



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



Health Research for Policy, Action and Practice

Resource Modules

Version 2, 2004

Module III
**Promoting the use of knowledge in policy
and practice**

Unit 3
**Advocacy: a new skill for the research
community**

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
INCLEN Trust

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Acronyms

ESRC	Economic and Social Council (United Kingdom)
ICT	Information and communication technology
RBM	Roll Back Malaria
SARA	Support for Analysis and Research in Africa (USAID Africa Bureau)
USAID	United States Agency for International Development

Module III. Promoting the use of knowledge in policy and practice

Unit 3. Advocacy: a new skill for the research community

Scope of this unit

This unit provides a view of advocacy in the context of interaction between those involved in the production (generation) of health research and those who use it, considering that both have a shared desire to improve health situations. It provides an introduction to **advocacy challenges and strategies** in this context, and gives linkages and references for further study.

The unit further explores the processes and competences involved in building **advocacy coalitions**. Particular attention is given to the concept of “research and learning coalitions”, and the role of interdisciplinary and intersectoral collaboration.

The [Tools and Resources](#) section provides information on useful web sites and manuals and exercises that could be used in training situations.

The [Recommended Reading](#) section provides annotated reading for self-study and illustrative case-studies which will be useful for self-study and as examples for training.

About advocacy

In the simplest terms, advocacy is the process of speaking out for something, such as a cause or a policy. The English word is actually derived from the Latin term “vocare” (“to call”). So with the prefix “ad” (which means “for” or “towards”), advocacy becomes “calling for”.

The training guide, *An introduction to advocacy* (Sharma, 1997), published by the USAID-supported programme, “Support for Analysis and Research in Africa” (SARA), lists 10 definitions for the term “advocacy”. Here are some of them:

- advocacy is an action directed at changing the policies, positions or programmes of any type of institution
- advocacy is speaking up, drawing a community’s attention to an important issue, and directing decision-makers towards a solution
- advocacy is putting a problem on the agenda, providing a solution to that problem, and building support for acting on both the problem and solution
- advocacy is the process of people participating in decision-making processes which affect their lives.

The definition of advocacy found in the *RBM (Roll Back Malaria) advocacy guide* (WHO, 2000) is:

- advocacy is winning the support of key constituencies in order to influence policies and spending, and bring about social change.

While clarifying a definition is important and helpful, it is more important to move on to the questions of the “why”, “what”, “to whom” and “how” of advocacy. These will be the issues that will occupy the rest of this unit.

Here may, however, be the place to consider the question – why should health researchers become involved in advocacy? Some researchers may prefer to remain “objective” or neutral as scientists, and leave the work of advocacy to others. The idea of speaking up for something (such as equity in health care) implies commitment to a value. It takes extra time and effort. And advocacy activities may in themselves be risky.

We do not wish individual readers of this unit to feel overwhelmed and powerless because of the scope and size of the challenges. Rather, the intention is to offer practical suggestions to both researchers and users of research for making advocacy an integral and everyday part of what they do.

Advocacy challenges and strategies

Working together

In the context of the CTP modules, users of knowledge include policy-makers (decision-makers), programme managers, practitioners, communicators (“the media”), the public – and other groups. This interaction is explored from the advocacy perspective, focusing on the advocacy responsibilities and actions of various participants in the research process.

The underlying premise in this unit is that health researchers (“producers”) have things they wish to communicate to groups (“audiences”) who are potential beneficiaries (“users”) of research knowledge. Further, it is suggested that this communication process is more effective when researchers and users identify shared interests and work together – leading to “win-win” situations. However, the research for policy, action and practice reality provides evidence that such “win-win” situations are not automatically guaranteed. In most cases, researchers have to “win” the potential users of research to effectively use this knowledge. Advocacy strategies can help them to do so.

An introduction to the advocacy process

For those interested in learning more about the advocacy process itself, several useful handbooks and guides are available. These are described below in the section on [Tools and Resources](#). Various models about the advocacy process are available as applied to the health sector (see [Box 1](#) for one model proposed by Batangan and Tan) and elsewhere. The headings below (stated as questions) may serve as a basic framework to help researchers think about their advocacy role.

- Why advocate?
- Advocacy about what?
- Advocacy to whom?
- How to do it?
- Advocacy with whom?

There is an obvious interdependence among these four elements. For example, the identification of an “advocacy audience” depends on the focus (the “what”) of the advocacy exercise. This in turn will influence the “how to do it” consideration.

WHY advocate?

As a general premise, there are two main reasons for engaging in the advocacy process:

1. There is a compelling (health) problem or situation that needs attention, analysis and action.
2. The solution to this problem or situation requires understanding and action by a variety of stakeholders, usually by a specifically designated “audience” or “actor”.

Depending on the goal of the advocates and the desired action of those to whom a particular message is given, the response to “why advocate?” can be refined further. In each case, some kind of change is intended. Here are some examples:

- a change in policy, or the creation of a new policy
- a change in a programme (objectives, criteria/standards, implementation, etc.)
- a change in practice (for example through practice guidelines, established by a society for a particular clinical specialism)
- a change in investment (funding) by a government ministry, agency or other donor
- a change in degree of awareness and understanding (for example, health messages to “the public”) which, it is hoped, will result in a change in attitudes and behaviour.

The list could go on. The key point here is for the protagonists to be clear at the outset about their reasons for engaging in an advocacy exercise. What will make the biggest difference, given the problem at hand? Is this primarily a policy issue? Or perhaps the policy is clear enough, but its implementation in a specific programme is unsatisfactory. And so on. It is essential that sufficient time and energy be devoted to analysing and defining the issue (the advocacy problem) early in the process. This is particularly important when mobilizing a broader coalition.

Advocacy about WHAT?

To help the user realize the importance of context in thinking about the “what” question, we suggest that you take a quick look at the case-studies at this point.

The various advocacy handbooks offer two key pieces of advice with regard to the “what” issue:

- be clear about the advocacy issue (as above) and set specific advocacy objectives
- base the advocacy exercise on credible and compelling evidence (“the facts”).

Stating advocacy objectives

[Box 2](#) provides some helpful guidance on defining advocacy objectives, while [Box 3](#) provides an example of an advocacy goal and specific objectives.

Box 1. Levels of involvement in advocacy for health research

Advocacy for health research follows a stepwise process of levels of engagement of the researcher with other stakeholders towards certain advocacy goals. The researcher should identify his or her short-term and long-term advocacy goals at the outset. This will help to define what level of involvement is needed.

Level 1. Research dissemination

The research outputs are presented to the main interest groups or individuals involved in the research. Researcher involvement may end with the presentation of research findings and recommendations or presentation of outputs may be a starting point for a process of discussing and elaborating on the recommendations to identify possible action points.

Level 2. Broadening of stakeholders

Beyond the dissemination phase, the recommendations of the study can be brought to the attention of other stakeholders using various media channels available to the researcher. Again, researcher involvement may end at this point, but bringing the results to the attention of other stakeholders will increase its value to potential partners (and adversaries) in the advocacy process.

Level 3. Working with stakeholders

More concrete expectations and common interests are identified in this level. The researcher has decided by this time that the research findings and recommendations should be integrated with existing programmes or institutions. The researcher decides to work now with some advocacy partners and they agree on the focal issues and strategies of the advocacy campaign.

			Advocacy activities	Implementation and assessment
				Planning and preparation for the activities
		Working with stakeholders	Consensus on the focal issues and strategies	
			Convergence of advocacy partners	
	Broadening of stakeholders	Identification of potential partners in advocacy		
		Use of other media venues (publication, Internet, conference, campaigns, etc.)		
Research dissemination	Processing of recommendations			
	Presentation of research report			

Level 4. Advocacy activities

The decisions made at the previous level are now translated into concrete plans and activities. This involves mobilization of resources to conduct the activities, and means greater involvement in the implementation of the activities. The activities will most likely focus on the research findings, but will also require considerable management and coordination skills. As the advocacy activities are implemented and after major activities are completed, there should be an assessment by the partners of the status of the campaign. This assessment will bring the group a more realistic appreciation of the level of accomplishment. In most cases, a re-strategizing and replanning process will be in order. This will also include the option of repeating the activities in the earlier phases to gain more momentum from the preparatory activities.

(Source: Developed by Batangan D and Galvez Tan J for the Collaborative Training Programme)

Box 2. What is an advocacy objective?

An advocacy objective aims to **change** the policies, programmes or positions of governments, institutions or organizations.

Your advocacy objective is **what** you want to change, **who** will make the change, by **how much** and **by when**. Generally, the time frame for an advocacy objective will be 1-3 years.

An **objective** is an incremental and realistic step toward a larger goal or your vision; it is not a general goal (e.g. to increase family planning takeup among couples). Rather, the policy advocacy objective must focus on a specific action that an institution can take. An **objective** should be *specific* and *measurable*.

(Source: Sharma R (1997:23))

Assembling the evidence

The challenge is to decide **what** information (facts) to select for a given “advocacy

Box 3. Sample advocacy goal and specific objectives

Goal: To complement efforts in pressing for the creation of an official community-based health insurance (CBHI) working committee within the Philippine National Health Insurance Program (NHIP) within the next 12 months.

Specific objectives

1. To prepare a position paper and organize an advocacy working group on the campaign within the first quarter of the campaign.
2. To identify and convene the stakeholders or link with existing initiatives on the issue by the second quarter of the campaign.
3. To be able to organize the stakeholders, mobilize additional resources and plan the joint activities of the partners by the third quarter of the campaign.
4. To be able to make a formal presentation of the position paper and recommendations to the appropriate agencies by the last quarter of the campaign.
5. To be able to secure a commitment from the appropriate agencies at least to initiate the process of creating an official CBHI working committee within the National Health Insurance Program by the end of the year.

(Source: Batangan, 2001)

audience” and **how** to present the selected information in a given situation. [Box 4](#)

contains a simple matrix that can be used to assemble evidence for an advocacy campaign. [Box 5](#) is an illustrative example of suggestions to RBM (Roll Back Malaria) advocates on assembling evidence to support RBM campaigns.

Advocacy TO whom? – the “advocacy audience”

Box 4. Matrix for assembling evidence

Topic and subtopics of the campaign	Objective of the campaign	Data needed to argue the objectives	Type and sources of data available	Method of securing or gathering and analysing the data
Topic				
Subtopic				

(Source: Developed by Batangan D and Galvez Tan J. for the Collaborative Training Programme)

Box 5. Assembling evidence for Roll Back Malaria advocacy

When planning long-term malaria advocacy efforts, a first step is to assess how you will obtain the facts about your own country or constituency that:

- show the severity of the malaria situation or worsening trends; use examples from your own country, as this means much more to your audience than an abstract global statistic
- show improvement in malaria control
- make malaria relevant to important constituencies
- document current spending on the disease
- show that malaria control makes economic sense
- demonstrate that RBM is at work in your country
- note the benefits of RBM for health infrastructure and development
- demonstrate the consequences of inaction.

(Source: WHO, 2000:6)

As suggested above, the identification of the advocacy audience is highly dependent on the goal to be achieved in any given “advocacy project”. An advocacy effort

(indeed, any “change process”) is more likely to be successful when common ground can be identified between the advocate (individual or group) and the advocacy “target”. The books on leadership and change have a lot to say about this – that is, looking for “win-win” situations.

This kind of thinking may be somewhat outside the experience of many health researchers. Still the strategy of collaboration (“working together”), if accepted as an operating principle, will significantly influence the nature of the interaction between researchers (as advocates) and their advocacy audience.

The list of potential advocacy audiences is quite long. The *RBM advocacy guide* includes a three-page table (pp. 15-17: “Targeting advocacy messages to different audiences”) which lists seven different audiences:

- decision-makers/politicians
- donors
- journalists
- nongovernmental organizations
- health practitioners
- corporations and industry
- general public.

Of course, a particular advocacy objective may best be met by targeting more than one group in this list.

Here, we comment briefly about three of the audiences above, with particular reference to attempts to summarize what is known about the effectiveness of interventions (including advocacy interventions) to promote the implementation of research findings.

Decision-makers/politicians

In a recent paper on “Bridging research and policy” by Diane Stone and colleagues (2001), it is suggested that the concept of “decision-maker” needs to be broken down into subcategories. The paper states that formal policy-makers (decision-makers) include:

- politicians (both executive level – such as ministers or secretaries of state – and members of parliament or congress)
- civil servants and appointed officials
- “street level” bureaucrats
- government-appointed experts, specialists and advisers (for example, appointees to a commission of inquiry).

There are many publications about how research can be communicated to decision-makers, for translation into policy.

See the [Recommended Reading](#) section for:

- Case studies from different countries, which demonstrate that often there are intercountry differences regarding the focus and conditions for advocacy. As a result, the strategies for advocacy will differ.
- *Influencing the UK policy-making process*, by Conor McGrath, which gives the policy-makers' perspective on the research-to-policy process. See [Recommended Reading](#) section.

Stakeholder mapping is a useful preparatory exercise to identify interests and perceptions in planning an advocacy or communication strategy.

See Tools and Resources section for [Exercise 1](#), which provides an illustration of how to prepare for stakeholder mapping.

In the 1990s, there was considerable interest in Europe in health technology assessment programmes. A group known as the EUR-ASSESS Subgroup on Dissemination and Impact was created to provide guidance for these programmes. This group reviewed the available literature regarding the effectiveness of dissemination and implementation strategies in changing the behaviour of policy-makers. The study (Granados et al., 1997) concluded that:

- personal contact with policy staff was more effective than distributing printed material
- printed reports should be short and should be written from the perspective of policy-makers, addressing the questions that need answering
- the style of presentation should be clear and compelling, rather than careful and hedging.

Health practitioners

For more than a decade, health practitioners around the world have been challenged to ensure that health interventions are “evidence-based”. Several organizations and services have been created to provide up-to-date and reliable information on health care.

Sources of reliable information on health care

- Perhaps the best known is the Cochrane Collaboration. This international nonprofit organization was created in 1993. There are now several thousand

professionals in more than 60 countries contributing to the work of this group, through the mechanism of review groups on specific health problems. Each group looks for relevant reports of research, then prepares reports of systematic reviews of the most reliable evidence. The reviews are published in *The Cochrane Database of Systematic Reviews*, which is part of the *Cochrane Library*. (See [Tools and Resources](#) section.)

- Several other databases on evidence-based health care are available. These include *Best Evidence 4th Edition* -- a CD-ROM published and updated annually by the BMJ Publishing Group and the American College of Physicians, and Evidence-Based Medicine Reviews, published by Ovid Technologies (Scandinavia and Finland, <http://www.ovid.com>).
- The School of Health and Related Research (ScHARR) in Sheffield, United Kingdom, produces a web site with links to other web sites related to evidence-based health care. (See [Tools and Resources](#) section).

Communicating effectively with practitioners

Grimshaw and colleagues (2001) recently analysed 44 systematic reviews of interventions to promote the uptake of research findings by health care providers. They found that educational materials (for example, distribution of noninteractive printed materials) and didactic educational meetings (lectures with little or no interaction) had little or no effect on changing professional behaviour.

Research transfer strategies that were found to be generally effective were:

- educational outreach visits
- reminders (such as computerized reminders to prompt behaviour change)
- interactive educational meetings.

The media

To some extent, the media and the public can be considered together, since “the public” is the main consumer group of the communication efforts of the media.

See [Tools and Resources](#) and [References](#) for:

- resources on working with the media
- checklists for various activities
- a guide from the Roll Back Malaria manual for preparing an effective news release and conducting an effective news conference.

Also see the web site of Johns Hopkins University Center for Communication Programs (<http://www.jhuccp.org>) which offers a virtual library of resources related to research and programmes for mass media communication for health behavioural change.

Grilli and colleagues (2001) conducted a systematic review of effects of mass media interventions on the use of health services. They reviewed 22 published papers between 1979 and 1999, including 17 time series analyses. The studies included a variety of media such as leaflets/posters, newspaper, radio and television. This systematic review concluded that both planned and unplanned media campaigns have consistent and positive effects on health services utilization. The authors concluded that the mass media should be considered one of the tools to encourage use of effective services and discourage the use of unproved services.

Advocacy coalitions and networks

Advocacy WITH whom?

When an organization is exploring whether to join one of these arrangements, the key consideration is the “tradeoff” between **benefits** on one hand, and the **costs** of involvement on the other. The tradeoffs are more likely to be political and social than economic. The benefits include factors such as increased access to information, increased impact of effort, increased recognition (profile) and increased influence (“leverage”). The costs include expenditure of time (including the time spent in establishing “trust relationships” with other groups), and loss of autonomy. [Box 6](#) provides a summary.

See [Recommended Reading](#) section for:

- A more detailed cost-benefit analysis of the various arrangements (Fowler, 1997).

The focus of this section is on how **organizations** (rather than **individuals**) can collaborate on an advocacy objective. Organizations create different arrangements in order to collaborate. Furthermore, there will be different meanings of “coalition” in different sociocultural and historical contexts. For example, alliances in labour unions are different from alliances among research institutions. A variety of descriptive terms are used to describe these arrangements: **networks**, **alliances**, **consortia**, **coalitions**, and so on.

Adapting a definition from the SARA/AED *An introduction to advocacy: training guide* (see [Tools and Resources](#) section), an advocacy coalition can be defined as: **a group of organizations working together in a coordinated fashion toward a common advocacy goal**. The assumption is that, by creating or joining an advocacy coalition, a specific advocacy objective can be achieved more effectively.

Various forms or types of coalition have been described. The nature of a given coalition can vary with regard to:

- duration (temporary or permanent)

- degree of formality – formal coalitions usually have published statements (about purpose, membership, methods of operation, and so on), and usually have membership dues
- focus – coalitions may be concerned with a single issue, or with several
- location – some coalitions are localized in a given geographic area; others are much more widespread, depending on the advocacy issue. In recent years, there have been more widespread, often global, advocacy coalitions – in part, because of the effective use of electronic communication.

Box 6. Advantages and disadvantages of working in coalitions

1. Advantages

- Enlarges your base of support; you can win together what you cannot win alone.
- Provides a safety net for advocacy efforts and protection for members who may not be able to take action alone.
- Multiplies existing resources by pooling them and delegating work to others in the coalition.
- Increases financial and programmatic resources for an advocacy campaign.
- Enhances the credibility and influence of an advocacy campaign, as well as those of individual coalition members.
- Helps to develop new leadership.
- Assists in individual and organizational networking.
- Broadens the scope of your work.

2. Disadvantages

- Distracts you from other work; can take too much time away from regular organizational tasks.
- May require you to compromise your position on issues or tactics.
- May require you to give in to more powerful organizations. Power is not always distributed equally among coalition members; larger or richer organizations can have more say in decisions.
- You may not always get credit for your work. Sometimes the coalition as a whole gets recognition, rather than individual members. Well-run coalitions should strive to highlight their members as often as possible.
- If the coalition process breaks down, it can harm everyone's advocacy by damaging members' credibility.

(Source: Sharma R (1997:87); the two lists were adapted by SARA from the Midwest Academy publication *Organizing for social change* (Bobo et al., 2001))

Readiness to join a coalition

Having considered the advantages and disadvantages of joining or creating a coalition, the leadership of an organization should then assess whether it is ready to proceed. This issue of “readiness” has been examined in various studies about intersectoral action for health, where collaboration among agencies from different sectors has been attempted. One lesson from these studies is the importance of making a conscious effort to determine readiness before actually entering into a collaborative agreement. A tool for assessing organizational readiness can be found in [Box 7](#).

Research and learning coalitions

Over the last few years, health researchers have become increasingly concerned about the gap between “producers” and “users” of research. Also, it has been realized that the process of closing this gap is complicated and time-consuming – there is much to learn on both sides. One response to this challenge has been the evolution of arrangements known as “research and learning coalitions”. Below is a summary of the main features of such coalitions, drawn from a report from Tanzania (Harrison, 2000).

- **Focus:** A problem, challenge or situation that captures the interest, concern and commitment of participants.
- **Inclusiveness:** Both producers of knowledge (researchers) and users of knowledge are included. Depending on the focus, user groups can include policy-makers, planners and managers, nongovernmental organizations, community groups and representatives, the media, the private sector, and so on. By working together on a common challenge, the capacities of both producers and users of research can be strengthened.
- **Teamwork:** The coalition functions through the creation of multidisciplinary and intersectoral teams. Teams are effective when each team member’s share of collective benefits are greater than the benefits of working alone. Incentives driving teamwork also include communication with colleagues and a sense of mutual purpose – in this case to improve the health of the people. Specific strategies to foster teamwork could include:
 - calling for and funding proposals from teams, rather than from individuals
 - facilitating ease of communication among team members (such as regular face-to-face discussions, electronic forums, exchange visits and so on)
 - national recognition of joint (team, rather than individual) outputs
 - recognition by academic institutions of non-journal publications.
- **Appropriate communications:** The creative use of a broader range of communication methods, depending on whether coalition members need to be in the same place at the same time (that is, a meeting). In particular, the

newer information and communication technologies have greatly increased the ability of persons to work together who are separated by geographical location and time zone.

- **Intentional learning:** The recent literature on science and technology suggests that “knowledge diffusion” is the key to innovation and development. The challenge is to develop a “culture of learning” or “to challenge assumptions and findings, and willingness to make and learn from their mistakes” (Harrison, 2000:48). Practical learning “tools” include reflective discussions, learning briefs, creating an environment in which people are constantly curious, and personal and team diaries that record the lessons being learned.
- **Leadership and facilitation:** It is helpful to involve persons who are skilled at facilitating coalition-building and teamwork, guiding the whole research process from identifying the problem through to implementing the research results.

Coalitions aim to bring about change

Working with advocacy coalitions entails organizing and political work. Some of this “work” involves creating or strengthening consensus on a particular issue, often with the aim of achieving change (in policies, programmes or public understanding).

Whether described as advocacy or research and learning coalitions, coalitions are about **collaboration** to bring about **change**. Change is driven both by increasing commitment and will to address an issue (advocacy) and increasing knowledge to produce a solution (research and learning). In the past, collaboration among policy-makers, researchers and communities has been talked about in terms of links between stakeholders. As Reynolds Whyte observes:

“The term *stakeholder* suggests that a party has an interest in an enterprise, something to gain or lose. The term *iron triangle* of stakeholders (researchers, policy-makers, and community) conveys a sense of rigidity, as if their interaction comprises a series of linear communications and trade-offs between the three groups. *Coalition* has another flavour. It is more action oriented, suggesting issue-based alliances, debates, and negotiation between disparate parties. Coalition members sometimes have conflicting interests, but commitment to a coalition implies an effort to accomplish something together, despite differences” (2001:108).

See Tools and Resources for [Exercise 3](#) on putting together an advocacy coalition.

Box 7. Tool to assess readiness for intersectoral action

Necessity

- Is the planned action important to achieve organizational goals?
- Does it ensure/enhance organizational survival?

Opportunity

- Are there adequate opportunities for the planned action to be undertaken and sustained by supportive environmental contexts?
- Are there clear “triggers” for action?

Capacity

- Have the health sector and the other participating organizations the capacity to undertake the action that is being planned? Is there a need to strengthen organizational support?
- Is there a need to identify resources for use in developing, negotiating, implementing, evaluating and sustaining the planned action?

Relationship

- Has the nature of the relationship between the sectors/organizations involved been negotiated?
- Is there a high level of trust and respect between the organizations?

Planned actions

- Do the people involved directly in the planned action recognize the need to work together?
- Is there an agreed way of working?

Sustained outcomes

- Are there ways of monitoring the outcomes of the action over time?
- Are the sectors aware that they may need to take ongoing action to sustain the outcomes?

(Adapted from: Harris et al., 1995:117-119. This tool reflects six “conditions” which, in the view of the authors, are needed for effective intersectoral action. These conditions appear in an appendix: “Checklist for undertaking effective intersectoral action”.)

Tools and resources

1. Manuals, guides and web sites

Sharma R (1997). An introduction to advocacy: training guide. Washington, DC, Support for Analysis and Research in Africa (SARA).

This training guide was prepared using the experience derived from an analysis of several USAID projects in Africa. Among the intended users of this guide are “researchers interested in promoting their findings”. The guide identifies nine basic elements of advocacy, devoting a chapter to each element. The tools in the guide include exercises (for individuals and groups), case-studies, definitions and examples. Available online at: http://www.dec.org/pdf_docs/PNABZ919.pdf.

WHO (World Health Organization) (2000). Roll Back Malaria advocacy guide (document WHO/CDS/RBM/2000.26). Geneva.

Although this advocacy guide is written in the context of the malaria situation (mainly in Africa), it has many useful features for wider application. The guide elaborates on four basic steps: gathering the facts; packaging the message; working with the media; mobilizing others. The guide includes helpful examples and tables. Though not intended specifically for researchers, many ideas will be useful to research groups.

Varvasovszky Z, Brugha R (2000). A stakeholder analysis. Health Policy and Planning, 15(3):338-345. (Section on: “How to do (or not to do) ...”)

This paper provides guidance on how to do a stakeholder analysis, whether the aim is to conduct a policy analysis, predict policy development, implement a specific policy or project or obtain an organizational advantage in one’s dealings with other stakeholders. It shows different ways of analysing, presenting and illustrating the information.

McGrath C. Influencing the UK policy-making process. United Kingdom Economic and Social Research Council.

This 11-page booklet by Conor McGrath provides tips for researchers about influencing the policy process from the perspective of policy-makers. It contains a concise, practical description of United Kingdom parliamentary procedures; the legislative process; and the role of political parties, civil servants, ministers, peers and special advisers in formulating policy. Points and method of entry into the policy process are identified, as well as tips on how best to communicate with policy-makers. Although the booklet is specific to the United Kingdom, much can be generalized to other parliamentary systems. Available online at: <http://www.esrc.ac.uk> – Publications.

The Cochrane Library: available on CD-ROM and Internet, published quarterly by Update Software (e-mail: update@cochrane.co.uk).

The Library includes: the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effectiveness, and the Cochrane Controlled Trials Register. Available online at: <http://www.cochrane.co.uk>.

School of Health and Related Research (ScHARR), Sheffield, United Kingdom.

See the web site, "Netting the Evidence", which provides up-to-date links to a wealth of sites devoted to evidence-based health care. Available online at: <http://www.nettingtheevidence.org.uk>.

The Edge magazine

The Edge is about social science research for key opinion-formers in business, government and the voluntary sector. Published every three to four months, it highlights the latest research funded by the United Kingdom Economic and Social Research Council. Available online at:

http://www.esrc.ac.uk/esrccontent/connect/the_edge.asp.

Center for the Advancement of Health. Communicating health behaviour science in the media: tips for researchers.

This publication by the Center for the Advancement of Health contains tips and a template for writing news releases, as well as advice on preparing for an interview and being interviewed (for print and television). Written by media/public affairs specialists, this is one of the best resources on the topic. Available online at:

http://www.cfah.org/pdfs/research_tips.pdf.

Walker D. Heroes of dissemination. United Kingdom Economic and Social Research Council.

This publication by the ESRC offers 10 vignettes of (United Kingdom) researchers' experience in dissemination of research – specifically, working with the media. It provides an argument for "why do it" that will resound with academics who needn't "change their spots" (that is, depart from the norms, values and criteria for success held by academia) in order to be successful in engaging with the media. Available online at:

<http://www.esrc.ac.uk/esrccontent/PublicationsList/4books/heroframeset.html>.

Vaitilingam R. Developing a media strategy. United Kingdom Economic and Social Research Council.

This ESRC publication provides practical guidance on how to develop a media strategy. Covered are a number of "usual" topics – what is a media strategy, why develop one, choosing targets, and how to write press releases – but also several topics not found in similar publications. These are: organizing public meetings, monitoring what the media is currently interested in and responding (demand vs supply-side media relations), setting up a media training programme for researchers and assessing the impact of a media strategy. Available online at:

<http://www.esrc.ac.uk/esrccontent/PublicationsList/4books/medframeset.html>.

Gaber I. Television and radio: a best practice guide. United Kingdom Economic and Social Research Council.

Another great ESRC publication developed to take some of the intimidation out of television and radio broadcasts as a medium for communicating research findings. Topics include the "who", "what", "when" and "where" of the news production chain, the commissioning process for radio and television programmes, the production

process, getting paid for work in connection with production, and guidelines for undertaking interviews. Available online at:

<http://www.esrc.ac.uk/esrccontent/PublicationsList/4books/toframeset.html>.

AIDS Candlelight Memorial Media Tools for Coordinators

This kit, prepared for community coordinators of the AIDS Candlelight Memorial, contains tips and strategies for planning a media campaign, along with pro-forma templates for preparing press releases, media advisories, public-service announcements and press kits. It is available in four languages: English, French, Spanish and Russian. Available online at:

<http://www.candlelightmemorial.org/howtopr.php>.

Global Health Council

The Global Health Council is dedicated to advocacy for needed policies, resources, building networks and alliance among those working to improve health, and communicating innovative ideas, knowledge and best practices in the health field. Its advocacy manual for the Global Health Action Network grassroots education and advocacy programme provides advice on writing a letter, making a telephone call and meeting an elected government representative. The manual is available online at:

http://www.globalhealth.org/assets/publications/advocacy_manual.pdf.

Please note that the site will soon migrate to: <http://www.globalhealthcouncil.org>.

2. Exercises

Exercise 1. Stakeholder mapping

Your research institution has convened a multisectoral consultation on your findings on drug pricing trends. Your study showed that: (1) Government pharmacies have the cheapest price but have limited stocks; (2) Private drugstores have better stock inventories but tend to have higher and fluctuating prices; (3) The closer private drugstores and pharmacies are to the hospital, the more expensive their prices.

The following individuals were invited to take part in the consultation: a food and drug regulatory officer, the hospital director, a public health officer in the area, local officials, private drugstore owners, other local officials, consumer groups and a representative of the agency that commissioned the research project. Before the consultation, you were advised by a colleague that the private pharmacy group were concerned about the implications of the study for their business interests. You decided to do a stakeholder mapping exercise so that you will better understand the interests and motivations of the different participants in the consultation in supporting or questioning the results of the study.

Below is the matrix you worked out to organize your thinking. Fill in as many cells as possible. How will you obtain the information needed to fill in the other cells?

Participant	Main interest or concern on the issue	Secondary interests or concerns on the issue	Effect of study findings and recommendations on their interests	Most likely response to study recommendations	Most likely allies
Food and drug regulatory officer					
Hospital director					
Public health officer					
Private drugstore owners					
Consumers					
Study's funder					

Exercise 2. Demand creation – identifying issues, strategies and skills for practising demand creation

(This section was contributed by Diego Rosselli, Andrés Otero & Rodolfo Dennis)

“Demand creation” is convincing potential consumers that they have a problem that needs to be addressed. Next, you have to make an argument that your product offers a satisfactory and cost-effective solution to that problem. In health research, the need to create demand appears at two different moments. Firstly, health researchers (suppliers) need to convince potential funding agencies (demanders) of the need to do research on a certain problem. Secondly, health researchers need to convince decision-makers (a second set of demanders) to use research results in their decision-making. Both situations (in which there are two different target audiences) are amenable to the demand-creation process.

This exercise is intended for use in a setting of 16-32 persons, but can be adapted for individual learning. Two scenarios are presented below; each scenario offers two perspectives – one from the “demand side” and the other from the “supply side”. Divide the group into two teams. Assign one of the scenarios to one team and the second scenario to the other. Each team should then split into two small groups; one takes the perspective of the “supply side”, while the other takes the perspective of the “demand side” of their given scenario.

Each small group should discuss their assigned perspective for 20 minutes, then get together with the other small group on their team for an additional 30-minute discussion. The focus of this is to identify issues arising from the different perspectives of the supply and demand sides, and to develop strategies for demand creation.

The main points of the discussion should be recorded, and shared in a general plenary session, intended to discuss general issues, strategies and skills for demand creation.

This exercise works best with small groups of 4-8 persons. Larger group settings might be divided into three or more teams with more than one team working on the same scenario.

Exercise 2, Scenario 2

Group C (demand side perspective)

After more than a decade working for a multinational pharmaceutical company, you have been given a managerial job in *Copius*, a local pharmaceutical laboratory dedicated to the production of high-quality, low-cost generics. Physicians in your country know very little about your firm, despite the fact that it is among the top three in terms of sales. Those who have heard about you believe you are in the business of cheap “copies”. Your main lines of production are anti-inflammatory drugs, antihypertensives and antibiotics, as well as a very successful copy of sildenafil. You are interested in improving the image physicians have of your company and believe financing local research is a viable means of reaching your objectives. You have arranged meetings with several top researchers in your country during the next couple of weeks. Consider the following points.

- What type of research do you believe will work best towards your goal?
- Apart from doing research, how do you believe research groups can help you out?

Group D (supply side perspective)

At the last international meeting on infectious disease that you attended, you were approached by a fellow-countryman whom you didn't remember having met before. He told you he used to work for one of the big multinational pharmaceutical companies and had spoken to you previously on several occasions (he even quoted a conversation you had the year before in Copenhagen). Now he is Marketing Director for *Copius*, a pharmaceutical company whose name is barely familiar to you, and which you immediately associate with generics of yet unproven quality. You, of course, did not mention this. He went on to tell you about his plans to improve the image of his firm and dropped some numbers about last year's sales and marketing budget – figures so large you were not able to retain them. When you returned home, you told your team about this opportunity. Your group approves of working with *Copius* and you have an appointment with him next week. Consider the following points.

- What other possibilities apart from research will you explore?
- What type of research do you believe they will be interested in?

Exercise 3. Putting together an advocacy coalition

Assume that you are putting together an advocacy coalition for a particular issue. You and your colleagues are thinking about involving another organizational partner in this coalition. Use the “10 Steps” (below) suggested by the WHO Roll Back Malaria (RBM) manual (WHO, 2000) in exploring this possible partnership.

1. Prioritize your target list. Who can help you the most? To whom do you have the best access? Who is most likely to support your cause, given their involvement in other issues?
2. Research your top targets. What role have they played on other issues? Who influences them? Do you have any mutual acquaintances? What are their personal interests?
3. Determine what you want. Even before making contact, have a clear idea of what you would like your (RBM) partner to do. However, be prepared to revise your request completely, should they show interest in another area.
4. Develop your presentation. Gather the relevant facts and information to make your case. Determine the most persuasive way to present this information.
5. Make contact. Introduce yourself and your organization by phone or letter, or preferably both. Don't try to gain support at this stage. The primary objective should only be to arrange a personal meeting.
6. Make your visit. Keep the meeting upbeat and friendly, but get to the point. Listen carefully to the partner's interests. Explore those issues that seem to interest and excite him or her. Ask for his or her support in a specific area. At the end of the meeting, make clear what next steps you will take to follow up on any concerns, ideas or areas of interest.
7. Make follow-up visits. Find legitimate ways to follow up your original conversation and keep informing your partner about the issue. Start to build a relationship.
8. Use other ways to reinforce your visit. Find other opportunities to ensure that your potential supporter is being asked to consider the issue (that is, the malaria burden). For example, letters from other organizations or questions from journalists might encourage them to take a stand on the issue.
9. Identify a “first-step” activity. In most cases, your first request should be an activity that is easy to undertake.
10. Be generous in your thanks, and ask for further involvement.

Case Studies

1. **Advocacy in creating and sustaining a policy dialogue: regulating private health providers in India**

(Abstracted from: Yesudian CAK (2001). Policy research in India: the case of regulating private health providers (Case-study prepared for the Alliance for Health Policy and Systems Research). Available online at: <http://www.alliance-hpsr.org> – Services – Alliance Information Products – Working Papers.)

In 1989, Mr Rabadi died in a Bombay private hospital. He had been treated by a resident doctor not qualified in allopathic medicine. His daughter sought legal redress in the High Court. A committee of experts under the chairmanship of the Deputy Municipal Commissioner (Health) was formed to investigate the city's nursing homes.

Deplorable conditions were found to exist in many of them. Most were tiny flatlets, under 200 square feet in size. One seventh of them were actually sheds or lofts in slums. Thirty-eight percent of all wards and 50% of beds were dirty and poorly lit. Some nursing homes did not disinfect the operating theatre more than once a week; some did it once every three days and very few did it after each operation. None incinerated infectious waste material, but instead dumped it in municipal bins, where scavengers were known to pick out needles, syringes and other materials for re-use. None of the nursing homes kept records of notifiable diseases, and only 10% recorded births and deaths.

The release of the committee's findings was accompanied by more complaints of medical negligence and medical malpractice against private hospitals and the doctors working in them. A public outcry arose. Headlines like "Private hospitals in morbid state" and "Unregistered nursing homes thrive in city" appeared in the city's leading dailies. Consumer groups and social activists took up the cause of patients advocating for changes to the outdated legislation governing nursing-home registration.

Endorsing the view of those advocating for change, the Centre for Enquiry into Health and Allied Themes (CEHAT) took the lead in initiating new legislation. It undertook two studies, on the basis of which it developed minimum standards for private hospitals and medium-sized nursing homes providing medical, surgical and maternity services. CEHAT presented the study results and standards to a variety of stakeholders, among them representatives of the private health care facilities, state government, municipal government, the Indian Medical Association, medical professional bodies, nongovernmental organizations working in the health field and academic institutions.

CEHAT was invited to prepare a draft Act for registering private health care facilities for the whole state of Maharashtra. Armed with this draft, the state government took, for the first time, the initiative of calling a consultation with stakeholders and experts. Satisfied with the feedback received, the state government has gone on to draft final legislation and place it before the Legislature Assembly.

CEHAT's policy entrepreneurship, however, did not end there. The policy dialogue sustained during the revision of the Act established a consensus about the need for incentives for continuous improvement through voluntary accreditation. CEHAT capitalized on this policy demand, developing an evidence base and the Forum for Health Care Standards. It is hoped that the latter will give rise to a state or even a national private health provider accreditation agency – bodies that are totally lacking in India today.

2. Effective communication — the doctor who made Poles kick the habit

(Condensed from: article in the *Baltimore Sun*, “The Man Who Made Poles Butt Out” by Bill Glauber, as printed in the *Hamilton Spectator*, 11 April 2002.)

For three decades, Witold Zatonski sought to stamp out Poland's fatal addiction to cigarettes.

In a nation of smokers, he was a nicotine noodge, a rebel doctor advancing a singular cause: to get Poland to kick a habit.

With the old Communists, this wily clinician talked pure science. With the new capitalists, he added an economic twist, saying the nation's health and wealth were going up in smoke.

“They thought I was a little crazy, a fanatic”, Zatonski said of those long-ago meetings with government bureaucrats, some of who, he added, puffed away on cigarettes while he made his pitch.

But the “fanatic” won – and so did Poland's national health – as the country moved into the forefront of Eastern Europe's fight against Big Tobacco.

Zatonski, who works at the Maria Sklodowska-Curie Memorial Centre and Institute of Oncology, directing the hospital's Epidemiology and Cancer Prevention Department, says his life and career are in “two parts”. In that first life, he was a clinician who treated patients, including those suffering from cancer. He read and travelled widely, forging links with medical colleagues in the West, including the United States.

But taking their antismoking message back to Poland – his “second life” – proved a daunting task. After the Second World War, smoking spread in Poland, with cigarettes viewed as symbols of prosperity and freedom. To smoke was to feel free, to feel western.

By the early 1980s, Poles were the world's heaviest smokers, with more than 60 per cent of the population lighting up daily – about 15 million people. That number has dropped to nine million.

The nicotine addiction fitted in nicely with a Communist regime that needed the influx of cash from the state-owned tobacco companies.

Few, it seemed, wanted to listen to Zatonski's simple message.

Before the fall of the Berlin Wall in 1989, Zatonski dealt mostly with government officials, scientists and several thousand adherents of the Polish Anti-Smoking Society, which he led. But with the rise of democracy throughout Eastern Europe,

Zatonski's no-smoking campaign gathered steam: "You could carry your message to the general public. More and more people wanted to hear that message".

But even as Zatonski was publicizing his cause, western tobacco companies were buying into the Eastern European market. Poland was a prize because of its ample supply of smokers.

But they didn't count on Zatonski.

Zatonski courted attention any way he could, going so far as to write Bill Clinton, the US president, that "We need your jeeps, your computers, your technology, your democracy. We don't need cigarettes".

For Zatonski, the major victory came in 1995 with the passage of the country's first batch of tough anti-smoking regulations. Further validation came earlier this year, when European health ministers gathered in Warsaw for a two-day conference to promote a tobacco-free Europe.

The meeting ended with a declaration calling for many of the tobacco controls in place in Poland.

3. Example of advocacy in action: the management of policy formulation and the Philippine Generics Act of 1988

(Adapted from the PhD dissertation of Edna Co, National College of Public Administration and Governance, University of the Philippines.)

National drug policy in the Philippines arises from an imperative to address problems in the pharmaceutical industry at both national and international level. The international context is characterized by the dominance of transnational pharmaceutical companies that, motivated by economic interests, pervade the market, stifling the growth of local drug manufacturers.

At the national level, the government fails to regulate the circulation of drugs. The Department of Health in 1986 decided to deal with problems in the pharmaceutical industry through a process of consultations and advocacy activities which lead to the landmark Generics Act of 1988. The law, among other provisions, required the generic labelling and prescription of pharmaceuticals in the Philippines.

The Department of Health used a systematic approach in integrating research and problem identification to set the agenda for policy reform. In the course of research and agenda-setting, it organized a task force that engaged the participation of different sectors, including academics, medical practitioners, nongovernmental organizations, consumer groups, the private sector and government. The process was participatory enough to reach a consensus in pushing for the legislation of the Generics Act. Consultations, task forces and committees engaged a wide array of players. The democratic character of the process then put the agenda on a moral high ground.

Below is an excerpt from the dissertation of Dr Co on the role of the Department of Health in the passing of the Generics Act.

“Anticipating the force of the Drug Association of the Philippines, the DOH [Department of Health] management indicated its presence during the Congressional Committee Hearings. The DOH legislative backstopping was evident from the beginning of the deliberations in the House of Representative and Senate Committees on Health. The department’s top-level managers actively lobbied in the committee hearings of both chambers. But above all, the DOH provided technical assistance to the legislators who sponsored the bill and assigned a high-level official or staff member to each key legislator. They explained each provision and ensured continued support throughout the entire legislative process.

The DOH purposely participated in all sessions so as not to [overlook] any possible debacle. Schedules of public as well as closed-door meetings were monitored by the DOH and allied groups. They were alerted about possible representations from [opponents] during meetings. They made sure they knew about all schedules of the Congress sessions, Committee hearings and public hearings. Espionage was nearly its ‘modus operandi’.

After each session, the DOH management sat together for assessment and further planning at every step of the way.

Technical inputs and information were provided by the DOH whenever necessary or when sought by the legislators during committee and public hearings. Interpellations and clarifications were also made by the DOH representatives until resolutions were clarified. For example, the DOH Executive Assistant informed the House about the efforts of the DOH to define rules and organization that will meet the requirements of the policy. The DOH takes credit for having lobbied intensively for the passage of the Generics Act.

On the whole, the DOH impressed upon the legislators that there was preparedness on the part of the Department to meet the responsibilities that would go with policy implementation. The in-house preparation and strengthening of the DOH also proved that the Department recognized the link between policy formulation and policy implementation. Vigilance throughout the process of the bill’s enactment was a key strategy of the DOH.”

4. Coalitions for Injury control in Uganda

The story of Uganda’s Injury Control Centre (ICC-U) illustrates a new kind of “critical mass”. Dr Olive Kobusingye, a trauma surgeon and epidemiologist, returned to Uganda in 1996 after some years of postgraduate training in the United Kingdom and United States of America. She became interested in the problem of road traffic accidents, but realized that the evidence base for defining and managing this problem was weak. Her work began with the development of a hospital-based trauma registry and a monitoring tool – the Kampala Trauma Score. With some external support, she established the Injury Control Centre in 1997. Working with colleagues in the Clinical Epidemiology Unit at Makerere University, she conducted further prevalence studies, as well as training sessions on the care of trauma victims.

It soon became apparent that, in order to reduce Uganda's burden of illness due to trauma, a range of stakeholders needed to be included in the work of the Injury Control Centre. And so various research "user groups" became involved – planners from the police traffic division, members of the Uganda Road Safety Council, and policy-makers from the Ministry of Health. The ICC-U group also organized pedestrian safety campaigns, involving local schools (both teachers and students). With the Kampala City Council, a feasibility study was conducted about the state of the city's ambulance services. All of this involved increasing experience in creating and managing effective intersectoral teams.

Along with research, advocacy and action elements, the Centre has also become an important learning centre. Postgraduate students from the university, serving as research associates, are conducting various studies related to the problem of injuries. Hospital personnel are being trained in the management of trauma victims. A specialized trauma library has been established.

With some initial funding from INCLIN, the Centre played a leading role in the creation of a problem-specific African coalition – the Injury Prevention Initiative of Africa (IPIFA). It now includes colleagues from eight African countries who are involved in various research, training and advocacy activities. Members of this group have also contributed to seminars and workshops related to injuries in other parts of the world.

And so the Injury Control Centre provides a good example of a "research and learning coalition" – the new form of "critical mass". There is a specific focus (injury control). Both research producers and users are included in research and action coalitions. National policy has been influenced – injury prevention and management is now included as a high priority in Uganda's new five-year health strategy. Intentional learning is included in the range of activities. And the Uganda team has demonstrated leadership in the creation of a regional injury control network.

5. An example of a coalition: ICT and health forum, Philippines

With support from the Rockefeller Foundation, the Institute of Philippine Culture at Ateneo De Manila University in the Philippines initiated the "Partnerships in People-Centered Health" project in 2000. Project activities entailed a process of defining a set of principles, values and strategies for the concept of "Resourcing public health" (RPH) and helping different stakeholders in health development to operationalize it. This process brought RPH into mainstream movements in the health sector of the various project countries. The core values of RPH reinforced current initiatives for reforms in those countries. This was evident in the strong support that the concept received from health research networks (e.g. the International Conference on Health Research for Development, Bangkok, 2000), health activists (e.g. the People's Health Movement, whose second Assembly is scheduled to take place in Cuenca, Ecuador, in July 2005) and local health development organizations in the Philippines, India and Sri Lanka.

The BUKAL (Bahaginan at Ugnayan sa Kalusugan) working group emerged from the Philippine Consultation on Partnerships for People-Centred Health. The participants

in the consultation are linked through an electronic discussion group. The BUKAL Working Group assisted in the management of the Asiarph web site, which served as a venue for knowledge networking around the Partnerships project and the Knowledge Management Component of the RPH project of the Foundation for Media Alternatives (FMA). This collaborative effort of the Foundation, the Institute of Philippine Culture and BUKAL has provided a forum for discussing initiatives on the use of information and communication technology (ICT) in health.

The ICT and Health forum has evolved into a loose coalition of civil society and government agencies that engage other agencies and organizations on selected health issues. The group works with existing interest groups and organizes high-profile activities to engage more stakeholders on the issues. The group has sponsored a national conference on partnerships in people-centred health, a symposium on bioterrorism, and a virtual conference on social health insurance in the Philippines.

The coalition of ICT and health institutions also works to elaborate certain policy and operation issues of the health care system and to supplement the pressure exerted by interest groups.

Recommended reading

Brugha R, Varvasovszky Z (2000). Stakeholder analysis: a review. Health Policy and Planning, 15(3):239-246.

"This paper reviews the origins and uses of stakeholder analysis, as described in the policy, health care management and development literature. ... Stakeholder analysis can be used to generate knowledge about the relevant actors so as to understand their behaviour, intentions, interrelations, agendas, interests, and the influence or resources they have brought – or could bring – to bear on decision-making processes."

Chunharas S (2001). Linking research to policy and action. In: Neufeld V, Johnson N, eds. Forging links for health research. Perspectives from the Council on Health Research for Development. Ottawa, IDRC Books.

This chapter analyses some of the experiences of developing countries in strengthening this link (between research and policy) over the past 10 years. It begins by identifying the key components of effective research-policy linkages. These include the dual processes of research and policy development, the context in which they both operate, the stakeholders involved, the products or outputs of both processes and the critical role of mediators.

COHRED Working Group on Research to Action and Policy (2000). Lessons in research to action and policy. Case-studies from seven countries (COHRED document No. 2000.10). Geneva. Available online at: <http://www.cohred.org>.

The case-studies about the research to action and policy process are:

- 1. vaccine research, development and production in Brazil*
- 2. the use of research for decision-making in the health sector: the case of "shared care" in Burkina Faso*
- 3. the social safety network in the health sector (SNN-HS): is health research used to improve the SSN-HS policies in Indonesia?*
- 4. research to action for reducing health inequalities: the experience of Lithuania*
- 5. research to action and policy: combating vitamin A deficiencies in South Africa*
- 6. Chagas disease and foot-and-mouth disease eradication in Uruguay*
- 7. the role of research in child health policy and programmes in Pakistan.*

Fowler A (1997). Striking a balance. London, Earthscan Publications Ltd. pp.107-119.

This helpful book has the subtitle: "A guide to enhancing the effectiveness of non-governmental organisations in international development". Relevant to this unit is a section (pp.107-119) on "Organizing and Managing Relationships between NGDO'S" (Non-Governmental Development Organizations). Fowler analyses the type and degree of benefit of these various arrangements: networks, alliances, consortiums, coalitions and coordinating centres. This chapter includes some helpful case-studies and a section (Box 5.6) on "Effective NGDO policy advocacy"(pp. 124-126).

Harrison D (2000). Health research in Tanzania. How should public money be spent? (COHRED document 2000.9). Geneva, Council on Health Research for Development.

An analysis of recent efforts by the health research community in Tanzania to set health research priorities. In a section about "Practical ways to seize the opportunities", there is a helpful subsection about designing team-based incentives to fill investment. Available online at: <http://www.cohred.org>.

Horton R (2002). The health (and wealth) of nations (editorial). Lancet, 359(9311):993-994.

Porter RW (1995). Knowledge utilization and the process of policy formation: toward a framework for Africa. Washington, DC, Support for Analysis and Research in Africa (SARA). A paper prepared by Porter/Novelli under a subcontract with SARA.

This useful paper analyses "what is known about how information is used and how policy is formulated ... to refine our thinking on the relationship between the information generated by research and changes in policy and policy implementation". The paper includes an analysis of USAID's 15-year experience with the policy project RAPID (Resources for the Awareness of Population Impacts on Development). The study includes useful conclusions and recommendations. The main conclusion is that "changes come about through a process of iterative interactions among three 'streams' of activity: defining the problem, suggesting solutions, and obtaining political consensus."

Porter RW, Pryor-Jones S (1997). Making a difference to policies and programs: a guide for researchers. Washington, DC, Support for Analysis and Research in Africa (SARA).

This guide is a product of a collaborative effort which included the SARA project (USAID), COHRED, the Joint Health Systems Research Programme (WHO) and the ENHR Africa Secretariat. "The basic premise of the Guide is that research informs policies and programs most effectively when there is a three-way process of communication linking researchers, decision-makers, and those most affected by whatever issues are under consideration". The last section of the Guide, on "Communicating research results", includes a useful set of practical suggestions for conducting personal briefings with decision-makers.

Trostle J, Bronfman M, Langer A (1999). How do researchers influence decision-makers? Case studies of Mexican policies. Health Policy and Planning, 14(2):103-114.

In this study, the authors present lessons regarding the research and policy link from five case-studies. They did this by interviewing researchers and policy-makers associated with four vertical programmes of the Mexican Ministry of Health. They identified a number of factors related to content, actors, process and context that enable or impede the uptake of research results.

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