micronutrients deficiencies; d) water and environmental sanitation; e) prevention and control of diseases transmitted by vectors: f) control and prevention of sexual transmitted diseases and HIV/AIDS; and g) Communication and information systems in Health.

Health Research

Until now, health research has not been an issue in the coordination efforts at the regional level. The majority of the Health Ministries in the region do not have a budget or specific institutions to carry out research. PAHO supplies most of the funding for the research needs of the Ministries.

At present, most of the research activity in the Central American region is carried out at the State Universities. This activity is relatively new and most countries are still in the process of developing their research capacity. Considering the present economic situation, this is only possible with international support.

In the case of Nicaragua, support from the Swedish Agency for Research Cooperation with Developing Countries (SAREC), has been essential for creating the foundations for an important research capacity in health issues.

Cooperation from universities and research institutions in North America and Europe has been also important in supporting groups in different Central American universities to strengthen their own research capacity.

More recently, PAHO has been supporting the cooperation between El Salvador and Cuba.

In July, a proposal was presented to the Central American Council of Higher Education (CSUCA) by the National University of Nicaragua aiming to create a regional program on health research. The idea is to develop a program of Essential Health Research at the regional level with the leadership of the state universities and the participation of the Ministries of Health, NGOs and grassroots organizations. The proposal is currently being discussed among the 16 sate universities. The results of the COHED meeting in Arusha, Tanzania, will be an important input for these discussions.

ADVANCES IN HEALTH RESEARCH SYSTEMS IN LATIN AMERICAN AND THE CARIBBEAN 2001-2002

Delia Sanchez

The past year has seen a particularly difficult socio-economic situation in most of Latin America.

The Region's GDP has fallen 3% with regards to the previous year[1], and the Argentinean economic crisis had a deep effect in the neighboring countries' economies, particularly the smaller ones. The prevailing economic model broke down in some of the Southern Cone countries, unemployment rose to some of the highest levels in history, (9% urban unemployment in the whole Region, but higher than 15% in Argentina, Colombia, Venezuela and Uruguay) and the banking system collapsed in Argentina and was deeply affected in Uruguay and Paraguay.

Health care systems based on Social Security models have suffered the impact of this situation, and some interesting experiences, like the Colombian health reform have been hampered , achieving to this date only a 50% coverage , when 100% was expected by the year 2002, to mention just an example.

Health research systems , heavily dependant on governmental funds, have also been affected, particularly in Argentina, but to a lesser degree in other countries too.

How long the crisis will last and what effect it shall have on scientific production in the coming years is hard to tell.

Despite this somber situation, and probably partly due to it, the ENHR concept, long overlooked in the Latin American region (not so in the Caribbean) has gained new acceptance. Chile and Brazil have created funds aimed at fostering strategic health research, Cuba has realigned much of its research system in order to better respond to national priorities, and health research priority setting exercises have been carried out or are planned in Ecuador and Uruguay.

Country to country cooperation mechanisms for the strengthening of health research systems has been supported by PAHO , alongside its continuing support of health research and new lines of work in the democratization of knowledge. Chile, Brazil and Mexico have been chosen to participate in the pilot testing of WHO's health research systems assessment instrument, now in development. These are interesting examples of regional and global integration.

As for COHRED, an important advance has been the translation of some basic publications into Spanish, and the participation of Latin American countries (Cuba, Brazil) in the working group on health research systems. An interesting research project has been completed in the Risaralda region of Colombia.

COHRED sponsored and supported a workshop on health research systems that was held in Cuba in October, where the need for a Latin American and Caribbean Health Research Forum was identified . Proceedings from that meeting follow.

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[1] Situation and perspectives. Economic Study for Latin America and the Caribbean. 2001-2001. ECLAC, 2002

COMH 65.4

Report of the Workshop on Latin American and Caribbean Cooperation in Health Research, Havana, Cuba, October 16-17 2002.

As a result of the Latin American consultative process in preparation of the Bangkok 2000 Conference, a need was identified to create an ongoing mechanism for the exchange of information and experiences regarding health research in the Latin American & Caribbean (LAC) region. Participants at a meeting held in Buenos Aires made a clear statement that priority research in our region should be focused on social and gender equity and a transparent and ethical approach to the research process. The region's weaknesses in terms of research production and international presence were considered major obstacles for the autonomous development of national health research systems.

One of the recommendations of the Bangkok 2000 Conference was that (sub) regional platforms could be the most suitable mechanisms for furthering international cooperation in health research, thereby emphasizing the principle of subsidiarity.

During Global Forum V in 2001 a parallel LA session was held in which it was agreed to foster regional collaboration and to identify horizontal cooperation mechanisms. A greater participation of the Council on Health Research for Development (COHRED) and other international Agencies was called for to support the development of Health Research systems in our region.

In view of the above and in preparation for the upcoming Global Forum VI to be held in Arusha, Tanzania in November 2002, a workshop on Latin American and Caribbean Cooperation in Health Research was convened in Cuba from October 16-17 2002 as part of the CITESA-Havana 2002 meeting.

This workshop was initiated and sponsored by COHRED, and most of the preparatory work was carried out by the Cuban Organizers.

During this 2 day workshop:

- Reports were made on developments/activities regarding Health Research Systems during the last year in Brazil, the Caribbean (CHRC), Chile, Cuba, Ecuador, El Salvador, and Nicaragua.

- Possibilities for LA & Caribbean Cooperation in Health Research were discussed.

- The Pan American Health Organization (PAHO) Research Coordination Unit Director made a presentation summarizing the history of PAHO cooperation in the field of health research. The present focus on the democratization of knowledge and the mechanisms that PAHO proposes and is currently implementing in some countries in order to achieve that aim were discussed.

- Examples were presented of technical cooperation among countries, supported by PAHO (e.g. Cuba-El Salvador and Cuba-Ecuador). COHRED expressed its willingness to join with others to continue to support of Essential National Health Research (ENHR) and the establishment of national health research systems in the LAC-region.

- National and sub-regional needs and opportunities regarding health research were identified:

Needs:

- Capacity development in health research; translation of research findings to policy development and action; knowledge management and health research management;
- Training in setting national and sub-regional priorities in health research;
- Technical assistance in developing national health research systems;
- Understanding funding mechanisms and making better use of them;
- Developing the demand side for health research;
- Training in health research ethics;
- A systematic assessment of health research capacities;
- Enhanced access to scientific information and current developments;

Opportunities:

- Existence of regional[2] and sub-regional[3] networks (University associations, research networks, the Caribbean Health Research Council, professional associations, etc.);
- PAHO's long term involvement in support of Health Research development and utilization;
- The existence of interesting experiences of country-country cooperation (TCC's = technical cooperation among countries);
- Common Health problems;

In view of the above, the participants at the Havana workshop considered that it is necessary to have a regional forum for health research for the LAC region in order to provide a stronger representative voice for the region at the international level, to enhance the countries' capacity to develop efficient national health research systems, to facilitate exchange of information and to conduct collaborative research when needed. Common research priorities could be targeted and existing networks should be involved. Despite this focus on a regional platform, collaboration at sub regional level was not precluded. On the contrary, similar developments, a common history and relative facility of communication justify working at this level.

The possible organizational structure of such a forum (in terms of loose vs. formal) was discussed. Several participants expressed the view that there should not be a new

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2 Regional refers to South America, Central America and the Caribbean

3 Sub-regional refers to groups of countries within the region, e.g. the Caribbean, Central America, etc

formal, rigid and bureaucratic structure based on old paradigms, but rather the forum should be a space for ongoing communication and collaboration amongst the many different stakeholders in health research within the region. This would ensure more flexibility and avoid the commitment of large amounts of funds for the upkeep of a structure. In any case, careful planning and preparatory work by a wider range of regional and sub-regional stakeholders will be required for the creation of such a forum.

Havana, Cuba, October 17 2002.

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School of Public Health

PARTICIPATORY RESEARCH AND ADVOCACY IMPROVE MALNUTRITION MANAGEMENT AND HOUSEHOLD FOOD SECURITY IN RURAL SOUTH AFRICA

DAVID SANDERS
School of Public Health,
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Presented at: Global Forum for Health Research
November 2002

OUTLINE OF PRESENTATION

- Health status and health system performance in South Africa
- Child health, nutrition & poverty in South Africa
- An illustrative case study on child nutrition in rural South Africa
- The role of research and advocacy
- Conclusion

HEALTH PERFORMANCE: SOUTH AFRICA IN INTERNATIONAL CONTEXT

	GNP per capita (US $)	U5MR (per 1000 live births)	National Immunisation Coverage (children 12-23 months)
South Africa	3 210	60 (59)	63%
Zimbabwe	720	59	c 70%
Sri Lanka	800	17	>80%
China	860	47	>90%

Source: UNICEF SOWC 2000 and DHS 1998

South Africa: Variation in Young Child Mortality and Immunisation status by Maternal Education

Maternal Educational Level	U5MR	Fully Immunised
Higher Education	29.3	72.5%
No Education	83.8	54%

Source: DHS 1998

Top Causes of Infant Death by Poor & Rich Magisterial Districts in South Africa (1996)

Infants <1 year

Poorest quintile (Magisterial districts)

Diarrhoea	23%
Low birth weight	13%
Lower respiratory infections	13%
Other respiratory conditions	10%
PEM	7.6%

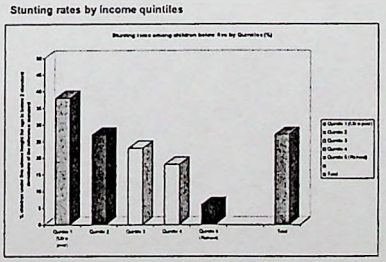
Richest quintile (Magisterial districts)

Low birth weight	14%
Ill-defined perinatal	8.4%
Diarrhoea	8.4%
Other perinatal	8.1%
Other respiratory conditions	7.1%

Personal Communication D Bradshaw

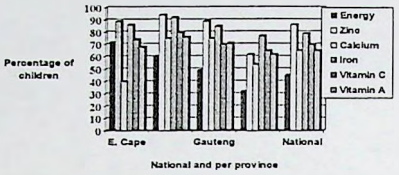
Child Nutrition in South Africa

Stunting rates by income quintiles



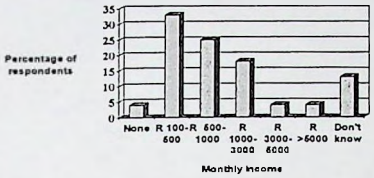
*Income quintiles based on adult equivalent household income Source: PSLSD, 1994

Figure 5.22 The percentage of children aged 1 - 3 years with nutrient intakes less than two-thirds of the RDA: South Africa 1999



POVERTY IN SOUTH AFRICA

Figure 3.10 Percentage of households as a function of monthly income: South Africa 1999



National Food Consumption Survey, 2000

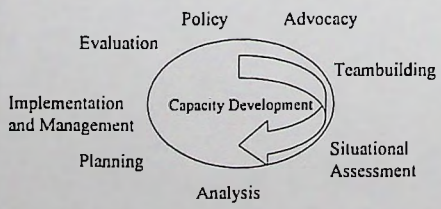
Programme-related Education and Training in Nutrition

- UWC SOPH & Health Systems Trust partnered with Mount Frere district – one of the poorest districts in the country
- Aim: "To help develop appropriate systems, structures and policies for the implementation of an integrated nutrition programme"
- Based upon the programme implementation cycle

INTEGRATED NUTRITION PROGRAMME

- PRIMARY PREVENTION – Address underlying socioeconomic and environmental causes
- SECONDARY PREVENTION – Regular Growth Monitoring with Nutrition Promotion & Supplementation
- TERTIARY CARE – WHO 10-Steps Protocol for the Management of Severe Malnutrition

Implementation Cycle



STUDY SETTING: MT. FRERE HEALTH DISTRICT

- Eastern Cape Province, South Africa
- Former apartheid-era homeland
- Estimated Population: 280,000
- Infant Mortality Rate: 99/1000
- Under 5 Mortality Rate: 108/1000

STUDY SETTING: PAEDIATRIC WARDS

- Nurses have the main responsibility for malnourished children

Per Ward:

- 2-3 nurses and 1-2 nursing assistants on day duty, and 2 nurses on night duty
- 10-15 general paediatric beds and 5-6 malnutrition beds

CASE FATALITY IN RURAL HOSPITALS (Former Region E)

PRE-INTERVENTION CFRs

Mary Terese 46%	Sipetu 25%
Holy Cross 45%	St Margaret's 24%
St. Elizabeth's 36%	Taylor Bequest 21%
Mt. Ayliff 34%	Greenville 15%
St. Patrick's 30%	Rietvlei 10%
Bambisana 28%	

WHO 10-STEPS PROTOCOL

Comparison of recommended and actual practices in Mary Theresa and Sipetu hospitals and perceived barriers to quality of care of malnourished children

SITUATIONAL ANALYSIS			IMPLEMENTATION	
Recommended practice	Practice prior to intervention	Perceived barriers to quality care	Programme intervention	Changes reported at follow up visits
Step 1 Treat/prevent hypoglycaemia Feed every 2 hours during the day and 3 hourly at night. Start treatment early.	Children were left waiting in the queue in the outpatient department and during admission procedures. In the wards, they were not fed for at least 11 hours at night. Hypoglycaemia not diagnosed	Lack of knowledge about risks of hypoglycaemia Lack of knowledge about how to prevent it Shortage of staff especially during the night No machine for testing for hypoglycaemia	Training to explain why malnourished children are at increased risk Training on how to prevent and treat hypoglycaemia Motivated for more night staff in paediatric wards Motivated the Department of Health to provide vitamin and HIV+ glucose and Dextrostix.)	Malnourished children fed every four hours and 2 hourly during day and night The number of night staff was increased Dextrostix and HIV+ glucose obtained

10-STEPS EVALUATION RESULTS

- Major improvements in the care of severely malnourished children:
  - Separate HEATED wards
  - 3 hourly feedings with appropriate special formulas and modified hospital meals
  - Increased administration of vitamins, micronutrients and broad spectrum antibiotics
  - Improved management of diarrhea & dehydration with decreased use of IV hydration
  - Health education & empowerment of mothers

10-STEPS EVALUATION RESULTS

- Problems still existed:
  - Intermittent supply problems for vitamins and micro-nutrients
  - Power cuts – no heat
  - Poor discharge follow-up
  - Staff shortage, of both doctors and nurses, and resultant low morale

CFRs: COMPARISON TO BASELINE

	SIPETU	MARY TERESE
Baseline (3/97-2-98)	25.4%	46.2%
Study (4/00-4/01)	25.2%	22.7%

Quotes from a current Community Service Doctor

"There wasn't enough emphasis on patient management in a lower level institution, our training was mostly theoretical…most patients are filtered out at this lower level therefore the students don't see them...

…it's not so much WHAT as WHERE the training takes place…

…the environment here is very different from both RCH and Pretoria Academic…some of the antibiotics we were taught to use aren't available so we have to look for alternatives...

…the Sister is teaching me a lot, I'm learning more than I ever learnt in my whole training!"

STEP 10 OF THE IMCI MALNUTRITION PROTOCOL

- Giving Nutrition Education to caregivers by health staff
- Planning Follow- up of the child at regular intervals post discharge

OBJECTIVES

- To determine Household Food Security(HHFS), caregiver knowledge & factors associated with malnutrition
- To look at the rate of recovery & health status at 1 month & 6 month post discharge

STUDY POPULATION

POST DISCHARGE HOME VISITS(HV)

- At 1 month (n) = 30
- At 6 month (n) = 24

DEMOGRAPHIC & SOCIO-ECONOMIC FACTORS

Average No. of people	8
Average No. of children < 6	2.5
Female Headed HH	40 %
Residing in mud houses	82 %
Subsistence Crop Production	83 %
Livestock keeping	90 %
Average family income	R550

CAREGIVER KNOWLEDGE OF NUTRITION

- 76% of caregivers had <9 years education
- 78% of caregivers were literate
- 76% remembered key messages about food fortification
- 71% of caregivers unable to implement acquired knowledge of feeding practices

STAPLE FOOD INVENTORY LIST

- Samp / Maize
- Beans
- Maize Meal
- Flour
- Rice
- Sugar
- Soup
- Tea / Coffee
- Milk
- Oil
- Peanut Butter
- Eggs

No. of food items in HH Cupboard	% of HH
0	7
1 – 4	40
5 - 8	30
9 - 11	23

HOUSEHOLD SOURCE OF INCOME

• PENSION GRANT	40 %
• MIGRANT LABOURERS	25 %
• NO INCOME FAMILIES	20 %
• DOMESTIC WORKERS	15 %
• CHILD SUPPORT GRANT	0 %
• ANTI POVERTY PROGRAMME	0 %

Advocacy Component

- Presentation of data to Government Commission on Social Welfare
- Newspaper articles on malnutrition and child welfare
- TV documentary – 'Special Assignment' – elicited unexpected response from both public and government
- Minister of Social Development visited Mt Frere and ordered mobile team in to process CSGs
- Questions in Parliament re child welfare
- Recent 'Sunday Times' articles on child malnutrition in Eastern Cape
- Massive Child Support Grant Campaign in E. Cape, October 2002

Sunday's Paper — The Sunday Times

Sunday September 15 2002

166 SA children die from starvation

Thabo Mkhize

Nineteen-year-old Khethelwa Mseke had no idea why her eight-month-old daughter, Andiswa, was suffering from broken skin and an enlarged abdomen when she took her to Mount Ayliff Hospital in the Eastern Cape.

Now she knows. Her daughter is one of more than 700 children in the area who have been admitted to hospital with malnutrition.

Andiswa is one of the lucky ones. Two weeks ago in nearby Lusikisiki, Hompiwa Mgedezi lost her 11-month-old son. He died of marasmus – a condition caused by lack of calories and protein.

In the first six months of this year, 166 children – virtually all of them under the age of six – have died of malnutrition in 11 hospitals in the northern reaches of the Eastern Cape.

The horrific figure was calculated by the University of the Western Cape, the Department of Health and the Health Systems Trust.

No money, No food: Khethelwa Mseke, 19, and her baby, Andiswa.

Picture: Richard Shorey

Sunday's Paper — The Sunday Times

Sunday, September 22 2002

Starving to death on arable land

Poverty is killing children in the Eastern Cape. But breaking out of its grip is no easy task, write Thabo Mkhize and Heather Robertson

A nutrition study by the University of Western Cape showed that Sunkelo is one of the more fortunate - 166 babies at 11 hospitals in the northeastern district have died of malnutrition

ONE-year-old Sunkelo Mbulawa has only a tattered blanket to cover his distended stomach and flaking skin. He has just returned home after two months in the Mount Ayliff Hospital where he was treated for kwashiorkor, a form of malnutrition.

EMPTY STOMACHS: Year-old Sunkelo is one of nine children that his jobless grandmother, Nofudska Mbulawa, has to feed

Picture: Richard Shorey

October 14 2002 at 11:19AM

DailyNews

Emergency aid pours into Eastern Cape

By Xolani Mbanjwa

'The government has been on the road engaging communities on a wide range of issues'

National and provincial government officials and local businesses came together on Sunday to curtail the scourge of poverty that has claimed hundreds of lives in the Eastern Cape.

Mount Frere residents received tons of food parcels as government, the private sector and Durban-based humanitarian food aid organisation Gift of the Givers Foundation and Tiger Foods joined forces to alleviate hunger in the area.

Deputy President Jacob Zuma, Social Development Minister Zola Skweyiya and Eastern Cape Premier Makhenkesi Stofile, visited and talked to people in the area, and said government had prioritised their mandate to fight diseases and poverty.

Through the Department of Social Development, Skweyiya donated R2-million for poverty alleviation programmes in the Alfred Nzo district. The officials visited most of the areas in the Eastern Cape during Imbizo Focus Week."

...

SKILLS DEVELOPMENT CONTINUUM

- Establish competency gaps/training needs through participatory research
- Plan training
- Training – with practice based component
- Supervision
- Support / Mentoring
- Materials development
- Develop advocacy skills as well as clinical and management skills

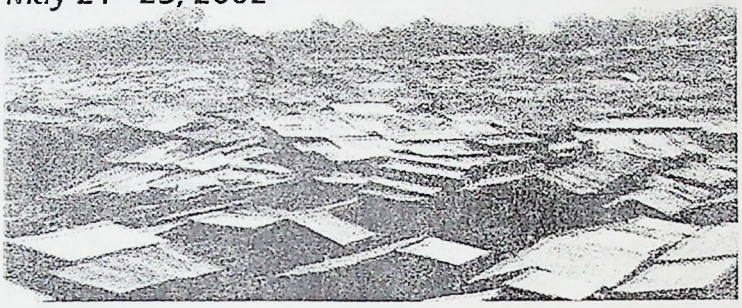
SUMMARY

- Major improvements in QOC possible in very under-resourced areas
- Staff are willing to address QOC issues
- Must work at many levels and sectors: ward, hospital, district and Provincial
- Need to take an integrated approach which involves advocacy
- Doctors quite often key
- Research evidence important for advocacy

"Land Reform for Sustainable Development"

National Civil Society Conference on Land Reform and the Land Question

KCCT Mbagathi, Nairobi
May 21—23, 2002



The Social and Economic Rationale for Land Reform in Kenya: Some Human Rights Concerns

by Mutuma Ruteere

Organised by

Kenya Land Alliance, KLA,
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The Social and Economic Rationale for Land Reform in Kenya:

Some Human Rights Considerations

By Mutuma Ruteere

Head of Research, Kenya Human Rights Commission

"The irony of this poor and overwhelming rural country's ... land policy is that it has resulted in the very problems it intended to redress: the vast inequality in the distribution of land and income, and persistent poverty in rural areas." M. Riad El-Ghonemy

Introduction

This paper is an evaluation of the link between poverty and inequality in land access and ownership in Kenya. It situates the economic and social considerations for land reform within a human rights paradigm and proposes a view of poverty suffered by the largely landless or near-landless Kenyans as a violation of all human rights. From this perspective, the paper seeks to link poverty incidence in Kenya to the land question.

Consequently, the policy recommendations in this paper touch on the wider questions of citizenship and individual rights that may not, ordinarily be part of an orthodox discussion on land reforms. Although it makes specific land reform policy, this paper emphasizes that any meaningful and viable land reform policy must be an integral part of a comprehensive framework aimed at eliminating the conditions of absolute poverty that distort capabilities and undermine the choices that the many poor Kenyans make.

The paper proposes a view of land reforms as a political process and concludes that only a redistribution approach to land policy can address the specific realities of the country.

The Reality of Poverty in Kenya

According to the United Nations Development Programme (UNDP) 2001 Human Development Report, Kenya is the seventeenth poorest country in the world.[1] It is also the third most unequal country in the world after South Africa and Brazil. In addition, Kenya is a poor performer in other indicators of well being such as education and health Kenya has consistently performed

[1] Human Development Report 2001, UNDP at http://www.undp.org/hdr2001/back.pdf

very poorly. And the situation is getting worse. Kenya is one of the eight countries singled out by the UNDP report for registering a Human Development Index lower than their 1990 level.

The reality of poverty is brought closer home by the 1999-2015 National Poverty Eradication Plan. According to the plan, an estimated 12.6 million Kenyans currently live in absolute poverty with 90% of these in rural areas.[2] About two thirds of the Kenyan population live in the rural areas and therefore constitute the bulk of the poor. The 1994 Welfare Monitoring Survey found out that the poorest of the Kenyans are found, in descending order, among the subsistence farmers, food crop farmers and pastoralists. See table below.

Socio-economic groups	**Incidence of poverty**
Cash crop farmers	36
Food crop farmers	46
Subsistence farmers	47
Pastoralists	42

[2] GOK, National Poverty Eradication Plan 1999-2015, 1999 p. xi

Public sector employees	16
Private sector employee	1.5
Informal sector	41

Source: GOK, Welfare Monitoring Survey, 1992

Colonialism imposed on Kenyans a land ownership system that advantaged the white settlers over the Africans. With the best of the arable land taken over for white cash crop farming, most Kenyans found themselves as squatters on these farms or joined the growing numbers of landless urban labourers.

Independence was expected to bring with it land reforms that would address the inequalities in land ownership and access as well as settle the landless. Such schemes as the Million Acre Settlement Scheme were financed to ensure land transfers within a willing seller-willing buyer framework. Over one million acres, previously owned by 2,000 Europeans were transferred through this scheme to 47,000 African small holders who had been advanced credit through the Agricultural Finance Corporation and the Agricultural Development Corporation.

This process of land transfers however, benefited only about 5% of the population. The rest were left to eke out whatever existence they could by accessing land through the customary tenure system or as squatters on government or trust land.

The independence government, conceiving poverty in purely growth terms, failed to undertake land reforms that would enhance the choices available to a majority of people. Ensuring the economic stability of the newly independent state became a favourite mantra for the new power elites. Any land reforms that would disturb the production of foreign exchange earning cash crop by the multinational corporations, foreigners and politically connected individuals were avoided. The assumption was that the continued wealth of the land owning elite would eventually reach the impoverished masses. As Firoze Manji has observed:

> ... [T]he discourse was not about development in the sense of developing the productive forces. It was about creating an infrastructure that advanced the capacity of the new ruling class

to accumulate and smoothing away those inefficiencies that hampered the capacity of international capital to continue its exploitation. It was expected that, through trickle-down effects, poverty would gradually be eliminated. This was the agenda of 'modernisation', the paradigm of development, which was to hold sway until the end of the 1970s.

Central to this paradigm was to see 'poverty', rather than rights and freedom, as the main problem facing 'developing countries'. The victims of years of injustices, whose livelihoods had been destroyed by years of colonial rule, were now defined as 'the problem'.... In Kenya, for example, peasants had been uprooted from their land and forced to eke out a living in marginal land with low yield-potential and which required immense labour to produce. The new paradigm [of 'development'] required that ways be found to enable them to find sustainable (and participatory) approaches for surviving on such land. The need for carrying out land reform that would

overcome the injustices created by colonialism was gradually forgotten.[3]

Unfortunately, this is the same philosophy that runs through the current National Poverty Eradication Plan. The plan states that "Every possibility of encouraging the transfer of land from the large to the small farming sector will, ... be taken" but concedes that "the new buyers will not be low income groups; but the extra demand for unskilled labour from small farms will help reduce poverty" (p.67).

The plan does not recognise the multidimensional nature of poverty, nor recognise the unique value of land, not as just yet another factor of production but as a socio-cultural and economic resource that determines to a very large extent the nature and quality of life of a majority of people.

About two thirds of the Kenyan population is dependent on the land for their livelihoods. These are people without other skills or the adequate

[3], Firoze Manji, 1998, "The Depoliticisation of Poverty" in D. Eade, ed., *Development and Rights: Development in Practice Readers Series*, Oxford, Oxfam GB p. 16

educational preparation to afford them real choices within the nascent industrial and service sectors. Thus their very basic existence is hinged on access to viable land holdings. As Aloys Ayako and Musambayi Katumanga have argued:

> The most crucial factor creating poverty in rural areas is inaccessibility to land. Nowhere else is inequality in land ownership is as pronounced as it is in Kenya- which, in this respect compares to apartheid South Africa. ...[the large farm sector] is under the control of just a few and provides employment to only 500,000 compared to 2,236,000 employed by the [small scale sector]. This concentration of land in a few hands has limited not only agricultural production but also avenues of employment. At the same time, agricultural policies that favour large-scale producers and urban populations have led the government to neglect infrastructure and information and marketing systems that would have promoted agricultural production in the rural areas.[4]

[4] Aloys Ayako and Musambayi Katumanga, *Review of Poverty* in Kenya, Institute of Policy Analysis & Research, 1997 p.13.

To be poor in Kenya thus means being condemned to low agricultural potential lands. With only a rudimentary infrastructure to support their mainly pastoralist economies, the regions of the Northern, North Eastern and Eastern Kenya have registered the highest levels of poverty incidence.[5] In these regions a large percentage of Kenyans enjoy command over food resources as a matter of chance. It is the daily experience of a majority of Kenyans in the Coast Province as well as poor urban areas whose relationship to the land they occupy is as squatters. These are people who lack the basic security that is at the core of the minimum threshold below which life is no longer consistent with human dignity. To be poor is to lack this security that access to land affords.[6]

Poverty as a human rights concern

In its 1995 *World Health Report*, the World Health Organisation, (WHO) lists

[5] National Poverty Eradication Plan 1999-2015, p. 16
[6] See, World Bank, *Voices of the Poor* at: http://www.worldbank.org/poverty/voices/

poverty as the most ruthless killer of all ailments known to medical science.[7]

Poverty

is the reason babies are not vaccinated, the cause of low life expectancy, starvation,

handicap, the reason why mothers die at childbirth, the reason why clean water is not

provided to the many who are poor, why curative drugs are unavailable and the reason

sanitation services do not exist for many.

Within the UN, the focus on poverty as a legitimate concern in human rights discourse was given impetus by the end of the Cold War and the subsequent collapse of the ideological polarisation between those for economic and social rights and those for the civil and political rights. Most significantly is the four major reports published by the Special Rapportuer of the UN Sub Commission Mr. Leandro Despouy between 1989 and 1992.

[7] Quoted in Leandro Despouy, 1996, "Final Report on Human Rights and Extreme Poverty, Submitted by the Special Rapporteur, Mr Leandro Despouy", Sub-Commission on Prevention of Discrimination and Protection of Minorities, at:
www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/851d196adb438b50008025669e00353

Although the report by Mr. Leandro Despouy was the first study by the United Nations on the question of extreme poverty and human rights, the ideal to eradicate poverty was part of the founding vision of the organisation. Going back to the League of Nations, the founding of the International Labour Organisation and the 1919 Treaty of Versailles stated that "Universal and lasting peace can be established only if it is based upon social justice" In 1941, President Franklin Roosevelt, a key architect of the United Nations, delivered his "Four Freedoms" address to the US Congress in which he stated:

> ...we look forward to a world founded upon four essential human freedoms. The first is freedom of speech and expression - everywhere in the world. The second is freedom of every person to worship God in his own way - everywhere in the world. The third is freedom from want - which, translated into world terms, means economic understandings, which will secure to every nation a healthy peacetime life for its inhabitants -everywhere in the world. The fourth is freedom from fear - which, translated into world terms, means a worldwide reduction of armaments to such a point and in such a

thorough fashion that no nation will be in a position to commit an act of physical aggression against any neighbor - anywhere in the world.[8]

In 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights noting in its preamble, "the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people." The twin 1966 covenants, the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights, drawing their inspiration from the UDHR both proclaimed in their preambles that "the ideal of free human beings enjoying civil and political freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights."

In his report Mr Leandro Despouy, Special Rapporteur of the UN Sub Commission, had pointed out that "extreme poverty involves the denial, not of a single right or a given category of rights, but of human rights as a

[8] Franklin D. Roosevelt, "Annual Message to Congress," January 6, 1941, *Congressional Record, 77th Cong.* 1st sess., LXXXVII, pt. I, 45-47, at: http://wiretap.area.com/Gopher/Gov/US-History/WWII/fdr-4-

whole. (...) . Extreme poverty is thus a particularly clear illustration of the indivisibility and interdependence of human rights."[9]

In 1998, the UN the United Nations Commission on Human Rights, established a mandate of the Independent Expert on Extreme Poverty and Human Rights and appointed Ms Anne-Marie Lizin to follow-up on the recommendations and studies already done by the UN on the question of extreme poverty and human rights.

An expert seminar convened by the Independent Expert in 2000 defined extreme poverty "from the viewpoint of human rights, as a denial of human rights and human dignity, and deprivation of basic capabilities."[10]

The nature of extreme poverty, which is often the experience of the landless or those confined to unproductive tiny pieces of land calls for a serious investment in social justice. Land redistribution policies are not at odds with a liberal state that protects human rights as well as private property.

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freedoms.txt

[9] Despouy Report, supra note 7.

[10] Report of the Expert Seminar on Human Rights and Extreme Poverty, 7-10 February 2001, E/CN.4/2001/54/Add.1 at: http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/b60d65532fe292adc125691e005ba01d?Opendocument

Going back to John Locke, the earliest proponent of a modern liberal human rights respecting state, there exists justification for property ownership that does not offend social justice. In his Second Treatise, Locke states that "Labour being the unquestionable Property of the labourer, no Man but he can have a right to what that is once joyned to, *at least where there is enough and as good left in common for others*." (27. 10-13; emphasis mine).

Locke's argument is that as a common resource and the basis for livelihood, land must then be accessible to all. Those who own it must leave 'enough and as good' for others. In a liberal democratic state such as Kenya aspires to be, land ownership and access are of critical concern as they determine the well being of individuals and therefore the nature and extent of their capability to function as citizens.

Which way Land Reform in Kenya?

If access and land ownership are linked to the experience of poverty and rights, land reform must be viewed as a political process rather than a purely legal exercise. Land reform is not aimed at achieving an across the board

ownership of land for the sake of itself. Rather, it is a process that requires a close analysis of the condition of the beneficiaries, the historical context of their deprivations and the formulation of clear objectives.

In the Kenyan context, one cannot address the matter of land reforms without taking into account the colonial context of the incorporation of Kenyans into the market system either as wage labourers, squatters or as pastoralists and peasants confined to marginal lands. This was a highly political matter. The post-independence efforts at land reform too are an important historical context.

Against these contexts, we must pose the question of what vision of the individual is proposed by our choice of economic and political system in general, and land policy in particular. What vision of the rights of the individual and citizen do our systems propose? Are these views consistent with the universally shared values of development as freedom?

These questions are important because the analysis we bring into the conditions of the individuals within Kenya will inform the approaches to land reforms.

Beginning from the consensus that poverty is the deprivation of human capabilities we need to establish its links to political choices and conditions. Historically, poverty, rights denial and inaccessibility to land are inextricably bound. The role of the state in these deprivations is central. Even in countries like Ethiopia, China, and Thailand where the contours of land ownership were not shaped by colonialism, the populace was incorporated into political and economic systems as unfree subjects through military occupations or annexations.[11]

If poverty is the state of unfreedom, we must look into an approach to land reforms that restores this freedom. We have seen that the land resettlement policies immediately after independence failed to respond to the real crises of landlessness and access to a majority of the Kenyans. In the 1960s, the Kenya government embarked on a process of demarcation of communally held land and transfer of title to individual owners. This process was driven by market rules and took place where there were willing sellers, in case of land purchased through co-operative efforts and through administrative bureaucracy in the case of communal land under customary tenure. In the

[11] S. Barraclough, 1999, "Land Reform in Developing Countries: The Role of the State and Other Actors", UNRISD Monograph 2 at: http://www.ifad.org/popularcoalition/pdf/mon2.pdf

1980s, the co-operative lands as well as the group ranches were carved up to provide individual title to the shareholders.

The process provided political entrepreneurs as well as other financially well-heeled state operatives and business people with the opportunity to acquire more land at the expense of the disadvantaged groups of squatters, smallholder farmers and the landless. As it has been observed of Kenya's land reform policy:

> " The irony of this poor and overwhelming rural country's post-1980s land policy is that it has resulted in the very problems it intended to redress: the vast inequality in the distribution of land and income, and persistent poverty in rural areas."[12]

This policy not only failed to adequately address the plight of the poor but also left many worse off than before. In particular, the privatisation of customary land tenure altered the user rights women previously had under customary land tenure, depriving them of command to food resources.[13]

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[12] M. Riad E-Ghonemy, 1999, "The Political Economy of Market-Based Land Reform" UNRISD Monograph 4, at: http://www.ifad.org/popularcoalition/re_mon_5.htm

[13] In Sub-Saharan Africa, women have traditionally commanded access to food, giving them a higher chance of well being than under the individual land title ownership.

The failure of these land reform efforts to change the conditions of Kenyans living in poverty call to question the efficacy of market driven land reform initiatives. The reality where the administrators double up as the local landlords, or politicians as the main employer suggests that the market system is ill suited for redressing the historical wrongs of landlessness and inequalities.

Comparative experiences from other countries reveal that market-driven approaches have resulted in continuing and persistent income and human development inequalities. All the three countries cited by the UNDP for the highest levels of income or consumption inequalities in the world, Kenya, Brazil and South Africa have gone through market-driven land reforms.[14]

Other indicators reinforce this point as the table below shows.

Selected Agrarian Indicators of Five Countries Implementing Land Market Reform

	Kenya	**Brazil**	**Colombia**	**Philippine**	**South**

[14] UNDP, Human Development Report 2001, supra note 1

				s	Africa
Agricultural population as % of total population (1995)	78	19	24	42	13
% of rural people in poverty	55	73	45	64	60.6*
The distribution of income share of lowest 20%	3.4	2.1	3.6	6.5	3.3
The distribution of income share of highest 20%	62.1	67.5	55.8	47.8	63.3

Note: * Black Africans

Source: M. Riad El-Ghonemy

Market driven land reforms have largely failed out of failure to embrace reforms as a political process. Where the political nature of land reform has been embraced, it has been driven by the ideology of developmentalism that saw the ruin of many African states since the 1960s and the desire to maintain the political and economic status quo while appearing to do something. This form of land reform has been palliative treatment where radical surgery was necessary. Little wonder then that the conditions of poverty and right deprivation have only gotten worse.

Economic arguments for land reform

Opposition to land reform has often made the pitch that fragmentation of large holdings will lead to food insecurity through reduced yields. However, there now exists a near-consensus that small-scale farmers are more efficient in agricultural production than large-scale farmers. In Kenya, it is a historical fact that large-scale colonial agriculture was a failure in spite of its utilization of cheap, coerced African labour. African small-scale agriculture within the reserves as well as squatter farming within settler farms quickly grew to the extent that the colonial government imposed restrictions on what Africans could produce and where they could market in an effort to protect the settlers from ruin. As Bruce Berman points out, "as early as 1917, the

District Commissioner of Naivasha reported that 'agriculture has made little progress except at the hands of native squatters' "[15]

Small-scale farmers utilize their resources better than large-scale owners as they have a more hands-on management of their holdings. Often they depend on family labour, tend their crops more carefully and utilize their inputs more optimally. Consequently, their productivity relative to their inputs and size is much higher than that of the large-scale owners.

Thus, there is no truth in the popular notion that food security of a country can only be secured if the large- scale units are retained intact.

Thus it is in the interest of the economy of the country to transfer land to the more efficient land user, in this case the small-scale holder. This will result in better food production and better utilization of land resources.

[15] Bruce Berman, *Control & Crisis in Colonial Kenya: The Dialectic of Domination* 1990, James Currey, London, p. 149.

Recommendations on the way forward in land reform in Kenya

Currently, in Kenya, there are some 3.5 million families with an average plot size of 1.6 hectares and some 800 to 1000 large farms with a modal size of between 500-1000 hectares, generally in the well-endowed areas.[16] Thus land reform in Kenya is necessary and unavoidable. What may be of contention is the appropriate approach. In our view, the approach will largely be determined by the objectives that we would want to achieve through the process. If we keep in mind the need to hoist a majority of Kenyans above the threshold of indignifying poverty and squalor, then it is important that we adopt an approach that ensures effective transfer of land to those in extreme poverty.

In view of this, the only viable approach to land reforms in Kenya is one of redistribution. This perspective must involve a comprehensive analysis of the conditions of those in absolute poverty, without land or access. Land redistribution is a political process and must therefore involve deliberate, focused and sustained government investment in education and health. In

[16] The World Bank, *Kenya Poverty Assessment*, 1995 p.47

other words, it should be part of a wider policy of enhancing the capabilities of those in extreme poverty to allow them to function socially.[17]

Income levels of a majority of Kenyans without the necessary skills to participate in the private manufacturing and service can be raised by creating demand for unskilled labour. The small-scale sector provides more jobs than the capital-intensive large scale-farming sector. Redistributing land to small-scale holders is therefore one of the ways to improve income levels.

Land redistribution need not evoke the images of anarchy that are often painted in popular discourses on reforms. In those countries where redistributive approaches have taken place, it has led to higher food production and freed the poor from the clutches of grain merchants and also

[17] I use this term in reference to Amartya Sen's capabilities approach in assessing development. The same approach has been further developed by Martha Nussbaum in relation to rights:
... I would argue that the best way of thinking about rights is to see them as *combined capabilities.* The right to political participation, the right to religious free exercise, the right of free speech- these and others are all best thought of as capacities to function. In other words, to secure rights to citizens in these areas is to put them in a position of combined capability to function in that area. ... By defining rights in terms of combined capabilities, we make it clear that a people in country C don't really have the right to political participation just because such language exists on paper: they really have this right only if there are effective measures to make people truly capable of political exercise. Women in many nations have a nominal right of political participation without having this right in the sense of capability: for example, they may be threatened with violence should they leave the home. In short, thinking in terms of capability gives us a benchmark as we think about what it is to secure a right someone. Martha Nussbaum, *Women and Human Development,* (Cambridge, Cambridge University Press, 2000), p.98. See also Amartya Sen, *Development as Freedom*, (Oxford, Oxford University Press, 1999)

spurred sharp declines in rural poverty. This was the experience of Egypt and South Korea among other countries.[18]

Redistribution must proceed on a legal footing through a conducive legislative framework. Parliament should enact laws for agrarian reorganization through redistribution. Such laws should propose acquisition of lands that are idle and the reduction of land holdings by individual holders.

Land redistribution in Kenya must look into the possibility of putting land ownership ceilings. Currently, 83% of landholders own less than two hectares with the rest of the holders occupying about 500 to 1000 hectares per person.

A viable redistribution process must also target not just the poor land. In the market approach, the big landlords have only been willing to sell off poor sections of their holdings. This has left the poor purchasers worse off, in tiny and barren holdings and without the resources to develop them.

[18] In South Korea, poverty incidence in rural areas dropped from 60 per cent to 9.8 per cent after reform. In Egypt, it fell from an estimated level of 56.1 per cent of total agricultural holdings in 1951 to 23.8 per cent in 1965 when redistribution was completed. Clearly land redistribution was of strategic importance in the early stages of economic development and social transformation in both countries. (El-Ghonemy, 1995 p.9)

On tenure, it is inappropriate to suggest the modern individual tenure to the exclusion of the customary, group tenure. The rights of women and other vulnerable minorities have been better served under the customary tenure system.[19] The subdivision of group ranches in the 1980s and the 1990s has contributed to widespread dispossession and destruction of livelihoods of many individuals. It is possible even as the country moves towards individuation of land ownership to provide for a communal system of land ownership, access and use. This will be the realistic accommodation of the pastoralist economy of the many areas of the country.

A reform policy guided by human rights norms must therefore ensure that those who are allotted the land are not left without the means. Rather there must be a process that enables them to make optimal use of the land, provide for their health and educational needs and ensure their access to inputs to develop the land.

[19] Adam Leach. "Land Reform and Socio-Economic Change in Kenya" pp. 192-225 in Smokin C. Wanjala (ed) *Essays on Land Law: The Reform Debate in Kenya*, 2000, University of Nairobi p. 195

A redistribution policy that does not take these into account will have failed the moral test of raising those in extreme poverty above the threshold of human dignity.

That is why the Presidential Commission of Inquiry into the Land Law Systems in Kenya (the Njonjo Commission), whatever its recommendations is bound to be yet another exercise in frustrated optimism. To task such a critical question of land reforms to a Commission of Inquiry is either a naïve assumption that the laws can resolve what is political, economic and moral, or a cruel trip of deception. After all, laws are but a reflection of the underlying philosophy of the state we have established. What ought to be in question is not merely the law but the moral vision of people, the extremely poor whose only claim to a piece of land will be the miserable graves that a system of exclusion to all rights condemns them to.

Conclusions

It is always difficult to reduce an area as complex and wide as land reform to a few pages of text. This paper in no way purports to be an exhaustive

examination of the land reform issue in Kenya. What the paper has attempted to provide is a different perspective of examining land reforms.

The paper has used a rights perspective to explore the rebuking reality of inequality and poverty in Kenya and argued that the poverty, especially rural poverty, is linked to inequality in land access and ownership.

The perspective of rights has the advantage of illuminating the interconnectedness of land ownership, poverty and the political process. The disadvantage is that in its embrace of the larger picture of the forest, it is very easy to forget the specific trees of the policy recommendations. The last section of this paper has attempted to provide in fairly broad strokes a proposal on the policy reforms that are necessary to achieve a land reform that hoists a majority of Kenyans above the minimum threshold of what it means to be human.

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SPEECH DELIVERED BY HIS EXCELLENCY DR. ALI MOHAMED SHEIN, VICE PRESIDENT OF THE UNITED REPUBLIC OF TANZANIA AT THE OFFICIAL OPENING OF THE SIXTH ANNUAL CONFERENCE OF THE GLOBAL FORUM FOR HEALTH RESEARCH AT AICC ARUSHA, ON 12TH NOVEMBER, 2002

Honourable Anna Abdallah,
Minister for Health of Tanzania,

Honourable Ministers for Health of the Member States,

Dr. Richard Feachem,
Chairman of the Global Forum for Health Research,

Honourable Daniel ole Njoolay,
Arusha Regional Commissioner,

Mr. Louis Currat,
Executive Secretary of the Global Forum
for Health Research,

Distinguished Guests,

Dear Delegates,

Ladies and Gentlemen,

First of all I wish to thank God for giving all of us good health and strength which have enabled us to be here today. I feel greatly honoured to be asked to officiate the opening of the Sixth Annual Conference of the Global Forum for Health Research here in Arusha. I would like to thank the organisers for giving Tanzania the Honour to host this important meeting.

My thanks also go to all those who have in one way or another, made it possible for this conference to take place. Let me take this opportunity to welcome distinguished delegates to Tanzania and Arusha in particular.

Distinguished Delegates,

This conference demonstrates the global stature of issues at hand, not only by its overwhelming attendance by participants from all over the world, but also for the fact that the topics which form the basis for its discussion are of a global nature. The conference is also a historical event for us, in Africa, since it is the first time that the Global Forum for Health Research is holding its annual conference in this continent which is known to be weighed down by a myriad of health problems more than any other continent.

Hopefully, the Conference will go beyond this historical moment and become an important milestone in the endeavours to correct the prevailing imbalance in the allocation, and use, of global health resources.

Out of the annual global health research budget estimated at US$ 70 billion, less than 10% goes to countries which shoulder 90% of the global disease burden. In essence, this imbalance weighs heavily in disfavour of the poor developing nations including Tanzania. This situation is a cause for serious concern because of its debilitating effects on the developing countries in their efforts to achieve economic development.

Mr. Chairman,

I wish to appreciate the fact that the Global Forum for Health Research represents a noble attempt in these endeavours. Not only that it has recognised the problem, but also most important it has marshalled the courage and determination to challenge, and indeed change, the system which has created and perpetuated this adverse situation.

I believe you all know that this imbalance is not confined only to the health sphere. Other sectors are also in a similar situation when it comes to the global share of resources because of the unfair and skewed system upon which economies in the world have been built and made to operate. It is in this view that the approach adopted by the Global Forum for Health Research is exemplary and provides lessons for other sectors to learn from and create, therefore, a broader awareness of global inequities and affirmative action to redress them. Our vision of uplifting the standard of life of all human beings can be realised only when we join and work together to eradicate preventable diseases and causes of ill health among the people.

Distinguished Delegates,

Developing countries are the ones which bear much of the burden of preventable diseases. Their economies are continuously retarded by poor health of the majority of their populations and they consequently do not have sufficient resources to eliminate these problems. But historically and under the present global economic system, these same poor populations have contributed, through labour and cheap raw materials, to the wealth of the economies of many developed countries. I believe it is fair to say that the rich countries have an obligation to assist the developing countries to get out of the vicious cycle of ill health, low productivity and poverty. As far as I know, it is in the long term interest of the rich countries to do so for their continued prosperity and stability.

Although they have the heaviest burden and suffer from the most terrible diseases such as malaria, tuberculosis and HIV/AIDS, African countries should not bank so much on assistance and become dependent on it. Instead they should regard it as complementary to their own efforts. But these efforts will be able to produce maximal benefits in the fastest possible way only if we take the most active part in the process. We need to remind ourselves that it is our own duty and responsibility to demand our fair share of the global resources as well as to lead the fight against diseases which are weighing us down. We need to develop our capacities and alternative ways for solving our own problems in agreeable ways and manner.

Distinguished Delegates,

While the rich nations have the obligation to extend necessary assistance and to allow the flow of resources to reach poor nations, we have also, on our part, the obligation to organise ourselves to meet the challenges posed by the diseases, to build the necessary capacities and infrastructure for sustainable development, and to use assistance in the most efficient and effective manner for good results.

Another matter which needs to be paid due attention in the whole exercise of reorganising ourselves is giving the issue of gender equity its continued and deserved priority. Much of the ill health afflicting our people is the result of the existing gender imbalance in the sharing of the gains of our labour and access to health services in our local communities.

Distinguished Delegates,

There is relationship between ill-health and poverty and development. Poor health reduces education achievements and life expectancy; affects investments and their returns; increases health inequities and poverty. Poverty, on the other hand, leads to malnutrition, diseases, low productivity and income, poor housing, low level of education, unplanned families, in access to safe drinking water and health services.

Most of our countries are caught up in this vicious cycle and are unable to break away without the mobilisation of efforts of all the sectors involved in the fight against diseases and other causes of ill health. It is, therefore, pertinent to emphasize that partnership between the public private and civil society sectors is crucial in this regard in order to bring about rapid and meaningful health achievements.

Mr. Chairman,

I wish to commend the pioneering work of the Global Forum for Health Research as pivotal in this process, in particular, in priority setting, resource flow monitoring, research capacity building and the role as catalyst of networks. Countries and regional groupings need to

create the necessary capacities to absorb and make use of these tools and the generated knowledge.

Partners and stakeholders in the health sector should strengthen their collaboration and efforts and seize this opportunity to work closely with the Global Forum for Health Research, the World Health Organisation, the Council on Health Research for Development and other funding bodies. This will make it possible to build better networks to allow greater leadership from the countries which carry the heaviest global disease burden and ensure that the resources reach the needy.

Distinguished Delegates,
Looking at the global resources it is possible to meet the noble targets of the United Nations Millennium Declaration. The Working Group Five of the Commission on Macroeconomics and Health has pointedly asserted in its recent report that "for the most part we know what to do. What is needed is to find ways of doing it; ways of managing it; and ways of financing it".

As a continent over burdened by the scourge of diseases, Africa needs to set realistic priorities in health research in order to achieve the required progress. Research must focus on the deadliest diseases namely malaria, tuberculosis, HIV/AIDS and other main killer and health debilitating diseases for affordable, sustainable and effective health outcomes.

Tanzania has taken appropriate steps in this direction and the National Health Research Forum which was created in 1999 is already bearing fruits in the form of shaping the national health research agenda, in issuing the national guidelines for health research and other measures.

The objective of health research is to find better ways of controlling and eliminating diseases and other causes of ill health among the people. It is imperative that research results should reach end users and I wish to stress the need to ensure that research findings are appropriately disseminated to the people to equip them with the needed knowledge in the fight against diseases.

Mr. Chairman and Distinguished Delegates,
Research efforts will have better impact if nations and regional groupings can create better functional networks and other mechanisms for concerted action in this area. The creation of these mechanisms will go a long way in ensuring that the voice of individual countries and regional entities is heard loud and clear at the global level and be allowed to take part in shaping the global health research agenda.

It is in this light that the inauguration of the African Health Research Forum during this Conference is a welcome development. Indeed, as the continent with the largest population without access to quality health services and shouldering the heaviest burden of diseases, Africa urgently needed to have a unified and independent health research forum. Without such a forum, Africa would have found it extremely difficult to influence effectively the global health research agenda; to define, and defend, African health research priorities; and to fight for equitable share of the global resources.

We have often been reminded that unity is strength and the key to success. Given the magnitude of the disease problem facing them and the need for multidisciplinary approaches to solve it, African countries need to give the Forum the support it needs to meet these challenges. What is expected from the Forum is better coordination of health research efforts and ensuring of synergy in the actions of different actors.

The government of the United Republic of Tanzania will provide all the necessary support to ensure greater participation of Tanzanian researchers and scientists in regional and global health research issues. We believe that they have the potential to play on important role in health research in Africa and at the global level.

It is encouraging to note that similar efforts are being made in other regions. The establishment, in particular, of the Asian and Pacific Health Research Forum and the on going process for the creation of the Latin American Health Research Forum are indeed, crucial developments in the interest of health research in general.

Distinguished Delegates,

It is ordinarily rare for government ministers responsible for health matters to meet and discuss pertinent issues with researchers, donors, community members and others. I wish to applaud the organisers of this conference for making this possible. But it is my hope that this meeting will facilitate a fruitful exchange of views and generate ideas which will contribute to better research utilization and strengthen the central role of research in health development in our respective countries.

Non-communicable diseases including mental, behavioural and neurological disorders are also increasingly becoming unbearable burden in the developing countries much like infectious diseases. They should be also the focus of our efforts to provide better health care. We are appreciative of the important role played by the Global Forum for Health Research in promoting research in these key areas. I am happy to say that Tanzania has recorded

modest achievements in the field of mental health which has been made an integral part of our primary health care in spite of the prevailing economic constraints and social challenges.

Mr. Chairman,
I am aware that distinguished delegates have serious business to conduct and conclude at this Conference. But as it has often been said "all work without leisure makes a researcher a dull person". I believe your visit to the Land of Kilimanjaro, Wildness of Serengeti, Ngorongoro Crater and Spice Islands of Zanzibar, has also provided you with the opportunity to experience the wonders of nature, the friendliness of the people and the culinary varieties of our country. I hope the distinguished delegates will find this to be conducive an environment for the conference.

Let me, however, not take much of your time but I wish to conclude my speech by wishing you fruitful deliberations.

Mr. Chairman, Distinguished Delegates, Ladies and Gentlemen,
It is my pleasure now to declare this sixth Annual Conference of the Global Forum for Health Research officially open.

I thank you all for listening to me.

COM H 65.8

The Global Forum
for Health Research
Correcting the 10/90 Gap in health research : A tool against world poverty

Presentation by Louis J. Currat
Executive Secretary
Global Forum for Health Research
Forum 6, Newcomers' Session
11 November 2002

Poor health: a key factor in the vicious circle of poverty (1)

Macro-link : Poor health has a negative impact on growth and development as a result of :

- lower life expectancy
- lower educational achievements
- lower production and employment
- a reduction in social and political stability

Poor health: a key factor in the vicious circle of poverty (2)

Micro-link: poor health directly reinforces the "vicious circle of poverty" which includes:

- malnutrition and diseases
- unemployment
- low income, poor housing
- low level of education
- low productivity
- lack of access to health care and drinking water
- larger number of children
- unwanted pregnancies
- substance abuse
- poor environment and discrimination

Role of health research?

One of the roles of health research is to ensure that the measures proposed to break out of the vicious circle of ill health and poverty are based, as far as possible, on evidence, so that the resources available to finance these measures are used in the most efficient and effective way possible.

The problem

- USD 73 billion investments in health research (1998), of which less than 10% for 90% of the world's health problems.
- Because of the vicious circle between poor health and poverty, correction of this gap could make a major contribution to the fight against poverty.

Attention to this problem started in 1990 only!

- Commission on Health Research for Development (civil society initiative)

Disease burden for major diseases

(as % of total years lost to diseases, etc.)

	1998	2020
• Pneumonia (ALRI)	6.0	3.1
• Perinatal conditions	5.8	2.5
• Diarrhoeal diseases	5.3	2.7
• HIV/AIDS	5.1	2.6
• Unipolar major depression	4.2	5.7
• Heart disease	3.8	5.9
• Cerebrovascular disease	3.0	4.4
• Malaria	2.8	1.1
• Road traffic accidents	2.8	5.1
• Tuberculosis	2.0	3.1

Disease burden due to selected risk factors (as % of total DALYs)

• Malnutrition	15.8
• Water/sanitation	6.7
• Unsafe sex	3.7
• Alcohol	3.3
• Indoor air pollution	3.3
• Tobacco	3.1
• Occupational hazards	2.6
• Hypertension	1.5
• Physical inactivity	1.0
• Illicit drugs	0.5
• Outdoor air pollution	0.4

How to solve the 10/90 gap?

We already have :

- Public sector (based on public interest).
- Private sector (based on market incentives).
- Civil society organizations (private sector, public interest).

The problem is that none of the above can, alone, solve the "public bads" (such as bad health).

We need partnerships between all three sectors.

WHY PARTNERSHIPS ???

- Magnitude of the problems
- Efficiency argument
- Interdisciplinarity argument
- Synergy argument
- Global public goods argument

Central objective of the Global Forum for Health Research

Help correct the 10/90 gap by creating a movement (public + private + CSOs) for analysis and debate on:

- health research priorities
- allocation of resources
- public-private partnerships
- access of all people to the outcomes of health research

Global Forum for Health Research Characteristics

- Started in January 98
- Legal status: Foundation
- Objective: help correct the 10/90 gap
- Partnership organization (no membership)

Constituencies of the Global Forum

- Government policy-makers
- UN & multilateral aid agencies
- Bilateral aid agencies
- Foundations
- International & national NGOs
- Women's organizations
- Research institutions
- Private enterprises (pharmas)
- Media

Nature and role of the Global Forum
(in the overall health research collaborative system)

- independent and evidence-based platform to analyze and debate the best ways to help correct the 10/90 gap
- network of networks, individuals and institutions linking efforts in reducing the 10/90 gap
- catalyst of these efforts and partnerships (but not itself a funding agency, except for seed money)

Global Forum for Health Research
Strategies 2003-2005

1. Organize an Annual Forum meeting focusing on the correction of the 10/90 gap
2. Analyze the 10/90 gap and health research priorities
3. Disseminate information on the 10/90 gap
4. Measure results

Strategy 1
Organize Annual Meeting focusing on the 10/90 gap

Objective

To review past achievements and define future actions in helping to correct the 10/90 gap

Forum 5 : October 2001 (700 participants)
Forum 6 : November 2002, Arusha, Tanzania
Forum 7 : November 2003, Geneva

Strategy 2:
Analyze the 10/90 gap and health research priorities

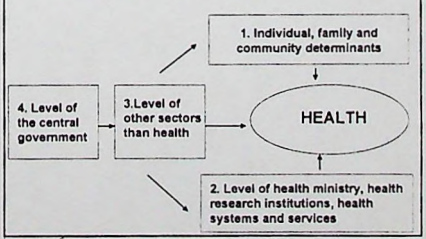
- Level 1: measuring the 10/90 gap and priority-setting methodologies
- Level 2: cross-cutting issues (gender, poverty, research capacity, policies)
- Level 3: major risk factors (malnutrition, unsafe water, unsafe sex, alcohol, tobacco, pollution,etc)
- Level 4: major diseases and conditions

Measuring the 10/90 gap
(work in progress)

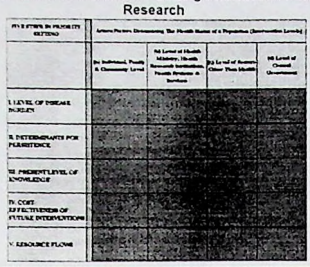
Total public and private sources:
- 1992: USD 56 billion
- 1998: USD 73 billion

Breakdown:
- 50% public sector
- 42% private sector
- 8% private non-profit sector

Priority-setting in health research



A Practical Framework for Setting Priorities in Health Research



Example of partnership:
Medicines for Malaria Venture (CSO)

- Start: November 1999 as a Foundation
- Secretariat: reporting to the Foundation Council
- Governance: Foundation Council, composed of nine members from public and private institutions
- Objective and Plan of action: first research projects have been selected and are being financed (USD 8million/year at present)
- Networking: one of the five strategies of the Roll-Back Malaria programme led by WHO

Example of partnership:
Public/Private Partnerships for Health (IPPPH)

- Start: June 2000
- Secretariat: Global Forum (Roy Widdus)
- Governance and partners: International Advisory Board (composed of 11 members from the public and private sectors)
- Objective and Plan of action 2001-2002: analyse existing PPPs and make information available; promote the development of effective new partnerships
- Networking: with all interested institutions and networks
- Budget: USD 1 million/year (World Bank, Rockefeller Foundation, Gates Foundation, Global Forum)

Example of partnership:
Cardiovascular Health in Developing Countries (Including Tobacco)

- Start: November 1998
- Secretariat: S. Reddy, CCDC, Delhi
- Governance and partners: Partnership Council (12 members, including IOM/USA, WHO, World Heart Federation, policy-makers, Global Forum, research institutions, CSOs)
- Plan of action 2001-2002: priorities are access to knowledge, surveillance system, etiological research, health promotion, hypertension, tobacco, capacity dev
- Networking: with all interested institutions
- Budget: USD 0.2 million (core Secretariat)

Strategy 3 :
Disseminate information on the 10/90 gap
(The 10/90 Report on Health Research)

Strategy 4 :
Measure results

Conclusions on health research, development and poverty

1. Correcting the 10/90 gap in health research : a major contribution to growth, development, the fight against poverty and security. HEALTH and HEALTH RESEARCH PAY! Health as an ECONOMIC sector in development.

2. Correcting the 10/90 gap is possible : it requires the individual and concerted efforts (partnerships) of the public sector, the private sector and the Civil Society Organizations.

Tanzania's Burden of Disease from an Equity Perspective

National Sentinel Surveillance System and
Adult Morbidity and Mortality Project Teams

Presentation Outline

- National Sentinel System
  - Context of Information Need
  - Vision & Mission
- Methods of Demographic & Mortality Surveillance and Poverty Measurement
- Findings for 1996 - 2001
- Conclusions

Context of Information Need

- Health Sector Reform
  - Ministry of Health
- Local Government Reform
  - President's Office
- Poverty Reduction Strategy
  - Vice President's Office
- Tanzania AIDS Commission (TACAIDS)
  - Prime Minister's Office

A National Sentinel Option

- Continuous
  - analysis of trends
- Not a national survey
  - but still representative
- Not 'routine administrative' data
  - but integrated into it
- Sub-national differences
  - equity & social welfare data (e.g. intervention coverage)

NSS Vision and Mission

- To generate & disseminate information from sentinel demographic surveillance sites for the equitable development of the Tanzanian people.
- To produce representative burden of disease and poverty estimates for policy, planning, monitoring and evaluation at district, regional and national levels.

AMMP: Tanzania Ministry of Health ❖ UK DFID ❖University of Newcastle upon Tyne

Methods of Surveillance

- Demographic Surveillance System (DSS)
  - complete enumeration of vital events & migration in a defined population
- Mortality Surveillance System (MSS)
  - active reporting of deaths in community
    - 'verbal autopsy' interviews
- DSS + MSS=National Sentinel System

AMMP: Tanzania Ministry of Health ❖ UK DFID ❖University of Newcastle upon Tyne

Context of Information Need

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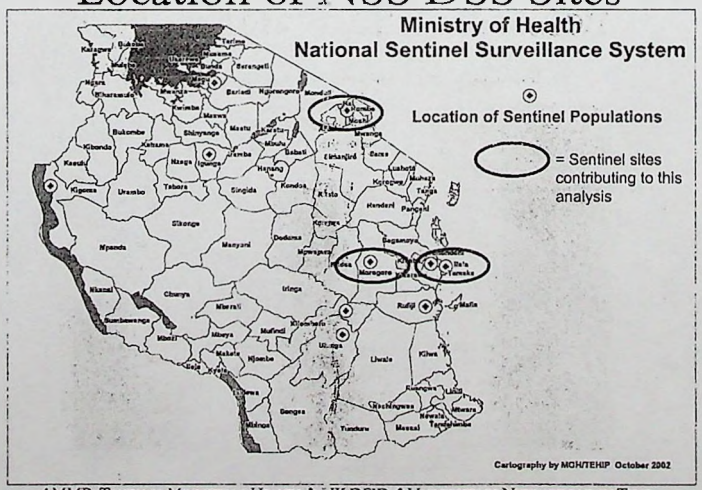
  - equity & social welfare data (e.g. . intervention coverage)

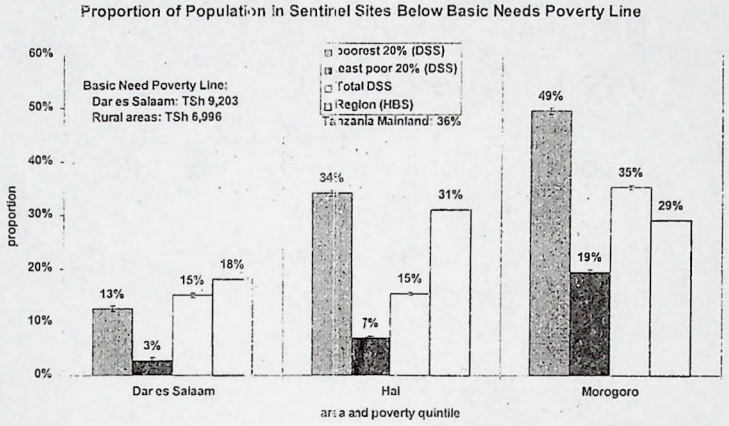
Poverty Measurement Methods

- Poverty Proxy tool validated against National Household Budget Survey
- Income Poverty Only
  - Tool allows estimate in TSh of monthly consumption expenditure per adult equivalent
- Preferable to asset indices because allows comparability
  - across sites, to national data, and to basic needs poverty line

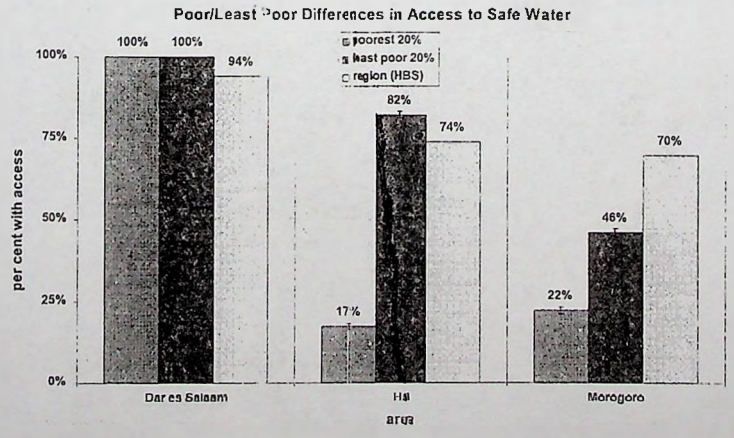
Location of NSS DSS Sites



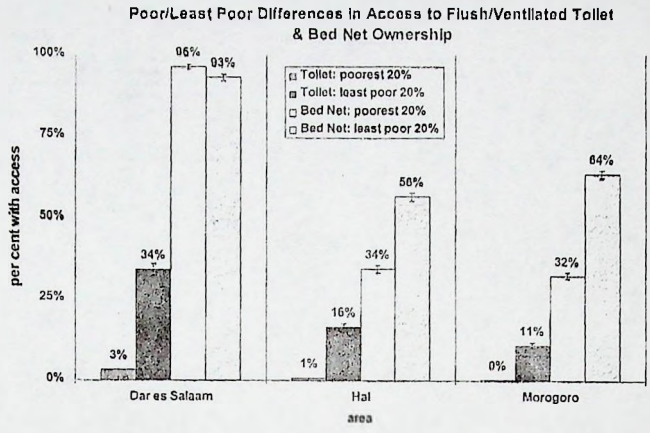
Income Poverty in NSS areas



Access to Safe Water in NSS



Access to Sanitation & Bed Nets



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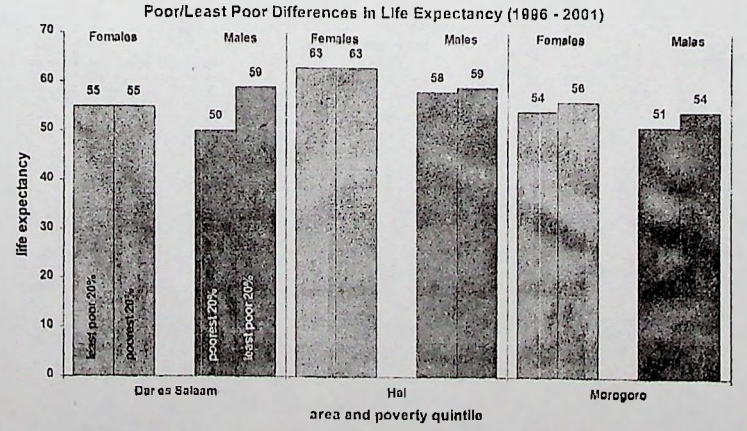
Survival



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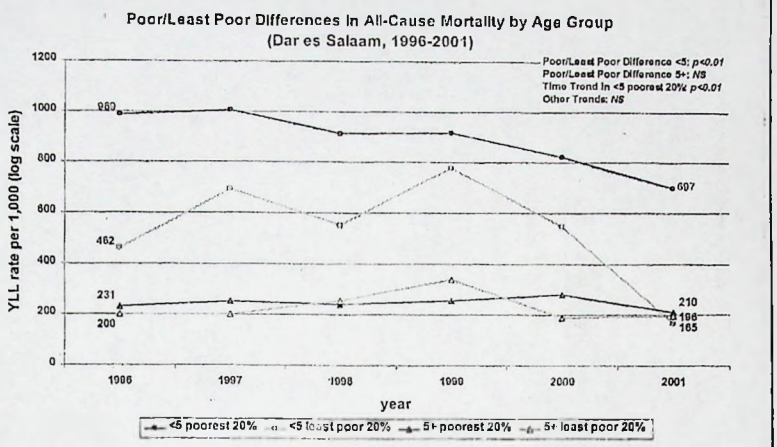
YLL rates per 1,000



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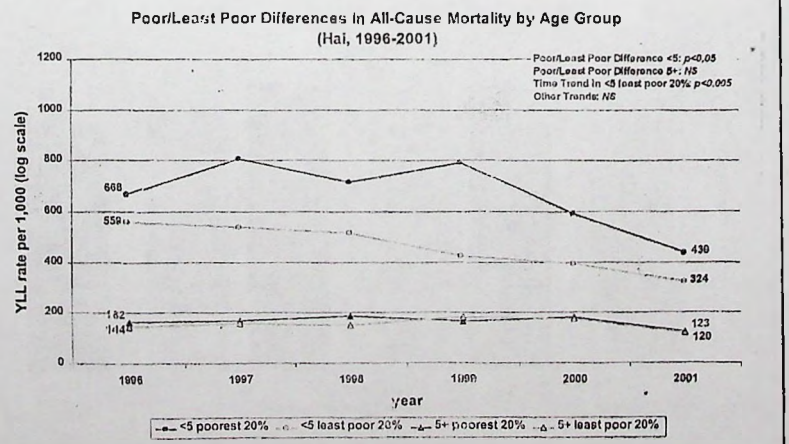

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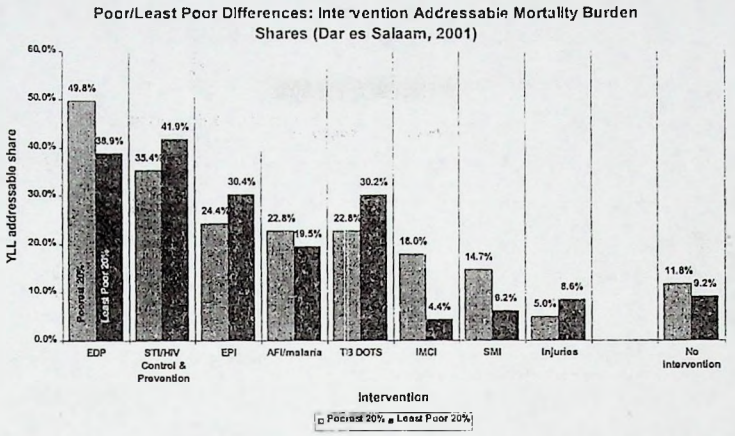
Intervention Addressable Shares



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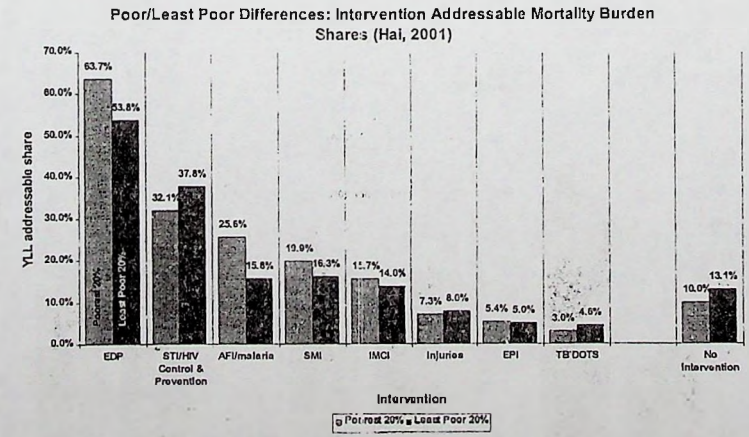

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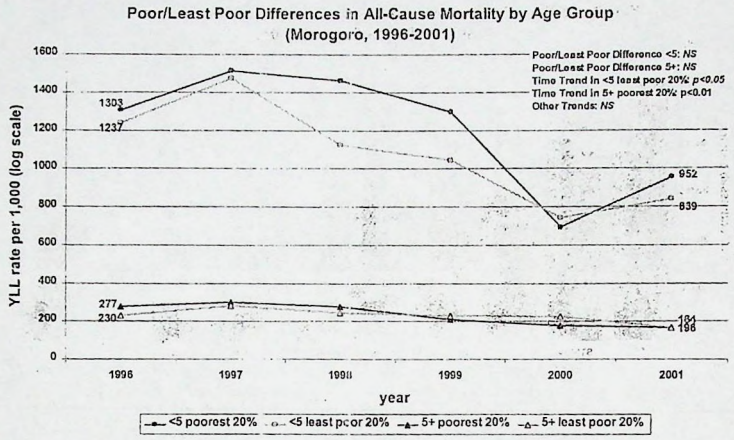

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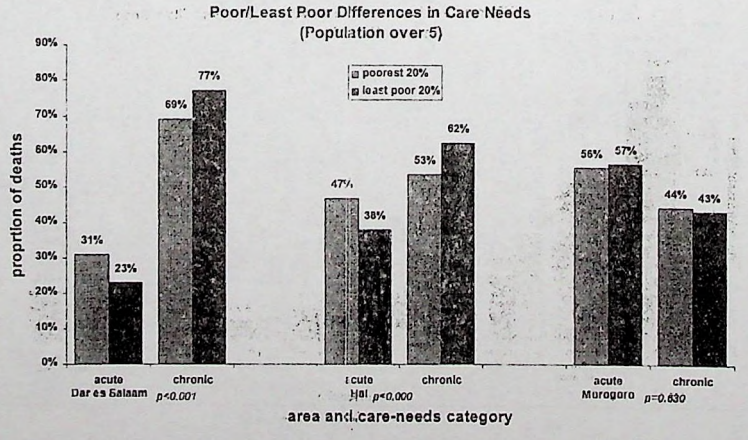
Care Needs



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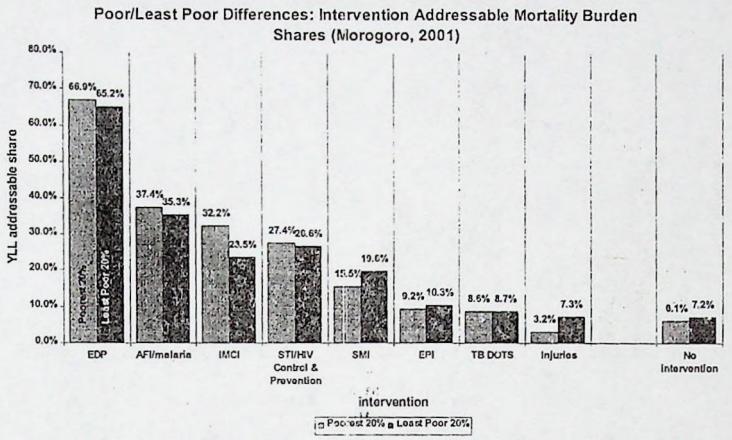

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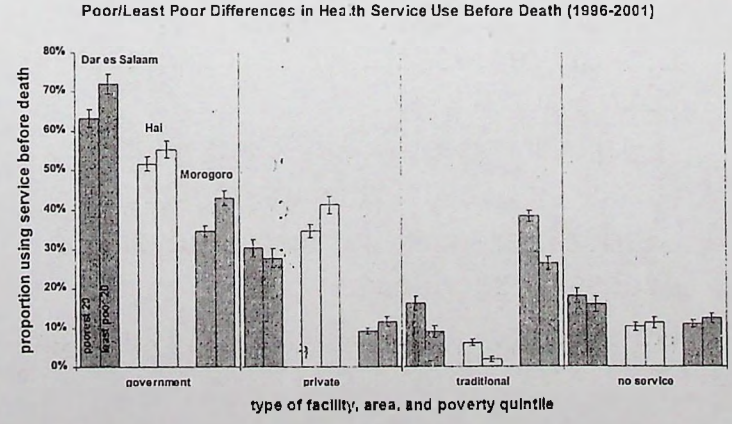
Health Service Use



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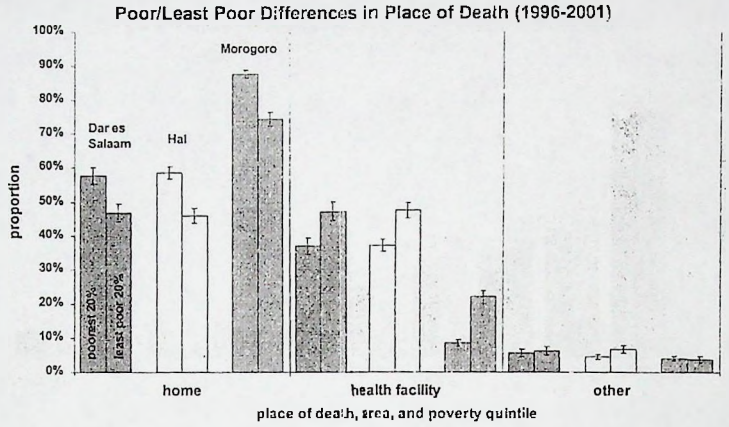
Place of Death



Conclusions: Conditions

- Poverty Conditions in NSS areas broadly representative of regional conditions (HBS)
  - Hai is an exception for income measures
  - Look into weighting factors for data
- Stark differences in income poverty & access to services
- Do these relate to different outcomes?

Conclusions: Outcomes

- Survival Indicators
  - consistent poor/least poor gaps for men, but not women
    - 9 years among men in Dar es Salaam
- Mortality Rates
  - Consistent gaps in mortality rates
    - especially for younger children & across areas for all ages
  - Time trends are stable or downward in both poorest & least poor
    - encouraging in the face of AIDS & malaria drug resistance
- Different policy & service planning implications?

Conclusions: Services & Policy

- Poor people use formal services less, and die at home more often than the least poor
- An equity perspective on burden of disease in Tanzania's sentinel sites suggest a pro-poor policy focussed on increasing access & coverage of current interventions.
  - Intervention & Care-Needs data do not suggest substantially different priorities for poor vs. least poor

Acknowledgements *(alphabetical order)*

- Analysis and Writing
  - *Yusuf Hemed, Philip Setel, David Whiting.*
- NSS & AMMP Teams
  - *Said Aboud, KGMM Alberti, Richard Amaro, Don de Savigny, Yusuf Hemed, Gregory Kabadi, Berlina Job, Judith Kahama, Joel Kalula, Ayoub Kibao, John Kissima, Henry Kitange, Regina Kutaga, Mary Lewanga, Frederic Macha, Haroun Machibya, Mkamba Mashombo, Honorati Masanja, Godwill Massawe, Gabriel Masuki, Louisa Masayanyika, Ali Mhina, Veronica Mkusa, Ades Moshy, Hamisi Mponezya, Robert Mswia, Deo Mtasiwa, Ferdinand Mugusi, Samuel Ngatunga, Mkay Nguluma, Peter Nkulila, Seif Rashid, JJ Rubona, Asha Sankole, Daudi Simba, Philip Setel, Nigel Unwin, and David Whiting.*

AMMP: Tanzania Ministry of Health ❖ U.K DFID ❖ University of Newcastle upon Tyne

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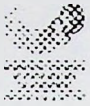

Forum 6 Arusha,
November 13, 2002
Business Meeting

Implementation of the Bangkok Action Plan : A Report from the Interim Working Party Secretariat

Bangkok Action Plan

- Endorsed by all participants
- Proposed establishment of a Working Party to continue the post Bangkok agenda
- To be hosted by WHO
- Terms of reference/remit spelled out (mandate)

Mandate of Working Party

1 Address concrete global partnership and complementarity issues & work out a proposal for a **governance structure** of the global health research system

2 Regular convening of an international **conference** on health research for development

3 Creation of a post-conference **communication and feedback** mechanism

Report of Activities

- "Interim" Working Party met in October, 2001 (Forum 5, Geneva)

Present at October 10, 2001 Meeting

- M.Jacobs, T.Pang (Co-Chairs)
- A.de Francisco (GFHR), L.Currat (GFHR), B.Carlsson (SIDA/Sarec), C.Sitthi-Amorn (THL), D.Meyrowitsch (DANIDA), F.Binka (Ghana), L.Freij (Swe), M.Ruiz (Mex), M.Tanner (STI), M.A.Lansang (INCLEN), M.Mugambi (Kenya), N.AlGasseer (WHO), P.Svensson (SIDA/Sarec), P.Makara (COHRED), S,Macfarlane (RF), U.Lele (WB), S.Chunharas (THL)

Report of Activities

- Interim Working Party met in October, 2001 (Forum 5, Geneva)
- Secretariat of the IWP formed based in WHO, Geneva (WHO, COHRED, GFHR)- part time assistant hired
- Regular meetings, email consultations and activities carried out on various issues related to the mandate

1 Governance Structure
2 International conference
3 Communication & feedback

2 Initial planning and conceptualisation for World Summit on Health Research for Development, Mexico, 2004

3 A. Progress Review post-Bangkok
B. Booklet on international initiatives and organizations in health research
(Dr M. Jegathesan)

A problem with Mandate 1....

- The issue of "governance" is a highly complex one with many contentious issues at national, regional and global levels
- Benefits of such a structure highly debatable, its existence may not be desirable nor appropriate
- Thus, Mandate 1 relating to global governance structure is unrealistic and impossible to achieve

Recommendation 1

- Amend mandate 1 of the Working Party for it to :
- **"act as catalyst and conduit of communication between interested organizations, with a view to assessing progress and working out collaboration principles and frameworks for cooperation"**

Recommendation 2

- The work of the IWP be continued by a virtual platform of organisations to promote dialogue and inputs on key issues related to the mandate of the Working Party

How? For example.....

- Continued inputs to planning for Mexico 04
- Continuous updating of information booklet-posting on web site (BKK2000 site)
- Commissioning situation analysis-mapping and landscaping to provide clues to future directions, where are we going?
- Regular reporting at future forums and Mexico 04.

Draft

"A BIENNIUM SINCE BANGKOK PROGRESS VISITED"

Prepared by:
Secretariat
The Interim Working Party
International Conference
Bangkok 2000
Geneva, October 2002

"A BIENNIUM SINCE BANGKOK PROGRESS VISITED"

INTRODUCTION:

It is now two years since **the International Conference in Health Research for Development** was held in **Bangkok** in October **2000 (hereafter referred to as Bangkok 2000)**. It is timely therefore:

- To **list and review the progress** that has been achieved in taking forward the **Action Plan** emanating from that landmark conference.
- To enable the forthcoming gathering of interested parties (including members of the **International Working Party**) at **Forum 6** in Arusha in mid November, 2002 to reflect on the achievements since Bangkok and help engender the momentum to accelerate the preparatory work that will be needed to meet the future challenges including the opportunities of:

  The planned **World Health Research Summit in 2004** in Mexico
  The Decision of the **WHO** to dedicate its **World Health Report 2004** to Health Research.
  The **annual** meetings of the **Global Forum for Health Research**
  The **Regional Health Research Fora**
  The **Country Research Agendas**

This report aims to **inform** this audience, to **stimulate** discussion and to **draw** concrete suggestions for emphasis and attention in the two years left to these important developments affecting the future of health research.

METHODOLOGY

The International Conference for Health Research for Development held in **Bangkok** in October **2000** has indeed left a mark on the health research scene at the **global**, **regional** and **country** levels. That conference had spelt out an **Action Plan** (For details see ANNEX 1), which tabulated activities that should be pursued in the areas of:

- **Knowledge production, use and management**
- **Capacity development**
- **Governance**
- **Financing**

An attempt is being made to list as many of the achievements to date in these different areas that were a consequence of the Bangkok Conference. (See Table 1). Inputs for this exercise were obtained from the following sources:

- WHO, Council on Health Research for Development (COHRED) and the Global Global Forum for Health Research which constitute the secretariat of the **Interim Working Party** (ANNEX 2)
- Respondents to a **questionnaire** sent out to some 350 participants of the Bangkok Conference of which over 20 replies were received to date.
- Other personal communications and publications, formal and informal

Draft

"A BIENNIUM SINCE BANGKOK PROGRESS VISITED"

Prepared by:
Secretariat
The Interim Working Party
International Conference
Bangkok 2000
Geneva, October 2002

OBSERVATIONS

There were some activities that:

- Were clearly the **direct consequence** of the Conference or the Action Plan and respondents, in a number of instances, have in fact cited them as the initiator for the action.
- Could be deemed to have **been given a stimulus**, or **been influenced** in some way or other by the Conference. These included the already ongoing activities of many players that have received a boost from the conference.
- Perhaps were **co-incidental** and would perhaps have happened anyway with or without the conference

A point to keep in mind in analyzing the effects of the conference is that the conference itself should be **viewed** not as a singular event but **part of a continuum of activities**, culminating in Bangkok but starting with the **preparatory phase of the conference**. This phase necessitated the convening and gathering of much inputs from countries and regions and had a catalytic effect in generating hitherto unavailable or inactive networks as well as providing a jump start to those that are already there. It moved seamlessly into the conference. The conference itself generated the **'Action Plan'**, which provides the **post conference agenda**. It now seems timely and appropriate to see the progress that has been made along that same continuum. The preconference regional consultations in particular had the effect of **facilitating the creation of a critical mass of experienced southern researchers** and managers who are now well placed to take the post conference agenda forward with some measure of self reliance. The bringing together of such varied players from such diverse backgrounds and sources provided an opportunity to **network,** understand each others' **comparative advantages**, niche areas and to be able to find avenues for future and extended **collaboration and cooperation**. All of this facilitated the relative ease with which the **formalization of the Regional Fora** has taken place. This was particularly evident in the case of Asia –Pacific, where the additional **spin-offs of hosting** the conference were evident in the increased opportunity for participation not only from the host country itself but its neighbours as well. The legacy of this is already being felt.

This consultative process and the Conference itself had a **multiplier effect on human resource development** in the health research community. It had **increased the sensitivity to and the responsiveness** of researchers in many developing countries to opportunities for advancing the field. On their return they became prime movers in their countries (e.g. Kazakhstan and Burkina Faso). There are interesting examples (personal communication) of where this enthusiasm has been reflected in key political leaders in the countries (like in Mali and Kyrgystan)

At the global level, the formation of the **Interim Working Party** amongst the key players themselves provided the opportunity for **continued synergy** amongst them which was extendable to many areas outside the ambit of the follow up to the Bangkok Action Plan.
Activities at the **country level** were gauged from a **limited survey** for a limited time. Hence what is available for listing here should be viewed as a sample only. However it does reflect the level and type of activities that have started in some countries and no doubt a more formal and thorough survey could have elicited a much longer and balanced inventory of country activities.

PROGRESS HIGHLIGHTS

Some landmark events that took place after Bangkok that can be highlighted here:

- The formation and/or strengthening of **regional fora** for health research such as the **Asia Pacific Health Research Forum** (already formed), the **African Health Research Forum** (to be launched at Forum 6) and the **Latin American Network** (in the gestational stage) together with a number of smaller regional and sub regional initiatives such as the proposal for the network for countries in **EMRO,** and the **Central Asian Forum** (under process)
- The actions taken by a number of Regional Offices of the WHO in consonance with the recommendations of the Conference. Amongst these the most remarkable one is the **EMRO** decision to **earmark 2% of its program budgets** to research activities. Others include **SEARO** efforts in recommending to its member states the need as well as the modus operandi (through a specific **document outlining a strategy for health research system development)** for a national health research system for their member states.
- The actions taken by a number of **countries** in instituting/strengthening national health policies/ research systems, sometimes with proposal for appropriate legislative instruments. Examples of these can be drawn from events in countries like **Lao PDR, Cuba, South Africa, Brazil, and India. Tanzania, Thailand, and Bangladesh.** There was also the instance of a significant public-private partnership set up in **Singapore.** (There would certainly have been more entries in this category had the survey been more extensive and been given more time)
- **COHRED** national health research system activities, which included some of the countries mentioned above as well as —**Indonesia, Ghana, Malawi, Cameroon, Pakistan, Uzbekistan and Kazakhstan.**
- The publication by the **Global Forum for Health Research** of **The 10/90 Report on Health Research 2001-2002** and the '**Monitoring Financial Flows for Health Research**"
- The introduction by the **Global Forum for Health Research** of the "**Combined approach matrix**" for priority setting and its **application by TDR**
- The pooling of resources to come up with the " **Collaborative Training Programme" by INCLEN, COHRED, the Alliance for Health Policy and the Global Forum for Health Research**
- The launch of the **WHO coordinated** Health Research Systems Analysis (**HRSA initiative**) with the pilot cluster of 16 countries
- The selection of **health research** as the **theme** for WHO's prestigious flagship document, the **World Health Report 2004**

OTHER GLOBAL EVENTS

We should also highlight **another group of global events**, which although **unrelated** to the conference may have a significant impact in the coming years to health and health research needs. These include:

- The **Millenium Development Goals** adopted at the **Millennium Summit** of the **United Nations** in September 2000;
- The work and report of the WHO **engendered Commission on Macroeconomics of Health** (which *inter alia* endorses the concept of a **Global Health Research Fund,** ANNEX 3); and the spin-offs of
- The **World Summit for Sustainable Development, Johannesburg 2002.**

Whilst the reference to research specifically is found in the Commission's report, there are certainly significant windows of opportunity for health research in enabling the realization of the objectives of the other two events. The **momentum** likely to be generated by these events in the coming months and years and the 'niche' for health research that they will provide should not be squandered. The health research community will be amiss if they do not position themselves to play a meaningful role.

CONCLUSION

What is presented here is certainly **not exhaustive** and should be considered only as **examples** only drawn from a limited sample, but it does provide an indication of the different kinds of **follow up action** that have taken place since Bangkok 2000. The significance of the information that was received does, however, show the effectiveness of the survey instrument and hence it's potential for a wider application. If necessary, therefore, a more detailed inquiry can be made.

Whilst it is perhaps a useful exercise to try to see what specific effect the conference had, it is equally relevant to consider the conference as a *fait a'compli* and history and what is important is the progress that has been made in the general landscape of the health research arena since that conference, irrespective of the specific and ascribable influence of the conference.

What is important is the future and the experience and lessons from the past should be conscripted to seize the opportunities of the present. At the same time it may be useful to reflect on what might have been missed or would otherwise have happened if the conference had not been held. However, perhaps what is more important is that these activities and achievements are taken a few pegs higher as a prelude and preparation for maximizing the opportunities the future may offer such as annual Forum meetings and the World Health Research Summit in Mexico in 2004.

The inputs of contributors to the content of this report is gratefully acknowledged. These included organizations and Institutions as well as a number of individual participants of the Bangkok Conference who responded to a questionnaire.

A detailed listing of activities and achievement is given in the following

TABLE 1

A. GLOBAL LEVEL

1. **Knowledge Production**

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Promote the role of universities in health research.	-The INCLEN trust supports the work of Clinical Epidemiology units based in universities in countries to promote research and training for better healthcare in developing countries	-This has been strengthened and there are now 65 units in 27 countries so supported.
Foster public-private partnerships to invest in health research and product delivery.	-The Initiative on Public-Private Partnerships (PPP) for Health (IPPPH) was already launched by the Global Forum for Health Research in July 2000	-The IPPPH has conducted a census of PPP -A new PPP is being planned between academe, public sector (e.g., WHO, IARC, US NIH) and industry (Merck, GSK) to accelerate transfer of HPV vaccine to developing countries for prevention of cervical cancer; to be supported by the Gates Foundation
Facilitate and support a global research initiative that encompasses the entire spectrum of sexual violence.		-A Sexual Violence Research Initiative, supported by the Global Forum for Health Research, has been under preparation by a number of partner institutions for the past two years
Advocate for research on child health during the World Summit on Children. Prepare by reviewing and synthesizing research on child health in the past 10 years, identify gaps and develop child health research priorities.	-A Child Health and Nutrition Research Initiative (CHNRI) was launched by Global Forum for Health Research in February 2000	-Under this initiative, regional groups have been funded to determine human resources, capacity and priorities at the regional level. In addition, a call has already been circulated inviting offers to host the secretariat in a developing country for the next two years -The WHO and the Global Forum for Health Research tabled a publication "Child Health Research: A foundation for improving child health at the World Summit on Children held on May 8-10, 2002. Also at the UN General Assembly Special Session on July 2001 in New York. This paper identified research priorities and gaps. -Mapping of health and nutrition research priorities and identification of players was initiated in Asia, Latin America and Africa by three separate groups. -The INCLEN Trust has affirmed child health research as a priority, providing support for the strengthening of the INCLEN Child Health Research Group,

2. Capacity Development

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Funding agencies should give priority to capacity development in support of national and regional activities. Capacity development should form an integral part of funding for research projects.	-This has been the policy of some organizations	-At the global level, this should be studied in the context of the reflections around the **Global Fund for Health Research** as proposed by the **Commission on Macroeconomics and Health**. A review of this question will also be included in the **World Health Report 2004.** -**CIDA Canada** has financed **two projects** in order to increase **capacity development** at the national and sub-regional level in **Latin America.** -**African initiatives (AMVTN/AMANET)** have been able to **attract increased funding** from **Netherlands (DGIS)** and from the **European Commission** for capacity building in **malaria research.**
Guidelines and practical tools are needed in support of management and leadership of research.	-**Ad Hoc Committee** report recommended this action -COHRED has identified this as an important need -**INCLEN** introduced its **LAMP** project. . This is implemented through INCLEN's regional networks and Clinical Epidemiology Units	-"**A Collaborative Training Program**" has been embarked on jointly by the **Alliance for HPSR, COHRED, the Global Forum for Health Research, and INCLEN,** essentially to develop and disseminate **learning modules** for translating **research to policy to action.** -The value and concept of such tools as necessary for capacity building initiatives and activities will be included in the World Health Report 2004. -**INCLEN** Trust continues to conduct its **Leadership and Management Program** to strengthen skills and competencies of health research leaders, both current and emerging, in member countries in the South.
Access to databases and literature is key in capacity development, particularly access by researchers/institutions to outside information. An international taskforce is needed to explore ways to facilitate such access.		-This is being taken up by RPC/WHO Geneva as an input for the World Health Report 2004. -**HINARI/WHO** was started in 2001 and currently provides some 2000 electronic journals to poor countries, on a differential pricing system. -The **INCLEN** Trust, through support from the **Rockefeller Foundation,** has embarked on a "**Knowledge Plus**" project, concerned with access to data/information on health care in developing countries and ability to process the information for efficiency, local applicability and improved equity. - There is a distinct impression amongst colleagues in the developing countries that there is a substantial increase in access to electronic journals. (Carel Ijsselmuiden, South Africa)

3. Governance

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
A governance structure - one that should ensure a wide representation of actors from all levels, also including the private sector - is needed to promote a spirit of complementarity and partnership between various actors and stakeholders in health research for development.		-An **Interim Working Party** has been formed at **Forum 5** in 2001. It is composed of the **representatives of the WHO, Global Forum for Health Research and COHRED, and the World Bank** with **the secretariat** lodged at the **WHO**. This Group, called the IWP has begun its interactions and will table a **progress report** at the **Forum 6** in Arusha in November 2002. Its **mandate** should also be **further discussed at Forum 6**. The IWP will also provisionally plan to convene a meeting of the full Working Party by Forum 7 in 2003 The **International Working Party**, based on the recommendations of Bangkok2000 will come up with its plan for the **governance structure for global health research system** in time for presentation at the **World Health Research Summit in Mexico in 2004**
A proposed step to achieve this is the formation of a Working Party with representation from WHO, international initiatives, such as COHRED and the Global Forum for Health Research, regional networks, national and international research institutions, the private sector and donors. It should be hosted by WHO but is independent of existing organizations and institutions.		Ditto
The mandate of the Working Party would be to address concrete global partnership and complementarily issues and to work out a proposal for a governance structure of the global health research system. Stewardship functions, initiated by the working party, could include ethical issues such as developing norms for ethical review committees in developing countries, the protection of intellectual property rights of researchers in developing countries and the development of a code of conduct for N-S health research co-operation.		Ditto
The secretariat function for the Working Party would be organized by the sponsors of the IC2000. Its initial task would be to convene the first Working Party meeting be held within the next few months.		Ditto
The proposed governance structure should be discussed at the next Global Health Research Conference, which would agree on a more permanent governance structure.		**-The International Working Party** to present these proposals at the **World Health Research Summit in Mexico in 2004.**

4. Financing

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Urge international agencies to dedicate a percentage of their health sector allocations to support health research institutions in the South.	-This was identified already in the Commission Report	-**WHO-PAHO has increased funding** for research for countries in their region and have also mobilized international funding from different sources. -It is noticed in **South Africa** that there is **increase in south based funding** through agencies such as **NIH Fogarty** and **B&M Gates Foundation**
Create endowments at international and institutional levels through strategic fund raising and stimulating private public partnerships.		-**Global Fund for Health Research,** as proposed by the Commission on macroeconomics for Health
Develop tools for the monitoring of resources flows into health research, use and impact of allocations at the global level to advocate a change.	-Adhoc committee attempted first measurement of resource flows (RF) -Global Forum for Health Research initiated a network to collect information -COHRED undertook three country studies and designed modules	-**The Global Forum for Health Research** has brought out the publication " **Monitoring Financial Flows for Health research"** in October 2001. Further updates on progress as well as pilot testing will be made available in Forum 7 (2003) and also in the World Health Report 2004. COHRED, in collaboration with the Global Forum for Health Research and WHO has started working on detailed studies in 6 developing countries
GENERAL----selection of health research as the theme for World Health Report 2004		-The selection of **Health Research as the theme** for WHO's prestigious flagship document, the **World Health Report for 2004** is indeed a major breakthrough for international advocacy for health research as an indispensable tool for equity and development in health. The convening of the Bangkok Conference, the ensuing Declaration and the Action Plan must certainly number amongst the various circumstances that have led to this momentous decision.
The Global 2000 burden of disease project:	Started in 2000	-Further progress in the last two years in the development and application of the tools for determining GBD
	-Different organizations have been developing their own tools for priority setting, such as the Commission report (1990), Adhoc Committee report (1996), Advisory Committee on Health Research (1997), ENHR projects (COHRED), Global Forum For Health Research and Bangkok 2000	The introduction of the Global Forum for Health Research combined approach matrix for priority setting **-brings together the different methodologies** introduced by different partners. Bangkok 2000 started the process of sharing experiences and attempts to synthesize the experiences of different initiatives -this matrix has been **applied by TDR** in determining its workplans and concluded that this analysis will be done annually with scientific working group meetings called every 5-6 years to carry out a thorough review. -this matrix has also been applied to the problem of **indoor air pollution (IAP)**

B REGIONAL LEVEL

1. Knowledge production

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Identify gaps in knowledge; establish regional clearinghouses for projects, funding, best practices and networks for data exchange.	-Many initiatives have been working on this e.g.PAHO and UNICEF have been working together to establish networks for data exchange.	-This is one of the aims of the **INCLEN** Trust's **"Knowledge Plus" Project,** but with a focus on priority health care interventions identified by the regions. -This subject was discussed at a meeting in Iran for countries of EMRO. Follow up action still awaited. -This will be one of the issues taken up by the African Health Research Forum -"AfriHealth" is funded by the Rockefeller Foundation
Develop regional organizations to promote health research; enhance existing regional mechanisms; promote South/North and South/South collaboration in priority research areas (TB, malaria, road traffic injuries, traditional medicine).	-The **African Health Research Forum,** which was already mooted in the regional consultations prior to Bangkok, became part of the Action Plan **-The Asian and Pacific Forum** illustrates the seamless continuum of activities that started before the Bangkok conference, pursued during it and taken forward post conference. The very first meeting, which served as part of the preparatory phase for the Bangkok Conference, was held in Manila in February 2000.	**-Follow up** (involving some 50 countries, and bringing in to the loop some 15 vertical regional networks) resulted in **the formation** and the first meeting of the **steering Committee** at Arusha, Tanzania in December 2001. A meeting of the **steering committee was held in July 2002, leading to the official launch of the Forum in Arusha** during Forum 6 this November 2002 - **follow up meeting was held at Bali** on 13-15 November 2001. which endorsed the need for a regional forum. **Indonesia** serves as **the interim focal point.** A **steering committee** has been formed, which will take it to the next meeting of the forum, which is planned for before the end of 2002. **-Latin and central America:** Numerous regional meetings were held in Latin and Central America in 2001 and planned for 2002 on issues including mechanism of regional collaboration, the functioning of national health research systems, and the setting of health research priorities at the regional level. In October of 2002, Cuba will host CITESA-HAVANA 2002, a national event but with a window to organize the follow through on the initiative to create the regional forum (through a COHRED sponsored Round table meeting on regional cooperation) -INCLEN Trust continues to provide support to strengthen its regional and country networks in their research and capacity strengthening activities, including inter-regional collaboration in priority areas.

		-A Lao PDR-Vietnam- Cambodia Symposium on Health Research is planned for the end of 2002 with the idea of strengthening the research capacities of these three neighboring countries. -The African Malaria Network trust (AMANET) has been incorporated with the goal of spearheading malaria research capacity in Africa. -EMRO network-COHRED has supported the establishment of an EMRO network with the region taking on its role as a full time collaborator in the ENHR movement. This step was followed closely in May 2001 with the holding of an informal consultation of the region in Iran to look primarily at the concept of national health research systems. 10 participants attended it from five countries in the region. The consultation was viewed by EMRO/WHO as a step towards the implementation of the Bangkok conference Action Plan. -COHRED has been supporting some networking initiatives in Central Asia and in the Francophone African countries. -Apart from its support for regional Fora and networks, COHRED has also used to advantage the strategy of 'sub-regional' groupings, which make for effective collaboration based on common historical, cultural, and linguistic as well as university systems. In this manner groups have been supported in south east Asia (Cambodia working with Thai support); the five former Soviet countries of Central Asia; five of the countries from the francophone grouping in West Africa.
Promote publication of regional research journals.		
Foster public-private partnerships		A number of global public-private partnerships are developing regional networks

2. Capacity development

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Study and develop existing models of regional collaboration regarding research capacity development.		-The African Forum looks at South/South collaboration
Promote political commitment.		-This was also discussed at the COHRED/ WHO EMRO informal consultation in Iran amongst EMRO countries in May 2001
Map centres of excellence for regional capacity development.	-This is an ongoing project for countries of EMRO	-Being given increased emphasis

3. Governance

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Map regional capacity building networks.	-This is an ongoing project for countries of EMRO	-continuing
Develop appropriate governance.		-SEARO: has recommended to its member states **a national health research system** through its ACHR.
Establish regional Health Research Forums.	-Process started during the regional consultations in preparation for Bangkok2000	-**Asian and Pacific Health Research Forum** -**African Health Research Forum.** -**Informal networks** serving the same function are already taking root in **Central Asia, Latin America** and the **francophone African countries** through COHRED support
Regional structures should be based on country needs.		-This is the model being followed by both the Asian and the African Forum in identifying focal points at country level

4. Financing

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Urge regional organizations to reserve a percentage of their funds for health research.		-**EMRO** has made the **landmark decision to earmark 2% of all its program budgets to research.** This is hoped to be implemented in the next biennium. The Bangkok Conference was cited as the catalytic factor in coming to this remarkable decision.
Regional priorities should be based on country priorities and determined by burden of disease, social and economic determinants, gender and social equity.	-This is precisely the prerequisite for COHRED supported regional networks	- will also be the modus operandi for the African and Asia Pacific Regional Health Research Forums.

C COUNTRY LEVEL

General Comment: COHRED has supported, since Bangkok2000 a number of countries in strengthening their health research systems. This support was often not focused on one component of the system and hence their inputs below may not be exactly compartmentalised as intended.

1. Knowledge production

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Assessment of research quality.	-A number of countries already have mechanisms for this. e.g. in South Africa the ENHR Committee, Medical Research Council and various Universities perform this function.	-There is an ongoing project in the Sudan
Dissemination of knowledge.		-The **COHRED working group on communication** looks specifically into the role of communication within the health research system and is trying to develop methods /tools to strengthen communication at country level -Countries now actively involved in this project are **Brazil, Cuba, Thailand, Philippines, Indonesia, Tanzania, South Africa, Ghana** -**Brazil: CAPES**, an agency under the Ministry of Education has sponsored a virtual gateway which offers some **3000 international journal titles to Brazilian researchers** -**India**: **documentation centres** have been developed that have started disseminating the results of research conducted in the country -**Lao PDR**: National Institute of Public Health has published the **first edition of health sciences bulletin** in both English and Lao and distributed across the national network of institutes -**Bulgaria**: a **new scientific journal** published entitled **"Health Management"** -Contributions from "**Collaborative Training Program**"
Involvement of all stakeholders. universities		-Thailand: networks of researchers from universities have been created to collaborate on interdisciplinary health issues. Study groups have started working on specific topics.
Build capacity for information and communication (IC) technologies.		**-Thailand: e-library** **(open to the public)** has been established to facilitate better assessment to journals and HSRI reports -India: a pilot study on Health Internet Project on Malaria and Tobacco use is initiated in India to use the IC technologies to increase the capacity of health personnel working in these fields -Cuba: a noticeable increase in activity in the last 2 years with increased web sites and books -**Philippines**: Commission on Higher Education has established national **Zonal Health Research Centers** in almost all regions of the country, which help in resource and information sharing.

Conduct research synthesis.		-Philippines: Various groups are doing Clinical Practice guidelines development and the Health Policy Development and Planning Bureau of the Department of Health and the Institute of Health Policy and Development Studies at the National Institute of Health are looking at policy implications of various researches.
Support national burden of disease (BoD) studies.		**-Lao PDR** has evaluated the implementation of **the 2nd five-year national health research master plan leading on to the preparation of the 3rd master plan (2002-2006) emphasizing diseases which are part of the national BOD**
Develop research policies and priorities.	**-COHRED** continues to support **national priority setting processes**. On the average 3-4 countries are supported each year	For 2001, the countries supported **were Malawi, Cameroon, Cuba, Mali and Pakistan** whilst in 2002 it is **Uzbekistan.** Methodologies and publications have been developed to support these national efforts both by COHRED and recently through the first module of the Collaborative Training Program. Research policy development is often linked to the priority setting process. **-India**: Indian Council of Medical Research has initiated the preparation of a **National Health Research Policy**, which envisages creating a national health research system. The draft policy is already available for final approval
Promote multidisciplinary research.		-Cuba: increased projects in child health research and conducted distance-training courses to build capacity involving some 200 people.
GENERAL		
Private-public partnerships		**-The Singapore Govt.** (Economic Development Board) has gone into a **partnership with Novartis** (Switzerland) to put up **a Novartis Institute of Tropical Diseases,** dedicated to R&D into **TB and dengue.** -Thailand: private insurance companies have supported some health financing related studies.

2. Capacity development

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
GENERAL: COHRED supported Country activities:	-**COHRED**, initiated in 1993 continued to provide **technical and financial support to countries** for their activities in priority setting, coordination networks and research capacity development.	-There was increased response to COHRED approaches from countries which it is felt was sensitized by the events of Bangkok 2000.) Since Bangkok, COHRED has made **some shift in its country support strategy,** giving **more emphasis to countries with greater need** and allowing countries already showing success to continue activities with their own resources. Countries selected for support are usually at least on three-year programs and not funded for 'one-off projects'. Some criteria have also been developed for assisting in the selection of countries for support. 2001: -**Mali: health research priority setting** for the development of health systems—first national workshop leading to a list of priorities -**Ghana: a study on the role of informed decision making** in **formulating health policy** -**Cameroon**: institution of the **priority setting process**. A promotion and advocacy workshop led to working groups to work on issues related to priority setting -**Malawi: drawing up of country level health priorities**: three day workshop has led to a provisional list of health priorities -**Pakistan: priority setting seminar** to discuss role of health research and priority setting. -**Chile**: seminar to address the need for a **national health research strategy**
Management training programmes.	- **Rockefeller Foundation funded International Awards Scheme** was conceived during the preparation for Bangkok2000	-**"Collaborative Training Project" undertaken by the Alliance for HPSR, COHRED, the Global Forum for Health Research, INCLEN** -At **Bangkok, 10 grantees** were announced based on their applications. **Progress reports** from the grantees have been received and a round table will be held in conjunction with **Forum 6** to discuss organizational and logistical issues connected with the awards. A selected number from amongst awardees will also be part of a **two day round table** showcasing their work. -Thailand: research management has been incorporated in research proposals as well as the strategic plan of Health Systems Research Institute's work plan -Lao PDR: the National Institute of Public Health regularly conducts courses in research methodology.
Viable research careers.		
Include all stakeholders.		
GENERAL: international partnerships:		-Lao PDR: has signed technical cooperation agreement with some foreign partner institutions.

3. Governance

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Take stock of current status of national health research systems.	-COHRED has been assisting countries to strengthen (and further develop) Health Research Systems	**-The COHRED working group on National Health Research Systems** works with country teams from 8 countries (**Brazil, Cuba, Thailand, Philippines, Indonesia, Tanzania, South Africa, Ghana with Laos and Cambodia involved as observers**) to carry out system analysis and to develop future plans. More countries will join this group in coming years. - a WHO organized **International workshop on National Health Research Systems hosted by the Thai Health Research Forum Cha-am, Thailand in March 2001** (and supported by GFHR , COHRED and Rockefeller Foundation) This conference, attended by **46 participants from 16 countries** including from **Africa, Asia and Latin America** had the objective (as a follow up to the Bangkok 2000's recommendations) of examining "national health research system as a concept, and to explore ways in which such systems could be strengthened to better address national priorities. The workshop came up with the definition for the health research system, a conceptual map for describing it and strategies and actions that might strengthen health research systems. **-Analysis of the National Health Research Systems** With **WHO** taking the lead a number of activities has been initiated to analyse the performance of national health research systems. A methodology is being developed through an **interregional consultative meeting held in Kuala Lumpur in July 2002**. This methodology will be used by countries to analyze their own strengths and weaknesses and to design the next steps in research capability building. This methodology is being finalized and should be ready for **pilot testing** by November 2002 It is envisaged to **scale up the involvement to 45 countries** by February 2003 and to have full implementation by 2004. The information gained from the application of this tool of self-assessment for countries will be a key content of the 2004 World Health Report. **-Brazil** will organize a landmark **"National Conference on Science and Technology in Health in 2003**. This idea was mooted at the XI th National Health Conference held shortly after the Bangkok Conference which had a catalytic effect in stimulating this initiative in the right direction **-Uzbekistan:** The experience of **COHRED** in stimulating the formation of a **national ENHR network in Uzbekistan**, involving some **80 national organizations,** which brought to fruition a new paradigm of an **inclusive process** for consensus, certainly augurs well for the future of the democratization of issues affecting the community. It was also 'ground breaking' in that the event was **funded mostly with resources raised from the private sector locally.**

		-**Philippines**: **National Health Research System Working group has been formed and is making a TOWS (threats opportunities, weaknesses, strengths) analysis** in the various aspects of their health research system, involving all important stakeholders.
Strengthen national governance structures.	-This is also part of the development issue of **COHRED's** country plans -The Tanzanian National Health Research Forum, established in 1999 serves as a role model for similar initiatives in other countries especially in Africa	-Countries which have been supported are **Iran, Bolivia, Colombia, Uganda, Nepal, and Azerbaijan.** -One or two countries in Africa are looking at this model for adoption **-Bangladesh**: ENHR Bangladesh with COHRED has taken **an initiative to form a National Health Research Forum**, with the Organization of a meeting in Dhaka where the key stakeholders participated including the chair of COHRED **-Cuba** organized in October 2002 its **Citesa-Habana conference of science and technology** which, while showcasing Cuban advances and opportunities in science and technology also provided **networking potential for participants from other agencies and countries.** It was supported by a number of International initiatives. The opportunity was also availed upon to take another step forward the **move to create a Latin and Central American Health Forum.** **-Thailand: governance structure for national health research system has been passed through legislative bodies** and has been provided for in **the draft National Health Act**. -South Africa: there is a proposal for a new health act, which proposes to make the existing ENHR committee a statutory body.
Involve all stakeholders in a National Health Research Forum.	❑ This has been the guiding principle in the setting up of the National Health Research Fora that are supported by COHRED	- **Lao PDR:** A **National Council of Sciences** has been officially established including proper representation for stakeholders in health research -Philippines: The Health research for Action National Forum is being conducted twice yearly involving various agencies presenting research with a national impact with the NIH also presenting main research findings to a national audience.

4. Financing

Bangkok Action Plan Recommendations	Activities initiated before Bangkok 2000	Actions undertaken to date (September 2002)
Allocation of 2% of national health budget and 5% of the health projects financed by foreign aid.		-See **Resource Flows Project Phase 2**, with joint efforts of WHO, COHRED and the Global Forum. There are **7 country case studies (Kazakhstan, Uzbekistan, Hungary, Cuba, Brazil, Cameroon, Burkina Faso) being supported by COHRED** with possibilities for others to join the effort. -**India**: the proposed **National Health Research Policy recommends that 1% of national health budget** be immediately be allocated for health research and be slowly be stepped up to 2%. **5%** of all projects funds financed by foreign agencies are allocated for research.
Establish a Central Planning Unit (with government, donors and NGO representatives) to monitor funding for health research to ensure it is aligned with national priorities.		-South Africa: a proposal that the ENHR Committee be given this task is awaiting approval from the government.
Negotiate with donors long-term funding of health research.		

ANNEXES

1. Bangkok Action Plan
2. Interim Working Party—Terms of Reference
3. Commission for Macroeconomics and Health: Investing in Health for Economic Development
4. Key Documents published since October 2000

BANGKOK ACTION PLAN

ACTION PLAN

ACTION PLAN ADOPTED BY CONFERENCE PARTICIPANTS

Recognizing that:

✿ The 1990 recommendations for strengthening health research for development made by the Commission on Health Research for Development have not been fully realized;

✿ the social, economic and political environment, as well as the organizational and institutional arrangements have changed over the last decade; and

✿ there is an opportunity to revitalize health research for development through concerted action:

the International Conference for Health Research for Development adopted the following framework for a Plan of Action in the context and spirit of the Bangkok Declaration (page 2 of the report).

Knowledge production, use and management

There was broad agreement that, in order to promote health equity, the health research for development system needs production of knowledge, of better quality, which is managed efficiently, and applied effectively to guide evidence-based policy and practice.

The specific actions proposed at each level include the following:

At national level:

✿ Systematic assessment of the quality of research output and processes.

✿ Wide dissemination of knowledge and its management based on the latest innovations in Information and Communication Technology.

✿ Dialogue for involving all stakeholders and communities in the knowledge cycle (production, use & management).

✿ Build capacity to raise ICT awareness, use of technology (e.g. search strategies), critical appraisal skills and technical support.

✿ Disseminate & apply research synthesis results to improve health care practice.

✿ Strategies for communication of knowledge at different levels to various stakeholders.

✿ Increase support for national burden of disease (NBD) studies.

✿ Develop national research policy and program for occupational health, including research priorities.

✿ Promote multi- and inter-disciplinary health research.

At regional level:

✿ Identify gaps in knowledge.

✿ Establish regional clearing house/database on human and institutional resources, projects, funds, and best practices.

✿ Establish networks for data exchange.

✿ Develop sustainable regional organizations to promote and support health research.

✿ Promote and enhance existing regional mechanisms e.g. WHO Collaborating Centers.

✿ Promote South-North and South-South collaborations in the following priority areas (non exhaustive) : road traffic accidents, traditional medicine, malaria, tuberculosis.
✿ Promote publication of regional health research journals.

At global level:

✿ Promote the role of universities in health research
✿ Foster long-term public private partnerships to invest in health research
✿ Facilitate and support a global research initiative that encompasses the entire spectrum of sexual violence
✿ Advocate for research on child health during the World Summit on Children. Prepare by reviewing and synthesizing research on child health in the past 10 years, identify gaps and develop child health research priorities.

Capacity Development

Capacity development and retention is crucial in ensuring production of research of quality and excellence, efficient and effective management of research and its use; as well as better formulation of needs and demands through the participation of the intended beneficiaries.
The proposed action for each level include the following:

At national level:

✿ Research management and leadership training plans and programmes should be established. Funds should be designated for research capacity development in its broadest sense.
✿ Viable research careers should be developed where they do not exist.
✿ Capacity development efforts should include all stakeholders – communities, health care providers, researchers and institutions – but should primarily focus on institutional development.

At regional level:

✿ Existing models of regional collaboration should be studied in order to develop models of collaboration for research capacity-building specific to the region.

Action Plan

✿ Supranational organizations should advocate for political commitment to regional collaboration.
✿ Centers of excellence for regional capacity-building (universities, research institutes, etc.) should be identified and mapped.

At global level:

✿ Funding agencies should give priority to capacity development in support of national and regional activities.
✿ Capacity development should form an integral part of funding for research projects.
✿ Guidelines and practical tools are needed in support of management and leadership of research.
✿ Access to databases and literature is key in capacity development, particularly access by researchers/institutions to outside information. An international task force is needed to explore ways to facilitate such access.
The targets identified for capacity development are involving all the players – researchers, and research managers, as well as policy-makers, health care practitioners and members and institutions of civil society.
Furthermore, through a range of strategic partnerships, a specific set of actions must be directed at retaining research capacity in the South.

Governance

In order to have well-aligned global structures for effective health research for

development, we need a universal code of good practice, which can govern all practice, not just country specific efforts. Such codes should not only cover traditional bioethics of the research itself, but should also extend to the ethics of partnerships and of practice. A mechanism for monitoring and reviewing should guide all endeavours, along with some efforts in the international arena to advocate for more research flowing to those who deserve and need it.

At country level:

✿ All countries should take stock of the current state of their national health research system.

✿ Countries should move rapidly and purposefully to optimally configure, and then to strengthen, their health research governance structures.

✿ This should be undertaken with due consideration for the inclusive involvement of all stakeholders in health research; an inter-institutional National Health Research Forum (including representatives of civil society) could be an appropriate mechanism.

At regional level:

✿ A mapping of regional health research and capacity building initiatives is required.

Action Plan

✿ Efforts to develop an appropriate governance structure are increasingly called for.

✿ Autonomous regional Health Research Forums could be established, with a secretariat and board as appropriate. They should work in close association with WHO and other major development partners.

✿ The strengthening of regional structures and mechanisms should originate in countries' needs for cooperation.

At global level:

✿ A governance structure– one that should ensure a wide representation of actors from all levels, also including the private sector – is needed to promote a spirit of complementarity and partnership between various actors and stakeholders in health research for development.

✿ A proposed step to achieve this is the formation of a Working Party with representation from WHO, international initiatives such as COHRED and the Global Forum for Health Research, regional networks, national and international research institutions, the private sector and donors. It should be hosted by WHO but be independent of existing organizations and institutions.

✿ The mandate of this Working Party would be to address concrete global partnership and complementarity issues and to work out a proposal for a governance structure of the global health research system. Stewardship functions, initiated by the working party, could include ethical issues such as developing norms for ethical review committees in developing countries, the protection of intellectual property rights of researchers in developing countries, and the development of a code of conduct for N-S health research cooperation.

✿ The secretariat function for the Working Party would be organized by the sponsors of the IC2000. Its initial task would be to convene the first Working Party meeting to be held within the next few months.

✿ The proposed governance structure should be discussed at the next Global Health Research Conference, which would agree on a more permanent governance structure.

Financing

Adequate financial support from both international donors and development agencies, and national coffers, is needed. Proposed proportions to be allocated for health

research for development are 2% of national health sector budgets and 5% of all donor health sector development budgets, as recommended by the Commission in 1990.

At national level:

✿ Establish a Central Planning Unit as an inclusive process (NGOs, international donors, governments) to attract, coordinate, distribute and monitor funds ensuring that their allocation is aligned with national priorities.

✿ Negotiate to change donor behaviour (national and international) towards facilitating longer term funding investments in institutions as well as projects.

At regional level:

✿ Urge existing regional organizations, including organizations not focused on health, such as OPEC, to allot a percentage of their budgets to create a fund for health research.

✿ Allocation of funds should be based on regional priorities drawn from country priorities and determined by burden of disease, social and economical determinants, gender balance and social equity.

✿ Establish an electronic database for knowledge management to identify resource needs, track results and impact, and to leverage resources.

At global level:

✿ Explore the possibility to generate funds for health research through investing a percentage of international debt interest payments, or introducing a tax (1USD) on international travel.

✿ Urge international agencies to dedicate a percentage of their health sector allocations to support health research institutions in the South.

✿ Create endowments at international and institutional levels through strategic fund raising and stimulating private-public partnerships.

✿ Develop tools for the monitoring, use and impact of allocations at the global level to advocate for a change.

To build the coalition for health research for development and to facilitate progress with action, the conference proposed the following priority actions:

At the national level:

✿ The creation of mechanisms for inclusive involvement of all stakeholders in health research, such as national forums for health research

At the regional level:

✿ The creation of regional health research forums to serve as platforms for cooperation and collective research for development;

At global level:

✿ The creation of a working party hosted by WHO, and managed under the auspices of the International Organizing Committee for the Conference (comprising the World Bank, COHRED, WHO and the Global Forum).

The remit of this working party would be to review options for global governance and institutional arrangements through a management structure which will:

- Reflect the spirit of the Conference;
- Be representative of all global constituencies;
- Be independent; and
- Report to a global assembly.

✿ Regular convening of an international conference on health research for development ("more often than once a decade")

A specific proposal was that:

- A meeting be held every two to three years;

- Process and content of research be integrated;
- There be wide representation; and
- Other opportunities for complementary meetings be considered, such as through both face-to-face and other forms of communication.
This could provide an opportunity for assessing progress.

✿ Creation of a communication and feedback mechanism for the post-conference period. This will include a dedicated site on the Conference website for comments on, and contributions to, the Action Plan.

ANNEX 2

INTERIM Working Party was formed at Forum 5

At a meeting held during Forum 5 at Geneva in October 2001, it was decided that an interim working party (IWP) should be created from the existing nucleus of interested institutions. Proposals for the activities of the IWP included the following:

- Examine governance issued in the field of health research
- Serve as a platform for ensuring communication networking and feedback
- Suggest follow up actions in response to the recommendations made in the pre-Bangkok meetings and in the Bangkok action plan.
- Respond to current challenges, e.g. follow up on the recommendations of the Commission on Macroeconomics and Health
- Begin the planning process for the World Health Research Summit planned for 2004 in Mexico

Commission on Macroeconomics and Health: Investing in Health for Economic Development.

The Commission was established by the Director General of the WHO in January 2000 and was able to present her with their report in December 2001. The work of the commission has also to be viewed in conjunction with the Millennium Development Goals enunciated at the Millennium Summit of the United Nations in September 2000. The report in devoting a section to health research stated that a sound global strategy for health should also invest in new knowledge. One critical area of knowledge investment is operational research regarding treatment protocols in low-income countries. In general, country specific projects should allocate at least 5% of all resources to project related operational research in order to examine efficacy, the optimization of treatment protocols, the economics of alternative interventions and delivery modes and population /patient preferences.

There is also an urgent need for investments in new and improved technologies to fight the killer diseases. The commission therefore calls for a significant scaling up of financing for global R&D on the heavy disease burdens of the poor. Basic and applied research in the biomedical and health sciences in the low-income countries needs to be augmented in conjunction with increased funding aimed at specific diseases.

To help channel the increased R&D outlays, the commission endorsed the establishment of a new Global Health Research Fund (GHRF) with disbursements of around 1.5 billion USD per year. The fund would support basic and applied biomedical and health sciences research on the health problems affecting the world's poor and on the health systems and policies needed to address them. Another 1.5 billion USD per year of R&D support should be funded through existing channels. The Global Forum for Health Research could play an important role in the effective allocation of this overall assistance. To support this increased research and development, the commission advocated the free Internet based dissemination of leading scientific journals thereby increasing the access of scientists in low-income countries to a vital scientific research tool.

In summary the Commission calls for increasing R&D in six major ways:

- 1.5 billion USD in annual funding through a new Global Health Research Fund for basic biomedical and health research
- 1.5 billion USD additional funding for existing institutions such as TDR, IVR, HRP and a number of private/public partnerships for various diseases
- Increased outlays for operational levels at the countries level, equal to at least 5% of country program funding
- Expanded availability of free scientific information in the internet
- Modification of the orphan drug legislation in the high countries to include the diseases of the poor and
- Precommittment to purchase targeted technologies such as vaccines for HIV/AIDS

ANNEX 4

KEY DOCUMENTS

1. Conference Report, International Conference for Health Research for Development, Bangkok, 10-13 October 2000
2. Measuring expenditure on Health –related R&D, OECD 2001
3. 10/90 Report, Global Forum for Health research, 2002
4. Monitoring Financial Flows for Health Research, Global Forum for HealthResearch 2001
5. Macroeconomics and Health: Investing in Health for Economic Development, WHO 2001
6. Millenium Development Goals from the Millenium Declaration, United Nations, 2001
7. Challenging Inequities in Health, from Ethics to Action, the Rockefeller Foundation and the Swedish International Development Agency, 2001.
8. SEARO: Strategy Development of Health Research Systems
9. The Utilisation of Health Research in Policy Making: Concepts, Examples, and Methods of Assessment, HERG Research Report Series No 28

Policy Health Research in Egypt: Lessons and Recommendations

By

Hoda Rashad*

Introduction:

The Arab Human Development Report of 2002 (UNDP, 2002) identified three basic internal challenges that undermine human development: freedom deficit, gender inequality and knowledge gap. In terms of the knowledge challenge, the introduction to the report states that Arab countries need to embark on rebuilding their societies on the basis of: "The consolidation of knowledge acquisition and its effective utilization. As a key driver of progress, knowledge must be brought to bear efficiently and productively in all aspects of society, with the goal of enhancing human well being across the region." (p. VII).

The discussion in this paper is very attentive to this challenge. It focuses on one field within the knowledge challenge and on the experience of one Arab country. It addresses "Policy Health Research in Egypt". The question being asked is: Has social science research in the field of health in Egypt been utilized to shape and guide policies? The objective is to build on one country experience - which we believe is not atypical of experiences in other developing countries – to draw more general lessons and recommendations.

The intention is not to be comprehensive and inclusive of all research efforts that might have individually contributed to policy, but to adopt a more macro approach which seeks to chart the overall directions of research, the utilization of findings, as well as key forces influencing both the choice of research agenda and its contribution to development.

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The discussion of policy health research in Egypt needs to be situated within two introductory remarks. The first argues for the false dichotomy between basic research and policy research. The second discusses the opportunities for integrating research and policy.

a) Dichotomy between Basic Research and Policy Research

The dichotomy centers around the definition quoted in Miro and Potter (1980) that "basic research aims chiefly to uncover truth, policy research seeks to aid in the solution of fundamental problems and in advancement of major programs" (Etzioni, 1971; 8).

This definition should not carry a value judgment on the relative relevance of each type of research. The discussion warns against confusing purpose with merit. Such a confusion runs the risk of over emphasizing narrow boundaries of policy research and producing ill advice to policy makers.

Policy research that is narrowly defined produces answers to already formulated questions but does not challenge the existing paradigms within which such questions were framed. Narrow policy research follows the question not the issue of concern.

Furthermore researchers need to undertake basic research to discover the truth before they are capable of guiding policies. Basic research should be seen as a step in a longer process of developing expertise and depth, not as a waste of energy and resources.

Among the two contrasting positions discussed in Miro and Potter (1980), this section argues strongly for the second. The positions are: "In stark contrast to those who advocate and defend policy research as a distinct and special activity are those who argue that what is needed for good policy is, simply, "good science." In this view, bad science carries a large portion of the blame for bad policy and, what many be equally injurious, over zealous superficial

policy analysis produces a lack of trust among decision-makers, greatly reducing the potential relevance of any research, good or bad". p. 422

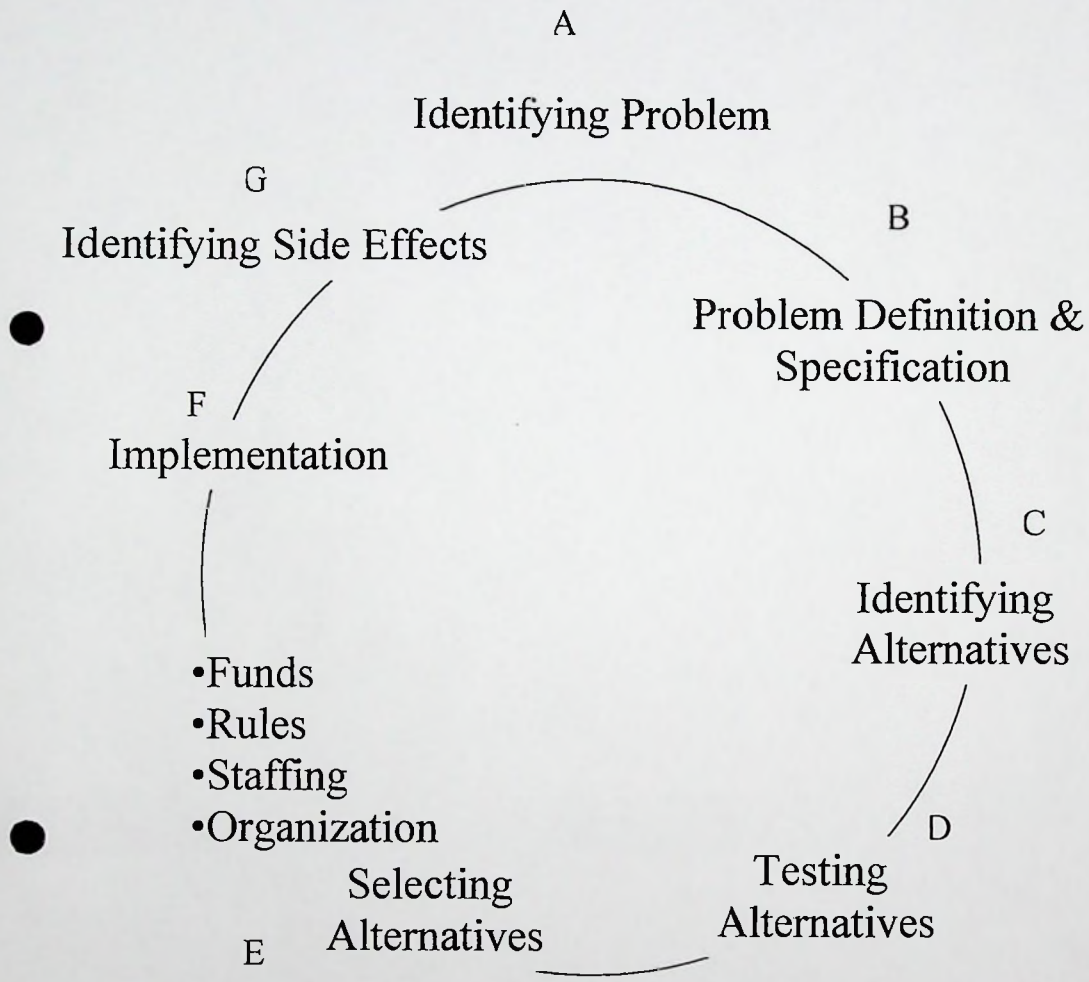
b) Integrating Research and Policy

The call for appreciating the importance of basic research is fully aware for the need to better integrate research and action. The multitude of entry points of policy research contrasts with the weak integration between research and policy in developing countries.

The following diagram details the policy and implementation cycle and illustrates the number of entry points for research in the policy and implementation cycle, namely:

1. The choice of the problem (A)
   Descriptive research on the magnitude and consequences of certain issues contributes both to advocacy and the prioritarization of the challenge.
2. The conceptualization and specification of the nature of the problem (B)
   Analytical research is quite valuable into identifying the underlying determinants and how they influence the issue of concern. Such research refines the theoretical conceptual framework and contributes to a better understanding of the interactive forces governing the issue of interest. Such an understanding guides the formulation of policies and the interventions adopted.
3. The appraisal of alternative approaches or programs for dealing with the problem (D)
   This usually comes in the form of operation research or pilot interventions.
4. Monitoring the implementation and its side effects. (G)
   Monitoring and evaluation research are used to modify the course of action and even the choice of the problem.

Policy & Implementation Cycle



A- Policy Makers, Practitioners, and Researchers.
B- Researchers & Practitioners.
C- Planners (Social Engineering).
D- Researchers & Practitioners.
E- Policy Makers.
F- Administrative Design & Practitioners.
G- Practitioners & Researchers.

Source: copied from an oral presentation made by Dr. Saad Nagi (1997).

It should be observed, though, that while both researchers and policy makers can do a better job at integrating research and action, it is nevertheless equally true that the policy making process does not always lend itself to an objective scientific rationalization. Powerful pressure groups as well as lack of societal accountability are key constraints on such integration.

The following section reviews the evolution of policy health research and its contribution to policy in the Egyptian context. The review will illustrate the danger of over emphasizing narrow boundaries for policy research. It will also recognize the relatively recent positive changes in health policy research, as well as identify key features for sound policy research.

Evolution of Policy Research

The following section suggests three distinctive stages of integrating research and policy in Egypt. These stages may be described as:

I. **From Policy to Research**
II. **From Research to Knowledge**
III. **From Knowledge to Policy**

I. From Policy to Research

a) Family Planning and more Family Planning

During late seventies and early eighties, population growth in Egypt was identified as the central development challenge. Policy research during this period confined itself to investigating fertility and family planning related issues. The term population research has come to be equated with fertility and family planning research, excluding all other social and health issues. Policy research during the period was not only narrowly defined in term of boundaries, but also in term of disciplines contributing to it. Demography blossomed as a policy science, while health policy research was barely visible.

The limited role of health policy research cannot be justified by the substantive focus of the agenda. Indeed fertility and family planning are topics that easily lend themselves to a wide array of health related questions. For example: Contraceptives' side effects, quality and models of service delivery, maternal and child health. So what explains the limited role of health policy research?

The narrowness and exclusiveness of policy research are simply explained by the nature of funders, the influence of policy makers and the absence of a supportive research environment.

In a country where research does not receive adequate national funding and where universities do not define and adopt coherent research programs, it was natural that researchers found an opportunity in the abundance of funding and the listening ears of policy makers.

The two key ingredients of funding and an interested audience produced a number of positive results. First and foremost research was used to advocate for policies. It demonstrated the consequences of continued high population growth and argued for the need to adopt population policies. Furthermore, it provided the family planning establishment the needed information for decision-making. The knowledge – Attitude – Practice (KAP) surveys were in particular an instrumental tool in filling a major knowledge gap in this area. Most importantly, policy research allowed monitoring and evaluation of effectiveness and impact of family planning programs. Egypt was among the many developing countries that took part in the World Fertility Survey. Indeed, fertility surveys furnished the needed data to address key policy questions and were used extensively for that purpose.

b) Family Planning and Child Survival

The abundance of demographic and social data and the research movement that accompanied it introduced major methodological refinements in the collection and analysis of data. It also improved the existing information on mortality levels, differentials and determinants. The experience of fertility surveys had demonstrated the crucial role of these surveys in filling the information gap, and also introduced the high mortality as an additional development challenge.

The adoption of child survival initiatives (particularly immunization and oral rehydration therapy) introduced a window of policy research on health issues. Fertility surveys soon expanded to demographic and health surveys. These new family of surveys continued to retain the traditional focus on family planning but allowed add on modules on breast feeding patterns, immunization as well as management of diarrhea and acute respiratory infection. Some of these surveys also included anthropometrics and disability modules.

c) Policy Research or Research Politics

The two main contributions of policy research - during the early seventies and eighties - were to provide the needed information on how things are and how they are going. Providing information on the level and trends of fertility were instrumental in guiding policy makers on how effective are their policies and whether more policies were required. Furthermore, the improved data base on mortality levels and differentials advocated the need for action and guided the child survival interventions.

Despite the many positive contributions of research, one need to emphasize that research during the period, only managed to provide information to serve policy makers not the knowledge to guide them. Research was introduced after the problem was identified, predefined and alternatives decided. The first three entry points (A, B, C) in the

research and policy cycle were given a priori. The high population growth was the challenge and family planning the only alternative. Research was needed to demonstrate the challenge and to implement the solution.

Donor funding, that is so valuable for research in developing countries, not only defined the paradigm of action but also narrowly defined what is worth researching and what are the relevant questions. The macro-level demographic rationale shaped the agenda and the questions followed naturally. Indeed Warwick (1994) in discussing the politics of research on fertility control quotes two leading critics (Paul Demeney and Julian Simon) of the influence of policy on research:

> "[S]ocial science research directed to the developing countries in the field of population has now become almost exclusively harnessed to serve the narrowly conceived short-term interests of programs that embody the existing orthodoxy in international population policy....Invoking the supposed urgency of the problems it is trying to solve, the population industry professes no interest in social science research that may bear fruit, if at all, the relatively remote future. Equally, it disdains work that may be critical of existing programs, or research that seeks to explore alternatives to received policy approaches. It seeks, and with the power of purse enforces, predictability, control, and subservience. (1988:470-471)

Julian Simon is harsher, labeling as "corruption... the nexus of connections among research funding, individuals' perquisites, individual and institutional decisions about research topics to pursue, choices of people to hire and invite, emphasis placed upon various findings in the research, and sometimes the research conclusions themselves (1990: 39-40)". (quoted in Warwick (1994: p. 180).

II. From Research to Knowledge

The family planning and child survival research movement produced two unintended effects: abundance of rich sets of data as well as analytical

expertise in handling such data. The opportunity now existed for broadening the research agenda.

Self-selection and opportunities in field of intellectual inquiry are not the only stimulus for research, funding and a supportive environment are badly needed. These pre-requisites were made possible through the introduction of an innovative regional research awards programs administered by the Population Council and funded by Ford Foundation, IDRC and others. MEAwards program was introduced during eighties and provided a breathing space for researchers pursuing substantive issues beyond the immediate concerns of policy makers. It provided funding to researchers through an open competition that emphasized quality of proposals and competence of researchers. It also allowed networking among bright young researchers searching for a paradigm shift. Within this program, the regional working group on "Child Survival, Reproductive Health and Family Resources" was established in late eighties. The concern with reproductive health was introduced and conceptualized by national researchers, the first community study was conducted, and ammunition existed for reorienting health policies in Egypt (Khattab, 1999). Indeed, regional scholars were no longer passive recipients of policies decided internationally but were contributing players in defining priorities. A paradigm shift was slowly evolving and the International Conference of Population and Development (ICPD, 1994) simply added the international endorsement to a nationally conceived priority.

III. From Knowledge to Policy

The paradigm shift of the mid nineties was not just an expansion of a substantive focus but more importantly an approach. An approach with open borders that allowed an individual lens in defining the research agenda. The population growth challenge was redefined as achieving reproductive intentions, and the population concerns encompassed a wide array of issues ranging from reproductive morbidities to empowerment of women.

The open borders and the individual lens, called for other expertise and other tools of analysis. Demographers and economists that dominated the field with their studies on the links between growth and macro development turned to other health and social disciplines to share their expertise in measuring ill health and understanding the parameters of individual actions. Furthermore, qualitative and microanalaytic studies of communities and individuals became as indispensable as large surveys in providing the information base. More importantly, the sharp divide between researchers, civil society and policy makers is being blurred. The following examples illustrate how the research field and players have been so dramatically changed.

a) Maternal Mortality: Research Guiding Action

The Ministry of Health in Egypt pioneered two national maternal mortality studies. It drew on international research expertise and foreign funding to conduct a maternal mortality survey during 1992/93. The survey not only documented high level of maternal mortality (184 per thousand) but also specifically identified preventable causes that are within the responsibility of the health sector. A number of interventions were adopted and a recent survey (2000) showed both a considerable decline in maternal mortality in Egypt as well as the need for more action.

Two key features of this example are the full participation of MOH in the research and the quality of research being conducted. The first feature facilitated the ownership of the research and the acceptance of responsibility, while the second ensured the relevance of findings.

b) Health System: Research Advocating Action

The Ministry of Health in Egypt hosted the Data for Decision Making (DDM) project. Another foreign funded activity (USAID) with expertise from Harvard University, aimed at providing better evidence on health and health systems. A particular contribution of this activity is the information it provided on national health accounts and out of pocket health expenditures.

The information contributed to building constituency for reorienting health policies and the call for more fair reallocation of resources. Indeed the Health Sector reform movement, in Egypt, has used this data as ammunition for action.

c) Consequences of Health Sector Reform: Research Modifying Action

The civil society and research centers in Egypt are playing a major role in protecting the vulnerable. They document the disparities between social groups, the impact of privatization and structural adjustments on the poor and the clustering of social and health problems.

On the health front, they advocate for the importance of the inclusion of essential health services (including reproductive health) in primary health care, and the need for gender and social sensitive safeguards within health sector reforms.

A joint activity between a civil society organization (Egyptian Society for Population Studies and Reproductive Health) and a research center (Social Research Center of The American University in Cairo) is being conducted (with funding form Population council and Ford Foundation) to monitor and evaluate impact of different models of reforms on women health. The MOH is collaborating in this activity.

d) Situation Analysis: Informing Strategies for Action

Another area of research that is proving very valuable for policy is the number of analytical reports being commissioned to assess the nature of challenges and inform policies. These reports provide the basis for adopting comprehensive country strategies and for targeting donor funding.

These reports have a number of key features that allow them to be quite influential. First, they are sponsored by a prestigious international body (World Bank, UNICEF, Population Council, UNDP, ...); they are endorsed

and spearheaded by an influential national body (National Council for Women, National Council for Childhood and Motherhood, consortium of research centers, ...) and they involve a participatory process where a large group of researchers and action groups form the core group of authors.

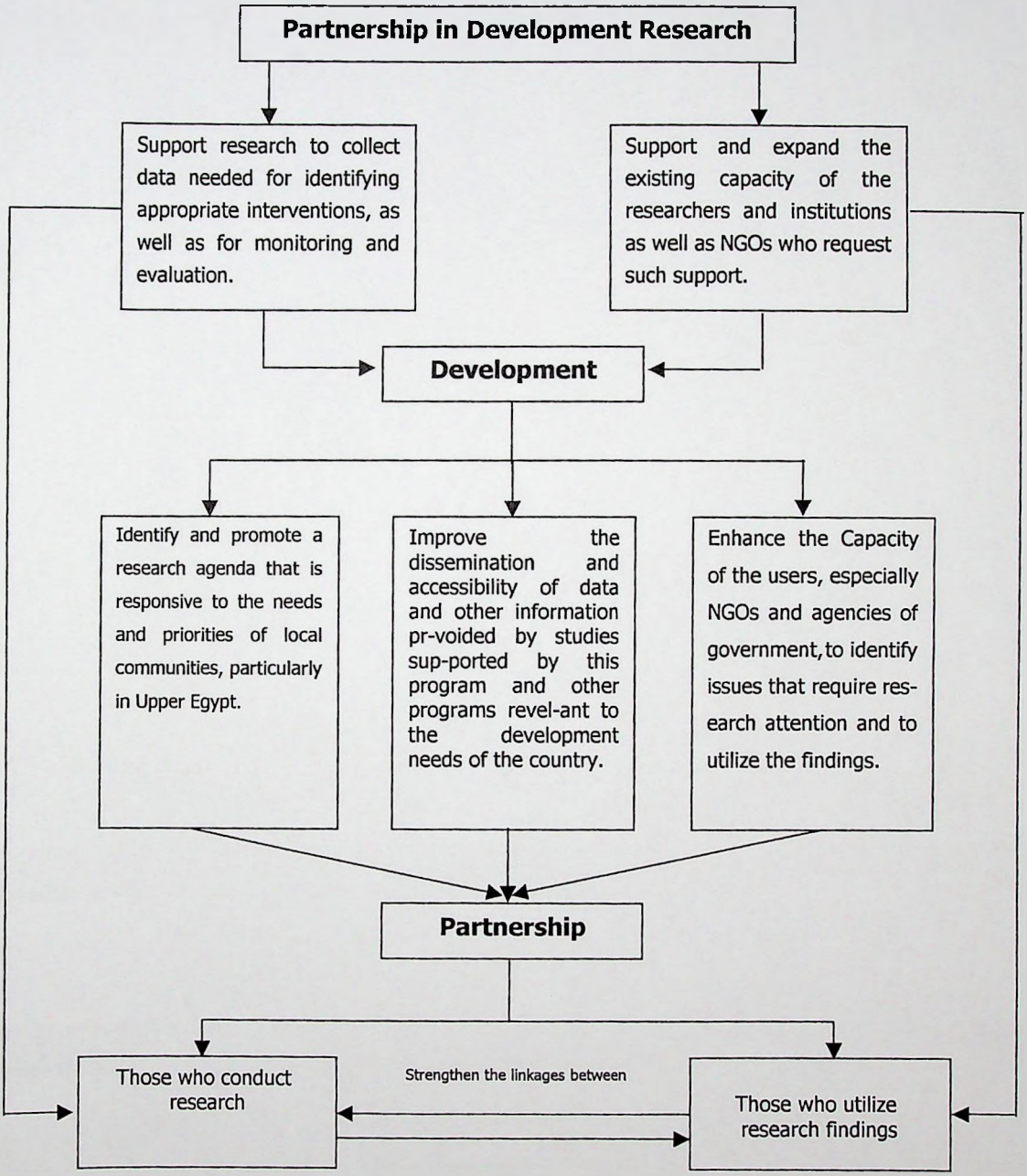
An example of these reports is "Situation Analysis of Children in Egypt" which is the base for programmatic action between UNICEF and Egypt. The report as stated by National Council of Childhood and Motherhood (NCCM) Secretary General: "A candid assessment of the situation of Egyptian children and women, an assessment not driven by illustrating the achievements, but rather motivated by highlighting the outstanding challenges and the ways to overcome them in the new decade" other examples include. "A country Gender Assessment" and "Transitions to Adulthood: A National Survey of Egyptian Adolescence".

e) Partnership in Development: Building Bridges

The Egyptian program entitled "Partnership in Development Research" was established in 1999 as part of an international program funded by the Netherlands Ministry of Foreign Affairs. The objective of the program is to inform development policies and strategies through linkages between those who conduct research and those who utilize its findings. It aims to enhance research capacity, to improve research quality, and to ensure that the findings are utilized. To this end, the program promotes a research agenda that is responsive to the needs and priorities of the local communities, particularly those in Upper Egypt, and to the needs of marginalized sectors of the population.

The Egyptian program is characterized by its multidisciplinary nature, its demand driven research responding directly to questions of relevance to local communities, and its geographical orientation towards relatively disadvantaged areas of Egypt.

The program has been conceptualized and is supervised and coordinated by an independent body of distinguished Egyptian experts and researchers. This group constitutes the Advisory Board, and from which the Steering Committee is elected The Social Research Center of the American University in Cairo Undertook the responsibility for implementing the program.


Partnership in Development Research
Support research to collect data needed for identifying appropriate interventions, as well as for monitoring and evaluation.
Support and expand the existing capacity of the researchers and institutions as well as NGOs who request such support.
Development
Identify and promote a research agenda that is responsive to the needs and priorities of local communities, particularly in Upper Egypt.
Improve the dissemination and accessibility of data and other information pr-voided by studies sup-ported by this program and other programs revel-ant to the development needs of the country.
Enhance the Capacity of the users, especially NGOs and agencies of government, to identify issues that require res-earch attention and to utilize the findings.
Partnership
Those who conduct research
Strengthen the linkages between
Those who utilize research findings

The program is starting to bear fruit. For example a recent study on "Street Children" resulted in the creation of a network of a number of NGO's concerned with Street Children. The purpose of the network is to combine efforts to find solutions to minimize this phenomenon. This network of organization will work directly (for the first time) with the government departments of the concerned ministries, i.e. Ministry of Interior (Delinquency Department), Ministry of Social Affairs, Ministry of Health and the National Center for Sociology and Criminology. Together they will all organize their efforts to have an integrated plan for dealing with street children.

The network is also expected to expand thus creating a spiral group of NGO's interested in this area.

Pre-requisites for Policy Research

The examples of positive contributions cited in the previous section guide towards a discussion for pre-requisites for policy research.

Good science with research and policy partnerships are ingredients for sound policies. These ingredients ensure a two way directions, whereby policy makers appreciate the role of knowledge and call on researchers to serve their needs, while researchers realize their potentials and utilize their skills to both answer already for mulated questions and also pose new ones.

Good science and partnerships need funding, supportive environment and an open society. Funding is crucial. It has the power to introduce programs and influence the content of research. Funding must play a conscious role in building bridges, institutional capacity and ensuring openness and transparency.

Supportive environment is a nurturing and a capacity building environment. It provides the breathing space for paradigm shifts and the academic freedom to accept differences.

An open society allows the policy watch role of civil society and academia to flourish. It pushes to the forefront of attention the need for action, the price of inaction and the side effects of reform actions. Most importantly, an open society is an accountable society where policy makers answer to the public not to individuals or power groups.

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What are the appropriate criteria for setting priorities in health? A pilot study of some stakeholders in Uganda

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Abstract

Abstract

Objective: To explore some stakeholders' values and criteria for priority setting in the health care sector in Uganda.

Methods: Ten group discussions (n=61) and survey (n= 413) in four districts in Uganda. Participants included health workers, planners, patients and the general population from four districts. Template analysis was done for the discussions. The survey data was analysed using SPSS.

Findings: Most of the respondents (>90%) supported the consideration of disease related criteria but there was marked lack of support for considering patient related criteria. The least supported criteria (< 50%) were political view, patient's power and influence, and religion. Criteria supported by most respondents included age, treatment costs, cost-effectiveness of intervention, severity of condition and equity of access. There was marked overlap between the criteria proposed by the group discussants and the survey.

Conclusions: Respondents supported the consideration of all the disease related and some societal criteria, thus qualifying them to be the necessary criteria in priority setting. Most of the patient related criteria are contentious, requiring debate. Religion, power and influence and political view are unacceptable criteria. These results contribute to informing debate on people's values for priority setting in setting with extreme resource scarcity. There is need for more such studies to inform priority setting processes.

Introduction

Because no health system can afford to pay every service it wishes to provide, priority setting is one of today's most important health policy issue. More so since the gap between health care and the supply of resources allocated to finance it necessitates painful decisions whose consequences are bound to be unfortunate for someone or other *(3,4)*. The absence of simple or technical solutions to priority setting makes it crucial for countries to develop an appropriate information set for priority setting in health *(1,2)*. Priority setting requires transparent approaches, with more explicit debates about principles and criteria used in health care resource allocation decisions *(5,6)*.

The literature on resource allocation in health uses priority setting and rationing inter- changeably *(7)*. However, priority setting can be defined as distribution decisions involving clear and direct limitations of access to beneficial care or just simply, a process of determining how health care resources should be allocated among competing programmes or people *(8,9,10)*. Williams, *(11)* also defines priority setting as who gets what and at whose expense. The what can either be donor organs, health worker time, laboratory procedures or most commonly, money *(2, 12, 13)*. Priority setting represents a complex interaction of multiple actors and occurs at various levels *(5)*.

Although there is a growing interest in research on priority setting, there still remains the question of the best way of doing it. Different approaches have been

proposed, ranging from guidelines, checklists, and minimum packages to explicit criteria *(4,14)*. For the developing countries, the Burden of Disease (BOD) and cost- effectiveness approach has been recommended (15). In addition to epidemiological data, BOD incorporates societal preferences on the value of future health and the value of a healthy life lived at different ages, and disability weights (16). While its robustness is appreciated, some have pointed out that the approach may not account for some important societal concerns and that some of the values used may not be acceptable to all (17,18).

Many argue that societal concerns of equity, and distribution of benefit, among others, need to be included in priority setting in health *(11, 19, 20)*. Singer, *(21)* has proposed that legitimacy and fairness should be considered in priority setting. To add legitimacy to their decision-making, Van der Grinten *(22)* and Nord *(23)* emphasise the need for measuring people's ethical preferences.

Several studies exploring societal values of relevance to priority setting in health have been carried out *(11,12,19,24)*.

The literature on priority setting discusses several criteria and values. The list is long: In a study done by Nord in Norway, such as equality of entitlement, seriousness of illness, cost-effectiveness, and benefit of the intervention outcome were though to be important *(23)*. In Sweden, the health of children and parents

of young children was given priority, indicating a consideration of age and responsibilities *(11,26)*. Furthermore lifestyle and a concern of equity were also considered important *(12)*. Potential effects of treatment on the patients' life expectancy, human dignity, solidarity and efficiency are additional proposed considerations *(11,13,21)*. Ubel found that urgency, level of family support, capability, religion, citizenship, race, family size and criminal history were considerations proposed by some respondents *(19)*. Costs, equity, survival capacity, number of people benefiting from an intervention, are additional criteria *(8,19,27)*. Furthermore, Griffiths defines some unjustifiable values such as social position, financial status, area of residence, and those that do not justify discrimination, namely, age, employment, lifestyle and learning disability *(28)*.

To the best of our knowledge, most of these studies have been carried out in developed countries. Such countries often use approaches and address problems that may be far removed from the realities in low-income countries *(25)*. Low-income countries are not only faced with extreme lack of resources but may have varying cultural values and other local realities, which may influence their choice of criteria for priority setting.

Study objective

The objective of the study was to establish the stakeholders' values and criteria for setting priorities in the health sector, in Uganda.

Methods and materials

The study consisted of group discussions and a survey.

The group discussions

The aim of the group discussions was to identify criteria and considerations without giving the discussants any cues or options.

We carried out ten group discussions (n=61). The group discussions involved health workers, administrators, patients and some members from the general public. Each group had 4-8 adults (Table 1). These were asked what they felt should be considered when setting priorities in health. No cues were given. After a brainstorming session, they ranked the values in order of relative importance. All discussions were audio-recorded.

The audio-recorded discussions were transcribed and translated. The emerging themes with regards to what the discussants thought ought to be considered when setting priorities in health were identified and grouped according to the theoretical framework. Since we didn't find any differences between the groups on analysis of results from the different districts, the groups were merged (to reflect their characteristics rather than district of origin). Hence we had: the chronically ill patients' group (HIV and hypertension), the Administrators' group, the outpatients' group, the general population's group and the health workers' group which we used in further analysis, to explain the survey data.

The survey

For purposes of the survey some of the key criteria and values identified from the literature were organised to reflect patient-, disease- and societal related criteria.

i) **Patient related attributes** - age, area of residence, social status, gender, religion, power or influence, mental features, responsibilities, physical capabilities and lifestyle responsible for cause of condition.

ii) **Disease related attributes** - treatment costs, benefit of intervention, cost-effectiveness of intervention, severity of condition and quality of available data on cost- effectiveness of intervention.

iii) **Societal related attributes** - Equity of access, community view, and political view.

These were presented to the respondents, in this study, as options in response to the statement:

In my opinion, the following should be considered when setting priorities for health in Uganda.

Responses indicated the degree of their agreement with the statement on a six-point scale: strongly agree, agree, neutral, disagree, strongly disagree and don't know.

The developed questionnaire was self-administered and respondents were from the ministry of health, the teaching hospital and four purposefully selected districts, for regional representation (Table 2). Respondents included a sample of purposefully identified health planners and workers, at the national and district levels, and representatives from the general population. A similar pattern was followed at the district level. Details of the respondents are summarised in Table 2. Respondents were reminded three times, after which, none response was registered.

Survey data were analysed using SPSS- version 6.0.

Using three cut-offs:

- >80% of the respondents agreeing = the necessary criteria (recommended by most literature)
- 50-80% agreeing = the contentious criteria (has substantial discussions)
- < 50% agreeing = the unacceptable criteria (un-defendable) for priority-setting, we derived a Uganda priority setting criteria matrix.

Furthermore, the independent variables and the responses were dichotomised for Chi-square tests. The six point range of possible responses were re-coded as: strongly agree and agree = agree and the rest (neutral, disagree, strongly disagree and don't know) = disagree.

Results

Both the discussants and survey respondents agreed that all disease related attributes are important in priority setting, while patient related attributes were rated less important.

Group discussion findings

Table 1 shows the characteristics of the group discussants.
(Table 1)

Most of the discussants mentioned severity of the disease, cost of care, and number of people affected as important for priority setting in Uganda. Other frequently mentioned values included availability of effective treatment, condition affecting children or the vulnerable (Table 2). These were also ranked high. The health workers', administrators' and the HIV groups were the only groups that mentioned benefit of the intervention, political view and conditions that are difficult to manage, respectively.
Additional values included, if condition affects development, consequences of the problem like the social consequences and if it is prone to becoming an epidemic, and ease of intervention. Most of the values mentioned were disease related.

(Table 2)

On ranking the values in order of perceived importance, all the groups except the administrators' group ranked severity of the disease highest (Table 3). Equity, although mentioned by most of the groups, was ranked relatively low. The rank order varied between groups. While cost of care was ranked high for the chronically ill group, health workers and administrators, it was ranked the lowest by the general population group and not mentioned at all by the outpatients' group. Furthermore, the administrators ranked severity lower and availability of effective treatment high relative to the other groups.

(Table 3)

Survey findings

The response rate was 67.7% (n=413). The majority of the survey respondents were health workers, working mainly at health sub-district level. Non-health workers accounted for 28% of the study population (Table 4). The mean age of the respondents was 30.4 years. Most of them (86.9%) considered priority setting in health as part of their regular work.

(Table 4)

In response to the question about considerations for priority setting, the majority of the respondents strongly agreed with all the disease related criteria. There was also a general agreement with the societal attributes apart from political view

(Table 5). However, there were wide variations in the responses for the patient related attributes, with the percentage of respondents agreeing ranging from 91% (for age) to 28% (for religion and power and influence).

(Table 5)

Using the matrix for analysis, all the disease related attributes are under the necessary criteria while most of the patient related attributes are under the contentious criteria. The unacceptable criteria in the study (<50% agree) included religion, power and influence, and political view.

(Table 6)

We cross-tabulated the responses with the respondents' age, designation and whether or not they considered priority setting as part of their duties. We found statistical differences between the respondents characteristics and the proportion agreeing to the consideration of gender, social status, quality of available information, benefit of intervention, community and political view. Most of these were dependent on whether or not the respondent considered priority setting as part of their work. We present only statistically significant findings (p-value < 0.05).

(Table 7)

Discussion

Most of the values supported by the respondents are consistent with those found in the literature *(16,29)*. Survey respondents agreed to the consideration of all the disease related attributes but refuted several of the patient related attributes. The group discussants, although not given cues, mentioned many of the attributes used in the survey and those considered in the Burden of disease and cost-effectiveness literature (16). However, they also had additional values that we had not included in the survey. This enriched our findings. However, the approach has its limitations.

Our sample has an over representation of health workers. Although these may be considered legitimate representatives of the public's interests, we are limited in knowing what a representative sample of the general population would have preferred. Being self- administered, the survey results are limited by several weaknesses *(30)*. The respondents needed to have the ability to read and write. This, if used alone, would have biased the results to the literate population. However, the group discussions, which also involved those people who are unable to read and write supplement the survey. The approach used in the discussions, although un-standardized, helped us get values that we may have otherwise identified had we used only the pre-enlisted values.

Most of the discussants mentioned the disease-related attributes, for example severity of disease, was mentioned by all the ten groups, this was contrary to the patient related attributes. Conversely, religion and area of residence were not mentioned at all. Possibly the discussants do not consider them to be important, although we cannot rule out their failure to associate those attributes with priority setting in health.

Some groups mentioned values, which were not mentioned by the other groups. This may be a reflection of people's personal experiences. It is thought that people are inclined to think only of themselves when they think about health policy *(2)*. This may have introduced some bias but may also underline the need for involving as many interest groups as possible in priority setting, to enable open discussions.

The rank order of the values was somewhat similar across the groups except for the administrators' and the health workers' groups. Health planners and administrators ranked cost of care and effectiveness of treatment higher than severity of condition, contrary to the other groups. This may imply that health planners and administrators do not subscribe to Hadorn's *(31)* rule of rescue, where preference is given to the very sick. Conversely, they may have responded according to their experience with the hard choices that need to be made when setting priorities *(4,11,32)* and may also demonstrate the differences in concerns at the different levels of priority setting *(33)*.

The Survey respondents' supporting the consideration of all the disease-related attributes, and their lack of support for most of the patient and some societal related attributes, is consistent with the literature. However, the overt lack of support for the consideration of political view was surprising since, elsewhere, political view is considered to be important *(29)*. In case respondents interpreted this to mean the patient's political preference, their response is reasonable, although given that the administrators' group felt it was important, may be a reflection of differences in values at the different levels of priority setting.

Social status, geographical residence and in some instances gender, are important determinants of people's health *(34)*, these were, surprisingly, not considered very important by the survey respondents. While gender, residence and social status may not be important in more equitable societies, in societies, such as Uganda, where these influence the burden of disease and access to health services, they, indeed maybe important to consider for affirmative action *(20, 34)*.

Age, although considered unacceptable *(29)*, was supported by most of the respondents, which is consistent with some other literature (*36, 37*). Since no clarifying questions were given, it may be difficult to determine, from the survey, which age should be given priority. However, the group discussants explicitly pointed out that conditions affecting children should be given priority. This is

consistent with Ratcliff's findings with regard to organ donation *(12)*. However, it may also be a reflection of concern for the vulnerable, given that infant and child mortality rate is high, and that most diseases affect children.

The significant differences between health workers and administrators (people involved in priority setting), and the rest of the respondents (not "traditionally" involved in priority setting), is not surprising. It may be a reflection of their personal values or for those involved in priority setting, it just may as well have been a reflection of what is written in the health policy and is considered in priority setting at their level *(38)*.

The similarities between the agreed upon attributes and the proposals from the group discussions contribute to an understanding of what a sample of Ugandans value as criteria for priority setting. For example, the ranks given to the attributes from the group discussion almost correspond to the attributes to which more than 80% of the survey respondents agreed.

Comparing our matrix (table 5) with the criteria in the literature, there is substantial overlap on most of the attributes, with the exception of age. We find additional unacceptable criteria in the literature, namely race or ethnicity, sexual orientation and genetic background (*29*). While the latter two may not be relevant in the Ugandan context, race or ethnicity, although not included in this current

study, was found to be an important determinant of health in Uganda, and hence ought to have been included *(39)*.

Conclusions

We propose that the findings such as those we present in Table six are used to facilitate further debate on criteria and values.

Qualitative methods could help illicit locally relevant values, which can be tested for representativeness in quantitative surveys. This would assist in eliciting locally relevant criteria. Emphasis should be put on wide participation of relevant stakeholders.

This study sheds light on the values held by some stakeholders in Uganda. We are, however, aware that we did not consider all the relevant values and criteria, hence, there is need for more studies in developing countries to inform debates on priority setting, increase transparency, reduce suspicion and give legitimacy to planners' decisions.

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Table 1. The Group discussants

Kampala District (Urban) (n)	Kamuli district (Rural) (n)
Health workers (5)	Health workers (6)
Hypertension patients (6)	HIV patients (7)
Out-patients (5)	Out-patients (8)
Health planners (6)	Health planners (4)
General population (6)	General population (8)

Table 2: Number of groups supporting the proposed attributes

Disease related attributes	Patient related attributes	Societal related attributes
Severity (10) Number affected (9) Cost of care (8) Availability of effective treatment (7) Preventable (5) Effectiveness of intervention (4) Consequences of condition (3) Benefit of intervention (2) Ease of intervention (1) Conditions that are difficult to manage (1)*	Affects children (7) Affects the disadvantaged (7) Gender affected (4) Responsible for cause (1)	Equity (6) Community felt problem (5) Equality (3) Affects development (2) Political view** (1)

Key:

()= Number of groups that identified the attribute

*Only mentioned by the HIV group

**Only mentioned by district administrators

Table 3: Group ranking of the values proposed for priority setting

Ranks*	Groups				
	Chronically ill Patients	**General population**	**Out- patients**	**Health workers**	**Administrators**
1	Severity	Severity	Severity	Severity	Cost of care
2	Cost of care	Number affected	Number affected	Affects children	Effectiveness of treatment
3	Conditions that are difficult to manage	Affects disadvantaged	Community felt problem	Cost of care	Community felt problem
4	Equity	Affects development	Affects children	Number affected	Severity
5	Number affected	Ease of intervention	Gender	Availability of effective treatment	Consequences of problem
6	Equality	Community felt problem	Availability of effective treatment	Benefit of intervention	Ease of intervention
7	Availability of Effective treatment	Cost of care	Equity	Consequences of condition	Affects children
8	Person responsible for cause	Effectiveness of intervention	Preventable	Equity	Affects disadvantaged

* Only ranks up to 8 are presented.

Table 4: Demographic characteristics of the survey respondents (n= 413)

Characteristic	Frequency (%)
Age	
<25	7
25- 35	49
36- 45	33
46- 55	9
55+	1
Designation	
Medical doctor	33
Allied health worker	46
Administrator	7
Politician	2
Other	13
Level of work	
National	9
District	6
Health sub- district	51
Teaching hospital	16
UN	3
Other	14
Consider priority setting as their work	
Yes	88
No	12

Table 5: Respondents' degree of agreement with considering the following attributes for priority setting in Uganda (n= 413).

Attributes and values	% Responses					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
Patient's:						
Age	68	23	5	3	1	0
Area of Residence	40	33	13	10	3	0
Social status	33	28	17	15	6	1
Responsibilities	26	37	20	11	4	1
Gender	30	32	24	8	3	2
Religion	11	18	31	24	15	2
Power and influence	9	20	28	25	14	4
Mental features	25	33	19	12	5	5
Responsible for Cause of the condition	33	37	14	8	6	3
Physical capabilities	27	42	15	10	4	3
Disease/ condition:						
Treatment costs	62	25	8	3	2	1
Benefit of intervention	55	33	7	2	1	2
Quality of available evidence	52	35	8	1	2	3
Cost-effectiveness	64	26	4	3	1	2
Severity of condition	63	27	5	3	2	1
Societal:						
Equity of access	58	32	5	1	1	3
Political view	14	32	23	18	13	1
Community view	42	41	12	4	2	0

Row totals = 100%

Table 6: Priority setting Criteria matrix

Criteria	Patient Related	Disease Related	Societal Related
Necessary (> 80% agree)	Age	Benefit of intervention Quality of available evidence on benefit Cost- effectiveness of intervention Severity of disease Number of people affected	Equity of access Community view
Contentious (50-80% agree)	Area of residence Social status Responsibilities Gender Mental features Lifestyle responsible for disease Physical capabilities	-	-
Unacceptable (> 50% agree)	Religion Power and influence	-	Political view

Table 7: Differences in the responses according to respondents' characteristics*

Attribute	Respondents' Age(%)		Respondents' Designation(%)		Is Priority setting part of respondents' your work	
	<35	>35	Health worker	Other	Yes	No
Patient Related:						
Gender						
Yes	113(54.9)	109(72.7)**				
No	93(45.1)	41(27.3)				
Social status						
Yes			173(63.6)	34(49.3)***	190(62.9)	16(42.1)***
No			99(36.4)	35(50.7)	112(37.1)	22(57.9)
Disease related :						
Quality of Evidence						
Yes	163(82.7)	135(91.8)***			271(88.3)	25(88.3)***
No	34(17.3)	12(8.2)			36(11.7)	10(28.6)
Benefit of intervention						
Yes					272(89.5)	27(73.0)***
No					32(10.5)	10(27.0)
Societal related :						
Community view						
Yes	154(77.8)	132(88.6)**	235(84.5)	50(73.5)***	260(84.4)	24(64.9)**
No	44(22.2)	17(11.4)	43(15.5)	18(26.5)	48(15.6)	13(35.1)
Political view						
Yes			134(48.6)	22(31.9)***	148(48.1)	9(25.0)***
No			142(51.4)	47(68.1)	160(51.9)	27(75.0)

*Only significant results presented: **P-value significant at 0.01, *** P-value significant at 0.05

Community Directed Treatment (ComDT) with ivermectin: a control strategy for Onchocerciasis in Africa. A multi-country Study

By Martyn Teyha Sama, Principal Research Officer, Epidemiology, Institute of Medical Research, Cameroon

INTRODUCTION:

Onchocerciasis is an important public health and socio-economic problem in Africa where 99 percent of the disease burden is found. Onchocerciasis is a devastating disease that is the third leading cause of blindness in Africa. Eighty million people are at risk of infection; eighteen million people are actually infected; one million are sight impaired and more than 350,000 are blinded by this parasitic disease that has historically attacked the poor and voiceless populations in most rural areas of the twenty-seven countries in Africa (World Bank Report 1995).

Onchocerciasis is recognized as a major cause of blindness in the central and eastern parts of the savannah belts of the northern tropics, which cuts across major portions of Cameroon, Central African Republic, Chad, Nigeria and the Sudan. In this sub region, some 6.5 million persons are infected (WHO 1995).

Following the introduction of ivermectin in 1987, Onchocerciasis control became possible. The principal challenge for the control of onchocerciasis is to deliver annual single dose treatment to the population of high-risk communities, and to sustain the delivery for a sufficiently long period to bring about the control of the disease as a public health problem. Sustained drug delivery to all high risk communities is difficult to achieve through the regular health services which are already overburdened with other responsibilities and short of human, material and financial resources.

Community Directed Treatment (ComDT) with ivermectin has been very effective. ivermectin treatment is popular and communities have responded enthusiastically to the concept of community directed intervention in which they are themselves in charge of planning and implementation. The African Programme on Onchocerciasis control (APOC) has established Community Directed Treatment (ComDT) with ivermectin as the cornerstone of its control strategy. The adoption of the concept of ComDT with ivermectin using Community Directed Distributors (CDDs) by the African Programme on Onchocerciasis control is an important miles-stone in Ivermectin treatment. APOC policies are based on strong values focusing on enhancing equity and social justice by increasing access of all populations to essential treatment.

RATIONALE

Community directed treatment (ComDT) with ivermectin has been shown to be an effective strategy for drug distribution. The international community attention has been drawn to the need to share this strategy with other community based health programmes and in particular working towards sustainability of the programme.

The international community is very much interested in knowing whether and how ComDT could be an entry point or a vehicle for other community based health programmes. This study is to provide information to the international community on the use of ComDT strategy as a vehicle for other community based control programmes involving Community-Directed Distributors (CDDs).

The backbone of ComDT are the CDDs whose mechanism of selection is embedded in APOC's philosophy of Community-directed treatment (ComDT) with ivermectin. This philosophy depends on the values, norms, local culture, and practice of the endemic communities.

During ComDT, CDDs have been involved in other health and development activities; the main objective of this study is to document the various health and developmental activities in which CDDs were involved and to determine the impact of these activities on ivermectin distribution.

MATERIALS AND METHODS

OBJECTIVES:

The main objective of the study was to examine whether CDDs are involved in other health and development activities in their communities and determine the impact of their involvement on ivermectin distribution.

The specific objectives were:

1. To examine whether CDDs are involved in other health and development activities.
2. To document what health and development activities CDDs are involved in their communities
3. To determine similarities of their other activities to their tasks as CDDs distributing ivermectin.
4. To determine whether the selection of CDDs for other health or development activities by their community or health service is as a result of their performance as CDDs for ivermectin distribution.

STUDY AREA

The study was conducted in the following sites: South Western Cameroon, Zamfara State of Nigeria, Kisoro district in South Western Uganda, and Raja Province of Southern Sudan.

Accessibility in most sites was difficult; in Cameroon accessibility in the study site is generally poor; roads are in a bad state. There are no tarred roads and the earth roads which exist become almost impracticable in the rainy season. There is no good connection between the health districts

by road, most of the accessibility is on foot through foot paths. A few solid motorcycles can make it but constant servicing and spare parts create a problem. However therapeutic coverage of ivermectin treatment has been above 50 percent.

In Nigeria, Zamfara state is eighty percent rural and accessbility is poor particularly during the rainy season. In the harmattan, it is very cold, windy, dusty and hazy. This State has a strong traditional and Islamic system, Islamic sharia law was declared in 2000. Ivermectin therapeutic coverage is above 70 percent.

In Uganda, the study site is mountainous with a poor road network. Most communities are not accessible with a vehicle or motorcycle. The only means of reaching some of these communities is by walking. The health service infrastructure here is poor; however the mean therapeutic treatment coverage is 79 percent.

In Sudan, Raja Province is made up of a group of remote communities with a population of 140000 where accessibility is difficult, and can only be reached by air. It is a conflict war zone with constant threat of fighting and displacement. It is hyper-endemic for onchocerciasis with a partially functioning PHC system. CDTI using CDDs has achieved a mean therapeutic coverage 70 percent.

DATA COLLECTION

Focus Group Discussions with community members and in-depth interviews with community leaders and peripheral health workers in onchocerciasis endemic communities were used to collect qualitative data in all the study sites. A total of 16 FGDs, 8 with males, and 8 with females in each site was conducted in 16 randomly selected communities. In-depth interviews were conducted with 8 peripheral health workers.
Quantitative data was collected using semi-structured questionnaire and administered to the CDDs.

RESULTS

TABLE 1: CDDs Involved in other Health related activities.

Country	N0. Of CDDs Interviewed	N0. Involved in other Health Activities	Ivermectin Coverage
1. Cameroon	65	58 (89%)	52%
2. Nigeria	72	72 (100%)	76.9%
3. Uganda	77	47 (61%)	79%
4. Sudan	60	29 (48.3%)	72 %
Total	**274**	**206 (75.2%)**	**70%**

TABLE 2: CDDs Involved in Development activities.

Country	N0 of CDDs Interviewed	N0. Involved in Development activities	Ivermectin Coverage
1.Cameroon	65	50(77%)	52 %
2.Nigeria	72	70(97.2)	76.9%
3.Uganda	77	52(68%)	79%
4.Sudan	60	25(42%)	70%
Total	**274**	**197 (71.2%)**	**70%**

In all the four countries where the study was conducted, a total of two hundred and seventy-four (274) community-directed distributors (CDDs) were interviewed and two hundred and six (206) 75.2 percent were involved in at least more than one other health related activity. Overall sites achieved a mean of 70 percent therapeutic ivermectin coverage rate.

In development related activities, 274 CDDs were interviewed with 197 (71.2%) involved in more than one developmental activity, still maintaining a good ivermectin therapeutic coverage rate. Females were more involved in other health related and developmental activities than males but this was not significant (P=0.6)

QUALITATIVE DATA

From indepth-interviews, and focussed group discussions, it was found that many CDDs made a clear distinction between the time they allocated for CDTI and other health and developmental activies in their communities. Involvement in these other activities instead increased their performance as CDDs.

<<<<.....my involvement in other activities does not affect me as CDD, because I plan my activities during the distribution period.....my performance as CDD has increased because of more popularity>> Female CDD-Cameroon.

<<.....my other activities do not affect my performance as CDD, they bring me popularity, I know people by name, if not of my other involvement I will not.....they call me doctor, I feel good about myself. Male-FGD, Nigeria.

In an indepth interview with the head of a peripheral health unit in Uganda *<<<<.....the CDDs from far places like Nteko parish, which is about 50km from this health unit are involved in many health activities such as vit.A distribution, mass immunization for polio, chloroquine distribution during malaria epidemics.....these places we cannot reach. The CDDs are doing a great job.*

DISCUSSION

Onchocerciasis is a disease of the rural poor communities at the "end of the road" with inadequate or no health services. Community-Directed Treatment with Ivermectin (CDTI) is about the only functional health activity in most of these areas.

The results of this study shows that CDDs can play an important role in tackling other priority local health and development programs in many "end of the road" communities. Many health care providers mentioned that the CDDs form a " potiental vital link" between the health service and the "end of the road " communities.

Following the interviews with CDDs, it became clear that involvement of CDDs in other health related activities gives them popularity and prestige. This agrees with the findings of Katabarwa and Mutabazi (1998) and Katabarwa et al (1999) who observed that CDDs performance was enhanced when they participate in multi-disease activities.

It is apparent from the results in Table 1 and 2 that CDDs involvement in both health related activities and developmental activities did not affect the level of their performance as encouraging coverage rate was achieved in all the study communities.

From the FGDs and Indepth interviews, it was consistent that community participation and acceptability to treatment is a common feature to rural communities with no health facilities. Akogun et al 2001; Brieger et al 1995; WHO 1995, 1996 justifies this finding that communities at the "end of the road" are more likely to participate in health and other developmental programs in their communities.

Because many of those who live in Sub-Saharan Africa (e.g >60 percent of those in Cameroon; Ngoumou et al; (1996) have no access to health facilities (United Nation Development Program, 1993), active community involvement needs to be an integral part of ivermectin delivery and distribution, to improve access to the drug, and promote a sense of ownership.Amazigo et al, (1998).

This study has shown that where there are no health facilities, CDDs are capable of administering the correct dosage of ivermectin to eligible subjects, and achieving good coverage rates, this agrees with the findings of Amazigo et al 1998; Brieger et al, 1995; Akpala et al 1993; and Anon 1996a.

The study documents an important strategy which can be used as a model in developing other community based programmes to fight against other diseases. Expansion of the CDDs experience to include other diseases would be of interest to onchocerciasis control programmes as it would strengthen CDTI sustainability through greater integration.

The study has documented an innovative approach to guide the thinking of a multi-disease application of CDTI by using CDDs.

ACKNOWLEDGEMENTS:

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Initiative on
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for Health

Research and Analysis Projects

Promoting effective collaboration on neglected health problems in developing countries

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The Initiative on Public-Private Partnerships for Health:

Research and Analysis Projects

The Initiative on Public-Private Partnerships for Health (IPPPH) was launched in 2000 to contribute to alleviating health inequities affecting poor countries by enhancing public private collaboration.

The aim of IPPPH is to increase the effectiveness of public-private collaboration, particularly by helping those seeking to develop, and improve access to, health products to fight neglected diseases and other health problems in developing countries.

IPPPH assists groups such as existing and prospective public-private partnerships and those who fund or otherwise influence the success of such alliances with research, information, communication, networking and advisory services.

It operates under the aegis of the Global Forum for Health Research, an independent international foundation helping to correct the 10/90 gap in health research.

The purpose of this document is to list the research and analysis projects developed by IPPPH. These projects provide health alliances with pragmatic answers to specific challenges they face, to identify practices that maximize health returns on funds invested, and to mitigate risks associated with such alliances, in order to enhance their overall effectiveness and to guide more financial support to the most appropriate collaborations.

IPPPH conducts research and analysis in four areas:

1. **Developments and trends** in the field of public-private collaboration;
2. **Organizational issues** of public-private partnerships, particularly in the areas of legal status, governance and mechanisms for balanced representation of stakeholders;
3. **Operational issues** affecting access to health products, such as production options, pricing of pharmaceuticals or management of intellectual property; and
4. **'Best practices' guidelines** in the development and management of effective public-private alliances.

IPPPH also provides **Documentation of Partnerships** – under the Information Services area and several studies are highlighted here.

How IPPPH Works

IPPPH facilitates investigator-led research by providing research assistance, access to data sources, administrative support, and publishing opportunities. While IPPPH has some limited funds to support such activities, it is not a major grant maker. Most of the studies involve authors and collaborators who have a strong interest in the research and whose organizations are willing to share

costs. IPPPH seeks to publish in both peer-reviewed journals and through the Global Forum's and its own publishing channels. IPPPH encourages evidence-based research and appropriate collaborations from all perspectives: government and intergovernmental agencies, nongovernmental and academic organizations, and commercial entities.

Capacity Building

IPPPH seeks collaboration with researchers from developing countries who have conducted studies involving cross-sectoral alliances or similar areas. In all IPPPH studies, investigators or reviewers are sought who can contribute intended beneficiary and country-level perspectives into the analysis.

Research and Analysis Projects

1. Developments and trends in Public-Private Collaboration

Intended to provide background about the origins and nature of public-private partnership, and to chronicle the development of this type of collaboration, these articles will be of special interest to policy-makers, financial supporters, and those considering new collaborations to help them understand the variety and options possible and the direction this form of public-private interaction is headed.

Title:	**"Public-private partnerships for health: their main targets, their diversity, and their future directions."**
Description:	The paper provides an overview of the global health public-private collaborations that have proliferated in recent years, the reasons for their formation, their objectives and methods of functioning. The focus is on those partnerships that have arisen in order to develop new products needed in developing countries, to address inadequate access to currently-available products through donation or negotiated pricing, or to generally strengthen or coordinate health services. Included are descriptions of the various organizational structures these partnerships can take, the incentives for involvement by government, commercial and civil society participants, and the possible roles of the collaborators by sector. The conclusion is that new ventures should be built on need, appropriateness, and lessons on good practice learnt from experience. Suggestions are made for public, private, and joint activities that could help to improve the access of poor populations to the pharmaceuticals and health services they need.
Author:	Roy Widdus, PhD
Published:	WHO Bulletin, Vol.79, No. 8, August 20001, Policy and Practice: Theme papers, pp. 713-720.

2. Organizational issues of public-private partnerships

These studies aim at helping IPPPH's clients understand the impact of different organizational, management and administrative options on the effectiveness of PPPs in achieving their health goals.

Title:	**"Public-Private Health Partnerships: a comparative analysis of the policies and guidelines governing the interactions of WHO, UNAIDS, UNFPA, UNICEF, and the World Bank with the commercial sector."**
Description:	The study documents and examines the approaches adopted by these multilateral organizations in their interactions with the commercial sector on global health issues. It discusses the risks perceived by the organizations as delineated by their particular mandates and portrays the organizational structures, guidelines, and procedures established to facilitate public-private collaborations and mitigate against potential risks. The study synthesizes extensive research based on content analysis of documents and interviews with management and staff involved in partnership policies and implementation at these institutions. The paper seeks to explain the underlying rationale for the different approaches and to assess some of the consequences thereof, with a view to promoting interagency learning and understanding for the partners from various sectors who are involved in such alliances.
Principle investigator:	Kent Buse, PhD and Roshan Ouseph, MPH, Yale School of Medicine
Availability date:	Late 2002, IPPPH or Global Forum Press, in its entirety. Mid-2003, three related articles submitted for publication in Social Science and Medicine, Health Policy and Planning, and Global Social Change.

3. Operational Issues

IPPPH commissioned a series of studies and reports on topics of shared concern to groups developing new or improved drugs, vaccines, and other health products for 'neglected' diseases and conditions in developing countries through public-private partnerships. The topics chosen are based on surveys of these partnerships to determine the perceived problems they face in discovering, designing, and developing health products through the 'pipeline' from basic research to product introduction. The analyses are written by experts and researchers in the subject matter and include input, examples and case studies from the product development partnerships. The following papers will soon be available or are in progress:

Title:	**"Valuating Industry Contributions to Product Development Public-Private Partnerships."**
Description:	The paper provides an overview to evaluating the contributions that private industry has made towards product development public-private partnerships (PPPs) in pursuit of treatments for diseases of poverty prevalent in the developing world including HIV/AIDS, TB, malaria, Chagas disease and others. The authors describe the types of contributions made by industry including those where a PPP pays industry for goods or services in a contractual agreement or business deal and those where industry makes outright "in-kind"(non cash) contributions for which it asks no monetary compensation. They briefly examine the organization of the R&D process and the division of labor between the public and private sectors. They review different methods applied in the for-profit world for structuring and assessing the value of deals that provide the tools needed to assess and compare the value of deals done by PPPs with private companies. The paper identifies the categories of contributions that companies can make with PPPs and presents illustrative case studies, including the deal structure and value of the industry role in each case. General findings and recommendations to PPPs for future collaboration with industry are presented which should help both PPPs and industry design productive alliances in which each of their contributions is clearly valued and understood.
Principle investigator:	Hannah Kettler, PhD, and Karen White, MBA, of the Institute for Global Health at University of California San Francisco.
Availability date:	Late 2002, IPPPH or Global Forum Press, in its entirety. Mid-2003, articles in peer-reviewed journals.

Title:	**"Getting to Price: Strategies for Acceptable Pharmaceutical Product Pricing in Product Development Public-Private Partnerships."**
Description:	The paper provides participants in public- private partnerships working on neglected disease priorities in developing countries with a common framework for understanding and addressing pricing issues and goals for the products their collaborations are intended to generate. The principal objective of this paper is to provide a basic description of the factors that influence the pricing of drug, vaccine, and other health product innovations in the research-based pharmaceutical and biotech industry, so that public sector participants in PPP's will have a better understanding of not only the commercial character of price, but also the decision processes that lead to price and industry pricing behavior. The paper will explore how price interrelates with market structure, and how points in the pricing equation may be susceptible to constructive external influence, including negotiating considerations. It also suggests ways in which these partnerships can develop common ground so that product pricing can ultimately be seen as an outcome that successfully enhances product development efforts, rather than frustrates them. The chief aim of this paper is to provide managers of PPP's with a practical framework for thinking about price and interacting successfully with their private and public sector collaborators.
Principle investigator:	Peter F. Young, President and CEO of AlphaVax, Inc., a U.S. biotech company involved in vaccine research for HIV and other neglected diseases.
Availability date:	Late 2002, IPPPH or Global Forum Press, in its entirety. Mid-2003, articles in peer-reviewed journals.

Title:	**"Intellectual Property: Management of Strategic Alliances Between the Public and Private Sector to Promote Access by Developing Countries to Needed Drugs and Vaccines."**
Description:	The paper will summarize the purpose and scope of "access conditions" contained in agreements that establish public-private partnerships related to drugs and vaccine research and development. The authors describe how intellectual property rights are commonly allocated in these agreements and explain the interdependence between the provisions on access and intellectual property. Suggested methods are proposed for allocating and managing intellectual property rights so as to promote access to drugs and vaccines in developing countries.
Principle investigator:	Richard Wilder, Sidley Austin Brown & Wood LLP and Melinda Moree, PhD, Program for Appropriate Technology in Health.
Availability date:	January 2003 in conjunction with a Legal Issues Workshop, organized by IPPPH for PPP managers and interest parties.

Title:	**"Low cost manufacture and supply of drugs, vaccines and other health products by public-private partnerships involved in new product development."**
Description:	The paper will cover the issues facing managers of product development partnerships regarding how they can begin early in the research and development process to plan for the optimization of materials sourcing and manufacturing of the eventual products with an eye on providing the best value, lowest cost, high quality, and reliable supply for the public sector in the developing world. Topics to be addressed include microeconomic considerations such as primary and secondary manufacturing, outsourcing various stages of production, good manufacturing practice (GMP), maintaining a reliable supply, consistent quality, and lowest cost of input materials, economic manufacturing scale (high volume), efficient plant utilization and capital expansion, process robustness, efficiency and yield consistently high with low variability, well developed logistics infrastructure and utilities supply, and access to highly skilled technical resources. Also to be addressed are macroeconomic factors that can influence production such as regulatory environments, political priorities for local production and capacity building, foreign direct investment economic incentives, import restrictions, taxes, tariffs, duties, technology transfer, and voluntary or compulsory licensing.
Principle investigator:	Giorgio Roscigno, Director of Strategy, Global Alliance TB Drug Development, and Joachim Oehler CEO, Concept Foundation.
Availability date:	Seeking additional collaborator, March 2003.

Planned areas for further analysis by IPPPH include:

Title:	**"Study of the Operations and Impacts on the Health Systems of Countries by Public-Private Partnerships for Improving Access to Specific Pharmaceuticals."**
Description:	A field study in two countries of the operations and impact on the national health systems by partnerships involving the large-scale donation of disease-specific drugs. Programs covered (with drug donor company) include the Mectizan® Donation Program (Merck), the International Trachoma Initiative (Pfizer), the Global Alliance to Eliminate Lymphatic Filariasis (GlaxoSmithKline), the Global Alliance to Eliminate Leprosy (Novartis), Global Guinea Worm Eradication Program (DuPont, Johnson&Johnson), Trypanosomiasis/Sleeping Sickness (Aventis). A small steering committee will determine protocol and country selection. A project team leader would manage the study, write the proposal, coordinate consultants and local advisors, data collection, and analysis.
Principle investigator:	To be determined.
Availability date:	Mid-2003.

4. 'Best practices' guidelines

These are based on the synthesis of systematic information gathering and accumulating experience in the field of public-private collaboration. The opinions and conclusions drawn in these articles are evidence-based and intended to promote the adoption of' 'best practices'.

Title:	**"Good Practices for the Establishment and Operation of Public-Private Partnerships."**
Description:	A simple guideline to follow when considering the organization of a new public-private alliance, based on accumulated experience and analysis to date on what makes successful collaborations.
Principle investigator:	Roy Widdus, PhD, Project Manager, Initiative on Public-Private Partnerships for Health.
Published:	Revision due in early 2003; originally published in October 2001.

Documenting Partnerships (Information Services)

Title:	**"An Inventory of Health Public-Private Partnerships in South Africa."**
Description:	An itemized report of partnerships, programs, alliances with offices or activities in the Republic of South Africa, that aim to improve public health, particularly through better access to drugs, vaccines, or other health products or services. For each, the name of the partnership, contact person, address and short account of the program is provided.
Principle investigator:	Sibongile Pefile, PhD, Consultant to IPPPH.
Published:	March 2002.

Title:	**"The Diflucan® Partnership Program: early experiences in South African Development Cooperation countries."**
Description:	The study looks at the donation program by Pfizer, Inc. in the context of its implementation in SADC countries. The study will provide an in-depth description of the origins, negotiations, evolution, and implementation to-date of the HIV/AIDS-related drug donation program, including attention to decision-making processes, governance structures, stakeholder representation, and a discussion of how the program measures its own effectiveness and coordinates with national health priorities. The objective is to draw on lessons to be learned in the early stages of a program, understand the challenges faced, and document accomplishments thus far.
Principle investigator:	Sibongile Pefile, PhD., Consultant to IPPPH.
Availability date:	IPPPH or Global Forum Press, January 2003

Title:	**"The Viramune® Donation Programme for the Prevention of Mother-to-Child Transmission of HIV-1: early experiences in implementation in Africa."**
Description:	The study looks at the donation program by Boehringer Ingelheim as it has developed in its early implementation, focusing on the African experience. The study will provide an in-depth description of the origins, negotiations, evolution, and implementation to-date of the HIV/AIDS-related drug donation program, including attention to decision-making processes, governance structures, stakeholder representation, and a discussion of how the program measures its own effectiveness and coordinates with national health priorities. The objective is to draw on lessons to be learned in the early stages of a program, understand the challenges faced, and document accomplishments thus far.
Principle investigator:	Sibongile Pefile, PhD., Consultant to IPPPH.
Availability date:	IPPPH or Global Forum Press, January 2003

Please contact us if you would like a copy (when available) of any of the above publications, please fill out the form below and fax, email, or send by post to:

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	"Low cost manufacture and supply of drugs, vaccines and other health products by public-private partnerships involved in new product development."
	"Study of the Operations and Impacts on the Health Systems of Countries by Public-Private Partnerships for Improving Access to Specific Pharmaceuticals."
	"Good Practices for the Establishment and Operation of Public-Private Partnerships."
	"An Inventory of Health Public-Private Partnerships in South Africa."
	"The Diflucan® Partnership Program: early experiences in South African Development Cooperation countries."
	"The Viramune® Donation Programme for the Prevention of Mother-to-Child Transmission of HIV-1: early experiences in implementation in Africa."

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Working Paper No. 2

Poverty Reduction Strategy Indicators Produced Using NSS/AMMP Data for 1998-2000

November 2001

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Summary and key findings

The national poverty reduction strategy requires a significant monitoring and evaluation effort and the production of key indicators. The Ministry of Health's National Sentinel System (NSS) of linked demographic surveillance sites can produce many of these indicators. Based on data currently available from three sites directly managed by the Ministry of Health, this paper demonstrates what such an output might look like, and provides estimates of 16 poverty indicators for districts representing different urban and rural poverty welfare quintiles.

The NSS's role in poverty monitoring

- The Ministry of Health's National Sentinel System of linked demographic surveillance can make a significant contribution to monitoring the impact of poverty reduction efforts in Tanzania.
- The NSS can also help gauge the extent to which the benefits of poverty reduction are equitably shared in Tanzania among men and women and in different geographic and poverty welfare strata.
- The system can provide continuous indicator estimates for analysis of trends and degree of change over time.
- Further work is needed in the attribution of sentinel sites to different urban and rural poverty and welfare quintiles.
- Work is also needed in reconciling differing methodologies used to set PRSP targets and to measure progress.

Preliminary findings

- PRSP targets in **human capabilities** and **survival** may have already been met in some sentinel areas but not in others.
- In terms of **human capabilities**, wealthier areas appear to have attained the PRSP goal of equality in primary education for girls and boys. A gap of 7% remains in poorer areas.
- Wealthier areas fare better with respect to indicators of **survival**, although life expectancies are fairly high by regional standards, even among poorer Tanzanians.
- Children in Tanzania who have lost one or both parents are an **extremely vulnerable** group and represent 7% of the population under-15 in rural sentinel sites.

Background and Purpose

The United Republic of Tanzania is currently implementing a national poverty reduction strategy. The measurement of progress toward the aims articulated in the country's Poverty Reduction Strategy Paper (PRSP) will require a substantial monitoring and evaluation effort. This effort is being organised under a National Poverty Monitoring Master Plan [1].

At the same time that the poverty reduction strategy is being implemented, the Ministry of Health is in the process of establishing a National Sentinel System of linked demographic surveillance sites (NSS). A demographic surveillance system (DSS) consists of the continuous registration of all vital events (births and deaths) and migrations in a population residing in a defined geographic area. In Tanzania, this surveillance is accompanied by attribution of cause of death to incident deaths, and the assessment of other socio-demographic, economic, and risk factor information at the individual, household and community level.

DSS has the potential to measure many of the indicators included in the National Poverty Monitoring Master Plan. A few of these are immediately available. They are based upon the output of three NSS sites directly under the management of the Ministry of Health and local councils. These sites are operated with the support of Adult Morbidity and Mortality Project in the rural districts of Hai (Kilimanjaro Region) and Morogoro (Morogoro Region), and in Dar es Salaam (municipalities of Temeke and Ilala). Additional data is expected to come soon from demographic surveillance sites operated by the Tanzania Essential Health Information Project (the Rufiji Demogoraphic Surveillance System), the Ifakara Health Research and Development Centre, and the TANESA Project.

This working paper provides an assessment of indicators currently proposed for poverty monitoring that can be generated by the NSS, and provides estimates of 16 indicators based on available NSS/AMMP data. These indicators may be generated without diverting the NSS from its core function of providing burden of

disease information to district councils and the Ministry of Health for policy and planning.

As the poverty reduction strategy is implemented, it will be necessary to monitor the degree to which the benefits of poverty reduction in Tanzania are equitably distributed [2]. One way to accomplish this is to draw upon systems that can reliably generate indicators stratified by poverty groups or other variables of importance from an equity perspective. One main objectives of this working paper is to demonstrate how the NSS can be of service in this regard.

Materials and Methods

Source of Indicators and Data

Table 1 contains the list of indicators from the second draft of the National Poverty Monitoring Master Plan. This list comes from a discussion document and so has yet to be finalised. The table shows the indicators that can be collected using DSS and notes which are currently available, which should be available from NSS/AMMP sites in the near future, and those for which data could be collected on a DSS platform given adequate resources.

Long-range and medium-term targets for many indicators are contained in Tanzania's Poverty Reduction Strategy Paper (PRSP) [3]. Of the targets listed there, four are measured in this working paper:

- *Achievement of gender equality in primary education by 2005 (human capabilities);*
- *Achievement of gender equality in secondary education by 2005 (human capabilities);*
- *Reduction of infant mortality to 85 per 1,000 live births by 2003;*
- *Reduction of under five mortality to 127 per 1,000 by 2003.*

The data set for calculation of indicator estimates was taken from the data bases of the NSS sites directly managed by the Ministry of Health and local councils for the period of January 1998 through December 2000. For most of the indicators, three years of data were available. Many demographic indicators (particularly those related to mortality) display great variation from year to year. These variations can make the interpretations of year-on-year indicator estimates extremely difficult. Wherever possible, we have used three years of data in order to 'smooth out' these variations and provide more stable estimates.

Determination of Poverty Quintiles

There are currently no estimates of poverty at the district level for Tanzania that cover the entire country. The most recent regional estimates come from the 1999 Poverty Welfare Indicators report of the Vice President's Office [4]. **Table 2** lists the poverty-welfare quintiles for all of Tanzania's 20 mainland regions and divides them into quintiles. The regions in which DSS sites are located are in boldface (including both NSS/AMMP-supported DSS and DSS operated by other projects/institutions).

For the purposes of this exercise, we have proposed that NSS/AMMP sentinel sites represent the poverty quintiles of the regions in which these sites are located. In addition 1999 rankings themselves are subject to some caveats in terms of the methodology used in their derivation, and in the quality of some of the regional level data sets. Thus, we recognise that this assumption of representativeness with regard to poverty-welfare rankings is crude and must be interpreted with caution.

Once reliable measures of income (or other) poverty measures are generated from the sentinel areas, it will be possible to generate estimates for all poverty welfare quintiles, and to adjust for confounding variables or area effects. The development of these methods will be enhanced by collaborations among the NSS, the National Bureau of Statistics, and the Research and Analysis Working Group on National Poverty Monitoring. The release of the National Household Budget Survey (expected in early 2002) and the poverty proxy information to be included in the 2002 National Census will be of great use in this regard.

In 2001 measures of income poverty using proxies of household consumption have been collected from all households in the centrally managed NSS sentinel sites. The data collection tools were developed using preliminary data from the National Household Budget Survey made available by the National Bureau of Statistics. The proxy models derived from these data for rural areas explained 65% of the variance in recorded consumption, and 75% of the variance in urban areas [5, 6]. These data will be available for analysis in early 2002.

Within the NSS it will also be necessary to develop methods for the extrapolation of sentinel data to produce national and regional estimates, as well as estimates by various poverty-welfare groupings and for sub-populations of equity interest on a national level. Preliminary work on the statistical and demographic methods for doing this extrapolation will be conducted in early 2002.

Taking these comments into account, our main intention in this working paper is to stimulate

discussion and to indicate what future analyses might look like.

Results and Discussion

Table 3 contains 15 indicators for each of the poverty quintile sentinels. One indicator, 'population with access to safe water,' was only available for the urban sentinel. Overall, we were able to calculate indicators for human capabilities, survival, and extreme vulnerability. Data for indicators on income poverty and additional indicators of human capability (e.g. access to safe water) will be available by mid-2002. We were unable to provide indicators for social wellbeing (governance) or nutrition. We do, however, anticipate that indicators on nutrition will be available in 18 - 24 months.

For many of the indicators, it was necessary to derive more precise definitions. Age ranges, for example, needed to be specified in several cases. These specifications are contained in the notations to Table 3. In addition, where our results seemed to offer further insight, we have expanded on the number of indicators called for by the Poverty Monitoring Master Plan. For example, in addition to the girl:boy ratio in primary education, we have also provided female:male ratio among adults with no education, and female:male ratio among those enrolled in secondary school.

It is important to note that most of the PRSP targets were set by applying a hoped-for percentage change in estimated baseline values for the nation. This is how many international targets are set (e.g. the Safe Motherhood Initiative goal of a 50% reduction in Maternal Mortality Ratios by 2000 [7], which Tanzania has adopted [8]).

From this perspective it is not the absolute value of the target that matters most, but the percentage change achieved from the baseline figure. This is particularly important to bear in mind because the national baseline figures are often derived using different methodologies to those used in the demographic surveillance of the NSS/AMMP. This can pose problems in comparison and interpretation that will need to be discussed by partners involved in the monitoring process.

For this reason, the ability of the NSS/AMMP data to provide trend information would allow an assessment of progress while eliminating the problem of comparing across methodologies [9]. In addition the NSS will enable a view of the impact of poverty reduction efforts by looking at change within specific geographic and administrative entities, and not just the status of those entities in relation to national targets.

Human Capabilities

Results

The indicators of human capabilities are centred on the equitable distribution of education among females and males.

The indicators for adults with no education and secondary education show a female advantage (i.e. less than one woman for every man with no education) in rural areas of 0.3 - 0.6, with more inequity in the poorer sentinel, and a male advantage in the urban sentinel.

The indicator for the girl:boy ratio in primary enrolment shows virtual equality for girls and boys in the wealthier quintiles (0.99 - 1.01), and a female deficit of 0.7 in the poorer quintile.

Discussion

Within the areas under demographic surveillance, wealthier areas appear to have attained the PRSP target of equality in primary education for girls and boys. The gap between poorer girls and boys in primary education is 0.07, indicating that 7% fewer girls than boys were in primary education between 1998 and 2000 in this sentinel area. It may be noted, however, that the gap is similar in size to the 6% gap in favour of women with respect to having any education.

The largest gap in any of these indicators of human capabilities is the 23% higher enrolment of girls compared to boys in secondary education in the highest rural poverty quintile. The fact that the indicator for gender equity in secondary education shows such strong female advantage may be related to the fact that the AMMP census records the characteristics of those who are resident in the area. If large numbers of boys are enrolled in secondary schools that require them to board outside of the surveillance areas, the indicator may not give an accurate overall picture of gender equity in secondary education.

Survival

Results

Mortality and life expectancy indicators show an expected gradient with universally more favourable values in the wealthier quintiles.

Unadjusted estimates for infant mortality indicate that the PRSP target of 85 per 1,000 live births may already be attained in all areas. It has been established that data from the AMMP census updates need to be adjusted for under-reporting of births. For the purposes of this preliminary assessment these adjustment procedures have not been applied. Thus, the adjusted estimates of infant mortality would be likely to drop. These estimates need to be

compared and considered in relation to other sources of information on infant and child mortality such as the Tanzania Demographic and Health Survey [10] and the Tanzania Reproductive and Child Health Survey [11].

Nevertheless, infant mortality as assessed through NSS/AMMP is both high in absolute terms (60 to 83 per 1,000 live births), and inequitably distributed. The PRSP target of under-five mortality of 127 by 2003 appears to have been achieved in the wealthier sentinel sites, but not in the sentinel for the 4th poverty welfare quintile.

Previously we have discussed issues in the measurement of maternal mortality in the NSS/AMMP areas [9]. Maternal Mortality Ratios (the number of maternal deaths per 1,000 live births) are notoriously difficult to measure, and usually require the application of large correction factors [12-14]. This measure is beginning to fall out of favour, and a variety of alternatives have been suggested. These alternatives include the Maternal Mortality Rate (a standard death rate per 100,000 due to direct and indirect maternal causes), the proportion of deaths to women of reproductive age due to maternal causes, and 'process measures' such as the proportion of attended deliveries. Here we report on the Matnernal Mortality Rate (not the Ratio) and the proportion of births in health facilities.

Compared to the most well-off sentinel for each of the mortality indicators, mortality is 38% higher for infants and 89% higher for under fives higher in the poorer sentinel. Maternal mortality is 137% higher.

Although it is not a measure of survival, we have included an approximation of percentage of births attended by skilled professionals. This is an increasingly accepted indicator of safe motherhood and of risk of maternal death. For the NSS/AMMP areas, this indicator also revealed a large differential by wealth quintile. Coverage ranged from 96% for the wealthy urban quintile down to 44% for the poorer rural quintile—a 118% difference. Between the rural quintiles there was an 80% gap.

In rural areas, life expectancy for women in the 4th poverty quintile was 10 years shorter than for women in the wealthiest quintile. By contrast, the gap among men was four years. In addition, women were outliving men in rural areas, but not in the wealthier urban area, where men had a one-year longer life expectancy. The largest gap in life expectancy is an 11 year deficit of poor rural men compared to wealthier rural women.

In the urban sentinel site, men have a longer life expectancy at birth than do women. This shows a reversal from conditions in the early 1990s in this area, when women were outliving men [15], and may well be due to the differential age-distribution of HIV/AIDS mortality among women and men.

Discussion

The survival indicators of mortality and life expectancy are commonly used measures of relative wellbeing. In sub-Saharan Africa, however, they are rarely available at a sub-national level.

Table 4 compares the survival indicators for NSS/AMMP sentinel areas with those for Tanzania as a whole, and with Tanzania's neighbouring countries. At the national level, Tanzania's estimated infant mortality rate of 99 per 1,000 live births [16] is high by comparison with the rest of Africa (88), and extremely high by global standards (56). Neighbouring countries have infant mortality ranging from 74 in Kenya to 135 in Mozambique. Overall, Tanzania's infant mortality places it in the middle of this group.

The life expectancies for Tanzania's women and men are virtually identical to those for Africa as a whole (55 for women, 52 for men). In global terms, however, there is a 15 deficit for women in Tanzania and 13 year deficit for men. Compared to other countries in the region, Tanzania has the highest life expectancies for both sexes (with the possible exception of Mozambique[*]). Even the life expectancy of poorer Tanzanians in NSS/AMMP sentinel areas compares favourably with those elsewhere in the region.

Extreme Vulnerability

Results

In all areas, the highest rates of orphanhood are among children whose fathers have died. In the wealthier rural sentinel site, the ratio of children who have lost fathers to those who have lost mothers is 3.4:1.

Those who have lost mothers and those who have lost both parents represent less than 1% of the population of under fives. The proportion of young children in the poorer sentinel area who have lost both parents is roughly twice that of the better off sentinels.

[*] The 2001 World Population Data Sheet lists life expectancies for Mozambique of 76 for women and 69 for men. These figures seem improbable give the years of civil war in the country, and given that it has the highest infant mortality in the region.

More than 6% of older children (5 – 14) have lost their fathers. This rate varied little across the sentinel areas. The ratios of those whose fathers had died to those whose mothers had died were similar to those for younger children. Looking across areas, 4.5% of older children in the sentinel for the 1st urban poverty quintile had lost both parents, compared to less than 1% of older children in the rural sentinels.

Discussion

Orphanhood appears to be a strong indicator of vulnerability. Within the NSS/AMMP areas, children under five whose parents are living had half the risk of mortality of those orphaned by one or both parents.

With the exception of older children orphaned by both parents, the vulnerability resulting from the loss of parents of both sexes is equally distributed among children regardless of their poverty status. The much higher rates of orphanhood among older children in the wealthiest urban quintile who have lost both parents should prompt more in-depth investigation.

The equitable distribution of orphanhood rates may seem anomalous given wide differentials of adult mortality. This can be explained in part by the fact that orphans themselves have roughly twice the mortality of non-orphans.

HIV/AIDS is the leading cause of adult death in these sentinel sites [17]. It may therefore be presumed to be the leading cause of orphanhood, and therefore of highly vulnerable children. Additionally, it may be asked in absolute terms, how many vulnerable children are there in these sentinel areas? **Table 5** estimates the 2001 orphan populations of each of the three regions where sentinel demographic surveillance takes place. The table indicates that more than 100,000 children under the age of 15 have lost one or both of their parents. These children, and the younger ones in particular, are at greatly increased of death.

Conclusions

This preliminary analysis of poverty monitoring indicators has demonstrated that the Ministry of Health's emerging National Sentinel System of linked demographic surveillance sites has the potential to make a significant contribution to monitoring the impact of poverty reduction efforts in Tanzania.

At present, it is only possible to allocate sentinel sites to poverty welfare quintiles in a crude manner. In order for the system to realise this potential, measurement of income poverty in sentinel areas needs to be improved. Using these measurements, more estimates for indicators across all poverty welfare quintiles can be generated, adjusted for confounding variables or area effects.

Based on these assumptions we have examined 16 indicators from an equity perspective. We have not aggregated data to provide national estimates, although this is an objective for early 2002.

Human Capabilities

NSS/AMMP data show that the PRSP target of gender equality in primary education by 2003 may have been met already in wealthier areas. There is, however, a female deficit of about 7% in the sentinel for the 4th poverty welfare quintile. Men without any education, however, appear to outnumber women with no education in rural areas.

Survival

As expected, all indicators of survival show wealthier areas faring better than poorer areas. Mortality rates are 60 to 137%higher in the poorer sentinel (4th poverty quintile) compared to the best-performing of the wealthier (1st quintile) sentinel sites. Life expectancies are higher for women in rural areas in both wealth quintiles for which data are available, but higher for men in the 1st quintile urban sentinel.

Extreme vulnerability

Orphans, whether of one parent or two, are at higher risk of death than other children. There are not major differences in the percentage of single-parent orphans in the NSS/AMMP areas. Young children in the poorer area had nearly twice the orphanhood rate for the deaths of both parents, while older children in the wealthier urban quintile had more than 5.7 times the odds of being orphaned by both parents.

Next steps

In the coming year, the NSS anticipates that the sites it manages in partnership with local councils and with support from AMMP will be in a position to substantially improve the depth and quantity of poverty monitoring indicators. It is expected that this will be done through:

- *Finalising the measurement of income poverty;*
- *Conducting special surveys on nutritional status (stunting, wasting, and body mass index);*
- *Developing methods for the extrapolation of data to national, regional, and district levels, to all income poverty quintiles, and to other subgroups of importance from and equity perspective.*

It is expected that efforts can be accomplished without detracting from the primary function of the NSS to provide continuous burden of disease information to the Ministry of Health and district councils for setting policy and for the production of annual district health plans. In order to do so it will be necessary to have active involvement with other Tanzanian organisations involved in poverty monitoring and research.

For some indicators, it may also be possible to produce a trend analysis for years leading up to the advent of the poverty reduction process. Such an analysis may aid in the refinement of the targets spelled out in the PRSP.

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Table 1. National Poverty Monitoring Indicators Amenable to collection in NSS/AMMP & other DSS Sites

Income poverty
Headcount ratio – basic needs poverty line[a]
Headcount ratio – basic needs poverty line (rural)[a]
Headcount ratio – food poverty line[c]
Asset ownership (as proxy for income poverty)[b]
Proportion of working age population not currently employed
Agriculture indicator (to be defined)
Overall GDP growth per annum
GDP growth of agriculture per annum
Percentage of rural roads in maintainable condition (good and fair condition) [c]
Human capabilities
Girl/boy ratio in primary education
Girl/boy ratio in secondary education
Transition rate from primary to secondary[a]
Literacy rate of population aged 15+[c]
Net primary enrolment[a]
Gross primary enrolment[a]
Drop-out rate in primary school[a]
Percent of students passing Std 7 with grade A,B,C
Prevalence of ARI in under-fives[b]
Prevalence of diarrhoea in under-fives[b]
Population with access to safe water[a]
Survival
Infant mortality rate[a]
Under-five mortality rate[a]
Life expectancy[a]
Seropositive rate in pregnant women[c]
Districts covered by active AIDS awareness campaign[c]
Maternal mortality rate (deaths per 100,000)
Malaria in-patient case fatalities for children under 5[c]
Children under 2 years immunised against both measles and DPT[c]
Births attended by a skilled health worker[a]
Social wellbeing (governance)
Ratio of primary court filed cases decided
Average time taken to settle commercial disputes
Nutrition
Stunting (height for age) of under fives[b]
Wasting (weight for height) of under fives[b]
Underweight (weight for age) of under fives[b]
Extreme vulnerability
Proportion of orphaned children[a]
Proportion of child-headed households[a]
Proportion of children in the labour force[a]
Proportion of children in the labour force and not going to school[a]
Proportion of elderly living in a household where no one is economically active[a]
Conducive development environment
Ratio of reserves to monthly inputs

[a] amenable to collection in NSS/AMMP areas (and possibly other DSS areas) with little or no refinement to current methods. Some indicators to be available by mid-2002.
[b] data planned for collection in NSS/AMMP areas through special survey in 2001 and to be available by mid-2002.
[c] amenable to collection in NSS/AMMP areas (and possibly other DSS areas) with moderate refinement to current methods (e.g. conducting a nested survey) and/or additional resources.

Table 2. Poverty-welfare quintiles and scores*

region	quintile	score
Dar es Salaam[a]	**1**	**22.25**
Ruvuma	1	21.00
Kilimanjaro[a]	**1**	**20.13**
Singida	1	17.88
Tabora[c]	**2**	**17.75**
Shinyanga	2	16.88
Mbeya	2	16.88
Iringa	2	16.00
Mwanza[c]	**3**	**15.88**
Arusha	3	14.63
Rukwa	3	14.00
Mtwara	3	13.13
Tanga	**4**	**11.88**
Morogoro[a,e]	**4**	**10.50**
Mara	4	10.50
Coast[d]	**4**	**9.75**
Kigoma[b]	**5**	**9.50**
Lindi	5	9.13
Kagera	5	8.88
Dodoma	5	8.25

* source: United Republic of Tanzania (1999). Poverty and Welfare Monitoring Indicators. Dar es Salaam, Vice President's Office.

[a] sentinel site directly managed by the Ministry of Health NSS in partnership with district and municipal councils and with support of AMMP.

[b] sentinel site planned for establishment by NSS/AMMP and local councils during 2002.

[c] TANESA

[d] Rufiji Demographic Surveillance System/Tanzania Essential Health Interventions Project

[e] Ifakara Health Research and Development Centre

Table 3. Summary of Poverty Reduction Indicators* Amenable to Collection through Demographic Surveillance for 1998-2000

	Human Capabilities				Survival					
Poverty Quintile	female-to-male ratio among those with no education	female-to-male ratio among those currently in primary school	female-to-male ratio among those currently in secondary school	population with access to safe water (%)	infant mortality rate[a] ($_1q_0$)	under-five mortality rate ($_5q_0$)	female life expectancy at birth (years)	male life expectancy at birth (years)	maternal mortality rate[b] (per 100,000 population)	births attended by a skilled health worker[c] (%)
1 (urban)	1.02	1.01	0.95	97	60	104	51	52	47	96
1 (rural)	0.97	0.99	1.23	--	61	85	59	54	30	79
4 (rural)	0.94	0.93	1.02	--	83	161	49	46	72	44

	Extreme Vulnerability					
Poverty Quintile	children under the age of 5 orphaned by father (%)	children under the age of 5 orphaned by mother (%)	children under the age of 5 orphaned by both parents (%)	children between the ages of 5 and 14 orphaned by father (%)	children between the ages of 5 and 14 orphaned by mother (%)	children between the ages of 5 and 14 orphaned by both parents (%)
1 (urban)	1.24	0.65	0.12	6.72	3.32	4.54
1 (rural)	1.53	0.45	0.10	6.20	2.03	0.72
4 (rural)	1.39	0.68	0.23	6.37	2.87	0.79

* for which data are currently available (see narrative).

[a] it has been established that data from the AMMP census updates need to be adjusted for under-reporting of births. For the purposes of this preliminary assessment these adjustment procedures have not been applied. Thus, the estimates of infant mortality are a likely under-estimate of the true rates.

[b] death rate due to direct and indirect maternal causes; not the maternal mortality ratio (deaths per 100,000 live births).

[c] defined as percentage of births in health facility, information on attended births as well as place of birth will be available in 2002.

Table 4. Comparison of survival indicators for sentinel areas and Tanzania with neighbouring countries

Poverty Quintile/ Country	infant mortality rate ($_1q_0$)	female life expectancy at birth (years)	male life expectancy at birth (years)
1 (urban)	60	51	52
1 (rural)	61	59	54
4 (rural)	83	49	48
Tanzania[a]	99	54	52
Burundi[a]	75	47	46
Dem. Rep. Congo[a]	106	50	45
Kenya[a]	74	49	48
Malawi[a]	104	40	39
Mozambique[a]	135	76	69
Rwanda[a]	107	40	39
Uganda[a]	97	43	42
Zambia[a]	95	38	37

[a] source: Haub, C. and D. Cornelius (2001). 2001 World Population Data Sheet. Washington, DC, Population Reference Bureau.

Table 5. Estimated number of orphans in regions having sentinel surveillance*

	Under 5			5 – 14			Under 14
Region	number orphaned by father	number orphaned by mother	number orphaned by both parents	number orphaned by father	number orphaned by mother	number orphaned by both parents	total orphaned by one or both parents
Dar es Salaam	3,334	1,748	323	30,965	15,298	20,920	67,148
Kilimanjaro	3,846	1,131	251	30,843	10,098	3,582	49,751
Morogoro	4,083	1,998	676	34,025	15,330	4,220	60,330

* estimates based on regional population projections using 1988 population census and 3.0% annual growth, and applying sentinel rates of orphanhood.

FIRST DRAFT

INTERNATIONAL HEALTH RESEARCH FOR DEVELOPMENT

A PROFILE OF SELECTED INTERNATIONAL ORGANIZATIONS

Produced by
The Secretariat,
The Interim Working Party
(International Conference, Bangkok 2000)
October, 2002

CONTENTS

FOREWORD

Introduction

This booklet lists and provides **brief thumbnail sketches** of a series of **international organizations in Health Research.** The purpose of this booklet is to inform the health research community of the major international players who have an impact or influence on the production, utilisation, resource flows, priority setting, policy making and governance of health research for development as well as being potential sources of institutional or individual research funding. There are hundreds of such organizations and therefore it is important to have some basic definitions which would determine which of these are to be included, as well as to have a way of classifying them.

Definitions

Taking the cue from the term **'international'**, organizations considered for inclusion in this list would be those that cover the world ,across regions (though not necessarily all), a region or a sub-region or be trans-national. However this should not exclude organizations, which are from one country alone if their influence or support goes outside their borders.
Taking the cue from the term **'health research'**, organizations could be included that:

- Exclusively deal with health research
- Have other activities but also have health research as a significant component
- For whom health research may be only a small component of its overall core businesses but is large enough to make an impact globally

Content

For each of the organizations listed, an attempt was made to include information concerning its nature, location, contact details including key officers, affiliation (parent body/sponsoring agency), type or character of the organization (government, NGO, non profit etc), its core business, its business related to health research, its role as a funding agency (whether direct/ catalyst/or clearing house), as well as its main thrust areas or areas of focus.

Classification

The entities are further classified into **ten categories**: international health organizations, multilateral development banks, national or bilateral development agencies, foundations and other research funding agencies, program or disease-based global networks, thematic initiatives, international research centers and university-based research institutes, the pharmaceutical industry, organizations with focused regional mandates, national bodies with international impact.

Sources

The information gathered here has been obtained from the following sources:

- The document " Health Research for Development: the Continuing Challenge" a discussion paper prepared for the International Conference for Health Research for Development Bangkok, 10-13 October 2000.
- Institutional memory in WHO/Global Forum for Health Research /COHRED (including the COHRED website)
- Participant list in major international conferences
- Internet search and
- Personal communication

Caveat

This list cannot lay claim to being a complete one and hence has to be of a dynamic nature with potential for updates, both of new initiatives as well as reflecting changes in existing ones. To facilitate this and to enhance its availability, it is proposed to post it in an appropriate host website.

A caveat should be made at this time that this document should be considered as a preliminary draft that is subject to amendments. While all effort has been made to authenticate the contents to reflect the true intent and philosophy of the organization being described, any inadvertent inaccuracies are regretted and subject to correction in the immediate next edition. To effect this please contact: mckayp@who.int

Conclusion

It is hoped that with this booklet, the health research community, especially from the developing countries will have access to information about the opportunities that are on offer. It will enable them to get in touch easily with those whom they feel can contribute to their own needs as well as to understand the myriad of roles that these international players can play.

It is acknowledged that this is but a draft but with sustained management it is hoped that it will emerge as a reliable and regularly updated resource portraying the many players in the landscape of health research in the world today.

List of Organizations Profiled

1. International Health Organizations

2. Multilateral Development Banks

3. National or Bilateral Development Agencies

4. Foundations & Other Research Funding Agencies

REPORTING FORM

SUBMITTED FOR : AMENDMENTS/NEW ENTRY

PLEASE SEND ELECTRONICALLY TO mckayp@who.int
OR FAX TO:...41 22 791 4169

Organization	
Location	
Date incorporated	
Type of organization	
Core business	
Research areas	
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	
Source of funding	
Publications	
Officers	
Contact details	

Organization	**Council for International Organizations of Medical Sciences (CIOMS)**
Location	Geneva
Date incorporated	1949
Type of organization	International, nongovernmental, non-profit-organization
Core business	To facilitate and promote international activities in the field of biomedical sciences, especially when the participation of several international associations and national institutions is deemed necessary.
Research areas	Bioethics · Health Policy, Ethics and Human Values - An International Dialogue · Drug Development and Use · International Nomenclature of Diseases
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	-Through its membership, CIOMS is representative of a substantial proportion of the biomedical scientific community. The membership of CIOMS in 2001 includes 51 international member organizations, representing many of the biomedical disciplines, and 16 national members mainly representing national academies of sciences and medical research councils -World Health Organization ; UNESCO ; United Nations Economic and Social Council (ESOSOC); International Council for Science (ICSU)
Governance	
Source of funding	
Publications	http://www.cioms.ch/frame_publications.htm
Officers	Professor Juhana E. Idänpään-Heikkilä, **Secretary-General** Mr Sev S. Fluss, **Special Adviser** **Email:** fluss@who.int
Contact details	c/o World Health Organization - CH-1211 Geneva 27 (Switzerland) Tel: (41-22) 791 34 06/791 21 11 Fax: (41-22) 791 31 11 - e-mail: cioms@who.ch (Visitors: World Council of Churches - Conseil Oecuménique des Eglises 150 Route de Ferney - 1202 Geneva) Tel.: +41 22 791 34 67 Fax: +41 22 791 31 11 E-mail: cioms@who.ch website: www.cioms.ch

Organization	**Council for Health Research for Development (COHRED)**
Location	Geneva, Switzerland
Date incorporated	1993
Type of organization	International Association under Swiss law
Core business	COHRED's mission is to act as a global activist in enhancing the development of effective national health research systems based on the ENHR strategy, including the values of equity and social justice, by working with in-country teams, by mobilising and supporting country and regional networks and by offering a platform for countries and regions to voice their concerns as equal partners in international forums.
Research areas	COHRED works directly with countries, facilitating technical and financial support for the development of effective national health research systems. It provides forums for exchange of information and experiences, through regional and country initiatives, networks, publications, and an interactive Web site. It stimulates and promotes partnerships at country, regional and global levels - between researchers, decision-makers, communities, and other interested stakeholders, such as the media, NGOs and donors. It collaborates in the production of tools that can be used to improve the effectiveness of research as a means of achieving equity in health development. It advocates for ENHR and voices the interests, needs and priority agenda of developing countries among international investors and other agencies.
Funding function	Catalyst, seed money and 'broker function'
Application mechanism	Contact the COHRED Secretariat
Total research Funds disbursed per annum	
Governance	COHRED Board
Source of funding	International and Bi-lateral funding Agencies
Publications	Regular newsletter-"Research into Action" Monographs ;Training Modules
Officers	Peter Makara, Coordinator Tel: 41 22 591 8900 Fax: 41 22 591 8910 E-mail: makara@cohred.ch; cohred@cohred.ch Chair of the Board-Marian Jacobs
Contact details	COHRED 11, Rue Cornavin 1201 Geneva 10 Switzerland Tel.+41 22 5918900 Fax.+41 22 5918910 email: cohred@cohred.ch http://www.cohred.ch

Organization	**Global Forum for Health Research**
Location	Geneva, Switzerland
Date incorporated	June, 1998
Type of Organization	Independent international foundation
Core business	The central objective of the Global Forum is to help correct the 10/90 gap in health research and focus research efforts on the health problems of the poor by bringing key actors together and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research.
Research areas	1. development and application of priority-setting methodologies to help correct the 10/90 gap. 2. the 10/90 gap and priorities regarding the global cross-cutting issues affecting health. 3. the 10/90 gap and priorities regarding the major risk factors affecting health. 4. the 10/90 gap and priorities regarding diseases and conditions.
Funding function	'Seed' money for projects related to the 10/90 gap.
Application mechanism	Prescribed forms to the Strategic and Technical Advisory Committee (STRATEC).
Total research Funds disbursed per annum	
Affiliation	Works with partners – governments, multi-lateral organizations, bilateral aid donors, international foundations, national and international civil society organizations and community organizations, women's organizations, research orientated institutions and universities, private sector companies and the media.
Governance	Managed by a 20-member Foundation Council assisted by a Strategic and Technical Advisory Committee (STRATEC) Council Chair: Richard Feachem STRATEC Chair: Pramilla Senanayake
Source of funding	Rockefeller Foundation, World Bank, WHO, Governments of Canada, Denmark, the Netherlands, Norway, Sweden and Switzerland. Targeted funding for forum supported networks: Bill and Melinda Gates Foundation, the Institute of Medicine of the US Academy of Sciences, the Department for International Development of the UK.
Publications	- The 10/90 Reports on Health Research (1999, 2000, and 2001- 2002) - Monitoring Financial Flows for Health Research, 2001. - Special targeted publications.
Officers	Louis J. Currat, Executive Secretary Tel: 41 22 791 3418, Fax: 41 22 791 4394 Email: curratl@who.int
Contact details	Address: c/o World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland Tel. 41 22 791 4260 Fax: 41 22 791 4394 Website: www.globalforumhealth.org

Organization	**United Nation's Children Fund (UNICEF)**
Location	HQ-New York, 7 Regional offices, 126 country offices
Date incorporated	1946
Type of organization	United Nations Organization
Core business	UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. Amongst its activities it strives to reduce childhood death and illness and to protect children in the midst of war and natural disaster
Research areas	http://www.unicef.org/programme/info/topic.html The UNICEF Innocenti Research Centre is based in Florence and is the main research arm of UNICEF, the United Nations Children's Fund, helping to shape the organization's human rights agenda for children--The Centre gives particular priority to problems of equity, economic affordability and the financing of social programmes to benefit children. Special interests—vaccination, (including polio eradication) HIV/AIDS - Research and Evaluation are essential functions.
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	National governments, NGOs (non-governmental organizations), other United Nations agencies and private-sector partners. Works within GAVI - UNICEF is responsible for buying and delivering the vaccines, auto-disable syringes and safety boxes that will be used to immunize millions of children in the next five years.
Governance	Executive Board Governing Body of 36 Nations
Source of funding	The 37 National Committees for UNICEF are private, not-for-profit organizations, primarily in industrialized countries, that support UNICEF programs Extensive networks of volunteers help the Committees raise funds, sell the well-known UNICEF greeting cards and carry out other activities.
Publications	http://www.unicef.org/infores/publications.htm Annual report. The 2002 UNICEF Annual Report summarizes major trends affecting children worldwide and the results secured by UNICEF and its partners on their behalf.
Officers	Carol Bellamy, Executive Director
Contact details	3 United Nations Plaza 44th Street between 1st and 2nd Avenues New York, New York Tel: 1 212 326.7000 - Switchboard UNICEF House Fax 1.212.887.7465 – Primary 1.212.887.7454 - Secondary http://www.unicef.org

Organization	**United Nations Development Programme (UNDP)**
Location	New York, USA
Date incorporated	
Type of organization	United Nations Organization
Core business	UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life.
Research areas	
Funding function	Supports some global health research initiatives such as TDR, HRP, IVI etc.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	On the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and our wide range of partners.
Governance	Executive Board which includes representatives from 36 nations around the world.
Source of funding	UN
Publications	
Officers	Mark Malloch Brown, Administrator
Contact details	One United Nations Plaza New York, NY 10017, USA Tel: (212) 906-5558 Fax: (212) 906-5364 European Office at Geneva Palais des Nations CH-1211, Genève 10, Switzerland Tel: 41 22 917 8542 Fax: 41 22 917 8001

Oganisation	**United Nations Educational, Scientific and Cultural Organization (UNESCO)**
Location	Paris, France
Date incorporated	1945
Type of organization	United Nations Organization
Core business	The main objective of UNESCO is to contribute to peace and security in the world by promoting collaboration among nations through education, science, culture and communication in order to further universal respect for justice, for the rule of law and for the human rights and fundamental freedoms which are affirmed for the peoples of the world, without distinction of race, sex, language or religion, by the Charter of the United Nations.
Research areas	
Funding function	UNESCO is not a research funding organization. Its budget is earmarked for projects planned and carried out by the Secretariat. However, UNESCO does welcome project proposals and in case it meets the organization's objectives, the Secretariat may request external partners to carry out the research.
Application mechanism	Support can only be given to projects presented to UNESCO by one of its Member States and included in the approved programme and budget. This kind of request should therefore be brought to the attention of the National Commission for UNESCO of the applicants country.
Total research Funds disbursed per annum	
Affiliation	http://www.unesco.org/general/eng/partners/index.shtml
Governance	Executive Board
Source of funding	1. Regular budget: $544 million for the biennium 2000-2001, composed of mandatory contributions from the Member States. 2. Extrabudgetary funds: An estimated $250 million for 2000-2001. Of these $62 million come from the UNDP and other UN agencies, $113 million from Funds-in-Trust (FIT). The FIT are funds for specific projects put at the disposal of UNESCO by donor countries to benefit a third party country.
Publications	http://upo.unesco.org/default.asp
Officers	Mr Georges B. Kutukdjian, Director
Contact details	1 rue Miollis SHS/HPE 75732 Paris Cedex 15 France Tel: 33 1 45 68 49 98 Fax: 33 1 45 68 55 15 Email: g.kutukdjian@unesco.org Website: www.unesco.org

Organization	**United Nations Fund for Population Activities (UNFPA)**
Location	New York
Date incorporated	1969
Type of organization	United Nations Organization
Core business	The United Nations Population Fund (UNFPA) supports developing countries, at their request, to improve access to and the quality of reproductive health care, particularly family planning, safe motherhood, and prevention of sexually transmitted infections (STIs) including HIV/AIDS. Priorities include protecting young people, responding to emergencies, and ensuring an adequate supply of condoms and other essentials.
Research areas	• Reproductive health, including family planning and sexual health. • Population and Development Strategy • Advocacy • Supports data collection and analysis to help countries achieve sustainable development
Funding function	
Application mechanism	UNFPA offers assistance only at a country's own request. While there is international agreement on population and development goals, each country decides its own approach.
Total research Funds disbursed per annum	
Affiliation	-United Nations -To promote cooperation and coordination among United Nations organizations, bilateral agencies, governments, non-governmental organizations (NGOs) and the private sector in addressing issues of population and development, reproductive health, gender equality and women's empowerment.
Governance	Executive Board which includes representatives from 36 nations around the world.
Source of funding	Extra-budgetary voluntary contributions from donor countries and private foundations. One fourth of the world's population assistance from donor nations to developing countries is channelled through UNFPA. The Fund provides a channel through which donors can direct assistance for specific population programmes or projects.
Publications	Http://www.unfpa.org/publications/pubmain.htm
Officers	Thoraya Ahmed Obaid, Executive Director
Contact details	United Nation Population Fund (UNFPA) Information and External Relations Division 220 East 42nd Street New York, NY 10017 USA Tel: (212) 297 5020 Fax: (212) 557 6416 Internet: http://www.unfpa

Organization	**World Health Organization (WHO)**
Location	Geneva, Switzerland , with 6 Regional Offices.
Date incorporated	1948
Type of organization	United Nations specialised agency for Health
Core business	Promotion and health protection remain the central and core business of WHO.
Research areas	Relevant Departments: - Department of Research Policy and Cooperation (RPC) strengthen the informational, scientific and ethical foundations of health research systems so that it can perform effectively and efficiently in contributing to health system development and health improvement, especially in poor countries. Located within the Evidence & Information for Policy (EIP) cluster at WHO headquarters in Geneva. - Tropical Disease Research (TDR) - UNDP/UNFPA/WHO/World Bank Special Programme of Research Development and Research Training in Human Reproduction (HRP).
Funding function	
Application mechanism	Technical Services Agreement
Total research Funds disbursed per annum	In 2000-2001 WHO disbursed approximately US$ 170 M in research funding with the majority spent by TDR ($74) and HRP ($55).
Affiliation	United Nations
Governance	WHO is governed by 191 Member States through the World Health Assembly.
Source of funding	Member states, Foundations, ……..
Publications	http://www.who.int/pub/en/
Officers	Dr Gro Harlem Brundtland – Director-General
Contact details	WHO Headquarters Avenue Appia 20 1211 Geneva 27 Switzerland Tel: 41 22 791 21 11 Fax: 41 22 791 3111 Website: www.who.int

ORGANIZATION	**African Development Bank**
Location	Abidjan, Cote d'Ivoire
Date incorporated	1964
Type of organization	The African Development Bank Group is a multinational development bank supported by 77 nations from Africa, North and South America, Europe and Asia. Headquartered in Abidjan the Bank Group consists of three institutions: • The African Development Bank [ADB], • The African Development Fund [ADF], • The Nigeria Trust Fund [NTF].
Core business	African Development Bank is dedicated to combating poverty and improving the lives of people of the continent and engaged in the task of mobilising resources towards the economic and social progress of its Regional Member Countries. Its mission is to promote economic and social development through loans, equity investments, and technical assistance.
Research areas	The Bank intends to play an increasingly important role in financing investments to foster health development as an integral part of socio-economic development in Africa. The overall objective is to facilitate the creation of health to enable populations to carry out the development process on a sustainable basis. The current development topics include: Healthy Population HIV/AIDS Women in development
Funding function	A portion of some project funds are earmarked for research
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	Other international and African Development Banks and Development Organizations.
Governance	Board of governors from sponsoring countries
Source of funding	
Publications	African >development Reviews African Development Reports and Economic Review Papers.
Officers	Omar Kabbaj, President K. Saiki (225) 20 20 41 18 (Media Contact) Samba Chifwambwa - S. Chifwambwa @afdb.org (Media Contact)
Contact details	Rue Joseph Anoma 01 BP 1387 Abidjan 01 Côte d'Ivoire Tel: (225) 20.20.44.44 Fax: (225) 20.20.49.59 Email: afdb@afdb.org

Organization	**Asian Development Bank**
Location	Manila, Philippines
Date incorporated	
Type of organization	
Core business	ADB is a multilateral development finance institution dedicated to reducing poverty in Asia and the Pacific.
Research areas	
Funding function	The adoption of poverty reduction as a strategy gave primacy to ADB's fight against poverty. ADB continues to carry out activities to promote economic growth, develop human resources, improve the status of women, and protect the environment, but these strategic development objectives now serve its poverty reduction agenda. Its other key development objectives, such as law and policy reform, regional cooperation, private-sector development, and social development, also contribute significantly to this main goal.
Application mechanism	There is no standard form for applications. Make sure your application contains all the following information. There are 18 items on this list. http://www.adb.org/PrivateSector/Operations/apply.asp
Total research Funds disbursed per annum	In 2001, in line with recent annual averages, ADB provided **loans** totaling US$5.3 billion, most of which went to the public sector.
Affiliation	
Governance	ADB is managed by a Board of Governors, a Board of Directors, a President, three Vice-Presidents, and the Heads of departments and offices. Each member country nominates one Governor and an Alternate Governor to vote on its behalf.
Source of funding	
Publications	http://www.adb.org/Publications/default.asp
Officers	
Contact details	Asian Development Bank (headquarters) 6 ADB Avenue, Mandaluyong City 0401 Metro Manila, Philippines P.O. Box 789 0980 Manila Philippines Tel: 63 2 632 4444 Fax: 63 2 636 2444 E-mail: information@mail.asiandevbank.org www.adb.org

Organization	**Caribbean Development Bank (CDB)**
Location	Barbados
Date incorporated	
Type of organization	
Core business	The purpose of CDB is "to contribute to the harmonious economic growth and development of the member countries in the Caribbean (hereinafter called the "region") and to promote economic cooperation and integration among them, having special and urgent regard to the needs of the less developed members of the region".
Research areas	
Funding function	• to assist regional members in the co-ordination of their development programmes with a view to achieving better utilization of their resources; making their economies more complementary, and promoting the orderly expansion of their international trade, in particular intra-regional trade; • to mobilise within and outside the region additional financial resources for the development of the region; • to finance projects and programmes contributing to the development of the region or any of the regional members; • to provide appropriate technical assistance to its regional members, particularly by undertaking or commissioning pre-investment surveys and by assisting in the identification and preparation of project proposals; • to promote public and private investment in development projects by, among other means, aiding financial institutions in the region and supporting the establishment of consortia; • to co-operate and assist in other regional efforts designed to promote regional and locally controlled financial institutions and a regional market for credit and savings; • to stimulate and encourage the development of capital markets within the region; and • to undertake or promote such other activities as may advance its purpose.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	
Source of funding	
Publications	
Officers	Dr. Compton Bourne, President (email: bournec@caribank.org) Mr. Neville Grainger, Vice President (email: graingn@caribank.org)
Contact details	Caribbean Development Bank P.O. Box 408, Wildey, St. Michael Barbados Fax : (246) 228-9670; (246) 426-7269 E-mail : info@caribank.org Tel: (246) 431-1600 Website : http://www.caribank.org

Organization	**Inter-American Development Bank**
Location	Washington DC
Date incorporated	1959
Type of organization	
Core business	The Bank was established to help accelerate economic and social development in Latin America and the Caribbean.
Research areas	
Funding function	- Creating appropriate regulatory mechanisms to encourage private investment - Supporting innovation and building institutional capacity to train the region's workforce for the future - Promoting the development of the small enterprise sector as the greatest source of economic growth and employment generation; and - Using equity as a development tool, by establishing special funds to invest in small-scale private sector enterprises.
Application mechanism	
Total research Funds disbursed per annum	Bank has mobilized financing for projects that represent a total investment of $273 billion. Annual lending has grown dramatically from the $294 million in loans approved in 1961 to $7.9 billion in 2001, after peaking at almost $10.1 billion in 1998.
Affiliation	
Governance	
Source of funding	
Publications	
Officers	Enrique V. Iglesias, President Donald F. Terry, Manager Investment Fund
Contact details	1300 New York Avenue, NW Washington, DC 20577 United States of America Tel: +202-623-1000 (Main Switchboard) http://www.iadb.org

Organization	**The World Bank**
Location	Washington
Date incorporated	1944
Type of organization	Bank is owned by more than 184 member countries.
Core business	The World Bank Group is one of the world's largest sources of development assistance.
Research areas	Relevant Department: Health, Nutrition & Population---: assist clients to improve health, nutrition, and population outcomes of poor people and protect people from the impoverishing effects of illness, malnutrition, and high fertility Nutrition Pop/Reproductive Health Poverty & Health Health Systems - Stewardship - Demand & Markets - Financing – Inputs Generation - Services - Performance Measures - Tools Public Health - HIV/AIDS - IMCI - Malaria - Mental Health - Onchocerciasis (Riverblindness) - Tobacco - Tuberculosis - Vaccines & Immunizations
Funding function	The World Bank Group is one of the world's largest sources of development assistance. In fiscal year 2002, the institution provided more than US$19.5 billion in loans to its client countries. It works in more than 100 developing economies with the primary focus of helping the poorest people and the poorest countries. Supports WHO programs like TDR, HRP etc.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	The Bank works with government agencies, nongovernmental organizations, and the private sector to formulate assistance strategies.
Governance	The World Bank is owned by 184 countries. Each member country is represented by a Board of Governors. The Governors carry ultimate decision-making power in the World Bank. The Executive Directors and the President of the World Bank - who serves as Chairman of the Board - are responsible for the conduct of the Bank's general operations and perform their duties under powers delegated by the Board of Governors.
Source of funding	http://wbln0018.worldbank.org World's capital markets, and, contributions from wealthier member governments.
Publications	http://publications.worldbank.org/ecommerce/ World Development Report Country data, projects and analysis
Officers	James D. Wolfensohn, President
Contact details	Headquarters – General Inquiries The World Bank 1818 H Street, N.W. Washington, DC 20433 U.S.A. Tel: (202) 473-1000 Fax: (202) 477-6391 Website:www.worldbank.org

Organization	**Agence Francaise de Development (AFD)**
Location	
Date incorporated	Established in 1992, changed name in 1998
Type of organization	Public industrial and commercial institution
Core business	The AFD provides financial facilities in order to support job-creating productive projects, both public and private, some of which cofinanced with other funding agencies. It also deploys and administers structural adjustment aid allocated by the Government.
Research areas	The AFD focuses its activities on the poorest countries. It is especially involved in 41 of the 48 countries classified as very low income by the United Nations.
Funding function	The AFD supports development through technical assistance and training programmes. Provides high-level technical training for senior officers and managers from developing countries and overseas France.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	The AFD is managed by a Chief Executive Officer appointed by Cabinet Decree on a proposal from the Minister for Economic Affairs, Finance and Industry, after consultation of the Ministers of Foreign Affairs, Cooperation, and Overseas France. The AFD Chief Executive Officer is assisted by a Deputy Executive Officer, three Executive Managers and a Secretary General
Source of funding	
Publications	All publications can be obtained by order form or by calling Communication Division on 01.53.44.33.72/34 17/39 74. You can also access Pressdoc, a weekly review of coverage of development issues by the French and international press and references bibliographic on development, and Produitdoc, which provides bimonthly and annual overview of trends on commodity markets
Officers	Henry-Philippe de Clercq, Secretary General Catherine Chevallier, Manager of Communication Tel: 33 1 53 44 36 78
Contact details	5, rue Roland Barthes 75598 PARIS Cedex 12 (France) Téléphone : 33 1 53 44 31 31 Fax: 33 1 53 44 38 24 www.cfd.fr Contact : com@cfd.fr

Organization	**Agencia Española de Cooperacion Internacional (AECI)**
Location	Madrid, Spain
Date incorporated	
Type of organization	Governmental
Core business	
Research areas	
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Government
Source of funding	http://www.reliefweb.int/ocha_ol/programs/response/donornet/index.html
Publications	
Officers	Mr. Jose Maria Ferreiro Moreno, Coordinator
Contact details	Avenida de los Reyes Catolicos, 4 28040 Madrid - Spain Tel:: +34 91 583 81 00/01/02 Fax : +34 91 583 83 10 /11/13 Email: centro.informacion@aeci.es Website: http://www.aeci.es

Organization	**The Australian Agency for International Development (AUSAID)**
Location	Canberra, Australia
Date incorporated	
Type of organization	Governmental
Core business	AUSAID's mission is to advance Australia's national interest by assisting developing countries to reduce poverty and achieve sustainable development.
Research areas	The aid program places high priority on effective partnerships with the countries it seeks to assist. Its programs are designed, delivered and assessed jointly with the governments and people of partner countries, tailored to meet their most pressing development needs. The five priority sectors are health, education, infrastructure, rural development, and governance. In the health sector, priority is given to communicable diseases, women's and children's health, non-communicable diseases, and health sector reform.
Funding function	
Application mechanism	Grants of up to $20,000 are available and preference will be given to proposals for projects in Asia and the Pacific. Applications for grants must be submitted to AUSAID ACPDS Guidelines are available on the AUSAID internet site http://www.ausaid.gov.au/business/other_opps or requests for the Guidelines can be made in writing to Carolyn Nimmo, Community Programs Section, AUSAID, GPO Box 887, Canberra ACT 2601, Fax: (61 2) 6206 4798 or email: Carolyn_nimmo@ausaid.gov.au. Telephone enquires about the ACPDS may be directed to Carolyn Nimmo on (02) 6206 4605. Contract Contact: Carolyn Nimmo (61 2) 6206 4605. Project Contact: Carolyn Nimmo (61 2) 6206 4605.
Total research Funds disbursed per annum	http://www.ausaid.gov.au/budget01/default.cfm
Affiliation	Government of Australia
Governance	
Source of funding	Government of Australia
Publications	Publications on AusAID health policy and NGO funding opportunities 2001 are also available from the AusAID website http://www.ausaid.gov.au/publications/pdf/health_policy1998.pdf http://www.ausaid.gov.au/publications/pdf/ngo_funding_opps_guidelines_2001.pdf
Officers	Andrew Rowell
Contact details	The Australian Agency for International Development (AUSAID) GPO Box 887 ACT 2601 Canberra Australia Tel: +61-2-62064000 Fax : +61-2-62064880 Email: Andrew_Rowell@ausaid.gov.au Website: http://www.ausaid.gov.au

Organization	**Canadian International Development Agency (CIDA)**
Location	Quebec, Canada
Date incorporated	
Type of organization	Government
Core business	CIDA supports sustainable development activities in order to reduce poverty and to contribute to a more secure, equitable and prosperous world. Four special areas-social development, health and nutrition, basic education, HIV/AIDS and child protection.
Research areas	Research in support of health systems, appropriate technologies, operations research.
Funding function	To support efforts to provide primary health care, basic education, family planning, nutrition, water and sanitation, and shelter. Canada will continue to respond to emergencies with humanitarian assistance. Canada will commit 25% of its ODA to basic human needs as a means of enhancing its focus on addressing the security of the individual.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	CIDA works in partnership with all elements of Canadian society, including the business community, non-governmental organizations (NGOs), professional associations, co-operatives, educational institutions and international agencies.
Governance	
Source of funding	
Publications	General information | Business and employment | Policies Strategies | Research papers | Reports to Parliament | Statistical Report on Official Development Assistance
Officers	Mr Len Good, President George Shaw, Director General
Contact details	200 Promenade du Portage Hull, Quebec K1A 0G4, Canada Tel: (819) 997-5006 Toll free: 1-800-230-6349 Fax: (819) 953-6088 E-mail: info@acdi-cida.gc.ca Website: www.acdi-cida.gc.ca

Organization	**Danish International Development Agency - DANIDA**
Location	Copenhagen, Denmark
Date incorporated	
Type of organization	Governmental
Core business	The main focus of all DANIDA projects is poverty reduction. Crosscutting issues are environment, gender and democracy, and good governance.
Research areas	HIV/AIDS Private Sector Development Children and Youth Conflict Prevention
Funding function	Support is therefore only given to researchers who have a clear and visible connection to the Danish research environment. Only research that can help solve the economic and social problems, which the developing world deals with, will be favoured. DANIDA finances also ad hoc activities related to other Danish supported projects or sector programs.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Ministry of Foreign Affairs
Source of funding	Government
Publications	http://www.um.dk/aspfiles/ny_publiste.asp?kat=82
Officers	
Contact details	http://www.um.dk/danida/

Organization	**Department for International Development Cooperation (Finnida)**
Location	Helsinki, Finland
Date incorporated	
Type of organization	Governmental
Core business	The main objectives of Finnida are: reducing poverty; assisting developing countries in solving their environmental problems; and promoting equality, democracy and human rights. Finnish development priorities emphasise the need for sustained economic growth, equitable income distribution and special arrangements for supporting the poor and enabling them to participate in productive activities.
Research areas	Promotion of global security Reduction of widespread poverty Promotion of human rights and democracy Prevention of global environmental problems Promotion of economic dialogue
Funding function	In an effort to achieve practical results in the alleviation of poverty, Finnida will emphasise basic education and health services. It also supports efforts to improve family planning and reproductive health as part of basic health services, and to strengthen the participation of women in social and economic activity
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	
Source of funding	
Publications	Government Decision-in-principle February 2001 Culture and sustainable development Finland's development policy report 1999 now available in English **Finland's Development Cooperation 2001, Democracy and Globalization: Promoting a North-South Dialogue**
Officers	Mr Hannu Vikman Contact Address: Finnida, Katajanokanlaituri 3, 00160 Helsinki 16, Finland Tel: +358 9 1341 6426 Fax: +358 9 1341 6428 E-mail: hannu.vikman@formin.fi
Contact details	Department for International Development Cooperation (Finnida) Kanavakatu 4a 00160 Helsinki, Finland Postal address: P.O. Box 127 FIN-00161 Helsinki Finland Tel: 358 9 1341 6370 or 1341 6349 Fax: 358 9 1341 6375 Email: kyoinfo@formin.fi Website: http://global.finland.fi/english/

Organization	**Department for International Development, UK (DFID)**
Location	London, UK
Date incorporated	
Type of organization	Government-relevant department-Health and Population department
Core business	DFID is the UK Government department working to promote sustainable development and eliminate world poverty.
Research areas	To help countries to develop and implement Intellectual Property Rights (IPR) regimes suited to their national circumstances,
Funding function	Investment in research and research capacity in developing countries and through partnerships with the science community in the UK and internationally. The outcomes of this research will be disseminated widely so that the maximum benefit can be derived from it. Application Form provided .
Application mechanism	DFID funds a considerable amount of research through international bodies. DFID helps make the necessary knowledge available and accessible by (i) promoting a pro-poor international health research agenda in its dialogue with other UK and international funders of health research, and (ii) supporting the knowledge-related activities
Total research Funds disbursed per annum	DFID spends well over £100 million each year on development-oriented research and capacity building managed by its Advisory Groups and country and regional programmes.
Affiliation	DFID is in partnerships with universities, non-governmental Organizations and the private sector to create the capacity to use knowledge effectively.
Governance	Government, advisory committees
Source of funding	UK government
Publications	Latest DFID Publications
Officers	
Contact details	DFID 1, Palace Street London SW1E 5HE, UK Tel: +44 (0) 20 7023 0000 Fax: +44 (0) 20 7023 0019 Email: enquiry@dfid.gov.uk Website: www.dfid.gov.uk/

Organization	**German Agency for Technical Cooperation (GTZ)**
Location	Eschborn, Germany
Date incorporated	1975
Type of organization	Governmental
Core business	GTZ's aim is to improve the living conditions and perspectives of people in developing and transition countries. In more than 130 partner countries, GTZ is supporting 2,700 development projects and programmes, chiefly under commissions from the German Federal Government. Within the framework of international co-operation, GTZ undertakes technical co-operation tasks.
Research areas	
Funding function	The development projects supported by GTZ cover a wide spectrum of thematic areas and tasks. These include, for example, AIDS prevention in Kenya, A project is sustainable when, among other things, it continues to function over the long term without external support.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	GTZ works jointly with the private sector in developing countries and countries in transition.
Governance	Government-owned corporation
Source of funding	Government
Publications	http://www.gtz.de/publikationen/english/
Officers	Dr. Annette Backhaus Senior Planning Officer
Contact details	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH Dag-Hammarskjöld-Weg 1-5 65760 Eschborn Germany Tel: +49 (0)6196 79-0 Fax: +49 (0)6196 79-1115 Website: www.gtz.de

Organization	**Japanese International Cooperation Agency (JICA)**
Location	Tokyo, Japan
Date incorporated	
Type of organization	Governmental
Core business	JICA is responsible for the technical cooperation aspect of Japan's ODA programs.
Research areas	
Funding function	JICA's technical cooperation is aimed at transferring technology and knowledge that can contribute to the socio-economic development of developing countries. However, JICA is not a funding agency and therefore, does not provide assistance in the form of cash grant.
Application mechanism	JICA's programs are available upon request through the official diplomatic channels set by the Government and the Government of Japan (GOJ). The Information booklets for the request survey are distributed to major government agencies every year usually in April with the deadline in July. Application forms with detailed explanation are contained in the booklet.
Total research Funds disbursed per annum	
Affiliation	
Governance	Government mechanisms. JICA has about 1,200 staff members working both in Japan and at its more than fifty overseas offices.
Source of funding	Government
Publications	http://www.jica.go.jp/english/publication/index.html
Officers	Mr Yushu Takashima, Vice President
Contact details	Japan International Cooperation Agency 6-13F, Shinjuku Maynds Tower 1-1, Yoyogi 2-chome, Shibuya-ku, Tokyo 151-8558, Japan Tel: 03-5352-5311/5312/5313/5314 Website: http://www.jica.go.jp/

Organization	**The Norwegian Agency for Development Cooperation (NORAD)**
Location	Oslo, Norway
Date incorporated	
Type of organization	Governmental
Core business	The main goal is to contribute towards lasting improvements in the economic, social and political conditions under which people live in developing countries, with special emphasis on assistance which benefits the poorest sector of the community.
Research areas	Basic and long-term research and higher education at university level Regional initiatives and international cooperation in research and higher education Long-term research cooperation based on the principle of equality Higher education programmes offered by Norwegian universities.
Funding function	
Application mechanism	NORAD does not support particular research projects that are not integrated in particular programmes of bilateral development aid. The NUFU-programme, i.e. the Norwegian Council of Universities Programme for Development in Research and Education, which is funded by NORAD, supports research cooperation between universities in Norway and the South, including health research. For further information, you may contact: siu@siu.no
Total research Funds disbursed per annum	
Affiliation	
Governance	
Source of funding	
Publications	Annual Reports
Officers	Lill-Ann Bjaarstad Medina, Research Advisor, Technical Department
Contact details	Tollbugaten 31, PO Box 8034 0030 Oslo Norway Tel: +47 22 24 02 48 Fax: +47 22 24 02 76 Email : informasjonssenteret@oslo.norad.telemax.no Email : lill-ann.medina@norad.no Website : http://www.norad.no

Organization	**Swedish International Development Cooperation Agency Department for Research Cooperation (SIDA/Sarec)**
Location	Stockholm, Sweden
Date incorporated	
Type of organization	Government Agency for bi-lateral international development co-operation
Core business	The objective of research co-operation is to support research which is of significance for development in developing countries. This is done by providing support to improve the capacity of developing countries to run research programmes of their own and by providing support to research which can contribute to the solution of important development problems.
Research areas	SIDA's support to health research stretches from biomedical to social science research on poverty related health problems like infectious diseases, malnutrition, sexual and reproductive health, and non-communicable diseases, which is increasing in prevalence developing countries. Furthermore, SIDA supports research within the areas of health policies, health system development and health economy.
Funding function	
Application mechanism	SIDA support to research is mainly given to universities after invitation in bilateral agreements and to regional networks, special programmes in priority areas and international programs after negotiations. A minor part of the budget is allocated for calls for proposals, a programme called "SIDA's research council" (only open for Swedish applicants) and for the South African-Swedish Research Partnership Programme.
Total research Funds disbursed per annum	
Affiliation	The support is being channelled through international organizations like WHO, regional networks and bilaterally to medical faculties at universities in Africa, Asia and Latin America, Embassies, European Union.
Governance	Swedish Government-Board and Research Council
Source of funding	Swedish Government
Publications	Most research results are published in international journals and not by SIDA. Only a minor part is published by SIDA. Publications can be ordered on the web site.
Officers	Senior Research Advisor, Ass. Prof Barbro Carlsson
Contact details	Division for Thematic Research SE 105 25 Stockholm Sweden Tel: +46 8 698 5000 Fax: +46 8 698 5656 Email: barbro.carlsson@sida.se Website : http://www.sida.org and http://www.eufou.se

Organization	**Swiss Agency for Development and Cooperation (SDC)**
Location	Bern, Switzerland
Date incorporated	
Type of organization	Governmental
Core business	The primary philosophy of SDC is to fight poverty through participatory programs, creating sustainable improvements in peoples' lives by involving them in the process. Its main intentions are to improve access to education and basic health care, to promote environmental health, to encourage economic and governmental autonomy, and to improve equity in labor.
Research areas	
Funding function	SDC provides services through direct operations, by supporting the programs of multilateral organizations, and by co-financing and making financial contributions to the programs of both Swiss and international private assistance agencies.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	Swiss Government
Governance	
Source of funding	SDC is organized and funded by the Swiss government and operates by financing programs both directly and in partnership with other agencies to countries around the world.
Publications	http://web.mit.edu/urbanupgrading/urbanenvironment/news/publications.htm
Officers	Mrs Barbara Hofmann
Contact details	Swiss Agency for Development and Cooperation (SDC) Federal Department of Foreign Affairs Eigerstrasse 73 CH - 3003 Bern Switzerland Tel. (Bern): ++41 31 323 21 06 Fax: ++41 31 324 16 94 Email: Barbara.Hofmann@deza.admin.ch Email: info@deza.admin.ch Website: http://www.sdc-gov.ch

Organization	**The US Agency for International Development (USAID)**
Location	Washington, USA
Date incorporated	
Type of organization	Governmental
Core business	USAID's mission is to support the people of developing and transitional countries in their efforts to achieve enduring economic and social progress and to participate more fully in resolving the problems of their countries and the world. USAID has defined its major functions and operations to address globalization and conflict through three program pillars. One pillar, the Global Health and Population pillar is to stabilize world population and protect human health. This pillar of activities includes maternal and child health, nutrition, women's reproductive health, HIV/AIDS, and programs that address other infectious disease such as malaria and tuberculosis.
Research areas	USAID is the principal US agency to extend assistance to countries recovering from disasters, trying to escape poverty, and engaging in democratic reforms. Through its Population, Health and Nutrition Programmes, USAID works to improve the quality of life for millions of people around the world. Child and Maternal Health Infectious Diseases HIV/AIDS Population/Reproductive Health
Funding function	Supports: 1) increased use by women and men of voluntary practices that contribute to reduced fertility (2) increased use of key maternal health and nutrition interventions (3) increased use of key child health and nutrition interventions (4) increased sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic and (5) increased use of effective interventions to reduce the threat of infectious diseases of major public health importance.
Application mechanism	www.usaid.gov/odw/covlet.html
Total research Funds disbursed per annum	http://www.usaid.gov/pubs/cbj2002/request.html
Affiliation	
Governance	
Source of funding	
Publications	www.usaid.gov/pubs
Officers	Robert Emrey
Contact details	Office of Health, Bureau for Global Health and Population 1300 Pennsylvania Avenue 20523-3700 Washington, D.C. USA Tel: 202-712-4583 Fax: 202-216-3702 Email : REMREY@USAID.GOV Website: www.usaid.gov

Organization	**AP Sloan Foundation**
Location	New York, USA
Date incorporated	
Type of organization	Non Governmental
Core business	
Research areas	Areas in this program include molecular evolution, theoretical neurobiology, computational molecular biology, astrophysics (Sloan Sky Survey), limits to knowledge (The Known, Unknown, Unknowable), and marine science (Census of Marine Life).
Funding function	The Foundation provides support in selected areas of research that are of scientific significance and where its support can make a difference. This usually means that there are no major government funders.
Application mechanism	The Foundation has no deadlines or standard forms. Prefer concise, well-organized proposals. The Foundation accepts proposals sent by e-mail. A brief letter of inquiry, rather than a fully developed proposal, is an advisable first step for an applicant, conserving his or her time and allowing for a preliminary response regarding the possibility of support.
Total research Funds disbursed per annum	From $500 to $45,000 (the maximum allowed) per proposal.
Affiliation	
Governance	
Source of funding	
Publications	
Officers	Paula J. Osiewski, Program Director Email: olsiewski@sloan.org Harold T. Shapiro, Chairman
Contact details	AP Sloan Foundation 630 Fifth Avenue Suite 2550 10111 New York NY USA Tel: +1 212-649-1649 Fax: +1 212-757-5117 Website : http://www.sloan.org

Organization	**Bill and Melinda Gates Children's Vaccine Program (CVP)**
Location	Washington, USA
Date incorporated	
Type of organization	
Core business	Established to promote equal access to lifesaving vaccines worldwide, CVP has been instrumental in revitalizing the commitment of the international community to universal childhood immunization. The Vaccine Fund is a financially independent mechanism designed to raise new resources for immunization and swiftly channel them to developing country health systems.
Research areas	Better Immunization Solutions for a Changing World Getting Vaccines to All the Children Who Need Them Working Together in Global Partnership
Funding function	The Vaccine Fund provides resources directly to country governments, not through other agencies. The three basic conditions for support from the Vaccine Fund are: 1. the country must have a functioning Inter-agency Coordination Committee (ICC) focussed on immunization (or an equivalent collaborative mechanism) to ensure local coordination and accountability; 2. the country must submit a recent assessment of national immunization services; and 3. the country must submit a coherent, multi-year plan for immunization, including plans for sustaining immunization activities after Vaccine Fund support is terminated.
Application mechanism	Vaccine Fund award decisions are based on an application process initiated by government health officials and partner agency staff in countries (e.g., UNICEF, WHO, bilateral development agencies). The proposals are submitted to the GAVI Secretariat and reviewed by an independent panel of experts. The GAVI Board then evaluates the panel's recommendations. The Board of the Vaccine Fund swiftly reviews the GAVI Board recommendations.
Total research Funds disbursed per annum	www.gatesfoundation.org/globalhealth/grants/default1.htm
Affiliation	
Governance	
Source of funding	Bill & Melinda Gates Foundation
Publications	
Officers	
Contact details	PATH (Program for Appropriate Technology in Health) 4 Nickerson Street 98109-1699 Seattle Washington USA Tel: (206) 285-3500 Fax: (206)285-6619 Email : info@childrensvaccine.org

Organization	**Bill & Melinda Gates Foundation**
Location	Seattle, WA, USA
Date incorporated	January 2000
Type of organization	Endowment foundation
Core business	The Bill & Melinda Gates Foundation is dedicated to improving people's lives by sharing advances in health and learning with the global community.
Research areas	The foundation's Global Health Program is focused on reducing global health inequities by accelerating the development, deployment and sustainability of health interventions that will save lives and dramatically reduce the disease burden in developing countries. Supports initiatives like GAVI.
Funding function	http://www.gatesfoundation.org/grants/default.htm
Application mechanism	The Bill & Melinda Gates Foundation is proactive in its funding, awarding the majority of its grants to organizations selected by program teams. The foundation favors preventive approaches and collaborative endeavors with government, philanthropic and not-for-profit partners. Priority is given to grants that leverage additional support and serve as a catalyst for long-term, systemic change. Please note that the foundation does not accept unsolicited proposals.
Total research Funds disbursed per annum	
Affiliation	
Governance	
Source of funding	Family Foundation
Publications	Global Health Program Newsletter
Officers	Joe Cerrell Director, Public Affairs Tel: (206) 709-3400 Fax: (206) 709-3252 Email: media@gatesfoundation.org
Contact details	Bill & Melinda Gates Foundation PO Box 23350 Seattle, WA 98102 USA Tel: (206) 709-3140 For general questions or grant inquires, please contact the foundation via email: info@gatesfoundation.org Website: www.gatesfoundation.org

Organization	**Carnegie Foundation**
Location	Menlo Park, CA, USA
Date incorporated	1905
Type of organization	Non Governmental Organization
Core business	A national and international centre for research and policy studies about teaching.
Research areas	
Funding function	The Foundation is an independent institution whose primary activities of research and writing have resulted in published reports on every level of education, from kindergarten through graduate and professional studies. It conducts its non-profit research activities through a small group of distinguished scholars who generate, critique and monitor advances in the theory and practice of education in the United States and worldwide.
Application mechanism	Apply for Higher Education Carnegie Scholars. Procedures available on website.
Total research Funds disbursed per annum	
Affiliation	
Governance	The Foundation is governed by a self-perpetuating board of trustees composed of leaders in education, business and government.
Source of funding	
Publications	E library, publications by Carnegie Foundation Scholars http://www.carnegiefoundation.org/Publications/index.htm
Officers	Charlie Moran, Administrative Coordinator: moran@carnegiefoundation.org Johanna Wilson, Secretary/special assistant to the president: wilson@carnegiefoundation.org
Contact details	The Carnegie Foundation for the Advancement of Teaching 555 Middlefield Road Menlo Park, CA 94025 USA Tel: 650-566-5100 Fax: 650-326-0278 Website: www.carnegiefoundation.org

Organization	**Fogarty International Center**
Location	Bethesda, USA
Date incorporated	1968
Type of organization	Governmental
Core business	The Fogarty International Center promotes and supports scientific research and training internationally to reduce disparities in global health.
Research areas	Such as tobacco, genetics, HIV/AIDS, malaria, emerging infectious diseases, environmental and occupational health, ecology of infectious disease, biodiversity, maternal and child health, international research bioethics, etc.
Funding function	http://www.nih.gov/fic/about/centerfacts/02fundstrategy.html New program-Global Health Research Initiative Program for new foreign investigators that concentrates on establishing research capacity for new investigators in their home countries.
Application mechanism	Applicants are encourage to access the application instructions and forms via the Internet. Several mechanisms are available for research and research training awards. http://grants.nih.gov/grants/forms.htm#applications
Total research Funds disbursed per annum	2002: 45.1 million USD
Affiliation	NIH, USA
Governance	Advisory Board
Source of funding	Appropriation from Congress of the USA
Publications	
Officers	Gerald T. Keusch, Director Tel: +301 496 1415 Fax: +301 402 2173 E-mail: keuschg@nih.gov Mark Miller, Associate Director for Research Tel: +1301496 0815 Fax: +1 301 496 8496 E-mail: millermark@nih.gov Bruce Butrum, Grants Management Officer
Contact details	Fogarty International Center National Institutes of Health 31 Center Drive, MSC 2220 Bethesda, Maryland 20892-2220 USA

Organization	**Ford Foundation**
Location	
Date incorporated	1936
Type of organization	
Core business	The Ford Foundation is a resource for innovative people and institutions worldwide. Goals are to: • Strengthen democratic values, • Reduce poverty and injustice, • Promote international cooperation and • Advance human achievement
Research areas	
Funding function	
Application mechanism	The Foundation does not have an application form. Instead, a brief letter of enquiry should be sent to determine whether the Foundation's present interests and funds permit consideration of the request. The letter should include: • The purpose of the project for which funds are being requested • Problems and issues the proposed project will address • Information about the organization conducting the project • Estimated overall budget for the project • Period of time for which funds are requested • Qualifications of those who will be engaged in the project
Total research Funds disbursed per annum	
Affiliation	
Governance	The Foundation is governed by an international board of trustees and managed by an international professional staff. The trustees determine board policies, set program and management budgets, approve appropriations, and review program and grant objectives and accomplishments.
Source of funding	The Foundation gets its funds from an endowment valued at $10.8 billion as of the fiscal year ending September 30, 2001. These assets are invested in a diversified portfolio that includes equities and fixed income securities (both U.S. and international), venture capital, and real estate investments.
Publications	Annual Report Quarterly Magazine
Officers	
Contact details	Ford Foundation (Headquarters) 320 East 43rd Street New York, NY 10017 USA Tel: (212) 573-5000 Fax: (212) 351-3677

Organization	**International Development Research Centre (IDRC)**
Location	Ottawa, Canada
Date incorporated	1970
Type of organization	Governmental
Core business	The International Development Research Centre (IDRC) is a public corporation created to help developing countries find long-term solutions to the social, economic, and environmental problems they face.
Research areas	• Ecosystem approaches to Human Health • Governance, Equity and Health • Research for International Tobacco Control • Partnership for Global Health Equity
Funding function	IDRC funds the work of scientists working in universities, private enterprise, government, and non-profit organizations in developing countries and provides some support to regional research networks and institutions in the Third World.
Application mechanism	Refer to : "How to Apply for IDRC Funding" To view the IDRC Funding guide, please visit: http://www.idrc.ca/institution/proposition_e.html
Total research Funds disbursed per annum	Budget $CAD 135.3 million (2000-2001)
Affiliation	
Governance	21-member, International Board of Governors oversees its operations
Source of funding	Canadian Government
Publications	Special monographs Health Systems Research (HSR) Training Series, IDRC/WHO (1992)
Officers	Maureen O'Neil, President Christina Zarowsky, Senior Scientist, Health
Contact details	250 Albert Street PO Box 8500 Ottawa , Ontario Canada K1G 3H9 Tel: +1 (613) 236 6163

Organization	**National Institute of Allergy & Infectious Diseases (NIAID)**
Location	Bethesda, MD, USA
Date incorporated	
Type of organization	
Core business	NIAID supports research on parasitic and other infectious diseases that predominantly affect populations living in developing countries but also are of global importance.
Research areas	- Vaccine Research - Allergy, Immunology, and Transplantation - AIDS Vaccine and Prevention Research - Paediatric Therapeutic Clinical Trials
Funding function	Approximately 80 % of NIAID's budget supports research conducted by scientists at universities, medical schools, and private research institutions, primarily within the United States.
Application mechanism	http://www.niaid.nih.gov/ncn/grants/default.htm
Total research Funds disbursed per annum	
Affiliation	
Governance	Part of NIH
Source of funding	Government
Publications	http://www.niaid.nih.gov/publications/
Officers	Laurie Doepel, Acting Director Communications Tel: + (301) 496-5717 ldoepel@nih.gov
Contact details	NIAID Office of Communications & Public Liaison Building 31, Room 7A-50 31 Center Drive MSC 2520 Bethesda, MD 20892-2520 USA Tel: 301-496-5717 Website. www.niaid.nih.gov

Organization	**Population Council**
Location	New York, USA
Date incorporated	1952
Type of organization	The Population Council is an international, non-profit institution.
Core business	The Population Council's mission is to improve the well-being and reproductive health of current and future generations and to help achieve a humane, equitable, and sustainable balance between people and resources.
Research areas	Biomedical Research and Productive Development Population and Social Policy Reproductive Health and Family Planning
Funding function	The Council helps to improve the research capacity of reproductive and population scientists in developing countries, through grants, fellowships, and support of research centers.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	The Council is governed by a board of trustees composed of men and women from 12 countries. This group includes leaders in research, policy development, and business.
Source of funding	The Bill and Melinda Gates Foundation, the Andrew W. Mellon Foundation, and the Rockefeller Foundation.
Publications	http://www.popcouncil.org/pubasps/publications.asp
Officers	Tammy Allen, special assistant to the president tallen@popcouncil.org
Contact details	New York Headquarters Population Council One Dag Hammarskjold Plaza New York, New York 10017 USA Tel: (212) 339-0500 Fax: (212) 755-6052 Email: pubinfo@popcouncil.org

Organization	**Rockefeller Foundation**
Location	New York, USA
Date incorporated	1913
Type of organization	
Core business	The Rockefeller Foundation is a knowledge-based, global foundation with a commitment to enrich and sustain the lives and livelihoods of poor and excluded people throughout the world. It works : - to help broaden the benefits and reduce the negative impacts of globalization on vulnerable communities, families and individuals around the world ; - to advance global health equity by pursuing the reduction of avoidable and unfair differences in the health status of populations.
Research areas	The Foundation has identified four themes, or subject areas of work: Creativity & Culture, Food Security, Health Equity, and Working Communities. A cross-theme of Global Inclusion supports, promotes and supplements the work of the four themes.
Funding function	The foundation is a pro-active grant-maker where the staffs seek out opportunities that will advance the Foundation's long-term goal. Unsolicited grant proposals are strongly discouraged. Also supports the WHO/Rockefeller Foundation International Awards. Scheme for capacity building in Health Research. Special emphasis on sub- Saharan Africa and South and Southeast Asia. There is also an offer of a unique place for study and creative endeavour through the Bellagio Study and Conference Centre in Northern Italy.
Application mechanism	Prospective applications should refer to the Information for Applicants section of the Foundation's webpage http://www.rockfound.org
Total research Funds disbursed per annum	
Affiliation	Will join with governments, industry, other foundations and non-governmental Organizations where appropriate.
Governance	Board of Trustees
Source of funding	From endowments
Publications	Monographs, annual reports
Officers	Associate Director, Health Sciences Division: Ms Sarah Macfarlane Chair: James Orr III President: Gordon Conway
Contact details	Health Sciences Division The Rockefeller Foundation 420 Fifth Avenue 10018 New York NY USA Tel: 1-212-852 8324 Fax: 1-212-852 8279 Email : smacfarlane@rockfound.org Website : http://www.rockfound.org Contact : Ms Sarah Macfarlane, Associate Director

Organization	**W.K. Kellogg Foundation**
Location	Michigan, USA
Date incorporated	1930
Type of organization	Non-profit organization
Core business	To help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations.
Research areas	Health, Food systems/rural development, Youth and education/higher education, Philanthropy and volunteerism.
Funding function	Funds research only as part of a broader program to which assistance is already provided. Grants are made only to non-profit institutions or organizations. • Create brighter futures through education by improving educational outcomes for youth. • Increase economic self-sufficiency through a growth in economic assets for families and neighbourhoods. The Kellogg Foundation, therefore, supports four fundamental activities in selecting neighbourhood-based settings: • Build and strengthen leadership capacity among youth and adults. • Build and strengthen social networks within neighbourhoods and between neighbourhoods, and the broader community. • Transform institutional policies and build institutional capacity at the neighbourhood and community level. • Impact broader public policies related to building economic assets and improving educational outcomes for children and youth.
Application mechanism	Grant applicants to submit their requests electronically using the Foundation's online application (http://www.wkkf.org/Grants/Application.asp). Grant applications who do not apply electronically should submit a pre-proposal letter through the mail address provided. Written pre-proposal letters should be addressed to: Supervisor of Proposal Processing W.K. Kellogg Foundation One Michigan Avenue East Battle Creek, Michigan 49017-4058, USA
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Trustees
Source of funding	
Publications	
Officers	Arriagada Riedemann, Program Director
Contact details	One Michigan Avenue East 49017-3398 Battle Creek MI USA Tel: +1 616 968-1611 Fax: +1 616 968-0413 Email : http://www.wkkf.org

Organization	**The Wellcome Trust**
Location	London, UK
Date incorporated	
Type of organization	A charitable Organization subject to regulation by the UK Charity Commission.
Core business	The Wellcome Trust is the world's largest medical research charity and its mission is to foster and promote research with the aim of improving human and animal health.
Research areas	Biomedical research, primarily through UK universities, but also in the developing world. Also funds research in the history of medicine and into the social and ethical implications of biomedical research.
Funding function	The Wellcome Trust has a long-standing interest in tropical medicine research and offers opportunities for training and for undertaking research projects in the tropical and/or developing countries of the world. The following awards are offered to scientists from developing countries: Training Fellowships for Scientists from Tropical and Developing Countries: intended to provide training and research experience for applicants from tropical and/or developing countries. Training can take place at international centres of excellence in any country of the developing world, in the UK or the Republic of Ireland, with a substantial period of research undertaken in the applicant's home country. Studies of infectious or non-communicable diseases are equally acceptable. Research Development Awards: these awards are to enable junior clinical and non-clinical researchers from developing countries to return to their home institution and establish a program of research with continued collaboration and support of a UK or Republic of Ireland sponsor. Studies of infectious or non-communicable diseases are equally acceptable. Also offers support for symposia, advance courses and media training Runs a research-funding program on biomedical ethics.
Application mechanism	Preliminary applications should include required details. If the preliminary details meet the requirements of the scheme, a full application form will be sent out. Applications are considered throughout the year and at least six months should be allowed between submission of the full application and the proposed start date. Details on the Trust's major funding policies can be found on http://www.wellcome.ac.uk/en/1/bio.html
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Governors, works through the Executive Board and is supported by Advisory Committees
Source of funding	The trust has assets worth some 15 billion pounds, starting with a bequeath from Sir Henry Wellcome
Publications	Annual Review 2001
Officers	Prog. Manager: Catherine Davies
Contact details	The Wellcome Building 183 Euston Road NW1 2BE London, UK Tel: +44 (0)20 7611 8888 Fax: +44 (0)20 7611 8545 Email: contact@wellcome.ac.uk

Organization	**Burroughs-Wellcome Fund (BWF)**
Location	Research Triangle Park, NC, USA
Date incorporated	1955
Type of organization	Independent private foundation
Core business	The Burroughs Wellcome Fund is an independent private foundation dedicated to advancing the medical sciences by supporting research and other scientific and educational activities. Within this broad mandate, BWF's general strategy is to help scientists early in their careers develop as independent investigators, and to support investigators who are working in or entering fields in the basic medical sciences that are undervalued or in need of encouragement. BWF, which is governed by a Board of Directors composed of distinguished scientists and business leaders, is not affiliated with any corporation.
Research areas	Basic biomedical sciences, infectious diseases, interfaces in science, science education, translational research.
Funding function	Research funder.
Application mechanism	BWF channels its financial support primarily through competitive award programs, which are directed by advisory committees composed of leading scientists and educators. Most awards are made to degree-granting institutions on behalf of individual researchers, who must be nominated by their institution.
Total research Funds disbursed per annum	With its endowment of about $600 million, BWF makes approximately $35 million in grants annually.
Affiliation	
Governance	Board of Directors.
Source of funding	Private endowment
Publications	Quaterly newsletter (Focus), Annual Reports, Programs & Grant guidelines.
Officers	President: Enriquetta Bond; Chair of Board: David M. Kipnis
Contact details	Burroughs Wellcome Fund Post Office Box 13901 Research Triangle Park, NC 27709-3901 USA Tel: (919) 991 5100 Fax: (919) 991 5160 Martin Ionescu-Pioggia, Ph.D., Senior Program Officer Email: mionescu@bwfund.org Website: www.bwfund.org

Organization	**Alliance for Health Policy and Systems Research (AHPSR)**
Location	Geneva, Switzerland
Date incorporated	2000
Type of organization	Program based global network, initiative fostered by the Global Forum for Health Research.
Core business	The aim of the Alliance is to contribute to health development and the efficiency and equity of health systems through research on and for policy. The Alliance engages in HPSR mapping and monitoring, supporting capacity for the undertaking of research, developing methodologies and tools and facilitating information and partnership development.
Research areas	Research to Evidence Research topics on Health Policy and Systems Research
Funding function	Research to Evidence Grants: short research projects involving empirical study or analysis of existing data. Young Researcher Grants: students who are doing Masters or Doctoral level dissertations in a relevant subject. Letters of intent on any HPSR topic will be considered.
Application mechanism	The individual applicant should have or be able to establish collaboration with another institution or internal unit leading to the formation of a team with at least one researcher and one policy/decision-maker. The supporting member(s) of the team should endorse the letter of intent. Applications will be accepted only from institutions in developing countries, but teams including developed country institutions are eligible. Current Alliance grantees are not eligible to apply as principal investigators.
Total research Funds disbursed per annum	Grants will be awarded for up to one year with a modest budget to support field work and office support. Young researcher grants have been supported in the past at an average of US$8,200 ($13,000 maximum) and Research to Evidence grants at an average of $19,400 ($31,200 maximum).
Affiliation	Global Forum for Health Research, WHO
Governance	Advisory Board
Source of funding	IDRC (Canada), Governments of Norway and Sweden, and the World Bank.
Publications	Alliance For Health Policy and Systems Research Newsletter, published 4x per year. Working Papers.
Officers	Dr Miguel Angel Gonzalez Block, Manager
Contact details	World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Tel: +41 22 791 2840/2890 Fax: + 41 22 791 4328 Email : alliancehpsr@who.int Website : http://www.alliance-hpsr.org

Organization	**Child Health and Nutrition Research Initiative (CHNRI)**
Location	Geneva - at the Global Forum for Health Research
Date incorporated	2001
Type of organization	Network of interested partners supported by the Global Forum.
Core business	Methodological issues of priority setting on child health, nutrition and development research and on a life cycle approach to child health and nutrition research. Others: Increasing the level of communication and discussion among players. Stimulating research and supporting the expansion of research into priority areas in child health and nutrition on a global basis especially in low and middle income countries.
Research areas	Child health and nutrition research/ priority setting
Funding function	Supports activities related to the core function
Application mechanism	Apply through secretariat, to be considered by the Board.
Total research Funds disbursed per annum	
Affiliation	Constituencies related to child health research and nutrition research
Governance	CHNRI Board Secretariat meant to rotate between developing country partners at regular intervals. Started off with being hosted by the Global Forum. Applications are now open for 'hosting the secretariat'.
Source of funding	Partners and other donors.
Publications	Publications: "Child Health Research: a foundation for improving child health", 2002 (jointly with WHO).
Officers	Secretariat: presently with John Hopkins University but open for letters of interest to host the Secretariat.
Contact details	Dr Andres de Francisco Global Forum for Health Research, c/o World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Tel: 41 22 791 3916 Fax: 41 22 791 4394 Website: www.globalforumhealth.org (CNHRI section)

Organization	**International Agency for Research on Cancer (IARC)**
Location	Lyon, France
Date incorporated	
Type of organization	A special research institute which is part of WHO.
Core business	IARC's mission is to coordinate and conduct research on the causes of human cancer, the mechanisms of carcinogenesis, and to develop scientific strategies for cancer control, disseminates scientific information through publications, meetings, courses, and fellowships.
Research areas	Cancer - epidemiological and laboratory research
Funding function	Conducts own research. Also offers post-doctoral fellowships in IARC, abroad and also visiting fellowships for senior scientists.
Application mechanism	Information on website.
Total research Funds disbursed per annum	
Affiliation	WHO
Governance	Director, elected and reporting to a Governing Council. Each Participating State has a representative on the Governing Council, which oversees the scientific programme, determines the budget and elects the Director. The Scientific Council looks reviews the scientific work.
Source of funding	The Agency's regular budget comes from contributions by its 16 participating countries which share their financial and scientific resources to reduce, through the work of the Agency on cancer incidence and mortality worldwide. Receives many donations and bequests from private institutions and individuals.
Publications	
Officers	Dr Paul Kleihues, Director Email: kleihues@iarc.fr
Contact details	150 Cours Albert Thomas F- 69372 Lyon cedex 08 France Tel: 33 4 7273 8485 Fax: 33 4 7273 8575 Website: www.iarc.fr

Organization	**International Center for Genetic Engineering and Biotechnology (ICGEB)**
Location	Two centers: New Delhi, India and Trieste, Italy, since 1996 administered from Trieste.
Date incorporated	1983 (under UNIDO) 1994: autonomous, international intergovernmental Organization
Type of organization	International intergovernmental Organization.
Core business	ICGEB is an international Organization dedicated to advanced research and training in molecular biology and biotechnology, with special regard to the needs of the developing world. Promotes the safe use of biotechnology
Research areas	• Molecular Biology • Biotechnology
Funding function	Institutions can apply for affiliation status.
Application mechanism	See website.
Total research Funds disbursed per annum	Over USD 1 million per year for collaborative research program.
Affiliation	Established research institutes in Member States which have attained, or have the potential for, high standard research. The total number of Affiliated Centres has now reached 32. Signatory members: 45 with another 19 still pending.
Governance	Board of Governors
Source of funding	
Publications	http://www.icgeb.trieste.it/RESEARCH/PUBLICATIONS/publ2001.htm
Officers	Director, New Delhi Component:Virander Chauhan Email: virander@icgeb.res.in Gita Prakash, Executive Secretary Email: gita@icgeb.res.in Director, Trieste component: Francisco Barrale
Contact details	ICGEB Padriciano 99, 34012 Trieste Italy Tel: +39-040-3757345 Fax: +39-040-3757363, Email: decio@icgeb.org Website: www.icgeb.trieste.it

Organization	**International Clinical Epidemiology Network (INCLEN)**
Location	Manila, Philippines
Date incorporated	Created in 1980 as a project of The Rockefeller Foundation,
Type of organization	INCLEN has been an independent non-profit organization since 1988.
Core business	Through carefully designed training and other support, helps clinicians to critically to assess the factors that determine the most effective prevention and treatment strategies. Promote improvement of equity, effectiveness and efficiency in health care of the poor through the production and use of the best evidence for addressing priority health problems. This is through building and sustaining excellence in research capacity and evidence-based health care, training in leadership and management, education of health professionals in developing countries, and linking health research to policy making at local, national, regional, and global levels. Also runs Short courses and master's degree level training in clinical epidemiology and related discipline (epidemiology, biostatistics, health social sciences, health economics). Provides a forum for researchers to discuss critical health issues through educational programs, global meetings, and an international communications network.
Research areas	Main thrusts - multiple health problems addressed: Infectious diseases, Family violence, Injury.
Funding function	Fosters multidisciplinary collaborative research through an international network of training centers and clinical epidemiology units based in universities and medical institutions worldwide.
Application mechanism	Grants disbursed by sub-committees for research and capacity building.
Total research Funds disbursed per annum	http://www.inclen.org/SPlan/translated.html
Affiliation	• INCLEN Membership is open to medical institutions worldwide on behalf of their clinical epidemiology faculty. **Clinical Epidemiology Faculty includes: physicians, health social scientists, health economists, biostatisticians and others in related health fields. Membership includes 64 medical institutions in 26 countries throughout the world • Partnerships with a number of other global networks such as COHRED, Alliance for Health Policy and Systems Research, Global Forum ,International Epidemiology Association etc
Governance	Board
Source of funding	
Publications	Abstracts of INCLEN meetings; study reports; INCLEN membership Directory; INCLEN newsletters, INCLEN monograph series.
Officers	Mary Ann D. Lansang, M.D. Executive Director Claire Bombardier, Chair of Board of Directors
Contact details	INCLEN Trust Executive Office Section E, 5/F Ramon Magsaysay Center 1680 Roxas Boulevard, Malate 1004 Manila Philippines Tel: (632) 521 3166 to 3185 Fax: (632) 400 4374 Email: inclen@inclentrust.org Website: http://www.inclen.org

Oganisation	**International Network for Rational Use of Drugs (INRUD)**
Location	
Date incorporated	1989
Type of organization	
Core business	INRUD was established to design, test, and disseminate effective strategies to improve the way drugs are prescribed, dispensed, and used.
Research areas	Research studies on behavioral aspects of drug use.
Funding function	INRUD sponsors research projects on behavior change to improve drug use in member countries.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	12 Board members
Source of funding	Supported primarily by the Danish International Development Agency, with ad hoc support from other donors such as the Pew Charitable Trusts, WHO Essential Drugs and other Medicines, Swedish International Development Agency, and US Agency for International Development (USAID).
Publications	Newsletters
Officers	Professor Kumud K. Kafle INRUD/Nepal Group Coordinator Head of Clinical Pharmacology Institute of Medicine Tribhuvan University Teaching Hospital Post Office Box 3578 Maharajgunj, Kathmandu, Nepal Tel: 977-1-412-303/412-605 Fax: 977-1-470-115 E-mail: inrud@healthnet.org.np Raúl Cruzado Ubillús INRUD/Peru Group Coordinator Seguro Integral de Salud - Ministerio de Salud Private University of Chimbote J.C. Tello 489 Lince - Lima, Peru Tel: 51-1–265-0259 / 51-1–330-5161 Anexo 51-1-831 / 044 - 217549 Fax: 51-1–387-9244 E-mail: rcruzadou@usis.minsa.gob.pe or rcruzado41@hotmail.com Dr. Tang Jingbo INRUD News - China Director of Dept. of Clinical Pharmacology Liu-Hua-Qiao Hospital No. 111 Liu Hua Hospital Guangzhou 510010 PR China Tel: 86-20-8666-2205, 9230 Fax: 86-20-8666-801
Contact details	See above

Organization	**International Union Against TB & Lung Diseases (IUATLD)**
Location	
Date incorporated	1920
Type of organization	Non-profit, non-governmental voluntary organization.
Core business	Dedicated to the prevention and control of tuberculosis and lung disease, to disseminating information about the hazards of smoking and to the promotion of overall community health.
Research areas	To conduct operational and applied research, cooperative international studies and trials through the scientific sections of the IUATLD and through technical assistance of national programmes; research units affiliated with the IUATLD are designed to answer questions of international relevance.
Funding function	Research is carried out in the fields of specialization of the IUATLD within the organization, in collaboration with its affiliated Research Units and in cooperation with external research institutions and organizations.
Application mechanism	Members and scientific groups within the organization may initiate research with a view to promoting collaborative links among the members and with external groups.
Total research Funds disbursed per annum	
Affiliation	Constituent, organizational and individual members
Governance	Board of Directors
Source of funding	
Publications	http://www.iuatld.org/ A documentation centre is available to provide essential information for those carrying out research in the fields of tuberculosis and lung health. The International Journal of Tuberculosis and Lung Disease, the Newsletter, training manuals.
Officers	President: Anne Fanning Secretary General: Elif Dagli
Contact Address	union@iuatld.org

Organization	**UNDP World Bank WHO Special Programme for Research and Training in Tropical Diseases (TDR)**
Location	Geneva, Switzerland
Date incorporated	1975
Type of organization	Supported by World Bank/UNDP/WHO and placed in the Communicable Diseases Cluster of WHO.
Core business	Established to improve existing and develop new approaches for preventing, diagnosing, treating, and controlling neglected infectious diseases (ten major tropical diseases) which are applicable, acceptable and affordable by developing endemic countries, which can be readily integrated into the health services of these countries, and which focus on the health problems of the poor.
Research areas	Basic and Strategic Research: Molecular entomology; Pathogen and genomics; Social Research. Product Research and Development: Diagnostics; Drugs; Vaccines Intervention Development and Implementation Research: Implementation research; Proof of principle. Research Capability Strengthening: Capacity strengthening, Multilateral Initiative on Malaria (MIM). TDR Diseases: Leishmaniasis, Leprosy, Malaria, Onchocerciasis, Lymphatic Filariasis, Schistosomiasis, Tuberculosis, Dengue, Chagas Disease, African Trypanosiamasis.
Funding function	TDR supports goal-oriented research. Research opportunities are set out in the various scientific workplans, which should be studied before submitting a grant application. In addition to the research opportunities outlined in the scientific workplans, specific calls for applications can be made at any time of year.
Application mechanism	http://www.who.int/tdr/grants/grants/rtg2003.htm
Total research Funds disbursed per annum	
Affiliation	The Wellcome Trust's Tropical Medicine Resource Liverpool School of Tropical Medicine Swiss Tropical Institute London School of Hygiene and Tropical Medicine
Governance	The Joint Coordinating Board (JCB) The Standing Committee The Scientific and Technical Advisory Committee (STAC)
Source of funding	United Nations Development Programme (UNDP), the World Bank and the World Health Organization (WHO).
Publications	Publications Monographs, Presentations, Newsletters.
Officers	Dr Carlos Morel, Director, Director Email: morel@who.int
Contact details	Special Programme for Research & Training in Tropical Diseases (TDR) World Health Organization 1211 Geneva 27 SWITZERLAND Tel: 41 22 791 3725 Fax: 41 22 791 4854 Email: tdr@who.int Website: www.who.int/tdr

Organization	**UNDP/UNFPA/WHO/WB Special Programme of Research, Development & Research Training in Human Reproduction (HRP)**
Location	Geneva, Switzerland
Date incorporated	
Type of organization	
Core business	Promotes research that plays a critical role in the process of identification of needs, arising from wide disparities in reproductive health, the selection of priorities and the development of strategies that are appropriate and relevant to individual countries. - such work is best done within and by the countries; - the building-up of national and regional self-reliance through capacity strengthening.
Research areas	• Adolescent reproductive health • Ageing • Cancers • Family Planning • FGM/Harmful Practices • Infertility • Maternal and New Born • Prevention of unsafe abortion • RTIs, STIs, HIV /AIDS Cross cutting issues: Best practices Economics & finance Emergency situations Ethics Gender Global monitoring Rights
Funding function	A number of capacity strengthening grants are available.
Application mechanism	Information on the website.
Total research Funds disbursed per annum	
Affiliation	Number of intergovernmental international Organizations and NGO's
Governance	Standing Committee
Source of funding	
Publications	Program reports, Progress newsletter
Officers	Dr Paul Van Look, Director
Contact details	Department of Reproductive Health and Research World Health Organization 1211 Geneva 27 Switzerland Tel: + 41 22 791 3372 Fax: + 41 22 791 4189 Email: reproductivehealth@who.int http://www.who.int/reproductive-health/index.htm

Organization	**Global Alliance for Vaccines and Immunization (GAVI)**
Location	Geneva, Switzerland
Date incorporated	1999
Type of organization	
Core business	GAVI's mission is to ensure that every child is protected against vaccine-preventable diseases.
Research areas	Among its activities: to accelerate R&D efforts for vaccines needed primarily in developing countries.
Funding function	GAVI has established six strategic objectives: - Improve access to sustainable immunization services; - Expand the use of all existing, safe and cost-effective vaccines where they address a public health problem; - Support the national and international accelerated disease control targets for vaccine-preventable diseases; - Accelerate the development and introduction of new vaccines and technologies; - Accelerate R&D efforts for vaccines needed primarily in developing countries; - Make immunization coverage a centerpiece in international development efforts.
Application mechanism	Only national governments can apply, which fall within general assessment criteria. There is no real deadline for submission, but reviews of applications are made twice a year, in May and September, so applications must be received in good time.
Total research Funds disbursed per annum	Estimated five-year commitment in US$ to 60 countries (June 2002) US$ 902,440,000.
Affiliation	
Governance	The GAVI Board
Source of funding	Bill and Melinda Gates Children's Vaccine Program, The World Health Organization (WHO) , The United Nations Children's Fund (UNICEF), The World Bank Group, Foundations, Developing country governments, Nongovernmental Organizations (NGOs), Government-Industrialized Countries, Research and technical health institutions, Vaccine Industry-Industrialized Country, Research and technical health institutions, Vaccine Industry-Developing Country.
Publications	A resource listing journals, publications, academic institutions, and other links http://www.healtheconomics.com/
Officers	Executive Secretary: Dr Tore Godal Lisa Jacobs, GAVI Secretariat Chair of the Boar: Ms Carol Bellamy
Contact details	GAVI Secretariat c/o UNICEF Palais des Nations 1211 Geneva 10 Switzerland Tel: +41.22.909.50.19 Fax: +41.22.909.59.31 Email: gavi@unicef.org Website: http://www.vaccinealliance.org

Organization	**Global TB Research Initiative**
Location	Geneva, Switzerland
Date incorporated	1975
Type of organization	Non-profit public/private partnership
Core business	It aims to help coordinate, support and influence global efforts to combat a portfolio of major diseases of the poor and disadvantaged.
Research areas	
Funding function	Encourages research funding agencies to address gaps in TB research.
Application mechanism	http://www.who.int/tdr/grants/grants/rtg2003.htm
Total research Funds disbursed per annum	
Affiliation	The Wellcome Trust's Tropical Medicine Resource Liverpool School of Tropical Medicine Swiss Tropical Institute London School of Hygiene and Tropical Medicine
Governance	
Source of funding	United Nations Development Programme (UNDP), World Bank World Health Organization (WHO),
Publications	http://www.who.int/tdr/publications/publications/default.htm Online Newsletter
Officers	Office of the Director Special Programme for Research & Training in Tropical Diseases (TDR) World Health Organization 1211 Geneva 27 SWITZERLAND Tel: 41 22 791 3804 Fax: 41 22 791 4854 Email: tdrgrant@who.in
Contact details	Communications Unit Special Programme for Research & Training in Tropical Diseases (TDR) World Health Organization 1211 Geneva 27 SWITZERLAND Tel: 41 22 791 3725 Fax: 41 22 791 4854 Email: tdr@who.int

Organization	**Initiative on Cardiovascular Health in Developing Countries**
Location	
Date incorporated	1998
Type of organization	
Core business	The programme aims to advance health research relevant to policies and programmes for the control of cardiovascular diseases (CVD) in the developing countries.
Research areas	A Scientific Secretariat was established in New Delhi in May 1999. Research proposals for early advancement were identified in February 1999 and six protocols were developed in May 1999. Each of the six projects involves a collaborative study in six developing countries, one from each developing region, with a common core protocol. Utilising seed grants from GFHR, WHO and other partners, these protocols are being developed into full grant applications for evaluation by international funding agencies.
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	The CVD Research Initiative was born in November 1998 as a joint programme of the WHO (NCD Cluster) and the Global Forum for Health Research (GFHR). The partnership has since expanded to include: Institute of Medicine (USA), World Heart Federation, National Public Health Institute (Finland), World Hypertension League, International Obesity Task Force, International Institute for Health and Development (Australia) and Institut Universitaire de Médecine Sociale et Préventive (Switzerland), Health Canada, Centres for Disease Control (USA), National Institutes of Health (USA), International Clinical Epidemiology Network (INCLEN), Medical Research Council of South Africa (South Africa) and National Public Health Institute of Mexico.
Governance	Board of Trustees
Source of funding	
Publications	
Officers	Dr Jie Chen, Executive Director World Health Organization (NCD) Mr Louis Currat, Executive Secretary Global Forum for Health Research
Contact details	http://www.ichealth.org/

Organization	**International AIDS Vaccine Initiative (IAVI)**
Location	New York, USA
Date incorporated	1996
Type of organization	International, non-profit, scientific organization
Core business	IAVI aims to ensure the development of safe, effective, accessible, preventive HIV vaccines for use throughout the world. IAVI's work focuses on three areas: accelerating scientific progress, mobilizing political support through advocacy and education, and encouraging industrial involvement in AIDS vaccine development. IAVI has created a virtual vaccine company model comprising the following elements: 1. Vaccine Development Partnerships; 2. Centralized laboratories and reagent production; 3. Large-scale development and manufacturing partnerships; 4. Partnerships for Phase III clinical trials in the developing world; and 5. Core regulatory dossier design.
Research areas	Product Development: IAVI's program of directed, goal-oriented research is working with industry to identify and develop promising vaccine candidates. The Initiative's work thus complements government-funded basic research efforts.
Funding function	Access: IAVI has negotiated agreements with its industry partners to help ensure that vaccines will be readily available in developing countries at reasonable prices.
Application mechanism	IAVI finances AIDS vaccine research only under contracts that assure that resulting products will be made available in developing countries rapidly after licensure, at reasonable prices and in sufficient quantities.
Total research Funds disbursed per annum	
Affiliation	IAVI is partnering with the World Bank, policy makers, and industry leaders to create incentives for industrial participation in AIDS vaccine development IAVI is working with governments around the world to create national AIDS vaccine programs. IAVI is also working to bring together the necessary participants for a coordinated global effort, including scientists, industry leaders, policy makers, and members of AIDS-affected communities IAVI's scientific effort is focusing on viral strains prevalent in developing countries and has enlisted developing country scientists as full partners
Governance	Board of Directors; Scientific Advisory Committee
Source of funding	Donor partners.
Publications	http://iavi.org/pub/ IAVI publishes fact sheets, backgrounders and policy papers about the organization's programs and a variety of issues concerning AIDS vaccine development.
Officers	Seth F. Berkley: President and Chief Executive Officer sberkley@iavi.org J.F. Garcia: Executive Assistant to the President jgarcia@iavi.org
Contact details	International AIDS Vaccine Initiative 110 William Street New York, NY 10038-3901, USA Tel: 1-212-847-1111 Fax: 1-212-847-1112 Europe Office: Postbox 15788 1001 NG, Amsterdam,The Netherlands Tel: +31 20 521 0030; Fax: +31 20 521 0039; Email: info@iavi.org

Organization	**Medicines for Malaria Venture (MMV)**
Location	Geneva, Switzerland
Date incorporated	1998
Type of Organization	Independent, not -for-profit foundation under Swiss law
Core business	The global objective of MMV is to bring public and private sector partners together to fund, and provide managerial and logistical support for, the discovery and development of new medicines for the treatment and prevention of malaria. The products should be affordable and appropriate for use by targeted populations in developing countries.
Research areas	Discovery and development of anti - malaria drugs
Funding function	Projects directed at discovery and development of anti-malaria drugs (total cost of project can range from about $ 50,000 for seed projects to about $1 million for major 'discovery' projects.
Application mechanism	Application in response to call for letters of intent. Can apply through website www.mmv.org
Total research Funds disbursed per annum	4-5 million USD
affiliation	Works with sponsors for funding and with academia and pharmaceutical companies for technical collaboration and scientific expertise.
Governance	The MMV is governed by a Board of twelve members, chosen for their scientific, medical and public health expertise in malaria and related fields, their research and management competence as well as their experience in business, finance and fund raising.
Source of funding	Bill and Melinda Gates Foundation, ExxonMobil Corporation, Global Forum for Health Research, International Federation of Pharmaceutical Manufacturers, Associations, Netherlands Ministry for Development Cooperation, Rockefellor Foundation, Swiss Agency for Development and Corporation, United Kingdom Department of International Development, World Bank, World Health Organization, Roll Back Malaria TDR.
Publications	Annual report
Officers	Dr Christopher Hentschel, Chief Executive Officer Email: hentschelc@mmv.org Dame Bridgit Ogilvie, Chair of the Board
Contact details	Medicines for Malaria Venture (MMV) ICC Building Entrance G, 3rd floor Route de Pré-Bois 20 Post Box 1826 CH-1215 Geneva 15 Switzerland Telephone: +41 22 799 4060 Facsimile: +41 22 799 4061 e-mail: info@mmv.org

Organization	**The Global Alliance for TB Drug Development**
Location	New York, Brussels, Capetown
Date incorporated	2000
Type of organization	Non-profit public/private partnership
Core business	Development of drugs for tuberculosis Mission is to accelerate the discovery and/or development of cost-effective new drugs which can : - Shorten or simplify treatment of TB - Provide a more effective treatment of multi-drug-resistant TB - Improve the treatment of latent TB infection
Research areas	Anti Tuberculosis drugs
Funding function	Acts as an "incubator and integrator" rather than a grant maker prepares for technology transfer and support for production in developing countries It provides staged funding, expert scientific and management guidance, and some limited infrastructure (project management, legal support, etc) to projects fitting within its portfolio development strategy.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	Stakeholders
Governance	Board of Directors
Source of funding	
Publications	TB Alliance Newsletters
Officers	Maria C. Freire, Chief Executive Giorgio Roscigno, Director of Strategic Development
Contact details	**New York** 59 John Street, Suite 800 New York NY 10038 USA Phone: +1 (212) 227-7540 Fax: +1 (212) 227-7541 **Brussels** 27 Boulevard Bischoffsheim B-1000 Brussels/Bruxelles Belgium Phone: +32 2 210 02 20 Fax: + 32 2 223 6938 **Cape Town** c/o Medical Research Council P.O. Box 19070 Tygerberg, Cape Town 7505 South Africa

Organization	**Malaria Vaccine Initiative (MVI)**
Location	Rockville, MD, USA.
Date incorporated	1999
Type of organization	International non-profit organization focused on malaria vaccine development.
Core business	MVI's mission is to accelerate the development of promising malaria vaccine candidates and ensure their availability and accessibility for the developing world. To accomplish the first part of its mission, MVI is identifying the most promising vaccines and technologies and implementing targeted partnerships with scientists, vaccinologists, and development projects. MVI works to link government, industry, and academia partners with field trial sites in malaria endemic countries as early as feasible in the development process. To help ensure access to the eventual vaccine(s), MVI works with other vaccine programs, vaccine development partners, and the Global Alliance for Vaccines and Immunization (GAVI) to explore commercialization, procurement, and delivery strategies that will maximize public health sector availability in the countries most affected by malaria.
Research areas	The Malaria Vaccine Initiative has nine vaccine development projects around the globe. Two of those have clinical trials in Africa underway. Each project is managed by a Joint Product Development Committee, with representation from MVI and the partner(s) involved in that particular project. Eight projects target *P. falciparum,* the most deadly form of malaria, while one focuses on *P. vivax,* the most widespread form.
Funding function	Funds vaccine development in partnership with other organizations.
Application mechanism	The mission of the Malaria Vaccine Initiative at PATH is to accelerate the development of promising malaria vaccines and ensure their availability and accessibility for the developing world. As such, MVI funds projects that: • test specific promising vaccines in animals and humans • target process development, scale-up, and pilot lot production of specific malaria vaccines MVI does not fund other types of projects or activities.
Total research Funds disbursed per annum	
Affiliation	Bill & Melinda Gates Foundation, PATH (Program for Appropriate Technology in Health), GAVI.
Governance	The Strategic Advisory Council (SAC) chaired by Sir Gustav Nossal provides MVI with strategic guidance.
Source of funding	Bill & Melinda Gates Foundation
Publications	Press releases
Officers	Director: Regina N. Rabinovich; Chair of SAC: Sir Gustav Nossal
Contact details	Malaria Vaccine Initiative at PATH 6290 Montrose Road, Suite 1000A Rockville, MD 20852, USA Tel: 1-301-770-5377 Fax: 1-301-770-5322 info@MalariaVaccine.org Website: www.malariavaccine.org

Organization	**ICDDR,B Center for Health & Population Research**
Location	Dhaka , Bangladesh
Date incorporated	
Type of organization	International Research Center, is a large (1600 staff), non-profit international health research organization.
Core business	The fundamental mission of the Centre is to develop and disseminate solutions to major health and population problems facing the world, with emphasis on simple and cost-effective methods of prevention and management, headquartered in Dhaka, Bangladesh.
Research areas	Initially focused on cholera and diarrhoeal diseases, the mandate of the Centre has broadened considerably and it is now a world leader in studies of and solutions for common conditions prevalent in developing nations and associated with poverty, including infectious diseases, malnutrition, high fertility, microbial and chemical contamination of the environment and the need for better health services.
Funding function	Conducts own research and also with collaboration with other institutes and researchers.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Trustees
Source of funding	Supported by about 55 donor countries and organizations, including Government of Bangladesh, UN specialized agencies, foundations, universities, research institutes and private sector organizations and companies that share the Centre's concern for the health problems of developing countries and value its proven experience in helping solve those recipient of the Gates Award for Global Health. http://www.icddrb.org/donar.html
Publications	http://www.icddrb.org/publications_cont.html Annual reports, manuals, newsletter (glimpse), journals, monographs, annual scientific meeting, publishes Journal of Health, Population and Nutrition.
Officers	Prof. David A. Sack: Director dsack@icddrb.org Mr. Ahmed Akhtar: Programme Manager Operations Research Project Health Systems Research Division akhtar@icddrb.org
Contact details	ICDDR,B: Centre for Health and Population Research (GPO Box 128, Dhaka) Mohakhali, Dhaka 1212, Bangladesh Tel: (8802) 8822467 (Direct) Fax: (8802) 8823116 and 8826050 E-mail: msik@icddrb.org and jhpn@icddrb.org Website: www.icddrb.org

Organization	**Institute for International Health (Australia)**
Location	Newtown, NSW, Australia
Date incorporated	
Type of organization	University based research Institute.
Core business	The aim of this program is to facilitate the prevention of premature death, serious ill health and disability from common causes of non-communicable diseases and injury. The program is oriented towards health issues of global significance, including those that affect people in lower income and newly industrialised countries, the prevention and treatment of heart and vascular diseases, injury and trauma, and mental illness.
Research areas	• Health promotion • Health policy and systems development • Health care delivery • Leadership in health reform
Funding function	The AIHI develops systems, Organizations, strategies and financing models for health promotion and disease prevention.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	University of Melbourne, Australia's premier teaching and research university.
Governance	Board of Directors
Source of funding	General support for the activities of the Institute are provided by: • University of Sydney • Royal Prince Alfred Hospital • Central Sydney Area Health Service • The Medical Foundation of the University of Sydney • National Health and Medical Research Council of Australia • NSW Health A donation from Servier Laboratories
Publications	
Officers	Terrie Agnew, Research & Executive Assistant Tel: +935 10030 Email: tagnew@iih.usyd.edu.au Mark Woodward, Program Director, Epidemiology and Biostatistics Tel: +935 10039 Woodward@iih.usyd.edu.au
Contact details	PO Box 576 144 Burren Street, Newtown, NSW 2042, Australia General Information: info@iih.usyd.edu.au

Organization	**Institute for Global Health**
Location	San Francisco, CA, USA
Date incorporated	1999
Type of organization	Institute associated with the University of California.
Core business	To improve health and improve access to effective and affordable health services in all countries. The Institute accomplishes this mission by conducting research, developing and evaluating policy, providing high-level training, and forging consensus on joint action among leading scientists and policy makers. These efforts allow the Institute to influence policy in the public and private sectors, and stimulate action by governments, corporations and international organizations.
Research areas	
Funding function	Conducting research, developing and evaluating policy by providing high-level training, and forging consensus on joint action among leading scientists and policy makers.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	• UN and multilateral organizations • Academic Institutions • US federal agencies • Non-US bilateral agencies • Foundations
Governance	
Source of funding	
Publications	http://igh.ucsf.edu/pubs/index.html
Officers	George W. Rutherford, Interim Director 74 New Montgomery Suite 600 San Francisco, CA 94105 Tel: (415) 597-9108 Fax: (415) 597-9213 E-mail: grutherford@psg.ucsf.edu
Contact details	Institute for Global Health 74 New Montgomery Street, Suite 508 San Francisco, CA USA 94105 Tel: 415 597-8200 Fax: 415 597-8299 Email: igh@psg.ucsf.edu Website: http://igh.ucsf.edu

Organization	**International Center for Research on Women (ICRW)**
Location	Washington D.C, USA
Date incorporated	1976
Type of organization	Private non-profit organization
Core business	• Supporting women as economic providers and innovators, nurturers and caregivers, community leaders and agents of change • Ensuring women's control of economic resources; guaranteeing reproductive rights, health and nutrition; strengthening capabilities and increasing political power • Fostering equity and respect for the human rights and dignity of all • Shaping policy and programs based on sound research and data • Building collaborative, mutually rewarding partnerships and networks to share skills and build capacity
Research areas	Research, technical support for capacity building, advocacy, poverty reduction, HIV/AIDS, reproductive health, social change, adolescence.
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Directors elected by funding partners.
Source of funding	http://www.icrw.org/about_fundingpartners.htm multiple national and international Organizations.
Publications	ICRW Biennial Reports and Updates Monographs and specific reports on selected topics. http://icrw.org/publications.html
Officers	Office of the President : Kathleen Barnett, Vice President Deanthia Mebane, Executive Assistant Michelle Powers, Special Gifts Initiatives Coordinator David Johnson, Institutional Database Coordinator/Resource Development Assistant
Contact details	International Center for Research on Women (ICRW) 1717 Massachusetts Avenue, NW • Suite 302 Washington, DC 20036 Tel: (202) 797-0007 Fax: (202) 797-0020 Email: info@icrw.org Website: www.icrw.org

Organization	**Karolinska Institute**
Location	Stockholm, Sweden.
Date incorporated	
Type of organization	University based
Core business	Karolinska Institutes mission is to improve the health of mankind through research, education and information.

Research areas	Molecular immunology, Cell Biology, Receptor Biology, Genetics, Developmental Biology, Molecular Biology, Molecular Genetics, Microbial Ecology.
Funding function	It accounts for 40 percent of all medical research at universities throughout Sweden and encourages research in molecular biology to public health science/care research. The research training offers students and postgraduate students opportunities to take part in advanced research under the supervision of established researchers.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	Collaborates internationally and nationally with healthcare and medical institutes, industry and other universities.
Governance	Board Members
Source of funding	Various Swedish Organizations and Companies
Publications	http://www.cmb.ki.se/cmb/english/publications/index.htm
Officers	Riitta Ljungström, Head of Administration Tel: 08-728 73 21 Department Secretary Tel: 08- 728 72 79
Contact details	Karolinska Institute SE-171 77 Stockholm Sweden. Tel: +46 8-728 64 00 Fax: +46 8-31 84 06 info@ki.se website: www.cmb.ki.se

Organization	**International Vaccine Institute (IVI)**
Location	Seoul, Korea
Date incorporated	1999
Type of organization	An International Organization established at the initiative of the United Nations Development Programme under the Vienna Convention of 1969 with the signatures so far of 33 countries and WHO.
Core business	An international center of research, training and technical assistance for vaccines needed in developing countries, Its major recent activities and accomplishments are: (1) Creation of a multi-national team of scientists and technical specialists in clinical assistance, and training at its headquarters in Seoul and in sites in various developing countries; (2) Formation of collaborative networks throughout Asia and elsewhere for studies of vaccines, integrating the relevant disciplines of epidemiology, clinical trials, economic analysis, behavioral science, and policy analysis; (3) Development of a multi-country, multidisciplinary program to accelerate the development and introduction of vaccines against the enteric infections cholera, Shigella, and typhoid fever; (4) Measurement of disease burden in Asian children of meningitis caused by *Haemophilus influenzae* type b (Hib). *Neisseria meningitides*, and *Streptococcus pneumoniae*; (5) Development of a multi-country, multidisplinary program in Japanese encephalitis to expand the use of existing vaccines and accelerate the development of new vaccines; (6) Provision of technical assistance and training programs for vaccine production and regulation in developing countries; (7) Formation of collaborative networks with vaccine manufacturers in developed and developing countires to accelerate vaccine research, development and technology transfer; (8) Provision of training in clinical evaluation of vaccines in developing country settings; (9) Formation of close collaboration with the World Health Organization (WHO) and the Global Alliance for Vaccines and Immunization (GAVI) in setting priorities, defining strategies, and undertaking needed vaccine-related activities; (10) Construction of a major research building with pilot plant at the site of the IVI headquarters in Seoul, Korea with completion expected by the end of 2002. A major IVI strength is capacity building in vaccine research, development, production and regulation in developing countries.
Research areas	Vaccine development in the following diseases: DOMI (Diseases of the Most Impoverished: typhoid, shigellosis, cholera), Japanese encephalitis (JE), bacterial meningitis in children, rotavirus, enterotoxigenic E. coli (ETEC).
Funding function	Supports activities related to the core functions
Application mechanism	Apply through secretariat, to be considered by the Board.
Total research Funds disbursed per annum	
Affiliation	WHO, Children's Vaccine Program, Netaid
Governance	Board of Trustees
Source of funding	Government of Korea, partners and other donors
Publications	The IVI Newsletter.
Officers	Director : Dr John D. Clemens; Chair Board of Trustees : Prof. B. Bloom .
Contact details	International Vaccine Institute Kwanak P.O.Box 14, Seoul, Korea 151-600 Tel: 82-2-872-2801, Fax: 82-2-872-2803 Email: iviinfo@ivi.int Website: www.ivi.int

Organization	**Institute of Nutrition of Central America and Panama (INCAP)**
Location	Guatemala
Date incorporated	1949
Type of organization	International research institute
Core business	At present and over the past 10 years, the institute has provided technical cooperated to the countries in implementing the regional initiative to promote nutrition and food security by collaborating on diagnostic studies and in the design, implementation, monitoring, and evaluation of programs and public nutrition projects at the municipal, national, and regional levels.
Research areas	The foundation of the institute's research policy, approved by the INCAP Council in 1991, is the search for solutions to the most serious food and nutrition problems of the member countries. The main strategies to promote research development include strengthening research capacity in the countries through multicenter studies and applied research, and the provision of training in research for staff working in the field of food and nutrition, with preference given to support for research centers and universities. INCAP tries to promote dynamic interaction between the generation of knowledge, the design of public nutrition programs, and the training of human resources. Research findings are used as input for programs and for defining educational curricula. The XLII Meeting of the INCAP Council in Panama in August 1996 defined the programming lines for INCAP technical cooperation, including research. They included the following: harmonization of food regulations; production of nourishing foods; nutrition and food safety in local development processes; education and training of human resources in food and nutrition; community food and nutrition education; prevention and control of nutritional deficiencies through micronutrient supplementation; health and nutrition of women and children; prevention of chronic noncommunicable diseases; and nutritional surveillance, monitoring, and evaluation.
Funding function	Research organization.
Application mechanism	Contact the Director.
Total research Funds disbursed per annum	
Affiliation	PAHO/WHO
Governance	INCAP Council
Source of funding	Member States, bilateral, multilateral agencies, NGOs, foundations and universities
Publications	Annual reports, technical notes, documents
Officers	Director: Dr Hernán L. Delgado
Contact details	Instituto de Nutrición de Centro América y Panamá (INCAP) Calzada Roosevelt, Zona 11, Apartado Postal 1188, Guatemala, C.A. Tel : 502 472 3762, Fax : 502 473 6529 Website: http://www.incap.org.gt (in Spanish)

Organization	**European Federation of Pharmaceutical Industries Association (EFPIA)**
Location	Brussels, Belgium
Date incorporated	1978
Type of organization	NGO
Core business	EFPIA's mission is to promote pharmaceutical research and development in Europe in order to find and bring to market medicines that improve human health and the quality of life around the world. To achieve this goal, EFPIA's priority is to foster a favourable environment in Europe which: • Promotes European pharmaceutical industry competitiveness in a global environment. • Nurtures and rewards pharmaceutical innovation to guarantee industry's continuous quest for better therapies. • Enables the industry to meet the growing healthcare expectations of present and future generations.
Research areas	
Funding function	
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	EU institutions (Parliament, Commission, Council, Economic & Social Committee), regulatory authorities (EMEA/CPMP), health experts, academics other trade associations, NGOs.
Governance	The Board comprises representatives of 11 full member associations and 11 full member companies. It carries out the tasks and duties determined by the General Assembly and ensures their implementation by the General Management.
Source of funding	
Publications	http://www.efpia.org/6_publ/default.htm
Officers	Brian Ager: Director General Maria Curatolo: Assistant (mariacuratolo@efpia.org) Marie-Claire Pickaert: Deputy Director General Fabienne Muylle: Secretary (fabiennemuylle@efpia.org)
Contact details	EFPIA Rue du Trône 108 B-1050 BrusselsBelgium Tel: 32 (0)2 626 25 55 Fax: 32 (0)2 626 25 66 info@efpia.org London Satellite: 27th Floor1 Canada Square Canary Wharf London E14 5AA Tel: 44 207 513 04 66 Fax: 44 207 513 04 67mailto:info@efpia.org Geneviève Mairy - Administrative Executive (email@efpia.compulink.co.uk)

Organization	**International Federation of Pharmaceutical Manufacturers Association (IFPMA)**
Location	Geneva, Switzerland
Date incorporated	1968
Type of organization	Non-profit, non-governmental Organization (NGO)
Core business	..The IFPMA represents the worldwide research-based pharmaceutical industry and manufacturers of prescription medicines generally. It is the main channel of communication between the industry and various international organizations that are concerned with health and trade-related issues, including the World Health Organization, the World Bank, the World Trade Organization and the World Intellectual Property Organization
Research areas	R&D for product development, Intellectual property protection, R&D innovation.
Funding function	The industry is working on more than 700 new medicines and vaccines for infectious diseases including HIV/AIDS, cancer, heart disease and stroke, and diseases that disproportionately affect women such as osteoporosis.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	Pharmaceutical Companies Global Health Partnerships International Organizations News and Media UN Organizations
Governance	As a federation it represents altogether 59 national industry Organizations from both developing and developed countries. Member Companies are from major global research based pharmaceutical and vaccine companies
Source of funding	
Publications	Issues Brief , Marketing code Brochures , Speeches and papers All the IFPMA documents and publications can be found through the Search engine on the website.
Officers	Patricia Goldschmid Director, Media Relations, Tel: +41 22 338 32 00 Fax: +41 22 338 32 99 Email: p.goldschmid@ifpma.org President: Mr Raymond Gilmartin Director General: Mr Harvey Bale Jr.
Contact details	IFPMA : 30 rue de Saint Jean 1211 Geneva 13 Switzerland Tel: +41 22 338 32 00; Fax : +41 22 338 32 99 Email : admin@ifpma.org Website: www.ifpma.org

Organization	**African Medical and Research Foundation International (AMREF)**
Location	Nairobi, Kenya
Date incorporated	1957
Type of organization	Independent non-profit, non governmental organization (NGO)
Core business	AMREF's mission is to empower the disadvantaged people in Africa to enjoy better health. AMREF defines the disadvantaged as people who suffer high prevalence and impact of major health problems and challenges like malaria, HIV/AIDS, adolescent and reproductive health, water and sanitation and have poor access to health care.
Research areas	
Funding function	AMREF has a set of defined, priority intervention areas. These are HIV/AIDS, TB, sexually transmitted diseases, malaria, water and basic sanitation, disaster management and response, family health, clinical outreach services to remote areas, development of health learning materials, training and undertaking of consultancies.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Governors
Source of funding	Funds raised mostly from Europe and North America. Donors include governments, foundation, trusts, individuals and corporate companies.
Publications	http://www.amref.org/publications.htm
Officers	
Contact details	AMREF Headquarters, Langata Road P.O. Box 00506 - 27691 Tel: 254-2-605220 Fax: 254-2-609518 Nairobi, Kenya Email: fundraising@amrefhq.org Uganda P.O. Box 10663, Kampala Tel: 256-41-250319 Fax: 256-41-344565 Email: info@amrefug.org Tanzania P.O. Box 2773, Dar es Salaam Tel: 7-51-116610 Fax:7-51-115823 Email:info@amreftz.org

Organization	**Multilateral Initiative on Malaria in Africa (MIM)**
Location	
Date incorporated	
Type of organization	
Core business	It aims to maximise the impact of scientific research against malaria in Africa, through promoting capacity building & facilitating global collaboration & coordination.
Research areas	Malaria Vaccines Immunology
Funding function	To strengthen and sustain, through collaborative research and training, the capability of malaria endemic countries in Africa to carry out research required to develop and improve tools for malaria control.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	(WHO/World Bank, African Malaria Control Initiative and Rollback Malaria), Centers for Disease Control and Prevention (CDC)
Governance	
Source of funding	The Wellcome Trust
Publications	
Officers	c/ o Malaria Foundation International CKathryn.Nason-Burchenal@malaria.org
Contact details	See above

Organization	**Multilateral Initiative on Malaria, USA (MIM)**
Location	Bethesda, MD, USA
Date incorporated	
Type of organization	MIM is an alliance of organizations and individuals concerned with malaria.
Core business	A global collaborative effort against malaria in Africa, MIM is an alliance of organizations and individuals concerned with malaria. It aims to maximize the impact of scientific research against malaria in Africa, through promoting capacity building and facilitating global collaboration and coordination.
Research areas	Malaria research capacity strengthening in Africa, conducting research relevant to addressing malaria control and prevention in malaria endemic countries. The projects supported so far, have addressed critical areas related to the epidemiology, chemotherapy, vector control and pathogenesis of malaria transmission and morbidity in Africa.
Funding function	Overall funds committed to malaria research have increased significantly from an estimated US$85 million in 1995 to a current figure of well over $100 million. MIM is also beginning to contribute to more effective use of global resources through promoting coordinated activities. Notably, NIAID has increased its commitment by more than 150% between 1995 and 1999 and the Wellcome Trust doubled its expenditure.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	The partners of MIM are a multilateral collaboration of agencies, institutes and governments and include: Governments - Norway, Japan, France, USA, Sweden Research Institutes - in malaria endemic countries and the North Research Funding Agencies - National Institute of Allergy and Infectious Diseases (NIAID), the National Library of Medicine (NLM) and the Fogarty International Center (FIC) of the National Institutes of Health (NIH), UK Medical Research Council (MRC), Institut Pasteur - France Foundations - Wellcome Trust, Rockefeller Foundation, Burroughs Wellcome Fund, UN Foundation United Nations - World Bank, World Health Organization/Control of Tropical Diseases (WHO/CTD), WHO Regional Office For Africa (WHO/AFRO), the Special Programme for Research and Training in Tropical Diseases of the WHO (WHO/TDR), WHO/Roll Back Malaria Control Agencies - United States Agency for International Development (USAID), Centers for Disease Control and Prevention (CDC)
Governance	Secretariat—Fogarty Institute at NIH
Source of funding	
Publications	MIM newsletter, reports
Officers	Dr Gerald Keusch, Director of the MIM Secretariat Dr Andrea Egan, Coordinator of the MIM Secretariat
Contact details	Fogarty International Center National Institutes of Health 31 Center Drive MSC 2220 20892 Bethesda MD, USA Tel: 1-301-402-6680 Fax: 1-301-402-2056 Website : http://mim.nih.gov

Organization	**Social Science and Medicine Africa Network (SOMANET)**
Location	Nairobi, Kenya
Date incorporated	
Type of organization	Independent non-profit making Organization
Core business	The network focuses on the promotion and advocacy for the application of interactive social and health sciences approaches in solving health problems in Africa. This unique approach is based on the rationale that closer collaboration between social, biomedical and medical scientists provides potential strength for broadening the basis for the understanding, identification and solutions to health problems in Africa. The network focuses on three main areas: networking; promotion of social sciences in health and capacity strengthening.
Research areas	
Funding function	Established effective communication mechanisms which will improve the flow of information and ideas concerning health issues in Africa. It endeavours to achieve this through convening biennial international conferences, constantly updating, circulating the directory of scientists, institutions working in SSH in Africa.
Application mechanism	
Total research Funds disbursed per annum	
Affiliation	
Governance	Board of Trustees
Source of funding	
Publications	SOMA-Net Brochures, Newsletters, BIODATA Forms, Annual Report & Grant reports.
Officers	Prof. J. K. Wang'ombe, Chair Dr. Clara Fayorsey, Secretary/Treasurer
Contact details	Social Science and Medicine Africa Network P.O. Box 20811, 00202 KNH Nairobi, Kenya Tel: +254 2 560569 Tel/Fax: +254 2 567577 Mobile: +254 (0) 733 605369 E-mail: somanet@africaonline.co.ke

Organization	**National Institutes of Health (NIH)**
Location	Bethesda, USA
Date incorporated	
Type of organization	Governmental.
Core business	NIH is the steward of biomedical and behavioural research for the US. Its mission is science in pursuit of fundamental knowledge about the nature and behaviour of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.
Research areas	Conducting research in NIH laboratories Supporting the research of non-federal scientists in universities, medical schools, hospitals and research institutions throughout the country and abroad Assisting in the training of research investigators Fostering communication of medical and health sciences information
Funding function	Grants may be awarded to universities, medical and other health professional schools, colleges, hospitals, and research institutes, for profit organizations and government institutions that sponsor and conduct biomedical research and development. Research grants may provide funds for salaries, equipment, supplies, travel and other allowable direct costs of the research as well as for indirect costs to the sponsoring institution or organization.
Application mechanism	Details concerning application procedures, application forms, and dates for submission of applications may be obtained electronically by e-mail from grantsinfo@nih.gov.
Total research Funds disbursed per annum	FY 2002 Appropriation by Budget Mechanism (Estimates) 448, 699 million www.niams.nih.gov/an/budget/fy2002/fy02actmechpie.htm
Affiliation	US Government Universities and academic health centres, independent research institutions and private industry, voluntary and professional health Organizations, and Congress, which consistently has supported this vast enterprise.
Governance	Office of the Director, Managed as 24 Institutes and Centres
Source of funding	Congress of the USA
Publications	Request a list of publications by calling GRANTSINFO at (301) 435-0714.
Officers	Director: Elias Zerhouni
Contact details	Office of Grants Information National Institutes of Health 6701 Rockledge Drive, MSC 7762 20892-7762 Bethesda MD USA Tel: +1 301 435-0714 Fax: +1 301 480-0525 Email: grantsInfo@nih.gov Website : http://www.nih.gov

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Reply-To: SONYSTRAVEL@HOTMAIL.COM
To: SOCHARA@VSNL.COM

YOUR TRAVEL INFORMATION

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DATE	FLIGHT INFO	FROM	TO	DEP	ARR	TRAVEL INFO
03NOV SUN	JET AIRWAYS 9W 442 M ECONOMY CLASS NON SMOKING BOEING 737-800 DINNER RESERVATION CONFIRMED	BANGALORE HINDUSTAN	MUMBAI CHHATRAPATI SHIVAJI TERMINAL 1	2030	2205	DURATION 1:35 NON STOP
04NOV MON	KENYA AIRWAYS KQ 201 Q ECONOMY CLASS BOEING 767-300/300ER RESERVATION CONFIRMED	MUMBAI CHHATRAPATI SH TERMINAL 2	NAIROBI JOMO KENYATTA	0300	0630	DURATION 6:00 NON STOP
06NOV WED	KENYA AIRWAYS KQ 410 Q ECONOMY CLASS BOEING 737-300 RESERVATION CONFIRMED	NAIROBI JOMO KENYATTA	ENTEBBE	0745	0855	DURATION 1:00 NON STOP
08NOV FRI	KENYA AIRWAYS KQ 417 Q ECONOMY CLASS BOEING 737-200 RESERVATION CONFIRMED	ENTEBBE	NAIROBI JOMO KENYATTA	0530	0635	DURATION 1:05 NON STOP
08NOV FRI	KENYA AIRWAYS KQ 753 Q ECONOMY CLASS BOEING 737-300 RESERVATION CONFIRMED	NAIROBI JOMO KENYATTA	DAR ES SALAAM INTL	0850	1000	DURATION 1:10 NON STOP
TC 0753 FLIGHT OPERATED BY TC AIR TANZANIA						
10NOV	AIR TANZANIA	DAR ES SALAAM	KILIMANJARO	1610	1700	DURATION

SUN TC 574 Y INTL 0:50
ECONOMY CLASS NON STOP
BOEING 737-200/200 ADVANCED
RESERVATION CONFIRMED

16NOV AIR TANZANIA KILIMANJARO DAR ES SALAAM 1830 1920 DURATION
SAT TC 766 Y INTL 0:50
ECONOMY CLASS NON STOP
BOEING 737-300
RESERVATION CONFIRMED

17NOV KENYA AIRWAYS DAR ES SALAAM NAIROBI 1500 1615 DURATION
SUN KQ 483 Q INTL JOMO KENYATTA 1:15
ECONOMY CLASS NON STOP
BOEING 737-300
RESERVATION CONFIRMED

17NOV KENYA AIRWAYS NAIROBI MUMBAI 1735 0200 DURATION
SUN KQ 200 Q JOMO KENYATTA CHHATRAPATI SHIVAJI 18NOV 5:55
ECONOMY CLASS TERMINAL 2 NON STOP
BOEING 767-300/300ER
RESERVATION CONFIRMED

18NOV JET AIRWAYS MUMBAI BANGALORE 0640 0815 DURATION
MON 9W 411 M CHHATRAPATI SH HINDUSTAN 1:35
ECONOMY CLASS TERMINAL 1 NON STOP
NON SMOKING
BOEING 737-800
BREAKFAST
RESERVATION CONFIRMED

*** HAVE A NICE FLIGHT ***

VIEW YOUR ITINERARY ONLINE AT HTTP://WWW.CHECKMYTRIP.NET
YOUR AMADEUS REFERENCE NUMBER IS: ZGT6FY

PEOPLE'S HEALTH MOVEMENT
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PEOPLE'S HEALTH MOVEMENT

To
Drs.Ravi Narayan & Thelma Narayan,
Community Health Cell,
Society for Community Health Awareness, Research and Action,
Bangalore,
INDIA.

Dear Drs. Ravi Narayan and Thelma Narayan,

RE: YOUR VISIT TO EAST AFRICA

With the good news about your visit to East Africa from 4th to 11th November before Forum 6 meeting in Arusha organized by GFHR, I take this opportunity to warmly welcome you and on behalf of my colleagues appreciate your interest of sharing the knowledge and experience that you have with us. My colleagues and I are happy and will do whatever we can to make the visit a success. The circle will cover your local boarding, lodging and travel expenses.

Thank you and looking forward to your visit and the interactions.
Karibu sana.

Mwajuma S. Masaiganah Ms.
PHM Coordinator East Africa
(signed)

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P.S: SOURCES:

(1). PHA DIRECTORY
(2). WHO/NGO DIALOGUE MEETING – WHO GENEVA – MAY 97
(3). IPHN MEETING KISUMU – NOBEMBER 98
(4). IPHN MEETING, BANGALORE NOVEMBER - 99

(Contact of Pat Nickson)

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P.S: SOURCES:

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(2). WHO/NGO DIALOGUE MEETING – WHO GENEVA – MAY 97
(3). IPHN MEETING KISUMU – NOBEMBER 98
(4). IPHN MEETING, BANGALORE NOVEMBER - 99

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P.S: SOURCES:

(1). PHA DIRECTORY
(2). WHO/NGO DIALOGUE MEETING – WHO GENEVA – MAY 97
(3). IPHN MEETING KISUMU – NOBEMBER 98
(4). IPHN MEETING, BANGALORE NOVEMBER - 99

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FORUM 6

Arusha International Conference Centre
Arusha, Tanzania
12-15 November 2002

Meeting Evaluation and Suggestions for Future Meetings

To help us plan future meetings, you are invited to express your opinions and suggestions concerning the meeting.

Please keep in mind the objectives of the meeting

- Assess progress in the major initiatives supported by the Global Forum for Health Research and its partners and plan further actions contributing to the correction of the 10/90 gap.
- Assess progress in the field of priority-setting methodologies (application of the framework for priority-setting, burden of disease analysis, cost-effectiveness analysis, resource flows analysis) and plan further actions contributing to the correction of the 10/90 gap.
- Reinforce synergies between the different players in the international health research system and identify the actions necessary for the efficient and effective correction of the 10/90 gap.
- Review progress on the implementation of the Action Plan adopted at the Bangkok Conference and plan further actions in line with the orientations given by the Working Party.

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1. ORGANIZATION OF THE MEETING

(Please circle your response on a scale from 1-5, where 1= lowest, 5= highest

A. How would you rate the overall organization of the meeting?

1 2 3 4 5

B. What can be improved in the next meeting?

_____

2. CONTENT OF MEETING

A. How would you rate the overall content of the meeting?

1 2 3 4 5

B. What areas were particularly useful?

_____

C. What can be improved at the next meeting?

_____

3. HOW WELL WERE THE FOLLOWING ISSUES ADDRESSED?

(Please circle your choice)

10/90 gap	1	2	3	4	5
Gender	1	2	3	4	5
Poverty	1	2	3	4	5
Research capacity strengthening	1	2	3	4	5
Priority-setting methodologies	1	2	3	4	5

Resource Flow Analysis 1 2 3 4 5

4. PARALLEL SESSIONS

A. Please rate your satisfaction with the content of the parallel session(s) you have attended, using the 1-5 scale:

Name of the session: 1 2 3 4 5

B. Which session in your view contributed best to the objective of the meeting?

_____

5. GLOBALLY: HOW SATISFIED ARE YOU WITH THE MEETING?

(Please circle your response)

dissatisfied* satisfied totally satisfied

* Please tell us why.

6. The Global Forum for Health Research is committed to helping correct the 10/90 gap. One of its strategies in achieving its goals is the Annual Forum. For Forum 7, in the year 2003, please tell us in the space below your ideas for consideration in preparing the scientific program for Forum 7.

-

_____

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Signature: **Date:**
(optional)

Plenary session on Using research results: research syntheses as a tool to help correct the 10/90 gap

Friday, 15 November 2002, 9.00-10.30

Vaginal disinfection for reducing the risk of mother-to-child transmission of HIV infection: a systematic review

Charles Shey Wiysonge, Ministry of Public Health, Cameroon

Introduction: HIV/AIDS is the leading cause of death in Africa and the fourth worldwide, and mother-to-child transmission (MTCT) of HIV infection is one of the most tragic consequences of the epidemic. MTCT of HIV currently results in about 1800 new paediatric HIV infections each day worldwide. The paediatric HIV epidemic threatens to seriously undermine long-established child survival programmes. This paper reports a systematic review of controlled trials to estimate the effect of an inexpensive, low technology intervention - vaginal disinfection - on the risk of MTCT of HIV and infant/maternal mortality and morbidity. The review illustrates how the 10/90 gap could be reduced in this sphere.

Methods: We searched the Cochrane Controlled Trials Register, PubMed, EMBASE, AIDSLINE, LILACS, AIDSTRIALS, and AIDSDRUGS. In addition, we searched reference lists of identified articles, relevant editorials, expert opinions and letters to editors, and abstracts of relevant conferences, and contacted subject experts. There were no language restrictions. Two reviewers independently assessed trial eligibility and quality, and extracted data.

Results: Only two small trials included an estimate of the effect of vaginal disinfection on MTCT of HIV and/or infant mortality. Even taken together, these do not show an effect of vaginal disinfection on MTCT of HIV (odds ratio 0.93, 95% confidence interval 0.65 to 1.33), and infant mortality (odds ratio 1.82, 95% confidence interval 0.61 to 5.44).

Conclusion: The systematic review shows the scarcity of reliable evidence evaluating the effect of an inexpensive, low technology intervention – vaginal disinfection – on an important contributor to the HIV/AIDS epidemic, MTCT of HIV infection. The available evidence is statistically compatible with a reduction in risk. Investment of funds in further research to assess the effects of this intervention will contribute in our endeavours to correct the 10/90 gap, and decide whether this is an intervention worth adopting.

Plenary session on Using research results: research synthesis as a tool to help correct the 10/90 gap

Friday, 15 November 2002, 9.00-10.30

The science of research synthesis and its relevance to the 10/90 gap

James Volmink, Director, Research and Analysis, Global Health Council, USA

A crucial first step when considering investment in new studies of the effects of interventions is a *systematic review* of relevant existing research. This will determine what is known about a particular intervention strategy, whether further evidence is needed and, if so, what areas should be targeted for research. Without such systematic synthesis, funds made available for health research will continue to be squandered on ill-conceived studies, a phenomenon especially regrettable in resource-constrained settings. By setting new studies in the context of other relevant research, systematic reviews also help to inform health care decisions and prevent confusion that results in people being denied effective health care or receiving interventions that are ineffective or even harmful.

Keeping track of the results of primary research has become a major challenge given the information explosion in the biomedical sciences. Traditionally, decision-makers have relied on expert opinion or reviews that do not use scientific methods, for insights on current evidence. However, in recent years the limitations of these approaches have been repeatedly demonstrated and formal methods of systematically reviewing studies have arisen in an attempt to produce more reliable and up-to-date summaries of research. In contrast with conventional methods, systematic reviews use transparent, rigorous methods for identifying, appraising and synthesizing evidence from scientific studies.

With the aid of relevant examples, this presentation will demonstrate why systematic reviews have come to be seen as the cornerstone of evidence-based health care. The methods used to limit the effects of bias and chance that frequently bedevil valid conclusions about the effects of health care will be discussed. Additionally, the role of the Cochrane Collaboration, an international network aiming to prepare, update, and disseminate systematic reviews across all health care topics will be highlighted. The presentation will conclude by drawing attention to the scientific and ethical obligation of funding agencies to invest resources in the preparation and maintenance of systematic reviews relevant to the developing world before investing in new research.

Plenary session on Using research results: research synthesis as a tool to help correct the 10/90 gap

Friday, 15 November 2002, 9.00-10.30

Malaria: progress in preparing and updating systematic reviews

Martin Meremikwu, Senior Lecturer, Paediatrics, College of Medical Science, University of Calabar, Nigeria

Background: Clinicians, public health practitioners, policy makers and researchers in malaria endemic countries need reliable information on the effectiveness of interventions that prevent or cure the disease. Narrative reviews are now unacceptable, as good empirical evidence show they are often unreliable. Research synthesis involves using scientific methods to prepare reviews which are summaries of reliable research, and the Cochrane Collaboration has been preparing and updating systematic reviews in malaria for the last 12 years.

Methods: The Cochrane Infectious Diseases Group started in 1991 at a meeting in Chulalongkorn University in Bangkok, Thailand. There are currently more than 70 reviewers from over 25 countries. Each review begins with a protocol specifying the methods which will be used to conduct the review. Explicit search strategies are used to identify relevant published studies and unpublished studies are sought through contact with researchers, pharmaceutical companies and organizations (including the World Health Organization). Data from eligible studies is then extracted and synthesized. Both the protocol and review undergo rigorous peer review processes prior to publication.

Results: There are now 15 completed reviews in malaria. Eleven of these have addressed therapeutic questions and four are on preventive interventions. About a third of the authors (7/22) are from middle or low-income countries. There are four published protocols of on-going systematic reviews in malaria: one on therapy and three on prevention. Three of these protocols are led by authors from malaria endemic countries. One protocol is a prospective individual patient data meta-analysis of 13 trials examining artesunate combination treatment. There are also six on-going protocols in early stages of development, which have not been published in the Cochrane Library.

Conclusion: Research synthesis is becoming increasingly important in global health practice and policy development. To meet the deficit of systematic reviews in malaria there is need to build capacity for systematic reviewing in middle and low-income countries.

Parallel session on TB research and initiatives

Tuesday, 12 November 2002, 16.00-17.30

Bridging implementation gaps in national TB control programmes: a policy process approach

Thelma Narayan, Coordinator, Community Health Cell, India

Tuberculosis, a major public health problem in India since the 1900s has a prevalence of around 14 million and an estimated annual mortality of 500,000 persons. Nation-wide government sponsored anti-TB public health measures introduced in 1948, developed into the National TB Programme in 1962.

Despite gains, implementation gaps between programme goals and performance, over 35 years, have been of a magnitude sufficient to cause concern. An integrative bottom-up cum top-down study used a policy framework and undertook a historical review and interviews with TB patients, elected representatives, front-line health workers, doctors, district and state staff, national programme managers, researchers and representatives from international agencies.

Policy process factors at national and international level and implementation factors at state and district level will be discussed. These include the importance of leadership, institutional development, capacity at patient provider interface, need for sustained policies functioning within an affirmative framework embodying social justice and safeguarding the interests of the majority of patients.

The focus of work was on health policy processes. Subsequently through a set of circumstances our centre has become deeply involved in health policy processes of our state government in Karnataka. We were members of a Task Force on Health set up by the Chief Minister. We used participatory processes, field visits and commissioned research to develop recommendations. We were later involved in monitoring implementation of recommendations and in developing a five year project proposal for an integrated health project focusing on primary health care and public health. We are also deeply involved in the peoples' health movement at state and national level. The policy approach has helped us to strategise. I have written the Integrated policy for the state which is currently in the process of being adopted.

Guidelines for Chairpersons and Rapporteurs at Forum 6

Faculty is requested to attend an introductory session followed by a reception with the Foundation Council on 11 November at 18:30 at the Arusha International Conference Centre, Twiga Room, Ngorogoro Wing.

Part I: Guidelines for Chair persons at Forum 6

The Global Forum is very appreciative of the important role of session chairs at Forum 6. These guidelines serve to remind chairs about the critical role they play and to standardize some of the rules so that the meeting is as efficient as possible.

1. Pre-session issues

Prior to each session the chair should:

- become familiar with the content and objectives of the session
- have reviewed the summaries of each presentation
- know the exact location and time of the session
- have identified a "rapporteur" for the session (in consultation with the focal point)
- reflected on the "expected output" from the session.

2. Introduction to a session

At the start of each session, the chair will:

- review the session's objectives
- introduce each speaker with institutional affiliation and topics of their presentation
- introduce the rapporteur of the session
- explain the time keeping mechanism (yellow and red cards)

Chairpersons will be provided with this information in advance.
This introduction should take the chairperson a maximum of 3 minutes.

3. Presentations

For each session, the focal point will give the Chairperson the time table for the session (time allotted for each presentation and for the discussion).

After the final presentation, the Chair will take over the proceedings to:

- remind the audience of the objectives of the session
- and open the session for discussion with these objectives in mind.

4. Conclusions by the Chair

The chair will reserve 5 minutes at the end of the session to:

- summarize the main points emerging from the discussion

The chair will thank all presenters for their contribution and the audience for their participation. Any associated sessions or presentations may be highlighted by the chair for the audience.

5. Post-session work

After the end of each session, the chairs should:

- ensure that their notes are handed over to the rapporteur who will pass them on to the focal point together with her/his report.

Important Note on Timing of sessions

Five minutes before the start of each sessions a bell will be rung by conference assistants outside all meeting rooms, in the Piazza and at the lunch area. Please assist us in directing people to the meeting rooms.

- *The presenters have been informed that the chairpersons must keep strict timing for each of the presentations.*
- *Because of the need for discussion time, under no circumstance should a presentation exceed the time allocated.*
- *The chair will raise a YELLOW CARD to indicate that 2 minutes are remaining before the end of a presentation. The chair will raise a RED CARD to indicate that the speaker should immediately end the presentation.*

Part II: Guidelines for Rapporteurs at Forum 6

The Global Forum very much values the work of the rapporteurs who will help in the documentation of events and ideas presented and discussed at Forum 6. These guidelines serve to help standardize the work of the rapporteurs, to assist them in their work and to help document important issues that emerge at this meeting.

Rapporteurs will be:

- identified by the responsible officer and focal point before the start of the session
- introduced by the chairs at the beginning of each session.

Rapporteurs will be responsible for:

- writing down the important points made in each presentation (including the next steps in the collaboration between partners and the conclusion by the chair)
- gathering all notes and documents used in the presentations and giving them to the Global Forum staff in the Documentation Centre in the AICC who will gather the notes and give them to the Responsible officers in the Global Forum Secretariat.

The rapporteur is free to add personal comments (with identification).

Thank you!
Louis Currat
Executive Secretary
Annex: List of Chairpersons, Responsible Officers, Focal Points and Rapporteurs

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TRANSPORT LOGISTICS FOR FORUM 6-PARTICIPANTS NOV-2002				
HOTEL NAMES	PICK UP TIME			
	TUE	WED-FRIDAY		
A.M	8:00	8:00		
ARUSHA COFFEE LODGE	7:30	8:00		
RESORT CENTRE	7:30	8:00		
DANISH	7:30	8:00		
DIK DIK	7:30	8:00		
ELAND	7:30	8:00		
EQUATOR HOTEL	7:30	8:00		
G & T HOTEL	7:30	8:00		
GOLDEN ROSE	7:45	8:00		
ILBORU SAFARI LODGE	7:30	8:00		
IMPALA	7:30	8:00		
KIGONGONI LODGE	7:30	8:00		
L'OASIS	7:30	8:00		
MERU INN	7:30	8:00		
MOIVARO LODGE	7:30	8:00		
MOUNTAIN VILLAGE	8:00	8:00		
NEW ARUSHA HOTEL	7:30	8:00		
NGARASERO	7:30	8:00		
NOVOTEL	7:30	8:00		
PALLSONS	7:30	8:00		
SAFARI SPA	7:30	8:00		
SPICES & HERBS	7:30	8:00		
VICTORIA HOUSE	7:30	8:00		

Kilimanjaro Centre for Community Ophthalmology

...dedicated to the elimination of avoidable blindness through the integration of programmes, training, and research focusing on the delivery of sustainable and replicable community ophthalmology services

KCMC/Tumaini University

An estimated 180 million people worldwide today are visually disabled; about 45 million of these are blind and cannot walk about unaided. Nine out of ten of these people live in the developing countries where the loss of sight causes enormous suffering for affected individuals and their families. It also represents a public health, social and economic problem for the countries where these people live.

The good news is that 80% of global blindness is avoidable. It could be prevented or cured using relatively simple technology and knowledge that is already available today. The challenge is to develop working programmes locally that make use of current technology and knowledge.

"Vision 2020: the Right to Sight" is a global campaign aimed at eliminating avoidable blindness. This initiative is the product of a series of consultations between the World Health Organization and many non governmental organizations working in the field of prevention of blindness.

The KCCO has been created in response to the Vision 2020 initiative and is dedicated to building the capacity of local workers at all levels to undertake programmes in disease control, to develop human resources, and to support and strengthen local infrastructure.

Activities of the KCCO

The KCCO works in the three areas of training, programme development (service), and research but always strives to find ways to make these overlap. Thus, programme and service activities will usually include elements of operational research, since the KCCO is dedicated to the concept of constantly improving our methods and using evidence-based approaches to improved service. Personnel at all levels who are involved in programmes and research will be receiving training as they are continually challenged to take increased responsibility, expanding their capacity to plan and implement projects.

Programme Development

- The KCCO is implementing community based programmes to reduce blindness from cataract and trachoma, the two major blinding diseases, as well as other conditions such as childhood blindness, and leprosy.
- The KCCO is developing a cataract surgical service programme which will be organizationally and financially self sustaining; we aim to increase significantly the number of high quality cataract surgeries provided while still ensuring care for the poorest.
- The KCCO conducts workshops in which we help eye care professionals to develop practical district-based prevention of blindness plans and programmes

Training

- The KCCO trains eye care professionals and public health workers in needs assessment, eye care programme planning and evaluation, epidemiology, and medical anthropology.
- The KCCO strengthens the academic training of ophthalmology residents, medical assistants, and public health students at KCMC by providing regular didactic teaching and supervision of practical community based field work
- The KCCO is developing collaborative relationships (north-south and south-south) with universities in Africa, Canada, Europe, Asia and the US to provide training for eye care providers
- The KCCO trains eye health professionals in practical research methodology and how to critically review medical literature

Research

- The KCCO is investigating cost effective ways to improve the uptake of, quality of, and satisfaction with eye care services
- The KCCO is studying the issue of gender and blindness and testing methods to increase utilization of services by women.
- The KCCO is studying the problems associated with accessing services for children with visual impairment with the aim of facilitating access to services for these children.

Administration

The KCCO works in collaboration with the Department of Ophthalmology at the Kilimanjaro Christian Medical College of Tumaini University in Moshi, Tanzania. The Centre is directed by Dr. Paul Courtright and Dr. Susan Lewallen.

Project Impact, a US based registered 501(c)3 serves as the support organization for the KCCO and is responsible for fund raising and account management.

Board of Advisors

- Dr. Moses Chirambo, Lilongwe, Malawi
- Dr. Daniel Etya'ale, Geneva, Switzerland
- Dr. Suzanne Gilbert, Berkeley, USA
- Mr. David Green, Hunt Valley, USA
- Dr. Peter Kilima, Dar-es-Salaam, Tanzania
- Dr. Volker Klauss, Munich, Germany
- Dr. Jack Rootman, Vancouver, Canada
- Mr. RD Thulasiraj, Madurai, India
- Dr. Mark Wood, Dar-es-Salaam,Tanzania

Start up financial support for the KCCO has been provided by

Al Noor Foundation,
Helen Keller Worldwide
International Eye Foundation
International Trachoma Initiative
Seva Foundation

Donations for general support or for specific projects are tax deductible and may be sent to:

Project Impact, Inc
1193 Sand Lake Hwy
Onsted, MI 49265
USA
Tel: 1 517 467-6415
Fax: 1 517 467-6575

For further information contact

Dr Paul Courtright or
Dr Susan Lewallen
KCCO
PO Box 2254
Moshi, Tanzania

Email: KCCO@KCMC.ac.tz

GLOBAL FORUM FOR HEALTH RESEARCH 6, ARUSHA TANZANIA, 12-15 NOVEMBER 2002

INVITATION TO VISIT MINISTRY OF HEALTH DEMOGRAPHIC SURVEILLANCE SITE IN KILIMANJARO, TANZANIA

FRIDAY 15 NOVEMBER 2002 2-5:30PM.

Overview

The Tanzania Ministry of Health is establishing a National Sentinel (NSS) system of linked demographic surveillance site for the long term monitoring of health and poverty condition.

Demographic surveillance sites are an increasingly important resource for research and routine information production in health development in developing countries. In Tanzania, findings from these sites have influenced national health policy and district resource allocation.

Participants are invited to visit the NSS's demographic surveillance site in Hai District, Kilimanjaro Region, to meet with representatives of the Tanzania Ministry of Health and local Council who operate the system, as well as view a presentation of the technical operations and output of the system. During the visit there will be presentations on the Hai district Demographic Profile, details of the fieldwork for the collection of demographic and mortality surveillance data, and discussions. GFHR participants will also get first hand information on fieldwork from the field enumerators and on the ways the outputs have benefited the district.

Participants in GFHR Forum 6 are invited to the NSS's demographic surveillance site in Hai District, Kilimanjaro Region on the 15th November 2-5:30p.m.

Transport will be provided. The bus will leave the AICC at 2.00PM from the main gate and will return participants after 5:30PM to their respective Hotels. Please sign up at the AMMP booth, as we will be able to accommodate up to 50 participants.

Focal Point: Philip Setel, Project Director. and Yusuf Hemed, Deputy Director, Adult Mortality and Morbidity Project, Ministry of Health, Tanzania

Adult Morbidity and Mortality Project (AMMP)
PO Box 65243
Dar es Salaam, Tanzania
Tel: +255 22 213388, Fax: +255 22 2153385
AMMP Website: www.ncl.ac.uk/ammp

Parallel session on Gender, mental health and disability

Wednesday, 13 November 2002, 11.00-12.30

Gender, mortality and the European transition economy countries

Florence Baingana, Senior Mental Health Specialist, Human Development Network, World Bank, Washington

In studying the transition economy countries of Eastern Europe, a striking finding is the large east-west mortality gap and the excess mortality of males. These countries have been characterized by profound economic, political and social changes and are now challenged by the emerging HIV/AIDS epidemic.

This presentation will outline the east-west mortality gap with a ranking of the top causes of mortality and disability. A hypothesis for the excess mortality will be posited including the contribution of mental and behavioral disorders. Finally, implications for policy development will be discussed.

(1) Selected Indicators — LE/M LE/F — Big LE Gap between M & F
Russia 50.3 60.6 →
Estonia

(2) Explanation — Collapse of System
East/West Gap = economic collapse
- control over life
- stress
- less Healthy Lifestyles
- More depressed

Transition - Dependency to Responsibility Took time for Health

(3) Quicker Recoveries - lower gap

(4) Gender Mortality Gap - Parity ↑ — 35-44 Mortality Peak
- Employment ↑
- Alcohol ↑

- Suicide Rates ↑ ← Risk Taking behaviours ↑
- 25-44 - East Europe
- Male Rate 2-6 times higher
- Interpersonal / Unintentional injuries
- excessive smoking of tobacco

Evidence of Alcohol excess
Liver cirrhosis ↑
CVD ↑
Stroke ↑

Etiology i) Interconnection of diseases

ii) depression and anxiety (no male & female breakdown)

iii) Induction?

Recommendations - Efforts to Preventable causes of Morbidity.

- Suicide
- Alcohol
- CVDs

- Special programmes to address youth

Parallel session on Gender, mental health and disability

Wednesday, 13 November 2002, 11.00-12.30

Gender and mental health research in developing countries

Vikram Patel, Senior Lecturer, London School of Hygiene and Tropical Medicine, India

The 10/90 gap in global health research is even more skewed for the specific area of mental health that has been a poor cousin of other health priorities in developing countries. The low profile of mental health research runs contrary to the large body of epidemiological evidence demonstrating the huge burden of mental disorders in all societies. This evidence points not only to the considerable disability produced by mental disorders, but also to the availability of cost-effective interventions for many mental disorders. This paper will explore the theme of gender and mental health research from the perspective of women's mental health issues. Depression and anxiety disorders, which are the most common of all mental disorders, are more frequently diagnosed in women. The most likely reason for the female excess may be found in the adverse social circumstances which women face in their daily lives. Two studies will be presented to demonstrate the influence of gender variables on women's mental health, i.e. oppressive relationships experienced by women in high-density townships in Harare and the sex of the newborn child of mothers in India. In the context of the limited funds and capacity for health research in developing countries, it is pertinent to consider how investment in mental health research may meet the needs of existing public health priorities. The strong relationship between gender and women's mental health will be explored from the context of reproductive health, a major public health priority in developing countries. The implications of this relationship provide an avenue for reducing the 10/90 gap in mental health research in developing countries. Rather than a separate mental health research agenda, the gap can be reduced by providing more attention to mental health paradigms in reproductive health and other public health research programs in developing countries, in particular programs where gender is a crucial variable.

- Why are mental disorders important for women
- Focus on gender with women's mental health programs
- Implication for 10/90 gap

—

- Common Mental Disorder - Anxiety/Depression/Neurosis

Epidemiology ~10% of comm.
30% of primary care often.
5% – long term feeling

- 11 Studies Review
  - Poverty –
  - Female Sex ~ 2 times more common

Gender and CMD

Biological

morbids r menstrual ch.
oral contraceptive pills
no consistent findings.

Social

Poverty r social disadvantage
(Sex of new born child and
poor natal depression (India)
(Severe life events and depression
of women (Zimbabwe)

Risk Factor - Poverty x3
Marital Widow x5
Child x1

Girl Child factor r Repression - when data disaggregated

What happens to women:

- No sympathy from family (she is lazy)
- Majority consult general health care: low recognition and care
- overuse of sleeping medicine
- CMD R, rarely applied to women

10/90 gap

1. Mental Health - poor coverage
2. Integrate mental health into
3. Reproductive r child health

Parallel session on Gender, mental health and disability

Wednesday, 13 November 2002, 11.00-12.30

Is there gender-inequity in global blindness?

Ken Bassett, Research Professor, Opthalmology, Kilimanjaro Centre for Community Opthalmology, Tumaini University, Tanzania; Iman Abou-Gareeb, Lyn Sibley; Susan Lewallen; Paul Courtright

In order to improve understanding of eye diseases and gender, the burden of blindness by sex was assessed using a meta-analysis of population-based blindness surveys. In addition, we explored why sex differences occur in blindness rates and utilization of eye care services. For the meta-analysis, we used the Cochrane Collaboration Review Manager to pool findings using both published and unpublished data. To understand sex differences in the use of eye care services, we reviewed published and unpublished literature. The overall odds ratio (age-adjusted) of blind women to men is 1.40, ranging from 1.39 in Africa to 1.41 in Asia. Women therefore account for 64.5% of all blind people in population-based prevalence estimates, most of who are over 50 years of age and most of who live in poorer countries. The finding of an excess burden of blindness for women holds for virtually all of the individual surveys and the pooled results. The excess burden of blindness among women is poorly understood and rarely has been systematically studied. Indeed, gender analysis has not become an explicit component of the WHO's worldwide blindness prevention strategy, Vision 2020. We do know that in developing countries, cataract and trachomatous trichiasis are the most common causes of blindness, occur more frequently in women than men, and women have less access to surgery. We conclude that the most likely explanation for the increased burden of blindness among women is inadequate access to eye care services. We recommend gender specific eye care program development.

Why do women bear the brunt of the burden of blindness?

Poverty - Gender - Disability

Biological explanation

- women live longer
- women live longer often become blind
- women have a higher biological risk

Social

- More susceptible to eye disease
- women use fewer eye services

- poverty
- Support and care

Parallel session on Gender, mental health and disability

Wednesday, 13 November 2002, 11.00-12.30

Do women have less access to cataract surgical services?

Paul Courtright, Co-Director, Kilimanjaro Centre for Community Ophthalmology, Tanzania

Women bear two-thirds of the blindness in developing countries. We sought to determine, from the existing literature, cataract surgical coverage rates (surgeries received among cataract blind) by sex and the proportion of cataract blindness that could be eliminated if women and men had equal access to cataract surgical services. Methodologically sound population-based cataract surveys from developing countries were identified through a literature search. Cataract surgical coverage rates were extracted from the surveys and rates for women were compared to those for men. Cataract surgical coverage rates were 1.2-1.7 times higher in males than in females. The odds ratio of having surgery for women compared to men was 0.67 (95%CI 0.60,0.74). If females received surgery at the same rates as males, cataract blindness rates could be reduced by a median of 12.5% (range 4.0 to 21.0%). In these surveys, women account for approximately 63% of all cataract cases in the population. Females are not receiving cataract surgery at the same rate as males and closing the gender gap could significantly decrease cataract blindness. Qualitative research in Tanzania (and elsewhere) has shown that the barriers to use of cataract surgical services are different for men and for women. While cost of service is a common concern, decision making at the household and community level is gender specific and currently implemented educational approaches generally do not incorporate an understanding of decision making in rural communities. Assistance needed to seek services is also gender-dependent with women often needing assistance to come to hospital. Men are more likely to be willing to travel to the hospital without assistance. Potential gender sensitive intervention activities will be discussed.

Parallel session on Gender, mental health and disability

Wednesday, 13 November 2002, 11.00-12.30

Eye care service decision-making by rural Malawians

Dr. Robert Geneau, British Columbia Centre for Epidemiologic & International Ophthalmology; Thomas Bisika; Paul Courtright

We used a multiple case study design to understand the various barriers to eye health care in Chikwawa District, Malawi and to assess how sociocultural factors (gender being one aspect) underlie or directly influence therapeutic choices. We selected two communities with contrasting characteristics in terms of geographical access to eye care services and medication. We collected information, through observation and semi-structured interviews, to determine: [1] Are men and women different in terms of perceived needs for eye care, perceived efficacy of western/traditional medicine and perceived barriers to eye care? [2] Are differences in the health care decision-making process defined by the normative expectations of gender-specific roles inside the family and the community? We found that perceived needs for eye care were higher for women, especially when it involved children, that some perceived barriers were more specific to women but that perceived efficacy about western/traditional medicine varied the same way between men and women (illness specific rather than gender specific). The specific context of each community was identified as an important factor in determining the diversity of family structures within the community (monogamous, polygamous, single/widow) and in access to resources by women. Greater access to resources in one area did not necessarily mean more control over resources. Family structure was a key factor in the analysis of the health care decision-making process and we observed variations within each community in regards of a level of autonomy by women to decide about health care/ability to use health care facilities. The barriers which prevent use of services varied between men and women but also within each groups through a complex interaction of individual, family and community factors. The impact of social systems on eye health and use of eye care services are discussed.

ADHOC / VAGUE !!

NO STRATEGY

What do we do?

1. Reallocate from Gen Revenue
2. Central revenue of Alcohol / Tobacco
3. From disinvestment
4. Increase Property Tax
   - Repatriation
   - Rural/urban

Plenary session on Successes in health research: mobilizing national resources

Tuesday, 12 November 2002, 14.00-15.30

The experience in India

N.K. Ganguly, Director General, Indian Council of Medical Research

Resource mobilisation refers to health financing strategies to generate resources to support or pay for the goods and services used in the production and delivery of health care. However, in this talk, resource mobilisation for health research would also be touched upon. Major strategies for resource mobilisation include government revenue, health insurance, user-fee, out-of-pocket expenses and non-government contributions. Unlike in other countries where there is usually one country-specific health financing strategy in a large country like India with diverse socio-economic conditions, the financing strategies have to be state-specific. During 1990-91, the health expenditure in India (about Rs. 27,000 crores) was 6% of its GDP (4.7% by the private sector and 1.3% by public sector). Among the public sector the Central Governments' share is nearly 2%, while that of the State's is close to 19%. Public contribution from the centre, states and local bodies, etc., has been variously estimated to be around 22%. The bulk of public health financing is by revenues from general taxation -- the share of social insurance is about 2%. The share of health expenditure in the major states shows a significant decline in proportion to health expenditure, from 6-7% in the 1980s to just over 5% in 1990s. However, there has not been any significant variation in the central government's share which has remained more or less at 1.25%. The real per capita spending on health has shown a steady increase in all states of India in varying degrees. Though the budget outlays have increased, the proportion spent on salaries and wages is going up, particularly in low-income states where salaries alone consume 80% of the funds leaving little for developmental activities, drugs and consumables. Two important features of Indian health care financing stand out. A large majority of people seeking ambulatory care during illness prefer private rather than public providers. However, a slight majority of ill people do seek care from public providers for conditions needing admission to the hospital. Even the visits to public facilities generally involve out-of-pocket expenditure. The average spending per outpatient episode at public facilities is about 40% of the average expenditure on visits to the private sector, while the inpatient treatment expenditure at public health care facilities averages a quarter of inpatient treatment costs at private facilities. Taken together these features imply that treatment from both categories impose considerable financial burden on individuals. The consistent pattern that emerges shows that about three-quarters of all the expenditure on curative services is private and only a quarter is public. These direct out-of-pocket costs are believed to push about 2% of Indians to below poverty line each year.

The situation of financing for health research is no better. Low and middle-income countries are struggling to reach the 2% mark of total health expenditure. India is close to 1.5%. As health research is multi-sectoral, at times it is difficult to quantify the contribution by each sector -- on the whole India spends about 8% of its total expenditure in R&D on health. Over the successive

years, the outlays for several R&D agencies in India have increased several fold, although the same does not hold true for the Indian Council of Medical Research (ICMR), the only national level body devoted exclusively to health research. To improve the situation, the ICMR has taken initiatives which have started to show positive results. The council took up an exercise that would generate data on the estimation of disease burden in the country, completed the first phase of priority setting, produced a draft health research policy and opened a dialogue with the planners and policy makers. It has also aligned its health research agenda to the national health policy. India has also tried out innovative strategies to attract funding for the health sector from the non-formal health sector. Foreign assistance too has been effectively used to supplement the national contribution in major health programmes like malaria, TB, HIV and blindness.

To improve the national resources for health several strategies have been used by various countries. These have been used alone or in combination and have produced variable results. The outcome of these studies in Bolivia, Cote d'Ivoire, Senegal, Sri Lanka and Zimbabwe and lessons learnt from them will be discussed. Finally, suggestions are floated for increasing resources for health through increasing central and state levies, utilizing revenues from disinvestments, charging user-fees and related problems and plausible methods of overcoming some of the hurdles.

Major strategies

1. Govt Revenue - Gen Taxation
   Specially taxes
2. Health Insurance
3. user fee
4. NGO
5. non-specific

1980 - 7%
2050 5%

1.3% of GDP - Centre
4.7% of GDP - Other Source

- BIMARU States - Mostly salaries
- 2% below poverty line every year due to medical expenses
- Poor do not get world bank

Health Research

Rural Dev Defence
MoHFW S&T
Chemicals Env.
Railways

Health = 8%

9th Plan - 263
10th Plan 1070

7% - Epidemiological

ICMR = Poorest Allocation

- Took stock of situation
- undertook priority setting exercise
- Std examination of disease burden
- State/Central Research Policy

- Special Programme
- Health Insurance — inadequate role
- Public Sector - user fees - inadequate role

Plenary session on Successes in health research: mobilizing national resources

Why measure resources for health research?

Tuesday, 12 November 2002, 14.00-15.30

Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research, Switzerland

Health research is essential to the design and implementation of health interventions, policies and health service delivery. Tracking resources can indicate the degree of priority given to research in specific health conditions or health research systems. Yet, tracing and analysing investments in health research remains a difficult, time consuming, and costly exercise.

The systematic measurement of investments in health research is relatively recent. The Commission on Health Research for Development reported in 1990 the importance of investing in health research for development for all countries, including the poorest. The 1996 Ad-Hoc Committee Report linked health research investments to an aggregate measure of disease burden using the 'five-steps process for priority setting'. The Ad-Hoc Committee described a mismatch between investments in health research and disease burden worldwide, which became known as the 10/90 gap in health research described by the Global Forum for Health Research. Malaria, for example, accounts for 2.7% of the global disease burden but accounted for less than 0.5% of total investments in health research in 1998. The Global Forum and partners estimated that global investments in health research amounted to USD73 billion in 1998 ('Monitoring financial flows for health research, 2001').

Measuring resource flows from sources to users provide important information. The extent to which national public expenditure is persistently invested in health research systems in a given country is a key measure of the future capacity of the country to tackle its health problems in a more efficient and effective way. Measuring resource flows allows the examination of trends of national and international funding, and permits to relate funding trends to specific initiatives, such as the creation of Government structures to promote and coordinate health research. Also, trends in private funding, which account for about half of total investments in health research worldwide, can reflect important developments for health research.

The presentation will illustrate examples of applications of resource flows analysis.

Health Research - Funding Report
- Countries 2% of H Expd
- Per Annum - 5% for Research

- 1992 - 56 billion US$ invested in H-Research
  - Related to Level of Disease Burden
  - (5 steps of Priority setting process)

GFHR-5 large discrepancy between the magnitude of disease burden and health resource

Monitoring financial Flows in Health Research — Int Advisory Group

	$ billion	%
Public Funds (Govt)	34.5	47
Developing	2.5	3
Pvt funds		
Pharma	30.5	42
Private-not-profit	6.0	8
	73.5	100

- 2.6% of total health expd worldwide
- modest increase in public & pvt
- Pharmaceutical/biotechnology ↑ USA mainly inside USA

R & D Investments % of HE

Brazil 1.42	Argentina 0.96
India 0.85	Cuba 1.4
Malaysia 0.40	Costa Rica 1.6

COHRED studies – Systematic mapping of institutions
– Linking sources and users of funds

Phase I – 1999-2004 – Increase importance

WHR 2004 - Knowledge for better health

Phase II – Health Research System

Research Effort ⇄ Prev → Examples

CLARITY ✓
STRATEGY ✓

Plenary session on Successes in health research: mobilizing national resources (examples from Asia and Latin America)

Tuesday, 12 November 2002, 14.00-15.30

Successes in health research: mobilizing national resources in Brazil

Cesar Jacoby, Consultant, Health Science and Technology, Ministry of Health, Brazil

Brazil is classified as an upper middle-income country by the World Bank (2002), with continental proportions and diverse demographic, economic, social, cultural, and health characteristics. In 1999, the overall spending in S&T was estimated in US$5,77 billion, which represents 0.9% of the Brazilian GDP, and it has been mostly (around 80%) funded by the public sector. The great challenge is to increase that percentage to 2%, while maintaining present levels of public spending and substantially increasing participation from the private sector.

Scientific and technological development plays an essential role in public health, including the development of health systems and services. In the context of fostering health research, the Brazilian government created the Health Sectorial Fund by Federal Law on December 19, 2001. With a budget of US$17 million for 2002, reaching US$23 million in 2003, this fund represents additional financial resources to the current annual federal budget of US$230 million invested in health research.

The scientific activities to be promoted in the health sector by this fund are as following: scientific and technological projects; experimental development of technologies; development of basic industrial technology; infrastructure set up; development and qualification of human resources; and documenting and dissemination of scientific and technological knowledge. The Health Fund will be managed by a steering committee which is responsible for establishing directives, setting up annual plans for investments, following up the implementation of actions and evaluating results. Besides the Health Fund, there are the Biotechnology Fund, the Green & Yellow Fund, which promotes the interaction between universities and private sector, and the Research Infrastructure Fund. With a budget of US$200 million in 2002, these funds will positively affect R&D in the health sector.

Health Fund
- 4.2% of GNP (2.8% from Public Sector)
- LE 66.2 — 1991 68.55 (2000)
- IMR 49/1000 1990 29/1000 (2000)

www.mct.gov.br
ministro/conferencias
/200/eva.htm

1950 — CNPq + (Capes)
1969 — FINEP

- National S&T Dev System (SNDCT)
↓
S&T 0.9% of GDP
60000 active scientists/technologists
2500 groups
15000 researchers
0.9% to 2% of GDP -

Brazilian contribution

42.1% of Latin America - indexed articles
1.33% of indexed articles (17th Position)

1000 ——— 6300 — 36000 PhD Students

Strategy

1. Formation of University-Company collaborative research nclus
2 Creation of Technology parks
3 Econ dev — National competitiveness
4 reforms in Health System & Science
5 Role of Tech dev in Health Syst evidence
6. Increase expenditure on HT in the years ahead

Funds

- 12 Funds for Res & Dev (Health is one of them) — 1/3rd billion $
- Green & Yellow fund - Univ-Business interact.
- Research collaborative fund -
- Annual Budget

Health Fund

- 17.5% of New Tax to this fund
- 17 million dollars / 23 million $ 2003
  2002
- Managed by Steering Comm = Priorities/Monitoring/Evaluation organisations
- Ministries & NGO funds (Steering Committee)

ANNOUNCEMENT OF ADDITIONAL SESSION

Tuesday 12 November
SESSIONS IN PARALLEL
11.00-12.30

Themi

Succès dans la recherche en santé : résoudre les problèmes en Afrique occidentale

Co-présidents:

- Mamadou Daff, Head, Research and Study Division, Ministère de la Santé publique et de l'Action sociale, Sénégal
- Amidou Baba-Moussa, Regional Adviser, Research Policy and Coordination, WHO Regional Office for Africa, Brazzaville [to be confirmed]

La séance, qui se déroulera en français, aura pour but de présenter la recherche en Afrique francophone, en particulier en ce qui concerne le développement d'interventions et leur impact sur la santé des populations africaines.

- Djibril Ndiaye, Head of Research, Research and Study Division, Ministère de la Santé publique et de l'Action sociale, Sénégal
  – *La gestion du processus de renforcement de la recherche en santé au Sénégal*
- Salimata Ki/ Ouédraogo, Responsible Officer, Health Research, Research and Planning Directorate, Ministry of Health, Burkina Faso
  - *La recherche en santé au Burkina Faso*
- Sidibé Toumani, Directeur du Centre de Recherches et d'Etudes sur la Documentation en Santé (CREDOS), Mali
  – *La présentation du CREDOS et une étude sur la santé des enfants à Kati au Mali*
- Martyn Teyha Sama, Principal Research Officer, Centre of Medical Research, Epidemiology, Institute of Medical Research, Cameroon
  - *Community-directed treatment with ivermectin: a control strategy for onchocerciasis in Africa*
- Absatou Soumare N'Diaye, Head of Epidemiology Service, Institut national de la recherche en santé publique, Mali
  – *Les journées nationales de vaccination et la mobilisation sociale en milieu péri-urbain de Bamako au Mali*
- Sylla N'nah Djenab, Head, Research and Documentation Section, Ministère de Santé publique, Guinée
  – *Seroprevalence of HIV/AIDS in Guinea*

Focal Point and Rapporteur: Absatou Soumare N'Diaye, Head of Epidemiology Service, Institut national de la recherche en santé publique, Mali

Details on the sessions in parallel **Successes in health research in West Africa** and **Southern Africa** will be announced.

Strengthening Regional Disease Surveillance Strategies in East Africa

L.E.G. Mboera, S.F. Rumisha & A.Y. Kitua

National Institute for Medical Research, Dar es Salaam, Tanzania

Summary

Communicable diseases are the major causes of ill health in East Africa, causing an enormous burden to health and economy. Malaria, HIV/AIDS, diarrhoeal diseases, immunisable diseases, acute respiratory tract infections and meningitis cases are present in high endemic forms and/ or occur with high frequency in the form of epidemics. Disease endemicity in East Africa is changing rapidly as a result of changes in climatic, topographical and human related factors. Essential components of disease control, which are still underdeveloped, include the health management and information system and epidemic preparedness. The poor health management information system hampers communication between the respective levels of health service delivery and planning, monitoring of disease, and evaluation of control measures at all levels. Without good health management information systems using the right indicators, national programmes face difficulties in monitoring and evaluating activities at all levels. With respect to communicable diseases an effective surveillance system is the basis of any information system. The effectiveness of a health information system at any level depends on the ability of the level staff to utilise the information properly. Increasing occurrences of disease epidemics such as Malaria, Ebola, Yellow fever and Rift Valley fever have been recorded in East Africa in recent years. These epidemics have inflicted a high incidence of mortality upon the affected population in the region. To some extent large-scale epidemics have been associated with climatic changes and increased human movements. Accordingly, there is a strong need for a regional and multi-institutional disease surveillance network to strengthen early detection, prevention and control. This has necessitated the establishment of the East African Integrated Diseases Surveillance Network. The general aim of this Network is to strengthen information sharing among the partner states and to improve disease detection, prevention and capacity at both the national and regional levels.

Parallel session on Succes dans la recherche en sante : resoudre les problemes en Afrique occidentale

Tuesday, 12 November 2002, 11.00-12.30

Community-directed treatment with ivermectin: a control strategy for onchocerciasis in Africa

Martyn Sama, Principal Research Officer, Epidemiology, Institute of Medical Research, Cameroon

Onchocerciasis is an important public health and socio-economic problem in Africa where 99 percent of the disease burden is found. Onchocerciasis is a devastating disease that is the third leading cause of blindness in Africa. It has historically attacked the poor and voiceless that live in the most rural areas of twenty-seven countries in Africa.

Following the introduction of ivermectin in 1987, Onchocerciasis control became possible. The principal challenge for the control is to deliver annual single dose treatment to the population of high-risk communities, and to sustain the delivery for a sufficiently long period to bring about the control of the disease as a public health problem.

Community Directed Treatment (ComDT) with ivermectin has been shown to be an effective strategy for Ivermectin distribution. The backbone of ComDT is the Community Directed Distributors (CDDs) whose mechanism of selection is embedded in the African Program for Onchocerciasis Control's philosophy of equity and social justice in consideration of the values, norms, local culture and practice of the endemic communities.

A multi-country study conducted in some of the endemic countries has demonstrated that ComDT is an effective strategy for drug distribution and that communities have been deeply involved in their own health care on a large scale. ComDT is a strategy which could be used as a model in developing other community-based programs and could also be a potential entry point in the fight against other diseases.

Plenary session on Celebrating African health research

Tuesday, 12 November 2002, 9.45-10.30

HIV/AIDS Research in Tanzania 1983-2002

Kisali Pallangyo, Professor, Internal Medicine, Muhimbili University, Tanzania

Background: AIDS struck at a time when Tanzania was reeling under severe economic recession, cyclical droughts and floods and protracted wars of liberation in southern Africa and Uganda from the rule of dictator Iddi Amin. It is easy therefore to understand why in such depressed economic environment expenditure on public health was severely constrained hence research of any significant magnitude on HIV/AIDS largely depended on external funding.

HIV/AIDS Research: External funding for HIV/AIDS research has been obtained under various types of agreements with the government, and/or local institutions. Occasionally, foreign researchers have designed and conducted research with minimal or without local collaborators. Funding for AIDS research in Tanzania during the past two decades falls into one or a combination of the following groups: UN agencies, Research Institutions from Europe/North America, International Development Organizations, Universities and NGOs.

Categories and Findings of AIDS Research: Studies done are classified as: Epidemiological, clinical, laboratory, socio-economic and behavioral. Although over 90% of adult population are aware of the routes of HIV infection further spread of the virus have continued unabated. Data from community based studies show HIV/AIDS to be the number one cause of adult mortality in both rural and urban areas. HIV has modified clinical presentation of tuberculosis, led to a fivefold increase of reported cases and over stretched TB control to breaking point. Studies from Kagera clearly demonstrated how HIV/AIDS negatively impacts on economic performance of individual families, villages, and communities. Provision of treatment for STI in the Mwanza study led to reduction of HIV incidence. Studies done in Dar es Salaam and elsewhere (PETRA) influenced strategies on prevention of mother to child transmission of HIV. Data from population based studies show steady decline of HIV prevalence overtime in Kagera.

Challenges: These include identifying strategies to: reduce further spread of HIV infections; provide improved care including use of antiretroviral drugs, eliminate stigma and discrimination and preparing for HIV vaccines.

Parallel session on Research by civil society organizations

Tuesday, 12 November 2002, 16.00-17.30

Participatory research and advocacy improve malnutrition management and household food security in rural South Africa

David Sanders[1], N. Sogaula[1], Thandi Puoane[1], D. Jackson[1], D. McCoy[2], N. Karaolis[3], A. Ashworth[3], M. Chopra[1]

Child malnutrition remains a major contributor to the global burden of disease. In South Africa, a middle-income country, chronic malnutrition and Vitamin A deficiency affect about a third of the countries' young children, significantly contributing to continuing high morbidity and mortality. Recognition of this in post-apartheid South Africa, has resulted in the development of an integrated nutrition strategy.

In attempting to develop a replicable model of nutrition policy implementation the School of Public Health at the University of the Western Cape, the Health Systems Trust, the Public Health Nutrition Unit of the London School of Hygiene and the Eastern Cape Dept. of Health have, since 1998, been involved in a research and service development project to address child malnutrition in the impoverished rural Transkei region.

Participatory research involving hospital staff resulted in the identification of deficiencies in hospital management of malnutrition. Targeted training and ongoing support has resulted in its improved management and reduced case fatality rates in eleven district hospitals. Follow-on research funded by WHO to formally evaluate the feasibility of implementation of its protocol on malnutrition management in district hospitals worldwide included a focus on constraints to successful nutrition rehabilitation post-discharge from hospital. These constraints, identified through home visits, included significant dietary inadequacy and household food insecurity, mostly as a result of inadequate incomes. A potentially major income source, a government-administered child welfare grant, had not been obtained by any of the thirty households interviewed, although almost all qualified. Major obstacles were extreme poverty, and poor access compounded by complex and unsympathetic bureaucracy.

Dissemination of these research findings through formal reports to government, published articles in journals and the popular media, and especially the production of a television documentary, resulted in a visit to the area by the Minister for Social Development, questions in Parliament and the rapid deployment of a mobile team to the area to expedite the processing of several thousand Child Welfare grants.

A national advocacy effort around malnutrition, poverty and child welfare continues to be informed by ongoing research in this region.

[1] School of Public Health, University of Western Cape, South Africa
[2] Health Systems Trust, South Africa
[3] Public Health Nutrition Unit, London School of Hygiene & Tropical Medicine, U.K.

Mobilising National Resources

Prof. N.K.Ganguly*

Director General
Indian Council of Medical Research,
New Delhi 110-029, India

Resource mobilisation refers to health financing strategies to generate resources to support or pay for the goods and services used in the production and delivery of health care. However, in this talk, resource mobilisation for health research would also be touched upon. Major strategies for resource mobilisation include government revenue, health insurance, user-fee, out-of-pocket expenses and non-government contributions. Unlike in other countries where there is usually one country-specific health financing strategy in a large country like India with diverse socio-economic conditions, the financing strategies have to be state-specific. During 1990-91, the health expenditure in India (about Rs.27,000 crores) was 6% of its GDP (4.7% by the private sector and 1.3% by public sector). Among the public sector the Central Governments's share is nearly 2 % , while that of State's is close to 19%. Public contribution from the Centre, States and local bodies etc., has been variously estimated to be around 22%. The bulk of public health financing is by revenues from general taxation, the share of social insurance is about 2%. The share of health expenditure in the major states shows a significant decline in proportion to health expenditure from 6-7% in 1980s to just over 5% in 1990s. However, there has not been any significant variation in central government's share which has remained more or less at 1.25%. The real per capita spending on health has shown a steady increase in all States of India in varying degree. Though the budget outlays have increased, the proportion spent on salaries and wages is going up, particularly in low-income States-where salaries alone consume 80% of the funds leaving little for developmental activities, drugs and consumables. Two important features of Indian health care financing stand out. A large majority of people seeking ambulatory care during illness prefer private rather than public providers. However, a slight majority of ill people do seek care from public providers for conditions needing admission to the hospital. Even the visits to public facilities generally involve out-of-pocket expenditure.

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* Presented at the Forum 6, Arusha, Tanzania. 12 November 2002

The average spending per out-patient episode at public facilities is about 40% of average expenditure on visits to private sector, while the in-patient treatment expenditure at public health care facilities averages a quarter of in-patient treatment costs at private facilities. Taken together these features imply that treatment from both categories impose considerable financial burden on individuals. The consistent pattern that emerges shows that about three quarters of all the expenditure on curative services is private and only a quarter is public. This direct out-of-pocket costs is believed to push about 2% of Indians to below poverty line each year.

The situation of financing for health research is no better. Low and middle-income countries are struggling to reach the 2 % mark of total health expenditure. India is close to 1.5%. As health research is multi-sectoral, at times it is difficult to quantify the contribution by each sector - on the whole India spends about 8% of the total expenditure in R&D on health. Over the successive years, the outlays for several R&D agencies in India have increased several folds, the same does not hold good for the Indian Council of Medical Research (ICMR) - the only national level body devoted exclusively to health research. To improve the situation, the ICMR has taken initiatives which have started to show positive results. The Council took up an exercise that would generate data on the estimation of disease burden in the country, completed the first phase of priority setting, produced a draft health research policy and opened a dialogue with the planners and policy makers. It has also aligned its health research agenda to the national health policy. India has also tried out innovative strategies to attract funding for health sector from non-formal health sector. Foreign assistance too has been effectively used to supplement the national contribution in major health programmes like malaria, TB, HIV and blindness.

To improve the national resources for health several strategies have been used by various countries. These have been used alone or in combination and have produced variable results. The outcome of these studies in Bolivia, Cote d' Ivoire, Senegal, Sri Lanka and Zimbabwe and lessons learnt from them would be discussed. Finally, suggestions are floated for increasing resources for health through increasing Central and State levies, utilizing revenues from disinvestments, charging user-fee and related problems and plausible methods of overcoming some of the hurdles.

Parallel session on Successes in health research: solving health problems in North Africa

Tuesday, 12 November 2002, 11.00-12.30

HIV/AIDS Pandemic: A North African profile

Ahmed M. A. Mandil, Professor, Epidemiology, High Institute of Public Health, Alexandria University, Egypt

Background: HIV/AIDS is one of the most important public health problems facing human kind for the last two decades, and is expected to continue like this well into the 21st century. Compared to other regions of the world, HIV has been late in its introduction to the North African Region, probably during the late 1980s. The region has been blessed by adherence of its people to religious beliefs, which helped much in keeping its prevalence among the lowest in the world. Nevertheless, two facts have to be considered. Firstly, North Africa shares borders with one of the most hardly-affected regions with the pandemic, namely: Sub-Saharan Africa. Secondly, the number of reported cases remains to increase since 1987, indigenously, especially among high risk groups (IDUs, prostitutes and bar girls).

Morbidity Burden of HIV/AIDS: More than 8000 AIDS cases were reported to WHO by North African states (by end of 2000), 43 % of whom from the Sudan, 27 % from Djibouti, 10 % from Morocco, and 7 – 8 % from Tunisia & Libya. **Most Important Causes:** ***As far as modes of transmission of such reported cases are concerned,*** most cases (78 %) were heterosexually transmitted [close to figures of Sub-Saharan Africa], 15 % parenterally, while only 3 % were perinatally transmitted (global figure stands at 4 %). About one third (28 %) of the reported cases were females, much less than the global figure of 42 %.

Preventive Measures & Interventions: To keep North Africa's HIV prevalence low (estimated at < 1 / 10,000 population), strict prevention and control measures (suitable to the Region's traditions and beliefs, and derived from meticulous situation analysis studies of distribution and determinants of HIV spread and infection) have to be adopted and adhered to. Examples are: wide-scale public health education (especially for the young and high risk groups); strict blood-safety and screening measures at health facilities (public and private); early detection/management of HIV/AIDS cases, T.B. as well as sexually-transmitted infections (through adoption of effective and active sentinel surveillance systems). ***Some such measures are already in place in some North African nations, and with some success.*** To achieve such goals successfully, cooperation between governmental and non-governmental institutions is both mandatory and indispensable. ***In addition, inter-country collaboration is mandatory in dealing with such a disease, which does not respect borders. Sharing information about the disease burden, modes of transmision, experience with effective interventions are all indespensible in effective HIV/AIDS prevention and control in the Region. Dealing with the pandemic in the Region, has to be in harmony with similar efforts in other neighboring regions / states, as well as in other parts of the world.*** The North African Region has to always keep in mind that heavy HIV infliction is just across its borders.

Plenary session on Celebrating African health research

Tuesday, 12 November 2002, 9.45-10.30

SAFE implementation for trachoma control with ITI support

Peter Kilima, Regional Coordinator, International Trachoma Initiative, Tanzania

Trachoma is the world's leading cause of preventable blindness. Caused by the bacterium *Chlamydia trachomatis*, the disease generally occurs in poor communities with limited access to water. Trachoma affects the inner upper eyelid and cornea. Repeated infections from childhood may lead to loss of sight during adulthood.

The magnitude of the problem worldwide is stunning—trachoma affects 10 times more people than onchocerciasis or river blindness. The World Health Organization estimates that 6 million people have been blinded by trachoma, 150 million people need immediate treatment, and 540 million people are at risk of disease. Communities in rural Africa and Asia are most vulnerable to the disease. In 1998, the World Health Organization (WHO) called on member states to work to attain the elimination of blinding trachoma by the year 2020.

The International Trachoma Initiative (ITI), founded in 1998 by the Edna McConnell Clark Foundation and Pfizer Inc, is dedicated to the elimination of blinding trachoma. The ITI supports countries to expand implementation of trachoma control through the WHO-recommended SAFE strategy (Surgery, Antibiotics, Face washing and Environmental improvement), which link treatment with prevention and building public health infrastructure. A key element of ITI-supported program is the inclusion of Pfizer-donated azithromycin (Zithromax®) for the antibiotic component of the effort.

In Africa, the ITI launched its first country programs in Morocco and Tanzania in 1999. Since then, programs have got underway in Ghana, Mali, Niger, and Sudan. The implementation of SAFE strategy with ITI support has promoted strong public–private partnerships, among governmental ministries, international agencies, local non-governmental organizations and the communities at risk. In two years, implementation of the SAFE strategy in Africa has had encouraging results with more than 19,0000 sight saving trichiasis surgeries; 3.5 million treatments of Zithromax, and millions more benefiting from health education. Program evaluations in Tanzania and Morocco revealed reduction in disease prevalence of more than 50 percent in certain program areas. Similar programming may soon begin in Egypt and Ethiopia with further expansion anticipated for the future.

The SAFE strategy integrates easily with other efforts aimed at improving health and hygiene. In fact, SAFE may have benefits beyond trachoma control related to other health problems such as helminthes infection and diarrheal diseases. ITI also supports applied or operation research to promote program innovation.

Plenary session on Celebrating African health research

Tuesday, 12 November 2002, 9.45-10.30

Research as a tool for development: the Tanzania National Lymphatic Filariasis Elimination Programme

Mwelecele Malecela-Lazaro, Director of Research Coordination and Promotion, National Institute for Medical Research, Tanzania

The Tanzania National Lymphatic Filariasis programme is one among the attempts to link research to implementation. It recognizes that lack of utilization of research results to solve health problems, leads to little appreciation of the value of research, giving countries little motivation to invest in research.

It is a programme, which is owned by the Ministry of Health, but housed and managed by the National Institute for Medical Research. The benefits of this linkage between research and policy/decision makers include direct use of research results for the planning and implementation of the programme. Policy and decision makers are made ton make use of the research to answer pertinent questions that arise during the implementation phase and hence appreciate the power of research. Being district based has enhanced awareness of the real cause of the disease and its management thus changing the wrong perceptions, which prevent change of health seeking behavior and life style.

The programme has delivered Mectizan® and Albendazole to 700,000 people in six districts in 2001 and intends to upscale to cover an additional one million people in five districts in 2002.

The important lessons learnt include that until research is fully understood in all its dimensions it will not be demanded; That researchers have an important role to demonstrate the usefulness of research and the benefits of investing in research and that the translation of the results or repackaging is an important element in demystifying research. Linking research to development increases leverage of securing funds for research from governments with already overstretched health budgets.

ANNOUNCEMENT OF ADDITIONAL SESSION

Tuesday 12 November
SESSIONS IN PARALLEL
11.00-12.30

Themi

Succès dans la recherche en santé : résoudre les problèmes en Afrique occidentale

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  – *Seroprevalence of HIV/AIDS in Guinea*

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Details on the sessions in parallel **Successes in health research in West Africa** and **Southern Africa** will be announced.

Parallel session on Successes in health research: solving health problems in North Africa

Tuesday, 12 November 2002, 11.00-12.30

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Ahmed M. A. Mandil, Professor, Epidemiology, High Institute of Public Health, Alexandria University, Egypt

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Parallel session on Successes in health research: solving health problems in North Africa

Tuesday, 12 November 2002, 11.00-12.30

From research to action: the Egyptian experience

Hoda Rashad, Director, Social Research Centre, American University in Cairo, Egypt

The presentation reflects on health research conducted in Egypt during the recent past. It particularly focuses on the link of research to action attempting to identify successful examples and how to build on them.

Parallel session on TB research and initiatives

Tuesday, 12 November 2002, 16.00-17.30

The Stop TB partnership and friends: initiatives to support research and disease control

Jacob Kumaresan, Executive Secretary, Stop Tuberculosis Partnership Secretariat, World Health Organization, Geneva

Objectives

- Familiarise participants with the background, structure, and progress of the Global Partnership to Stop TB (GPSTB).
- Describe the Partnership's contribution to research on tuberculosis, with emphasis on the Partnership's Working Groups on DOTS Expansion, TB/HIV, MDR-TB, New Drugs, New Diagnostics, and New Vaccines.
- Describe some associated initiatives and research networks, with particular reference to those seeking to engage the private sector and those working to mobilize society for TB control.

Expected Outcomes

Participants will understand the GPSTB's contributions to research, and become conversant with a range of related collaborative initiatives to improve TB control.

The presentation will introduce the Global Partnership to Stop TB (GPSTB), including aspects of its founding, vision, values, and structure. It will then discuss in greater detail the Partnership's mechanisms for co-ordinating operational research (including on MDR-TB and TB/HIV) and basic/applied research on new drugs, diagnostics and vaccines. The presentation will outline the achievements of these components of the Partnership, and point to areas that need strengthening, including in the organization, finance, and substance of their work.

Finally, other partnerships and networks for TB control in relation with the GPSTB will be discussed. The Global TB Drug Facility will be highlighted as an example of a successful collaboration in support of TB control. Drawing on examples from countries including Malawi, Netherlands, China, and India, the presentation will also focus on experiments in engaging the private sector and on initiatives to increase case detection and mobilize society for TB treatment. Two kinds of public-private partnerships will be discussed: those working with private health-care providers, and those working with employers. Initiatives around case detection and social mobilization will include COMBI projects as well as novel initiatives that enlist non-profit organizations and community members as partners. The presentation will close with a discussion of innovative partnerships around MDR-TB and TB/HIV.

INITIAL EXPERIENCE AND FUTURE PROSPECTS

SPECIAL SESSION

14th November 2002

Forum 6
Global Forum for Health Research
12th – 15th November 2002
Arusha, Tanzania

Time: 18.00 – 19.30

Speakers:
Prof. Demissie Habte, World Bank, Washington D.C., United States of America
Dr. Lola Dare, ACOSHED International, Abuja, Nigeria
Miguel Gonzalez-Block, Alliance for Health Policy and Systems Research, Geneva
Prof. James Tumwine, ACOSHED-Uganda
Jimmy Volmink, Global Health Council, United States of America

For more information, please contact:
Dr. Lola Dare
Executive Secretary (International Secretariat)
African Council for Sustainable Health Development [ACOSHED]
House B, Plot 722
Isiyaku Rabiu Estate
Wuse II, Abuja
Nigeria
Tel: 234 2 810 2401; Fax: 234 2 810 2405; Cell: 234 803 305 1418,
Email: acoshed@yahoo.com; web site: www.acoshed.net

YOU ARE CORDIALLY INVITED

ACOSHED:
Initial Experience and Future Prospects

The African Council for Sustainable Health Development [ACOSHED] was created in 1998 to continue with the work of the World Bank Expert Panel for Better Health in Africa, but this time, on African soil with a true sense of ownership, leadership and participation by African governments and people. Following a transition period of three years, the Council has firmly established operations with an International Secretariat in Abuja Nigeria in February 2001.

The vision of ACOSHED is to foster African ownership of health development, promote good governance and improve performance of African health system within innovative partnerships that engage all stakeholders, including communities and households. The Council opines that although significant improvements and investments have been made to develop new drugs and technologies to combat the major disease burdens in Africa, secure and strengthened health systems are required to sustainably deliver these benefits to people where they live and work.

ACOSHED's focal themes of advocacy, evidence for health policy reform and systems development, human resource and leadership development, communications and organizational development are responsive to continuing challenges in African health systems including those related to inequity, partnerships and participation. Programs are identified within the overall context of targets set by African governments in the health component of New Partnership for African Development [NEPAD], the United Nations Millennium Declaration and the attainment of the Mid-Decade Goals [MDG] by African nations. ACOSHED is a unique partnership between African governments, its civil society and development partners.

The session will present an evaluation of the initial experience in establishing the operations of the International Secretariat in Africa, and present key actions of emerging country chapters. It will discuss the criteria for accreditation of country chapters as well as guidelines for their operations. Finally it will present key programs/initiatives in its Strategic Plan as well as its prospects for contribution to health policy reform, systems development and sustainable development in Africa. A key output of the session is broader understanding of the Council's work, and its prospects to meaningfully contribute to health policy reform and the establishment of not only secure but also sustainable health systems in Africa.

Special Session
Forum 6

Global Forum for Health Research
12th – 15th November 2002
Arusha, Tanzania

Title	ACOSHED: Initial Experience and Future Prospects
Date of the Session:	14 November 2002
Time of the Session:	18.00 – 19.30
Objectives of the Session	1. Present the initial experience and progress of the Council, its work on advocacy for health reform and systems development in Africa 2. Present highlights of the evaluation of its initial experience 3. Highlight key programs in the Strategic Plan of the International Secretariat of the Council 4. Present guidelines for the accreditation and operations of country chapters
Expected Output of the Session	1. Improved understanding of the work and potential role of the Council and its Chapters in advocacy for evidence based health sector reform and systems development in Africa 2. Increased participation in, and support for the work of the Council at country, regional and global levels 3. Build new partnerships and strengthen existing ones
Chair (s)	Prof. Demissie Habte, World Bank, United States of America

Speakers /Topics	Opening Remarks - Prof. Demissie Habte, World Bank, United States of America	18.00 – 18.05
	ACOSHED: An Independent Voice of African led reforms - Dr. Lola Dare, Executive Secretary, International Secretariat, ACOSHED	18.05 – 18.10
	An evaluation of the Initial Experience – Miguel Gonzalez-Block, Program Manager, Alliance for Health Policy and Systems Research, Geneva	18.10 – 18.20
	Highlights of the Strategic Plan – Dr. Lola Dare, Executive Secretary, International Secretariat, ACOSHED	18.20 – 18.30
	Guidelines for Country Chapter Accreditation and Operations – Prof. James Tumwine, Chair, ACOSHED-Uganda	18.30 – 18.40
	Prospects for contribution to health policy and systems reform – Jimmy Volmink, Program Officer, Research and Analysis, Global Health Council, United States of America	18.40 – 18.55
	General Discussions	18.55 – 19.25
	Closing remarks	19.25 – 19.30
Rapporteur (s)	Ms. Olamide Bandele - Secretary, ACOSHED-Nigeria	
	Mr. K.I. Faleye - Ministry of Health, Ekiti State, Nigeria	

Hotel directory

A.M.
P.O. Box 10045, Arusha, Tanzania
T 255 27 250 7168
F 255 27 507816
Central, inexpensive hotel. Single, double and triple rooms. Minibar, TV, telephone. No credit cards.

Arusha Resort Centre
P.O. Box 360, Arusha, Tanzania
T 255 27 250 8333; 250 8326-7
F 255 27 250 8233
Cell phone 255 741 342890
E-mail philpht@africaonline.co.tz
Apartment hotel with modest lodgings of all sizes.

Dik Dik
P.O. Box 1499, Arusha, Tanzania
T 255 27 255 3499
T/F 255 741 510490
Satellite phone **873 762 060473
Satellite fax **873 762 060474
E-mail dikdik@atge.automail.com
Website www.dikdik.ch
Very pleasant country hotel with comfortable bungalows. Swiss-owned and managed. Excellent restaurant. Shop. Pool. Gardens. Bird lake.

Eland Motel
P.O. Box 7226, Arusha, Tanzania
T 255 27 250 6892; 255 27 250 7967
F 255 27 250 8468
E-mail elandmotel@yahoo.com
Contact: Gerald Munaawa
Popular hotel, located on the main Moshi road, slightly out of the centre. Radio/TV in rooms. No credit cards.

Equator
P.O. Box 3002, Arusha, Tanzania
T 255 27 250 8409; 250 3727
F 255 27 250 8085
E-mail nah@tz2000.com
Newly renovated hotel (2001) in central location. No lift. Rooms have minibar, TV, telephone, room service. Bureau de change. Internet café. Pleasant garden. Accepts VISA, Mastercard.

G&T
P.O. Box 2133, Arusha, Tanzania
T 255 27 250 265/6
F 255 27 254 8887
E-mail oliverlyimo@yahoo.com
Centrally located, in town. Rooms have telephone, TV, room service. Garden. No credit cards. Twenty new rooms will be finished by October 2002.

Golden Rose
P.O. Box 361, Arusha, Tanzania
T 255 27 250 7959
F 255 27 250 8862
E-mail goldenrose@habari.co.tz
Website www.goldenrose.com
Modest, centrally located hotel. Rooms have minibar, TV, telephone, room service. Garden. Bureau de change. Internet café. Accepts VISA and Mastercard. Twelve new rooms will be finished by August 2002.

Herbs & Spices (Ethiopian Restaurant)
P.O. Box 2732, Arusha, Tanzania
T 255 27 250 2279
E-mail axum-spices@hotmail.com
Website www.theethiopianhotel.com
Very central location. Excellent Ethiopian Restaurant has some rooms. Modest. Internet café. Accepts VISA.

Ilboru Safari Lodge
P.O. Box 8012, Arusha, Tanzania
T 255 27 250 7834, 255 27 250 9658
Cell phone 0744 276 976
E-mail ilboru-lodge@yako.habari.co.tz
Website www.habari.co.tz/ilborulodge
Calm, comfortable hotel in garden setting. Individual rondavels (bungalows) and new wing (2002). Rooms have telephone, room service. Satellite TV in bar. Pool. Restaurant. Souvenir shop. Internet café. Short unpaved access road.

Impala
P.O. Box 7302, Arusha, Tanzania
T 255 27 250 2398; 250 2962; 250 7083; 250 8449-51
F 255 27 250 8220; 250 8680
E-mail impala@yako.habari.co.tz or impala@cybernet.co.tz
Website www.impalahotel.net
One of the largest hotels in Arusha. Central location. Some rooms recently renovated; new wing. Indian, Italian and Chinese restaurants. Conference facilities, secretarial services, business centre, Internet café. Catering, room service. Pool, sauna, gym and fitness centre. Bureau de change. Credit cards accepted.

L'Oasis Lodge and Restaurant
P.O. Box 14280, Arusha, Tanzania
T 255 744 286731
F 255 27 250 7089
Cell phone 255 741 510531
E-mail loasislodge@mailafrica.net
or avenellsteve@yahoo.co.uk
Website www.loasislodge.com

Close to town centre. Rooms have telephone and room service; satellite TV in bar. Splendid gardens, jogging. Pool 800m from hotel. Cultural walking tours in vicinity. Souvenir shop. Bureau de change. Internet café. No credit cards.

Manor
P.O. Box 1702, Arusha, Tanzania
T 255 27 250 3750; 250 0613-4
F 255 27 250 254 8746
E-mail pkingazi@yahoo.com
Website www.monsoon-safaris.com
Modest, centrally located hotel. TV, minibar and telephone. Cash payment only (Tanzanian shillings or US$).

Meru House Inn
P.O. Box 14875, Arusha, Tanzania
T 255 744 288740; 255 744 593596; 255 744 303931
E-mail victoriaexp@habari.co.tz
Website www.victoriatz.com
Modest, centrally located hotel.

Moivaro Coffee Plantation, Lodge and Estate
P.O. Box 11297, Arusha, Tanzania
T 255 27 255 3326 (booking office); 255 27 255 3243 (reception)
T/F 255 27 255 3242
E-mail reservations@moivaro.com
Website www.moivaro.com
Comfortable lodge with rondavels. Room service. Forty acres of grounds; splendid gardens, jogging track. Swimming pool. Internet café. Credit cards accepted (not American Express). Situated 7 km from Arusha town, unpaved access road.
Kigongoni Lodge with 14 rooms is under construction and will be finished in the Summer of 2002. For information contact Moivaro Coffee Plantation, Lodge and Estate.

Mountain Village Lodge
P.O. Box 2551, Arusha, Tanzania
T 255 27 255 3313-5
F 255 27 255 3316
E-mail mtvillage@arena.co.tz
www.serenahotels.com
Comfortable lodge with rondavels. Splendid gardens. Pool. Souvenir shop. Bureau de change. Situated 7 km from Arusha town, unpaved access road. VISA, Mastercard, JCB cards accepted.

New Arusha
P.O. Box 3002, Arusha, Tanzania
T 255 27 250 8409
F 255 27 250 8085
E-mail nah@tz2000.com
Hotel close to the Conference Centre, in process of renovation.
TV, telephone, room service. Conference facilities, secretarial services, business centre, Internet café. Catering, room service. Swimming pool, gardens. Bureau de change. Souvenir shop. Credit cards accepted.

Ngare Sero Mountain Lodge
P.O. Box 425, Arusha, Tanzania
T 255 27 255 3638
F 255 27 254 8690
Cell phone 255 741 512138
E-mail ngare-sero-lodge@habari.co.tz
Website www.ngare-sero-lodge.com
Very comfortable lodge. Room service. Splendid gardens, forest and lake. Swimming pool. Bird watching, trout fishing, wild life. Internet café. Situated 30 minutes' drive from Arusha town, unpaved access road. Credit cards not accepted.

Novotel Mount Meru Hotel
P.O. Box 877, Arusha, Tanzania
T 255 27 250 88925
F 255 27 250 8503
E-mail sales-novotel@cybernet.co.tz
Web site www.novotel.com
One of the largest hotels in Arusha. Central location. TV, telephone, room service. Conference facilities, secretarial services, business centre, Internet café. Catering, room service. Swimming pool, gardens. Bureau de change. Souvenir shop. Credit cards accepted.

Centrally located hotels
international standard
Equator, Impala, New Arusha, Novotel Mount Meru
more modest
A.M., Arusha Resort Centre, Eland, G&T, Golden Rose, Herbs & Spices, Manor, Meru House Inn

Lodges outside Arusha
Dik Dik, Ilboru Safari Lodge, L'Oasis, Moivaro Coffee Plantation, Mountain Village Lodge, Ngare Sero Lodge

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www.globalforumhealth.org

Global Forum for Health Research

Helping correct the 10/90 gap

The Global Forum for Health Research invites its partners to discuss recent progress in helping correct the 10/90 gap, disseminate key research findings, review plans for the coming year and develop longer term action plans for promoting health research for development and the fight against poverty.

FORUM 6

12-15 NOVEMBER 2002

Arusha, Tanzania

www.globalforumhealth.org

2. The context

Health research is essential to improve the design of health interventions, policies and service delivery. Every year more than US$70 billion is spent on health research and development by the public and private sectors. However, only about 10% of this is devoted to 90% of the world's health problems, a misallocation, from a global point of view, often referred to as the '10/90 gap'.

Forum 6 is the sixth annual meeting of the Global Forum for Health Research and the first to be held in Africa. Problems of the 10/90 gap will be examined by a broad range of partners including representatives from governments, multilateral and bilateral aid agencies, international and national foundations and NGOs, women's organizations, research institutions and universities, the private sector and the media.

Global objective

To review progress in helping correct the 10/90 gap and plan further actions.

Expected results

- Report on the major networks engaged in helping correct the 10/90 gap and discussions regarding further actions.
- Progress report on the major aspects of work on priority-setting methodologies and identification of next steps.
- Opportunities for partner organizations to discuss cross-cutting issues in the field of poverty, gender and capacity strengthening as they relate to health research.
- Update on the new agenda for more efficient and effective collaboration in health research.
- Opportunities for newcomers to the Global Forum to join in the effort to help correct the 10/90 gap.

Who will take part?

Forum 6 – a policy meeting on the 10/90 gap – will bring together decision-makers in the field of health, health research, development, foreign aid and media to present their latest results and contribute ideas for the next stages of work in health research for development and the fight against poverty.

The programme will include:

- Plenary sessions of 90 minutes on global topics, which take place each morning. Topics foreseen include:
  - Resource flows vs burden of disease: how far are we?
  - Are we progressing on gender issues?
  - Health research and development: what issues after the Report of the Commission on Macroeconomics and Health?
  - How important is nutrition in fighting the 10/90 gap?
  - What results from research in low-income countries?
  - Is health research governance improving?
  - What perspectives for the 10/90 gap?

- Parallel sessions, also of 90 minutes each, which take place each afternoon. Sessions include debates, such as:
  - What burning issues in measuring the burden of disease?
  - Is there a 10/90 gap?
  - Research by NGOs
  - What strategies for research-capacity strengthening?
  - Intellectual property rights and access to drugs
  - Latest developments in priority setting
  - Sharing information on health research: is there a worldwide network?
  - The fourth dimension: results from public-private partnerships

  and presentations and panel discussions focusing on CVD research, research on AIDS, violence against women, reproductive health research, TB initiatives, road traffic injuries, conflicts and disasters, mental health and neurological diseases, child health and nutrition.

- The Marketplace with stalls where individuals and institutions will showcase their work, share results of recent research, display publications, exchange ideas and make or renew contacts.

The programme is set up to allow time for discussion and interaction: breaks and free time over lunch will be focused around the Marketplace to stimulate maximum contact. Space is reserved for late-breaking sessions on topical issues.

Programme outline

	Tuesday 12 November	Wednesday 13 November	Thursday 14 November	Friday 15 November
7.30 - 9.00	Registration	Working breakfasts	Working breakfasts	Working breakfasts
9.00 - 10.30	Newcomers' Session	Plenary	Plenary	Plenary
10.30 - 11.00	Break / Marketplace			
11.00 - 12.30	Opening Plenary	Plenary	Plenary	Closing Plenary
12.30 - 14.00	Lunch break / Marketplace			Closing
14.00 - 15.30	Parallel sessions	Parallel sessions	Parallel sessions	
15.30 - 16.00	Break / Marketplace			
16.00 - 17.30	Parallel sessions	Parallel sessions	Parallel sessions	
18.00 - 19.30	Opening Reception	Parallel sessions	Regional Meetings	

Additional sessions (working or special interest group meetings) may also be scheduled from 20.00 to 21.30 in some hotels.

4. Organization and logistics

The Global Forum for Health Research is an independent international foundation established in 1998 in Geneva, Switzerland. Its central objective is to help correct the 10/90 gap by focusing research efforts on diseases, determinants and risk factors representing the heaviest burden on the world's health and by facilitating collaboration between partners in both the public and private sectors. The National Institute for Medical Research in Tanzania is our local partner for the organization of Forum 6.

Meeting venue, dates and time

Forum 6 will be held at the International Conference Centre in Arusha, Tanzania. It will open on Tuesday 12 November at 9.00 and close on Friday 15 November at 14.00.

Language

Forum 6 will take place in English.

Travel and accommodation

- Participants are responsible for their own travel arrangements and hotel reservations.
- Kilimanjaro International Airport is the closest airport to Arusha, a 45-minute drive from the town. Several international airlines land at Kilimanjaro and local airlines operate daily flights connecting to Dar es Salaam.
- Block bookings have been made in various Arusha hotels. When registrations are confirmed, participants will receive full details on hotels so as to be able to make their reservations directly.

Visas and vaccinations: participants' own responsibility

- Visitors to Tanzania must be in possession of a valid passport and visa. Participants are recommended to apply for their visa immediately after their registration is confirmed.
- Vaccination against yellow fever is required for those coming from or via an infected area. Participants should check requirements with their travel agent or consult sources on international travel and health such as WHO or CDC websites: www.who.int/ith or www.cdc.gov.travel.

Costs

Participants are asked to pay a contribution towards the expenses of the meeting. The participation fee (US$250 for OECD countries; US$50 for others) covers all meeting activities, including:

- Documentation.
- Working lunches, contact breaks, the opening reception and any other refreshments or entertainment offered as part of the official programme.
- Transfers between Kilimanjaro International Airport and hotels.
- Transfers between hotels and the Arusha International Conference Centre at the beginning and end of each day.

Participants are separately responsible for the costs of their travel and accommodation.

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Global Forum for Health Research
Helping correct the 10/90 gap

FORUM 6 ARUSHA, TANZANIA, 12-15 NOVEMBER 2002

Geneva, 23 September 2002

Dear Dr Narayan,

We are delighted that you will take part in Forum 6 and play an active part in the programme.

For your information and planning, please find enclosed the following:

- a confirmation letter for official use
- a visa form*
- a list of Arusha hotels (with map) and details on booking*
- information on the Marketplace (with reply form)*
- a preliminary programme overview
- the Guide to Forum 6
- guidelines for faculty (including a description of the Global Forum's gender policy)
- luggage labels. *[Items marked* require immediate attention.]*

Full details regarding the financing of your participation can be found in "The Guide".

The detailed programme is in preparation and regular updates will be published on our website: www.globalforumhealth.org.

We draw your attention particularly to the following deadlines:

- **For those of you who are making a presentation, please send us urgently the summary of your presentation (300 words).**
- **16 September:** Deadline for receipt of full papers (or powerpoint presentation)
- **11 November** (18.30-21.00, including dinner): Faculty Orientation Meeting in the Arusha International Conference Centre, which we ask you to attend.

Please feel free to contact the responsible officer or the focal point for your session if you have any questions about your session.

We look forward to welcoming you to Arusha.

Yours sincerely,

Louis J. Currat
Executive Secretary

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The Guide

The most recent information on the programme for Forum 6, on logistical arrangements and the meeting venue can be found on the website www.globalforumhealth.org.

SUPPORT FOR PARTICIPATION

The Global Forum is pleased to support your participation in Forum 6.

This support includes:

- An agreed economy return fare from your place of residence to Arusha
- An allowance of US$500.00 (five hundred US dollars) to cover the following costs associated with your participation:
  - Accommodation in Arusha
  - Transport to and from the airport in your country of residence
  - Incidental expenses during travel
  - Meals not provided during Forum 6
  - Visa fees, vaccination costs and airport taxes.

Details of payment will be provided upon registration in the Conference Centre.
Travel insurance is provided by the Global Forum to cover medical emergencies and repatriation (detailed insurance conditions are available upon request from the Secretariat). However **insurance for personal belongings is not provided**. Please make sure you have your own insurance against loss or theft.

TRAVEL AND ACCOMMODATION

Visas

All participants are responsible for acquiring their own visas for Tanzania. Nationals of some countries (including Bangladesh, Lebanon, Pakistan, Nigeria and Somalia) need a "referred visa" which requires special clearance. **You should start the application procedure as soon as possible.** A visa application form is enclosed in this package. A list of Tanzanian missions/consulates abroad (with full contact details) can be found on the Tanzania National website: www.tanzania.go.tz/tanzaniaembassiesf.html.

Vaccinations

Vaccination against yellow fever is required for participants coming from or via an infected area. Please check requirements with your travel agent or consult sources on international travel and health, such as the World Health Organization or US Centers for Disease Control websites: www.who.int/ith or www.cdc.gov/travel.

Travel to Arusha

Raptim, the Global Forum's travel agent, will contact you with a proposed itinerary from your nearest airport and via the most direct route to Arusha and return, in economy class. Arrival will be scheduled, as far as possible, for Monday 11 November – in time for the Faculty Orientation Meeting – and departure on Friday 15 or Saturday 16 November, depending on flight schedules.

Please confirm this itinerary **as soon as possible after receipt**, directly with Raptim. Changes will be considered as long as the cost stays within the price originally quoted. Raptim may be contacted by e-mail jc.puippe@raptim.ch; fax: +41 22 791 6499 or telephone: +41 22 791 6187.

Accommodation
The Global Forum for Health Research has made block bookings at favourable rates for accommodation in conveniently located hotels in and around Arusha; see separate sheets for full information on prices, amenities and contact details. **Please make your own reservation directly with the hotel of your choice.**

Special needs
Participants with special needs are asked to inform the Secretariat as early as possible so that their dietary or access requirements can be properly taken into consideration.

THE PROGRAMME: TYPES OF SESSIONS

Plenary sessions
- all participants together
- at the beginning of each morning and afternoon
- keynote speech(es), panel discussions, reports, comments from the floor
- themes are fixed and sessions put together by the Programme Committee

Parallel sessions
- follow from the plenary themes
- participants choose according to their interest
- presentations by a panel, debates, discussion with participants
- can take the form of debates
- topics can be added according to relevance, priority and available space
- sessions are coordinated by a focal point under the responsibility of the Programme Committee

Marketplace
- open all day; participants visit stalls in their free time
- central position in AICC
- participants reserve stalls and are on hand to present their work
- place to display documents and publications, make computer presentations
- posters are also included (proposals are reviewed by the Programme Committee) on topics addressing the 10/90 gap in health research

Satellite meetings
Throughout Forum 6, special interest groups and business meetings will be scheduled to allow participants to take advantage of the presence of colleagues in Arusha. Some of these gatherings (such as Board meetings) will be closed, others will be open for participants to join in freely (special interest groups). Information will be given in the final programme.

Time has been deliberately left free within the programme for participants to get together: for example, over breakfast (some hotels will set aside a room or reserve tables upon request), during coffee and tea breaks, at lunchtime or in the evening.

FORUM 6 VENUE

Arusha

Arusha is located in the northern part of Tanzania. Kilimanjaro International Airport (KIA) is the closest airport, approximately 45 kilometres or 45 minutes away. Participants arriving from Europe (via KLM) can fly directly into KIA. Other airlines go to Dar es Salaam, with connecting internal flights to KIA.

Finding the Arusha International Conference Centre (AICC)

The AICC is situated in the centre of Arusha. A transfer service will be provided between hotels and the Conference Centre each morning and at the end of programme activities in the evening. Only participants who stay in hotels situated in the very centre of Arusha could envisage walking to the Conference Centre.

FORUM HOURS

Forum 6 programme
All sessions take place at the AICC.
There will be an introductory session for newcomers on Monday 11 November at 17.30, followed by an Orientation Session for Forum 6 faculty at 18.30.
The official opening will take place on Tuesday 12 November at 9.00.
The programme will end on Friday 15 November at 14.00.

Conference Centre hours
The Arusha International Conference Centre will be open from 7.00 to 20.00 during Forum 6. As the AICC is located in the same complex as the UN International Criminal Tribunal for Rwanda, tight security is in place in parts of the complex, including the wing in which the Plenary Hall is situated. Time must be allowed for security clearance.

Registration
Participants may register for Forum 6 and pick up their badge and documentation:
1. upon arrival in the Kilimanjaro Airport at the Welcome Desk.
2. in the Conference Centre
   Monday 11 November 14.00-19.00
   Tuesday 12 November from 7.00

Marketplace set up and take down
Participants who have reserved a market stall should note the following times:
set up
Monday 11 November 14.00-19.00
Tuesday 12 November 7.00-9.00
take down
Friday 15 November 14.00-17.00

PRELIMINARY PROGRAMME OVERVIEW*

12 September 2002

	Tuesday 12 November	Wednesday 13 November	Thursday 14 November	Friday 15 November
7.30-9.00	*Transfers to AICC* Registration	*Transfers to AICC*	*Transfers to AICC*	*Transfers to AICC*
9.00-10.30	**PLENARY 1** **OPENING AND KEYNOTE ADDRESS President of Tanzania** **Celebrating African health research**	**PLENARY 3** **Measuring progress in gender issues**	**PLENARY 5** **Health research and development: what issues after the 2001 Report of the Commission on Macroeconomics and Health and the Millennium Development Goals?**	**PLENARY 7** **Using research results: research synthesis as a tool to help correct the 10/90 gap**
10.30-11.00	Coffee break/Marketplace			
11.00-12.30	**PARALLEL SESSIONS** Successes in health research: solving health problems Examples from African regions: • Southern Africa • East Africa • West Africa • North Africa	**PARALLEL SESSIONS** • Gender, child health and nutrition • Gender, mental health and disability • Gender and noncommunicable diseases • Gender, sexual and reproductive health • Gender, infectious and tropical diseases • Gender, work and occupational health • Violence against women	**PARALLEL SESSIONS** • Genomics, intellectual property rights and the 10/90 gap • Latest developments in priority-setting • Strategies for improving access to drugs • World Health Report 2002: Reducing risks, promoting healthy life	**CLOSING PLENARY** **What perspectives for the 10/90 gap and what recommendations to the partners in the Global Forum?**
12.30-14.00	Lunch break/Marketplace			CLOSING EVENT
14.00-15.30	**PLENARY 2** **Successes in health research: mobilizing national resources** (examples from Asia and Latin America)	**PLENARY 4** **Health research collaboration: national, regional and global health research forums**	**PLENARY 6** **Monitoring the results of research capacity strengthening**	
15.30-16.00	Coffee break/Marketplace			
16.00-17.30	**PARALLEL SESSIONS** • Debate on Asian/LAC successes in mobilizing national resources • Research by CSOs • Research on AIDS • Research to roll back malaria • TB initiatives	**PARALLEL SESSIONS** **Regional meetings** • Africa Health Research Forum + launch • Asia + Pacific Forum • Latin + Central America	**PARALLEL SESSIONS** • Debate on the evaluation framework for research capacity strengthening • Health research systems analysis • The views of MRCs on brain drain and RCS • Research for policy and practice	
18.00-19.30	**OPENING RECEPTION hosted by the Chair of the Global Forum** **+ African Show**	BUSINESS MEETINGS AND SPECIAL EVENTS • ACOSHED • Bangkok Action Plan • High blood pressure in Africa: planning group • MIHR launch • Oral health • Road traffic injuries • SHARED • Medical Research Councils dinner	SPECIAL INTEREST GROUPS • Cardiovascular diseases • Child health and nutrition • ENHR • INDEPTH • International Health Research Awards • Maternal health • Mental health and neurological disorders • Measuring BoD • Public-private partnerships • Road traffic injuries • World Report on Violence	

** The titles and timing of specific sessions are preliminary. The overall programme structure is however fixed.*

Guidelines for faculty

The Global Forum for Health Research acknowledges the important contribution made by faculty to the success of its annual meeting. The presentations at Forum 6 will address the latest thinking on the 10/90 gap and will act as a catalyst for action during the coming year. We are grateful for your contribution and for your efforts to explain and lessen this gap in health research.

Please take the time to read through these Guidelines which contain important information to ensure the smooth running of the meeting.

Orientation Meeting

You are requested to take part in an Orientation Meeting, together with members of the Foundation Council and the Secretariat of the Global Forum, on **Monday 11 November** in the Arusha International Conference Centre starting at 18.30. Please ensure that you make travel arrangements accordingly.

The agenda for the meeting is as follows:
18.00 Registration
18.30 Familiarization with the Centre, meeting rooms and technical equipment
19.30 Welcoming remarks by the Chair and orientation
20.00 Buffet dinner and preparatory meetings for individual sessions (to be arranged by the Focal Point).

A "prep" room will be available and a technician on hand to assist you with any last-minute arrangements. The Focal Point for each session will work with session faculty to make a test run of the presentations and, if presenters are planning presentations from a notebook computer, will organize the presentations onto one computer so that session timings are respected.

Technical Information

The large meeting rooms in the Centre will be equipped with a flipchart, an overhead projector and an LCD projector for computer presentations. (Please note that **notebook computers are not provided; presenters who plan to make a computer presentation are requested to bring their own notebooks).**

Slide projectors/VHS video projection (specify NTSC or PAL/SECAM) can be arranged upon request. Requests should be sent to Kirsten Bendixen by e-mail bendixenk@who.int or by fax +41 22/791 4394 before 1 September 2002.

DOCUMENT DEADLINES

Summaries

Presenters have been asked to summit a one-page summary of their presentation(s) by **19 August 2002.** Summaries should be sent to the Global Forum (attention Alina Pawlowska, e-mail: pawlowskaa@who.int) in electronic format, preferably e-mail, either in the body of the text or as an attachment (Microsoft Word document preferred). Summaries should be text only, without graphs, tables or other illustrations.
Each summary must include:

- Title of the presentation
- FAMILY NAME (in capital letters) and first name of the presenter
- Presenter's institution and country of institution
- Summary (maximum 300 words) including objectives and expected outcomes of the presentation.

Summaries that are received by 19 August will be made available as follows:

- on the Global Forum's web site (Forum 6 programme section)
- copies placed in the meeting room where the session will take place
- copies available on request through the Document Centre at Forum 6.

For administrative reasons, the Global Forum may be obliged to remove from the programme the presentation or the names of presenters whose summaries are not received by 15 September 2002.

Full papers and transparencies

Full papers of the presentation must be submitted to the Global Forum (Alina Pawlowska, e-mail: pawlowskaa@who.int) **by 16 September 2002.** The full text of your presentation should be sent in electronic format, preferably in Microsoft Word or Powerpoint. Papers received by 16 September will be made available to participants at the Document Centre at Forum 6. After this date, the Global Forum will not be able to guarantee inclusion of your paper in official conference documentation and you will be requested to provide copies to the Document Centre for distribution to interested participants.

FACULTY ROLES

Focal Points

The Focal Point for a session works together with the Secretariat of the Global Forum to:

- define the objectives and expected outcomes for the session
- select the chair(s), presenters and rapporteur(s) for the session and brief them on the objectives and expected outcomes
- manage the content of presentations and review summaries
- plan the timing of the session
- brief the chair of the session on time allocations and other issues of relevance
- facilitate the session preparation during the orientation meeting on 11 November.
- compile presentations, documents and rapporteur's summary and submit to the Secretariat of the Global Forum.

GENERAL POLICY OF THE GLOBAL FORUM REGARDING GENDER AND HEALTH RESEARCH

The Global Forum believes that a systematic approach to gender issues forms a central part of its objective to help correct the 10/90 gap. It is estimated that more than 60% of the world's poor are women. The health of these women is often adversely affected not only by their poverty but by the gender inequalities that continue to divide many of the world's poorest countries.

Though they have many health problems and health care needs in common, women and men are divided by both their biological sex and their social gender. Unless these differences are taken into account, the delivery of medical and public health services will be severely constrained in their efficacy and their equity. Under these circumstances it is likely to be women in the poorest communities who will be worst affected.

Thus the Global Forum for Health Research integrates gender issues in all aspects of its work. The overall principle is that both sex and gender are integrated as key variables in all the other strategies of the Global Forum:

- annual Forum meeting
- measurement of the 10/90 gap and the development of priority-setting methodologies
- synthesis review of research capacity strengthening efforts in low- and middle-income countries
- communication and information
- overall monitoring and evaluation of the Global Forum activities.

With respect to Forum 6:

- all processes, such as calls for proposals, review of proposals and preparation of sessions explicitly include gender concerns
- documents prepared for the annual meeting include specific gender content, i.e. they indicate what gender issues will be addressed, why they are important and how they will be addressed
- participants always include gender-sensitive persons and organizations, recognizing that special gender expertise is needed as for any other technical concern.

Focal points, presenters, chairs and rapporteurs are asked to take these points into account in the preparation of sessions.

Presenters

Presenters work together with the Focal Point to develop various aspects of the session. Presenters will:

- plan and prepare a presentation within the guidelines given by the Focal Point
- submit a summary (as outlined above) to the Secretariat of the Global Forum
- attend the Orientation Meeting to review the organization of the session and make a test run of their presentation
- keep the presentation within the time frame (the chair will signal time with a yellow card meaning two minutes left and a red card meaning stop)
- provide the Focal Point with a copy of their presentation and related documents.

Chairs

Working together with the Focal Point, the Chair(s) will:

- attend the Orientation Meeting and meet with the Focal Point and presenters to finalize the organization of the session
- be familiar with the content and objectives of the session
- have reviewed the summaries of each presentation
- know the exact location and time of the session
- manage the session with strict adherence to timing, focusing on the "expected output."

In managing the session, the Chair will:

- review the session's objectives/expected outputs
- introduce each speaker with institutional affiliation and the topics of the presentation
- introduce the rapporteur of the session
- indicate clearly the time allocation for each speaker (manage the yellow card)
- indicate the time set aside for the discussion period.

Following the presentations, the Chair will:

- facilitate a discussion and summarize the issues emerging from the discussion
- summarize the main points from the presentations and the discussion
- thank presenters for their contribution and the audience for their participation.

Rapporteurs

Rapporteurs play a key role in documenting important issues emerging during each session. Rapporteurs are asked to:

- be familiar with the content and objectives of their session and attend the Orientation Meeting to finalize the organization of the session
- write a report which will
  - highlight three or four important points raised in each presentation
  - highlight the main issues identified in the discussion
  - summarize the conclusions by the chair
  - document the next steps that will define the research agenda for that topic
- note any change from the printed programme (faculty, affiliations, etc.)
- discuss any issues for clarification with the Focal Point and Chair at the end of the session
- ensure that the presenters' notes, rapporteur's notes and all material from the session are handed over to the Focal Point
- submit their own report to the Focal Point as soon as possible and by 30 November latest
- send one copy to the Global Forum Secretariat and keep one for their own record.

Rapporteurs are free to use any style of reporting provided the above conditions are fulfilled. They may also add in their own comments (with identification).

The Marketplace

Forum 6, the 2002 annual meeting of the Global Forum for Health Research, is composed of different types of sessions and activities. The multiplicity of types of "meeting opportunities" is deliberate and reflects the very nature of the Global Forum: catalytic, flexible, inclusive, bringing together many partners to contribute to all aspects of the discussion, a network of networks.

In addition to the more formal plenaries, debates, panel discussions and structured sessions, Forum 6 offers many opportunities to meet other participants – old colleagues and new friends alike. The Marketplace is one such opportunity, which lasts throughout the meeting.

If you would like to display your projects, research results, publications or present your point of view to other participants – provided only that these are relevant to helping correct the 10/90 gap in health research – why not sign up for a stall in the Marketplace? Just complete and return this form (preferably by fax to +41 22 791 4394). You can also reply via the website www.globalforumhealth.org.

The Marketplace will be open throughout the meeting (Tuesday 12 to Friday 15 November). Stalls will be listed in the final programme and published on the Forum 6 website.

Yes, I would like to take part in the Marketplace. Please reserve for me a market stall with table and panel (at no charge).

FAMILY/first name: _____

Name of institution represented (this will be the name of your stall):

Please return to: Forum 6
Global Forum for Health Research
c/o World Health Organization
20 avenue Appia, 1211 Geneva 27, Switzerland
Tel: (41 22) 791 4260
Fax: (41 22) 791 4394
e-mail: forum6@globalforumhealth.org
This form is also available on our website: www.globalforumhealth.org.

PLEASE NOTE: The Marketplace is open to registered participants only. Presentations or market stalls cannot be of a commercial nature (sales are not permitted). Participation in the Marketplace is free of charge. Participants who will bring electrical/electronic equipment for their stall should inform the Global Forum in advance since not all stalls will have access to electricity.

Hotel reservation form

To the Hotel _____

From:

FAMILY NAME: _____

First name: _____

Organization: _____

Address: _____

City/postal code: _____

Country: _____

Telephone: _____ Fax: _____

E-mail: _____

Please reserve me a room for ____ nights

from (arrival date) _____ **to (departure date)** _____

(please indicate one)

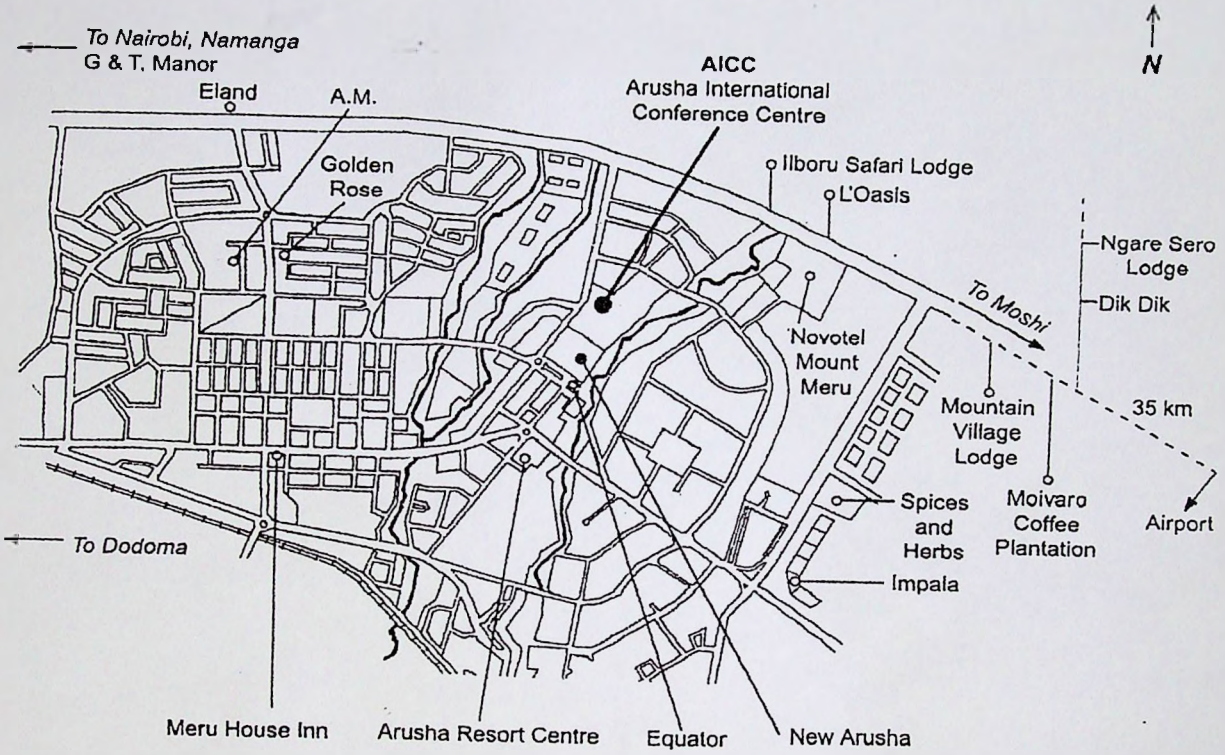
single occupancy

double occupancy name of second guest: _____

Signature: _____

Please note:
Some hotels may require the reservation to be guaranteed by a credit card. If so, you will be asked to provide details.
Quoted rates are for room, breakfast, and taxes. Participants are responsible for settling all charges upon check-out. Quoted rates are valid only for reservations made before 15 September.
For additional information, please visit the Global Forum's website:
www.globalforumhealth.org.

Conference hotels in Arusha



(ORIGINALS)

Global Forum for Health Research

Helping correct the 10/90 gap

6 ARUSHA, TANZANIA, 12-15 NOVEMBER 2002

Geneva, 23 September 2002

Forum 6
Arusha, Tanzania
12-15 November 2002

To whom it may concern

The Secretariat of the Global Forum for Health Research hereby confirms the registration of

Dr Ravi Narayan
Community Health Cell, India

as a participant in its 2002 annual meeting, Forum 6.

The Global Forum will cover travel to and from Arusha, accommodation and incidental expenses for the duration of the meeting.

Participants are recommended to arrive in Arusha on the evening of Monday 11 November (those taking part for the first time in the annual Forum are recommended to arrive early enough to participate in the Newcomers Session on Monday evening at 17.30). Participants are expected to stay until the close of the meeting in the afternoon of Friday 15 November.

In addition to the official programme, other meetings and professional or cultural visits might necessitate a longer stay.

Louis J. Currat
Executive Secretary

Global Forum for Health Research • c/o World Health Organization • 20 avenue Appia • 1211 Geneva 27 • Switzerland
Telephone: +41 22/791 4260 • Fax: +41 22/791 4394 • forum6@globalforumhealth.org • www.globalforumhealth.org

PEOPLE'S HEALTH MOVEMENT
EAST AFRICA CIRCLE,
P.O. BOX 240,
BAGAMOYO, TANZANIA
EAST AFRICA
Tel: +255 23 2440062
E-mail: masaiganа@africaonline.co.tz
mwinoki@yahoo.com.

PEOPLE'S HEALTH MOVEMENT

To
Drs.Ravi Narayan & Thelma Narayan,
Community Health Cell,
Society for Community Health Awareness, Research and Action,
Bangalore,
INDIA.

Dear Drs. Ravi Narayan and Thelma Narayan,

RE: YOUR VISIT TO EAST AFRICA

With the good news about your visit to East Africa from 4th to 11th November before Forum 6 meeting in Arusha organized by GFHR, I take this opportunity to warmly welcome you and on behalf of my colleagues appreciate your interest of sharing the knowledge and experience that you have with us. My colleagues and I are happy and will do whatever we can to make the visit a success. The circle will cover your local boarding, lodging and travel expenses.

Thank you and looking forward to your visit and the interactions.
Karibu sana.

Mwajuma S. Masaiganah Ms.
PHM Coordinator East Africa
(signed)

KAMPALA:
Ms. Alice Drito
P.O. Box 23711,
Kampala, Uganda
Drit12@hotmail.com

TANZANIA.
Ms. Mwajuma S. Masaiganah
P.O. BOX 240,
Bagamoyo, Tanzania
Mobile: 0744 281260
masaigana@africaonline.co.tz

MOMBASA, KENYA
Mr. Malachi O. Orondo
P.O. BOX 93045,
Mombasa, Kenya
oromal@yahoo.com

NAIROBI, KENYA.
Mr. Samwel Ochieng
Consumer International Network
P.O. Box 7569,
00300 Nairobi, Kenya
Tel: 781131
cin@insightkenya.com

ARUSHA, TANZANIA
Dr. Mr. Melchiory Masatu
Center for Education Development Arusha (CEDHA)
P.O. BOX 1162
Arusha, Tanzania
cmasatu@yahoo.com

HEPS, Uganda
Ms. Rossete Mutambi
P.O. Box 2426.
Kampala, Uganda
heps@utlonline.co.ug

Subject: **INVITATION TO VISIT PEOPLES HEALTH MOVEMENT KENYA(PHM) FROM 4th. TO 6TH.NOVEMBER 2002.**
Date: Thu, 10 Oct 2002 00:33:27 -0700 (PDT)
From: Malachi Orondo <oromal@yahoo.com>
To: sochara@vsnl.com
CC: masaigana@africaonline.co.tz, heps@utlonline.co.ug, ndesumbuka@yahoo.com, drit12@hotmail.com

Dear Mr. Ravi Narayan and Thelma Narayan ,

You are kindly invited to visit us in Kenya from 4th.to 6th.November, 2002 to share with us your experiences in health issues pertaining to PEOPLES HEALTH MOVEMENT.We shall offer for you full accommodation during your stay in Kenya.

We remain hoping to receive and host both of you during your stay in kenya .

yours faithfully

MALACHI O. ORONDO

PHM. Kenya National Coordinator.

Phone : 0091-80-5531518 / 5525372
Fax : 0091-80-5525372
email : sochara@vsnl.com

Society for Community Health Awareness, Research and Action - SOCHARA

Regd. Office : No. 326, V Main, I Block, Koramangala, Bangalore - 560 034.

October 19, 2002

TO WHOMSOEVER IT MAY CONCERN

Dr.Ravi Narayan, MD(AIIMS), DTPH (LONDON), DIH (UK), Community Health Adviser of the Community Health Cell, Society for Community Health Awareness, Research and Action, Bangalore, has been invited by Ms. Mwajuma S.Masaiganah, PHM Coordinator East Africa, Peoples Health Movement (PHM), East Africa Circle, P.O.Box 240, Bagamoyo, Tanzania, East Africa to attend a series of health meetings and workshops in Nairobi (Kenya), Kempala (Uganda), Dar-es-Salaam and Arusha (Tanzania) from 4th to 11th November 2002 and by Mr.Louis J.Currat, Executive Secretary, Global Forum for Health Research (GFHR), C/o World Health Organization, 20 avenue Appia, 1211 Geneva, Switzerland, to attend its 2002 annual meeting, Forum – 6, from 12th to 15th November 2002 in Arusha, Tanzania.

Dr. Ravi Narayan has been a Member of Community Health Cell, Society for Community Health Awareness, Research and Action, Bangalore, for the past 18 years and the Community Health Adviser of Community Health Cell for the past three years. The Society is very pleased about the professional opportunity and has permitted Dr. Ravi Narayan to undertake this visit to Nairobi, Kempala, Dar-es-Salaam and Arusha in East Africa from November 4th to 17th, 2002, as on duty.

All expenses for his travel and accommodation are being covered by PHM – East Africa Circle and GFHR respectively.

for SOCIETY FOR COMMUNITY HEALTH AWARENESS,
RESEARCH AND ACTION,

Dr.Mohan Issac
Vice President

Phone : 0091-80-5531518 / 5525372
Fax : 0091-80-5525372
email : sochara@vsnl.com

Society for Community Health Awareness, Research and Action - SOCHARA

Regd. Office : No. 326, V Main, I Block, Koramangala, Bangalore - 560 034.

October 19, 2002

TO WHOMSOEVER IT MAY CONCERN

Dr.Thelma Narayan, MBBS, Ph.D (LONDON), Coordinator of the Community Health Cell, Society for Community Health Awareness, Research and Action, Bangalore, has been invited by Ms. Mwajuma S.Masaiganah, PHM Coordinator East Africa,Peoples Health Movement (PHM), East Africa Circle, P.O.Box 240, Bagamoyo, Tanzania, East Africa to attend a series of health meetings and workshops in Nairobi (Kenya), Kempala (Uganda), Dar-es-Salaam and Arusha (Tanzania) from 4th to 11th November 2002 and by Mr. Louis J.Currat, Executive Secretary, Global Forum for Health Research (GFHR), c/o World Health Organization, 20 avenue Appia, 1211 Geneva, Switzerland, to attend its 2002 annual meeting, Forum - 6, from 12th to 15th November 2002 in Arusha, Tanzania.

Dr. Thelma Narayan has been a Member of Community Health Cell, Society for Community Health Awareness, Research and Action, Bangalore, for the past 18 years and the Coordinator of Community Health Cell for the past three years. The Society is very pleased about the professional opportunity and has permitted Dr. Thelma Narayan to undertake this visit to Nairobi, Kempala, Dar-es-Salaam and Arusha in East Africa from November 4th to 17th, 2002, as on duty.

All expenses for her travel and accommodation are being covered by PHM – East Africa Circle and GFHR respectively.

For SOCIETY FOR COMMUNITY HEALTH AWARENESS,
RESEARCH AND ACTION,

Dr.Mohan Issac
Vice President

The Guide

The most recent information on the programme for Forum 6, on logistical arrangements and the meeting venue can be found on the website www.globalforumhealth.org.

SUPPORT FOR PARTICIPATION

The Global Forum is pleased to support your participation in Forum 6.

This support includes:

- An agreed economy return fare from your place of residence to Arusha
- An allowance of US$500.00 (five hundred US dollars) to cover the following costs associated with your participation:
  - Accommodation in Arusha
  - Transport to and from the airport in your country of residence
  - Incidental expenses during travel
  - Meals not provided during Forum 6
  - Visa fees, vaccination costs and airport taxes.

Details of payment will be provided upon registration in the Conference Centre.
Travel insurance is provided by the Global Forum to cover medical emergencies and repatriation (detailed insurance conditions are available upon request from the Secretariat). However **insurance for personal belongings is not provided**. Please make sure you have your own insurance against loss or theft.

TRAVEL AND ACCOMMODATION

Visas

All participants are responsible for acquiring their own visas for Tanzania. Nationals of some countries (including Bangladesh, Lebanon, Pakistan, Nigeria and Somalia) need a "referred visa" which requires special clearance. **You should start the application procedure as soon as possible.** A visa application form is enclosed in this package. A list of Tanzanian missions/consulates abroad (with full contact details) can be found on the Tanzania National website: www.tanzania.go.tz/tanzaniaembassiesf.html.

Vaccinations

Vaccination against yellow fever is required for participants coming from or via an infected area. Please check requirements with your travel agent or consult sources on international travel and health, such as the World Health Organization or US Centers for Disease Control websites: www.who.int/ith or www.cdc.gov/travel.

Travel to Arusha

Raptim, the Global Forum's travel agent, will contact you with a proposed itinerary from your nearest airport and via the most direct route to Arusha and return, in economy class. Arrival will be scheduled, as far as possible, for Monday 11 November – in time for the Faculty Orientation Meeting – and departure on Friday 15 or Saturday 16 November, depending on flight schedules.

Please confirm this itinerary **as soon as possible after receipt**, directly with Raptim. Changes will be considered as long as the cost stays within the price originally quoted. Raptim may be contacted by e-mail jc.puippe@raptim.ch; fax: +41 22 791 6499 or telephone: +41 22 791 6187.

Accommodation
The Global Forum for Health Research has made block bookings at favourable rates for accommodation in conveniently located hotels in and around Arusha; see separate sheets for full information on prices, amenities and contact details. **Please make your own reservation directly with the hotel of your choice.**

Special needs
Participants with special needs are asked to inform the Secretariat as early as possible so that their dietary or access requirements can be properly taken into consideration.

THE PROGRAMME: TYPES OF SESSIONS

Plenary sessions
- all participants together
- at the beginning of each morning and afternoon
- keynote speech(es), panel discussions, reports, comments from the floor
- themes are fixed and sessions put together by the Programme Committee

Parallel sessions
- follow from the plenary themes
- participants choose according to their interest
- presentations by a panel, debates, discussion with participants
- can take the form of debates
- topics can be added according to relevance, priority and available space
- sessions are coordinated by a focal point under the responsibility of the Programme Committee

Marketplace
- open all day; participants visit stalls in their free time
- central position in AICC
- participants reserve stalls and are on hand to present their work
- place to display documents and publications, make computer presentations
- posters are also included (proposals are reviewed by the Programme Committee) on topics addressing the 10/90 gap in health research

Satellite meetings
Throughout Forum 6, special interest groups and business meetings will be scheduled to allow participants to take advantage of the presence of colleagues in Arusha. Some of these gatherings (such as Board meetings) will be closed, others will be open for participants to join in freely (special interest groups). Information will be given in the final programme.

Time has been deliberately left free within the programme for participants to get together: for example, over breakfast (some hotels will set aside a room or reserve tables upon request), during coffee and tea breaks, at lunchtime or in the evening.

FORUM 6 VENUE

Arusha

Arusha is located in the northern part of Tanzania. Kilimanjaro International Airport (KIA) is the closest airport, approximately 45 kilometres or 45 minutes away. Participants arriving from Europe (via KLM) can fly directly into KIA. Other airlines go to Dar es Salaam, with connecting internal flights to KIA.

Finding the Arusha International Conference Centre (AICC)

The AICC is situated in the centre of Arusha. A transfer service will be provided between hotels and the Conference Centre each morning and at the end of programme activities in the evening. Only participants who stay in hotels situated in the very centre of Arusha could envisage walking to the Conference Centre.

FORUM HOURS

Forum 6 programme
All sessions take place at the AICC.
There will be an introductory session for newcomers on Monday 11 November at 17.30, followed by an Orientation Session for Forum 6 faculty at 18.30.
The official opening will take place on Tuesday 12 November at 9.00.
The programme will end on Friday 15 November at 14.00.

Conference Centre hours
The Arusha International Conference Centre will be open from 7.00 to 20.00 during Forum 6. As the AICC is located in the same complex as the UN International Criminal Tribunal for Rwanda, tight security is in place in parts of the complex, including the wing in which the Plenary Hall is situated. Time must be allowed for security clearance.

Registration
Participants may register for Forum 6 and pick up their badge and documentation:
1. upon arrival in the Kilimanjaro Airport at the Welcome Desk.
2. in the Conference Centre
   Monday 11 November 14.00-19.00
   Tuesday 12 November from 7.00

Marketplace set up and take down
Participants who have reserved a market stall should note the following times:
set up
Monday 11 November 14.00-19.00
Tuesday 12 November 7.00-9.00
take down
Friday 15 November 14.00-17.00

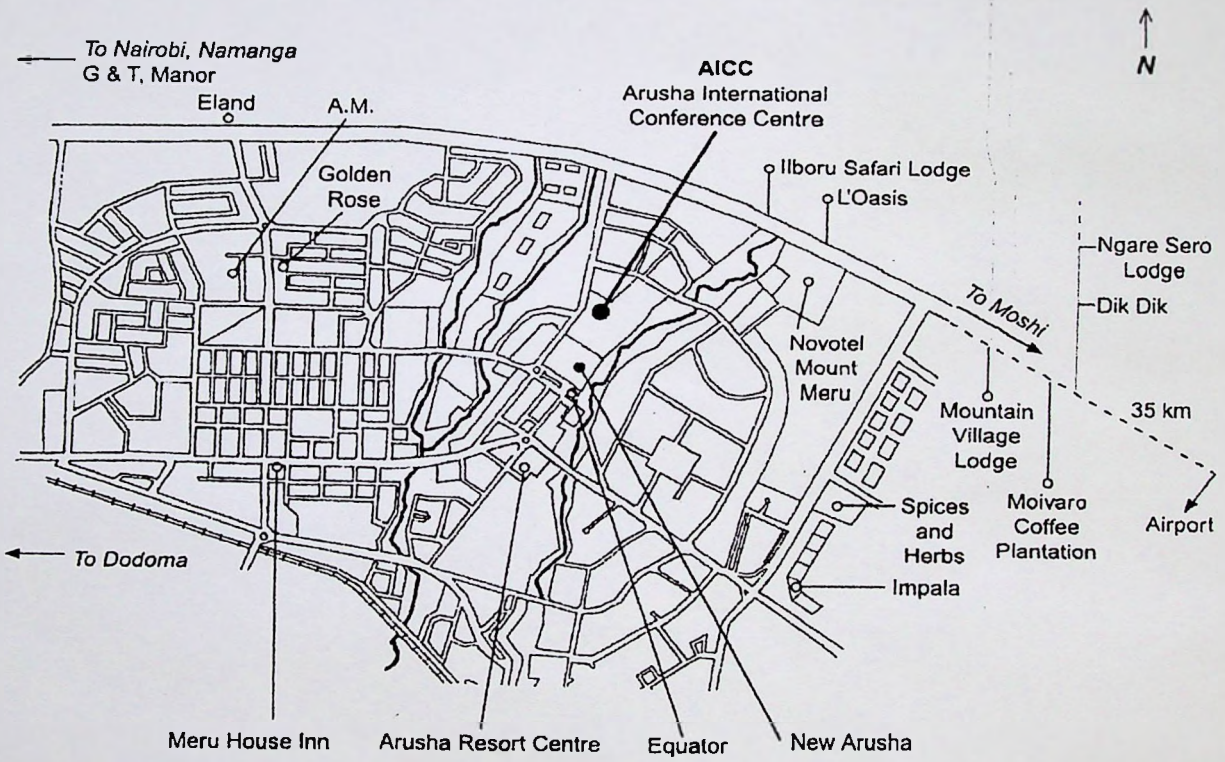
PRELIMINARY PROGRAMME OVERVIEW*

4 October 2002

	Tuesday 12 November	Wednesday 13 November	Thursday 14 November	Friday 15 November
7.30-9.00	*Transfers to AICC* Registration	*Transfers to AICC*	*Transfers to AICC*	*Transfers to AICC*
9.00-10.30	**PLENARY 1** **OPENING AND KEYNOTE ADDRESS** **President of Tanzania** ——— **Celebrating African health research**	**PLENARY 3** **Measuring progress in gender issues**	**PLENARY 5** **Health research and development: what next after the Commission on Macroeconomics and Health and the Millennium Development Goals?**	**PLENARY 7** **Using research results: research synthesis as a tool to help correct the 10/90 gap**
10.30-11.00	Coffee break/Marketplace			
11.00-12.30	**PARALLEL SESSIONS** Successes in health research: solving health problems Examples from African regions: • Southern Africa • East Africa • West Africa • North Africa	**PARALLEL SESSIONS** • Gender, child health and nutrition • Gender, mental health and disability • Gender and noncommunicable diseases • Gender, sexual and reproductive health • Gender, infectious and tropical diseases • Gender, work and occupational health • Violence against women	**PARALLEL SESSIONS** • Genomics, intellectual property rights and the 10/90 gap • Latest developments in priority-setting • Resource flows • Strategies for improving access to drugs • World Health Report 2002: Reducing risks, promoting healthy life	**CLOSING PLENARY** **What perspectives for the 10/90 gap and what recommendations to the partners in the Global Forum?**
12.30-14.00	Lunch break/Marketplace			CLOSING EVENT
14.00-15.30	**PLENARY 2** **Successes in health research: mobilizing national resources** (examples from Asia and Latin America)	**PLENARY 4** **Health research collaboration: national, regional and global health research forums**	**PLENARY 6** **Monitoring the results of research capacity strengthening**	SITE VISIT • MOH Demographic Surveillance System
15.30-16.00	Coffee break/Marketplace			
16.00-17.30	**PARALLEL SESSIONS** • Debate on Asian/LAC successes in mobilizing national resources • Research by CSOs • Research on AIDS • Research to roll back malaria • TB initiatives	**PARALLEL SESSIONS** **Regional meetings** • Africa Health Research Forum + launch • Asia + Pacific Forum • Latin + Central America	**PARALLEL SESSIONS** • Brain drain and RCS • Debate on the evaluation framework for research capacity strengthening • Health research systems analysis • Research for policy and practice	
18.00-19.30	**OPENING RECEPTION** **hosted by the Chair of the Global Forum** **+ African Show**	BUSINESS MEETINGS AND SPECIAL EVENTS • ACOSHED • Bangkok Action Plan • Cost-effectiveness analysis • High blood pressure in Africa: planning group • MIHR launch • Oral health • Road traffic injuries board • SHARED • Medical Research Councils dinner	SPECIAL INTEREST GROUPS • Cardiovascular diseases • Child health and nutrition • ENHR • INDEPTH • International Health Research Awards • Maternal health • Mental health and neurological disorders • Measuring BoD • Public-private partnerships • Road traffic injuries • World Report on Violence	

** The titles and timing of specific sessions are preliminary. The overall programme structure is however fixed.*

Conference hotels in Arusha



Global Forum for Health Research

Helping correct the 10/90 gap

Strategic Orientations 2003–2005

October 2002

Contents

Global Forum for Health Research
Strategic Orientations 2003–2005

Introduction: Objective of the paper, audience and approach

The Global Forum for Health Research started its operations in 1998 with the objective to help correct the 10/90 gap in health research. Every year, more than US$70 billion is spent worldwide on health research by the public and private sectors. But only about 10% of this is used for research into 90% of the world's health problems. This is what is called the 10/90 gap. The Global Forum is an independent international foundation, managed by a 20-member Foundation Council and a small Secretariat based in Geneva.

The objective of this document is to revisit the global strategic orientations of the Global Forum for Health Research after five years of operations and define them for the period 2003–2005.

This paper is intended for different audiences, covering:

- the needs of the partners of the Global Forum to develop the best synergies among themselves in helping to correct the 10/90 gap (including government decision-makers, research institutions and universities, multilateral and bilateral aid agencies, foundations, national and international CSOs, women's organizations, private-sector companies, media)
- the needs of the donors to the Global Forum, asking themselves if the resources entrusted to the Global Forum are well invested
- the needs of the Foundation Council and the Secretariat of the Global Forum in their search for the ways and means to increase the efficiency, effectiveness and impact of the actions of the Global Forum.

To fulfil this mandate, it is necessary:

1. to revisit the vicious circle between ill health and poverty and the urgency to correct the 10/90 gap in health research (chapter 1)
2. to summarize the original mandate and first five years of activity (1998–2002) of the Global Forum (chapter 2)
3. to present the vision, values, central objective and specific objectives of the Global Forum (chapter 3)
4. to define the main partners of the Global Forum and the specific role of the Forum among the large number of institutions active worldwide today in the field of international health (chapter 4).

Then, on the basis of the first four chapters, chapter 5 summarizes the new orientations in the Global Forum's strategies, designed to increase the Forum's impact on the correction of the 10/90 gap during the period 2003–2005.

In line with the revision of the strategies, Chapter 6 summarizes the criteria for the approval of projects supported by the Global Forum.

Chapter 7 describes the role of the Governing Bodies of the Global Forum, as well as the functions of the Secretariat.

Chapter 8 identifies the financial resources needed by the Global Forum Core Secretariat to fulfil its mandate in the coming three years, as well as the policies of the Global Forum regarding funds-in-trust and the mobilization of resources to help correct the 10/90 gap.

Chapter 1. Main problems: ill health, poverty and the 10/90 gap in health research

1.1 Ill health and poverty

Ill health has a negative impact on growth and development as a result of a reduction in life expectancy, educational achievements, production and employment as well as a reduction in social and political stability. These factors affect the whole population, particularly the poor.

Beyond this general negative impact on the economic and social situation of a country, ill health directly reinforces the vicious circle of poverty, which includes malnutrition, disease, unemployment or underemployment, low income, poor housing, low level of education, low productivity, lack of access to health care services and drinking water, larger number of children, unwanted pregnancies, substance abuse. In addition, poor people are more likely to suffer from the degradation of the environment and from discrimination. For people trapped in this vicious circle, the chain of causality is very difficult to break.

Breaking out of the health crisis requires breaking out of the vicious circle of poverty, an immense and complex task. The solution is unlikely to come from any single intervention, but rather from a combination of many different interventions, bearing on the political, social, economic, physical and cultural causes of poor health. Ill health is a crucial link in the vicious circle of poverty. This was again underlined by a number of recent international conferences and reports, including in particular the United Nations Millennium Summit (September 2000)[1], the World Development Report 2001[2], the International Conference on Health Research for Development (Bangkok, October 2000)[3], the People's Health Assembly (Dhaka, December 2000)[4] and Forum 5 (October 2001)[5], among others.

1.2 A major problem: the 10/90 gap in health research

One of the roles of health research is to ensure that the measures proposed to break the vicious circle of ill health and poverty are based, as far as possible, on evidence, so that the resources available to finance these measures are used in the most efficient and effective way possible.

Even though crucial to promote development and help break the vicious circle between ill health and poverty, health research has suffered from insufficient funding and severe disequilibrium. For the past decade, and since the ground breaking work of the Commission on Health Research for Development in 1990[6], the disequilibrium in health research has been captured in the expression "the 10/90 gap" to indicate the huge discrepancy between the magnitude of disease burden and the allocation of research funding worldwide. It is estimated that the public and private sectors invest more than USD70 billion per annum in health research, of which less than 10% are devoted to 90% of the world's health problems.

1.3 Causes of the 10/90 gap in health research

There are numerous causes for this imbalance in research funding:

- A first cause is the failure of the public sector in high-income countries to allocate health research funding on the basis of a systematic analysis of priorities, taking into account national and international health issues.
- A second cause is the limited capacity for research in the public sector of many low- and middle-income countries as a result of limited funding for research in general and lack of appropriate policies and organization.

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[1] United Nations Millennium Summit, *Millennium Development Goals*, September 2000.
[2] World Bank, *The World Development Report 2000/2001, Attacking Poverty*, September 2000.
[3] International Conference on Health Research for Development, *Conference Report*, October 2000.
[4] People's Health Assembly, *People's Charter for Health*, December 2000.
[5] Global Forum for Health Research, *The 10/90 Report on Health Research 2001-2002*, May 2002.
[6] Commission on Health Research for Development, *Health Research, Essential Link to Equity in Development*, 1990.

- A third cause is the limited research on neglected[7] diseases and determinants undertaken by the private sector in all countries as a result of insufficient commercial perspectives.

1.4 Consequences of the 10/90 gap in health research

The main consequence of the 10/90 gap in health research is that the vast majority of the world's population, particularly the poor, benefits little, if at all, from health research. More specifically, the consequences can be summarized as follows:

- The state of health of the majority of the world's population is far worse than it could be, with direct consequences not only for individuals and their families, but for the overall growth and development of their country.
- For the absolute poor (at least 20% of the world's population) who are trapped in the circle of ill health and poverty, the 10/90 gap in health research means that the hope for breaking out of that circle is slimmer than it would otherwise be.
- For the world as a whole, this results in lower growth and development and increased global insecurity.

Chapter 2. The first years of the Global Forum (1998–2002)

The Global Forum for Health Research started its operations in January 1998 and became a legal entity (a Foundation) in June 1998. As defined at that time, the central objective of the Global Forum was to help correct the 10/90 disequilibrium and focus research efforts on the health problems of the poor by improving the allocation of research funds and by facilitating collaboration among partners in the public and private sectors.

To reach this objective, the Global Forum selected the following five strategies:

(a) Organization of an annual Forum meeting

Since its creation, a Forum meeting was held each year, the last one (Forum 5) being held in October 2001 in Geneva with the participation of 720 partners. At the Annual Forum meeting and throughout the year, the Global Forum acted as a "marketplace" where health problems and priorities could be examined by a variety of decision-makers, policy-makers and researchers. Presentations at the annual meeting addressed the latest thinking on the 10/90 gap and acted as a catalyst for action during the following year.

(b) Undertaking of analytical work for priority setting

The main actions supported by the Global Forum in the field of priority-setting methodologies during the period 1998–2002 were mainly concentrated in the following two areas:

- Development of priority-setting methodologies: over that period, the Global Forum reviewed the main methodologies in the field of priority setting and proposed a "combined approach matrix" (based on these earlier methodologies) which was tested and applied, with some adaptations, by the Special Programme on Research and Training in Tropical Diseases (TDR) in 2001. The results of this work were published in *The 10/90 Report on Health Research 2001-2002* of the Global Forum.[8] As part of the development of priority-setting methodologies, the Global Forum also helped support a number of specific studies in the field of burden of disease and cost-effectiveness analysis undertaken by partner institutions or networks.
- Monitoring investments in health research: beginning in 1999, the Global Forum supported efforts to develop and implement a system for tracking and reporting investments in health research together with an international group of investigators. The study proposed a classification method that can be used to incorporate information from low- and middle-income countries, countries in transition and high-income

[7] "Neglected (or orphan)" diseases are defined as diseases representing a high burden on the world's health, but for which interventions are limited and not commensurate with the disease burden. The expression "neglected (or orphan)" diseases sometimes refers to "rare" diseases, representing a very low burden on the world's health, but with severe consequences for the persons affected. In the context of the present paper, the use of "neglected" diseases refers only to diseases representing a high burden on the world's health, but for which interventions are very limited.

[8] Global Forum for Health Research, *The 10/90 Report on Health Research 2001-2002*, May 2002.

countries. The proposed classification distinguishes between the following five categories of research: fundamental research, research into diseases/injuries; research into determinants; health systems research; and research capacity building. The results of the first phase of this study were published in October 2001.[9]

(c) Support for networks and partnerships in key areas of health research
Over the period 1998-2002, the Global Forum gave catalytic support (both in kind and seed money financing) to a limited number of networks and partnerships active in key areas of health research, primarily the following: health policy and systems, malaria, tuberculosis, cardiovascular health, child health and nutrition, violence against women and public-private partnerships. In each case, the focus and role of the Global Forum was limited to bringing partners together to analyse jointly problems which were beyond the capacity of any of the partners, so as to be in a better position to define the necessary actions.

(d) Information and communication
During the same period, the activities under "information and communication" were concentrated on the development of a network of partners, a number of publications (the flagship publication of the Global Forum – *The 10/90 Report on Health Research* – which was published in 1999, 2000 and 2002 and *Monitoring Financial Flows for Health Research*, published in 2001), the development of a website, contacts with the media and participation in international conferences, where issues of the 10/90 gap and actions undertaken by Global Forum partners have been presented and discussed.

(e) *Monitoring and evaluation*
Progress indicators have been developed to monitor partial results under each of the strategies identified above. The Global Forum partners play a central role in monitoring progress towards the correction of the 10/90 gap. An external evaluation was conducted in 2001, the results of which were published in December 2001.[10]

Finally, during the 1998-2002 period and under each of the above-mentioned strategies, the Foundation Council underlined its commitment to the following policies:

- gender analysis, in an effort to promote progress towards social justice and ensure valid and reliable research outcomes
- strengthening research capacity, as a powerful and cost-effective means of advancing health and development.

Chapter 3. Vision, values, central and specific objectives of the Global Forum for 2003-2005

Based on the experiences gathered during first phase of the Global Forum (1998-2002) and the 2001 External Evaluation Report, the Foundation Council revisited the central vision, values, objectives and strategies of the Global Forum and adopted them in September 2002 for the second phase of the activities of the Global Forum (2003-2005). They are summarized below.

3.1 Vision of the Global Forum

The vision of the Global Forum is a world in which health research is recognized as a global public good and a critical input in health system development, a world where priority is given, at the global and national levels, to the study of those factors with the largest impact on people's health and to the effective delivery of research outcomes for the benefit of all people, particularly the poor.

[9] Global Forum for Health Research, *Monitoring Financial Flows for Health Research*, October 2001.

[10] Fred Binka, Jan Holmgren, Nirmala Murthy, *Findings from the External Evaluation, A report to the Foundation Council of the Global Forum for Health Research*, December 2001.

3.2 Values and principles of the Global Forum

In all its activities and within its vision as defined above, the Global Forum is committed to the values of human rights, equity, gender equality, ethics, justice, democracy, the defence of the vulnerable, protection of the environment, transparency and accountability.

The Global Forum is a not-for-profit foundation, tied to no political, religious, partisan or national interests.

3.3 Central objective of the Global Forum

The central objective of the Global Forum is to help correct the 10/90 gap in health research and focus research efforts on the health problems of the poor by bringing together key actors and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research.

3.4 Specific objectives of the Global Forum

In pursuit of this central objective, the Global Forum pays particular attention to the following specific objectives:

- Contribute to the efforts to measure the 10/90 gap, monitor developments and disseminate pertinent information regarding this gap, including on its causes and consequences.
- Support the development of priority-setting methodologies and policies to identify research priority areas, including in sectors other than health which have a crucial role to play in the promotion of health.
- Identify and debate critical, controversial and burning issues affecting the 10/90 gap in health research.
- Give special consideration to the health problems of the poor.
- Ensure that gender analysis is consistently and systematically applied to all work on the 10/90 gap.
- Be a platform for debate and synthesis review of efforts in the field of research capacity strengthening, paying special attention to the needs of the national health research systems.
- Support concerted efforts and the development of networks/partnerships (between the public sector, private commercial sector and civil society organizations) in the priority sectors of health research, when appropriate and when the benefits of joint action are larger than the sum of individual actions.

Chapter 4. The need for partnerships and the role of the Global Forum

This chapter aims to (a) explain why individual actions will not be sufficient for correcting the 10/90 gap, necessitating therefore the further development of collaborative efforts; (b) identify the Global Forum's partners in the correction of the 10/90 gap; and (c) situate the role of the Global Forum within the system of health research institutions and partnerships.

4.1 The need for partnerships

As the evidence of interdependence grows in the world, there has been a gradual movement within each institution towards "more global thinking", i.e. towards the integration (internalization) of the international public health needs. The Global Forum believes however that this will not be sufficient to solve the global health challenges facing the world today and that the solution to these challenges requires the further development and strengthening of health research partnerships, linking the efforts of many actors around priority areas of health research.

(a) The magnitude of the problems: the magnitude of the problems to be solved is such that they are beyond the capacity of any single institution to resolve; this magnitude can be described in terms of the number of cases (reaching into the hundreds of millions), the number of countries (often more than half of the world) and the complexity of the diseases; these characteristics indicate that solutions can only be found by the joining of forces of a large number of institutions, at the local, national, regional and global levels.

(b) The efficiency argument: with good management, the benefit/cost ratio of a joint undertaking may be very high, i.e. the benefits of joint action (better understanding of the problem; better identification of the priority research areas; definition of more effective strategies for reaching solutions; better communcation; better focus of research efforts on the most promising areas; decrease in the duplication of efforts; more effective solutions), can be much greater than each institution could obtain separately for the same amount of time and resources invested. In cases where the overall estimated benefits become limited, while the costs remain high, it is justified to stop the investment in the network/partnership.[11]

(c) The interdisciplinarity argument: most institutions active in the field of health research are necessarily specialized and focus on a limited type and number of interventions. However, the effectiveness of a given intervention often depends on a chain of complementary actions being taken at the same time. In this sense, partnerships can play a key role in ensuring the solidity of this chain and the participation of all relevant disciplines to the solution (bio-medical and social sciences, sectors other than health but having an important impact on health, macroeconomic policies). Similarly, different disciplines and institutions share the same need for basic science, information, epidemiology or management issues and may find it profitable to join forces in their upstream research.

(d) The synergy argument: beyond the efficiency and interdisciplinarity arguments, partnerships stimulate synergistic interactions between institutions, i.e. dynamic processes which lead to greater outputs for the same amount of resources invested by each institution individually.

(e) The global public goods argument: it is increasingly recognized that better health for anyone, anywhere in the world, benefits everyone else. As such, health (and health research) can be described as a global public good. Like other global public goods, global health and health research suffer from insufficient investment. Partnerships have a key role to play in helping to correct this under-investment in global public goods, as partners identify the benefits accruing to themselves as a group.

4.2 Who are the partners in the Global Forum?

Therefore, correcting the 10/90 gap requires the commitment of thousands of institutions and individuals in the North and South, including the following: government decision-makers; research institutions and universities; multilateral agencies; bilateral development organizations; private foundations; private-sector companies; women's organizations; national and international CSOs; the media.[12] All of them have an impact on the 10/90 gap and therefore are considered to be partners in the Global Forum. No attempt is made to create an actual "membership" of the Global Forum as such, not only because of the practical difficulties involved, but also because of the many institutions which, for different reasons, would not become members, while having a large impact on the 10/90 gap. The objective therefore is rather to create a *movement* for the correction of the 10/90 gap in which partners, concerned by the very negative consequences of such misallocation of resources, contribute in very different ways to the overall objective.

4.3 The role of the Global Forum

In the past two decades, many institutions have taken individual and joint actions contributing in very different ways to the correction of the 10/90 gap in health research, including the development of networks and partnerships at the national, regional and global levels.

In this maze of research institutions and networks interested in helping to correct the 10/90 gap, what is the role and comparative advantage of the Global Forum? In summary, the Global Forum sees its role as follows:

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[11] Clearly, the benefit-cost ratio of a specific network/partnership is rarely calculated. It is an estimation made by the partners as to whether the time invested in networking yields results beyond those that could be reached separately with the same investment in time and resources.

[12] Most of these constituencies are represented in the Foundation Council of the Global Forum.

- as an independent, evidence-based and informal platform bringing together very different actors from the public and private sectors to encourage critical debate and to analyse the best ways to help correct the 10/90 gap
- as a network of individuals, institutions and networks, linking the efforts of very diverse institutions having an impact in reducing the 10/90 gap
- as a catalyst for these efforts[13] and facilitator of work by others, but not itself a research funding agency.

In these collaborative efforts between the national, regional and global levels, the view of the Global Forum is that the principle of subsidiarity should apply, i.e. the regional level should only undertake what cannot be done at the country level and the global level should concentrate on issues which go beyond the regional level. In this sense, overall health research collaboration at the global level could be the result of a bottom-up approach starting with the national health research systems and relayed by the regional efforts. With the many sovereign and autonomous institutions involved, the efforts could focus on a set of collaborative principles which could contribute much to the allocation of health research funds to priority health research needs. This draws attention to the crucial role to be played by the "national health research systems" in the construction of an international collaborative system in health research.[14]

Chapter 5. Global strategies of the Global Forum and types of support

Based on its:
- vision
- values and principles
- central objective of helping to correct the 10/90 gap
- specific objectives
- comparative advantages and experience over its first period of activity (1998-2002),

the content and emphases of the key strategies of the Global Forum over the period 2003-2005 will be developed along the lines defined below. The common denominator of all strategies is the role of the Global Forum to bring actors together to analyse, debate and propose actions on key issues in international health research affecting the 10/90 gap. These strategies are so designed as to be mutually supportive in the pursuit of the objectives of the Global Forum.

5.1 Strategy 1: Organization of an annual Forum meeting

In the words of the External Evaluation Report of December 2001, "There is practically unanimous opinion that the annual Forum meeting is a very useful and, in many ways, unique opportunity and market place where health problems and priorities are discussed by a variety of decision-makers, policy-makers and researchers; no other organization can replace the Global Forum as a convener of this type of meeting."

Based on the recommendations of the External Evaluation and discussions in the Foundation Council, the annual Forum meeting will be given greater emphasis in the coming years. More specifically, this strategy will be implemented along the following lines over the period 2003-2005:
- Analyse and enlarge systematically the constituencies of the Global Forum by mobilizing main decision-makers (such as medical research councils, heads of research institutes, heads of research in health ministries, etc.) to help correct the 10/90 gap, including in sectors other than health; identify gaps in representation from constituencies, countries and gender and target invitations to fill identified gaps.
- Keep a clear view of the mandate and comparative advantages of the Global Forum in organizing its annual meeting, which should not substitute for what other conferences are undertaking.

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[13] The Global Forum is a member of the Interim Working Party (together with WHO, COHRED, the World Bank and a number of other national and international institutions) launched at the 2000 Bangkok Conference to study the issues of collaboration in the context of international health research.

[14] International Conference on Health Research for Development, Conference Report, October 2000. It should also be mentioned that the 2004 World Health Report will focus on a description and analysis of the national health research systems in the context of global health research.

- Define the annual meeting programme based on the established priorities for helping to correct the 10/90 gap.
- While the 'classic' topics around the 10/90 gap are the common denominator of the annual Forum, give an opportunity for new themes and participants to be included through, for example, a call for contributing ideas to the correction of the 10/90 gap.
- Identify controversial issues (for example, in the field of ethics, intellectual property rights, etc.).
- Promote systematically the translation of research into practice.
- Include research capacity strengthening as a standard theme in the annual meeting, promoting research in and by low- and middle-income countries.
- Act as an annual link between larger periodic conferences (such as the 2000 Bangkok conference and the planned 2004 Mexico conference).
- Give an opportunity periodically for regional discussions on specific topics of interest.
- Secure increased financing for the annual Forum so as to be able to finance additional participants, particularly from low- and middle-income countries and civil society organizations influential in the work on the 10/90 gap.

Indicators

The following indicators, in terms of effectiveness, efficiency and value added, will be used for measuring the contribution of the annual Forum meeting to the correction of the 10/90 gap:

- Participants: representation of key actors influencing the 10/90 gap, representation of the diversity of Global Forum constituencies, geographical distribution, gender balance.
- Programme: relevance to the 10/90 gap issues.
- Value added: contribution of each annual meeting to the progress made in solving the 10/90 gap issues.
- Costs: comparison of total costs for the annual Forum with other similar meetings.

5.2 Strategy 2: Analytical work on the 10/90 gap and health research priorities

The 10/90 gap is a multidimensional problem which is, at least in part, the consequence of the complexity of identifying priorities at the global and national levels in a multidimensional environment, and following up with joint actions. Since the early 1990s, an attempt has been made to set priorities in health research based on a systematic assessment of the burden of diseases – basically identifying as priority any disease (or condition) representing a very high burden on the world's health (in terms of mortality and morbidity as given by the DALY indicator or similar indicators)[15], while research funding for that particular disease remained limited.

Following this first effort at systematization, it was quickly realized that the "disease focus" is only one dimension of health research and that major risk factors affecting health have to be prioritized themselves, as they are competing for the same funding as disease-focused priorities. But to make things more difficult, there are at least two other dimensions to health research which have to be prioritized, i.e. the global cross-cutting issues affecting health and the methodologies for priority-setting themselves.

Thus, the second strategy of the Global Forum is to support analytical work on the 10/90 gap in health research, focusing on the four dimensions mentioned above, which are all part of health research and competing for the same funds, i.e.:

(a) development and application of priority-setting methodologies to help correct the 10/90 gap

[15] The DALY (Disability-Adjusted Life Year) is an indicator developed for the calculation of the burden of disease which quantifies, in a single indicator, time lost due to premature death with time lived with a disability. A number of explicit choices about age weighting, time preference and preference for health states are made in the calculation of the DALYs. Other indicators have been developed in recent years (HEALYs, QALYs for example) based on the same model. The results of the various models however lead to similar conclusions about the burden of disease and risk factors in the world and their likely evolution in the coming years. Reference: Christopher J.L. Murray and Alan D. Lopez, Global Burden of Disease and Injury Series, The Global Burden of Disease, A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projections to 2020, Harvard University Press on behalf of the World Health Organization and the World Bank, 1996. The World Health Organization is currently undertaking a new global burden of disease assessment for the year 2000, the so-called GBD 2000 Project. See "Global Programme on Evidence for Health Policy, Discussion Paper No. 36, WHO, November 2001".

(b) the 10/90 gap and priorities regarding the global cross-cutting issues affecting health
(c) the 10/90 gap and priorities regarding the major risk factors affecting health
(d) the 10/90 gap and priorities regarding diseases and conditions.

These various dimensions are presented below:

(a) Development and application of priority-setting methodologies to help correct the 10/90 gap
The main components of this strategy are the following:

(i) Application of priority-setting frameworks:
Following the review of the main methodologies in the field of priority-setting and the development of the "combined approach matrix"[16] during the period 1998-2002, the Global Forum is interested in the further development of the matrix (and its components), progress in the application of other frameworks, the resulting identification of gaps in research on diseases and risk factors, and the dissemination of the results regarding research priorities, at the national and global levels.

Indicators of efficiency, effectiveness and value added by the Global Forum will be used to measure the contribution of this strategy to the correction of the 10/90 gap as follows:
- Application of priority-setting matrices (to diseases, risk factors).
- Further analysis and debate among partners of priority-setting methodologies.
- Identification of research priorities.
- Dissemination of information regarding research priorities.

(ii) Monitoring investments in health research:
Regarding high-income countries, this analysis will focus on the allocation of funds by governments to health research globally and to the international health research agenda, including the contributions made to the health sector in the development aid budgets (following the recommendation of the 1990 Commission on Health Research for Development to allocate at least 5% of these budgets to health research and capacity development in low- and middle-income countries).

In low- and middle-income countries, this analysis will focus on the efforts of governments to reach the objective set in the 1990 Commission on Health Research for Development of allocating at least 2% of national health expenditures for research and capacity development.

Finally, this strategy will also include the analysis of the contributions made by the private commercial sector, the non-profit private sector and public-private partnerships to health research.

(b) The 10/90 gap and cross-cutting issues affecting health
The health status of a population is influenced not only by behaviour, genetics, health care and immediate risk factors but by a number of cross-cutting issues such as gender, poverty, research capacity and government policies. The strategies of the Global Forum with respect to these four cross-cutting issues are summarized below.

(i) Integration of gender issues in the correction of the 10/90 gap

[16] The "combined approach matrix" incorporates the criteria and principles for priority setting defined in the Essential National Health Research approach, the Visual Health Information Profile proposed bye the Advisory Committee on Health Research, and the five-step process of the Ad Hoc Committee on Health Research (magnitude of disease burden, determinants, present level of knowledge, cost-effectiveness of interventions, resource flows). These five steps are linked with the four broad groups of actors and factors determining the health status of a population (individuals and communities; Ministry of Health, research institutions, and health systems and services; sectors other than health; central government and macro-economic policies) to form a proposed matrix for priority setting. The "combined approach matrix" is useful to incorporate and summarize all information obtained through a variety of processes and sources. Information gathered at country, regional and global levels can be processed to identify gaps and help set priorities in health research.

The Global Forum believes that a systematic approach to gender issues must be a central part of its objective to help correct the 10/90 gap. It is estimated that more than 60% of the world's poor are women. The health of these women is often adversely affected not only by their poverty but by the gender inequalities that continue to divide many of the world's poorest countries.

In recent years, gender issues have been highlighted by most organizations concerned with the promotion of development and the enhancement of human wellbeing. They have integrated these issues into their ongoing work, justifying this with two main arguments. First, *efficiency and effectiveness* require that both women and men are at the heart of development. So long as artificial constraints prevent the full participation of both sexes, societies will be unable to reach their potential for meeting the needs of their citizens. Second, *equity* requires that both women and men should have the same opportunity to be active citizens, participating in the development process and having equal access to its benefits. Unless this is achieved, individuals will not be able to realize their potential for health and wellbeing.

Though they have many health problems and health care needs in common, women and men are divided both by their biological sex and their social gender. Unless these differences are taken into account, the delivery of medical and public health services will be severely constrained in their efficacy and their equity. Under these circumstances it is likely to be women in the poorest communities who will be worst affected.

Thus the strategy of the Global Forum for Health Research is the integration of gender issues in all aspects of its work..The overall principle is that both sex and gender are mainstreamed as key variables in all strategies of the Global Forum.

A number of different measures will be used to ensure that sex/gender issues are integrated in all strategies and activities of the Global Forum, including content of papers and participation in the annual Forum meetings, consistent application of the gender component of the "combined approach matrix" for priority-setting, use of guidelines for gender-sensitive work, efforts towards gender balance in research capacity strengthening, attention to gender issues in project design and partnerships, measuring project results.

(ii) Poverty and health research

As underlined in Chapter 1, ill health is a crucial link in the vicious circle of poverty. A large number of epidemiological and social studies have pointed out the disparity of health status by socio-economic levels, often with significant gender differentials.[17] Disease burden studies have corroborated these findings. Poor people die earlier and get sick more frequently. There is a call for a shift from analysis of rich/poor differences to the question of what to do about them. This draws attention to the central role that health research can play to enlighten these issues.

Thus the strategy of the Global Forum for Health Research is to bring out the poverty issues in the various aspects of its work, promote analysis and debate around these issues, study how to ameliorate poverty and disseminate results.

For example, in the analytical work on the 10/90 gap in health research supported by the Global Forum, analysis and measurement of progress will focus on the following aspects:

- scaling up of interventions and delivery of services to the poorer segments of the population

[17] For example :
World Bank, *Voices of the Poor (Can Anyone Hear Us, Crying for Change, From Many Lands)*, Oxford University Press, December 2000.
World Bank, The World Development Report 2000/2001, *Attacking Poverty*, September 2001.
The Rockefeller Foundation, *Challenging Inequities in Health*, Oxford University Press, 2001.

- risk factors by socio-economic levels
- disease burden by socio-economic levels
- cost-effectiveness and sustainability of interventions in reference to the situation of the poor
- more generally, integration of poverty issues in the application of the "combined approach matrix" for priority setting
- throughout these studies, the interaction of poverty and gender will be systematically analysed.

(iii) Platform for debate and synthesis in the field of research capacity strengthening
Although health (and health research) is increasingly recognized as one of the driving forces behind development and the fight against poverty and in spite of efforts undertaken in the past decades, research capacity in many low- and middle-income countries remains limited. On the whole, training opportunities remain fragmented with no coherent international approach. This lack of capacity is a critical factor perpetuating the 10/90 gap as problems specific to the low- and middle-income countries do not receive the attention they deserve.

Thus, this component of the strategy is to support a synthesis review and debate on the efforts for research capacity strengthening and collaboration. These activities will be conducted jointly with interested partners active in this field, such as the Special Programme for Research and Training in Tropical Diseases (TDR), the Reproductive Health and Research Programme (HRP), NIH, COHRED, INCLEN, the Alliance for Health Policy and Systems Research, research councils and academic institutions, amongst others. This strategy also includes dissemination of findings. The specific contribution of the Global Forum will be based on its comparative advantages (see Chapter 4.4).

One particular issue concerns the results of the efforts undertaken at the national level in a number of countries regarding the capacity of the national health research systems (funding, roles of respective institutions and collaboration between national research institutions). Another issue is the link between these national efforts and those undertaken by the regional and global networks, as well as their relations to the international health research agenda. In this context, it is important to underline the joint benefits, i.e. by Northern as well as Southern institutions, which would be derived from such joint analysis and debate. The more specific content of this strategy will be defined together with the concerned partners in early 2003.

(iv) Health policies and systems
Health policies and systems vary greatly in their performance – in how efficiently they improve health conditions, extend access and contain expenditure growth. Yet there remains a surprising lack of information on the performance of systems and on how policies have affected performance. There is an urgent need to improve understanding on how and for what purposes societies organize themselves to achieve health goals, including how they plan, manage and finance activities to improve health, as well as the roles played by different actors in these efforts, their perspectives and interests. Furthermore, there is a need to better understand the relationship between macroeconomic and health policies.

The Global Forum is particularly interested in the following research issues on which many partners have been working:
- impact of health policies and systems research on health systems and people's health
- relationship between macroeconomic policies and the 10/90 gap in health research
- effectiveness of public-private partnerships in narrowing the 10/90 gap
- factors affecting the transferability of research findings between countries.

(c) The 10/90 gap and major risk factors affecting health
Risk factors causing the heaviest burden in low- and middle-income countries in 1998 were the following[18]: malnutrition, unsafe water/sanitation, unsafe sex, alcohol, indoor air pollution, tobacco, occupational risks,

[18] Based on the Global Burden of Disease 2000 Project, Global Programme on Evidence for Health Policy, WHO, 2001. The World Health Report 2002, scheduled to be published in October 2002, is devoted to "Reducing the risks, promoting healthy life."

hypertension, illicit drugs, violence and road traffic accidents. These risk factors affect particularly the poor. The challenge is now, as indicated in the 10/90 Report 2001-2002, to continue to expand this analysis and obtain better estimates of the contribution of risk exposure by region and socio-economic status, as well as determine their policy implications. These elements can be handled within the "combined approach matrix". This work will be supported by the Global Forum during the 2003-2005 period.

(d) The 10/90 gap and major diseases and conditions

Diseases representing the heaviest burden worldwide in 1998 were the following[19]: childhood diseases, CVD, mental health and neurological disorders, HIV/AIDS and other sexually transmitted diseases, tuberculosis and tropical diseases. During the past three years, work has been conducted on malaria and other tropical diseases as well as epilepsy using the "combined approach matrix". This work in the application of priority-setting methodologies will be pursued during the period 2003-2005 on a country and disease basis.

Progress in the definition of health research priorities based on evidence emerging from the analytical work of the Global Forum and its partners will be summarized in "The 10/90 Report on Health Research 2003-2004" to be published in May 2004.

(e) Type of support given by the Global Forum in analytical work on the 10/90 gap

The support given by the Global Forum to projects may be of different nature, depending on the most efficient and effective way for the Global Forum to support a particular action, and the opportunities presenting themselves. The main types of support are the following:

(a) Support for the financing of analytical studies: this is based on a request for proposals which is then submitted to a peer review panel; commissioned studies are undertaken following a selection process involving specialists in the field.

(b) Support for the publication of papers/monographs: documents published by the Global Forum follow a process of peer review.

(c) Support for the financing of crucial meetings, involving as many key actors as possible.

(d) Support for partnerships and networks in key areas of health research: for the reasons given in section 4.1 above (magnitude of the problems, efficiency, interdisciplinarity, synergy, global public goods), many networks have been created in the past two decades at the national, regional or global levels. Some of them can make an important contribution to the correction of the 10/90 gap. Thus the Global Forum may decide, on a case-by-case basis and based on its criteria for granting such support, to give its temporary and catalytic support to the development of some partnerships/networks in the priority areas of health research, when it is judged that such support may contribute importantly to helping correct the 10/90 gap. This support may be of different nature. For example:
    - technical support in kind may be given for the identification of partners, establishment of a core group, dissemination of information, administrative support, sessions in the annual Forum meeting, formulation of a workplan, networking
    - financial support in the form of seed money may be given for activities such as the recruitment of a consultant, financing of meetings, publications.

Thus, in summary, the analytical work studies supported by the Global Forum during the period 2003-2005 will fall in the following categories:

[19] Based on Christopher J.L. Muray and Alan D. Lopez, Global Burden of Diseases and Injury Series, op.cit.

Table 1: Overview of the Strategy "Analytical work and the 10/90 gap"
Classification of projects and studies supported by the Global Forum

Type of support: / Research on:	1 Analytical studies	2 Meetings	3 Publications	4 Networks/ partnerships
A. Development and application of priority-setting methodologies	A1	A2	A3	A4
B. Cross-cutting issues affecting health	B1	B2	B3	B4
C. Risk factors affecting health	C1	C2	C3	C4
D. Diseases and conditions	D1	D2	D3	D4

5.3 Strategy 3: Information and communication

The third strategy of the Global Forum concerns what is known about the 10/90 gap (information) and how to use this knowledge to bring about change (communication). It also concerns building the image, influence and identity of the Global Forum.

In addition to being a strategy in itself, information and communication has a role to play in all other strategies, in terms of both specific activities and indicators of success. The main components of this strategy are the following:

(a) Documents and publications

The Global Forum's flagship publication *The 10/90 Report on Health Research* is published in alternate years; the next report is planned for May 2004 (same year as the WHO World Health Report on health research). It will take into account presentations made in both Forum 6 and Forum 7 and focus on progress in helping correct the 10/90 gap. Other publications in planning include a report on Phase II of the work on monitoring financial flows (October 2003), a study on gender and the 10/90 gap, illustrated with material presented at Forum 6 (October 2003) and results of analytical work supported by the Global Forum.

Dissemination will include the distribution of documents and publications of the Global Forum and its partners (both in print and electronic form), the maintenance of accurate, up-to-date contact information on target audiences in the Global Forum's database, and further research to identify key contacts in specific target groups.

(b) Website

The Global Forum's original website was redesigned in October 2001, to include new features that have proved popular and useful for visitors. These include a listserve for news from the Global Forum, a publications order form, an automatic 'contact us' response mechanism. Future work will look at the feasibility of additional interaction with partners, strengthening the concept of the Global Forum as marketplace.

(c) Media

With the changing global political landscape and renewed interest in the relationships between health, poverty, development and global security (described in Chapter 1 of the 10/90 Report 2001-2002), usage of the term '10/90 gap' has broadened. There seems to be increased awareness of the problem in political

circles. The strategy in working with the media will continue to build relationships with leading journalists in key media and to disseminate appropriate and timely information that they might use. It is important to pursue such partnerships at the international, country and sometimes local level, focusing on relevant print, broadcast and web-based media.

(d) Representation at international meetings

The Global Forum has in the past taken the opportunity offered by a few large health-related meeting to become better known to certain target audiences. Representation has taken the form of participation in the official programme (own session, panel presentation, poster, roundtable), having a stall or booth in the conference's exhibition and/or general participation and networking. It is planned to continue such public relations activities, in combination with other specific opportunities that present themselves. The Global Forum Secretariat will continue to produce and circulate a list of international meetings of relevance to health research. Representation at international meetings will continue to be a regular agenda item for discussion with the Foundation Council and with partner networks in the hope of making best possible use of synergies.

(e) Internal communication

This includes:

- communication work directly serving other Global Forum strategies (annual forum, analytical work on the 10/90 gap)
- information flow between the Secretariat, STRATEC, the Foundation Council, networks supported by the Global Forum, donors and other close partners
- proposals for new methods of communication, where these are thought necessary
- institutional identity, i.e. sharpening the image of the Global Forum and adaptation of current material to reflect optimally a new phase in the Global Forum's existence.

The Global Forum's database and resource centre are important tools to support external and internal communication activities:

- the database is the central source of information on the Global Forum's partners; in addition, it has been developed into a meeting management system allowing the efficient and effective control, from a unique source, of information concerning participants (registration, logistics, role in programme) and programme content
- the resource centre centralizes printed material on partners, together with newly received documents and publications, for use by the Secretariat and immediate partners.

Effectiveness, efficiency and value added in the field of Communication are measured as follows:

- quality and effective distribution of information to key actors
- quality and use of the website made by Global Forum partners
- presence of the issues focusing on the 10/90 gap in the media (quantity and quality)
- presence of the 10/90 gap issues in international meetings (quality and quantity)
- cost comparisons and analysis.

5.4 Strategy 4: Monitoring and evaluation

The fourth strategy of the Global Forum to help correct the 10/90 gap is measuring results of the work of the Global Forum through the monitoring of the progress indicators listed under each of the strategies mentioned above and periodic external evaluations. In this monitoring and evaluation process, the role of the Global Forum partners is central, particularly at the country level, while that of the Global Forum Secretariat is of a catalytic nature. An external evaluation is planned to take place every five years. The next external evaluation is planned for 2006.

Chapter 6. Projects supported by the Global Forum: origin and criteria

6.1 Origin of projects

The analytical work to be supported by the Global Forum is identified in the Annual Workplan and Budget approved by the Foundation Council. The institution(s) responsible for undertaking projects are identified through a 'call for proposals' or as part of a procedure for a 'commissioned study' organized by the Secretariat. The objective of this procedure is to ensure that the Global Forum has access to the best sources of knowledge. The Global Forum actively promotes the participation of partners from the South in the analytical work and studies it supports.

A commissioned study is undertaken when the Global Forum is confronted with a specific problem in the context of its work on priority setting requiring a time-limited scientific input by one or several researchers (unlocking function to facilitate progress in a component of analytic work).

6.2 Criteria for the selection of priority areas and projects

Proposals reaching the Global Forum are evaluated by the Forum's Secretariat, before submission to STRATEC, based on the following criteria:

- Value added by the project to the correction of the 10/90 gap in health research (based on the scientific quality of the proposals and an independent peer review, as per Global Forum policy).
- Value added by the Global Forum in supporting the project (based on the comparative advantages of the Global Forum).
- Clear information on the following elements: definition of the problem, including poverty and gender issues; global and specific objectives of the project; strategies chosen to reach the stated objectives (including gender sensitivity in research design); identification of the main partners in the project; definition of the organization of the project and decision-making mechanisms; estimated costs and sources of financing; expected results and risks of the project; indicators of success and sustainability.
- Inclusiveness of as many key actors as possible in a field of activity, thus enlarging the debate to varied points of view, enriching the solutions, and decreasing the risk of duplication of efforts.
- Longer term sustainability of the project and its results (the technical and financial support given by the Global Forum is only of a temporary and catalytic nature, i.e. seed money financing).

6.3 Time-limited support

The policy of the Global Forum is to continue to support a project as long as its estimated benefits are high and promising as compared to its estimated costs (both overall costs and costs to the Forum). At each stage in the support given to a project, the Global Forum makes a critical analysis of results achieved and perspectives, based on the criteria listed under 6.2 above. The support given to a project by the Global Forum is normally limited in time (although different forms of support may be given for different time periods).

Chapter 7. Governing bodies and management

7.1 Foundation Council

The Foundation Council, composed of 20 members representing the constituencies of the Global Forum, is the highest policy- and decision-making body of the Foundation. It gives the broad orientations of the Global Forum and is responsible for the definition of its objectives and priority areas as well as its long-term vision. Its duties and powers are defined in Article 8 of the Global Forum's Statutes.

7.2 STRATEC

The Foundation Council is assisted by a Strategic and Technical Advisory Committee (STRATEC), composed of six members selected from Council members. The functions delegated by the Foundation Council to STRATEC (described in Article 3.1 of the by-laws) are twofold:

(a) Strategic functions:

- Generating new ideas: initial policy-making and strategy development. Discussions and outputs are forwarded to the Foundation Council for further deliberations and final decision-making.
- Helping to convert the broad orientations given by the Foundation Council into strategies and inputs for the Workplan and Budget prepared by the Secretariat.
- Helping the Secretariat in identifying the most efficient and effective tools for reaching the objectives of the Global Forum.
- Acting upon other specific tasks which may be delegated by the Foundation Council.

(b) Technical functions:

- Approval/disapproval of project proposals submitted by the Secretariat.
- Acting upon other specific tasks which may be delegated by the Foundation Council.

7.3 Core Secretariat

The Foundation Council and STRATEC define the objectives, policy guidelines and budget for the Secretariat which is responsible for reaching these objectives within the given policies and orientations and reporting as appropriate to the Foundation Council and STRATEC.

Chapter 8. Strategic budgets and financing

8.1 Core activities

(a) Core budget

The total approved budget for 2002 amounts to USD3.1 million. In line with the catalytic role of the Global Forum and its policy of seed money financing, it is foreseen that progression in the overall budget in the coming years will remain limited to a range of 5 to 10% per annum.

For the period 2003-2005 and in line with the new strategic emphases given by the External Evaluation Report and the Foundation Council, the annual budget distribution is planned to evolve in the following directions (Table 2) :

- **Annual Forum meeting**: a stronger accent will be placed on this component. From 16% of the total budget in 2002, it is foreseen that this component will increase in the coming years to reach possibly 20% in the period 2003-2005.
- **Analytical work on the 10/90 gap**: with the planned relative increase in the budget allocation for the Annual Meeting and the Information and Communication components, the relative share of this component in the total budget will decrease somewhat in the coming years from about 49% to 44%. It is estimated however that this may be *compensated* by an increase in co-financing. Indeed, the mobilization of co-financing for this component is relatively easier than for the Annual Meeting, Information and Communication or the Core Secretariat components. However, w*ithin* the component "Analytical work on the 10/90 gap", the share of "gender" and "research capacity strengthening" will increase, as these activities are starting from a relatively low base.
- **Information and communication:** in line with the recommendation of the External Evaluation Report and the Foundation Council, it is foreseen that the share of this component will increase in the coming years from 16% at present to 18% in 2003-2005.
- **Governing and advisory bodies:** in line with experience in recent years, it is expected that the budget for this component will decrease from 6% of the total at present to about 5% in the coming years.
- **Core Secretariat**: it is planned that the expenses under this component will remain at about 13% of the total in the coming years.

Table 2: Budget distribution 2002-2005 (in US dollars)

Budget headings	2002		2003		2004	2005
	US Dollars	% of total	US Dollars	% of total	% of total	% of total
Annual Forum Meeting	510'000	16%	657,000	20%	20%	20%
Analytical work on the 10/90 gap	1,535,000	49%	1,445,000	44%	44%	44%
Information and communication	490,000	16%	591,000	18%	18%	18%
Governing and advisory bodies	180,000	6%	164,000	5%	5%	5%
Core Secretariat	414,000	13%	428,000	13%	13%	13%
TOTAL in US dollars	3,129,000	100%	3,285,000	100%	100%	100%

(b) Core financing

The Global Forum Secretariat is presently financed by the governments of Canada, Denmark, the Netherlands, Norway, Sweden and Switzerland and the Rockefeller Foundation, the World Bank and the World Health Organization. Contacts have been made with other bilateral agencies for possible support in the future.

8.2 Activities in trust

At the request of a donor and upon approval of the Foundation Council, the Global Forum may accept extrabudgetary funds and channel them to earmarked projects. Such funds have been received in the past years from the World Bank, the Rockefeller Foundation, the Bill and Melinda Gates Foundation and the governments of the Netherlands and Canada. We distinguish between two types of in-trust funding:

- *Funds for projects supervised by the Global Forum:* the projects are managed according to the rules and regulations governing the Global Forum. The accounts of the project are audited annually by the auditing firm approved by the Global Forum.
- *Funds for projects supervised by the financing institution:* the projects are appraised, approved and supervised by the funding institution and, based on its instructions, an agreement for the channelling of the funds is prepared between the Global Forum and the beneficiary institution. The accounts of the project follow the financial rules and regulations of the beneficiary institution.

8.3 Funding for helping to correct the 10/90 gap

The correction of the 10/90 gap will require very large funding from the international community. A proposal for the creation of a research fund for the diseases of the poor was made by the Commission on Macroeconomics and Health. Such initiatives are central to the correction of the 10/90 gap and are therefore part of the mandate of the Global Forum. On a selective basis, the Global Forum is ready to participate in preparatory discussions about these funding initiatives and to contribute its views to the creation of such funds.

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Annex:
Reference list of important documents

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Global Forum for Health Research

Helping correct the 10/90 gap

List of participants

as of 1 November 2002

FORUM 6

12-15 NOVEMBER 2002

Arusha, Tanzania

List of participants

The distribution of this document is restricted to participants in Forum 6, the 2002 annual meeting of the Global Forum for Health Research.

The Information Desk at Forum 6 can provide contact details of individual participants.

The list is not for circulation outside Forum 6 and must not be used in any way for commercial purposes.

The Global Forum gratefully acknowledges the generous support of the following partner organizations in making possible the participation of colleagues from developing countries who would not otherwise have been able to come to Arusha:

- Alliance for Health Policy and Systems Research
- Canadian International Development Agency
- Council on Health Research for Development
- DANIDA
- Initiative on Cardiovascular Health Research in Developing Countries
- Initiative on Child Health and Nutrition Research
- Initiative on Public-Private Partnerships for Health
- Medicines for Malaria Venture
- Rockefeller Foundation
- Swedish International Development Cooperation Agency (SIDA/SAREC)
- World Health Organization

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Amechi Nweze

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Olugbemiro Sodeinde

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Akwaugo Onwubere
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Onyukwu Onyukwu

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APPNA SEHAT
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Student Medical Society
Mohammed Elkhazin
Khalifa Elmusharaf
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George Soule

Sequella Global Tuberculosis Foundation
Lawrence Geiter

Sidley, Austin, Brown and Wood
Richard Wilder

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University of Massachusetts
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University of Michigan
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United Nations Joint Programme on HIV/AIDS (UNAIDS), Geneva
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Com H 65.

Global Forum for Health Research

Helping correct the 10/90 gap

Programme

FORUM 6

12-15 NOVEMBER 2002

Arusha, Tanzania

Programme overview

	Tuesday 12 November	Wednesday 13 November	Thursday 14 November	Friday 15 November
7.30-9.00	*Transfers to AICC* Registration	*Transfers to AICC*	*Transfers to AICC*	*Transfers to AICC*
9.00-10.30	PLENARY OPENING AND KEYNOTE ADDRESS Vice President of Tanzania Celebrating African health research	PLENARY Measuring progress in gender issues	PLENARY Health research and development: what next after the Commission on Macroeconomics and Health and the Millennium Development Goals?	PLENARY Using research results: research synthesis as a tool to help correct the 10/90 gap
10.30-11.00	Coffee break/Marketplace			
11.00-12.30	PARALLEL SESSIONS Successes in health research: solving health problems Examples from African regions: • East Africa • Southern Africa • North Africa • West Africa	PARALLEL SESSIONS • Gender, child health and nutrition • Gender, mental health and disability • Gender and noncommunicable diseases • Gender, sexual and reproductive health • Gender, infectious and tropical diseases • Gender, work and occupational health • Violence against women	PARALLEL SESSIONS • Genomics, intellectual property rights and the 10/90 gap • Latest developments in priority-setting • Resource flows • Strategies for improving access to drugs • World Health Report 2002: Reducing risks, promoting healthy life	CLOSING PLENARY What perspectives for the 10/90 gap and what recommendations to the partners in the Global Forum?
12.30-14.00	Lunch break/Marketplace			CLOSING EVENT
14.00-15.30	PLENARY Successes in health research: mobilizing national resources	PLENARY Health research collaboration: national, regional and global health research forums	PLENARY Monitoring the results of research capacity strengthening	SITE VISIT • MOH Demographic Surveillance System
15.30-16.00	Coffee break/Marketplace			
16.00-17.30	PARALLEL SESSIONS • Debate on Asian/LAC successes in mobilizing national resources • Research by CSOs • Research on AIDS • Research to roll back malaria • TB initiatives	PARALLEL SESSIONS Regional meetings • Launch of the African Health Research Forum • Asia + Pacific Forum • Latin + Central America	PARALLEL SESSIONS • Brain drain and RCS • Debate on the evaluation framework for research capacity strengthening • Health research systems analysis • Research for policy and practice	
18.00-19.30	OPENING RECEPTION hosted by the Chair of the Global Forum for Health Research	SPECIAL INTEREST GROUPS • ACOSHED • Bangkok Action Plan • Cost-effectiveness analysis • High blood pressure in Africa: planning group • Oral health • SHARED	SPECIAL INTEREST GROUPS • Cardiovascular diseases • Child health and nutrition • ENHR • INDEPTH • International Health Research Awards • Maternal health • Mental health and neurological disorders • Measuring BoD • Public-private partnerships • Road traffic injuries • World Report on Violence	

14.00 **Registration opens.**

14.00–17.00 **Marketplace set up.**

Transfers from Forum 6 hotels to AICC (see bus schedule).

17.30–18.15 Mbayuwayu

Newcomers Session

Chair: Louis J. Currat, Executive Secretary, Global Forum for Health Research

Recommended for all those new to the Global Forum's meetings and activities.

Transfers from Forum 6 hotels to AICC (see bus schedule).

18.30–20.30 Twiga

Faculty Orientation Briefing and Reception

Chair: Louis J. Currat, Executive Secretary, Global Forum for Health Research

All faculty are requested to attend.

Transfers from AICC to Forum 6 hotels (see bus schedule).

Transfers from Forum 6 hotels to AICC (see bus schedule).
For the Opening Session, participants are required to be in their seats in Simba Hall by 8.50 at the latest.

7.00 **Registration opens.**

9.00-9.45 Simba Hall

PLENARY SESSION

Opening and Keynote Address

Co-Chairs:

- Anna Abdallah, Minister of Health of the United Republic of Tanzania
- Richard G.A. Feachem, Chair of the Foundation Council, Global Forum for Health Research; Executive Director, Global Fund to Fight AIDS, Tuberculosis & Malaria

Keynote address:

- Ali Mohamed Shein, Vice President of the United Republic of Tanzania

In the presence of Tanzanian guests including:

- Arcado Ntagazwa, Minister of State, Vice President's Office (Environment and Union Affairs)
- Pius Ng'wandu, Minister for Science, Technology and Higher Education
- Daniel Ole Njoolay, Regional Commissioner of Arusha
- Paul Lother Laiser, Mayor, Arusha Municipal Council
- Mariam J. Mwaffisi, Permanent Secretary, Ministry of Health
- Mary Mushi, Permanent Secretary, Ministry of Community Development, Women and Children
- Laurian Rwebembera, Representative of the Permanent Secretary, Ministry of Energy and Minerals
- Fred Mhalu, Chairman of the Council, National Institute for Medical Research
- Valentine Eyakuze, Former Chairman of the Council, National Institute for Medical Research

Focal Points: Louis J. Currat, Executive Secretary, Global Forum for Health Research, Andrew Y. Kitua, Director General, National Institute for Medical Research, Tanzania

9.45–10.30

Simba Hall

PLENARY SESSION

Celebrating African health research

Co-Chairs:

- Anna Abdallah, Minister of Health of the United Republic of Tanzania
- Richard G.A. Feachem, Chair of the Foundation Council, Global Forum for Health Research

The session will present African health research successes, with particular emphasis on the development of interventions by African institutions and their impact on the health of African populations, particularly the poor.

- Peter Kilima, Regional Coordinator, International Trachoma Initiative, Tanzania
  – *SAFE implementation for trachoma control with ITI support*
- Mwelecele Ntuli Malecela-Lazaro, Director, Research and Training, National Institute for Medical Research, Tanzania
  – *Research as a tool for development: the Tanzania National Lymphatic Filariasis Elimination Programme*
- Hassan Mshinda, Director, Ifakara Health Research and Development Centre, Tanzania
  – *African successes in the field of malaria*
- Kisali Pallangyo, Professor, Internal Medicine, Faculty of Medicine, Muhimbili University, Tanzania
  - *HIV/AIDS research in Tanzania 1983-2002*
- Andrew Y. Kitua, Director General, National Institute for Medical Research, Tanzania
  – *The regional and global impact of NIMR*

Rapporteur: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research
Focal Points: Louis J. Currat, Executive Secretary, Global Forum for Health Research, Andrew Y. Kitua, Director General, National Institute for Medical Research, Tanzania

10.30–11.00

Piazza and room N

Break and Marketplace

11.00-12.30

Mbayuwayu

SESSIONS IN PARALLEL

Successes in health research: solving health problems in East Africa

Co-Chairs:

- Joseph Kahamba, Senior Lecturer, Orthopaedics, Trauma and Neurosurgery, National Institute for Medical Research, Tanzania
- Joseph Shija, Chairman, Tanzania National Health Research Forum, Tanzania

This session will present health research in the East Africa region, with particular emphasis on the development of interventions and their impact on the health of African populations, particularly the poor.

- Mohamed Said Abdullah, Treasurer, National Health Research and Development Centre, Kenya
  – *The African Health Research Forum*
- Wenceslaus Kilama, Managing Trustee, African Malaria Network Trust, Tanzania Commission for Science and Technology, Tanzania
  – *From the African Malaria Vaccine Testing Network (AMVTN) to the African Malaria Network Trust (AMANET)*
- Davy Koech, Director/Chief Executive, Kenya Medical Research Institute, Kenya
  – *Achievements of the Kenyan Medical Research Institute*
- Leonard Mboera, Scientist, Infectious Disease Surveillance, Research Coordination and Promotion, National Institute for Medical Research, Tanzania
  – *Strengthening regional disease surveillance strategies*
- Raphael Owor, Director, Uganda National Health Research Organisation (UNHRO), Uganda
  – *Health research in Uganda with regional and global impact*

Focal Point and Rapporteur: Andrew Y. Kitua, Director General, National Institute for Medical Research, Tanzania

Manyara

Successes in health research: solving health problems in North Africa

Chair:

- Hossein Afzali, Deputy Minister, Research and Technology, Ministry of Health and Medical Education, Islamic Republic of Iran

The session will present health research in North Africa with particular emphasis on the development of interventions and their impact on the health of African populations, particularly the poor.

- Ahmed Mandil, Professor, Epidemiology, High Institute of Public Health, Alexandria University, Egypt
  – *HIV/AIDS pandemic: a North African profile*
- Hoda Rashad, Director, Social Research Centre, American University in Cairo, Egypt
  – *From research to action: the Egyptian experience*
- Elsheikh Mahgoub, Professor, Microbiology & Parasitology, University of Khartoum, Sudan
  – *Successful research initiatives amidst meagre resources and civil conflict*

Rapporteur: Samia Yousif Idris Habbani, Officer in Charge, Technical Staff, WHO, Sudan
Focal Point: Elsheikh Mahgoub, Professor, Microbiology & Parasitology, University of Khartoum, Sudan

11.00–12.30

Twiga

Successes in health research: solving health problems in West Africa
Succès dans la recherche en santé: résoudre les problèmes en Afrique occidentale

The session will take place in English and French. La séance se déroulera en français et en anglais.

Co-Chairs:

- Fred Binka, Executive Director, INDEPTH Network, Ghana
- *to be announced*

The session will present health research in West Africa with particular emphasis on the development of interventions and their impact on the health of the African populations, particularly the poor.
La séance aura pour but de présenter la recherche en Afrique occidentale, en particulier en ce qui concerne le développement d'interventions et leur impact sur la santé des populations africaines.

- Fred Binka, Executive Director, INDEPTH Network, Ghana
  – *Vitamin A supplementation and child mortality in Ghana*
- Salimata Ki/ Ouédraogo, Responsible Officer, Health Research, Research and Planning Directorate, Ministry of Health, Burkina Faso
  – *La recherche en santé au Burkina Faso*
- Martyn Teyha Sama, Principal Research Officer, Centre of Medical Research, Epidemiology, Institute of Medical Research, Cameroon
  – *Community-directed treatment with ivermectin: a control strategy for onchocerciasis in Africa*

Focal Points and Rapporteurs: Fred Binka, Executive Director, INDEPTH Network, Ghana; Absatou Soumare N'Diaye, Head of Epidemiology Service, Institute of Public Health Research, National Institute of Public Health Research, Mali

Tausi

Successes in health research: solving health problems in Southern Africa

The session will present health research in the Southern Africa region with particular emphasis on the development of interventions and their impact on the health of African populations, particularly the poor.

Details to be announced

Focal Point: Marian E. Jacobs, Director, Child Health Unit, School of Child and Adolescent Health, University of Cape Town, South Africa

12.30–14.00

Free time over lunch

A self-service buffet is available in the ground-floor restaurant of the AICC.

Participants are encouraged to visit the Marketplace, join informal groups or set up their own meetings. A gender group will meet over lunch in the garden behind the restaurant (Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom). All are welcome.

14.00–15.30

Simba Hall

PLENARY SESSION

Successes in health research: mobilizing national resources

Co-Chairs:

- Richard G.A. Feachem, Chair of the Foundation Council, Global Forum for Health Research
- Adolfo Martinez-Palomo, Director General, Center for Research and Advanced Studies, Mexico

The session will present success stories on the mobilization of national resources to conduct health research from some Latin American and Asian countries and the reasoning behind measuring resource flows.

- Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research
  – *Why measure resources for health research?*
- Nirmal K. Ganguly, Director-General, Indian Council of Medical Research, India
  – *The experience in India*
- Cesar Jacoby, Consultant, Health Science and Technology, Ministry of Health, Brazil
  – *Successes in health research: mobilizing national resources in Brazil*
- Wiput Phoolcharoen, Director, Health Systems Research Institute (HSRI), Thailand
  – *The experience in Thailand*

Rapporteurs: Veloshnee Govender, Public Health Specialist, Global Forum for Health Research; Alison Young, International Health Consultant

Focal Point: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

15.30–16.00

Piazza and room N

Break and Marketplace

16.00-17.30

Manyara

SESSIONS IN PARALLEL

Successes in mobilizing national resources in Asia and Latin America: what did we learn?

Chair:
- Adolfo Martinez-Palomo, Director General, Center for Research and Advanced Studies, Mexico

Following on from the plenary, this session will present practical experiences of fundraising activities by national programmes for health research.

- Jorge Arriagada-Caceres, Executive Secretary, National Council on Health Research, Chile
  – *Health research profile of Chile*
- Gloria Ines Palma Alvarez, Head, National Program of Science &Technology in Health, Subdirection of Science and Technology, Consejo Nacional de Ciencia y Tecnologia, Colombia
  – *An alternate pathway for funding health research in Colombia*
- Bienvenido P. Alano, President, Center for Economic Policy Research, Philippines (*to be confirmed)*

Rapporteur: Alison Young, International Health Consultant
Focal Point: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

Tausi

Research by civil society organizations

Co-Chairs:
- Zafrullah Chowdhury, Projects Coordinator, Finance and Administration, Gonoshasthaya Kendra, Bangladesh
- Timothy G. Evans, Director, Health Equity Program, Rockefeller Foundation, USA

The session will review examples of research conducted by civil society organizations and the use of their results in programme formulation.

- Mushtaque Chowdhury, Deputy Executive Director, Research and Evaluation Division, Bangladesh Rural Advancement Committee (BRAC), Bangladesh
  – *Do poverty alleviation programmes reduce inequities in health? Evidence from Bangladesh*
- Bernard Pecoul, Director, Campaign for Access to Essential Medicines, Médecins sans Frontières (MSF), Switzerland
  – *Stimulating research and development for drugs for neglected diseases*
- Margareta Skold, External Relations Officer, Civil Society Initiative, External Relations and Governing Bodies, World Health Organization, Geneva
  – *Research on civil society organizations and health*
- David Sanders, Professor, Director, School of Public Health, University of Western Cape, South Africa
  – *Participatory research and advocacy improve malnutrition management and household food security in rural South Africa*

Rapporteur: Veloshnee Govender, Public Health Specialist, Global Forum for Health Research
Focal Point: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

16.00–17.30

Mbayuwayu

Research on HIV/AIDS

Chair:

- Jose Esparza, Coordinator, Vaccines and Biologicals, United Nations Joint Programme on HIV/AIDS (UNAIDS), Geneva

The session will focus on research priorities and the factors influencing implementation of research in policy.

- Jose Esparza, Coordinator, Vaccines and Biologicals, United Nations Joint Programme on HIV/AIDS (UNAIDS), Geneva
  – *Research priorities in HIV/AIDS*
- Geeta Rao Gupta, President, International Center for Research on Women, USA
  – *Gender perspective in HIV research*

Rapporteur: Abdel Ghaffar, Public Health Specialist, Global Forum for Health Research
Focal Point: Jose Esparza, Coordinator, Vaccines and Biologicals, United Nations Joint Programme on HIV/AIDS (UNAIDS), Geneva

Themi

Research to roll back malaria

Chair:

- Wenceslaus Kilama, Managing Trustee, African Malaria Network Trust, Tanzania Commission for Science and Technology, Tanzania

The session will review research inputs into programme formulation to help roll back malaria, identify research gaps where work is needed to improve control efforts.

- Achille Benakis, Professor, Phamacology, Centre Médical Universitaire de Genève, Switzerland
  – *Research opportunities with Artemesia annua*
- J. Carl Craft, Chief Scientific Officer, Research & Development, Medicines for Malaria Venture, Switzerland
  – *Overview on malaria research*

Focal Point and Rapporteur: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

16.00–17.30

Twiga

TB research and initiatives

Chair:

- Giorgio Roscigno, Senior Advisor, Director of Strategic Development, Global Alliance for TB Drug Development, USA

The session will review strategies and research initiatives aiming at improving TB control, evaluate strategies to increase access and treatment for TB patients, identify the limitations of current approaches and ways in which research will increase the impact of TB control programmes.

- Jacob Kumaresan, Executive Secretary, Stop Tuberculosis Partnership Secretariat, World Health Organzation, Geneva
  – *The Stop TB partnership and friends. initiatives to support research and disease control*
- Thelma Narayan, Coordinator, Community Health Cell, India
  – *Bridging implementation gaps in national TB control programmes: a policy process approach*
- Giorgio Roscigno, Senior Advisor, Director of Strategic Development, Global Alliance for TB Drug Development, USA
  – *A global overview of strategies and research initiatives to increase reaching TB patients*

Rapporteur: Walter H. Gulbinat, International Health Consultant

Focal Point: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

18.00–19.30

Piazza

Opening Reception

Richard G.A. Feachem, Chair of the Foundation Council, Global Forum for Health Research, invites all participants to a Reception, with African entertainment.

Transfers from AICC to Forum 6 hotels (see bus schedule).

Transfers from Forum 6 hotels to AICC (see bus schedule).

7.00 **Registration opens.**

9.00–10.30 PLENARY SESSION

Simba Hall

Measuring progress in gender issues

Co-Chairs:

- Christina Zarowsky, Senior Scientific Adviser, Program and Partnership Branch, International Development Research Centre, Canada
- Andrew Kitua, Director General, National Institute for Medical Research, Tanzania

The session will identify the progress made and the challenges remaining in the integration of gender into health research.

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom
  – *Overview of progress 1990 to 2002*
- Ruth Bonita-Beaglehole, Director, Surveillance (CCS), Noncommunicable Diseases and Mental Health (NMH), World Health Organization, Geneva
  – *The prevention and control of chronic diseases: a gender perspective*
- Geeta Rao Gupta, President, International Center for Research on Women, USA
  – *Gender issues in HIV/AIDS research*
- Barbara Klugman, Senior Specialist, Women's Health Project, School of Public Health, Witwatersrand University, South Africa
  – *Revaluing research priorities: challenges of mainstreaming gender in health research*

Focal Point and Rapporteur: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

10.30–11.00 **Break and Marketplace**

Piazza and room N

11.00–12.30

SESSIONS IN PARALLEL

Mbayuwayu

Gender and child health research

Chair:
- Mary Ann Lansang, Executive Director, INCLEN Trust, Philippines

The session will discuss the need for gender-sensitive programmes and review the role of research on gender for programme formulation.

- Shally Awasthi, Professor, Paediatrics, King George Medical College, India
  – *Access to health services for the child from a gender perspective*
- Marien E. Jacobs, Director, Child Health Unit, School of Child and Adolescent Health, University of Cape Town, South Africa
  – *Rights perspective on child health research*
- Shafika Nasser, Professor, Public Health & Nutrition, Faculty of Medicine, University of Cairo, Egypt
  - *Child health: a gender perspective*

Rapporteurs: Zulfiqar Bhutta, Professor of Child Health, Paediatrics, Aga Khan University Hospital, Pakistan; Veloshnee Govender, Public Health Specialist, Global Forum for Health Research
Focal Points: Sameera Al-Tuwaijri, Forum Scientific Officer, Global Forum for Health Research; Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

Twiga

Gender and infectious and tropical diseases

Chair:
- Martine Berger, Special Advisor on Public Health, Multilateral Affairs Section, Swiss Agency for Development and Cooperation, Switzerland

with:
- Uche Amazigo, Chief, Sustainable Drug Distribution Unit, African Onchocerciasis Control, WHO Regional Office for Africa (WHO/AFRO), Burkina Faso
  – *Promoting gender sensitivity in community-directed tropical disease control programmes: the case of onchocerciasis*
- Jeannine Coreil, Professor, Community and Family Health, University of South Florida, USA
  – *Women's support groups for chronic tropical diseases*
- Rachel Tolhurst, Research Associate, International Health Research Group, Liverpool School of Tropical Medicine, United Kingdom
  – *Researching gender issues in malaria management: a case study from the Volta region of Ghana*

Rapporteur: to be announced
Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

11.00-12.30

Dikdik

Gender and noncommunicable diseases

Chair:
- Nikolai Napalkov, Director Emeritus, N.N. Petrov Research Institute of Oncology, Russian Federation

with:
- Nicola Christofides, Project Manager, Women's Health Project, South African Institute for Medical Research, South Africa
  – *Why gender issues are an essential component in any research strategy relating to tobacco use in developing countries*
- Teresinha Da Silva, Consultant, Legal and Judiciary Training Centre, Mozambique
  – *Elder abuse as a public health problem*
- Kate Hunt, Senior Research Scientist, MRC Social and Public Health Sciences Unit, Glasgow University, United Kingdom
  – *Sex, gender and coronary heart disease: the geographical distribution of recent evidence*

Rapporteur: to be announced

Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

Manyara

Gender, mental health and disability

Chair:
- Rashidah Abdullah, Director, Asian-Pacific Resource & Research Centre for Women, Malaysia

with:
- Florence Baingana, Mental Health Specialist, Human Development Network, Health, Nutrition and Population, World Bank, USA
  – *The importance of gender in understanding trends in health and illness in transition societies*
- Paul Courtright, Co-Director, Kilimanjaro Centre for Community Ophthalmology, Tanzania
  – *Do women have less access to cataract surgical services?*
- Vikram Patel, Senior Lecturer, London School of Hygiene and Tropical Medicine, United Kingdom
  – *Gender and mental health research in developing countries*

Rapporteur: to be announced

Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

11.00–12.30

Tausi

Gender, sexual and reproductive health

Chair:
- Adrienne Germain, President, International Women's Health Coalition, USA

with:
- Geetanjali Misra, Director, Creating Resources for Empowerment in Action, India
  – *Developing a gender-sensitive research strategy for sexual and reproductive health*
- Charles Nzioka, Professor, Sociology, University of Nairobi, Kenya
  – *Understanding the role of men in reproductive health research*
- Naana Otoo-Oyortey, Technical Officer, Gender and Youth, International Planned Parenthood Federation, United Kingdom
  – *The sexual and reproductive health of young people: research and programme issues*
- Sonia Pagliusi Uhe, Scientist, Vaccines and Biologicals, Health Technology and Pharmaceuticals, World Health Organization, Geneva
  – *Development of human papillomavirus vaccines for prevention of cervical cancer: a powerful tool to improve global women's health*

Rapporteur: to be announced
Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

Kagera

Gender, work and occupational health

Chair: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

with:
- Sophia Kisting, Chief Researcher, Occupational & Environmental Health Research Unit, School of Public Health and Primary Health Care, University of Cape Town, South Africa
  – *Gender, work and aspects of the African joint effort of WHO/ILO in occupational health and safety*
- Sally Theobald, Lecturer, International Health, Liverpool School of Tropical Medicine, United Kingdom
  – *Gender and work: who does the caring in the community and at what cost?*
- Suchart Trakoonhutip, Project Coordinator, Friends of Women Foundation, Thailand
  – *Research to promote better health for electronics workers: lessons from Northern Thailand*

Rapporteur: to be announced
Focal Point: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

11.00–12.30

Themi

Violence against women

Chair:

- June Pagaduan-Lopez, Associate Professor, Psychiatry and Behavior Medicine, College of Medicine, De La Salle University, Philippines

with:

- Claudia Garcia-Moreno, Coordinator, Gender and Women's Health, Family and Community Health, World Health Organization, Geneva
  – *The prevalence of sexual violence in four countries: first results from the WHO Multi-Country Study on Women's Health and Domestic Violence*
- Mary Koss, Professor, Health Promotion Sciences, University of Arizona College of Public Health, USA
  – *Conducting gender-based violence research in conflict-afflicted populations: lessons from two pilot sites*
- Lillian Liberman, Chairperson, Yaocihuatl A.C., Mexico
  – *Proposal of a model to prevent physical, emotional and sexual abuse in children*
- Matthew Shaw, Research Fellow, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom
  – *A qualitative evaluation of the impact of the Stepping Stones sexual health programme on domestic violence and relationship power in rural Gambia*

Rapporteur: Sameera Al-Tuwaijri, Forum Scientific Officer, Global Forum for Health Research
Focal Point: Claudia Garcia-Moreno, Coordinator, Gender and Women's Health, World Health Organization, Geneva

12.30–14.00

Free time over lunch

A self-service buffet is available in the ground-floor restaurant of the AICC.

Participants are encouraged to visit the Marketplace, join informal groups or set up their own meetings. A group will meet on strengthening mental and neurological research in the Tausi room (Focal Point: Florence Baingana, Mental Health Specialist, Human Development Network, Health, Nutrition and Population, World Bank, Washington, DC). All are welcome.

14.00–15.30

Simba Hall

PLENARY SESSION

Health research collaboration: national, regional and global health research forums

Chair:

- Carlos M. Morel, Director, Special Programme for Research and Training in Tropical Diseases (TDR), Geneva

The session will present the progress made in the past two years in health research collaboration efforts at the regional and global levels.

- Mutuma Mugambi, Principal Vice-Chancellor, Kenya Methodist University, Kenya
  – *The African Health Research Forum*
- Agus Suwandono, Secretary, National Institute of Health Research and Development, Indonesia
  – *The Asia-Pacific Health Research Forum*
- Delia Maria Sanchez, Researcher/ Head, Health Technology Assessment Unit, Grupo de Estudios en Economia Organizacion y Politicas Sociales (GEOPS), Uruguay
  – *Collaboration efforts in the Latin American and Caribbean region*
- Gerald T. Keusch, Director, Fogarty International Center, USA
  – *Collaboration between international research organizations*
- John Frank, Scientific Director, Institute of Population and Public Health, Canadian Institutes of Health Research (CIHR) and Jerry M. Spiegel, Director, Global Health, Liu Centre for the Study of Global Issues, University of British Columbia, Canada
  – *The Canadian experience: the Coalition for Global Health Research*
- Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva
  – *International health research collaboration efforts: post-Bangkok review*

Rapporteur: Happiness Minja, Research Officer, Council on Health Research for Development (COHRED), Switzerland
Focal Points: Louis J. Currat, Executive Secretary, Global Forum for Health Research; Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland

15.30–16.00

Piazza and room N

Break and Marketplace

16.00–17.30

Simba Hall

SESSIONS IN PARALLEL

Launch of the African Health Research Forum

Chair:

- Raphael Owor, Director, Uganda National Health Research Organisation (UNHRO), Uganda

This session will mark the launch of the African Health Research Forum, whose overall goal is to promote health research for development in Africa and strengthen the African voice in setting and implementing the global research agenda.

- Mohamed Said Abdullah, Treasurer, National Health Research and Development Centre, Kenya
  – *The African health research leadership*
- Ahmed El Hassan, Professor, Pathology and Immunology, Institute of Endemic Diseases, University of Khartoum, Sudan
  – *North-South collaboration in health research: an appraisal of the collaboration between Sudan and Denmark*
- Lawrence Gikaru, Member of the Steering Committee, African Health Research Forum
  – *Using the tools of advocacy to strengthen the work of the African Health Research Forum*
- Rose Leke, Associate Professor of Parasitology and Immunology, Faculty of Medicine and Biomedical Sciences, University of Yaounde, Cameroon
  – *Ethics in research in Africa*
- William M. Macharia, Associate Professor of Paediatrics, Department of Paediatrics, University of Nairobi, Kenya
  – *African Health Research Forum survey on existing regional health research networks*

Rapporteur: Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research

Focal Point: Mutuma Mugambi, Principal Vice-Chancellor, Kenya Methodist University, Kenya

16.00-17.30

Mbayuwayu

Asia and Pacific Health Research Forum

Chair:

- Charas Suwanwela, Chair of the University Council, Chulalongkorn University, Thailand

This session will present the collaboration efforts undertaken by the Asia and Pacific Health Research Forum in the past years, results to date and perspectives for the coming years.

- Agus Suwandono, Secretary, National Institute of Health Research and Development, Indonesia
  – *The Asia and Pacific Health Research Forum and national health research efforts*
- Somsak Chunharas, Director, Department of Medical Sciences, National Institute of Health, Ministry of Public Health, Thailand
  – *The Thai Research Fund*
- Bakhytkul Sarymsakova, Professor, Health Policy and Management, Kazakhstan School of Public Health, Kazakhstan
  – *The Central Asia Health Research Forum*
- Bienvenido P. Alano, President, Center for Economic Policy Research, Philippines
  – *Networking of health research systems in the Philippines and Asia Pacific region*
- Gopal Prasad Acharya, Chairman, Nepal Health Research Council, Nepal
  – *The role of the Nepal Health Research Council*
- Jan Pryor, Secretary, Pacific Health Research Council, Fiji
  – *Health research in the Pacific Islands*

Rapporteurs: Adnan Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA; Wiput Phoolcharoen, Director, Health Systems Research Institute (HSRI), Thailand
Focal Point: Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland

16.00–17.30

Tausi

Latin American and Caribbean health research collaboration

Co-Chairs:

- Jorge Arriagada-Caceres, Executive Secretary, National Council on Health Research, Chile
- Delia Maria Sanchez, Researcher/ Head, Health Technology Assessment Unit, Grupo de Estudios en Economia Organizacion y Politicas Sociales (GEOPS), Uruguay

The session will present collaboration efforts undertaken in the Latin American and Caribbean region in the past years, results to date and perspectives for the coming years.

- Delia Maria Sanchez, Researcher/ Head, Health Technology Assessment Unit, Grupo de Estudios en Economia Organizacion y Politicas Sociales (GEOPS), Uruguay
  – *Introduction: health research collaboration and networking in Latin America and the Caribbean*
- Ernesto Medina Sandino, President, Nicaragua Universidad Nacional Autonoma, Nicaragua
  – *Health research collaboration in Central America*
- David Picou, Director of Research, Caribbean Health Research Council
  – *Networking for health research in the Caribbean: experiences of the Caribbean Health Research Council*
- Cesar Hermida, Executive Director, National Association of Faculties of Medicine, Ecuador
  – *Health research in Ecuador*
- Eric Martinez-Torres, Director, Division of Science and Technology, Ministry of Public Health, Cuba
  – *Health research in Cuba*

Rapporteur: Izzy Gerstenbluth, Head, Epidemiology and Research Unit, Medical and Public Health Service, Curaçao, Netherlands Antilles

Focal Points: Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland, Delia Maria Sanchez, Researcher/Head, Health Technology Assessment Unit, Grupo de Estudios en Economia Organizacion y Politicas Sociales (GEOPS), Uruguay

Transfers from AICC to Forum 6 hotels (see bus schedule).

18.00–19.30

Themi

BUSINESS MEETINGS AND SPECIAL INTEREST GROUPS

ACOSHED: initial experience and future prospects

Chair:

- Demissie Habte, Consultant Health Specialist, African Region, Human Development, World Bank, USA

The session will present the initial experience of the African Council for Sustainable Health Development (ACOSHED) and its work on advocacy for health reform and systems development in Africa. Participants will learn of the key programmes in the strategic plan of ACOSHED's International Secretariat and of guidelines for accreditation and operations of country chapters.

- Miguel Gonzalez-Block, Manager, Alliance for Health Policy and Systems Research, Switzerland
  – *An evaluation of the initial experience*
- Lola Dare, Executive Secretary, African Council for Sustainable Health Development, Nigeria
  – *Highlights of the Strategic Plan*
- James Volmink, Director, Research and Analysis, Global Health Council, USA
  – *Prospects for contribution to health policy and systems reform*

Rapporteurs: Olamide Bandele, Secretary, Administration, Center for Health Sciences Training, Research and Development (CHESTRAD) International, Nigeria; Kolawole Faleye, Malaria Control Officer, Malaria Control, Ministry of Health - Ekiti State, Nigeria

Focal Point: Lola Dare, Executive Secretary, African Council for Sustainable Health Development, Nigeria

18.00–19.30

Kagera

High blood pressure in Africa: planning for programme-relevant research

Co-Chairs:

- Arun Chockalingam, Assistant Director, Institute of Circulatory and Respiratory Health, Canada
- George Mensah, Chief, National Center for Chronic Disease, Cardiovascular Health Branch, Centers for Disease Control and Prevention (CDC), USA

The objective of the session is to strengthen planning for operational research relevant to prevention and control of high blood pressure, especially as appropriate to the African context.

- K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India
  – *Introduction*
- Daniel Lemogoum, Cardiologist and Epidemiologist, Preventive Cardiology, School of Public Health, University of Yaounde, Cameroon
  – *How to improve hypertension care in sub-Saharan Africa*
- Ivor J. Katz, Head of Department, Nephrology, Commission on Global Advancement of Nephrology, South Africa
  – *Hypertension and diabetes in Africa*
- Shanthi Mendis, Coordinator, Cardiovascular Diseases, World Health Organization, Geneva
  – *WHO Cardiovascular Risk Assessment and Management Package*
- Ruth Bonita-Beaglehole, Director, Surveillance (CCS), Noncommunicable Diseases and Mental Health (NMH), World Health Organization, Geneva
  – *Integrating NCD surveillance into HBP research*

Discussants:

- Marie-Danielle Comeau, Doctor, Union des Médecins Haïtiens, Haïti
- Hervé Koffi Yangni-Angate, Chairman, Department of Cardiovascular Disease, University of Bouaké, Côte d'Ivoire
- Akwaugo Onwubere, Assistant Chief Public Health Nurse, Community Medicine, Health Visiting Unit, University of Nigeria, Nigeria

Focal Point/Rapporteur: K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India

18.00-19.30

Tausi

Implementation of the Bangkok Action Plan: a report from the Interim Working Party Secretariat

Chair:

- Marian E. Jacobs, Director, Child Health Unit, School of Child and Adolescent Health, University of Cape Town, South Africa

with:

- Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva
  – *Review of progress since the 2000 Bangkok Conference*

Focal Point and Rapporteur: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

Dikdik

Partnerships in oral health

Chair:

- Lois Cohen, Associate Director, International Health, National Institute of Dental and Craniofacial Research, USA

The session aims to raise awareness about international collaborative research opportunities related to oral health.

- Lois Cohen, Associate Director, and Kevin Hardwick, International Health Officer, National Institute of Dental and Craniofacial Research, USA
  – *Opportunities for global partnerships for research: the case of the WHO Collaborating Center for International Collaboration in Dental and Craniofacial Research*

Focal Point and Rapporteur: Lois Cohen, Associate Director, International Health, National Institute of Dental and Craniofacial Research, USA

18.00-19.30

Mbayuwayu

SHARED: Scientists for Health and Research for Development

Chair:

- Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research

Progress in the SHARED network: what is happening at the regional level.

- Agnes Soares da Silva, Scientific Secretary, SHARED, Netherlands Organization for Scientific Research (NWO), Netherlands
  – *Introduction to the SHARED network*
- Bienvenido P. Alano, President, Center for Economic Policy Research, Philippines
  – *SHARED Asia*
- Olive Shisana, Executive Director, Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, South Africa
  – *SHARED Africa*
- Jorge Walters, Coordinator, Information Technology & System Development, BIREME WHO, Brazil
  – *SHARED Latin America and the Caribbean*

Rapporteur: Stephen Chandiwana, Coordinator, Social Aspects of HIV/AIDS Research Alliance, Human Sciences Research Council, South Africa
Focal Point: Agnes Soares da Silva, Scientific Secretary, SHARED, Netherlands Organization for Scientific Research (NWO), Netherlands

Manyara

WHO-CHOICE: choosing interventions that are cost-effective

Chair: Tessa Tan-Torres Edejer, Coordinator, Global Programme on Evidence for Health Policy, World Health Organization, Geneva

This session will present the framework, methodology and results of WHO-CHOICE and elicit expressions of interest from participants.

- Raymond Hutubessy, Economist, Global Programme on Evidence for Health Policy, World Health Organization, Geneva
  – *Application of WHO-CHOICE in the field of cardiovascular diseases: model, costs and results*
- Tessa Tan-Torres Edejer, Coordinator, Global Programme on Evidence for Health Policy, World Health Organization, Geneva
  – *WHO-CHOICE: presentation of framework and methods*

Rapporteur: Veloshnee Govender, Public Health Specialist, Global Forum for Health Research
Focal Point: Tessa Tan-Torres Edejer, Coordinator, Global Programme on Evidence for Health Policy, World Health Organization, Geneva

Transfers from AICC to Forum 6 hotels (see bus schedule).

Transfers from Forum 6 hotels to AICC (see bus schedule).

7.00

Registration opens.

9.00–10.30

Simba Hall

PLENARY SESSION

Health research and development: what issues after the 2001 Report of the Commission on Macroeconomics and Health and the Millennium Development Goals

Co-Chairs:

- Timothy G. Evans, Director, Health Equity Program, Rockefeller Foundation, USA
- *to be announced*

The session will explore and debate some of the main issues after the Report of the Commission on Macroeconomics and Health and the Millennium Development Goals.

- Jozef Ritzen, Vice President, Human Development Network, World Bank, Washington DC
  – *How difficult will it be to reach the Millennium Development Goals?*
- Gerald T. Keusch, Director, Fogarty International Center, USA
  – *Global health research funding: an exploration of the options*
- Sergio Spinaci, Executive Secretary, Commission on Macroeconomics and Health, World Health Organization, Geneva
  – *Country responses to the CMH Report and the way forward*
- David Sanders, Professor, Director, School of Public Health, University of Western Cape, South Africa and Ronald Labonté, Director, Saskatchewan Population Health and Evaluation Research Unit, Canada
  – *A report card on G8 health and development commitments*

Rapporteur: Susan Jupp, Senior Communication Officer, Global Forum for Health Research
Focal Points: Louis J. Currat, Executive Secretary, Global Forum for Health Research; Sergio Spinaci, Executive Secretary, Commission on Macroeconomics and Health, World Health Organization, Geneva

10.30–11.00

Piazza and room N

Break and Marketplace

11.00–12.30

SESSIONS IN PARALLEL

Tausi

Genomics, the 10/90 gap and intellectual property rights

Chair:
- Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva

with:
- Sandy Thomas, Director, Nuffield Council on Bioethics, United Kingdom
  – *Intellectual property rights and health: patents, medicines and DNA*
- Janis Lazdins-Helds, Scientist, Product Research and Development (PRD), Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland
  – *Issues emerging from the Conference on Biotechnology and Genomics (Havana, Cuba, March 2002)*

Rapporteur: to be announced
Focal Points: Janis Lazdins-Helds, Scientist, Product Research and Development (PRD), Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland; Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva

Twiga

Latest developments in priority-setting

Chair:
- Carlos M. Morel, Director, Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland

The session will review experiences using priority-setting methods and explore future global agendas for health research.

- Tasleem Akhtar, Chair and Executive Director, Pakistan Medical Research Council, Pakistan
  – *Priority setting for health research: the Pakistan experience*
- Gerald T. Keusch, Director, Fogarty International Center, USA
  – *Disease control priorities project*
- Jan H.F. Remme, Manager, Research Strategic Planning, Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland
  – *TDR's priority setting framework for tropical diseases research*

Rapporteurs: Abdul Ghaffar, Public Health Specialist, Global Forum for Health Research; Walter H. Gulbinat, International Health Consultant
Focal Point: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

11.00–12.30

Themi

Monitoring resource flows

Chair: Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

The session will review progress on monitoring financial flows for health research and familiarize participants with operational issues on the measurement of financial flows.

- Armen Gazaryan, Director, Economy, Forum on Health Research for Development, Uzbekistan
  – *Solutions to practical barriers in the implementation of country studies in Uzbekistan*
- Andrew Kennedy, Statistician, Research Policy and Cooperation, World Health Organization, Geneva
  – *Global approach to estimate resource flows at the country level*
- Grant Lewison, Head, Bibliometrics Research Group, Information Science, City University, United Kingdom
  – *A bibliometric approach to estimating malaria research funding*
- Bienvenido P. Alano, President, Center for Economic Policy Research, Philippines
  – *Methods for detailed country studies*

Rapporteurs: Veloshnee Govender, Public Health Specialist, Global Forum for Health Research; Alison Young, International Health Consultant
Focal Points: Bienvenido P. Alano, President, Center for Economic Policy Research, Philippines; Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

Mbayuwayu

New strategies for improving access to drugs, vaccines and other products for health

Chair:
- John Kilama, President, Global Biodiversity Institute, USA

The session will review new approaches to improving access to health products, particularly at country level.

- Abaneh Tamar Desta, Technical Officer, Essential Drugs and Medicines Policy, WHO Regional Office for Africa, Brazzaville
  – *Evolving strategies for assuring access to essential drugs in Africa*
- Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Geneva
  – *Public-private partnerships in developing – and improving access to – new drugs and vaccines*
- Liza Kimbo, Executive Director, Cry for World Shops, Sustainable Health Enterprises Foundation, Kenya
  – *Essential drug franchising in East Africa*
- Richard Wilder, Attorney at Law, Sidley, Austin, Brown and Wood, USA
  – *Managing intellectual property to achieve access to new medicines for all*

Focal Point and Rapporteur: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Geneva

11.00–12.30

Manyara

World Health Report 2002: Reducing risks, promoting healthy life

Chair:

- Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

The objectives of the session are to understand the conceptual basis of comparative risk assessment globally; to review the results for selected risk factors at the global level; and to discuss specific methodological issues in applying burden of disease methods to risk factors.

- Tessa Tan-Torres Edejer, Coordinator, Global Programme on Evidence for Health Policy, World Health Organization, Geneva
  – *Cost-effectiveness analysis: WHR 2002*
- Majid Ezzati, Fellow, Risk, Resource, and Environmental Management, Resources for the Future, USA
  – *Comparative risk assessment and the World Health Report 2002*

Discussant:

- Vendhan Gajalakshmi, Consultant Epidemiologist, Epidemiological Research Centre, India

Focal Point and Rapporteur: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

12.30–14.00

Free time over lunch

A self-service buffet is available in the ground-floor restaurant of the AICC.

Participants are encouraged to visit the Marketplace, join informal groups or set up their own meetings.

14.00–15.30

Simba Hall

PLENARY SESSION

Monitoring the results of research capacity strengthening

Co-Chairs:

- Barbro Carlsson, Senior Research Officer, Division for Thematic Research, Department for Research Cooperation, Swedish International Development Cooperation Agency, Sweden
- Demissie Habte, Consultant Health Specialist, African Region, Human Development, World Bank, Washington DC

The objectives of this session are to present and discuss the framework for evaluation of research capacity strengthening and the results of three completed research programmes that address different aspects of research capacity development.

- Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research
  – *Framework for evaluating research capacity strengthening: measuring impact*
- Demissie Habte, Consultant Health Specialist, African Region, Human Development, World Bank, Washington DC
  – *The crisis of human resources for health research and health care: a call for action*
- Carel B. Ijsselmuiden, Director, School of Health Systems and Public Health, University of Pretoria, South Africa
  – *AfriHealth: increasing public health capacity in Africa*
- Bente Ilsoe, Programme Administrator, The ENRECA Programme, Danish International Development Agency, Denmark
  – *Partnerships as a tool for RCS: twelve years of DANIDA's ENRECA programme*
- Aberra Geyid, Director, Ethiopian Health and Nutrition Research Institute, Ethiopia
  – *Research capability strengthening in support of AIDS research in Ethiopia*

Rapporteur: Eduard Sanders, Programme Manager, Ethiopian Netherlands AIDS Research Project, Ethiopia
Focal Point: Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research

15.30–16.00

Piazza and room N

Break and Marketplace

16.00-17.30

Themi

SESSIONS IN PARALLEL

Debate on the evaluation/monitoring framework for research capacity strengthening

Co-Chairs:

- Joel G. Breman, Senior Scientific Advisor, International Epidemiology and Population Studies, Fogarty International Center, USA
- Lindiwe E. Makubalo, Cluster Manager, Department of Health, Information, Evaluation and Research, Ministry of Health, South Africa

As a follow-up to the plenary, the session will further discuss the framework for the evaluation of research capacity strengthening and indicators for measurement.

- Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research
  – *Introduction*
- Tasleem Akhtar, Chair and Executive Director, Pakistan Medical Research Council, Pakistan
  – *Health research capacity in Pakistan. An evaluation of the research performance of doctoral level health professionals*
- Olusola Gbotosho, Senior Lecturer, Malaria Research Laboratory, Postgraduate Institute for Medical Research and Training, University of Ibadan, Nigeria
  – *Reviewing the MIM/TDR antimalarial drug resistance network: is research capacity being developed?*

Discussants:

- Howard D. Engers, Director, Armauer Hansen Research Institute, Ethiopia
- Phyllis Freeman, Professor, Law Center, College of Public and Community Service, University of Massachusetts, USA

Rapporteur: Olumide A.T. Ogundahunsi, Scientist, Research Capability Strengthening, Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland
Focal Point: Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research

16.00-17.30

Mbayuwayu

Brain drain and research capacity strengthening

Co-Chairs:

- Nirmal K. Ganguly, Director-General, Indian Council of Medical Research, India
- Ragna Valen, Director, Department of Medicine and Health, Research Council of Norway, Norway

The session will present the results of studies on trainees' return rates over the last decade. A discussion on what to do about this problem will incorporate participants' recommendations.

- Demissie Habte, Consultant Health Specialist, African Region, Human Development, World Bank, Washington DC
  – *The problem of brain drain*
- Linda Kupfer, Evaluation Officer, Advanced Studies and Policy Analysis, Fogarty International Center, USA
  – *Strategies to prevent brain drain*
- Nancy Gore Saravia, Executive Director, Corporacion CIDEIM, Colombia
  – *Plumbing the "brain drain"*

Discussant:

- Keith McAdam, Director, Medical Research Council Laboratories, Gambia

Rapporteur: Jean-Claude Mbanya, Head, Endocrine and Diabetes Unit, University of Yaoundé, Cameroon
Focal Point: Thomas C. Nchinda, Senior Public Health Consultant, Global Forum for Health Research

Twiga

Health research for policy, practice and action

Chair:

- Anne Mills, Senior Lecturer, Head, Health Economics and Financing Programme, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom

The session will discuss the achievements of collaborative training strategies to strengthen the interfaces between policy making and health research

- Rodolfo Dennis, Senior Programme Consultant, Pontifica Universidad Javeriana, Colombia
  – *Linking research to policy in developing countries: some lessons from INCLEN*
- Indra Pathmanathan, Consultant, and Victor Neufeld, Professor Emeritus, Faculty of Health Sciences, McMaster University, Canada
  – *The modules on research to policy and training strategy*
- Miguel Gonzalez-Block, Manager, Alliance for Health Policy and Systems Research, Switzerland
  – *Assessment and capacity strengthening for research to policy*
- Anthony Robbins, Professor, Family Medicine and Community Health, School of Medicine, Tufts University, USA
  – *The research to policy process: a report from Talloires. What steps next?*

Rapporteur: Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland
Focal Point: Miguel Gonzalez-Block, Manager, Alliance for Health Policy and Systems Research, Switzerland

16.00–17.30

Tausi

Health research systems analysis

Chair: to be announced

The session will focus on the gathering of evidence in countries and across countries to strengthen national health research systems' capacity and scientific output to improve health.

- Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva
  – *Context of the Health Research Systems Analysis Initiative*
- Ritu Sadana, Scientist, Research Policy and Cooperation, World Health Organization, Geneva
  – *Methods for the In-Depth Country Analysis of Health Research Systems*
- Hossein Afzali, Deputy Minister, Research and Technology, Ministry of Health and Medical Education, Islamic Republic of Iran
  – *Perspective from the Islamic Republic of Iran*
- Alan Pettigrew, Chief Executive Officer, National Health and Medical Research Council, Australia
  – *Perspective from Australia*

Discussant:

- Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

Focal Point and Rapporteur: Ritu Sadana, Scientist, Research Policy and Cooperation, Evidence and Information for Policy, World Health Organization, Geneva

Transfers from AICC to Forum 6 hotels (see bus schedule).

18.00-19.30

Themi

SPECIAL INTEREST GROUPS

Child Health and Nutrition Research Initiative

Chair: Andres de Francisco, Senior Public Health Officer, Global Forum for Health Research

The session will explore the child health and nutrition conceptual framework for reducing the 10/90 gap, define the challenges in neonatal health in developing countries and discuss the role of actors in child health and nutrition research in the developing world.

- Andres de Francisco, Senior Public Health Officer, Global Forum for Health Research
  – *The conceptual framework of the Child Health and Nutrition Research Initiative (CHNRI)*
- Zulfiqar Bhutta, Professor of Child Health, Paediatrics, Aga Khan University Hospital, Pakistan
  – *A community-based evaluation of perinatal and neonatal mortality in rural Pakistan using a modified verbal autopsy tool*
- James Irlam, Director MCH Resource Centre, Paediatrics, Child Health Unit, University of Cape Town, South Africa
  – *Research priorities for child health and nutrition in Africa*
- Pilar Jimenez Ramos, Associate Professor, Behavioral Sciences, De La Salle University, Philippines
  – *Regional mapping in Asia*
- Ricardo Uauy, Professor, Human Nutrition, Instituto de la Nutricion y Tecnologia de los Alimentos, Chile
  – *The burden of childhood disease in Latin America: a challenge for health and nutrition research*

Rapporteurs: Veloshnee Govender, Public Health Specialist, Global Forum for Health Research; Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA
Focal Point: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

18.00–19.30

Kagera

Community-based prevention and control of cardiovascular disease: special issues in research

Co-Chairs:

- Darwin R. Labarthe, Professor of Public Health, Centers for Disease Control and Prevention (CDC), USA
- Sylvie Stachenko, General Director, Health Policy and Services, Centre for Chronic Disease Prevention and Control, Population and Public Health Branch, Canada

The session will focus on the relevance and results of qualitative research in evaluating capacity for CVD control and will also identify prioritized areas for policy research.

Part 1:

- K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India
  – *Introduction*
- Arima Mishra, Social Scientist, Initiative for Cardiovascular Health Research in Developing Countries, India
  – *Assessment of capacity for the control of cardiovascular diseases: a qualitative study*
- Jean-Claude Mbanya, Head, Endocrine and Diabetes Unit, Department of Internal Medicine and Specialities, University of Yaoundé, Cameroon
  – *Results of qualitative research for assessment of capacity for the control of CVD and diabetes: Cameroon report*
- Buppha Sirisassamee, Associate Professor and Deputy Director, Institute for Population and Social Research, Thailand
  – *Assessment of capacity for prevention and control of cardiovascular diseases in Thailand*

Part 2:

- Sylvie Stachenko, General Director, Health Policy and Services, Centre for Chronic Disease Prevention and Control, Population and Public Health Branch, Canada
  International experiences and initiatives in policy research for NCD/CVD prevention
- Shanthi Mendis, Coordinator, Cardiovascular Diseases, World Health Organization, Switzerland
  WHO perspective on community control programmes

Discussant:

- Robert Beaglehole, Public Health Advisor, Evidence and Information for Policy, World Health Organization, Geneva

Focal Point and Rapporteur: K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India

18.00–19.30

Kololo I

Impact of the International Health Research Awards in strengthening the research environment and capacity building at the national level

Chair:
- Marian E. Jacobs, Director, Child Health Unit, School of Child and Adolescent Health, University of Cape Town, South Africa

The International Health Research Awards were announced at the International Conference on Health Research for Development held in Bangkok in 2000. The aim of the Awards was to strengthen research capacity in developing countries by supporting innovative research projects which will promote the development of an enabling environment. The objective of this session is to highlight achievements of some of the projects and discuss their impact at the national level.

- George Gotsadze, Director, Curatio International Foundation, Georgia
  – *Development of the National Health Research Agenda*
- Naomi Webster, Project Manager, South African Gender Based Violence and Health, Medical Research Council, South Africa
  – *Development of a national research agenda for gender-based violence*
- C. Ashok Kumar Yesudian, Professor and Head, Department of Health Services Studies, Tata Institute of Social Sciences, India
  – *Strengthening health research in non-governmental organizations in India*
- Gopal Prasad Acharya, Chairman, Nepal Health Research Council, Nepal
  – *Development of a national health research agenda and national ethical guidelines*
- Gustavo Nigenda Lopez, Senior Researcher, Instituto Nacional de Salud Publica, Mexico
  – *Outcome of research projects on reproductive health within the framework of health sector reforms*
- Lynn Silver, Visiting Researcher, Karolinska Institutet, Sweden
  – *Capacity strengthening for consumer protection*

Focal Point/Rapporteur: Abha Saxena, Scientist, Research Policy and Cooperation, World Health Organization, Geneva

Tausi

The INDEPTH Network: bridging the gap

Chair:
- Steve Tollman, Chairman, Board of Trustees, INDEPTH Network, Ghana

This session will present the mission and objectives of INDEPTH, its historical development, ongoing projects and call for action (monitoring health outcomes, capacity strengthening).

- Steve Tollman, Chairman, Board of Trustees, INDEPTH Network, Ghana
  – *Mission, objectives and strategic plan of INDEPTH*
- Fred Binka, Executive Director, INDEPTH Network, Ghana
  – *Summary of projects and call for action*

Focal Point and Rapporteur: Fred Binka, Executive Director, INDEPTH Network, Ghana

18.00–19.30

Twiga

Key lessons in the development of national health research systems

Chair:

- Somsak Chunharas, Director, Department of Medical Sciences, National Institute of Health, Ministry of Public Health, Thailand

The session will discuss the key issues and lessons learned in the development and strengthening of national health research systems in a number of countries.

- Barbara Klugman, Senior Specialist, Women's Health Project, School of Public Health, Witwatersrand University, South Africa
  – *Health research policy in South Africa: process and lessons*
- Godwin Ndossi, Director, Food Science and Nutrition, Tanzanian Food and Nutrition Centre and Joseph Shija, Chairman, Tanzania National Health Research Forum, Tanzania
  – *The challenges of establishing a national health research forum: the Tanzania experience*
- Mario Villaverde, Director, Health Policy Development and Planning Bureau, Department of Health, Philippines
  – *Philippine National Health Research System Assessment*

Focal Point/Rapporteur: Sylvia De Haan, Communication and Research Officer, Council on Health Research for Development (COHRED), Switzerland

Manyara

Maternal health: translating research into practice

Chair:

- Oluwole Akande, Consultant, World Health Organization, Geneva

The session aims to introduce a region-wide training programme to policy-makers and programme managers and to promote the introduction of the new WHO antenatal care. The session will emphasize the importance of creating a critical mass of health workers knowledgeable in evidence-based decision-making.

- Oluwole Akande, Consultant, World Health Organization, Geneva
  – *Introduction*
- Per Bergsjo, Professor Emeritus/Physician, Obstetrics and Gynecology, University of Bergen, Norway
  – *Introducing the new WHO antenatal care model from research to practice*
- Louise Spruyt, Specialist Scientist, Medical Research Council, South Africa
  – *WHO training of trainers course*

Focal Points: Catherine D'Arcangues, Coordinator, Reproductive Health and Research, World Health Organization, Geneva; Andres de Francisco, Senior Public Health Specialist, Global Forum for Health Research

18.00–19.30

Kololo II

Mental and neurological disorders research

Chair:
- Donald Silberberg, Director, International Medical Programs, School of Medicine, University of Pennsylvania, USA

The session will provide an overview of mental and neurological disorders research taking place around the world, giving an opportunity for researchers involved in such work to network with each other. What are the best strategies for strengthening mental health and neurological disorders research?

- Shekhar Saxena, Coordinator, Mental Health Determinants and Populations, World Health Organization, Geneva
  – *WHO Atlas Project and the mhGap*
- Gerald T. Keusch, Director, Fogarty International Center, USA
- Carmen Lopez Stewart, Coordinator, Gender and Mental Health, Directorate of Public Health, Ministry of Health, Chile
  – *The Chile Mental Health Profile and Policy Template*
- Donald Silberberg, Director, International Medical Programs, School of Medicine, University of Pennsylvania, USA
  – *Neurological disorders research around the world: opportunities and challenges*

Rapporteur: Walter H. Gulbinat, International Health Consultant
Focal Point: Florence Baingana, Mental Health Specialist, Human Development Network, Health, Nutrition and Population, World Bank, Washington DC

Mbuni

New developments in measuring the burden of disease

Chair: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

The session will introduce new applications of burden of disease methods and attempt to understand the critique of measuring the burden of disease at country level.
- Tayyeb Masud, Programme Manager, National Injury Research Centre, Health Services Academy, Pakistan
  – *Groping in the dark: compilation of information for BOD in Pakistan*
- Dele Ogunseitan, Associate Professor, Environmental Analysis and Design, School of Social Ecology, University of California, USA
  – *Linking global environment change to local burden of disease*
- Ritu Sadana, Scientist, Research Policy and Cooperation, World Health Organization, Geneva
  – *Obtaining meaningful social values on health states required for burden of disease analysis: an empirical study in Cambodia*

Rapporteur: Sameera Al-Tuwaijri, Forum Scientific Officer, Global Forum for Health Research
Focal Point: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

18.00–19.30

Mbayuwayu

Public-private partnerships in the South

Co-Chairs:
- Banu Khan, National AIDS Coordinator, National AIDS Coordinating Agency, Botswana
- Akira Homma, Director, Bio-Manguinhos, Oswaldo Cruz Foundation, Brazil

The session will share experience and perspectives on public-private partnerships in low- and middle-income countries.

- Nirmal K. Ganguly, Director-General, Indian Council of Medical Research, India
  – *Experience from India with public-private partnerships for health*
- Alex Mwita, Programme Manager, National Malaria Control Programme, Epidemiology and Disease Surveillance, Ministry of Health, Tanzania
  – *Public-private collaboration for malaria control in Tanzania*
- Akira Homma, Director, Bio-Manguinhos, Oswaldo Cruz Foundation, Brazil
  – *Public-private collaboration for endemic disease problems in Brazil/Latin America*
- Mwelecele Ntuli Malecela-Lazaro, Director, Research and Training, National Institute for Medical Research, Tanzania
  – *Access initiatives for neglected diseases: initial conclusions and future needs (report from a satellite meeting)*

Focal Point/Rapporteur: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Switzerland

Dikdik

Road traffic injury research network

Chair:
- Olive C. Kobusingye, Director, Injury Control Center, Makerere University, Uganda

The session will explore priority research areas for reducing the 10/90 gap in road traffic injuries, define the challenges for research in road traffic injuries in developing countries and discuss the role of the road traffic injury network in addressing research priorities.

- Cristina Inclan Valadez, Researcher, Health Systems Research Center, Instituto Nacional de Salud Publica, Mexico
  – *Social capital: exploring their relevance for traffic injury prevention. The case of Cuernavaca neighbourhoods*
- Arjan Bastiaan van As, Head, Pediatric Surgery, Trauma Unit, Red Cross Children's Hospital, South Africa
  – *Data mining the CAPFSA Red Cross Children's Hospital database 1991-2000 as part of injury prevention planning*
- Kitugi Samwel Nungu, Consultant, Muhimbili Orthopaedic Institute, Tanzania
  – *Road traffic accidents in Dar es Salaam: data collection*
- Robyn Norton, Director, Ramsay Health Care, Institute for International Health Research and Development, Australia
  – *Road traffic injury research network*

Rapporteurs: Abdul Ghaffar, Public Health Specialist, Global Forum for Health Research; Robyn Norton, Director, Ramsay Health Care, Institute for International Health Research and Development, Australia
Focal Point: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

18.00-19.30

Simba Hall

World Report on Violence and Health

Chair: to be announced

The session will provide an overview of the Report and describe the Global Campaign for Violence Prevention. What are the best strategies for implementing the Report's recommendations?

- Alexander Butchart, Scientist and Team Leader, Prevention of Violence, World Health Organization, Geneva
  – *World Report on Violence and Health*
- Bakhytkul Sarymsakova, Professor, Health Policy and Management, Kazakhstan School of Public Health, Kazakhstan
  – *Violence prevention and public health: perspective from Kazakhstan*

Rapporteur: Dinesh Sethi, Consultant and Senior Lecturer, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom

Focal Points: Alexander Butchart, Scientist and Team Leader, Prevention of Violence, World Health Organization, Geneva; Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

Transfers from AICC to Forum 6 hotels (see bus schedule).

Transfers from Forum 6 hotels to AICC (see bus schedule).

9.00–10.30

Simba Hall

PLENARY SESSION

Using research results: research synthesis as a tool to help correct the 10/90 gap

Co-Chairs:

- Robert Hecht, Acting Director, Health, Nutrition and Population, World Bank, Washington DC
- Mariam J. Mwaffisi, Permanent Secretary, Administration Department, Ministry of Health, Tanzania

The session will present the results of health research synthesis in the world as a tool for reducing the 10/90 gap.

- James Volmink, Director, Research and Analysis, Global Health Council, USA
  – *The science of research synthesis and its relevance to the 10/90 gap*
- Martin Meremikwu, Senior Lecturer, Paediatrics, College of Medical Science, University of Calabar, Nigeria
  – *Malaria: progress in preparing and updating systematic reviews*
- Charles Shey Wiysonge, Head, Epidemiological Surveillance Unit, Enlarged Programme of Vaccination, Ministry of Public Health, Cameroon
  – *Vaginal disinfection for reducing the risk of mother-to-child transmission of HIV infection: a systematic review*

Discussants:

- Andrew Haines, Dean, London School of Hygiene and Tropical Medicine, United Kingdom
- K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India

Rapporteur: Sameera Al-Tuwaijri, Forum Scientific Officer, Global Forum for Health Research
Focal Points: Louis J. Currat, Executive Secretary, Global Forum for Health Research; James Volmink, Director, Research and Analysis, Global Health Council, USA

10.30–11.00

Piazza and room N

Break and Marketplace

11.00-12.30

Simba Hall

PLENARY SESSION

What perspectives for the 10/90 gap?
What recommendations to the partners in the Global Forum?

Co-Chairs:

- Anna Abdallah, Minister of Health, Ministry of Health, Tanzania
- Carlos M. Morel, Member of the Foundation Council, Global Forum for Health Research

In the Closing Plenary, panellists and speakers from the floor will express their views on the perspectives for reducing the 10/90 gap and make recommendations to the partners in the Global Forum.

Focal Point and Rapporteur: Louis J. Currat, Executive Secretary, Global Forum for Health Research, Switzerland

12.30-14.00

Piazza

Closing Reception

The Foundation Council and Secretariat of the Global Forum for Health Research invite all participants to a *verre d'amitié* with traditional Tanzanian entertainment.

We look forward to receiving all your ideas on helping correct the 10/90 gap, with concrete proposals for our next annual meeting:

Forum 7
11-14 November 2003
Geneva, Switzerland
www.globalforumhealth.org

Transfers from AICC to Forum 6 hotels and to Kilimanjaro International Airport (see bus schedule).
Transfer from AICC for the visit of the National Surveillance System's site in Hai District.

14.00-17.30

SITE VISIT

Visit to Ministry of Health Demographic Surveillance System in Northern Tanzania

The Tanzanian Ministry of Health is establishing a National Sentinel Surveillance (NSS) system of linked demographic surveillance sites for the long-term monitoring of health and poverty conditions. Demographic surveillance sites are an increasingly important resource for research and routine information production in health development in developing countries. In Tanzania, findings from these sites have influenced national health policy and district resource allocation. Participants are invited to visit the NSS's demographic surveillance site in Hai District, Kilimanjaro Region, meet with representatives of the Tanzanian Ministry of Health and local Council who operate the system, as well as view a presentation of the technical operations and outputs of the system. Transport and refreshments will be provided. Arrangements can be made for participants who are leaving Arusha that evening to be taken directly to the airport at the end of the visit.

Focal Point: Yusuf Hemed, Deputy Director, Adult Morbidity and Mortality Project, Ministry of Health, Tanzania

Market stalls

- **African Council for Sustainable Health Development (ACOSHED)**
  Lola Dare, Executive Secretary, African Council for Sustainable Health Development, Nigeria
- **Alliance for Health Policy and Systems Research**
  Miguel Gonzalez-Block, Manager, Alliance for Health Policy and Systems Research, Switzerland
- **ARROW, Malaysia**
  Rashidah Abdullah, Director, Asian-Pacific Resource & Research Centre for Women, Malaysia
- **Asian Collaborative Training Network for Malaria (ACT Malaria)**
  Tee Ah Sian, Director, Public Health, Asian Collaborative Training Network, Ministry of Health, Malaysia
- **Atherosclerosis Centre Giancarlo Descovich, Massa Lombarda Program, Italy**
  Simona Nascetti, Student, Clinical Medicine and Applied Biotechnology, Atherosclerosis Centre Giancarlo Descovich, Italy
- **Center for Health Sciences Training, Research and Development (CHESTRAD) International**
  Olamide Bandele, Secretary, Administration, Center for Health Sciences Training, Research and Development (CHESTRAD) International, Nigeria
- **Child health and nutrition in Africa**
  James Irlam, Director, MCH Resource Centre, Paediatrics, Child Health Unit, University of Cape Town, South Africa
- **Coalition for Global Health Research, Canada**
  Alita Perry, Manager, Global Health Research Initiative, Canadian Institutes of Health Research (CIHR), Canada
- **Collaborative Training Programme on Health Research for Policy, Practice and Action**
  Happiness Minja, Research Officer, Council on Health Research for Development (COHRED), Switzerland
- **Council on Health Research for Development (COHRED), Switzerland**
  Sylvia De Haan, Communication and Research Officer, Council on Health Research for Development (COHRED), Switzerland
- **Creating Resources for Empowerment in Action (CREA), India**
  Geetanjali Misra, Director, Creating Resources for Empowerment in Action, India
- **Dalhousie University Faculty of Medicine, Canada**
  Katherine Orr, Manager, International Health Office, Faculty of Medicine, Dalhousie University, Canada
- **Fogarty International Center, USA**
  Gerald T. Keusch, Director, Fogarty International Center, USA
- **Genomics and world health**
  Pauline McKay, Programme Assistant, Research Policy and Cooperation, World Health Organization, Geneva
- **Global Forum for Health Research**
  Alina Pawlowska, Information Management Officer, Global Forum for Health Research
- **Health System Research Institute, Thailand**
  Chanpen Choprapawon, Programme Director, Dept. of Mental Health, Health Systems Research Institute, Ministry of Public Health, Thailand

- **INCLEN Trust**
  Mary Ann Lansang, Executive Director, INCLEN Trust, Philippines

- **Initiative for Cardiovascular Health Research in Developing Countries**
  K. Srinath Reddy, Coordinator, Scientific Secretariat, Initiative for Cardiovascular Health Research in Developing Countries, India

- **Initiative on Public-Private Partnerships for Health (IPPPH)**
  Armelle Armstrong, Communication Officer, Initiative on Public-Private Partnerships for Health, Switzerland

- **International Planned Parenthood Federation (IPPF)**
  Naana Otoo-Oyortey, Technical Officer, Gender and Youth, International Planned Parenthood Federation, United Kingdom

- **Kilimanjaro Centre for Community Ophthalmology, Tanzania**
  Paul Courtright, Co-Director, Kilimanjaro Centre for Community Ophthalmology, Tanzania

- **Liverpool School of Tropical Medicine, United Kingdom**
  Sally Theobald, Lecturer, International Health, Liverpool School of Tropical Medicine, United Kingdom

- **Medicines for Malaria Ventures (MMV)**
  Diana Cotran, Human Resources and Administrative Manager, Medicines for Malaria Venture, Switzerland

- **M.S. Swaminathan Research Foundation, India**
  Subbiah Gunasekaran, Research Assistant, Informatics Centre, M.S. Swaminathan Research Foundation, India

- **National Foundation for Research and Development, Uganda**
  Rhona Mijumbi, Intern, National Foundation for Research and Development, Uganda

- **National Institute for Medical Research (NIMR), Tanzania**
  Virdiana Mvungi, Research Scientist, National Institute for Medical Research, Tanzania

- **Osmangazi University, Turkey**
  Burhanettin Isikli, Assistant Professor, Public Health, School of Medicine, Osmangazi University, Turkey

- **SHARED: Scientists for Health and Research for Development**
  Agnes Soares da Silva, Executive Secretary, Netherlands Foundation for the Advancement of Tropical Research, Netherlands Organization for Scientific Research (NWO), Netherlands

- **Special Programme for Research and Training in Tropical Diseases**
  Jens Kastberg, Advocacy and Fund Raising, Special Programme for Research and Training in Tropical Diseases (TDR), Switzerland

- **Universidad Peruana Cayetano Heredia, Peru**
  Diana Rodriguez, Professor, Clinical Epidemiology Unit, Faculty of Medicine, Universidad Peruana Cayetano Heredia, Peru

- **Women's Health Project, South Africa**
  Nicola Christofides, Project Manager, Women's Health Project, South African Institute for Medical Research, and Barbara Klugman, Senior Specialist, Women's Health Project, School of Public Health, Witwatersrand University, South Africa

- **World Report on Violence and Health**
  Alexander Butchart, Scientist and Team Leader, Prevention of Violence, World Health Organization, Geneva

Posters

- **Arjuna Aluwihare, Professor, University of Peradeniya, Sri Lanka**
  Disaggregated data in prioritising resource allocation

- **Monika Arora, Research Assistant, Initiative for Cardiovascular Health Research in Developing Countries, India**
  School- and home-based learning reduces tobacco experimentation

- **Antonia Bankoff, Laboratory Coordinator, Sports Sciences, Physical Education Faculty, State University of Campinas, Brazil**
  Study of postural problems of children in the public schools caused by undernourishment, malnutrition and overwork

- **Lizzeth Betancourt, Director of Health District, Ministry of Health, Honduras**
  Antimalarial drugs use in the Northern coast of Honduras, Central America

- **Chona R. Echavez, Senior Research Associate, Research Institute for Mindanao Culture, Xavier University, Philippines**
  The boon and the bane in GO and NGO partnership in the delivery of health services for women and children

- **Funmilayo Fawole, Lecturer and Consultant, Epidemiology and Medical Statistics, Preventive and Social Medicine, University of Ibadan, Nigeria**
  Violence against female hawkers in motor-parks in Nigeria

- **Gururaj Gopalakrishna, Head, Epidemiology, National Institute of Mental Health and Neurosciences, India**
  Road traffic injuries in India and South East Asia : an epidemiological perspectve

- **Satish Kumar Kannappa, Professor, Institute of Health Systems, India**
  District family health survey for small area mortality and analysis : a pilot study

- **Lydia Kapiriri, Student, Centre for International Health, Faculty of Medicine, University of Bergen, Norway**
  Considerations for priority-setting in health : a pilot study of stakeholders in four districts in Uganda

- **Andrew Martin Kilale, Medical Research Scientist, Muhimbili Research Station, National Institute for Medical Research, Tanzania**
  Trends in road traffic accidents

- **Henry Kitange, National Sentinel System Task Group Leader, Policy and Planning, Health Information and Research Section, Ministry of Health, Tanzania**
  Tanzania national sentinel system for burden disease surveillance

- **Stephen Kunda, Research Scientist, Muhimbili Research Station, Tuberculosis Laboratory, National Institute for Medical Research, Tanzania**
  Tuberculosis

- **Gunnar Kvale, Director, Centre for International Health, University of Bergen, Norway**
  A Norwegian centre for research and education on poverty related diseases
- **Grant Lewison, Head, Bibliometrics Research Group, Information Science, City University, United Kingdom**
  A bibliometric approach to estimating malaria research funding
- **Sayoki Mfinanga, Student, Centre for International Health, University of Bergen, Norway**
  Tribal difference in perception of tuberculosis: a possible role in tuberculosis control in Arusha, Tanzania
- **Jean-Claude Mwanza, PhD Fellow, Centre for International Health, University of Bergen, Norway**
  HIV-infection and uveitis
- **Lipika Nanda, Health Consultant, Poverty Eradication, Health, Society for Elimination and Rural Poverty, India**
  The Andhra Pradesh health systems responsiveness study 2001
- **Bjorg Evjen Olsen, Research Fellow, Medical Faculty, Centre for International Health, University of Bergen, Norway**
  Maternal deaths in rural Northern Tanzania
- **Faiza Mohammed Osman, Head, Epidemiology and Clinical Studies, Institute of Endemic Diseases, Khartoum University, Sudan**
  Health policy and system research
- **Supa Promtussananon, Researcher, University of the North, South Africa**
  The development of health: promoting hospital model
- **Dinesh Sethi, Consultant and Senior Lecturer, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom**
  Injuries in refugee and host populations in Northern Uganda
- **Agus Suwandono, Secretary, National Institute of Health Research and Development, Indonesia**
  Resource flows: health research and development in Indonesia

The Marketplace will also include posters by the recipients of the International Health Research Awards (2000).

The following meetings are in general by invitation only. Participants who would like additional information about any of these groups should contact the Focal Point or ask at the Forum 6 Information Desk.

Sunday 10 November

All day meetings

9.00–17.30
Impala Hotel

COHRED Board Meeting
BY INVITATION. Meeting followed by a reception.
Focal Point: Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland

Impala Hotel

Child Health and Nutrition Research Initiative Board Meeting
BY INVITATION
Focal Point: Robert Black, Chair, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

Impala Hotel

Johns Hopkins University Research Ethics Program for Africa
BY INVITATION
Focal Point: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

Impala Hotel

Roundtable on supporting cooperation in health research for development: a review of the International Health Research Awards
BY INVITATION
Focal Point: Abha Saxena, Scientist, Research Policy and Cooperation, World Health Organization, Switzerland

Afternoon meeting

Novotel
Mount Meru

Public-private partnerships for improving access to pharmaceuticals: lessons from field implementation in selected countries
BY INVITATION
Focal Point: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Switzerland

Evening meeting

Novotel
Mount Meru

Future challenges facing the World Health Organization
BY INVITATION
Focal Point: Timothy G. Evans, Director, Health Equity Program, Rockefeller Foundation, USA

Monday 11 November

7.30–10.30 — Novotel Mount Meru

Interim Working Party on the Implementation of the Bangkok Action Plan
BY INVITATION
Focal Point: Tikki Pang, Director, Research Policy and Cooperation, World Health Organization, Geneva

All day meetings

Dik Dik Hotel

Canadian Institutes for Health Research/African Forum for Health Research
BY INVITATION
Focal Point: Alita Perry, Manager, Global Health Research Initiative, Canadian Institutes of Health Research (CIHR), Canada

10.00–17.30 — Impala Hotel

COHRED Board Meeting (continued)
BY INVITATION
Focal Point: Peter Makara, Coordinator, Council on Health Research for Development (COHRED), Switzerland

Impala Hotel

Johns Hopkins University Research Ethics Program for Africa (continued)
BY INVITATION
Focal Point: Adnan A Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

Impala Hotel

Roundtable on supporting cooperation in health research for development: a review of the International Health Research Awards (continued)
BY INVITATION
Focal Point: Abha Saxena, Scientist, Research Policy and Cooperation, World Health Organization, Geneva

Novotel Mount Meru

Future challenges facing the World Health Organization (continued)
BY INVITATION
Focal Point: Timothy G. Evans, Director, Health Equity Program, Rockefeller Foundation, USA

Novotel Mount Meru

Public-private partnerships for improving access to pharmaceuticals: lessons from field implementation in selected countries (continued)
BY INVITATION
Focal Point: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Switzerland

Wednesday 13 November

12.30–14.00
Tausi Room
AICC

Strengthening mental and neurological research
OPEN MEETING
Focal Point: Florence Baingana, Mental Health Specialist, Human Development Network, Health, Nutrition and Population, World Bank, Washington DC

17.15–18.00
Press Room
AICC

MIHR launch press briefing
BY INVITATION
Focal Point: Nicholas Mellor, Senior Programme Officer, Management of Intellectual Property in Research and Development, United Kingdom

18.00–19.30
Simba Hall
AICC

MIHR launch and reception
BY INVITATION
Focal Point: Nicholas Mellor, Senior Programme Officer, Management of Intellectual Property in Research and Development, United Kingdom, George Soule, Associate Director, Office of Communication, Rockefeller Foundation, USA

18.00–19.30
Mbuni Room
AICC

Road Traffic Injury Research Network: Board Meeting
BY INVITATION
Focal Point: Adnan A. Hyder, Assistant Professor, International Health, Bloomberg School of Public Health, Johns Hopkins University, USA

18.00–21.00
Moivaro Coffee Lodge and Plantation

Reception and Working Dinner for representatives of medical research councils
BY INVITATION. Transport will be provided from AICC at 18.00
Focal Point: Susan Jupp, Senior Communication Officer, Global Forum for Health Research

Thursday 14 November

12.30–14.00
Dikdik Room
AICC

SHARED workshop 1
BY INVITATION
Focal Point: Agnes Soares da Silva, Scientific Secretary, SHARED, Netherlands Organization for Scientific Research (NWO), Netherlands

Friday 15 November

7.30–8.30
Impala Hotel

Special session on the Alliance for Health Policy and Systems Research
BY INVITATION
Focal Point: Miguel Gonzalez-Block, Manager, Alliance for Health Policy and Systems Research, Switzerland

Afternoon meetings

15.00–18.00
Impala Hotel

Global Forum for Health Research: Foundation Council Meeting
BY INVITATION. Meeting followed by dinner.
Focal Point: Kirsten Bendixen, Meeting Organizer, Global Forum for Health Research

Impala Hotel

SHARED workshop 2
BY INVITATION
Focal Point: Agnes Soares da Silva, Scientific Secretary, SHARED, Netherlands Organization for Scientific Research (NWO), Netherlands

Novotel
Mount Meru

Afrihealth: building capacity for public health
BY INVITATION
Focal Point: Carel B. Ijsselmuiden, Director, School of Health Systems and Public Health, University of Pretoria, South Africa

Novotel
Mount Meru

Drugs for Neglected Diseases Initiative
BY INVITATION
Focal Point: Bernard Pecoul, Director, Campaign for Access to Essential Medicines, Medecins sans Frontieres (MSF), Switzerland

Novotel
Mount Meru

Human resources
BY INVITATION
Focal Point: Diane L. Eckerle, Rockefeller Foundation, USA

Novotel
Mount Meru

Workshop on clinical trials capacity in low and middle income countries: experiences, lessons learned and priorities
BY INVITATION
Focal Point: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Switzerland

Saturday 16 November

8.30-12.30
Impala Hotel

Global Forum for Health Research: Foundation Council and STRATEC Meeting
BY INVITATION. Meeting followed by lunch.
Focal Point: Kirsten Bendixen, Meeting Organizer, Global Forum for Health Research

All day meetings

Novotel Mount Meru

Afrihealth: building capacity for public health (continued)
BY INVITATION
Focal Point: Carel B. Ijsselmuiden, Director, School of Health Systems and Public Health, University of Pretoria, South Africa

Novotel Mount Meru

Workshop on clinical trials capacity in low and middle income countries: experiences, lessons learned and priorities (continued)
BY INVITATION
Focal Point: Roy Widdus, Project Manager, Initiative on Public-Private Partnerships for Health, Switzerland

Sunday 17 November

All day meeting

Novotel Mount Meru

Afrihealth: building capacity for public health (continued)
BY INVITATION
Focal Point: Carel B. Ijsselmuiden, Director, School of Health Systems and Public Health, University of Pretoria, South Africa

ACKNOWLEDGMENTS

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- to the participants in Forum 6
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  - Andrew Kitua, Director General, NIMR
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  - Arnold Buluba, Swiss Agency for Development and Cooperation, Tanzania
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  - Virdiana Mvungi, NIMR
  - Gasper Mponda, NIMR
  - Leah Mgonja, NIMR
  - Deogratias Mdamu, Ministry of Tourism of Tanzania
  - Justin Nyamoga, Kilimanjaro Christian Medical College
  - William Kisoka, NIMR
  - Charles Kajeguka, NIMR

FORUM 6
12-15 NOVEMBER 2002

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WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

ADVISORY COMMITTEE ON HEALTH RESEARCH

Thirty-fourth session

Geneva, 15 - 18 October 1996

Agenda item 6

Annex 2

REPORT ON DISCUSSIONS AT THE EXECUTIVE BOARD

The attached document contains the official Summary Records of discussions held at the Ninety-seventh Session of the Executive Board in January 1996. The last report of the ACHR included a peer review of the draft report of the "Ad Hoc Committee on research relating to future intervention options" (Annex 3 of the ACHR report). This Committee had been established in March 1994 at the instigation of some donors and in the wake of the publication by the World Bank of its World Development Report 1993 entitled "Investing in Health". It has since been disestablished in June 1996, after completion of its final report.

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(1) broad-based supply services responding to requests for both technical and more general items from Member States or from programmes;
(2) services purchasing drugs, biologicals and other highly technical products and providing technical assistance to countries in order to enable them to strengthen their own procurement and materials management systems;

2. to report to the Executive Board at an appropriate time on the result of the study.

4. REPORTS OF SCIENTIFIC ADVISORY BODIES AND RELATED ISSUES: Item 9 of the Agenda

RESEARCH POLICY AND STRATEGY - REPORT ON MEETING OF THE GLOBAL ADVISORY COMMITTEE ON HEALTH RESEARCH (ACHR): Item 9.1 of the Agenda (Document EB97/17 and Corr.1)

Professor FLIEDNER (Chairman, Advisory Committee on Health Research), said that the global Advisory Committee on Health Research (ACHR) was convinced that all relevant health challenges that lay ahead of nations could be mastered only with the support of science and technology as well as of appropriate qualified persons to identify the issues of crucial importance, weigh them in accordance with society's priorities and develop approaches to resolving them. Recalling its terms of reference, he said that the ACHR system was dedicated to helping preserve the integrity of WHO as the directing and coordinating authority on international health work. WHO's constitutional mandate to promote and conduct research in the field of health and to promote cooperation among scientific and professional groups contributing to the advancement of health established a clear-cut leadership role. WHO should therefore conduct research necessary to advance global health and should mobilize the scientific community to utilize its resources to address global health issues, thereby broadening and deepening the scientific basis for essential political decisions and government initiatives. ACHR was of the opinion that those constitutional mandates should be given greater emphasis in the Organization's future policy. Ways and means should be found to maximize the contribution of science and technology in the light of the evolving problems that were of critical significance to global health.

A major activity of ACHR was to develop, by the end of 1997, a research agenda to support the renewed health-for-all strategy aimed at improving health conditions and health services at global level in spite of the dynamics of global developments; that research agenda was to be presented and proposed for implementation at the Health Assembly in 1998. It would establish a consensus on scientific and technological priorities concerning the health conditions of the individual, health care systems, environment and health, social behaviour and nutrition. It would also deal with the way in which innovations in communications technology could improve links between academic and research institutions, resulting in a new commitment of the science and technology of the North to the problems evident in the South and facilitating the communication of research findings more directly from research institutions to decision-makers. ACHR would also seek to mobilize the world's science and technology organizations to address themselves more to global issues, and that would require new intellectual approaches.

ACHR had reviewed research plans and activities at global and regional levels, and its members had acquired first-hand information on programmes dealing with aging and health, maternal and child health and family planning, neurosciences and mental health and safety promotion and injury control. Several regional ACHRs had presented constructive initiatives, had cooperated closely with the respective research councils and were prepared actively to support the development of a new global research agenda; however, unfortunately, the European Region had been led, apparently by severe financial constraints, temporarily to suspend the work of the European ACHR at a time when it was urgently needed to bridge the gap between West and East in health and health services research.

ACHR had welcomed the WHO initiative on the scientific activities of the environmental health programme, and also the proposal of the local authorities in Kobe, Japan, to establish a research centre to deal

with global health development issues; it would welcome the creation of similar WHO-owned research centres in other parts of the world, and was prepared to advise on the development of such centres.

At its meeting in October 1995, ACHR had reviewed the DALY (disability-adjusted life years) approach to measuring the disease burden and the report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options entitled "Investing in health research and development: an agenda to address the problems of the poor". ACHR had concluded that the DALY indicator should not be used for setting research priorities and that verification of its methodology, validation of its underlying concept and its utility in practice had not yet been achieved. As for the peer review of the work of the Ad Hoc Committee, the Committee's Chairman had been present at the ACHR meeting and had accepted most of the points raised. ACHR had serious reservations about using DALY for measuring the cost-effectiveness of public health interventions and research prioritization, excluding other alternatives. The proposal to create new institutional arrangements had had in principle little to do with the thrust of the report, and was potentially destructive because the new consortium suggested could undermine the institutional integrity of WHO and subsume its mandate as the organization within the United Nations system responsible to nearly 200 Member States for directing and coordinating international health work, including research. WHO should continue to fulfil that constitutional mandate and should not allow its responsibilities to be relinquished to other bodies or diluted; it must maintain and strengthen its capacity actively to meet current and growing challenges in health development and health research. ACHR would contribute substantially to the renewal of the health-for-all strategy by developing an agenda for science and technology to support health for all in the coming decades.

Professor GIRARD said the topic of research policy and strategy was one of the most important subjects to be debated by the Board at the current session, and indeed, in the work of the Organization. Two high-calibre groups had taken radically different, but possibly complementary, approaches which opened the way to debate on the subject. Research, together with training, was generally deemed to be the key to the future. It was critical to WHO's response to the most important challenge of the next 50 years, namely, how to reconcile health marketing and medical ethics.

Clearly, the situation at present was far from perfect. Most health problems were experienced by the countries of the South, while research was generally in the hands of teams from the North which tended to overemphasize the health problems encountered in the North. Some health sectors were given greater attention than others: for example, research on health care systems was treated as secondary, since the tradition in the North was to treat diseases rather than to work on the facilities for providing care. Health care professionals had done little to popularize their own activities and were facing a terrible dilemma. The more they progressed, the more they perceived the complexity and diversity of health matters. Yet all researchers knew that an experiment involving several variables would yield no results: success could only be achieved by looking at a single parameter at a time. They were therefore wary of attempts to incorporate complicated questions such as housing and employment in research on health.

Perhaps the time had come to acknowledge that research was too vitally important to be left in the hands of researchers alone. If that was the case, then WHO and Member States must have the courage to look for new approaches, such as the notion of health partnerships referred to by the Director-General. Partnership was most useful in elaborating and implementing solutions; it was less effective for decision-making, which was the province of representative bodies. The organ where States came together at the highest level to decide on health policy was WHO, and that body was therefore best qualified to determine the future course of health research. Article 2 (n) of the Constitution conferred on WHO the responsibility to promote and conduct research in the field of health. If Member States now took a different view of the Organization's responsibilities, then the Constitution would have to be amended. New approaches were also needed in respect of the need to reconcile health marketing with medical ethics. A number of countries were uncomfortable with the idea of treating health like just another commodity, of letting market forces loose in that sphere, with no opposing forces to counteract them. In developing new approaches, however, it was important to take account of established approaches. Just as health reforms should not go against physicians, new approaches to research should not go against researchers.

The analyses being undertaken by the Ad Hoc Committee and the ACHR were at two levels, the scientific and the institutional. In terms of scientific analysis, he had already pointed to the disparity between WHO's multisectoral approach to health and the single-minded approach of researchers, that could quickly lead to territorial disputes and conflicts over areas of competence and authority, as had been shown in dealing with AIDS within the United Nations system. Furthermore, financing decisions had an impact on programme performance: those programmes financed from extrabudgetary resources were less solid than those financed, at least partly, out of the regular budget.

The task before the Board was to look at research prospects well beyond the year 2000. The Ad Hoc Committee had made a powerful contribution to the debate on research policy and strategy, as had the reaction by the ACHR. It might be useful to consider combining the two bodies to work out a new approach to research policy for the future.

Dr BOUFFORD, endorsing the eloquent comments by Professor Girard, agreed that the topic under discussion was of paramount importance: one of the Organization's critical functions was to mobilize the expertise available in the research community. WHO, in preparing the new research agenda for 1998, must give due attention to the need to articulate recommendations for research and development priorities that were consistent with the health-for-all agenda. Most observers would agree that WHO had a responsibility to identify gaps in research and to try to encourage investigation into critical areas, such as basic research, drug development and technology development.

She requested clarification on the status of the draft report from the Ad Hoc Committee vis-à-vis the report of the ACHR peer review group, which had criticized the conclusions reached by the Ad Hoc Committee. Both documents were issued by WHO, yet they offered vastly different viewpoints on how to mobilize the research community around the health needs of developing countries. The core differences revolved around the use of the DALY instrument. She had been somewhat surprised by the intensity of the polemic on that subject and considered it important to explore measures that went beyond the classic research tools, including intersectoral measures that were becoming increasingly important in the health field.

A recommendation had been made concerning a consortium to look further into those issues. Such a consortium could be sponsored by WHO in the spirit of new partnerships, new collaborations. The structure outlined for the consortium, involving governments, universities and research institutes, was exactly the kind of approach being sought in other new partnership endeavours. Surely such a group could be integrated into the work of ACHR.

It would be useful to hear suggestions on ways of reconciling the contents of the two reports, so that WHO could adopt a unified position on methodology, and on how such efforts could advance the health-for-all research agenda.

She noted that stress had been laid on neurosciences in the review of the mental health programme, but recalled that behavioural research was equally important, since 50% of preventable morbidity and mortality fell into the category of behavioural problems. Finally, she would appreciate more information on the work being undertaken in the safety promotion and injury control programme.

Dr LEPPO welcomed Professor Fliedner's emphasis on the development of a research policy and agenda by 1998 and agreed that it was important to mobilize the scientific community in conjunction with renewal of WHO's health-for-all strategy. In his view, the first step should be the preparation of a synthesis of existing knowledge that could be used in determining health policy. Value-driven, evidence-based policies were needed, and he was pleased to learn that the scientific community was ready to respond to the challenges in that regard.

He endorsed the comments of Professor Girard. It was important to debate fundamental issues openly and to reconcile different views within and outside WHO. Several drafts were available of the report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options, and it was not clear whether they were WHO documents. The work of the Ad Hoc Committee was an informative, well documented coverage of current scientific knowledge; however, he had serious reservations regarding some of the conclusions and the final chapter of its report, on institutional arrangements, which implied that regulatory control should be loosened in order that more resources could be obtained for research. The ground rules

for new forms of partnership should be set. He agreed with the criticism by the ACHR about use of the DALY approach; the technique required further development.

The research community should be mobilized to support WHO in its endeavours for achieving better health through research, and the work of the ACHR and the Ad Hoc Committee should be brought together to reach that goal.

Dr PAVLOV (adviser to Professor Shabalin) noted the importance of health research in the implementation of WHO programmes. The principle of using strictly scientific criteria for choosing the basic directions and for formulating WHO health programmes was the only correct approach to implementing the health strategies at the country level. Use of a scientific approach in choosing priorities for action and for drawing up plans to implement them had also guaranteed the prestige of WHO and had confirmed its normative functions. Research was an indispensable component of that approach. Health research programmes carried out under the auspices of WHO should be strengthened, and optimal conditions should be created for using the untapped potential of science to further health and well-being.

The ACHR had tried to make the best use of scientific resources and to involve the scientific community in resolving regional and global problems. A further strengthening of the coordinating role of ACHR was important, particularly during the present period of crisis in WHO. There was a danger that WHO's research programme might be pushed into the background at a time of resource curtailment; any weakening could quickly have strongly negative effects. The ACHR could help WHO to take a proper scientifically based decision to resolve its present difficulties.

Dr KILIMA recommended a cautious, strategic approach to the question of research. As a health manager and researcher, it was his experience that it should respond to the most important local problems. Health providers and policy-makers should have prior knowledge and involvement in order to bridge the gap between researchers and themselves. They should therefore be involved in identifying priorities for research and in following its progress. Furthermore, the research should be reported in such a way that it was comprehensible to the users, perhaps by publishing the results in two forms, one in scientific language, the other directed to a more general audience. Research institutions should monitor and evaluate the impacts of their research, to determine whether the results were being used and, if not, why. Social and anthropological research might clarify why some research results were not used.

Dr BLEWETT noted that the percentage of resources represented by extrabudgetary funds, which was the main type of research funding, had been decreasing. There were two sources of tension which should be addressed: the use of DALY and the differences between ACHR and the Ad Hoc Committee, which should be resolved in the interests of the health of WHO. Both the criticisms of the DALY approach by ACHR and reports from organizations that had developed and used the method should be considered, in order to resolve the issue of how health and research priorities should be attributed. For example, the World Bank, an international agency that was an important source of funds for health, had used DALY, and it would be interesting to have its opinion. It would also be interesting to hear whether any countries were using DALY in setting priorities. The issue of methodology was central to debates about resource allocation priorities. The other source of tension was criticism by the ACHR of certain assessments made by the Ad Hoc Committee. It would be useful to know whether a later version of the report of that Committee had met some of the concerns and criticisms of the ACHR and whether any of their conclusions had been altered as a result of those criticisms. He agreed with Professor Girard that an open debate was required to reconcile the differences on those topics within the scientific community.

Dr REINER endorsed the views of Professor Girard, Dr Boufford and Dr Blewett. Further, he supported the proposal to strengthen the links between the ACHR and the programme on environmental health. He was also concerned that the European ACHR had not been able to meet during the biennium due to financial constraints, as detailed in paragraph 23 of document EB97/17. Urgent debate and concrete action were needed to remedy such a situation and he therefore endorsed the recommendation made in paragraph

24. The brain-drain already existed in the countries of central and eastern Europe and new independent states, and was having serious consequences for health research in those countries.

Dr KALUMBA said that a number of matters covered in the report required further clarification, in particular the use of the DALY approach for setting priorities and WHO's status as the core body responsible for issuing authoritative statements on health and setting the health research agenda. National policy-makers were concerned with how to gain political support to ensure effective implementation of health strategies, how to ensure health protection and promotion, more efficient and equitable management of health systems and community involvement, and how to integrate individual programme strategies. Research programmes should be matched to those priority areas. If the DALY approach was not appropriate, other suggestions were needed. In his country DALYs were used, but in a modified form in order to take into account ethical issues, for example, questions of equity. But both governments and researchers were sometimes caught up in practical decisions where value judgements had to be made. He also had some serious reservations on scientific grounds regarding some of the comments made in the full ACHR report, (document ACHR33/95.14), made available to members of the Board, in particular regarding the components of health policy research.

Dr TSUZUKI, commending the printed report and the oral presentation, said that Board members should do all they could to complement and reconcile the efforts of ACHR and the Ad Hoc Committee, notably by helping to mobilize more resources to strengthen research programmes. It was, however, the constitutional responsibility of the Organization as a whole to define health and research priorities.

Dr AVILA (alternate to Dr Antelo Pérez) submitted that the procedure followed in nominating the Ad Hoc Committee had been controversial. Current calls for conciliation would have been unnecessary had the two committees' work been properly coordinated from the outset.

The report before the Board contained much valuable information for those directing research in the countries, and some commendable conclusions, including the idea of integrated intervention packages. But given that the basic issue was poverty and inequality, and that the polemic centred on how best to use what little resources were available in poor countries, he found there to be a somewhat excessive technical content and too little in the way of ethical considerations. He himself would have preferred an approach which favoured social rather than technocratic issues. At first sight, the idea that developing countries should concentrate on research oriented towards short-term impact on their own health problems did not appear out of place. However, it implied that the international scientific community of the South would be cut off from research at the frontiers of knowledge, where the world scientific community was working, thus further widening the gap between scientific research in the South and in the developed world, and halting research on projects which could generate resources and help to strengthen health systems. To place scientific resources where there was most need, even though it would lead to disparities in their geographical distribution, ignored the basic problem of concentration of scientific capability. Further, he pointed out contradictions in the conclusions of the report. For example, that biomedical sciences had little importance in noncommunicable diseases compared to demographic research, when information provided in the report itself indicated that they had to be of comparable importance.

What was important was the need for more investment in research and more political commitment on the part of governments to the health of their people; that was more a political than a scientific matter. Discussion on mobilizing resources for research in the South was focusing on participation of the private sector within countries, which was a limited view. Mobilization of resources for development was a global, not a national, problem, and should be dealt with in negotiations in which the Organization should support the poorest countries.

Professor SHEIR also wondered why the subject of ethics in research had been neglected in the report. While individual countries and regions must obviously identify their own research priorities, it should be generally acknowledged that high-technology biomedical research was essential as the world approached a new century, and should definitely form part of the remit of WHO's research committees.

There was a need for an adequate information system that permitted research groups to communicate the results of their work and to receive proposals and process queries from around the world. Although research programmes were too important to be sacrificed to budgetary constraints, those constraints should be borne in mind by programme planners in achieving a balance between high-technology programmes, on the one hand, and albeit "basic" research that the regions needed.

Lastly, she questioned the importance attached in the report to the brain drain from poorer European countries and what appeared to be special pleading on their behalf, if not on behalf of the Region as a whole, with regard to the allocation of resources. The phenomenon affected all regions, and should be addressed in a equitable fashion everywhere.

Mrs HERZOG said that she detected no fundamental difference of opinion on the importance of the ACHR programme and the need to support and strengthen it. However, tension between the two committees - although it could on occasion prove creative - might lead to each hampering the other's work. She suggested that the problem might be solved by establishing a joint body with a comprehensive mandate. To her mind, priorities in health research should reflect the objectives of the health-for-all strategy and the reform process. She agreed with the comments of previous speakers on the behavioural aspects of research.

Dr PICO (alternate to Dr Mazza), commending the report and the oral presentation, endorsed in great measure the views expressed by Professor Girard, Dr Boufford and Dr Leppo, in particular. It was WHO's responsibility to define research priorities which should be in accordance with the needs of countries and regions. Special attention should be accorded to the social and biological aspects of research, as Dr Boufford had said; but the question as to how resources could best be used for the benefit of the community and better and more rational use be made of technological progress was also important. He shared Dr Kalumba's ideas on areas of research. The quest for greater efficiency, ethical aspects of decision-making, and improvement of the quality of health services were all major concerns. In addition, the achievement of social equity was a fundamental mission of the Organization, calling for the mobilization of the international community on the advancement of the three interrelated causes on which human well-being in the health field depended: research, teaching and the provision of medical care.

Professor BERTAN, welcoming the report and oral presentation, said there was no need to dwell on the importance of the subject. Research priorities should be in alignment with the priorities defined in the health-for-all strategy and with WHO's views, as the lead agency in international health matters, concerning the most pressing global issues. Wide dissemination and application of research findings were obviously important; one matter which deserved more attention was the need to strengthen the Organization's advisory role in determining which of various - sometimes contradictory - research findings could or should be generally applied and in assisting countries in adapting the outcomes of research to specific circumstances: the calculation and use of DALYs was a case in point.

Dr DEVO said that research undoubtedly played a valuable part in the endeavour to achieve well-being for all. He fully supported the remarks made by Professor Girard, in particular. One question which remained unanswered in the report and the excellent oral presentation concerned the difficulty, where research was concerned, of maintaining a balance between the rights of individuals, the interests of society and the limited resources of the environment. He called his colleague's attention to the work of the 1994 WHO-CIOMS workshop on the impact of scientific progress on health, and echoed the views of other Board members concerning the need - in the name of worldwide solidarity - to bear ethical considerations constantly in mind.

Mr SMYTH (alternate to Mr Hurley) endorsed Dr Blewett's remarks on the subject of the World Bank and its use of DALYs. The health portfolio of the World Bank was understood to be currently valued at US$ 8 billion to be increasing by US$ 2 billion each year - a major investment by any standards. If WHO wanted to develop links with the Bank and other agencies, then it would have to develop a clear strategy structured around priorities which were themselves based on good quality research. The controversy with

regard to DALYs should thus be resolved as a matter of urgency if it was not to have a negative effect on the critical investment decisions, both by WHO and by other potential strategic parties.

Dr BANKOWSKI (Council for International Organizations of Medical Sciences), speaking at the invitation of the CHAIRMAN, said but for constraints of time, he would have wished to say a few words on CIOMS collaboration with ACHR and, through ACHR, with WHO.

Dr FEACHEM (World Bank) noted that since 1992 the World Bank and WHO had been working actively together on the measurement of burden of disease. The concept of disability-adjusted life years (DALY) constituted only part of that exercise, which had other important components, including, for example, the construction of a comprehensive picture of mortality by cause, place of residence, gender and age, for the world as a whole. The work on burden of disease had proved useful to client countries in considering priorities and guiding the allocation of public resources. Burden-of-disease work was also under way, using either DALY or local modifications of that indicator, in sub-Saharan Africa (in Eritrea, Ethiopia, Guinea, Kenya, Mauritius, Uganda, United Republic of Tanzania and Zambia); Asia (in India, Indonesia, Sri Lanka and Turkey); in the Middle East and North Africa (in Algeria, Jordan, Morocco and Tunisia); Latin America and the Caribbean (in Chile, Colombia, Guatemala, Jamaica, Mexico and Uruguay); and Eastern Europe and the former Soviet Union (in Estonia, Georgia, Kyrgyzstan, Turkmenistan and Uzbekistan). It appeared that the quantification of burden of disease and associated cost-effectiveness analysis would be of increasing assistance to policy-makers in wealthy and poorer countries alike in making difficult policy choices and resource allocation decisions. While there was no single approach to the analysis of burden of disease, it was fair to say that the joint work of WHO and the World Bank had constituted a great contribution and incentive to research in that field. As Dr Kalumba had pointed out, institutional, political and social factors and parameters had also to be taken into account, along with data on burden of disease and cost-effectiveness, when taking policy decisions and allocating resources.

As for the Ad Hoc Committee, it was an independent group bringing together broad national, professional and disciplinary representation. Its work had been widely debated in both low- and middle-income countries. The World Bank was but one of the 12 sponsors of the Ad Hoc Committee, the others being six governments (Australia, Canada, Norway, Sweden, Switzerland, United Kingdom), four major foundations and the International Health Policy Programme. In October 1995, the sponsors had met with representatives of low- and middle-income countries to discuss a draft report by the Ad Hoc Committee. The meeting had found merit in the work of the Ad Hoc Committee and had agreed to refine, develop and take forward its recommendations, in close collaboration with other partners. The World Bank intended to be part of that process and regarded WHO's continuing active involvement as being essential to an appropriate and agreeable outcome.

The World Bank was a supporter of the virtue of free markets, the most import of which was the free market of ideas. It therefore welcomed the vigorous debate among technical specialists. While that debate continued, health planners, those allocating health resources and international assistance agencies would make use of the best methods and techniques available, in anticipation of their further refinement and development.

Dr HU Ching-Li (Assistant Director-General) said that the comments by members of the Board indicated that, despite economic constraints, WHO should not weaken its role of directing and coordinating health research, and that the research policy and agenda should complement the renewal of the health-for-all strategy. Concern had been expressed about ACHR and the Ad Hoc Committee. The Board and the Health Assembly gave ACHR its mandate, while ACHR transmitted its recommendations and views regarding the coordination of health research to the governing bodies through the Director-General. The Ad Hoc Committee was an independent body focusing on health research. Some of its meetings had been hosted by WHO in Geneva and its views had been put before ACHR. In accordance with its mandate, the latter had established review groups to consider the work of the Ad Hoc Committee and the DALY indicator, and had submitted its views to the Board. As the Director-General had said, new partnerships were needed to coordinate efforts to setting priorities in health research, but decisions would ultimately be taken, after discussion in the Executive Board, by the World Health Assembly. In response to Dr Boufford's request for

more information about safety promotion and injury control, he said that the information would be provided to her directly by programme staff outside the meeting.

Professor FLIEDNER (Chairman of the Advisory Committee on Health Research), responding to the debate, reiterated that for the past 36 years ACHR - a body set up at the behest of WHO's governing bodies - had endeavoured to fulfil its mandate, using its best scientific judgement. It had therefore been with some distress that he had listened to the earlier discussions on WHO's priorities and noted the omission of any mention whatsoever of scientific research. The only way to cope with the diseases targeted as priorities lay through the generation and dissemination of new knowledge. The involvement of the scientific community was, therefore, essential and he urged the Board explicitly and without delay to recognize the importance of scientific research. Health was not a static affair; rather, it was linked to global development, particularly population dynamics, industrialization and environmental issues. The year 2020 was likely to be fraught with complex health questions requiring complex responses, not only from the sciences - medical and social sciences, economics and engineering - but also from the humanities with regard to ethics. In that connection, he remarked that CIOMS - whose representative had not been able to develop his intervention fully at the present meeting - had been addressing ethical issues somewhat extensively over the past few years and its findings were readily available. For the moment, little attention was paid in national research institutions to the complexity of global development and that was why the scientific community must be alerted to that dimension. Governments understandably wished to use research funds in the first instance for national benefit. New, globally-oriented thinking was, called for. Against that background, ACHR was trying to help WHO identify a future research agenda and to mobilize the scientific community to accept that agenda. But efforts were also needed to encourage donors - as well as scientists - to think globally in terms of research and to make governments aware of the potential contribution of the sciences to health.

Professor SAYERS (Advisory Committee on Health Research) said that the ACHR DALY review group believed that major decisions regarding the allocation of health resources should be based on information that was as good and as dependable as possible. The essence of his own particular contribution to ACHR's conclusions on the ad hoc report was that it was unwise to base a major study on a single health measure, especially one which was as yet unverified and unvalidated and which seemed to ACHR to be not yet a mature and reliable instrument. Three types of difficulty had been encountered with DALY. First, there was a structural difficulty: omissions must be remedied and there was scope for substantial modification, requiring further scientific debate. Second, there were ethical problems which called for debate. Third, there were consequential problems flowing from the manner in which the DALY indicator was used, in particular for calculating the health burden. DALY was valuable in certain circumstances in an appropriate form but in general where there were multipathologies or long-standing and more remote causes of disease and disability DALY was felt to be at present inappropriate; its uncritical widespread acceptance seemed to reflect the fact that expectations were too high for a single index. In fact, one of ACHR's conclusions was that users of DALY needed to understand that in its present form it failed to accommodate the multifactorial nature of disease and the existence of both long-standing and immediate determinants of disease or to recognize the common situation where multiple pathologies could and did exist. Thus the use of DALY in its present form, without full cognizance of those limitations, should be discouraged, especially for the allocation of resources to improve community health.

If DALY was not to be used, then what could be? ACHR was currently investigating at least two new approaches to the indicator problem, and intended in due course to throw the question open to the scientific community, together with some ideas designed to catalyse thought on the matter.

Dr GODAL (Tropical Disease Research), speaking in his capacity as Study Co-Director of the Ad Hoc Committee on Health Research Relating to Future Intervention Options, thanked Board members for their positive comments and constructive criticisms of the current and past drafts of the ad hoc review. He said that the review's basic aim was to strengthen the analytical basis for decision-making with regard to the allocation of resources for health research and development. When the Committee had chosen to use DALY as an aggregated measure of disease burden usually expressed in terms of mortality and disability, it had done

so for four reasons. Firstly, the reality was that decision-makers had to make their decisions regarding the allocation of resources by taking an aggregated approach to the disease burden. Secondly, it was very important to have a unifying measure of disease burden for further analysis and, for example, assessing risk factors or determinants; there was a need for cost-effective interventions in health research and development, and it was a great advantage in doing cost-effectiveness projections to have a single, unifying measure. Thirdly, DALY had been developed as an intersectoral collaboration, and that was very important as a foundation for strengthening the multisectoral approach to health. Fourthly, DALY were explicit in their assumptions, and those assumptions could be debated and modified to meet local, regional and national needs. All the basic data that had been used for constructing DALY in terms of the report would be available in the accompanying documentation. What DALY did not do was to deal with the considerable underlying uncertainty in the data; numbers appearing after the decimal point still had to be treated with caution. There was undoubtedly scope for improvement with regard to DALY, but that debate could most usefully be conducted in the scientific literature. He said the Ad Hoc Committee was very concerned about resources for health research and development; its calculations had shown a decline in resources going to populations in greatest need, especially those in developing countries. It was a serious ethical issue as well as an economic one; for example, vaccines had been developed in the North which had not been advanced in terms of testing in the South. Turning to the "consortium" issue, he said that the Ad Hoc Committee had observed that the organization of health research and development was very fragmented, and there was a need for strong advocacy to counteract the declining trends. An example had been taken from the agricultural research system: the Committee had suggested a voluntary forum in order better to aggregate, consolidate and to coordinate activities. WHO's role in that had been set out in the latest version of the document responding to some of the concerns expressed by ACHR. If the Organization were to take the lead in the establishment of such a forum, with the help of other key players, there would be many advantages, including a speedy aggregation of dispersed research and development activities. The Ad Hoc Committee had addressed and incorporated the ACHR criticisms in the version of the document made available to members of the Board, except for the maintenance of the DALY approach; it had also noted the other comments that had been made by members of the Board, which would be incorporated in the final version of the document. Finally, he said he was confident that the Ad Hoc Committee would commit itself to collaborate with every body concerned in order to make sure that the resources available for health research and development were used in the best possible manner to combat the world's health problems, especially those of the most disadvantaged populations.

Dr MACFADYEN (Regional Office for Europe) noted the view of the Chairman of ACHR that research was being neglected in the European Region. A decision had been taken to wind up the research programme - it had been allocated zero regular budget programme resources and zero human resources. The reason for that decision was the East-West health gap, which WHO must assist governments in closing on a very short time scale. Since it was the Regional Committee that had taken the decision in question, it could easily reverse it in the 1998-1999 biennium, but that would mean another programme would have to be terminated. When Regions made such difficult choices, they must be firm in adhering to them. The European Advisory Committee on Health Research would, nevertheless, be convened during the coming biennium, jointly with the Standing Committee, and would focus on the health-for-all update and on ensuring that it was evidence-based.

As had been pointed out, paragraphs 23 and 24 of the Director-General's report (document EB97/17) were fairly critical of the decision taken by the Regional Committee. Yet that decision had related only to the budget of the Regional Office; it did not prevent the Regional Office from sponsoring research in the Region. Programme managers would mobilize funds in the way research was usually funded - by competitive bidding for available resources based on high-quality proposals.

Mention had also been made of the serious problem of research in the Central and Eastern European countries: that, too, might usefully be discussed by the European Advisory Committee on Health Research. The situation in Central and Eastern Europe was unusual in that there was an established research structure, yet no funds were available to maintain laboratories and pay young researchers. The problem was how to preserve that intellectual and physical capital.

In conclusion, he said the decision to roll back the research programme had arisen from the specific circumstances of the European Region; he would not necessarily advise other Regions to follow suit.

The DIRECTOR-GENERAL thanked Professor Fliedner for chairing ACHR, which had provided constructive advice as well as criticism with regard to WHO's health research activities. The Ad Hoc Committee, too, had made a great contribution to the Organization's vision and to thinking on its future research policy. Research activities always entailed competition and often involved duplication. All WHO programmes had research components which were coordinated under the aegis of the ACHR system. Under the new extended partnership, ACHR would provide constructive oversight of the research carried out by the Ad Hoc Committee.

As Professor Girard had noted, health research was a most complex endeavour. Its outcomes must be applicable in the implementation of health care programmes at country, regional and global levels. Dr Kalumba had stated a few days earlier that WHO concentrated on figures for mortality, to the detriment of those on morbidity. Yet the Ad Hoc Committee was now looking at aggregated data on mortality, morbidity and disability.

A number of methods had been developed for deciding on the allocation of health resources. These included "disability-free life expectancy", "quality-adjusted life expectancy", DALY and, in the Organization for Economic Co-operation and Development, "years of productive life lost". Application of the DALY indicator alone at the country level of an indicator for allocation of resources might give misleading results. For example, in The World Health Report 1995 (page 38 of the English version), the first table shown in box 9 indicated that in Finland in 1986 independent life expectancy of men aged 65 was 13.4, but disability-free life expectancy was 2.5; in Egypt, a developing country, male life expectancy at age 65 in 1989 had been 12.1, and disability-free life expectancy, 10.8. The values thus varied widely with the health conditions and economic resources of the country concerned. As had been pointed out by Professor Sayers, the question required further study, and new research partnerships should be established. Research results should not, however, be imposed, abused or misused for the formulation of national policy. The sovereignty of countries must be respected, and the Regional Directors and the WHO Secretariat concurred that the role of WHO was to facilitate and support the establishment of national policies and not to impose a particular method for the allocation of resources. The Secretariat always considered the results of research conducted within, as well as outside WHO not only for the sake of integrity, but also for transparency and accountability supporting the development of national health policy.

Dr PIEL (Cabinet of the Director-General), at the request of the CHAIRMAN, read out a conclusion to the discussion on the report of the ACHR for inclusion in the summary record: "The Executive Board appreciates and endorses the ongoing work of the Advisory Committee on Health Research in conformity with its mandate and in particular supports its efforts to develop a proposed research policy and agenda to complement the renewal of the health-for-all strategy and to mobilize the scientific community and scientific knowledge in support of international health work."

Dr AL-AWADI (alternate to Dr Al-Muhailan) expressed warm understanding of Professor Fliedner's appeal for at least some mention of research in the context of priority-setting. Research was a basic component of progress. Indeed, without research there would be no progress. That fact deserved due recognition.

Dr BOUFFORD suggested that besides endorsing the conclusion read out by Dr Piel, Board members might wish to encourage ACHR, with appropriate partners, to accelerate the investigation of burden-of-disease measurements that could be used in health policy decision-making.

The Board took note of the report.

The meeting rose at 13:35.

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Global Forum for Health Research

HELPING CORRECT THE 10|90 GAP

FORUM 8
Mexico City
16-20 November 2004
www.globalforumhealth.org

Background

The Millennium Development Goals (MDGs) adopted by the United Nations in 2000 provide an opportunity for concerted action to improve global health. They place health at the centre of development and establish a novel global compact among developed and developing countries through clear, reciprocal obligations. However, despite revolutionary progress in biomedicine, research advances and new knowledge are not reaching populations in greatest need.

At present rates of progress, the MDGs will not be realized for a majority of the world's population. There is an urgent need to create new products and tools and to identify structures and means to translate knowledge to effective intervention. This will require the development of delivery strategies that achieve effective and sustained coverage in diverse cultural and economic settings. It also may require a fundamental restructuring of interaction between the research, disease control and development communities, a systematic programme of research related to building capacity at multiple levels, from operational research through community-based intervention.

Forum 8 will focus on global efforts to expand health research in neglected areas to support the achievement of the MDGs.

The World Summit on Health Research

Forum 8 will take place in parallel to the World Summit on Health Research, organized by the World Health Organization and hosted by the Mexican Government. The Summit will focus on the country level: action on health research and knowledge management to strengthen health-sector response to achieve the MDGs.

The Summit and Forum programmes include a number of joint sessions: the opening ceremony, a plenary session and coffee break each morning, evening receptions and the closing plenary.

Who will take part?

The Global Forum's annual meeting provides the opportunity for presentations and exchange of views on key issues on the global health agenda. This year's theme allows examination of health research needed to meet each of the MDGs. In addition, it poses questions of health priorities not covered by the goals themselves.

Participants from a broad range of constituencies are expected to be present: health and development ministries, multilateral and bilateral agencies, research-oriented bodies and universities, NGOs, the private sector, the media.

The programme

The programme (see the overview) provides opportunities for both formal presentations and constructive debate. Time is set aside for networking and personal meetings. Features include:

- joint Forum 8/Summit plenary sessions
- plenary sessions
- panel discussions
- parallel sessions including presentations, roundtables, discussion groups, workshops
- special interest group meetings
- poster sessions
- the Marketplace

Programme sessions will be constructed around invited presentations but contributions are also welcome. A call for abstracts on the specific programme themes is open. The deadline for receipt of abstracts is 31 May 2004.

A feature of Forum 8 is the Marketplace with stalls where individuals and institutions will showcase their work, share results of recent research, display publications, exchange ideas and make or renew contacts.

The programme is set up to allow time for discussion and interaction: breaks and free time over lunch will be focused around the Marketplace to stimulate maximum contact.

Limited space is reserved for business meetings and special interest groups (Thursday evening 18 November). In addition, a number of satellite meetings can be arranged on the two days before and after Forum 8. Please contact the Secretariat for further details.

Preliminary programme overview (as of April 2004)

Time	Tuesday 16 November	Wednesday 17 November	Thursday 18 November	Friday 19 November	Saturday 20 November
9.00–10.30		Joint Forum 8 + Summit Plenary Session 1 Knowledge access and sharing	Joint Forum 8 + Summit Plenary Session 5 Turning knowledge into action: Bridging the 'know-do' gap	Joint Forum 8 + Summit Plenary Session 9	Joint Forum 8 + Summit Plenary Session 13 - Presentation of Mexico Declaration - Presentation of Forum 8 Statement
10.30–11.15		Break/Marketplace	Break/Marketplace	Break/Marketplace	Break/Marketplace
11.15–13.00		Session 2 *The 10/90 gap in health research and the MDGs* Plenary 1 Overview: The Global Forum and the MDGs Panel discussion Plenary 2 Contributions towards reaching the MDGs by: - public sector - private sector - civil society Panel discussion	Session 6 *Delivering better health to families and communities* Plenary 5 Child and maternal health Panel discussion Plenary 6 Health research for a sustainable environment Panel discussion	Session 10 *Measuring progress towards the MDGs: research and the 'don't-know' gap* Plenary 9 - Financial flows and priority setting - Health systems performance - Indicators of progress Panel discussion	Joint Forum 8 + Summit Plenary Session 14 Panel from Summit and F8 Dialogue session between Summit and Forum 8 participants
13.00–14.00		Lunch/Marketplace	Lunch/Marketplace	Lunch/Marketplace	Final Lunch
14.00–15.45	Registration	Session 3 *Cross-cutting issues and the MDGs* Plenary 3 Poverty and equity Panel discussion Plenary 4 Gender Panel discussion	Session 7 *Health research on diseases and determinants* Plenary 7 Combating infectious diseases Panel discussion Plenary 8 Combating noncommunicable/chronic diseases, violence, injuries Panel discussion	Session 11 *Partnerships in health research for development* Plenary 10 Networks Panel discussion Plenary 11 PPPs Panel discussion	
15.45–16.15		Break/Marketplace F8 Poster Session 1	Break/Marketplace F8 Poster Session 2	Break/Marketplace F8 Poster Session 3	
16.15–18.00	Joint Opening Session	Session 4 Parallel sessions, including: Ageing, youth and ageing Disability Equity Gender Poverty Research capacity strengthening	Session 8 Parallel sessions, including: Communicable diseases Environment Maternal and child health NCDs Violence and injuries	Session 12 Parallel sessions, including: Partnerships Policies Priorities	
Evening	Joint Opening Reception	Global Forum hosts Joint Reception	Forum 8 Special Interest Groups	Joint Gala Dinner	

Global Forum for Health Research

The Global Forum for Health Research is an independent international foundation established in 1998 in Geneva (Switzerland). The main objective of the Global Forum is to help correct the 10/90 gap in health research. In 2004, it is particularly looking at ways in which the gap needs to be reduced if the Millennium Development Goals are to be achieved. The Global Forum also seeks to focus research efforts on the health problems of the poor by bringing together key actors and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research.

Meeting venue

Forum 8 will be held at the Hotel Sheraton Centro Historico, Mexico City.
The meeting opens in the late afternoon of Tuesday 16 November and closes at lunchtime on Saturday 20 November.

Language

English is the working language of the meeting. Joint plenary sessions with the World Summit will be interpreted in English and Spanish.

Travel and accommodation

Participants are responsible for their own travel arrangements.
Convention Center, the Global Forum's mandated agent for arrangements in Mexico City, handles participation fees, hotel reservations, sightseeing and local logistics:
Convention Center, Barrilaco 410, Lomas de Chapultepec, CP 11000, Mexico DF.
Tel. + 52 55 5201 7930 Fax +52 55 5520 9284 forum8@convention-center.net

Visas

For details of visa requirements please consult the nearest Mexican consulate or embassy.

Participation fees

Participants are asked to pay a contribution towards the expenses of the meeting. The fee is:

- US$100 for participants from low- and middle-income countries
- US$500 for participants from high-income countries.

The fee covers all meeting activities including:

- full documentation
- working lunches, contact breaks, the opening reception and any other refreshments or entertainment offered as part of the official programme
- transport between the airport and Forum 8 hotels on arrival/departure.

Participants are separately responsible for the costs of their travel and accommodation.

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Mexico FORUM 8
Mexico City, 16-20 November 2004

Global Forum for Health Research
HELPING CORRECT THE 10|90 GAP

REGISTRATION FORM

Please type or PRINT

Title: Dr Ms Mr Prof _____ Sex: M F

First name: _____

FAMILY name: _____

Nationality: _____

Position: _____ Department: _____

Division: _____

Organization: _____

Address: _____

PO Box: _____

Postal/zip code: _____ City: _____

State/Province: _____ Country: _____

Tel: _____ Fax: _____

E-mail: _____

Web site: _____

Areas of personal interest/expertise *(you may choose more than one)*

A Research on diseases / conditions

- ◯ Cardiovascular
- ◯ Childhood-related
- ◯ HIV/AIDS
- ◯ Injuries
- ◯ Malaria
- ◯ Mental health
- ◯ Tuberculosis
- ◯ Other communicable diseases *(please specify):*
- ◯ Other non-communicable diseases *(please specify):*

B Research on determinants

- ◯ Child abuse
- ◯ Access to health services
- ◯ Education
- ◯ Malnutrition
- ◯ Physical inactivity
- ◯ Pollution:
  - ◯ Air
  - ◯ Water
  - ◯ Other: _____
- ◯ Substance abuse:
  - ◯ alcohol
  - ◯ drugs
  - ◯ tobacco
  - ◯ Other: _____
- ◯ Unsafe sex
- ◯ Violence
- ◯ Other *(please specify):*

C Priority-setting methodologies

- ◯ Priority-setting frameworks (general)
- ◯ Cost-effectiveness
- ◯ Disease burden
- ◯ Resource flows into health research
- ◯ Equity measurement
- ◯ Other *(please specify):*

D Cross-cutting issues affecting health research

- ◯ Capacity strengthening
- ◯ Gender
- ◯ Health policy and systems research
- ◯ Health research communication
- ◯ NGO research in developing countries
- ◯ Poverty
- ◯ Public-private partnerships
- ◯ Other *(please specify):*

Payment *(please indicate the method chosen)*

◯ Bank transfer to (in US dollars):
Meetings and Conventions SA de CV, Bank Santander Serfín, Branch 0400 Palmas Corinto, Plaza 001, Mexico DF
Account number: 82500241524 • **Wire transfer:** 014180825002415247

◯ Charge to: ◯ American Express ◯ MasterCard ◯ VISA Card number _____

Expiry date *(MM/YY)* _____ Cardholder's name _____

Signature of cardholder _____

You may also register via our website www.globalforumhealth.org

Global Forum for Health Research

HELPING CORRECT THE 10|90 GAP

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Mexico FORUM 8

Mexico City, 16-20 November 2004

REGISTRATION FORM

Registration for Forum 8 can be completed on line on our website **www.globalforumhealth.org**. Or you may complete and return this printed form by fax or mail, to the address below.

When your registration is received, you will be sent an acknowledgment.
The Global Forum will confirm registrations from May 2004 onwards.

Registered participants will then receive:

- a confirmation letter for use in visa applications, in requests for funding or leave of absence
- information on visa applications
- details on the programme and speakers for Forum 8
- a registration form for the Marketplace.

Between May and November, additional information on programme content, confirmed speakers and logistics will be posted on our website. Participants are invited to bookmark the site for regular visits.

Payment of fees, hotel reservations, sightseeing and local logistics will be handled by the Global Forum's mandated agent in Mexico City, **Convention Center**.

The participation fee for Forum 8 is US$100 for those from low- and middle-income countries; US$500 for participants from high-income countries.

This fee covers all meeting activities including:

- full documentation
- working lunches, contact breaks, the opening reception and any other refreshments or entertainment offered as part of the official programme
- transport between the airport and Forum 8 hotels on arrival/departure.

Participants are separately responsible for the costs of their travel and accommodation.

Payment can be made by:

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Mexico FORUM 8
Mexico City, 16-20 November 2004

Global Forum for Health Research
HELPING CORRECT THE 10|90 GAP

REGISTRATION FORM

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Areas of personal interest/expertise *(you may choose more than one)*

A Research on diseases / conditions

- ◯ Cardiovascular
- ◯ Childhood-related
- ◯ HIV/AIDS
- ◯ Injuries
- ◯ Malaria
- ◯ Mental health
- ◯ Tuberculosis
- ◯ Other communicable diseases *(please specify):*
- ◯ Other non-communicable diseases *(please specify):*

B Research on determinants

- ◯ Child abuse
- ◯ Access to health services
- ◯ Education
- ◯ Malnutrition
- ◯ Physical inactivity
- ◯ Pollution:
  - ◯ Air
  - ◯ Water
  - ◯ Other: _____
- ◯ Substance abuse:
  - ◯ alcohol
  - ◯ drugs
  - ◯ tobacco
  - ◯ Other: _____
- ◯ Unsafe sex
- ◯ Violence
- ◯ Other *(please specify):*

C Priority-setting methodologies

- ◯ Priority-setting frameworks (general)
- ◯ Cost-effectiveness
- ◯ Disease burden
- ◯ Resource flows into health research
- ◯ Equity measurement
- ◯ Other *(please specify):*

D Cross-cutting issues affecting health research

- ◯ Capacity strengthening
- ◯ Gender
- ◯ Health policy and systems research
- ◯ Health research communication
- ◯ NGO research in developing countries
- ◯ Poverty
- ◯ Public-private partnerships
- ◯ Other *(please specify):*

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