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for Scientific
Research in Development
Problems

Framework for a Ghanaian- Dutch Programme of Health Research for Development

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Health Research Council

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CONTENTS

Preface

1. Introduction

- 1.1 Background
- 1.2 Objectives and policy principles
- 1.3 Selecting Ghana as a pilot country
- 1.4 Working method

2. Directions for a Ghanaian - Dutch programme of health research

- 2.1 Policy framework for a joint programme of health research
- 2.2 Mechanisms for supporting and promoting joint research activities

3. Expertise in the Netherlands that is relevant for development-related health research

- 3.1 Results of the questionnaire
- 3.2 Conclusion

4. Organizational structure

- 4.1 International Programme Committee
- 4.2 Support and Liaison Office
- 4.3 The Joint (Ghanaian-Dutch) Programme Committee
- 4.4 Executive secretariat
- 4.5 Joint Task Forces
- 4.6 Assessment of project proposals

5. Extending the programme to other countries, and budget requirements

- 5.1 Choosing other African countries
- 5.2 Budget requirements
- 5.3 National and international coordination

Annexes

- Annex 1 Composition of the Programme Study Committee
- Annex 2 Report of the workshop “Developing a Ghanaian-Dutch programme of health research for development”, Amsterdam, the Netherlands, 28 - 29 May 1997
- Annex 3 Background information on the health situation in Ghana, the government’s health policy, and the environment for health research
- Annex 4 List of abbreviations

Preface

This report to RAWOO and RGO presents an outline for a Ghanaian-Dutch programme of health research for development. It must be seen in the context of the RAWOO advisory report “A Medium-term Perspective on Research for Development”, issued in 1994, which recommended that a long-term South-North research programme be established in the area of health and development. As the government’s response to this recommendation was positive, RAWOO and RGO took the initiative to launch a study aimed at formulating the policy and organizational framework for such a programme. The present report, which is the result of this study, was prepared under the auspices of RAWOO and RGO by a committee made up of members of both Councils, as well as researchers and representatives of NWO and the Dutch ministries of BuZa/DGIS and OCenW.

First of all, the Councils would like to express their appreciation for the report. The Councils support the programme outline put forward: both the policy framework for the joint research activities at the district level, and the options proposed for the organizational structure. The committee has succeeded in designing a partnership programme in which the research needs of the country concerned, in this case Ghana, are taken as the point of departure, and in which both partners have an equal say in policy, decision-making, and programme management. The Councils especially appreciate the initiatives taken by the Ghanaian partners to draw local stakeholders into the effort to define a national agenda for health research. They also welcome the emphasis placed on promoting needs-based, user-driven research that is relevant to policy and action at the regional and district levels; as well as the attention that has been given not only to research, but also to capacity-building; and the balance that has been struck between biomedical research, research on health systems and health-related socio-economic research. The Councils are of the opinion that the programme document, as well as the process through which it was prepared, is consistent with the conditions stated in the government’s response to the above-mentioned recommendations.

As regards the organizational structure, the Councils recommend the following:

- The Joint Programme Committees (JPCs) should have the final responsibility for policy and decision-making and thus for allocating research funds to projects on the basis of their own procedures and criteria. They should report to the funding agencies regarding the results achieved and the way the money has been spent, and they should keep the International Programme Committee (IPC) informed of the programme’s progress. The committees must be truly independent; their composition should reflect the various stakeholders involved, both in the country concerned and in the Netherlands.
- The International Programme Committee (IPC) should have the task of advising the donors regarding the development of the programme as a whole. This includes: monitoring the programme and advising the donors whether its objectives are being met; advising the donors regarding the choice of other countries to be involved in the programme; stimulating the involvement of Dutch research groups in the country programmes; stimulating the exchange of knowledge and information between the various country programmes, and between the programme as a whole and other interested parties; and seeking the support of other donor organizations.
- The Support and Liaison Office (S&L office) in the Netherlands should support the JPCs and the IPC, and should channel programme funds to the country-based executive secretariats. To this end, the S&L office and the country-based secretariats should work closely together, actively exchanging information and coordinating operational and practical matters. The S&L office should be hosted by an organization whose main agenda does not interfere with the policy principles and approach underlying the programme. In RAWOO’s view, the host organization should have professional experience in the field of demand-driven research and institutional development in developing countries. The RGO

advises to entrust the task of hosting the S&L office to a combination of NWO and the Royal Tropical Institute.

- A stakeholders' platform should be an integral part of the programme's structure in order to ensure that the parties involved in health research in Ghana continuously add their input to the policy-making and decision-making process.

As outlined in the report, a pre-implementation phase is needed in order to give the Ghanaian-Dutch programme firm roots in Ghana. During this phase, research needs and priorities at the district level will be further specified through a dynamic process involving researchers, health professionals, and representatives of NGOs and CBOs. The pre-implementation phase is also needed to put in place the organizational structure for the programme's implementation. This phase should be conducted under the responsibility of RAWOO and RGO in order to ensure that the right conditions for a successful programme are created. At the start of the implementation phase, the JPC will take over this responsibility.

The Councils would like to thank the members of the preparatory committee, in particular its chair, RAWOO member Dr. Joost Ruitenbergh; the Ghanaian counterparts, in particular Dr. Sam Adjei; and all the other persons and organizations in Ghana and the Netherlands who contributed to the report.

Finally, the Councils hope that the programme will break new ground in the support of joint research and capacity-building activities that contribute to better health and improved health care for the Ghanaian population, particularly in the rural areas. They trust that the funding organizations involved will react positively to the proposal presented, and will supply the necessary financial resources for its implementation.

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1. INTRODUCTION

1.1 Background

This report presents the results of a study aimed at formulating a collaborative (South-North) programme of health research for development. It describes the origin of the initiative, the policy principles underlying it, the selection of Ghana as the first partner country to be involved in the programme, and the interactive process of involving all actors in the programming exercise: the research community (both in Ghana and in the Netherlands), policy-makers, and representatives of the end users in the society-at-large. It also sets out the major policy directions and the organizational structure of the proposed joint Ghanaian-Dutch programme, and it concludes by suggesting when and how this programme could be extended to include one or two other Southern countries.

The present study was conducted under the auspices of two sector councils based in the Netherlands: the Advisory Council for Scientific Research in Development Problems (RAWOO) and the Health Research Council (RGO). Funding for this study was provided through the Sector Councils Consultative Committee (COS)

It started with the RAWOO advisory report “A Medium-term Perspective on Research for Development”, issued in 1995, which recommended, among other things, that a long-term South-North research programme be established in the area of health and development. The Minister for Development Cooperation (speaking also on behalf of his fellow ministers of Education, Culture and Science; and Agriculture, Nature Management and Fisheries) responded positively to this recommendation and expressed the government’s willingness to help fund such a programme. However, he also mentioned a number of conditions that the programme should comply with and asked RAWOO to see to it that these conditions would be taken into account¹.

The government’s intentions were confirmed in its bi-annual Science Budget 1997, which indicated that the relevant government departments—the Directorate General for International Cooperation (DGIS) and the Ministry of Education, Culture and Science (OC&W)—had incorporated the programme into their long-term financial planning.

Simultaneously, the Netherlands Organization for Scientific Research (NWO) expressed an interest in developing an international programme of health research. It had allocated funds for this purpose in its multi-annual policy plan “Knowledge enriched”. It seemed logical to bring the RAWOO/RGO initiative and the NWO initiative together and to develop a comprehensive programme.

¹ The conditions mentioned by the Minister for Development Cooperation were the following:

- the choice of country (preference for countries with which the Netherlands has longstanding relationships in the area of development cooperation);
- a society-driven or demand-driven approach (the research needs of developing countries should come first; no steering or lobbying from the supply side);
- attention for capacity-building;
- equal partnerships (the partners from the South should be involved on an equal footing in the formulation and implementation of the programme);
- co-financing (link development with science funding and try to involve international organizations that support research, such as the EU) ;
- appropriate governance and management structure (in which the Southern partners have an equal say, thus reflecting genuine cooperation);
- need for innovative and new approaches (no ‘business as usual’).

RAWOO and RGO appointed a committee to provide guidance as the study was being conducted. This committee consisted of RAWOO and RGO members and representatives of the Dutch research community, NWO (MW and WOTRO), and the relevant ministries (DGIS and OC&W) (*see Annex I*).

1.2 Objectives and policy principles

The present study had two main objectives:

- (a) to design the policy and organizational framework for a collaborative programme of health research for development. More specifically:
 - to identify the countries in the developing world which will be the main geographical focus the partnership programme;
 - to identify needs and priorities regarding health research, including those in the area of capacity-building and institution-building;
 - to propose a structure of governance and management for the programme's implementation.
- (b) to build consensus among the key actors in the research environment, and to win their commitment to the policy and organizational framework of the future programme. These actors include researchers, policy-makers and end users of the research results in the South; and researchers and policy-makers in the North.

In other words, the expected outcome was defined in terms of the product to be delivered: i.e., a research programme in outline form, to be conducted so as to achieve a certain process.

The policy principles guiding the programming process initiated through this study are the following:

(a) Steering health research through a society-driven or demand-driven approach

The proposed research programme will give priority to research relevant to the health problems of the poor and the policy and institutional constraints related to these problems. This means that the process of setting the research agenda will be driven by societal needs. Steering research using a society-driven or demand-driven approach implies that research needs and priorities are assessed and articulated by the relevant stakeholders in the research community, government and society. This is not a one-time consultation, but a continuing process.

Involving the user community is important, not only at the national policy-making level but also at the programme and project level. There is growing awareness that the utilization of research results can be enhanced by involving representatives of user groups in the different stages of the research process. The user community includes relevant policy-makers and government officials at various administrative levels (national, provincial, district), health professionals, the private sector, non-governmental organizations (NGOs), and community-based organizations (CBOs) representing the beneficiaries of health services.

(b) Developing a comprehensive approach aimed at integrating support for collaborative research and support for building and strengthening national capacity for health research

Developing a strong and sustainable national capacity for health research in developing countries will be one of the central concerns of the programme. This includes support for efforts:

- to provide research training (and make better use of existing, often under-utilized capacity);
- to develop methodologies for assessing needs and setting priorities (e.g. through workshops, participatory approaches, and networking);
- to build up and strengthen health research institutes and other research infrastructure (libraries, and information and communication facilities);
- to develop mechanisms for linking research, policy and practice (e.g. through networks, seminars, and workshops);
- to create an institutional and policy environment that enables Southern countries to design, implement and manage policies and programmes for health research.

(c) Research cooperation on an equal footing

It is important that Southern researchers participate as equal partners in the design and implementation of the collaborative programme, and that they have an equal say in the policy and decision-making process and in the governance and management structure. This means an equal say not only in the process of priority setting, but also in assessing research proposals, in allocating research grants to projects, and in administering the programme. Equal partnership is essential for the long-term sustainability of collaborative programmes.

(d) Coordinating programmes of health research for development, and the bilateral, multilateral and international initiatives of organizations and networks that support research

A number of bilateral and multilateral donor organizations - such as SAREC, IDRC, Danida, GTZ, ODA, the World Bank, WHO and the EU - support programmes of health research for development. It is clear that the present initiative, with its emphasis on building long-term capacity for health research, has to be coordinated with these organizations' other programmes of research and capacity-building. The Southern countries themselves are in the best position to coordinate the efforts of donors - all the more so if they have their own policy for health research which indicates national needs and priorities.

International NGOs and research networks can also play a role in coordinating health research. Among them are the Council on Health Research for Development (COHRED), which has been a pioneer in developing, promoting and disseminating the concept of Essential National Health Research (ENHR). Other organizations and networks that can play a role are the Joint Health Systems Research Project, the Network of Community-Oriented Educational Institutions for Health Sciences, the International Clinical Epidemiology Network (INCLIN), the International Health Policy Programme (IHPP), and SOMA-Net². In general these networks emphasize problem-oriented, needs-

² The Council on Health Research for Development (COHRED) was established in 1993 and consists of member countries, organizations and agencies. It has a board of 18 individuals, the majority of whom come from developing countries; its secretariat is located within the United Nations Development Programme (UNDP) in Geneva. COHRED has developed the concept of Essential National Health Research (ENHR), which is characterized as follows. Emphasis is placed on *Essential* (need-based and relevant), *National* (all levels and all stakeholders must be included in the agenda-setting exercise), *Health* (in the broad sense of the word, intersectoral) and *Research* (high quality, both discipline-based and multidisciplinary, and translatable into policy and action). The ENHR approach stresses the importance of the interplay between the community, researchers and policy-makers as health research is formulated and implemented which is need-based and relevant. ENHR includes two kinds of research efforts: country-specific health research and global health research. These complement each other. Exactly which mix of research is essential must be defined by each country, but it will contain at least some measure of these two basic components. COHRED encourages countries to adopt ENHR strategies and to start a national consultative process to define ENHR priorities. It recognizes that, until recently, donors and Northern institutions could manipulate the national context and push their own priorities because

based research that is often interdisciplinary or transdisciplinary, and stress the importance of the interplay between the community, researchers and policy-makers for formulating and implementing health research which is relevant and useful for policy and action.

1.3 Selecting Ghana as a pilot country

In view of the policy principles explained above, the committee decided to develop a country-specific programme focusing on two or three countries in the South, and to select one country in sub-Saharan Africa for a pilot programme. A survey was made and criteria were developed to obtain a shortlist of possible partner countries. This resulted in the selection of three countries: Benin, Ghana and Mozambique. A team visited these countries in April 1996 in order to identify the possibilities for setting up a joint programme of health research and to collect information on the health research environment (policies, research infrastructure, organization and funding) and on the key actors involved. The mission resulted in three country reports and a comparative analysis leading to the conclusion that Ghana would be the best candidate to start off with.

The reasons for selecting Ghana were the following. First, Ghana has a favourable health policy environment, which is an important precondition if research results are actually to be used. The country (like most sub-Saharan countries) is faced with the challenge of reforming its health sector against the background of increasing demand as a result of high rates of population growth. Health improvement is one the cornerstones of the government's overall policies for development and poverty alleviation. The Medium-Term Health Strategy (MTHS), which defines the government's health policy for the coming ten years, illustrates this priority and recognizes the role research can play in improving health policies and programmes. The MTHS policy document also puts forward proposals for devolving health care delivery to the district and community levels and for involving civil society (NGOs and CBOs) in the planning and implementation of health programmes. This policy shift is important with a view to involving the end-user community in the formulation and implementation of research, and thus increasing the chances that research responds to the needs of those that could benefit from its results. Second, Ghana has a relatively well developed health research system and a critical mass of highly qualified and competent researchers. Third, the country has a relatively stable political climate. Fourth, the ENHR process has already got off the ground; researchers, policy-makers and practitioners have started a dialogue and are relatively autonomous vis-à-vis the donor community.

The choice of Ghana also met the conditions put forward by the Minister for Development Cooperation in his response to RAWOO's advisory report for the medium term.

Once experience has been gained with the Ghanaian-Dutch programme, one or two other countries can be selected for the extension of the programme.

1.4 Working method

Given the study's objectives and the importance of the consultative process that these imply, the committee drew up a plan of activities consisting of a series of meetings and workshops.

In January 1997 a meeting was organized for the Netherlands' research community in order to inform it about the study's objectives, policy principles and approach, and in doing so to involve it in the process of developing the joint Ghanaian-Dutch programme of health research.

This meeting was followed by a national Ghanaian workshop on setting an agenda for health research, which was held on 25-27 February 1997 in Accra, Ghana. The purpose of this workshop was to bring

there were no national health research policies in developing countries. This explains the importance attached to agenda-setting and prioritization on the basis of national needs and development relevance.

together researchers, policy-makers and representatives of the user community from all over Ghana to discuss modalities for strengthening research in support of changes in the health sector. The recommendations of this meeting were taken up by an interim Steering Committee and further worked out in a draft policy document entitled “Policy guidelines for strengthening research to support the Medium-Term Health Strategy in Ghana”³.

This document served as major input for the workshop “Developing a Ghanaian-Dutch programme of health research for development”, which took place on 28-29 May 1997 in Amsterdam, the Netherlands. The main objective of this two-day meeting was to discuss the policy and organizational framework of a collaborative Ghanaian-Dutch programme of health research, taking into account the guidelines and directions set out in the Ghanaian policy document mentioned above. The workshop was attended by 45 persons, including ten from various organizations involved in health research in Ghana - researchers, policy-makers and representatives of NGOs. The report of the Amsterdam workshop is attached as Annex 2.

As a follow-up to the Amsterdam workshop, a questionnaire was sent around to collect additional information about the knowledge and expertise available in the Netherlands that could be relevant in terms of the research areas identified in the workshop; and to ascertain the degree to which Dutch research groups would be interested and willing to participate in a joint programme.

Sections 2 and 4 of the present report are based largely on the outcome of the two workshops, while section 3 is based on the results of the questionnaire.

³ This document is available at the RAWOO secretariat.

2. DIRECTIONS FOR A GHANAIAN - DUTCH PROGRAMME OF HEALTH RESEARCH

As described in section 1.4, the parties involved in health research in Ghana drafted a policy document entitled “Policy guidelines for strengthening research to support the medium-term health strategy in Ghana”. This document was based on the outcome of the national agenda-setting workshop held in February 1997 in Accra, and served as major input for the Amsterdam workshop held in May 1997. The main conclusion of the latter workshop was that it would be possible to develop a joint Ghanaian-Dutch programme of health research on the basis of the policy directions set out in the Ghanaian document.

The following outline of the proposed Ghanaian-Dutch Programme of Health Research is based on the results of the Amsterdam workshop. It does not contain a list of priority research themes or topics, but provides a policy framework for further articulating research and capacity-building needs at the regional and district levels through a dynamic process involving researchers, public and private health-care providers, and representatives of NGOs and CBOs. This process should result in a comprehensive programme of activities, in which research, research training, networking, infrastructure development, and activities aimed at improving the dissemination and utilization of research results are integrated.

2.1 Policy framework of the joint programme of health research

There are different documents available which describe the state of health in Ghana, the major health issues, the changes in the health sector, the government’s health policy, and the health research environment. The reader is referred to Annex 3, which provides some background information.

The Ghanaian health-care system faces a number of challenges, which are currently being addressed in the Medium-Term Health Strategy. The guiding principle of the MTHS is to address the problem of poor health status more from the perspective of issues that affect the performance of the health sector than from the perspective of diseases that afflict Ghanaians, or specific interventions that need to be implemented. It is recognized that the delivery of health interventions is constrained by five ‘cross-cutting’ or ‘cross-country’ issues⁴:

- (1) Access to health services;
- (2) Quality of health services;
- (3) Efficiency in the use of resources;
- (4) Linkages in the health sector;
- (5) Health financing and health technology assessment.

The Ghanaian partners strongly believe that health research should generate knowledge in support of the current and future changes in the health sector and, more in particular, should contribute to solving the priority ‘cross-cutting’ issues defined in the MTHS. In their view research should be better attuned to the changes in the health sector and to the MTHS strategy in order to ensure that research results are relevant and respond to the needs of the potential users-in other words, that they are translatable into policy and action.

As a result of the Amsterdam workshop, the health systems issues were linked with the priority health interventions through a matrix, which can also be used as a tool for linking Health Systems Research

⁴ These issues are further elaborated in the Ghanaian policy document, pages 8 - 10 (see note 3).

(study of the health-care system and its accessibility, supply and demand, quality, financing, etc.) with social and economic research (medical anthropology, research on gender and health, health economics, action research on interventions) and biomedical research (molecular biology, cell biology, animal experiments, clinical research, epidemiology) (see Table 1).

Table 1. Matrix linking health systems issues with priority health interventions

	CROSS-CUTTING SYSTEMS ISSUES	A	B	C	D	E
	PRIORITY HEALTH INTERVENTIONS	ACCESS TO HEALTH SERVICES	QUALITY OF HEALTH SERVICES	EFFICIENCY IN THE USE OF RESOURCES	LINKAGES IN THE HEALTH SECTOR	HEALTH FINANCING AND HEALTH TECHNOLOGY ASSESSMENT
1.	Immunization through EPI					
2.	Reproductive health programme · Family planning services · Essential and emergency obstetric care					
3.	Prevention and control of infections with epidemic potential · Cholera · Cerebro-spinal meningitis · Yellow fever					
4.	Health protection and promotion · Bednet use · Nutrition and diet · Alcohol, drugs and tobacco · Sexually transmitted diseases (STD)/HIV · Hygiene and sanitation					
5.	Prevention and control of micronutrient deficiencies · Vitamin A · Iron · Iodine					
6.	Management of selected endemic diseases: · Malaria · Tuberculosis · Leprosy · Respiratory tract infections- ARI · Sexually transmitted diseases (STD) · Diarrhoeal diseases · Guineaworm diseases · Onchocerciasis, Schistosomiasis, yaws, buruli ulcer · Hypertension and diabetes					
7.	Emergency care for accidents and trauma					

It was agreed during the workshop that the matrix would serve as the framework for the joint programme and for identifying specific needs for research and capacity-building at the regional or district level. This should be done through an interactive, consultative approach involving the potential

users-decision makers, programme managers and health professionals in the public and the private sectors. The process of further articulating research and capacity-building needs would include translating health issues into researchable problems. The Joint Task Forces that will be set up will play a leading role in this process (see 4.5.).

To illustrate the kind of research that might come out of this process, the following are examples of research topics: the quality of malaria control and prevention; the efficiency of resource use with respect to sexually transmitted diseases (STD); access to STD-HIV health services; the linking of tuberculosis services to HIV-AIDS services; and on assessing new technologies for immunisation programmes.

2.2 Mechanisms for promoting and supporting joint research activities

The Ghanaian research policy document proposes four mechanisms for supporting future health research on the priority topics⁵:

(1) Working groups

Multi-disciplinary and inter-institutional working groups of qualified professionals will be set up at the national level in order to undertake coordinated studies on particularly complex policy issues. Researchers from a wide range of disciplines and institutions (universities, NGOs, private consultancy bureaus, etc.) will make up the working groups and will jointly design and implement the studies. The working groups will exist for a fixed duration and report their findings to the Ministry of Health.

(2) Research networks

Networks of researchers from universities and NGOs represent the second mechanism, which will be the main approach used to support independent research. Once priority research topics have been selected by the task forces, interested researchers will be invited to submit proposals for investigating these topics. The best proposals will be selected for funding by a review panel. The investigators leading the selected projects will constitute a network, the members of which will meet regularly to discuss and review one another's work.

(3) Research stations

The Health Research Unit (HRU) runs three field research stations, each in a unique ecological setting: the station at Navrongo in the northern savannah zone, the station at Kitampo district in the central forest zone, and the Dangme West station in the coastal zone. These stations are working in close cooperation with regional and district health authorities. They conduct studies, train mid-level professionals and, in general, have built up research capacities at the district level. The intention is to increase the support for these stations, and to increase the amount of research that the stations undertake with respect to the five priority issues identified. These stations provide an excellent opportunity for researchers to focus their efforts on practical health problems and intervention studies.

(4) Research by district and regional staff

A special effort will be made to promote research by district and regional staff. This research will be conducted not by full-time researchers, but by government health-service workers and administrative

⁵ For more detailed information on these mechanisms, the reader is referred to the Ghanaian policy document, pages 11 and 12 (see note 3).

personnel, who will undertake practical data collection and analysis activities alongside their managerial and clinical duties. Staff training and technical guidance in research methodology will be needed to support these activities. This can be provided by universities, research institutions and/or NGOs, for example.

As everyone at the Amsterdam workshop agreed, it can be expected that all or some of these support mechanisms can be incorporated into the joint Ghanaian-Dutch programme of health research, depending on the outcome of the process described under 2.1.

As regards research training and career development activities, the joint programme will emphasize:

- short training courses, in Ghana, on applied health research, including participatory methods;
- MSc/MA degrees;
- PhD degrees.

In this context, attention will be given to the need to “train the trainers”; and to staff training in the area of research management and the writing of research proposals. This could be done, for example, through proposal-writing workshops, and the joint development of training modules. Research training funded through the joint programme will be geared as much as possible to the five ‘cross-cutting’ priority issues.

Involvement of NGOs - as users but also as researchers - will be encouraged. Attention will also be given to the research infrastructure (literature, books, equipment, electronic communication facilities). As the Ghanaians have pointed out, the present facilities are rudimentary and inadequate.

3. EXPERTISE IN THE NETHERLANDS THAT IS RELEVANT FOR DEVELOPMENT-RELATED HEALTH RESEARCH

In order to assess the possibilities for a Dutch contribution to meeting Ghanaian research needs, a questionnaire was sent to Dutch research groups. The purpose of this questionnaire was to make an inventory of relevant knowledge and expertise and to measure willingness to cooperate with Ghana. The questionnaire included questions relating to:

- know-how and expertise in the research areas identified in the matrix;
- availability of expertise;
- track record in working with developing countries;
- experiences with and possible contribution to activities in the area of capacity-building;
- willingness to cooperate with Ghana, and;
- willingness to apply financial or other resources to the research.

The results of the inquiry will be made available to the Ghanaian counterparts so that they have an overview of possible Dutch partners, their specific expertise, their research activities, their experience, and their methodologies.

3.1 Results of the questionnaire⁶

Of the 40 questionnaires distributed, 23 were returned. Questionnaires were not returned for the following reasons: a) the request was sent to several departments of one institute, but only one responded (also on behalf of the others); and b) some networks decided to send in a single questionnaire for all members. Overall, it seems fair to say that the majority of the relevant health (and health-related) research groups reacted⁷.

Type of organization, size and mandate

The 23 institutions which responded to the questionnaire vary considerably in nature: 13 of the 23 are university departments or institutes with 2-20 staff members working in health-related research and training activities with a focus on countries in the South.

It is difficult to fit the other ten institutions into categories:

- The Royal Tropical Institute (KIT) has 25 scientific staff members and 15 laboratory technicians working in research and training in the biomedical field and in areas relevant to health care systems. KIT's focus is almost exclusively on countries in the South.
- The Gender and Health Network and CERES are networks of researchers working in various universities and other research institutions;
- The ISS is an international institute offering courses for students from the South and conducting research on a wide range of development-related problems. Three or four staff members work on health-related issues.
- The Central Laboratory of the Netherlands Red Cross has ten staff members involved mainly in questions of blood transfusion and the transmission of infectious diseases in countries in the South.
- The Netherlands Interdisciplinary Demographic Institute (NIDI) has ten staff members working in fields related to population studies and reproductive health in the South.

⁶ The full set of questionnaires which were returned to us have been compiled into a separate document.

⁷ It should be added here that the programme is not restricted to the research groups and institutes that responded to the questionnaire.

- TNO/ Public Health and Prevention Division is a large organization with 15-20 per cent of its work (10-12 staff members) being done in the South and in the countries of the former Eastern Bloc.
- The International Water and Sanitation Centre (IRC) and the International Institute for Infra-structural, Hydraulic and Environmental Engineering (IHE-Delft) specialize in reducing the transmission of diseases that is related to poor water and sanitation conditions. The IRC has nine staff members involved in development-related research; IHE-Delft has 42.
- The Municipal Health Service Amsterdam has 50 staff members involved in health research and training, but most of them are in an AIDS Research Programme in Ethiopia.

Expertise

The 23 research groups or networks cover quite a broad range of research expertise. Some of the more general topics (e.g., gender and ageing) were mentioned more than once. One can distinguish three major areas of research expertise:

A. *Biomedical research*

B. *Research into the functioning of the health care system*

C. *Social and economic research in relation to health*

In addition, a fourth category of expertise was mentioned which has to do with methodologies for research and training: research methodology and statistics; data and survey analysis; project design and evaluation; various quantitative and qualitative methodologies for (gender-specific) health research; multidisciplinary research; and participatory research, qualitative as well as quantitative.

Table 2 below shows which of the three major areas the institutions in the survey focus on, and whether or not training is an important component of their work.

Table 2. Main focus of the work and expertise of the Dutch research groups or institutions

Main focus of work	Institution ⁸	Substantial training component
Biomedical Research	<ul style="list-style-type: none"> • Amsterdam: Tropical Medicine • Central Laboratory Neth. Red Cross • Erasmus: Paediatrics • IHE-Delft (water and sanitation) • Leiden: Parasitology • Municipal Health Service Amsterdam • Nijmegen: Institute International Health • Nijmegen: Parasitology • Royal Tropical Institute • Wageningen: Food Technology and Nutritional Sciences 	<ul style="list-style-type: none"> • yes • yes • yes • yes • yes
Research on the Functioning of the Health Care System	<ul style="list-style-type: none"> • Amsterdam: Social Medicine • Erasmus: Public Health • Maastricht: Mundo • Nijmegen Institute International Health • Royal Tropical Institute • TNO: Public Health and Prevention Division 	<ul style="list-style-type: none"> • yes • yes
Social and Economic Research in Relation to Health	<ul style="list-style-type: none"> • Amsterdam: Inst. Development Research • Amsterdam: Medical Anthropology • CERES Research School • Gender and Health Network • Groningen: Population Research Centre • IRC 	<ul style="list-style-type: none"> • yes • yes • yes

⁸ Some institutions appear in more than one box: Royal Tropical Institute; Maastricht/Mundo.

	<ul style="list-style-type: none"> • ISS • Maastricht: Mundo • NIDI • Vrije Universiteit: Health Care & Culture 	<ul style="list-style-type: none"> • yes
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Country experience

The 23 institutions listed the different countries in which and with which they are actively involved in research and training. Three of the answers were not specific ('most developing countries', 'various countries', 'mainly developing world'). All the other respondents already work in Africa, while 15 are already cooperating with Ghanaian counterparts. These projects can be very modest in size. They vary from belonging to the same international network to being engaged in a joint research programme (e.g. IHE-Delft).

As regards willingness to cooperate with Ghana on the issues mentioned in the matrix, and the place of the institution's research work in that matrix, analysis of the questionnaires revealed the following.

Table 3. Willingness to cooperate with Ghana on the issues mentioned in the matrix

<i>Name institute, department, programme or network</i>	<i>Department</i>	<i>Are you willing and able to cooperate with Ghana on issues mentioned in the matrix ? (see Table 1)</i>	<i>Are you willing and able to match funds or other resources?</i>	<i>Where would you place your research work in the matrix ? (see Table 1)</i>
<i>Universities:</i>				
University of Amsterdam	Institute of Social Medicine, Academic Medical Center	yes	to a limited extent	4A,B,C,D and E 5A 6A,B,C,D and E
University of Amsterdam	Medical Anthropology Unit	yes	yes	1A,B,C and D 2A and B 4A and B 6A and B
University of Amsterdam	Institute for Development Research Amsterdam (InDRA)	no capacity at the moment	not relevant	2A, B, C and D
University of Amsterdam	Department of Tropical Medicine, Academic Medical Center	yes	no funds	3A,B and C 6A,B and C
Erasmus University Rotterdam	Centre for Decision Sciences in Tropical Disease Control	yes	yes	mainly issues E and C
Erasmus University Rotterdam	Department of Paediatrics	yes	yes	6B and E
University of Groningen	Population Research Centre	yes	yes	2A,B,C,D and E 4A,B,C,D and E
Leiden University	Department of Parasitology	yes	yes	6A,B,C and D
Maastricht University	MUNDO	yes	yes	most areas of the matrix
University of Nijmegen	Nijmegen Institute for International Health	yes	costs (gross salaries, travel, per diem) should be covered; overhead negotiable	activities do not fit in the matrix. Activities: capacity- building, curriculum development, health systems development
University of	Section Medical	yes	willing but unable	6B and C

Nijmegen	Parasitology			
Vrije Universiteit, Amsterdam	Health Care and Culture	yes	yes	2A,B and C 4A,B,C and D
Wageningen Agricultural University	Department of Food Technology and Nutritional Sciences	yes	willing to raise funds	Major thematic areas: nutrition and epidemiology, and food technology. Major involvement in and commitment to capacity-building
<i>Institutes:</i>				
International Institute for infra-structural Hydraulic and Environmental Engineering (IHE-Delft)		started cooperation with Kumasi University recently	through the cooperation project mentioned	6B

Institute of Social Studies (ISS)		yes	very little possibility	difficult to fill out the matrix
International Water and Sanitation Centre (IRC)		yes	to a limited extent	4A,B,C,D and E 6B and D
Netherlands Inter-disciplinary Demographic Institute (NIDI)		yes	yes	2A,B,C,D and E 4A,B,C,D and E
Royal Tropical Institute	1. Health Care and Disease control 2. Biomedical Research 3. PHC 4. Health Care Training	yes	difficult, but can be discussed	1A,B and D 2A,B,C,D and E 4A,B,C,D and E 6A,B,C,D and E
TNO Prevention and Health	Public Health and Prevention Division	quite willing	limited	1A and B 2A,B,C and E 4B and C 5A and B 6A,B,C,D and E
<i>Other:</i>				
Central Laboratory of the Netherlands Red Cross/ Blood Transfusion Service (CLB)		willing and able	yes	1C, 4B and C, 6C
Gender and Health Network		yes, provided agreement about the line of approach	willingness to try	all areas of study have gender dimensions
Municipal Health Service, Amsterdam		not possible	-	not possible
Research School for Resource Studies for Development (CERES)		please contact contact person	-	1B,D and E 2C and D 4A, B and C 6A, C, D and E

Not every institution found it easy to fit their skills, experience and ongoing activities into the matrix. Many respondents answered in terms such as 'We are doing this in country x and we can do that in Ghana too'. Most respondents managed to fill out the matrix, but they added comments, such as:

- “It should be realized that when a comprehensive view of health technology assessment is taken, access to health services (A), quality of health services (B) and linkages in the health sector (D) are an integral part of technology assessment.”
- “ ‘Gender and health’ is a field of study which is very much in a stage of development and as such is continuously exploring new areas of study and developing new approaches to do so. All the health systems issues and health problems or interventions mentioned in the matrix have gender dimensions, which need attention.”

Looking at the possible contribution of Dutch researchers to the issues in the matrix, we see that all the squares are marked at least once. This is mainly because the respondents working in the field of gender and training answered that their work fits into all categories. If we ignore these answers and focus on those who answered this question more specifically, we see that Dutch expertise seems to be weakest in the following horizontal categories: 3 (prevention and control of infections with epidemic potential), 5 (prevention and control of micronutrient deficiencies) and 7 (emergency care for accidents and trauma). The horizontal categories, however, are not as important for the Ghanaian-Dutch research programme as the vertical ones. Looking at the vertical categories, we see that especially B (46 ‘hits’) and C (47) are best represented, although A (41), D (34) and E (36) also seem to offer possibilities for research cooperation. The differences are small and not very meaningful. The analysis is a quantitative one and not a qualitative one. It is therefore impossible to say that any one specific area would be most appropriate for cooperation. In any case, this would not be in agreement with the idea of the programme as a total process.

Willingness and ability to participate in a Ghana programme

Except for two of the respondents, all said they are ‘willing’, ‘quite willing’, or ‘willing and able’ to cooperate with Ghanaian researchers, although some expressed conditions, such as agreement on a line of approach. There is also willingness to match funds, although most institutions indicated that their resources are limited.

3.2 Conclusion

This survey of Dutch research and training capacity in the field of development-related health shows that there is a positive attitude towards a joint Ghanaian-Dutch programme of health research. Most of the 23 questionnaires that were returned were filled out with care and in considerable detail. It is clear that Dutch researchers are willing and able to work together on the research issues identified by the Ghanaians. It is also clear that the institutions which responded have limited funds to invest, but they are willing to see whether they can match funds provided from elsewhere. The questionnaires sent in show that there is expertise in many different fields and countries, especially in Africa and even in Ghana. It is also a positive sign that many institutions have experience in capacity- building through training and other methods. In short, it seems there is a healthy basis for research cooperation between Ghana and the Netherlands, although one of the challenges will be to coordinate the contributions on the Dutch side through the mechanisms described in the next section.

4. ORGANIZATIONAL STRUCTURE

An important aspect of the proposed research programme is that emphasis is placed on the context in which the research cooperation is taking place. The programme is driven by Ghanaian needs at three levels of the national health research system: the need for research to support the changes in the health sector, capacity building needs related to this and the need for an enabling environment (policies, funding mechanisms and linkages between the actors involved) to make the research meaningful. Therefore, the organizational set-up of the programme will have to support the development of Ghanaian research to become a tool for the improvement of health. To maintain the emphasis on Ghanaian needs a continuous process of consultation with the Ghanaian stakeholders is essential and this leads to a specific organizational set-up that will guide the research cooperation.

The principles for organizing and managing Ghanaian health research are set out in the policy document entitled: "Policy guidelines for strengthening research to support the medium-term health strategy". This document defines the roles and responsibilities of the different bodies involved in drafting and implementing health research policy in Ghana. A (Ghanaian) Steering Committee (SC) acts as the governing body and is responsible for policy and decision-making. This includes allocating funds, from both national and external sources, to research projects. This SC exists already and was actually one of the reasons for starting the RAWOO/RGO initiative in Ghana. The Ghanaian stakeholders are represented in the SC.

Below, a proposal is presented for the organizational structure of the health research for development programme in general and the Ghanaian-Netherlands country programme in particular. As there was no consensus on this point in the committee, it presents two options which essentially differ with respect to the role and functions of the International Programme Committee (IPC) and the Netherlands-based Support and Liaison Office (S&L office) vis-à-vis the country programme committees and the country-based (executive) secretariats.

The first option (*see Figure 1*) emphasizes the independent responsibility for policy and decision-making which is accorded to the country programme committees (JPCs), and the responsibility of the country executive secretariats for programme administration and the disbursement of funds. The role of the IPC is primarily of an advisory nature while the S&L office has primarily an intermediary function. By contrast, the second option (*see Figure 2*) assigns the IPC not only an advisory task but also responsibility for steering or monitoring the country programmes from a distance (without interfering with the country programme committees' independence in matters of policy and decision-making, however). The second option gives the S&L office the task of managing financial resources on behalf of the funding agencies (clearing-house function).

These two alternatives should be kept in mind when reading the following sections on the role and functions of the different bodies that constitute the organizational structure of the research programme. Moreover, the proposal addresses some general principles and guidelines; it does not go into detail. The committee thinks that the assigning of specific tasks and responsibilities should be dealt with later.

4.1 International Programme Committee

An International Programme Committee (IPC) has the task of advising the donors on the further development of the programme as a whole. This includes: reviewing the country programmes, selecting other countries to be involved in the programme, promoting international coordination by maintaining contacts with international organizations and networks, looking for additional funding possibilities,

exchanging information on the programme's policies and activities, and stimulating a dialogue on demand-driven research by organizing seminars and meetings on relevant policy issues.

The second option, however, would add responsibility for steering or monitoring the programme 'at arm's length'. This means that the IPC would have the final responsibility, but it would not interfere with the day-to-day affairs of the country programmes. It would formulate the policy principles of the programmes and see to it that the work programmes of the JPCs comply with these principles; it would approve the work programmes, but would not interfere with their implementation.

The IPC consists of three members from the South and three from the Netherlands. IPC members are appointed by the funding agencies for two years and may be reappointed once. They should support the policy principles underlying the programme and be committed to promoting problem-oriented, needs-based health research-and to increasing the national institutional capacity for conducting such research-that is relevant for policy and action in the countries concerned.

4.2 Support and Liaison office

A Netherlands-based Support and Liaison office (S&L office) supports the International Programme Committee and acts as an intermediary between the IPC and the country programme committees and between the country programmes and the Netherlands research community. For this purpose, the S&L office and the country-based secretariats work closely together, actively exchange information and coordinate operational and practical matters. The S&L office is responsible for involving Dutch research groups in the country programmes and for promoting cooperation and coordination at the Dutch side. It also has the task of communicating about the programme's activities, for example through a bi-annual newsletter, email and a website.

In case of the second option, administrative and budget responsibilities are added. The S&L office would be the contracting party and implementing organization for the funding agencies.

4.3 The Joint (Ghanaian-Netherlands) Programme Committee

A Joint (Ghanaian-Netherlands) Programme Committee (JPC) steers the joint programme and is responsible for directing the programme's policies, for approving the yearly work programmes and related budget provisions, for allocating and distributing grants to projects and for reporting to the funding agencies. The JPC communicates with the Ghanaian SC and the International Programme Committee. It is independent. JPC decisions cannot be overruled by the Ghanaian SC or the IPC. However, this independence is restricted in the second option, where the IPC has certain responsibilities for steering or monitoring the programme as a whole, which includes the country programmes.

The JPC has six members (three from Ghana and three from the Netherlands). From the Ghanaian side the JPC will reflect the different Ghanaian stakeholders (researchers, users of research and policy makers). In order to be sure that the joint research programme relates to Ghanaian health research policy and will not become an isolated activity at least one member of the (Ghanaian) SC will also be a member of the JPC. Members from the Dutch side are nominated by the IPC and appointed by the funding agencies. The following criteria are important in this respect: scientific background (JPC members cannot be involved in active research in Ghana) and experience with development issues, in particular with needs-based, user-driven health research. All JPC members are appointed for two years and may be reappointed once.

Terms of reference describing in more detail the specific tasks and responsibilities of the JPC will have to be drawn up later.

4.4 Executive secretariat

The JPC is supported by a Ghana-based executive secretariat headed by an executive secretary or programme coordinator. The secretariat is responsible for preparing and implementing the policy and the decisions of the JPC and for administrating the programme. This includes: preparing JPC meetings, drawing up the yearly work programmes and related budgets, organizing the process of soliciting, ranking and assessing research proposals, facilitating the work of the JTFs, managing the budget, handling administrative and financial affairs, drawing up progress reports and communicating with all relevant actors inside and outside Ghana, in particular the Netherlands-based Support and Liaison office and the programme's sponsors. The secretariat is (or is hosted by) a legal entity which acts as the contracting party with the funding agencies and does budget control/treasury on conditions to be defined by these agencies.

The responsibilities of the country-based executive secretariats will be different in the second option, where the S&L office also has the task of managing the financial resources on behalf of the funding agencies (clearing-house function).

4.5 Joint Task Forces

Joint Task Forces (JTFs) are set up whose principal task is to advise the JPC on priority research topics. The activities of the JTFs are especially important during the take-off stage of the joint research programme when much work has to be done. The JTFs coordinate their activities with the working groups mentioned in section 2.2.

Responsibilities of the JTFs are:

- further conceptualizing the cross-cutting issues, taking into account the framework that links these issues with the seven priority health interventions;
- involving decision makers, health professionals and NGOs at the regional and district level in the process of needs assessment and priority setting;
- reviewing completed and ongoing research, scientific as well as grey literature, before embarking on new research;
- selecting research and capacity building priorities, and;
- taking into account the existence of research groups in Ghana and the Netherlands that would be able and willing to implement these priorities.

It is proposed to establish two JTFs, one for a cluster combining the cross-cutting issues "accessibility to health services", "quality of health services" and "efficiency in the use of resources", and one for a cluster combining the issues "linkages in the health sector" and "health financing and health technology assessment".

The JTFs consist of six members, three from Ghana and three from the Netherlands, representing the health, biomedical and social and economic sciences. JTF members are appointed by the JPC. The Dutch JTF members will frequently communicate with their colleagues in the Netherlands about developments in the joint Ghanaian-Netherlands research programme. It is up to the JPC to decide whether the JTFs will remain active after the start-up phase, in the same form or in an adapted one, to further advise the JPC on priority research themes and topics.

4.6 Assessment of project proposals

It is the responsibility of the JPC to further develop procedures for submitting (joint) research proposals. Assessment of project proposals will be performed by joint sub-committees, which will take

into consideration both societal relevance (including criteria pertaining to the utilization aspects of the proposal) and scientific merit. The scientific subcommittees will have Ghanaian and Dutch members. Membership from other Southern countries will be possible. The JPC will further specify the criteria to be used by the review committees. A repair mechanism may be needed for improving proposals that have high priority, but fail to meet criteria of scientific quality.

5. EXTENDING THE PROGRAMME TO OTHER COUNTRIES, AND BUDGET REQUIREMENTS

As said earlier, Ghana was chosen as the first country to be drawn into the collaborative (South-North) programme of health research that is envisaged. At a later stage a second and a third country could be added. Since the Ghanaian-Dutch programme must be regarded as an experiment, in terms of both the way it has been developed and its organizational structure, it seems wise first to review the experience of putting the programme in place, and then to decide on how to expand it to include other countries. The committee therefore recommends that any decisions regarding the programme's extension be based on a review of the first phase of the programme with Ghana. This review could be conducted at the end of 1998 and should focus specifically on the institutional and organizational aspects of the pre-implementation phase of the joint research programme. The IPC, mentioned in 4.1, should undertake this review and inform the donors of its results.

5.1 Choosing other African countries

First of all, the committee thinks that the country-specific approach outlined in this document should, in principle, be continued when extending the programme. In other words, helping countries to develop Essential National Health Research strategies comes first; supporting existing regional networks comes later-only after national policies and support structures for health research are in place. The two approaches can complement each other, but the sequence is important.

For the decisions regarding the second and third countries to be involved in the programme, similar criteria can be applied as were used to choose Ghana (pressing health needs; clear government policy on health; decentralization and the involvement of society and some progress in developing a system for health research - at least the beginnings of Essential National Health Research, or ENHR). An extra challenge would be to pay special attention to countries where extensive cooperation with Dutch researchers is already taking place. The existing coordination among these projects could be used as a tool, and in cases where such coordination has not been developed, it could be encouraged.

Whichever method is used to decide about the involvement of other African countries, the same steps have to be taken as in the case of Ghana: creation of platforms for communication between the various stakeholders, the organization of workshops, and the formulation of clear ideas about a national policy for health research. To ensure that a joint research programme is rooted in the national context of the country, and to guarantee a demand-driven perspective, stakeholders in this country must decide together what the content and structure of the programme is to be.

5.2 Budget requirements

It must be realized that the Dutch national budget for science allocates only a limited amount of money to health research for development, and this amount is all the more limited if capacity-building is also a major aim. If divided over two or three countries and spread over a long time, the annual budget for each country research programme would be modest indeed. This is why the Dutch injection of capital should be seen as a catalyst to initiate a process, and the means of financing only a modest percentage of a country's total research and capacity-building efforts.

The committee recommends that 500,000 Dutch guilders be earmarked for the pre-implementation phase of the Ghanaian-Dutch Programme of Health Research. This start-up phase of one year is needed in order to set up the JPC, the JTFs and the executive secretariat. It is envisaged that at the end of this period a detailed five-year plan will have been developed by the JPC (including plans for research, training, capacity-building, and managing the health-research environment), which can be

submitted to funding agencies. The committee recommends allocating at least five million Dutch guilders to this five-year plan, but if it seems reasonable to spend more, this should also be possible. However, this will have an immediate effect on the number of other countries that can be involved in the programme at large.

National and international coordination

The JPCs can be effective in encouraging research-funding agencies to coordinate their health research activities with the country programmes funded by the Netherlands. At the same time, the IPC can play a role in promoting international coordination by maintaining contacts with the international organizations and networks that support research. The committee believes that the IPC should give high priority to co-financing by other donors. Mobilizing additional funding for the country programmes is essential if the institution-building and capacity-building objectives of these programmes are to be met. The committee recommends that, as a first step, an effort is made to involve other European partners in the programme so that research proposals can be submitted to the European Commission for funding-to both the science directorate (DG XII) and the development directorate (DG VIII).

ANNEX 1

Composition of the Programme Study Committee (PSC)

Chairman:

Prof.dr. E.J. Ruitenber*g*, *member of RAWOO; director CLB* (as of 1 January 1997)

Prof.dr. E.J. de Kadt, *former chairman RAWOO* (till 1 January 1997)

Secretary :

Drs. A.P. Smits, *RAWOO secretariat*

Members:

Drs. M. de la Bey, *Ministry of Foreign Affairs, DGIS/DCO*

Dr. J.E. van Dam, *Ministry of OC&W*

Dr. E.C. Klasen, *NWO/MW*

Prof.dr. L. Muller (alternate Ms dr. R.R. van Kessel-Hagesteijn), *NWO/WOTRO*

Ms prof.dr. E. Postel

Ms prof.dr. A.J.M. Richters, *member of RAWOO; Leiden University*

Ms dr. M. Stegeman, *Ministry of Foreign Affairs, DGIS/DSI*

Prof.dr. A. Struyvenberg, *chairman RGO*

Prof.dr. H.A. Valkenburg (alternate Dr. E.C. Klasen), *NWO/MW*

Ms prof.dr. C. Varkevisser, *KIT*

Corresponding member:

Mrs dr. Duong Quynh Hoa, *member of RAWOO*

External advisor :

Prof.dr. I. Wolffers, *Vrije Universiteit Amsterdam*

ANNEX 2

Report of the workshop “Developing a Ghanaian-Dutch programme of health research for development”, Amsterdam, the Netherlands, 28 - 29 May 1997

CONTENTS

- 1. Introduction**
- 2. Objectives and key questions**
- 3. Workshop programme**
- 4. Opening session**
- 5. Changes in the Ghanaian health sector, government policy and research needs.**
- 6. What should be the focus of a joint programme of health research?**
- 7. Support mechanisms and management principles**
- 8. Conclusions**

Appendices

Appendix 1 List of participants

Appendix 2 Framework for setting research agenda

Appendix 3 Organizational framework

1. Introduction

This report contains the outcome of the workshop “Developing a Ghanaian-Dutch programme of health research for development”, which was held on 28 - 29 May, 1997, at the Amsterdam Marriott Hotel, in the Netherlands. It was organized under the auspices of two Dutch sector councils: the Advisory Council for Scientific Research in Development Problems (RAWOO) and the Health Research Council (RGO). The workshop was attended by 45 participants, ten of whom were from organizations involved in health research in Ghana. The participants included researchers, policy-makers and representatives of NGOs (Appendix 1, List of participants).

The two-day meeting was part of an interactive process of consultation and dialogue aimed at developing the policy and organizational framework of a collaborative Ghanaian-Dutch programme of health research for development. This process should result in a programme document that has broad support among the actors involved in Ghana and the Netherlands. This document will be submitted to the relevant Dutch funding agencies in September/October 1997.

The Amsterdam workshop followed on a workshop held in Accra, Ghana, on 25-27 February, 1997. The purpose of that workshop was to bring together stakeholders to discuss modalities for strengthening research to support changes in the health sector in Ghana⁹. The recommendations of that meeting were taken up by an interim Steering Committee and further worked out in a draft policy document entitled “Policy guidelines for strengthening research to support the Medium-Term Health Strategy in Ghana”. This document served as major input for the Amsterdam workshop.

2. Objectives and key questions

The main objective of the workshop was to discuss the content and organization of a collaborative Ghanaian-Dutch programme of health research for development, taking into account the guidelines and directions set out in the policy document “Policy guidelines for strengthening research to support the Medium-Term Health Strategy in Ghana”.

The meeting addressed the following key questions:

- What should be the main research areas of such a collaborative endeavour, and what could the research community of the Netherlands contribute?
- Through which mechanisms could joint research activities be promoted?
- How can research collaboration and capacity-building be integrated?
- How can the programme be organized?
- What should be the follow-up? (What are the next steps in order to realize the programme as envisaged?)

3. Workshop programme

The workshop was a two-day meeting with five sessions: an opening session, a session on the Ghanaian policy context and the Dutch environment for development-related health research, two working group sessions, and a closing session). There were three parallel working groups, each with 13 or 14 participants. They all had the same assignment and reported to the plenary, where the findings were debated and final conclusions were reached. The working groups each had a chair and a rapporteur (alternating Ghanaian and Dutch).

⁹ See “Report on workshop to strengthen research in support of the health sector in Ghana”, Preparatory Committee, April 1997.

The first working-group session focused on the content of a joint health research programme - the 'what' question. The second working-group session focused on the support mechanisms and management structure - the 'how' question.

4. Opening session

Dr. Joost Ruitenbergh, member of RAWOO and chair of the RAWOO/RGO committee guiding the programming exercise in the Netherlands, opened the workshop. He welcomed the participants, in particular those from Ghana, and acknowledged the fact that they had been able to produce the health research policy document in the relatively short time that was available. He went on outlining the objectives, the procedure and the expected outcome of the workshop, thereby referring to the background and policy principles underlying the RAWOO/RGO initiative to establish a collaborative Ghanaian-Dutch programme of health research for development.

Dr. Ruitenbergh's presentation was followed by the keynote address of Dr. Ivo Nuyens, coordinator of the Council on Health Research for Development (COHRED), who related the experience gained with building up and strengthening Essential National Health Research (ENHR) in the developing world. COHRED was established in 1993 and consists of member countries, organizations and agencies. It has a board of 18 individuals, the majority of whom come from developing countries; its secretariat is located within the United Nations Development Programme (UNDP) in Geneva.

According to Dr. Nuyens, COHRED has played a pioneering role in developing, promoting and disseminating the concept of Essential National Health Research, which he characterized as follows. Emphasis is placed on *Essential* (needs-based and relevant), *National* (all levels and all stakeholders must be included in the agenda-setting exercise), *Health* (in the broad sense of the term, and intersectoral) and *Research* (quality, both discipline-based and multidisciplinary, and applicable to policy and action). The ENHR approach stresses the importance of the interplay between the community, researchers and policy-makers in formulating and implementing health research which is needs-based and relevant. ENHR includes two kinds of research efforts: country-specific health research, and global health research. These complement each other. Exactly which mix of research is essential must be defined by each country, but it will contain at least some measure of these two basic components. COHRED encourages countries to adopt ENHR strategies and to start a national consultative process to define ENHR priorities. It recognizes the fact that, until recently, donors and Northern institutions could manipulate the national context and push through their own priorities because developing countries did not have their own national policies for health research. This is why agenda-setting and prioritization on the basis of national needs and relevance to development is so important.

Subsequently, Honourable Richard Dornu Nartey, Member of Parliament, Government Chief Whip, and former chairman of the parliament committee on health, presented the Ghanaian view of the process of developing a Ghanaian-Dutch programme of health research, in the light of policy developments in the health sector in Ghana. He welcomed the Dutch initiative to establish such a joint programme and pointed out that research could play an important role in providing the knowledge needed to support health sector reforms in Ghana. The Medium-Term Health Strategy (MTHS) outlines the government's health policy for the coming years. The most important pillars of this policy are to improve efficiency in the use of health services; to improve the quality of care; to ensure access to services for vulnerable groups; to enhance linkages among different types of providers; and to ensure cost-effectiveness. In Mr. Dornu Nartey's view, the joint research programme should address these issues and move towards filling development needs and meeting real demands of people at the district and community levels.

5. Changes in the Ghanaian health sector, government policy and research needs

In the second workshop session, the Ghanaian research needs and priorities were presented from four different perspectives: the government perspective, the university perspective, the NGO perspective, and the district perspective. These presentations were followed by a presentation on the context of development-related health research in the Netherlands.

Research priorities in Ghana: the setting of a research agenda, Dr. Sam Adjei, director of the Health Research Unit, Ministry of Health (HRU)

Dr. Sam Adjei started his presentation with an overview of the major trends in health policy-making and health-care delivery in Ghana. He noted that the role of research was emphasized in the government's Medium-Term Health Strategy and that the policy framework for health research as presented was based on the principles laid down in the MTHS document. The guiding principle of the MTHS is to address the problem of poor health status more from the perspective of 'cross-cutting' issues that affect the performance of the health sector, than from the perspective of diseases that afflict Ghanaians or specific interventions that need to be implemented. It is recognized that the delivery of health interventions is constrained by shortcomings related to the following 'cross-cutting' or 'cross-country' issues (Appendix 2: Framework for setting the research agenda):

- (1) Access to health services;
- (2) Quality of health services;
- (3) Efficiency in the use of resources;
- (4) Linkages in the health sector;
- (5) Health financing and health technology assessment.

In the opinion of Dr. Adjei, research should address these health systems issues, and by so doing, help policy-makers and health professionals to make sound, well-informed decisions. The research needs related to these issues should be further articulated and specified at the district level through a dynamic process involving decision-makers, programme managers and operational staff. Dr. Adjei added that, in his view, the selection of specific research topics is not a one-time activity but an ongoing process, which should be linked to cycles of programming and budgeting as envisaged in the five-year Programme of Work.

Research-capacity needs in Ghana: how can they be integrated into a research programme?, Prof. Anamuah Mensah, pro vice-chancellor, University of Cape Coast

Dr. Anamuah Mensah elaborated on the need to build capacity for conducting health research in Ghana. He began by saying that some general principles are needed to guide policies on this issue: for example, the principles that all health providers should be in a position to acquire research capacity; that research should be problem-oriented and multidisciplinary; that research management should be done properly; and that capacity-building should be tailored to the level of the personnel involved.

There are different stakeholders involved in health research in Ghana: the public health sector, universities, research institutions, NGOs and private health-care providers. They all need to develop their capacity for health research, albeit in different ways and tailored to their specific needs. The Ministry of Health has made considerable progress in developing its research capacity at the national level; increased attention should now be given to the regional and district levels. Dr. Anamuah Mensah found that universities are still too discipline-oriented and too isolated from society. In his opinion, a re-orientation towards more integrated multidisciplinary approaches is needed. He observed that capacity for health systems research is gradually increasing. Universities should also open up to the user community, create networks with health workers, and go down to the community level to talk with

public and private health-care providers and with the potential beneficiaries of health services. This would entail a need to restructure research methodology by making it more community-oriented.

As for career-oriented development programmes, Dr. Mensah mentioned different mechanisms for supporting post-graduate research training. For example, partner universities could help to develop and implement joint courses in the priority research areas identified in the Ghanaian research policy document. Supervision of students could also be jointly organized by a Ghanaian and an external institution. Furthermore, workshops on writing proposals could be conducted in order to enhance the proposal-writing skills of young researchers.

Mechanisms for disseminating and utilizing research results: how can they be built into the research cycle?, Mrs. Yaa Amekudzi , Centre for the Development of People (CEDEP)

Mrs. Yaa Amekudzi highlighted some of the key policy issues related to the dissemination and utilization of research results. She observed that the dissemination of research findings through existing mechanisms (journals, conferences and seminars, reports, mass media, audio visuals and newsletters) is often inadequate. Simple dissemination in one or two sources, as is often the case, is not enough. In her view, proper dissemination of research results requires a communication strategy that bears in mind the various audiences for research and the way in which such audiences can be reached. At present, dissemination is not always as effective as it could be--the presentation of results is often not consumer-friendly; researchers often lack the expertise required to market and communicate findings to the various consumers and constituencies; research reports are often vague or insufficiently concrete or specific; too often, researchers communicate only through journals or other mechanisms that only researchers read and use. In other words, there is a need for other, more effective dissemination mechanisms that bring research results to the various user groups, including the potential beneficiaries at the grassroots level (for example, by using mass media, but also performing arts).

According to Mrs. Amekudzi, the limited demand for research is one of the key factors affecting the utilization of research findings. In her view, enhancing the demand for research is crucial for improving its utilization. In this context, the following mechanisms could be of use: consensus-building seminars; participatory methods for planning research : i.e., involving all stakeholders, including local communities, in priority-setting; increased attention for basic training in research; and access to research findings via modern information and communication technology (databanks, the Internet, etc.).

Impact of the new health policy, and research in the context of the district centre, Dr. Evelyn Lutterodt Ansah, district medical officer, Dangme West district

Dr. Lutterodt Ansah looked at the implications of the research policy guidelines for the district level. How can districts organize themselves in order to play their role effectively, and what support do they need to carry out the research agenda? The Dangme West district, one of the two purely rural districts in the greater Accra region of Ghana, with a population of 100,000 inhabitants, was used as an example to illustrate the district perspective.

Within the Dangme West district, health systems research (HSR) is carried out and implemented by the district medical officers. Examples were given of simple and more professional HSR. In general, such research starts by identifying and prioritizing health needs, and then translating these into research questions. The results are used to put interventions in place. At the moment, several externally funded HSR studies are being implemented. Therefore, districts have the ability to select their priorities and to conduct applied research that is needs-based and relevant, and that is used to develop health

programmes and to guide action. Several needs still must be addressed, however, if the districts are to do their research work more effectively. The support needed by districts includes:

- **Capacity-building**
More district medical staff should be trained to carry out HSR. This should be done across the board in all districts. Otherwise a gap is created any time that trained staff is transferred, and replaced by staff from an area where training has not occurred. In addition, capacity-building should not create full-time professional researchers out of service providers, because this would be to the detriment of service delivery. Instead, research skills should become an integral part of a good service provider.
- **Infrastructure development**
Districts at the moment are constrained by a lack of certain basic infrastructure to assist them in their work. Though a few districts are better off, still more are in need of such basic facilities as libraries, computers and laboratories.
- **Financing**
There is a need to ensure that funds will be available which enable staff at the district level to conduct research alongside their clinical and managerial duties. Depending on the level of research, these funds could be obtained from any of the following sources: (1) government allocations, (2) donors, and (3) district assemblies and communities.
- **Technical assistance**
Although technical assistance would be valuable to district-level staff, the question here is “How can districts have access to the technical staff they need without being overrun by overzealous professional researchers or forced into the role of professional researcher?”. Areas of technical assistance include: (1) simplified manuals and protocols for training at various levels (i.e., district, sub-district and community levels), (2) manuals to help staff at different levels to collect good-quality routine data, and to analyze and use it as HSR information for planning service delivery at different levels, (3) in-country assistance from experts in universities and research institutions, and (4) external assistance from partner universities and research institutions in the North and in the South.

The Ministry of Health should play a central role in several areas: in setting up the structures for feedback and the exchange of information between the districts, regions and policy-makers; in making technical assistance available; and in providing funds for HSR at the district level (through a special item in the government’s budget for districts).

Overview of development-related health research in the Netherlands, Prof. dr. A.W.C.A. Cornelissen, chairman of NWO/WOTRO

Dr. Cornelissen briefly outlined the organizational and funding structure of development-related health research in the Netherlands. Basically, this structure has three components: (1) core funding of universities and research institutes through the Education and Science budget (OC&W), (2) project and programme funding through the Netherlands Organization for Scientific Research (NWO), and (3) project and programme funding and commissioned research through the Development Cooperation budget (DGIS) and other national and international research funding organizations such as the European Union (EU). According to Dr. Cornelissen, a major portion of the present programmes of health research in partnership with developing countries are financially supported by the INCO-DC Programme of the EU. He noted that these EU-funded programmes focus mainly on biomedical, disease-related research, while, in contrast, DGIS-funded programmes focus on HSR. He also noted that capacity-building and institution-building activities are part of so-called Overseas Development Assistance (ODA) and are therefore mainly funded by DGIS.

As for the possible collaboration with Ghana, Dr. Cornelissen emphasized that a wide array of knowledge and expertise in the Netherlands, which is organized in different networks, could be mobilized to take part in a partnership programme. Linking up with these networks, and supporting multidisciplinary approaches that combine HSR, biomedical and socio-economic research, would be particularly important in this respect.

6. What should be the focus of a joint programme of health research?

This section presents the conclusions of the discussions on the ‘what’ question: i.e., what should be the focus of a joint Ghanaian-Dutch programme that uses the Ghanaian research policy document as its point of departure? As outlined by Dr. Adjei in his presentation on research priorities in Ghana (see section 5), this framework consists of five ‘cross-cutting’ issues that affect the functioning of the health system.

In this context the following questions were addressed:

- (1) Which of these priority research issues could be tackled in a joint Ghanaian-Dutch programme of health research?
- (2) What are the Ghanaian research needs and what could be the contribution of the Netherlands’ research community?
- (3) Which institutes could play a role in a cooperative programme?

Which priority research issues could be tackled in a joint Ghanaian-Dutch programme of health research?

The ‘cross-cutting’ health system issues identified in the Ghanaian policy document served as starting point for the discussions. The participants agreed that linking these issues with the priority health interventions through a matrix approach could be helpful for identifying specific research themes and topics. In addition, it was recognized that such an approach also has the advantage of linking HSR (research on the health-care system, access to it, demand and supply, quality, financing, etc) with socio-economic and biomedical research (molecular biology, cell biology, animal experiments, clinical research, epidemiology)¹⁰.

In the matrix, the ‘cross-cutting’ health-systems issues are placed on the horizontal axis, while the major health problems and related interventions are placed on the vertical axis.

¹⁰Definitions as formulated in 1993 by RGO-NWO-KNAW-DMW-ZON

	CROSS-CUTTING SYSTEMS ISSUES PRIORITY HEALTH INTERVENTIONS	A ACCESS TO HEALTH SERVICES	B QUALITY OF HEALTH SERVICES	C EFFICIENCY IN THE USE OF RESOURCES	D LINKAGES IN THE HEALTH SECTOR	E HEALTH FINANCING AND HEALTH TECHNOLOGY ASSESSMENT
1.	Immunization through EPI					
2.	Reproductive health programme <ul style="list-style-type: none"> · Family planning services · Essential and emergency obstetric care 					
3.	Prevention and control of infections with epidemic potential <ul style="list-style-type: none"> · Cholera · Cerebro-spinal meningitis · Yellow fever 					
4.	Health protection and promotion <ul style="list-style-type: none"> · Bednet use · Nutrition and diet · Alcohol, drugs and tobacco · Sexually transmitted diseases (STD)/HIV · Hygiene and sanitation 					
5.	Prevention and control of micronutrient deficiencies <ul style="list-style-type: none"> · Vitamin A · Iron · Iodine 					
6.	Management of selected endemic diseases: <ul style="list-style-type: none"> · Malaria · Tuberculosis · Leprosy · Respiratory tract infections-ARI · Sexually transmitted diseases (STD) · Diarrhoeal diseases · Guineaworm diseases · Onchocerciasis, Schistosomiasis, yaws, buruli ulcer · Hypertension and diabetes 					
7.	Emergency care for accidents and trauma					

Although the matrix was seen as a useful instrument for further articulating research needs, the Ghanaian partners emphasized that the process of selecting specific research themes and topics should be a dynamic, ongoing process and driven by the needs of the potential users - decision-makers, programme managers and health professionals in the public and private sectors - at the regional and district levels. It was also emphasized that the five 'cross-cutting' issues should be worked out in more detail. For instance, the issues of gender and vulnerable groups should be taken into consideration as aspects of the 'access to health services' issue. Maintaining a balance between professional standards and the needs of users should be brought in as an important aspect of the 'quality' issue; and

'organization', 'the supply system' and 'the use of human resources' should be distinguished as different aspects of the 'efficiency' issue.

In general, it was felt that before anyone embarks on new research, it would be useful to review completed and ongoing research as reported in both published and unpublished literature. It was concluded that task forces, in which Ghanaian and Dutch researchers would be equally represented, should play a pivotal role in the process of articulating research needs on the basis of the matrix approach.

What could be the contribution of the Netherlands, and which institutes could play a role in a cooperative programme?

The general feeling was that expertise could be provided in most of these areas, although it was clear that no definite answers could be given because the information available was incomplete. It was suggested therefore that additional information be collected about the knowledge and expertise available in the Netherlands in the areas identified in the matrix. With such an overview, it would be easier to determine where research demand and research supply could be brought together. For the Ghanaian side, this would offer the advantage of insight into the relevant health research groups in the Netherlands.

However, a distinction should be made between the mere existence of Dutch expertise on the one hand, and availability and willingness to cooperate in the proposed research endeavours on the other hand.

It was proposed that a questionnaire be sent out together with the Ghanaian policy document and the workshop report. The questionnaire should include questions relating to:

- know-how and expertise in the research areas identified in the matrix;
- availability of expertise;
- track record in working with developing countries;
- experiences with and possible contribution to activities in the area of capacity-strengthening;
- willingness to cooperate in a joint Ghanaian-Dutch programme of health research;
- willingness to contribute or match financial or other resources.

7. Support mechanisms and management principles

This section presents the conclusions of the discussions during and after the second working group session, on mechanisms for implementing the priorities for research and capacity-building, and on the principles on which the joint programme should be organized and managed.

In this context three key questions were addressed:

- (1) Which support mechanisms would be most appropriate for the joint programme of health research?
- (2) How can research collaboration and capacity-building be integrated?
- (3) How can the career development programmes mentioned in the document be related to this?

Which support mechanisms would be most appropriate for the joint programme?

In general it was felt that the support mechanisms proposed by the Ghanaian partners could be incorporated into the proposal for the collaborative programme. The Ghanaian policy document mentions four mechanisms for promoting and supporting research, both at the national and regional or district levels, on the six priority issues:

- (1) working groups;
- (2) research networks;
- (3) research stations;
- (4) research conducted by staff at district and regional levels.

How can research collaboration and capacity-building be integrated, and how can the career development programmes mentioned in the document be related to this?

As regards research training and career development programmes, emphasis should be placed on:

- development of cooperation mechanisms that provide opportunities to learn together;
- short training courses, in Ghana, in applied health research, including participatory methodology;
- MSc/MA degrees;
- PhD degrees.

It was agreed that research training activities funded through the joint programme should, as much as possible, be geared to the five 'cross-cutting' priority issues.

Other points mentioned in this respect were that attention should be given to:

- the need to "train the trainers";
- staff training in the area of research management;
- improving the skills of researchers for writing research proposals: for example, through proposal-writing workshops;
- the joint development of training modules.

In addition, the involvement of NGOs both as users and as researchers was seen as an essential element of capacity-strengthening.

Attention should also be given to research infrastructure (literature, books, laboratories, equipment, electronic communication facilities). As the Ghanaian participants pointed out, the present facilities are rudimentary and inadequate. It is still much easier to find books on Ghanaian health issues in Amsterdam than in Accra, let alone in the rural areas.

Principles for organizing and managing the joint programme of health research

A major part of the discussion in the second working-group session was devoted to the organizational set-up and management structure of the joint research programme.

The structure presented in Annex 4 of the Ghanaian document was taken as a point of departure (see Appendix 3: organizational framework). It defines the roles and responsibilities of the different bodies involved in drafting and implementing health research policy. A Steering Committee (SC) would act as the governing body and be responsible for policy and decision-making, which includes allocating research funds to projects.

It was suggested that the management structure of the Ghanaian-Dutch programme of health research should be consistent with the organizational set-up outlined in the Ghanaian document. In this context the following issues were discussed:

- It was suggested that a Joint (Ghanaian-Dutch) Programme Committee (JPC), consisting, say, of six members (three from Ghana and three from the Netherlands) would be responsible for the cooperative programme. This committee should be connected to the Ghanaian Steering Committee;
- It was also suggested that ad-hoc Joint Task Forces (JTFs) be set up whose principal task would be to advise the JPC on priority research topics. This would include:
 - * further conceptualizing the ‘cross-cutting’ issues, taking into account the framework that links these issues with the seven priority health interventions;
 - * involving decision-makers, health professionals and NGOs at the regional and district levels in the process of assessing needs and setting priorities;
 - * reviewing completed and ongoing research;
 - * selecting research and capacity-building priorities;
 - * taking into account the existence of research groups in Ghana and the Netherlands that would be able and willing to implement these priorities.

The JTFs would consist of six members--three from Ghana and three from the Netherlands--representing the health, biomedical and social and economic sciences. It was proposed to establish two JTFs, one for a cluster combining the ‘cross-cutting’ issues “accessibility to health services”, “quality of health services” and “efficiency in the use of resources”, and one for a cluster combining the issues “linkages in the health sector” and “health financing and health technology assessment”.

- Assessment of project proposals will be performed by joint subcommittees, which will take into consideration both societal relevance (including criteria pertaining to the utilization aspects of the proposal) and scientific merit (two “green” lights). A repair mechanism may be needed for improving proposals that fail to meet criteria of scientific quality.

- A secretariat is needed in the Netherlands to facilitate Ghanaian-Dutch research cooperation, to support the Dutch members of the JPC and JTFs, and to coordinate activities with the Ghanaian secretariat.
- Audits and treasury management will be performed by a legal entity, on conditions to be defined by the financing bodies.
- The structure of the programme should be designed in such a way that it will be possible to link up with other South-South and South-North programmes (regionalization).

8. Conclusions

Discussions during the workshop led to the final conclusion, shared by both sides, that further steps could be undertaken to formulate and institutionalize a joint programme of health research, taking into account the following.

Matrix approach

Consensus was reached on the usefulness of a matrix approach that relates the ‘cross-cutting’ policy issues with the major health problems. This will be used as a tool for identifying more specific research themes and topics and also for linking health-systems, social-science and biomedical research.

Articulating research needs and priorities

It was recognized that the process of further articulating research needs and priorities, within the framework of the matrix developed, should encompass the following:

- an elaboration of the ‘cross-cutting’ issues;
- a user-driven approach involving decision-makers, health professionals (programme managers and operational level staff) and NGOs at the regional and district levels in needs assessment and the selection of topics for research;
- a review of completed and ongoing research.

Potential contribution of Dutch research

As regards the potential contribution of Dutch research, it was observed that expertise could be provided for most of the research areas in the matrix. It was also clear, however, that no reliable answers could be given because the information available was incomplete and not up-to-date. It was suggested, therefore, to send around a questionnaire together with the Ghanaian policy document and the workshop report.

Support mechanisms

It was agreed that the support mechanisms proposed in the Ghanaian document could be incorporated into the joint research programme. This includes: working groups, research networks, research stations, and research conducted by district and regional staff.

Management structure

It was suggested that the management structure of the Ghanaian-Dutch programme of health research should be consistent with the organizational set-up outlined in the Ghanaian document. This would mean that:

- A Joint (Ghanaian-Dutch) Programme Committee (JPC) with, say, six members (three from Ghana and three from the Netherlands) would be responsible for the cooperative programme. This committee should be connected to the Ghanaian Steering Committee.

- Ad-hoc Joint Task Forces (JTFs) would be responsible for advising the JPC on priority research topics. The JTFs would consist of six members, three from Ghana and three from the Netherlands, representing the health, biomedical and social and economic sciences. It was proposed to establish two JTFs, one for a cluster combining the 'cross-cutting' issues "accessibility to health services", "quality of health services" and "efficiency in the use of resources", and one for a cluster combining the issues "linkages in the health sector" and "health financing and health technology assessment".
- Assessment of research proposals would be performed by joint subcommittees, which would take into consideration both societal relevance (including the utilization aspects) and scientific merit (two "green" lights).
- A secretariat would be established in the Netherlands to facilitate Ghanaian-Dutch cooperation, to support the Dutch members of the JPC and the JTFs, and to coordinate activities with the Ghanaian secretariat.
- Audits and treasury management would be performed by a legal entity, on conditions to be defined by the financing bodies.

Timetable

The following timetable was adopted. The programming study should be completed in September 1997. Decisions on the financing of the programme should be made in the fall of 1997.

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ANNEX 3

BACKGROUND INFORMATION ON THE HEALTH SITUATION IN GHANA, THE GOVERNMENT'S HEALTH POLICY, AND THE HEALTH RESEARCH ENVIRONMENT¹¹

The health situation in Ghana; some facts and figures

The total population of Ghana was estimated at 16.5 million in 1994. Ghana has one of the highest rates of population growth in the world. Its population almost doubled between 1970 and 1994. If the country keeps up its current growth rate of 3 per cent per annum, the population will be 19.5 million by the year 2000. Although the rural population is still the majority, the urban population is growing fast. By the year 2000, nearly 40 per cent of the population will be living in urban areas, mainly in the large and medium-sized cities of Accra, Tema, Kumasi, Sekondi Takoradi and Tamale.

The high level of fertility in Ghana produces a youthful demographic structure and a high dependency ratio. The current average life expectancy is 56 years. This average is heavily influenced by high infant and child mortality rates. Life expectancy for those who survive the first five years is 63 years. 45 per cent of one-year-old children are not immunized, and national immunization coverage for the main diseases that kill children is 70 per cent. Unlike the birth rate, the death rate in Ghana has steadily declined over the years.

The morbidity pattern has not changed significantly over the years, with the population suffering the same diseases, such as malaria, tuberculosis, respiratory and gastro-intestinal infections, as well as nutritional deficiencies. However, non-communicable diseases like diabetes and cardio-vascular disorders are beginning to assume significance. The emergence of new infectious agents such as HIV adds to the growing public-health burden.

Malaria continues to be the disease most commonly reported. It is the leading cause of mortality in children under five years, is a significant cause of adult morbidity, and is the main reason for lost workdays due to illness. The numbers of reported cases of tuberculosis has continued to rise, and there is an increasing risk of tuberculosis combined with HIV infection. Acute respiratory infections in children under five are second only to malaria in causing morbidity and mortality. Childhood malnutrition continues to be a major cause of ill health and death, especially among the poor. Ghana also faces a number of serious reproductive health problems. Many adult women die from complications of pregnancy, childbirth or unsafe abortion, and the rate of HIV infection is increasing rapidly.

The indicators for health and health care delivery in Ghana are strongly correlated with the spread of poverty. Rural Ghana, in particular Northern Ghana, records the poorest health in terms of health indicators. For example, only 11 per cent of the population of the three Northern regions have access to health facilities; these regions also record the highest child, infant and maternal mortality rates in the country, while 45 per cent of all women and 65 per cent of pregnant women in northern Ghana are malnourished, compared with 30 per cent and 45 per cent respectively in the south.

¹¹ The information compiled in this annex is based on the following documents and articles: (a) Government of Ghana (1995), *Medium-term Health Strategy; Towards Vision 2000*, (b) Government of Ghana (1996), *Five Year Programme of Work*, © Tetteh Hormeku (1997), *Ghana report*. In: *Social Watch*, Roberto Bissio (ed), (d) Eric Amuah (1996), *ENHR in Ghana; institutional arrangements, capacity building and networking mechanisms*. In: *Science in Africa; Essential National Health Research*, American Association for the Advancement of Science.

The health system faces a number of challenges. The most important constraints are the following:

- limited access to health care;
- inadequate quality in services;
- inadequate funding of health services;
- inefficient allocations of resources;
- poor links within the community, and between the public and private sectors

Factors outside the health care system which contribute significantly to the relative slowness with which the population's health status is improving include: poverty; the poor nutrition of vulnerable groups; low literacy rates especially among women; a high rate of population growth; and limited access to safe water and sanitation.

Ghana's medium-term health strategy

Since 1983 the Ghanaian government's strategy for economic growth and poverty reduction has been strongly influenced by the Structural Adjustment Programme (SAP) of the IMF and World Bank. The figures point to an overall reduction between 1983 and 1992 in the percentage of people living in poverty; the drop was particularly marked in rural areas. However, there is evidence in recent studies and reports that this trend is reversed. There has been a downturn in general welfare since 1993 and in the last four years poverty has increased. Three-quarters of the poor are to be found in rural areas, in particular in the forest areas and the ecologically fragile savannah areas of the north. The figures also highlight the grave impact of SAP in the urban areas, where poverty has increased sharply. The 1992 figure of 23 per cent of Accra's population living in poverty marks a dramatic jump over the 1988 figure of 8.5 per cent. Evidence from various surveys and other sources suggests that women suffer a greater share of the burdens of poverty than men.

The government's strategy for poverty alleviation includes, among other things, improving health care and other basic social services, particularly for the poorest and most needy. This policy thrust is reflected in the 'Medium-Term Health Strategy: Towards Vision 2020', issued in 1995, which defines long-term goals for improving the health status of the population as part of a wider strategy to reduce poverty. This document provides a framework for guiding reform and delivery in the health sector. The five-year Programme of Work in the Health Sector translates this framework into a series of key strategies to help regions, districts and health institutions to formulate their own five-year strategies, plans and annual budgets.

The overall objective of national health policy is to improve the health status of all Ghanaians. More specific objectives include: increasing access--in both geographical and financial terms--to basic health services, especially in the rural areas; improving the quality of health care; establishing a health system effectively oriented toward delivery of public health services; improving efficiency in the health sector; fostering closer collaboration and partnerships between the health sector and other sectors, and between allopathic and traditional providers of health care and the communities they serve; and increasing efficiency in the use of resources.

Despite these commitments, health expenditure is low - lower even than other low-income countries. In real terms, the resources available to the health sector have been shrinking over the years. For the last decade, government allocation to the Ministry of Health has been \$6 per capita, which is less than 2 per cent of GDP. In 1978 it was \$10 per capita. The inadequate funding of the public health sector is reflected in a number of problems, such as insufficient infrastructure and inadequate health personnel, whose poor pay helps to create low morale.

The rural areas and the poor receive less than their fair share of public health spending. In 1989, the urban areas of Ghana, where one-third of the country's population lives, received 42 per cent of the total government health budget and accounted for 50 per cent of total outpatient spending. By 1992 this urban share had increased to 49 per cent and 55 per cent respectively. Also, whereas the top 20 per cent of the population in terms of income received 33 per cent of government expenditure on health, the poorest 20 per cent enjoyed only 12 per cent of this expenditure.

The most important challenges facing the Ministry of Health are:

- the decentralization of health care: strengthening district health systems, which requires shifting resources and responsibilities to the district level and involving communities in the process of health reform;
- financial reform so that health services recover some of their own costs;
- health insurance.

The Ghanaian health research environment

The key actors in the environment for conducting health research are the following:

Government Health Research

The **Health Research Unit (HRU)** of the Ministry of Health was established as a central body to deal with research issues: helping the Ministry to utilize research and to stimulate research in relevant priority areas. HRU runs three field stations, which are placed to correspond with the three ecological zones of the country (i.e., the northern savannah zone, the central forest zone, and the coastal zone). HRU and the field stations operate mainly in research areas of national concern. The job of HRU is to set research standards and priorities; to direct research funded by the Ministry; to coordinate and disseminate research results; and to appoint steering committees for research. HRU has been very active in introducing and promoting ENHR in Ghana through consciousness-raising (i.e., by stimulating the demand for research, and organizing consultative meetings involving representatives of the Ministry of Health and other ministries as well as universities, research institutions, non-governmental organizations and donor agencies). It also promotes ENHR through capacity-building (i.e., programmes to train trainers, and research training at the regional and district levels) and through networking (i.e., internal networking through the National Health Research Advisory Committee, a facilitators' network, consultative meetings, and external networking with institutions abroad).

Universities

The most important university institutes conducting health research--which is defined here to include biomedical research, research on health systems, and socio-economic research--are the following:

A. University of Ghana

- University of Ghana Medical School (UGMS);
- Centre for Tropical Clinical Pharmacology and Therapeutics (CTCPT/UGMS);
- School of Public Health (SPH);
- Institute of Statistical, Social and Economic Research (ISSER);
- Institute of African Studies/Development and Women Studies (ISA/DAWS);
- Department of Sociology/Centre for Social Policy Studies;
- Noguchi Memorial Institute for Medical Research (semi-autonomous).

B. University of Capecoast

C. University of Development Studies (UDS), Tamale

D. University of Science and Technology (UST), Kumasi

- School of Medical Sciences

NGOs

There is a flourishing NGO world in Ghana. Their precise number cannot be given because NGOs can be defined in different ways. In 1990 a study was made of 312 organizations; of these, 52 per cent were based in Accra, 26 per cent in the Ashanti region, and less than 6 per cent in Brong Ahafo and the Northern, Upper East and Upper West regions combined. The three major NGOs related to health care and health research are:

- Integrated Social Development Centre (ISODEC);
- Centre for the Development of People (CEDEP);
- Christian Health Association of Ghana (CHAG).

ISODEC and CEDEP have their own research units and have already conducted quite a number of studies, whereas CHAG does research on a more incidental basis.

Others

The **Ghana Health Policy Analysis and Development Group** (HPADG), founded in 1993 with the assistance of the International Health Policy Programme (IHPP) and the Carnegie Foundation, is made up of representatives of the major organizations involved in health policy and health research, such as the Ministry of Health and its HRU, the Council for Scientific and Industrial Research (CSIR), and several institutes of the University of Ghana. The Group's mission is to conduct policy-related research and to advise the government and other actors in the health field regarding the policies and strategies to be pursued.

The **Council for Scientific and Industrial Research** (CSIR) is a government body with a mandate to coordinate all government-funded research, including health and health-related research.

ANNEX 4 List of abbreviations

CBO	Community-Based Organization
CEDEP	Centre for the Development of People
CERES	Research School for Resource Studies for Development
CHAG	Christian Health Association of Ghana
CLB	Central Laboratory of the Netherlands Red Cross/Blood Transfusion Service
COHRED	Council on Health Research for Development
COS	Sector Councils Consultative Committee
CSIR	Council for Scientific and Industrial Research
CTCTP	Centre for Tropical Clinical Pharmacology and Therapeutics
DANIDA	Danish International Development Agency
DAWS	Development and Women Studies
DGIS	Directorate General for International Cooperation
ENHR	Essential National Health Research
EC	European Commission
EU	European Union
GTZ	German Association of Technical Cooperation
HPADG	Health Policy Analysis and Development Group
HRU	Health Research Unit
HSR	Health Systems Research
IDRC	International Development Research Centre
IHE-Delft	International Institute for Infrastructural, Hydraulic and Environmental Engineering (Delft)
IHPP	International Health Policy Programme
INCLEN	International Clinical Epidemiology Network
IPC	International Programme Committee
IRC	International Water and Sanitation Centre
ISA	Institute of African Studies
ISODEC	Integrated Social Development Centre
ISS	Institute of Social Studies
ISSER	Institute of Statistical, Social and Economic Research
JTF	Joint Task Force
JPC	Joint Programme Committee
KIT	Royal Tropical Institute
MoH	Ministry of Health
MTHS	Medium-Term Health Strategy
MUNDO	Maastricht University Centre for International Cooperation in the Development of Education
MW	Medical Research Council / NWO
NGO	Non-Governmental Organization
NIDI	Netherlands Interdisciplinary Demographic Institute
NWO	Netherlands Organization for Scientific Research
OC&W	Ministry of Education, Culture and Science
ODA	Overseas Development Administration
RAWOO	Advisory Council for Scientific Research in Development Problems
RGO	Health Research Council

SAP	IMF/World Bank Structural Adjustment Programme
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SC	(Ghanaian) Steering Committee
S&L office	Support and Liaison office
SPH	School of Public Health
UDS	University of Development Studies, Tamale
UGMS	University of Ghana Medical School
UST	University of Science and Technology, Kumansi
WHO	World Health Organization
WOTRO	Netherlands Foundation for the Advancement of Tropical Research / NWO

List of RAWOO publications in English

General Recommendations 1:

Health and Illness in Developing Countries; research needs and priorities. January 1984 (*abridged English version*).

General Recommendations 2:

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Internal conflicts, security and development. RAWOO lectures and seminar. Edited by Bas de Gaay Fortman and Marijke Veldhuis. May 1997.

Publication no. 15:

Framework for a Ghanaian-Dutch Programme of Health Research for Development. March 1998.

Publication no. 16:

Developing a Ghanaian-Dutch programme of health research for development. Results of a questionnaire to identify relevant expertise in the Netherlands and willingness to cooperate with Ghana. February 1998.

Publication no. 17:

Framework for a Philippine-Dutch Programme of Biodiversity Research for Development. March 1998.