



**Global Forum
for Health Research**
HELPING CORRECT THE 10|90 GAP



Health Research for Policy, Action and Practice

Resource Modules

Version 2, 2004

Introduction

We welcome readers' comments to enable us to continually update and improve this material.

THE COLLABORATIVE TRAINING PROGRAMME
Alliance for Health Policy and Systems Research
Council on Health Research for Development
Global Forum for Health Research
INCLIN Trust

INTRODUCTION

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Acronyms

Alliance for HPSR	Alliance for Health Policy and Systems Research
COHRED	Council on Health Research for Development
GFHR	Global Forum for Health Research
ICHRD	International Conference on Health Research for Development, Bangkok, 2000
INCLIN	International Clinical Epidemiology Network

INTRODUCTION

Challenges in health research for development

The potential of health research for development remains largely unfulfilled. More than 800 participants (from about 100 countries) at the International Conference on Health Research for Development (ICHRD – Bangkok, 2000) acknowledged the current realities about global health at the beginning of the 21st century ([Box 1](#)). The Conference resolved that the realities must be confronted honestly, and that efforts to address these realities need to be intensified (IOC, 2001)

ICHRD: A pre-conference discussion paper, the conference summary, and other relevant documents can be found at the COHRED web site: <http://www.cohred.org>.

Greater investment in research

The “Bangkok analysis” has been reinforced and strengthened by the report of the Commission on Macroeconomics and Health (CMH, 2001), entitled: *Macroeconomics and health: investing in health for economic development*. The report begins with the assertion that “health is a priority goal in its own right, as well as a central input into economic development and poverty reduction”. The commissioners propose a plan for increasing investment in health to US\$ 66 billion per year above current spending, with the claim that this investment will yield a sixfold return – a gain of at least US\$ 360 billion – while at the same time saving eight million lives per year.

Need for advocacy and leadership

A statement from the press release issued at the time by the Commission on Macroeconomics and Health can be understood as an advocacy and leadership challenge.

“With bold decisions in 2002, the world could initiate a partnership between rich and poor of unrivalled significance, offering the gift of life itself to millions of the world's dispossessed and proving to all doubters that globalization can indeed work to the benefit of all humankind.”

http://www3.who.int/whosis/cmh/cmh_press/e/who_hq_20Dec2001.pdf

Box 1. New realities confronting the global health research community

Widening disparities – Despite some indications of progress in human development in the 1990s, health and socioeconomic disparities have widened in many countries and populations. Over 80 countries have lower per capita incomes than a decade ago, and the income gap between the richest and poorest quintiles of the world's people continues to widen, from 30-to-1 in 1960, to 60-to-1 in 1990 and 74-to-1 in 1997. With some exceptions, the health gap between countries is widening as well, particularly for three country groups: African countries, suffering most severely from the AIDS epidemic; countries in Eastern and Central Europe, where infrastructures have collapsed and diseases with socio-behavioural causes are escalating; and countries ravaged by prolonged and devastating internal conflicts. Again with some exceptions, within-country disparities in health have also widened – a phenomenon not limited to developing countries.

Globalization – Even though some aspects of globalization have a long history, the last decade has seen an accelerated growth in this phenomenon. Examples include new markets, new organizations (for example, the World Trade Organization), new rules and faster communication tools. Some aspects of globalization do improve the conditions of the poor (“globalization with a human face”) but, for the most part, it has increased poverty, inequality and insecurity. Globalization has had an impact on health, for example, through the actions of transnational corporations in the sale and control of pharmaceuticals and the marketing of tobacco in low-income countries.

Continuing pandemics – Several major health conditions affecting millions of people around the world loom larger than they did a decade ago, such as the epidemic of tobacco-related diseases, accounting for perhaps four million deaths in 2000. Another is the AIDS epidemic – HIV-1 is now the single largest cause of death from infectious disease, expected to account for 2.5 million deaths in 2000. When measured in terms of disability-adjusted life years (DALYs), injuries (both intentional and unintentional) account for 16% of all DALYs, and more than six million deaths annually. Malaria continues to worsen, particularly in Africa.

Knowledge and new information and communication technologies – Over the past decade, knowledge has become a central element in human development. Many high-income countries now call themselves “knowledge societies”, reflecting the impact of the knowledge explosion on economic and social development. The new information and communication technologies (ICT) are a major feature of this remarkable trend. Yet the world's poorest people, two billion or more of them, are missing out on the potential benefits. Despite some promising innovations, such as the use of community-based telecentres, large investments of money, persistence, and creativity are still needed to ensure that health knowledge improves the lives of the poor.

New understandings of health and development – The development community increasingly sees health as an integral part of human development. The 1990s brought us three important insights:

- investing in health is crucial for economic productivity and human development
- greater equity promotes economic growth and development
- the application of knowledge is central to global development.

(Source: Suwanwela & Neufeld, 2001:241-243)

Why the unfulfilled potential for research?

The partner organizations supporting this collaborative training project reviewed the following questions: Why is there unfulfilled potential for health research for development? Who will speak out for a bold new approach? Where will the leadership for change be found?

They concluded that at the heart of this discussion lies a paradox. In many ways, health researchers – as individuals and as organizations – are in the best position to advocate and lead transformation. They have the experience and knowledge, and many have the “long view” that sees the potential for health knowledge as an “essential link to equity in development” (CHRD, 1990). However, the real world of the researcher is driven by other knowledge-related incentives – objectivity,

comprehensiveness, career development and sheer survival (“publish or perish”). Researchers, for the most part, are not rewarded for identifying with a cause, participating in advocacy coalitions, stimulating and participating in policy debates or joining in with social action. In some situations, this paradox has become a conflict, exacerbated by increasingly pressing social problems and the recognition that knowledge may be available to understand and address these problems.

Rationale of the CTP resource materials

The partner organizations identified some hitherto neglected issues for which strengthened capacity in the research community would be useful in addressing these challenges. Firstly, as affirmed by the Bangkok conference, there remains a large and unfinished research agenda. However, priorities for this agenda need to reflect health priorities. Secondly, the four sponsoring organizations, along with many others, share a vision that health research is an essential link for equity in development. Each organization has taken on large mandates. Also, the partner organizations are concerned not only with the production of research, but also with its use (application). Because the mandates are value-driven, advocacy is required. Because the mandates are large and challenging, special leadership is needed.

These resource modules address these “neglected” areas. And this is why the overall title of this collaborative project is “Health Research for Policy, Action and Practice”. There are no doubt other neglected areas, and we welcome readers’ comments to enable us to continually improve this material.

Overview of Modules and Units

Module I Improving equity and development in health through research

Unit 1 Equity in development: the role of health research

This unit:

- Reviews discussions and action regarding the role of health research in contributing to improved equity in health
- Highlights some of the major research initiatives on inequity in health

Unit 2 Leadership for health research

This unit:

- provides an introduction to basic concepts about leadership
- discusses key challenges to health research leaders
- discusses fostering of leaders, succession planning and mentoring

Module II Setting priorities for health research

Unit 1 Introduction

This unit:

- Reviews the evolution of priority-setting initiatives
- Discusses the rationale for priority setting
- Identifies different contexts for priority-setting

Unit 2 Practical steps and critical issues

This unit presents a practical process for priority-setting that:

- is derived from a manual developed by COHRED based on experiences in a large number of countries
- is enhanced by lessons from the experiences of GFHR at the global level
- includes issues affecting priority-setting at the institutional level, derived from the experiences of INCLEN

Unit 3 Critical analysis of experiences

This unit provides:

- a brief description of major approaches that have been developed during the 1990s
- a comparative analysis of the different approaches
- a summary of lessons learned

Module III Promoting the use of knowledge in policy and practice

Unit 1 Introduction

This unit sets the stage for this module by providing:

- an overview of the explosion of information
- the rationale for improving the management of knowledge
- definitions of key terms

Unit 2 Communicating knowledge: overview

This unit discusses how to enhance the use of knowledge in:

- policy development and health system management
- health care practice
- direct action by health service users

Unit 3 Advocacy: a new skill for the research community

This unit:

- provides a view of advocacy in the context of interaction between actors
- provides an introduction to advocacy challenges and strategies
- explores the processes and competences in building advocacy coalitions

Unit 4 Knowledge networks

This unit:

- introduces the concept of “knowledge networks” within health research
- describes features of knowledge networks for health
- provides tools to assess knowledge networks

Unit 5 Electronic tools for managing knowledge

This unit provides an overview of the use of electronic tools to:

- communicate — using various methods of e-dialogue
- work together — using digital work-spaces
- disseminate knowledge — using the Internet, CD-ROM and DVD
- locate and access information

How to use these modules

The modules in this series are similar in format. They are intended to provide a ready source of information, tools and ideas. They are available in electronic (online and CD-ROM) formats.

Each module consists of several units. Each unit includes a topic note, an annotated recommended reading list and a section on tools and resources that includes web sites and extracts from manuals. The topic notes include boxes with illustrative examples and experiences, and illustrative extracts from key documents.

The annotated readings and the tools and resources sections provide easy access to a wide range of useful information, which is the main strength of these resource materials.

The resource modules are designed for individual self-learning and as a user-friendly and readily accessible source of key information on the selected topics. They can be used as resource materials for planned events, such as workshops or a series of small-group tutorials or seminars.

Box content colour guideline

Pale yellow:	"About this unit" and general information
Pink:	Navigating within document e.g. "See Tools and Resources"
Blue:	Practical tips from publications
Green:	Illustrative examples
Bright yellow:	Exercises (were brown in earlier units)
Grey:	Illustrative examples from national practice

Users of the resource materials will:

- become more informed about the topics in the various units
- develop new skills and competences by using the various tools and resources, and trying out the suggested exercises
- be able to apply their newly acquired information and skills to actual situations, problems and challenges: this objective is of particular importance.

Readers are urged to consider a “learning while doing” strategy, focused on everyday, real-life situations in which they are involved.

The authors also hope that the module-related activities will stimulate further learning beyond the scope of the modules.

Finally, in the spirit of this “collaborative” project, the authors invite feedback from module users about how the modules can be improved. In particular, we welcome descriptions of how the various tools and resources were actually *useful* in a specific situation.

References and further reading

CHRD (Commission on Health Research for Development) (1990). *Health research: essential link to equity in development*. New York, Oxford University Press.

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