Pan American Health Organization World Health Organization

XXVIII MEETING OF THE ADVISORY COMMITTEE ON HEALTH RESEARCH

Montevideo, Uruguay
20-23 August 1991

ACHR 28/91.16
Original: English

THE TASK FORCE ON HEALTH RESEARCH FOR DEVELOPMENT

BACKGROUND

Dr. Richard Wilson
Task Force on Health Research Secretariat
Geneva, Switzerland
July 1991

22 July 1991

The Task Force on Health Research for Development

Background

The Commission on Health Research for Development was established in 1987 by sixteen sponsoring agencies to study and make recommendations on how research might improve the health and well-being of the peoples of the developing world. The Commission released its report in February 1990 at the Karolinska Institute Nobel Conference with the participation of over 90 representatives from developing and developed countries, UN agencies, development agencies, private foundations, community organizations and academic institutions. The Conference endorsed the Commissions's four major recommendations, especially the concept of Essential National Health Research (ENHR). The Conference requested IDRC and SAREC to accept responsibility for a "Task Force" to carry forward the Commission's Recommendations over a 2 year period. Thus the Task Force on Health Research for Development came into being on 1 January 1991.

Membership

Prof. V. Ramalingaswami (India) Chairman
Prof. Adolfo Martinez-Palomo (Mexico) Vice-Chairman
Mr. F.H. Abed (Bangladesh)
Prof. Eusebe Alihonou (Benin)
Dr. Isao Arita (Japan)
Prof. David Bradley (United Kingdom)
Prof. Gelia Castillo (Philippines)
Prof. Lincoln Chen (United States of America)
Prof. Esmat Ezzat (Egypt)
Prof. Marvellous Mhloyi (Zimbabwe)
Dr. Carlos Morel (Brazil)

The Task Force is assisted in its work by members of the original Commission, consultants from many disciplines and countries and by a **Management Support Group** consisting of representatives of IDRC (Canada), SAREC (Sweden), The Edna McConnell Foundation (USA) and the GTZ (Germany).

Objectives

To promote, facilitate and support ENHR in countries that wish to undertake it.

- to promote and facilitate the strengthening of national health research capacities in association with ENHR;
- to work with 8 - 10 countries to analyze and compare their ENHR experiences.

To develop and evaluate options for longer term mechanisms for the support of ENHR.

- to develop links with international agencies (in particular WHO and UNICEF) and international "Networks" active in health research;
- to present the work of the Task Force to countries and national and international agencies.

To promote synergism between research on global health problems and ENHR.

- to serve as a "broker" for international research initiatives on selected global health problems;
- to link research on global health problems to country ENHR endeavors.

ESSENTIAL NATIONAL HEALTH RESEARCH

In its Action Agenda, the Commission described ENHR as follows:

> "To understand its own problems, to enhance the impact of limited resources, to improve health policy and management, to foster innovation and experimentation, and to provide the foundation for a stronger developing-country voice in setting international priorities, the establishment and strengthening of an appropriate health research base in each developing country, no matter how poor, is essential. This Commission has named such a base *essential national health research*. -------
>
> --------- Exactly what mix of research is essential must be defined by each country, but it will contain some measure of two basic components, country-specific health research and global health research."1/

While the Commission Report describes the health information and analyses that should be available to each country and how these may improve health policy and management, the Report is less explicit regarding the ultimate goal of these better policies and management. For clarification, the Task Force turned to "**Equity in Development**" as expressed in the title of the Commission's Report.

The Task Force believes that **Equity in Health** is the overriding objective of Health Research. And that ENHR is the process through which this can be achieved.

ENHR is an integrated strategy for organizing and managing research, whose defining characteristics include its goal, its content and its mode of operation:

1/ "Health Research - Essential Link to Equity in Development", Oxford University Press 1990

- ENHR's goal is to promote health and development on the basis of equity and social justice.

- ENHR's content includes the types of research commonly described as epidemiology, health and human behavior research, clinical and biomedical research, health services research, policy analysis, and management and communications research; but is specifically orientated toward issues affecting the entire population, with particular emphasis on the poor, disadvantaged and other vulnerable groups whose health needs are often overlooked and ignored.

- ENHR's mode of operation is characterized by inclusiveness. It involves researchers, health care providers and representatives of the community in planning, promoting and implementing research programs and in the application of the results of research.

  To ensure appropriate inputs from various disciplines, ENHR promotes multidisciplinary and intersectoral research and establishes mechanisms to close the gap between research and application. The ENHR process ensures that the results of research are effectively translated to action; that objective scientific analysis guides policy and action; and that setting priorities for health research involves health care givers, policy makers and the public at large.

Equity in Health

Equity in Health involves all the people of a country. Therefore, the ENHR Process must:

- focus national resources for research - human, institutional and financial - upon the health problems of all the people, especially those who are poor, disadvantaged and deprived;

- find solutions for their health problems which are desired, realistic, effective and within national means;

- enable the people, their families and their communities to take responsibility for their own health and to contribute to maintain it; and ENHR must

- improve and maintain the quality of their lives.

Only then has there been movement towards **Equity in Health.**

Components of ENHR

To move towards Equity, the ENHR process must include three crucial components:

(1) A NATIONAL FOCUS.2/ ENHR is national and country specific. ENHR focuses upon national or sub-national (geographic) areas and communities. ENHR aims to evolve national policies and allocate national resources to solve national problems. Thus the ENHR Process is just as applicable to developed as to developing countries. Indeed, the Task Force has had a number of enquiries about the application of ENHR from developed countries.

(2) THREE CONSTITUENCIES. Three constituencies participate in the ENHR Process:

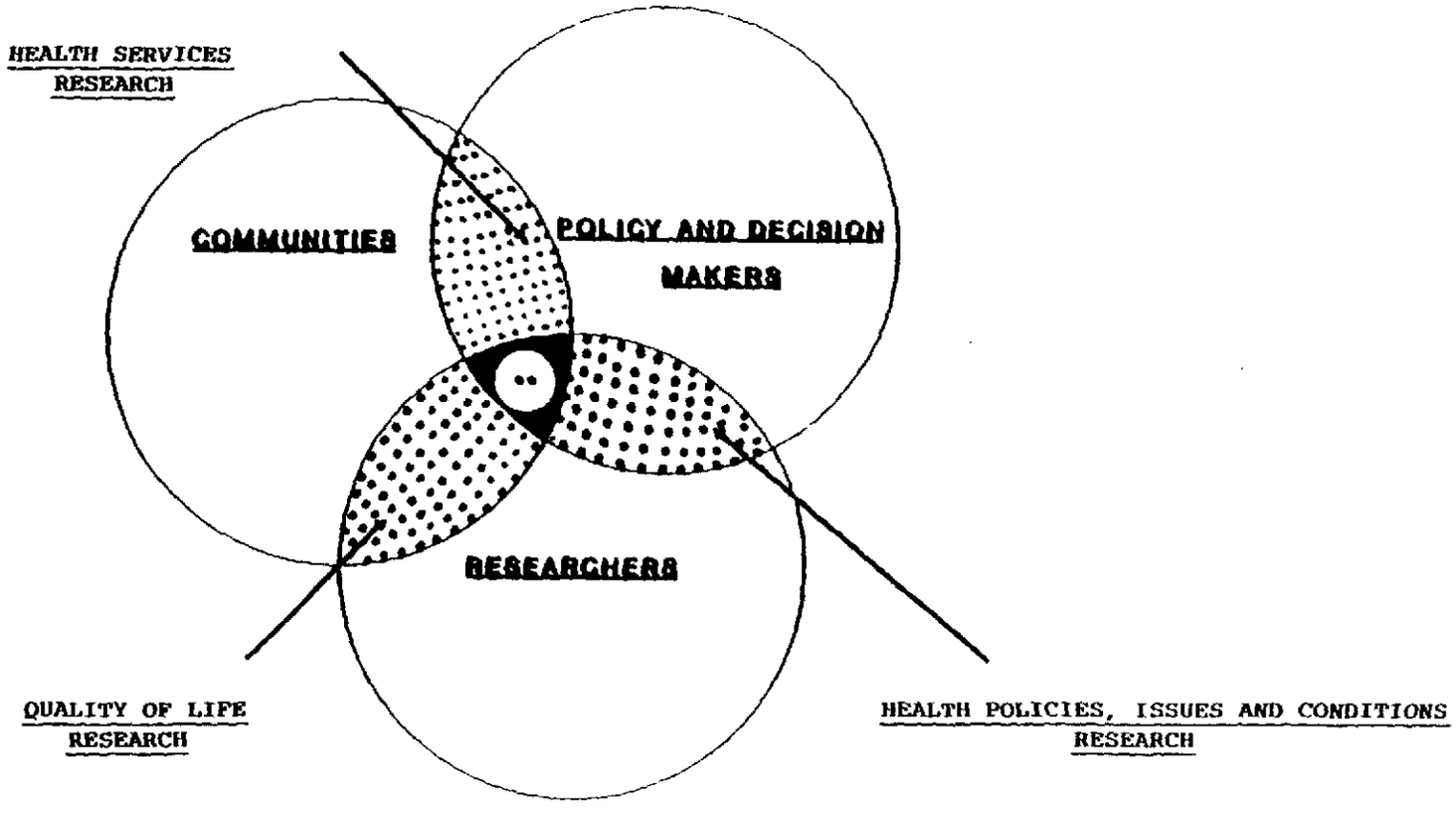
- Decision Makers (from the village to the central government);

- Researchers (from all the necessary branches of the biological, social and physical sciences); and

---

2/ Major Health Inequities exist between countries and these must also be addressed through a process similar to ENHR.

THE ESSENTIAL NATIONAL HEALTH RESEARCH PROCESS



•• EFFECTIVE AND SUSTAINABLE SYSTEMS OF COMMUNITY HEALTH AND IMPROVED QUALITY OF LIFE

- People representing their Communities.

All three constituencies are crucial for the identification of Health Problems, the setting of priorities for research, the application of the results of research, the elaboration of interventions, the development of policies and the allocation of resources.

(3) LINKAGES AND COMMUNICATION. Effective linkages and true dialogues must be forged amongst the three constituencies. The sharing of information and the results of its analysis leads to mutual trust and facilitates collaboration. If this is achieved, the identification of problems and the setting of priorities become easier. Priorities established through ENHR inevitably focus first upon more immediate health problems and this is appropriate. However, as more resources become available, the national health research agenda may include initiatives which will provide results relating to longer-term problems. The interaction of the three ENHR Constituencies is illustrated in Figure 1.

Making ENHR Operational

ENHR is country specific and each country evolves its own ENHR plans in its own way. However, experience has shown that most countries follow a series of steps based upon the three components listed above. The steps usually, but not always, follow in sequence.

- Formation of a group of 6 - 8 people, including representatives from each of the three constituencies, to promote the concept of ENHR and assess its national applicability. (support from the Task Force is available for this promotion and planning)

- A 2 - 4 day Workshop, including representatives of each

of the three constituencies, to consider the value and feasibility of ENHR; if it is decided to go ahead,

- the institutionalization of the ENHR Process and the production of the ENHR plan. (support from the Task Force is available for this)

- Networking with groups in other countries carrying out their own ENHR Process.

- Acceptance of the ENHR Plan and the organization for its implementation and financing, both national and external. (Task Force assistance is available for this if desired)

- Implementation, monitoring and evaluation of the ENHR Plan and the continuation of the Process.

Research which could be part of the ENHR Process

The Commission noted that "country specific" health research was neglected in many countries. The priority health problems identified through the ENHR Process will be country specific and will require various types of research disciplines, methodologies and approaches. Frequently solutions to the problems will be sought through multidiciplinary research initiatives. Typical examples are:

- Epidemiological research at the national and sub-national levels to define the nature, distribution patterns and extent of health problems;

- Participatory research in the community to identify and prioritize community health problems;

- Field research to evolve, test and evaluate technical and social interventions to solve priority health problems;

- Operational research to improve the cost/effectiveness of the management of health systems and the appropriateness of resource allocation;

- Economic research to find mechanisms to pay for efficient and effective health systems;

- Behavioral research to understand the nature of human (health) behaviour and how it might be improved;

- Communications research to evolve means of improving the health behaviour of individuals, families and communities; and

- Policy research to elaborate appropriate health policies and actions to move towards **Equity in Health.**

Any of the above might include research on specific diseases e.g. Malaria, health conditions e.g. diabetes and/or health issues such as water supply and sanitation.

Countries require many different kinds of knowledge to address the problem of health inequities. There are those who would argue that research is not the instrument with which to address issues of Equity. As a matter of fact, it is research which has illuminated and defined the Inequities in health and it is through research that we will find the means to eliminate them. The ENHR Process is one step in this direction.

TASK FORCE PLANS

The Task Force will meet six times during its tenure (1 January 1991 - December 1992).

8, 9 and 10 March 1991	-	Geneva, Switzerland
10, 11 and 12 July 1991	-	Geneva, Switzerland
18, 19 and 20 November 1991	-	Cotonou, Benin
25, 26 and 27 March 1992	-	Ismailia, Egypt
14, 15 and 16 September 1992	-	Geneva, Switzerland
7, 8 and 9 December 1992	-	Rio de Janeiro, Brazil

The Task Force has formed two Working Groups and one Sub-Committee to assist it in its work.

- Research Capacity Strengthening;
- ENHR Analyses and Evaluation; and
- Future Mechanisms to Support and Monitor ENHR and Research on Global Health Problems.

The Task Force is already collaborating with over twenty-five countries wishing to begin or already undertaking the ENHR Process and many others are expected to join this network. Close links have been established with WHO, UNICEF, UNDP and with international networks such as INCLEN (International Clinical Epidemiology Network), IHPP (International Health Policy Program), the Community based Health Educational Institutions and the other signatories of the Puebla Declaration. A monograph describing the ENHR process and analyzing ENHR experiences during the first year following the release of the Commission Report will be completed in August 1991. The newsletter ENHR Forum is being published in New Delhi with the collaboration of the South Asia Regional Office of IDRC. The work of the Task Force may culminate in an international conference early in 1993.

Resources

A group of Countries, Agencies and Foundations provide the resources for the Task Force. These include most of those who sponsored the Commission. The broad base of support from North America and Europe has been gratifying and it is hoped that more sponsors will join the group. A conscious attempt is being made to attract as many sponsors as possible and to keep individual contributions relatively small.

SECRETARIAT

A four person secretariat located at the UNDP offices in Geneva, Switzerland supports the Task Force.

INFORMATION

To obtain further information about the Task Force and its work, please contact:

Raphael Owor, or Richard Wilson, Coordinators
Task Force on Health Research for Development
c/o UNDP Palais des Nations
CH-1211 Geneva, Switzerland
Tel: (41 22) 798 5783 or (41 22) 798 5850 (ext. 348)
Fax: (41 22) 733 1452 or (41 22) 798 7524
Tlx: 415 464 undp ch