

A Developing Country Perspective on International Research Partnerships on Health

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INTRODUCTION

A partnership involves two or more parties working to achieve common interests and goals. The concept of partnership is used by many international agencies and African policy makers without a precise definition. There is the tendency to refer to agencies that provide financial and technical support as ‘partners’. In reality not all of these agencies are in partnership with the recipient body. Partnerships in international research on health exist in developed as well as developing countries. However, it is the relationship between the have (developed economies) and the have-nots (developing economies) that have always been the subject of discussion. In practice this concept involves a relationship between an industrialised country and a developing country (north-south partnership). However, partnerships also exist between entities in the developing world (usually referred to as south-south partnership). In general there is more of north-south international research partnerships than south-south arrangements. There are other expressions like collaboration¹ and networks that are used sometimes to reflect the meaning of ‘partnership’. In its broader sense collaboration and networks may be part of a partnership arrangement.

The principles underlying a partnership have been described in various ways but many take inspiration from the principles in the “Guidelines for Research in partnership with Developing Countries” of the Swiss Commission for Research Partnership with Developing Countries (KFPE). The Globethics.net Board’s outlines twelve principles that should underline partnership in health research².

In general these principles include ownership, mutual trust and respect, shared responsibility, clearly defined roles, sustainability, capacity development and utilisation of research findings to inform health decision making and health practice. In no particular partnership arrangement are all these principles manifested.

In this paper, we describe examples of models of international research partnership and discuss some of the problems associated with them. These are only examples and do not in anyway attempt to give an exhaustive account of the numerous arrangements in existence.

MODELS OF RESEARCH PARTNERSHIPS

Existing models of research partnership in health depend on the institutional relationships underlying the partnership arrangements. The arrangements in academia may not be the same as that between governments, governments and academic/research institutions and between a ‘Funding agencies’ and research institutions.

¹ Collaboration is a structured, recursive process where two or more people work together toward a common goal—typically an intellectual endeavour that is creative in nature - by sharing knowledge, learning and building consensus.

² http://www.globethics.net/globethics_research (accessed 1st February 2008)

Anthony Costello and Alimuddin Zumla in their paper “Moving to research partnerships in developing countries”³ describe three approaches of research partnership in developing countries that is referred to as the pre-colonial model. They describe “Postal research” – involving developing country scientist collecting and shipping samples to colleagues in the north; “Parachute research” – where northern researchers travel to Africa or Asia for brief periods and take back biological samples and data; and “Annexed sites” for field research led and managed by expatriate staff. These types of partnership arrangements still exist despite their obvious disadvantage to the developing country (southern partner).

These research partnerships do not promote solutions for the health problems of developing countries, including capacity building and infrastructure development for research. In addition, the contribution of the southern partners to knowledge development is minimised as they are not prominent in publications that are usually published in journals that are not readily accessible to the scientists and policy makers. An important deficiency of many of the examples of these kinds of partnership is the lack of respect of the health development needs of the southern partner.

In response to the disparity between investments for health research in relation to the health problems of the developing world other models of partnership have emerged. Some are entirely new ideas while others strive to improve on existing arrangements. In those partnership arrangements based on developed countries investment in health research there is the tendency for the partnership to reflect the northern partner’s international development cooperation agenda.

“Annexed Site” Model:

The Medical Research Council (MRC) of Britain’s investment in health research in Africa, for example, operates on a stand-alone model, similar to the “Annexed site” model. This has resulted in developing long-term investment in infrastructure, opportunities to develop long-term relationships with local communities and the government and capacity building. Research findings have been utilized in national public health programmes locally and internationally. There still exist expatriate influences in the local administration of the research units. A major disadvantage of this model is that it tends to attract good scientists from national institutions. In West Africa, for example, the MRC in the Gambia attracts scientists trained by neighbouring English-speaking countries to the detriment of the neighbouring country. The incentive is usually better remuneration and research opportunities. Prospects for career advancement are poor and there is the tendency for the local scientists to move to other institutions other than their own countries.

The MRC has recently held a multi-stakeholder consultation to examine its investment in health research in Africa that takes into consideration many of the concerns raised about their current strategy.

“Grants and Call for Proposals” Model:

Many organisations in developed countries approach international research partnership creation by pre-defining conditions requiring the participation of northern partners in research calls. Sometimes the conditionalities go beyond determination of a partnership and include who should lead and who should determine the use of resources. In such arrangements the northern partner ends up being a greater beneficiary of the available resources.

³ BMJ 2000;321:827-9

Within African tertiary institutions one finds a mixture of partnership arrangements but dominated by arrangements based on existing relationships (individual or institutional) and through specific calls from funding bodies for international partnerships. The ensuing proposals and projects may build on existing multi-institutional relationships or collaborations, but they can also be built strategically from scratch. Institutions like DfID, Wellcome Trust have had a longstanding interest and commitment to Africa. Some insist that the lead partner of the partnership is based in a ‘Southern’ institution while others privilege leadership from ‘Northern’ institutions. However what binds these new funded partnerships is their focus on ‘capacity building’ in African tertiary institutions.

The European and Developing Countries Clinical Trial Partnership (EDCTP) funded by the European Union has a partnership arrangement that seeks to empower African research institutions and scientist to respond to their health needs. The governance arrangements for the EDCTP ensure a significant contribution of African scientists’ voice in decision making including the award of grants. One condition of its calls for proposals is the requirement of the involvement of northern partners in the projects.

The EDCTP focuses on three health problems, Malaria, Tuberculosis and HIV/AIDS and then limits its funding to the development of clinical trial expertise. It can be argued that the capacity built may be applied to other health problems; however, Africa’s health problems are not limited to these three conditions although at the moment they constitute the major focus of research funding.

“Hub and Spokes” Model:

In recent times, a new way of promoting south-south collaboration and putting African scientists in the forefront of the research agenda is a “Hub and spokes” model involving nodes of excellence or networks of excellence. The EDCTP is presently pursuing this approach. This concept allows research institutions in a region to form consortia. The arrangement allows for the well established institutions in the consortium to support the smaller research centres to grow through exchange of experts, capacity building and sharing of expertise and resources. While the participation of northern partners is not a requirement, the consortia arrangement allows for investment by other funding organisations.

“Southern-led Northern-Funded” Model:

In the early 1992, the Netherlands Development Assistance Research Council (RAWOO) took the initiative to set up an innovative partnership for health research between Ghana and the Netherlands as part of its new policy shift in development cooperation. The partnership had three pillars:

- a) to better attune health research to the needs of public policy-makers, health workers and end-users or beneficiaries in Ghanaian society-at-large, and thus to make it more demand-driven.
- b) to put greater emphasis on the need to strengthen national capacity for health research, and to enhance local ownership by empowering the Ghanaian research partners and local stakeholders.

- c) to redress imbalances in North-South collaborative research by promoting genuine research cooperation between researchers from Ghana and the Netherlands; such cooperation based on mutual trust, sharing of experience, joint learning and equal say and equal influence in decision-making and programme management.

At the same time efforts were ongoing in Ghana through the Health Research Unit of the Ministry of Health to bridge the research-policy divide and to make health research relevant to national development. As part of the Sector-wide approach to health development the Ministry of Health formulated the Medium Term Health Strategy. The strategy recognised health research as an essential ingredient that would generate knowledge that could contribute to better policy responses and management practices, to informed evidence-based decision-making, to more widely accessible health services of better quality, and, in the end, to better health for the people of Ghana. The Ghanaian-Dutch Health Research Programme (HRP) was seen as an instrument for the pursuit of these objectives.

From design to implementation it was clear that a new type of arrangement was being created. An arrangement that combined the concepts of ownership and partnership and best seen as a new paradigm in research funding in which the southern partner had control of funding provided by a northern body. Although the inception phase took about five years the effort was worthwhile as it laid a solid foundation for programme implementation. The process of interaction and consensus-building among the local stakeholders and between them and the research partners produced a research agenda for health research rooted in the needs of policy-makers, health workers and local communities.

The Ghanaian-Dutch Health Research Programme broke new grounds in making health research more responsive to national development needs, and in enhancing and sustaining national capacities for the design, implementation and management of essential research pertaining to national health. The Ghanaian-Dutch Health Research Programme demonstrates that developing countries have the capacity for demand-driven research and pursue local ownership. A clear view of the partnership arrangement and its limitations is required for a more honest dialogue and expectation.

DISCUSSION

In general, many of these partnership arrangements have a number of themes that reflect the principles of partnership. These partnerships aim to:

- Create equitable and sustainable relationships between institutions and individual partners
- Maintain shared ownership of project – from conception through completion to dissemination
- Build capacity through their projects (if capacity building is not the main goal) – eg. training young promising researchers, developing and building local leadership, supporting human resources and infrastructure in a variety of ways (administrative, governance, financial) to deliver world class research
- Ensure transparency, trust and other ethical considerations within the partnership and between the partnership and its research/target communities.

However, many of these aspirations are not met to the full. There are several accounts showing failure of the partnership principles. It may be argued and indeed it is true that at the national level many developing countries do not have in place the required policy to direct health research. This was one of the major concerns expressed by African Ministers of Health

(and Ministers of Health from other developing countries) during the recent High-Level Ministerial Meeting held in Accra in June 2006. Another issue related to the absence of national health research policy was the absence of mechanisms to articulate priority health problems for research.

The dependence on funding from development ‘partners’ also contributes to the inability to dissociate the donors’ interests from the research agenda of the developing countries. It upset the implementation of a demand-driven approach and local ownership. Access to approved research funds has been a problem resulting from a perceived weakness in the accounting structures of recipient institutions. Largely most of the funds are retained in the northern partner country; being used to shore up their research infrastructure and capacity building for themselves.

Developing country governments provide inputs into research institutions through the provision of research infrastructure and their maintenance, salaries of local staff and tax exemptions. These in themselves essentially mean that funding for actual research activities is not readily available. African Ministers of Health have agreed to allocate 2% of their health budget to health research. It appears this target has not been met by but a few countries (including Ghana). Co-funding is an important principle of partnership and although contributions may not be equal proportion it must be respected.

A major deficiency of many of the partnership arrangements is the distribution of knowledge from the research activities to the local partners and their policy makers. As part of any partnership arrangement efforts should be made to ensure that the research findings are made available to researchers, policy makers, health administrators and the general community. Many of these research publications are also published in journals that are not readily accessible to African researchers and policy makers. A recent article showed growth in health research and journal activity on the African continent⁴. The majority of the journals surveyed were English, had a circulation of less than 1000 and about half covered general medical interest while the remaining half were specialist journals. The major challenges identified included limited inclusion in international databases and accessibility to African researchers. Thus publishing African health research in high-quality African journals remains to be achieved; and yet this is important for health development.⁵

Editors and publishers of established journals, in Africa and elsewhere, have a role to play in improving the quality of African medical journals. There are ongoing efforts to correct some of these publication issues including, The Forum for African Medical Editors (FAME)⁶, the African Health Journals Partnership project⁷ and the have shown some of the approaches to adopt to achieve a better international and national presence of African medical journals. The HINARI project⁸, that involves publishers of many key international journals, has brought scientific publications nearer to scientists and health practitioners than ever before. The increasing availability of internet access and open access policy of many journals should enhance the distribution of knowledge.

⁴ Siegfried N, Busgeeth K and Certain E. Scope and geographical distribution of African Medical Journals active in 2005 South African Medical Journal; 96(6): 533-537

⁵ Ofori-Adjei D, Antes G, Tharyan P, Slade E, Tamber PS. Have Online International Medical Journals Made Local Journals Obsolete? PLoS Med. 2006 Aug 29;3(8)

⁶ Supported by WHO/TDR

⁷ Funded by the US National Institutes of Health (through the National Library of Medicine and the Fogarty International Center) and facilitated by the Council of Science Editors

⁸ www.who.int/hinari/en

Partnership arrangements should also build capacity in research methods, report writing and scientific writing. The Ghanaian-Dutch Health Research Programme, for example, runs research writing workshops in collaboration with the Ghana Medical Journal for researchers who have finished their projects. The workshops are co-funded by the African Health Journals Partnership.

Many of these research partnerships have resulted in joint publications but the influential policy papers tend to have the foreign partners as lead authors. “It is the conceptual or theoretical paper that separates the ‘jobbing’ academic from the real scholar and it is the scholar who will carve out a highly respected and lucrative international career”.⁹ Sometimes northern partners will write articles and submit these for publication without consulting their local partners or including their names as co-authors. This behaviour affects the career development of local scientists in addition to proper acknowledgement of the contribution of local scientists.

Evaluation of research partnerships with developing countries are performed by the northern institution providing the funding. These evaluations usually focus on four key criteria: relevance, effectiveness, efficiency and sustainability. These four criteria are elaborated on through specific questions relating to the tenets of the partnership. In Ghana’s HRP the local ownership arrangement allowed for an internal evaluation in addition to the external evaluation procured by the northern funding agency. A series of questions proposed by Costello A and Zumla A¹⁰ would make an interesting application. In an analysis of the impact of the first sixteen research projects and the relationship with application-enhancing methods in the research cycle of the Ghanaian-Dutch Health Research Programme, Maarten Kok¹¹ looks at the application of health research findings in policy and practice using an “application-enhancing method”. He concludes that “elements of *knowledge translation method*, the *demand-driven research method* and the *linking and knowledge method* are related to the impact the research projects have on health care and that there are strong indications that these elements contribute to this impact”.

In conclusion, international research partnerships between northern and southern partners have been in existence since colonial times in different models and continue today in various forms. Although these partnership arrangements have contributed to knowledge development and changes improvements in health and health policy there still exist room for improvement. In particular, developing countries should be empowered to take charge of their health research needs. The HRP model suggests that it is possible to reverse the current approach of northern dominated partnership and for the recipient (southern partner) to be the primary partner. This will re-enforce the principles of demand-driven research, ownership and utilisation of knowledge.

⁹ Views expressed by Ghanaian social scientist

¹⁰ Costello A and Zumla A Moving to research partnerships in developing countries British Medical Journal 2000;321:827–9

¹¹ Maarten Kok The impact of the Health Research Programme on health care in Ghana 2006