



Task Group on Building Partnerships
Canadian Coalition for Global Health Research (CCGHR)
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BUILDING A PARTNERSHIP FOR RESEARCH IN GLOBAL HEALTH

Analytical Framework

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INTRODUCTION

Currently, there is agreement on the importance of research for development and health and on the need for a collaborative and cooperative approach towards the development of health research geared towards action. However, 15 years after the recommendations of the Commission on Health Research for Development, the 10/90 gap remains to be bridged.

Building a partnership for global health research emerges as a strategy to reduce this gap and strengthen the capacity for research and decision-making in global health. Although there has been progress in the partnership experience, the inequality under which research is carried out in developing countries remains as a challenge.

In order to identify new models to build and consolidate partnerships and strengthen research capacity in global health, we have drafted this proposal as part of a complementary and potentially synergetic perspective involving the [rights approach], the principle of equality, and socially sustainable development.

We assume that research in global health is a complex issue requiring a new perspective and a fresh look. Today, health research requires the introduction of a global perspective into the analysis of health.

To show the importance of introducing a global perspective to the analysis of health, we present in the first part of this study a survey of global health identifying the global factors that are having an impact on populations and on health systems.

In the second part of the study we present a comprehensive partnership model aimed at preventing the fragmentation of research and establishing a systemic approach to strengthening capacities.

We hope to encourage partnership building. To do so, we have set forth some guidelines for the task with a commitment to research geared towards action intended to impact on health inequalities and strengthen health and research systems.

This proposal is the result of a bibliographic review of global health issues and partnership building for research.

Moreover, the paper includes the proposals made by the Task Group for Building Partnerships-CCGHR during the meetings held in April and June 2005 in Quebec and Ottawa, respectively.

GLOBAL HEALTH RESEARCH AND ISSUES

The perspective from which global health issues are perceived has a direct effect on the type of research priorities identified, on the cooperation models implemented for the development of knowledge and on decision-making.

Existing literature shows that the most systematic efforts to establish a set of health research priorities were made in the nineties. However, the debate on identifying the priorities of global health research is just beginning. And this debate is not limited to establishing priorities; it also involves the definition of global health issues and the role of health research.

The literature reviewed distinguishes several ways of understanding global health and different models to set the priorities of health research. On one hand, there is an acknowledgement of the process of globalization and its impact on health research. However, the debate on globalization and its impact on health is still in its infancy.

There is a variety of approaches to global health and, therefore, the research priorities identified also vary.

Literature shows a trend toward understanding the effects of global factors on health. This trend, however, is incipient and requires a debate on the complex interrelation between globalization and health.

Although some theoretical models have been proposed to analyze the interrelation of globalization and health issues (Woodward, Drager et al. 2001; Lee, Bradley et al. 2002), there is no consensus on the patterns and mechanisms through which globalization affects the health.

However, global factors that affect health have been identified, and there is evidence of the adverse impact of these factors on the health, health systems, and the environment and living conditions.

Global health research: background

From a historical perspective, efforts to present models to identify the priorities of health research and development have been made since 1990 (Ghaffar, de Francisco et al. 2004, COHRED 2000; Ad Hoc Committee on Health Research 1996; Commission on Health Research for Development 1990).

Health research for development: key events	
1987	First meeting of CHRD
1990	CHRD report presented in Stockholm Forty-third World Health Assembly: “The role of health research in the Strategy for Health for All by the Year 2000” International Conference on Essential National Health Research (ENHR), Pattaya, Thailand
1991	Task Force on Health Research for Development begins work
1993	Council on Health Research for Development (COHRED) created World Bank publishes <i>World development report 1993: Investing in health</i> (World Bank, 1993) Ottawa Conference: “Future Partnerships for the Acceleration of Health Development”
1996	WHO publishes <i>Investing in health research and development</i> (Document TDR/Gen/96.1) COHRED interim assessment
1997	ACHR publishes <i>A research policy agenda for science and technology</i> (ACHR, 1997) Global Forum for Health Research established World Bank Group publication <i>Sector strategy: health, nutrition, and population</i>
1999	WHO creates Department of Research Policy and Cooperation
2000	International Conference on Health Research for Development, Bangkok, Thailand
2004	Global Forum for Health Research, Global Forum 8 “Health Research to achieve the MDGs” Mexico City

Adapted from Health Research for Policy, Action and Practice, 2004

The International Conference (Bangkok, 2000) recommended that efforts be directed towards strengthening health systems with research based on the development issues affecting each individual country. Subsequently, the famous 10/90 Gap report (Global Forum for Health Research 2001) showed the divide in health research investment between developed and developing nations in relation to the global disease burden.

Several global health research and international cooperation initiatives, such as the Global Fund to fight AIDS, TB, and Malaria and the Global Alliance for Vaccines and Immunization, subscribe to the logic of reducing the global disease burden and understand global health issues in a general sense, i.e. they refer to health in a “global dimension”, taking into account global health in relation to the health issues of populations, but on a global scale. From this point of view, research tends to focus on the health issues of populations on a world level and, especially, on the burden of disease and cost-benefit factors, without addressing the determinants of the state of health of these populations.

Noteworthy amongst the Millennium Development Goals (MDGs) (2000), which were adopted by 147 countries, are reducing infant mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

A large part of current research is positioned between the logic of reducing the disease burden and achieving the Millennium Goals.

Based on our bibliographical review, the priorities identified from these perspectives, the research carried out in the framework of the Global Forum for Health Research (Global Forum for Health Research 2004) and the MDGs, there is a strong trend towards research driven by risk factors, with priority given health consequences from a biomedical and epidemiological point of view, combined with cost-benefit studies (DALYs).

We believe that one of the shortcomings of these perspectives is that, by focussing on the disease burden and on risk factors, they disregard the determinants of health (Commission on Social Determinants of Health 2005), the problems of health equality (Östlin 2004), and the possibility of developing research aimed at strengthening health systems (World Health Organization 2004).

On the other hand, there is concern that health-related MDGs may not be reached by the majority of the world population by 2015, due to systemic barriers and the fragility of the health systems in developing countries (op. cit.).

In an effort to address global health issues more precisely, other proposals identify global factors that go beyond national borders and affect human health, such as environmental degradation, poverty, war and conflicts, while also factoring in the burden of disease (Labonte and Spiegel 2001).

Some definitions, such as that set forth in the *Canadian Consultation Paper on Global Health Research* (2001 in Delisle, Roberts et al. 2005), consider global health problems as the health problems of the individuals and societies in the less developed countries with less resources, i.e. the poorest regions in the world.

It should be noted that the research promoted by the Council on Health Research for Development (COHRED 2000) is geared towards health equality based on the identification of national needs and priorities.

1.2 Research agendas: an approximation

Based on our bibliographical review, we can suggest that, generally speaking, there are two trends¹:

¹ Identifying these general trends does not mean we do not recognize other research that does not necessarily follow these paths. However, for the purposes of this proposal, we are trying to show the "direction" taken by research, since this accounts for the profile of the research agenda.

- a) one of the trends may be placed under what is known as health research, focussed on the traditional subjects of public health, systems and policies; this trend exists in developing and developed countries;
- b) another, emerging trend introduces global issues in relation to health and is more prevalent in developing countries.

Trends in health research and health policies and systems

These are characteristically focussed on traditional public health issues, including epidemiological studies, the environment, poverty and health, maternal-child health, and reproductive health. They tend to address local issues and predominantly consist of descriptive studies from a biomedical perspective, generally based on a particular discipline with small teams or individual projects.

There are scant population studies that introduce the determinants of health and equality issues.

The priorities identified are related to the results of the determinants (morbidity, lack of access to services, insufficient resources, etc.) and to the problem of managing expenses with the scant resources available.

On one hand, it would seem that the logic of the research agenda follows the criteria used in programs focussing on health intervention. On the other hand, it appears to be an operational type of research which prioritizes the consequences but reproduces the fragmentation of focussed intervention.

Health systems and policy studies give priority to subjects related to systems analysis, disease burden, management and organization, accessibility, financing, human resources, healthcare models, and health system reform.

There are evaluative studies which argue that there is a link between the issues of interest to researchers and the level of income in a particular country: countries with high incomes tend to favour subjects such as local health systems/decentralization, equality and political processes, and program assessment; countries with medium incomes tend to favour insurance; and countries with low incomes are interested in disease burden and accessibility to health services (Gonzalez-Block 2004).

This type of research requires small teams, mainly composed of doctors, and is usually carried out in the government sector. Cooperation is episodic, intermittent and personal rather than institutional.

However, there is a tendency to recognize that the best type of cooperation comes about when projects are formulated (jointly) between researchers and decision-makers, with tailored products that allow results to be implemented.

Results are applied to the area of work of the researchers and, to a lesser degree, they are transferred to other system services or programs, on average between 6 and 24 months after the research is completed (op.cit.).

Emerging trends in global health:

As mentioned above, [the concept] is still new and [there is more awareness of it] in the developed countries, where a debate on global health has begun.

Generally speaking, we have identified several suggestions about research priorities, all related to equality, determinants of health, and global factors.

The working group on equality, coordinated by Pirooska Östin (2004) (WHO-Europe), proposes five general lines [of enquiry] and offers a set of questions for each of them. The main suggested lines [of enquiry] are the following:

- 1) Global factors and processes affecting health equality and/or limiting the possibilities for countries to modify their patterns of inequalities. Here they suggest addressing the following issues: foreign debt, market liberalization, strategies directed by international financing organizations to reduce poverty, international trade agreements.
- 2) Specific political and social structures – inequality regarding access to healthcare. The working group suggests examining the specific policies that transform the relationship between the State and society and impact on equality; governance (favourable) and its relationship to equality; processes linked to production, organization, and use of knowledge that may strengthen enfranchisement in relation to health.
- 3) The interrelation between individual and social factors. Enquire into which are the factors contributing to inequality and which are the best strategies to reduce it (short-term) and bring about change (long-term).
- 4) Factors impacting on health systems and affecting health equality. The working group suggests examining reform policies and focus on the development of human resources. Recent assessments show that the brain drain of health professionals in South Africa almost collapsed the health system, which had already been weakened by the impact and financial shrinkage caused by HIV-AIDS.
- 5) Documentation and broad dissemination of the experiences that succeeded in reducing inequality. Research on equality has typically focussed on describing inequality. The current suggestion is to direct the research towards the identification of political solutions that may link health programs to the strengthening of health systems and actions on the determinants.

In our view, these recommendations seek to steer research towards the production of evidence to impact on the causes of inequality, and not only on the consequences.

Research suggestions for a more academic focus on global health propose working towards a conceptual distinction between international health and global health,

examining the interface between local and global affairs, new perspectives and methods and tools for global health, and analyzing governance in global health (Buse and Walt 2002).

1.3 Outlining global health: a global perspective on health research

Globalization has been defined in several ways and has brought about a debate between those who see advantages and those who identify obstacles and negative consequences in healthcare and living conditions.

Our purpose is not to discuss the different positions. However, it should be noted that globalization has been one of the key changes faced by health systems, decision-makers and health professionals, as well as the users of health services.

Although literature is increasingly underscoring the importance of globalization in healthcare (Deaton 2004; Labonté 2004; Wade 2002; Cornia 2001; Lee 2001), there is still no agreement when explaining the types of interrelations, mechanisms, and patterns of globalization that affect health.

However, certain global factors seem to affect health directly, and there are studies that show evidence of the type of consequences caused. On the other hand, there is evidence of the growing tension between the new rules, the new players and the markets characterizing globalization and the capacity of countries to protect and promote health.

To outline the complex issues enveloping global health, and to simulate reflection and discussion, we have identified some global factors affecting health in different ways and on diverse levels, based on the existing bibliography.

One of the characteristics we noted is that these global factors act jointly on a global level and impact negatively not only on the determinants but also on the state of health, the right to health, and the possibilities of governance in health.

We could say that there is a complex network of causes and effects where multiple forces come into play, sometimes in a contradictory way. We believe that, once health as affected by globalization is acknowledged, there is a need for more horizontal, even interdisciplinary perspectives allowing for a comprehensive, multidimensional reading of the issue.

We think that introducing a global perspective into health issues requires research that takes into account global factors, resulting in a better understanding of health as a global asset (Chen, Evans et al. 1999) and redirecting actions in global health.

Our intention is not to present a long list of issues that could comprise the research agenda in global health; we have opted to identify the global factors that impact on health in different ways. The idea is not to conduct a meticulous analysis of each one of the factors; rather, this is a brief outline of global factors with respect to the structuring, interrelated aspects of health issues. These interrelations seek to identify the *which* and the *where*. We could equate the centrality of the global health issue with the idea of promoting a more comprehensive and strategic research, in tune with the possibilities of action.

In this regard, prioritizing the research agenda and the items within it takes on an important role, specifically to link research to action. Consequently, we suggest establishing priorities for the agenda, based on the following:

- a) *What* should we prioritize, *how* should we establish priorities, and *who* should do it?
- b) *What criteria* should serve as the basis to establish priorities?

a) International trade agreements: implications regarding the right to health

The rules and regulations governing world trade arise from multilateral trade agreements (MTAs). Each of the agreements has serious implications on health policies and in the state of health in the specific countries, e.g. the General Agreement on Tariffs and Trade (GATT)

- The *Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS)* is a minimal package to protect intellectual property rights, including patents, copyrights, trademarks and industrial designs.

The TRIPS has implications affecting public health in countries with low and medium incomes because it impacts directly on the production and marketing of pharmaceutical and vaccines.

The belief that this agreement could facilitate access to cheaper medication in poor countries is difficult to support when data show that 75% of the population in these countries consume only 14% of the world medication and industrialized countries consume over 80% of the pharmaceutical produced.

- The *General Agreement on Trade in Services (GATS)* favours the growth of trade in health services, covering the movement of suppliers and consumers across borders, direct foreign investment in health and the emergence of e-business and tele-medicine.

In countries with low and medium incomes, the agreement has favoured the commodification of health and the growth of the private sector, impacting negatively on social inequality and increasing the level of exclusion in healthcare.

On the other hand, some studies show that the commodification of health and the growth of the private sector are related to quality, price and distribution of private health services (Bhat, 1999 in Kumaranayake and Lake, 2002; Stenson et al.1997; Kumaranayake, 1997; Bennett and Ngalande-Banda 1994; Yesudian, 1994; Bennett 1991).

The implications of these trade agreements also affect developed countries. In Canada, for example, the North American Free Trade Agreement (NAFTA) and the agreements signed at the World Trade Organization (WTO), as well as the GATS, show contradictions between the principles that underlie these international trade covenants and

the principle of a universal right to health on which rests the Canadian health system (Commission on the Future of Healthcare in Canada 2002).

All countries are affected by international agreements, but the impact varies in relation to the independence to develop health policies and the degree of vulnerability in light of global forces. There is a noticeable difference in the capacity to regulate and establish strategic policies leading to implementation between low and medium income countries on one hand and high income countries on the other.

The former have a weak regulatory capacity, whereas the developed countries have a strong regulatory legal framework with a solid capacity to regulate and negotiate with international corporations.

Regulation is inherently political. Some experiences, such as the debate on treatment for HIV-AIDS and the TRIPS, emphasize the role of the consumer coalitions, NGOs and international organizations that have been key to social regulations guaranteeing access to medication.

On the other hand, at the government level, there are experiences such as that of the ministries of health of South African Development Council (SADC) countries, which joined forces to negotiate within TRIPS a policy for lower prices for the treatment of HIV-AIDS (Taitz, 2000 in Kumarayake, 2002). Regional cooperation for regulation can be effective and, at the same time, provide a strategy to develop capacity and improve negotiating positions.

b) Global Public-Private Partnerships (GPPPs): implications in health governance

The literature reviewed confirms that another structural element of the globalization process is the growing involvement of private players, the Global Public-Private Partnerships (GPPPs), in the development of public policies, particularly in developing countries (Reinicke and Witte 1999).

We believe this aspect is worthy of note since, in the context of globalization, GPPPs in conjunction with international trade agreements have brought about qualitative changes in the dynamics of power, both globally and nationally, thus altering the capacity and the manner in which the national states of developing countries can formulate and implement policies and enforce regulations (Lee and Goodman, 2002; Brugha and Zwi, 2002).

Buse and Walt (2002) suggest that the GPPPs represent a new hybrid form of governance with the interaction of two processes: interdependence and globalization. Meanwhile, Knight (1992) argues that an intergovernmental system has arisen as a result of the weakening of some nation-states in conjunction with the growing power of the GPPPs and, with it, new disciplines and changes have impacted on the determinants of health in such a way as to widen the divide in terms of inequality (Coburn, 2004; Neri, 2000; Loewenson, 1999).

Most agree that, in developing countries, one of the areas involved in this context of multilateral governance is health policy. These changes in health governance have been observed in the implementation of sectoral reform agendas in developing countries, where national states have had a low regulatory capacity and, due to structural conditions, have had a very narrow negotiating margin for the agenda (Almeida, 2004; Buse and Walt, 2002; Franco, 2002; Lee and Goodman, 2002;).

The series of measures prescribed by the GPPPs, involving changes to national and local public policies, is seen in a context where most ministries of health in Latin America and Africa are characterized by a reduced political autonomy to guarantee health rights.

In several African countries, healthcare is almost exclusively in the hands of the private sector, the Church or NGOs. In Latin America and the Caribbean, only three countries have universal healthcare, namely Cuba, Brazil and Costa Rica.

The remaining countries have mixed systems characterized by high fragmentation compounded with insufficient coordination between subsystems, a deteriorating public

infrastructure, lack of information systems, scant resources to finance operational expenses, low regulatory capacity, an incipient decentralization and low service coverage.

Under these conditions, the ministries of health of many developing countries are typically too weak to deal with the international players when it comes to regulations and key negotiations to direct health policies (Brugha and Zwi, 2002). One of the tangible consequences of these reform policies has been the expansion of the private sector and the negative impact on health exclusion and the inequality divide (Homedes and Ugalde, 2002; Brugha and Zwi, 2002; Almeida, 2000; Bustelo, 2000).

c) Inequality and exclusion: implications for development

One of the most studied issues has been poverty, as well as the economic and social inequalities that still prevent many enjoying good health. These inequalities are persistent and increasing in several regions of the world, posing obstacles to development, the strengthening of capacities and the improvement of the quality of life.

Poverty is the harshest epidemic confronting the global public health community and the greatest obstacle to development; therefore, changes to promote global health and development are linked to poverty eradication strategies (People's Health Movement, GEGA et al. 2005). Looking ahead to the future, there is a risk that inequalities may not be reduced and, on the contrary, may become further entrenched (Organización Mundial de la Salud, 2004).

The *World Report on Knowledge for Better Health* (World Health Organization, 2004) points out that, although there have been improvements in the disease burden and life expectancy, the distribution of these benefits has not been equitable. While one fifth of the world population enjoys a life expectancy of about 80 years (relatively free of disease), two thirds of the world population in Africa, Asia and Latin America carry most of the burdens of disease and premature death. In some African countries, life expectancy

has diminished to under 40 years, as a result of HIV-AIDS together with poverty and social and health exclusion.

Compounding the difficulties of poverty are the issues arising from health problems, lack of food safety, environmental deterioration, violence and conflicts.

Meanwhile, the increase in poverty has brought along greater inequality and exclusion. Although poverty and inequality has been greater in the poor countries, they have also increased in wealthy countries over the past two decades² (People's Health Movement, GEGA et al., 2005).

² of the works of Ichiro Kawachi on inequality and the negative effects of health in the US. Regarding Canada, see the works of Denis Raphael, Esyllt Jones and Anne Ste-Croix Rothney (2002), Robert Chernomas (1999), *The social and economic causes of disease*, and Monica Townson (1999), *Health and wealth : how socioeconomic factors affect our well-being*, www.policyalternatives.ca.

CHALLENGES

RESEARCH

Develop strategic research in global health directed towards:

- Strengthening health systems and national health research systems, as well as governance in research and health.
- Impact on the causes of inequality, promoting development.
- Produce scientific quality knowledge helping to guarantee the production and delivery of global/national/local assets and the right to health and health services.
- Build knowledge to support political decisions and interventions aimed at promoting health and equality.

RESEARCH AGENDAS

- Identify priorities by coordinating research and action agendas seeking a balance between global and local priorities:
 - identifying a consistent set of issues that ensures the incorporation of knowledge focussed on the highest priorities to impact considerably on inequality;
 - preventing fragmentation and duplication, and enhancing synergy and capacity building;
 - identifying central issues that may:
 - strengthen global/local health governance;
 - strengthen the capacity for research and decision-making at the local/regional/global level;
 - and enhance the critical mass of researchers.

THEORY AND METHODOLOGY

- Encourage a theoretical-conceptual debate to progress in:
 - the understanding of global health specificities, the key issues, the interfaces between global and local health, the patterns and mechanisms of the global impact on health and health systems, which in turn requires:
 - new perspectives, methodologies and tools for inter/multi/trans-disciplinary studies able to factor in different aspects, levels and dimensions; and
 - linking different social and institutional players, as well as organizations;
 - i.e. empirical approaches geared to resolving practical as well as conceptual problems, seeking an understanding of global/local health issues while producing action-driven knowledge;
 - strengthening the avenues of enquiry into subjects of transformation formulated positively, to have an effect on causes, e.g. identifying and understanding the best strategies for governance in relation to equity.

BUILDING A HEALTH RESEARCH PARTNERSHIP

PROMOTING A PARTNERSHIP FOR HEALTH RESEARCH: PROGRESS AND PERSISTENT INEQUALITIES

Fifteen years after the recommendations of the Commission on Health Research for Development, there has been progress in reaching an agreement on the following statements:

- a) health is central to development;
- b) research plays an important role in the improvement of health and decision-making by directing actions for equality; and
- c) the link between research and social organizations, NGOs and civil society is not only important but is strategically necessary to build a partnership geared towards health- and equity-driven research.

However, with respect to other Commission recommendations on the establishment of partnerships and working networks, literature shows that progress has not met expectations.

The suggestions offered by the Commission were based on the belief an exchange between the countries of the North and the South in relation to expertise as well as local and scientific knowledge could impact positively on health and on the research and decision-making capacity.

These beliefs are still valid but the expected results have not yet come to fruition. There has been progress, but considerably limited by the challenges set out in the following chart:

- health research was still not sufficiently valued by national leaderships as an investment in development.
- research systems in general, and health research systems in particular, were often poorly organized and managed.
- many countries lacked a critical mass of researchers, a lack that was often part of a wider problem of inadequate human capacity.
- skills development was mainly focused on the 'supply side' (researchers and research institutions) rather than enhancing the capacity of 'users' of research (e.g. policy-makers and community groups).
- research has not often been translated into policy or action.

In evaluating efforts made to implement the recommendations of the Commission on Health Research for Development, the Bangkok Conference also concluded that:

- a much stronger Southern voice was needed to counter the dominance of Northern institutions over global health research.
- research needed to shift from knowledge generation to knowledge management.
- countries, as units of policy, financing and governance, are key to having an impact on health and development through health research – this led to the concept of a 'national health research system', developed further by WHO and other partners
- a more unified and inclusive approach was needed to increase synergy and reduce fragmentation.

Source : (Neufeld and Johnson 2001; (International Organizing Committee 2001) en (People's Health Movement, GEGA, et al. 2005

With respect to working networks, considerable efforts were made towards consolidation and expansion. However, the construction of a partnership culture for research linked to development and equality remains a challenge.

Another challenge for partnerships is the lack of equality and equity regarding the conditions and capacities for research between the developed and developing countries (COHRED 2001; Global Forum for Health Research 2001). These conditions of inequality hamper the establishment of a partnership and also hinder the development of research aimed at impacting on health inequalities.

Problems faced by research communities in developing countries: different levels

On a global level, they face an increased number of players, from institutions and organizations to the private sector and individuals, all involved in health research, who in some cases direct the research agendas according to the criteria of excellence of the Northern countries, e.g. global alliances that focus on a limited number of diseases causing high mortality and morbidity indexes.

Regarding the new private players, the public/private partnership model is emerging in the field of global health. This model tends to use new assistance instruments that are

Box B1.7 Global Public Private Initiatives (GPPIs)

There are currently about 80 GPPIs, the overwhelming number of which are linked to a specific disease or to the development of a new drug or vaccine. Examples include the Global Fund for HIV/AIDS, TB and Malaria; Roll Back Malaria; Stop TB; Global Alliance for Vaccines and Immunization; Global Polio Eradication Initiative; and the Global Alliance for the Elimination of Lymphatic Filariasis. WHO and UNICEF are the principal international governmental or multilateral actors involved, but the World Bank also plays a prominent role. On the private side, the Bill and Melinda Gates and Rockefeller Foundations are prominent, as are several for-profit pharmaceutical companies. Some NGOs are also involved, particularly with GPPIs they have helped to launch. However, certain groups are systematically under-represented, particularly poorer countries' governments and civil society organizations. On the whole, decision-making power sits in the hands of multilateral institutions and the commercial sector. (Source: Wemos 2004)

introduced to the initiatives advanced by the global alliances, e.g. Global Fund to Fight AIDS, TB, and Malaria and the Global Alliance for Vaccines and Immunization. These initiatives require new resources to be implemented in a focalized manner; however, their implementation means diverting human and financial resources from the public

health systems in developing countries (Walt, Pavignani et al. 1999; Lee and Mills 2000; Werner and Sanders 2000; ALILIO, BYGBJERG et al. 2004).

These public/private partnership trends tend to concentrate on vertical intervention models, such as the Sector-wide Approaches (SWAPs), the Poverty Reduction Strategy Papers (PRSPs) and the Program-based Approaches (PBAs), which are governed by

“selectivity” criteria, i.e. they concentrate support in the countries where they can best be employed and not necessarily in the poorer or less stable countries.

These financing trends, together with the selectivity criteria and the public/private partnership model, seek an impact on health problems but nevertheless disregard the strengthening of health systems subject to a systematic erosion of national health governance (Lee and Mills 2000).

This model of partnership and intervention has limited the impact on health inequality, and furthermore hinders research and decision-making capacities.

In some countries, there is evidence that some of these international players have been partly responsible for the fragmentation of research, affecting the capacity building process for research at a national level (Sitthi-amorn, Somrongthong et al. 2000).

Vacuum, duplication and fragmentation in research and financing are common problems (op. cit.). It seems there is difficulty understanding the dynamics of the partnerships that could strengthen capacities in the developing countries. However, according to one assessment, they are not properly understood (KFPE 2001).

Nationally, in some developing countries, changes in health governance are occurring in the context of political instability affecting research initiatives and conditions.

On the other hand, there is reduced financing for research and, furthermore, health systems in many countries are under enormous pressure (World Health Organisation 2004) and do not have national health research systems; when they do, these are in a precarious situation.

Institutionally, research faces the challenge of scant financial resources, which affects the development of capacities in individuals, institutions, and organizations with respect to research and decision-making.

Consequently, existing literature underscores the importance of consolidating a solid exchange with the research communities in developed countries promoting capacity building and development for health research (Gonzalez-Block and Mills 2003; Neufeld, Gyapong et al. 2003; Mancuso 2004).

Finally, there is consensus regarding the idea that an integrated link between research and the political decisions that govern health remains to be established. Moreover, closer ties are required between researchers, decision-makers, NGOs, and the public in general (Davis and Howden-Chapman 1996; International Development Research Center, Coalition for Global Health Research et al. 2003; COHRED 2004; Start and Hovland 2004).

Persistent inequalities in partnership building for health research

Research financing: Although global expenditures in health and development tripled between 1990 and 2001, the investment was mostly made in high income countries with the objective of generating products and technologies for their own markets (Global Forum for Health Research 2004).

Specific data for each country show that investment in research has improved but geared towards maintaining a deteriorated infrastructure and to pay for the salaries of researchers (Murray et al. 1990, Kitua et al. 2002, COHRED 2004 in People's Health Movement, GEGA et al. 2005).

The lack of financial resources together with a fragile research governance makes developing countries vulnerable: to conduct research they depend on foreign funds and, consequently, in many cases the donors will control the agenda.

Inequality in the agenda and timeline: One of the guiding principles of partnerships geared toward the production of knowledge is equality amongst partners. Nevertheless, experience shows a tendency not to apply this principle. Nor is there equality upon

establishing the agendas, which are usually directed by the partners from the North, nor in establishing the timelines (Costello and Zumla 2000; COHRED 2001; KFPE 2001).

Partnership building is a long-term process which requires support to be sustained and sufficient. This tends not to be taken in account by the donors, who prefer to finance short- and medium-term projects based on their own interests and not on the needs of the partnership building process.

Inequalities in the publication of knowledge and access to information: Literature shows evidence of isolation in some scientific communities in the South due to scant publishing opportunities and limited access to information. Therefore, a great deal of effort is spent on exchanging information with the scientific communities of developed countries, on building national and international networks and on improving access to information on the Internet (Costello and Zumla 2000; Edejer 2000).

Wealthy countries enjoy relatively easy access to information. On the other hand, access to the Internet or subscriptions to scientific journals in developing country could prove highly expensive. For example, Internet access in Africa represents 1% of world access, 95% of which takes place in South Africa (World Health Organisation 2004).

Together with intellectual isolation, there is inequality when it comes to publishing knowledge. Over 90% of scientific publications specialized in health research are published by researchers in developed countries (Organización Mundial de la Salud 2004).

Inequality in working conditions and opportunities – the brain drain: The brain drain shows different mobility patterns, from rural to urban settings, from the public to the private sector and abroad. Emigration is increasingly prevalent (Padarath A, Chamberlain C et al. 2005). This phenomenon is caused by a combination of factors related to the collapse of health systems in poor countries where salaries are not high enough to survive (Amore 2000; Varkevisser, Mwaluko et al. 2001; Hyder, Akhter et al. 2003), precarious

working conditions, scant resources for research, limited possibilities for education and training and, finally, reduced real opportunities for the future.

All these factors are compounded by the proactive recruitment of health professionals and researchers promoted by the countries of the North, which in some cases has caused a dramatic impact on the already deteriorated health systems (Martineau T, Decker K et al. 2002).

Conclusions

Although international efforts to strengthen capacities and research in developing countries has been recognized (Varkevisser, Mwaluko et al. 2001; Almeida 2004), in light of our analysis, it is apparent that many of the problems hindering the building of partnerships and the possibilities of research development are linked to *how* health research is governed (Lee and Mills 2000; Sitthi-amorn, Somrongthong et al. 2000).

Introducing the global perspective to the analysis of health, together with an examination of the conditions and opportunities available to researchers in developing countries, we find that the problems of health governance are closely linked to research governance.

This link is evident in the relationship we identified between the structural conditions of the research communities in the countries of the South and the capacity of the governments to effect health governance and include research in their national plans.

It is recognized that the ideal situation is one where health systems and health research systems are mutually dependent, to solve the problems of health and inequality, to strengthen public health systems and to convert knowledge into action (World Health Organization, 2004); however, the reality is that we are far from this ideal in the developing countries.

In this analysis of partnerships we started on the assumption that capacity building for health governance and the governance of health research³ are cornerstones in the process of building partnerships, which leads us to a search of new perspectives and strategies focussed on this challenge.

³ We believe that health research governance concerns the rules and values which are given priority and which frame the decisions regarding the types of research that are considered important and the criteria used to establish hierarchies amongst these priorities.

DEFINING PARTNERSHIPS FOR HEALTH RESEARCH

Partnerships are an empirical concept found in the private sector, e.g. business, as well as in the fields of health and development. The definition depends on the specificity of the field in question and on the governing interests and perspectives.

Partnerships, as understood here, are based on new forms of solidarity. This solidarity is based on the recognition of human dignity, which will not be lasting if the recognition is not mutual and shared throughout society.

Recognizing the need for solidarity as a guarantee of human dignity leads us directly into the subject of rights and health [...] which are linked by their common capacity for “social order”.

This relationship between rights and health imposes an order on social possibilities. However, we do not contend there is one “single” social order.

We intend to show that a vision of society can be seen through this relationship. Depending on how a society understands this relationship, there will be acceptable options (unacceptable options will be ruled out) and viable agreements will be identified regarding some basic conditions; extremely unjust situations and inequality will thus be identified. Therefore the “ordering” nature of the relationship between rights and health is expressed through the social choices made and the options discarded.

In this sense, our partnership model is based on the *choice* of a perspective of social change. This goal goes beyond action; it invests research partnerships and decision-making processes with a sense of direction and specificity geared towards development and health equality.

A partnership is not an end in itself. It is a strategy that:

- a) exists in time: a partnership is a process that requires longer timelines than research projects;
- b) it consists of a system of players: individuals, institutions, social entities, organizations;
- c) it brings together different rationales and diverse conditions for cooperation.

A partnership is a cooperation strategy between two or more structures or individuals which, a priori, favour cooperation above substitution, subordination or competition. From our perspective, the rationale of health research partnerships requires the condition that all reasoned attempts⁴ to introduce social change must help us, under real conditions, to achieve better results.

This does not mean establishing the condition that there must be no unintended effect. We are assuming that the process of building a partnership for health research and decision-making is also a learning process based on experience.

The available literature defines partnerships in general terms. However, if we intend to introduce changes to global health, it would be relevant to identify the specifics of health partnerships. It is in the specifics that the possibilities and potential of the partnerships take shape; the specifics also give direction to the efforts made.

In this regard, partnership building is a long-term process in which different combined actions and progressive commitments seek to impact on the inequitable conditions faced by health researchers and decision-makers.

In an attempt to identify the specifics of a global health partnership, we propose the following definition:

⁴ i.e. identifying acceptable options.

A partnership for research in global health is:

- a) a cooperation strategy involving a relationship between players and structures (institutions, organizations, social entities);
- b) based on the principle of equality and shared responsibility; it recognizes diversity;
- c) governed by a comprehensive and inclusive perspective, geared towards strengthening governance in global/local health and governance in global/local health research seeking equality in health, and therefore:
- d) promotes synergetic actions and initiatives which, in an upward continuum, favour autonomy, an expansion of the association network and an increase in the capacity and potential to strengthen governance in health and research.

PERSPECTIVE OF PARTNERSHIPS FOR RESEARCH AND ACTION IN GLOBAL HEALTH

A partnership concerned with strategic research intended to promote development and equality could be more effective if it uses a comprehensive and inclusive approach to frame the research and the decision-making processes and, at the same time, offers parameters to follow up on and assess the partnership process, the research and the use of the results.

Along these lines, we are interested in an approach that will open up space for strategies aimed at strengthening governance in global/local health and research, focussed on enhancing health systems as well as research systems.

In this model for a partnership in global health research we have introduced a structured perspective based on the following guiding principles:

- Focus on rights: gears the partnership towards the production of knowledge and decision-making, to progress in relation to health equality and guarantee global public assets.
- Principle of equity: directs partnership building towards research and action intended to impact on determinants.
- Socially sustainable development: the model adopts the “maximum criteria”, thus gearing cooperation towards research and decisions for action, closely linked to the ethics of shared responsibility for an equitable transfer from one generation to the next.

Focus on Rights:

The right to health is part of a set of human rights adopted by 193 countries. However, only 109 countries recognize these rights in their constitutions and 83 have ratified them in regional agreements.

Human rights are guarantees of international standards and offer a legal framework to protect human dignity, framing the responsibility of the States to guarantee the rights to decent living conditions. Characteristically, these rights are universal, indivisible and interdependent, and are not be subject to hierarchies.

Furthermore, the right to health is recognized in the constitution of the World Health Organization and was confirmed in the Alma Ata declaration. However, in the context of globalization, guarantees for this right appear further that they were in 1978.

This focus on human rights offers a framework for partnership building which we now propose in two different ways:

Firstly, it promotes a situational analysis of countries to establish research priorities, underscoring the importance of focussing on determinants (entirety of causes) to achieve equality.

Secondly, in relation to the above, it allows us to identify partners and commit to a progressive [phase-in] of rights. In other words, it establishes an operational mode in a process that is built working *with* the other, not *for* the other as is the case with paternalistic, assistance-driven perspectives.

Moreover, this rights-based approach provides a guideline to monitor cooperation in global health and follow up on the health consequences of political decisions and international agreements, offering an express recognition of the highest standards in terms of health and quality of life.

The rights-approach is a guide that also allows us to direct actions and decisions in a framework opposed to the assistance-driven, charitable perspective, where health is considered a commodity.

On the other hand, the criterion of progressive [phased-in] rights creates the responsibility of directing the most effective decisions and actions. And this underscores the importance of identifying priorities; from a rights-based perspective, these would have to be identified through a gender perspective and would have to take into account the inequalities prevalent in different social groups.

Finally, the right-based approach identifies benchmarks and indicators to monitor advances in the implementation of these rights.

In operational terms, the rights-based approach favours:

- a) the establishment of an ethical perspective to build a coherent *observation* partnership for the production of scientifically and socially relevant knowledge;
- b) the production of data and evidence to advance in terms of development and health equality;
- c) the establishment of criteria to identify research and decision-making priorities which, jointly and from the very beginning, allow us to bring about inter-connectivity between the research and the action agendas;

- d) follow-up and assessment: the infeasible considerations that give rise to the rights can be used as standards to compare results; in this regard, the rights-based approach can be used as a guideline to monitor and assess:
- the partnership building process;
 - international cooperation and research financing;
 - policies impacting on health and health research governance;
- e) the identification of strategic allies and the conditions to build and develop advocacy to strengthen health governance; many national constitutions do not consider health as a right; some do, but impose legal barriers that must be overcome in order to, say, assign resources to guarantee the right to health. In this sense, the rights-based approach allows us to identify what is required to resolve legal issues affecting advocacy.

Principle of equality

Promoting equality in a partnership reflects a commitment to reducing inequalities in the training opportunities, working conditions and access to financing, information and knowledge required to conduct research.

Promoting health equity reflects a commitment to eliminating health inequalities. These inequalities are not natural or random; they are systematically associated with disadvantaged social groups (Braverman P 2003)..

The principle of equality provides guidance to the partnership building process but also directs health research and decision-making.

The comprehensive capacity of this principle is noteworthy. It links the partnership building process to the inter-connectivity between the research and action agendas, in a

framework of common interest and commitment to impacting on the pattern of inequality.

In this regard, we could suggest that, if the partnership process and the inter-connectivity between the research and action agendas are built on the basis of a commitment to social and health equality, we would gradually advance towards the materialization of the right to health and, consequently, we would be strengthening governance in health and research.

Socially sustainable development

Particularly important from the perspective of socially sustainable development, is the need to address the conditions under which the “capacity to do and to be” (Sen 2000) are transferred equitably from one generation to the next.

This approach introduces:

- a) an inter-generational commitment;
- b) a perspective where projects have a vision of future social development.

We would hope that socially sustainable development can protect potentialities, strengthen the capacities of specific generations, and facilitate transfer to the next generation. This would imply keeping in mind the elements that preclude the establishment of potentialities⁵ (poverty), enhancing of capacities (exclusion and vulnerability) and inter-generational transmission (inequality).

It would also require adopting the “maximum criteria”, as a social, precautionary principle in the partnership building process, and identifying priorities for research and political decisions.

⁵ Here we underscore the need not to mistake socially sustainable development for the war on poverty.

Adopting this “maximum criteria”—associated with the highest attainable health standards and entrenched in the parameters of universality, without exceptions—begs our commitment to an examination in light of the ethics of shared responsibility and human rights, to promote guarantees of social and health equality.

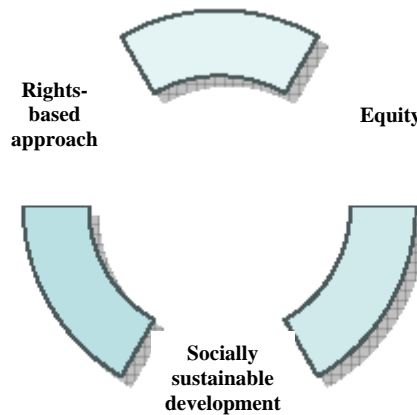
From the perspective of socially sustainable development, global public assets, including health, are all interrelated.

Global public assets are by nature closely linked to the set of human rights in a relation of non-hierarchic inter-connection and inter-dependence.

Conclusion

The rights-based approach, the principle of equity and the perspective of socially sustainable development offer a comprehensive (and inclusive), integrated (and integrative) and potentially synergetic framework to:

- a) establish a principle of coherence between an ethical perspective and a practical approach to cooperation, research and action; and
- b) guide the building of partnerships through a progressive, upward process towards:
 - reducing inequalities in research conditions; and
 - strengthening health governance and research governance towards equity in health and development.



STRATEGY FOR COOPERATION AND CAPACITY STRENGTHENING FOR GLOBAL HEALTH RESEARCH AND ACTION

Traditionally, there has been a tendency to consider developing countries as receivers of help (technical and financial) and knowledge.

However, there is now sufficient experience to show that the research needs and capacities of developing countries are not the same across the board (Whyte 2004).

Some countries have advanced in the development of capacities, which have translated into progress in health research and have produced high quality results as shown in the following graphic:

The value of national health research capacity in low and middle-income countries

- Brazil discovered Chagas disease: Carlos Chagas discovered American trypanosomiasis in 1909.
- India developed oral rehydration therapy: H N Chatterjee published the first human study of ORT in 1953.
- Chile led contraceptive development: Jaime Zipper Abragan and Howard Tatum developed the first copper intrauterine contraceptive device in 1969.
- China developed the treatment of malaria: Chinese researchers isolated the plant extract, artemisinin, from a traditional fever remedy in 1972.
- Sudan changed its malaria treatment protocol: the country used national research on resistance to chloroquine.
- Cuba developed the first meningitis B vaccine: Gustavo Sierra and Concepción Campa published the first randomized controlled trial of their meningitis B vaccine in 1991.
- Thailand built up evidence for health systems development: health research and good research management played a pivotal role in reforming the Thai health system over the past decade, and are considered central to efforts to implement, monitor and evaluate further reforms

Source: People's Health Movement, GEGA, et al. (2005)

This is why we are starting on the assumption that countries in the South are also producers of knowledge, which allows them to make contributions to countries of the South and also the North.

Nevertheless, we admit that there are countries facing obstacles that have not allowed them to make considerable progress in research development.

Furthermore, there are also disparities within countries in terms of needs and levels of capacity development between the research communities in the capitals and the local regions.

Based on the different levels of capacity development and the different types of research development needs, we believe that a **diversified and decentralized partnership** strategy would be relevant to the situation, factoring in the existing needs and capacities.

On the other hand, the progress achieved by some countries of the South, together with the need for a partnership able to strengthen autonomy, leads us to examine the implementation of a coherent cooperation strategy, with the objectives of the model we are proposing and in accordance with the disparate landscape of capacity development.

In this regard, we believe there is room for a **triangular cooperation strategy**, whereby the North-South relationship is steered towards strengthening the South-South relationship and increasing the South-North relationship.

This strategy could help maximize financial, technical and logistic resources, since the research community and the decision-makers of one country or region in the South could receive the support of partners in the North.

Alternatively, a community in the South that has shown more progress in research and capacity development could cooperate with another Southern community that has not advanced as much. This would bring about a partnership building process able to impact

on research development and capacity building and, at the same time, consolidate the networked fabric, thus establishing the conditions to promote regional development.

In the partnership model we are proposing, the strengthening of capacities acquires a strategic value. We believe there is a difference between building capacity for research in general and building capacity for research geared towards equality and development; the latter, in our view, should impact on health governance and research governance.

In this regard, the strengthening of individual/institutional capacities for research and action should be examined on the assumption that the components are separate but maintain a relationship of hierarchic interdependence: (1) systems and roles, structure, (2) materials and human resources, (3) technical capacity and professional training, and (4) tools (Potter and Brough 2004).

Potential results

- Insofar as global health research is promoted through participative and inter-/multi-/trans-disciplinary modalities facilitating the involvement of health managers and decision-makers, NGOs⁶ and social organizations, we would be progressing along the road to build a partnership and strengthening the capacities for research, management, decision-making and advocacy.
- From a perspective integrating capacity building and political advocacy, we could impact on the conditions affecting human resources in the health sector and reduce the brain drain.
- Strategic training together with participative research could offer sustainable solutions to promote systemic changes in global health and could also create bridges between different sectors and between research and action geared towards equality and development.
- Strategic capacity building could give rise to a new range of results, i.e. with the involvement of different players, there could be a better understanding of the

⁶ There are studies showing the importance of considering the NGOs as allies of research development. Delisle, H., J. Roberts, et al. (2005). "The role of NGOs in global health research for development." Health Research Policy and Systems 3(1): 3.

levels of commitment and it would be possible to manage the differences through innovation and by strengthening the development of action-driven research.

MODES OF ASSOCIATION FOR HEALTH RESEARCH AND ACTION

Literature shows that partnership building can take different shapes and can be initiated from different points of contact. Partnership experiences, beyond diversity, show a pattern similar to the cooperation building process.

These experiences confirm that the mover that initiates the partnership construction process is related to:

- recognition of the need to establish cooperation links;
- will to share and exchange, to offset the lack of resources and opportunities, and participate and make others participate.

The most common way to start a partnership is to leverage the interpersonal relationships between researchers or decision-makers. Although these initial relationships lack institutional visibility and could be reduced to individual relationships, they are fertile ground to build a broader network of personal, institutional and organizational relationships that would result in a more structured process focussed on the established objectives.

Networks

The concept of a network appeared in the health sector in the sixties. Networks are relational, flexible and open forms of organization or coordination, as opposed to rigid and static pyramid structures. Typically, networks comprise a non-structured group of players and/or institutions that maintain close communication in relation to a common project or interest.

Networks have a potential mobilizing capacity and are often used to organize participation and action, which can appear in different forms depending on the level of involvement, e.g. organizing information/training workshops or symposiums, either virtual or on location, working in cooperation with other similar networks, and conducting research or carrying out actions in a context related to other associations and groups that have a common project or issue, developed in different regions.

One of the problems with networks is that, because of their loose structure, they have flexible mechanism and a diffuse decision power, which can at times paralyze the decision-making process. On the other hand, the distribution of tasks and responsibilities is more the result of a willing disposition and not coordination. Although the voluntary participation spirit propels the network, this type of motivation is not always constant, which often causes problems in the levels of involvement.

EQUINET: a regional network for equity in health in southern Africa

Established in 1997, EQUINET is a network of institutions working on equity issues in southern Africa. Its aims are:

- to further the conceptual framework and policy issues in relation to equity in health in southern Africa
- to gather and analyse information to support scientific debate and decisions on equity in health in southern Africa
- to engage stakeholders and, in particular, those social groups whose interests would be better served by more effective pursuit of equity measures in health
- to use all of the above to provide input into policies affecting health at the national level and the regional level of the Southern African Development Community.

The network is supported financially by the International Development Research Centre, Canada (IDRC), and coordinated by Dr Rene Loewenson, Director of the Training and Research Support Centre in Harare, Zimbabwe. An international steering committee, consisting mostly of members from southern Africa, guides the work of EQUINET. Among other activities, the network has published a series of policy papers.

Health Research for Policy, Action and Practice 2004

There is a variety of network types, such as:

- a) alliances – long-term commitments undertaken by groups and organizations with common interests and with a competitive edge in relation to other organizations;
- b) coalitions – groups of political institutions or players advocating particular goals in a given sector such as health, education, etc.

Observatories

In recent years, observatories began to appear in the field of health. These are characteristically structured organizations with high levels of autonomy and inter-sectoral representation. Observatories combine the functions of producing information and disseminating information that could serve as the basis to formulate policies. They also analyze, monitor and assess the dynamics of the objects of observation.

Another feature of the observatories is that they are formed with the participation of different groups of institutional players, such as health authorities, training institutions for health professionals and social organizations. Observatories may be regional, local, national or, as in the case of the example below international.

The European Observatory on Health Systems and Policies

Supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM).

PARTNERSHIP BUILDING: BEGINNING THE PROCESS

Partnerships tend to be initially established between players or between institutions, based on interpersonal relationships. During a second phase, partnerships expand outwards, away from the initial group.

A partnership building process tends to evolve from the very first contacts onwards, from participation to cooperation and finally association.

This evolution depends on key aspects for success, such as:

- ✓ Egalitarian relationships, respecting diversity and recognizing differences in order to overcome them.
- ✓ Relationships based on mutual trust.
- ✓ Communication is valued.
- ✓ Increase in credibility of each partner.
- ✓ Acknowledgement of each one's role and capacity.
- ✓ Increase in each one's level of participation through progressive involvement.

The practices of participation, cooperation and association evolve as the process unfolds, leading to learning and synergy between individuals, institutions and organizations.

Lessons drawn from experience suggest that the conditions required to consolidate the partnership building process are as detailed below (Netherland Development Assistance Research Council (RAWOO) 2001; Handicap International 2002; Byrne and Robin 2003; Hardy, Hudson et al. 2003; Tennyson 2003; Lasker RD and ES. 2003; Cissé 2004; European Commission Support 2004; Harris 2004; IJsselmuiden C, Duale S et al. 2004; Marselli, Lys et al. 2004).

- Have clearly identified objectives and be open to participation and cooperation.
- Know the structure of the association; carry out preliminary work to minimize conflicts
- Identify allies in the different sectors as well as possible alliances.
- Understand the potential of working together and anticipate problems, for which we recommend:
 - reflect on one's own vision of cooperation and identify strengths and weaknesses;
 - enquire about the specific sources of potential problems;
 - interview the allies identified and assess their strengths and weaknesses.
- Agree with allies on the definition of problems and on setting priorities.
- Establish a perspective; an essential quality in partnership building is the ability to adopt new perspectives to assess problems, thus producing new energy and creativity in the development of a vision
- Develop a plan of action with expected results.
- Assess the process and the results.
- Visualize, institutionalize and replicate success.

ELEMENTS AND CONDITIONS CRITICAL TO PARTNERSHIP BUILDING

The experience in partnership building teaches us that the process consists of a variety of elements and conditions that may hinder the process. The impact of these elements and the weight of these conditions affect the duration of the partnership and vary depending on when the process is started or implemented.

The context outside the institutions and individuals may favour or hinder the process. In this regard, and in the framework of North-South relations, there must be a commitment from the North towards the South and vice-versa since [these relations] could affect the dynamics of the partnership.

One of the strategies suggested to minimize the impact is to diversify the sources of support.

Regarding internal elements [or factors] in the process, we have identified the following:

1) Lack of willingness to participate

To stimulate participation, we suggest actions to raise awareness, starting a dialogue between potential players, institutions and organizations to encourage commitment.

2) The time factor – different interests

Schedules are necessary for the implementation of partnership building processes but may also hamper the progress of projects.

A considerable amount of time is spent starting the process, overcoming hurdles arising from different views, unequal conditions, different levels of representation, fear of losing sight of specific objectives, and accepting the leadership of a working group.

On the other hand, often there are conflicts between the timelines dictated by the partnership building process and the project financing schedules. Therefore, it is advisable not to depend on a single source of financing. The tighter the fabric of the association, the easier it will be to overcome obstacles.

3) **Differences**

Differences may arise either in the process or upon implementation. In the partnership building process, it is important to learn how to manage differences. Managing tension and leveraging differences determine the conditions under which everyone's participation is encouraged and goals are achieved.

The potential emergence of differences is seen here in appositive light. Interest to participate is contingent on the ability to leverage differences, emphasizing and giving priority collective action over specific interests.

We believe that producing an abstraction of this (possible) confrontational set of dynamics is [could affect] the partnership building process; it would run the risk of becoming non-viable and, on the other hand, it would [reveal] the naivety of the participants.

MONITORING THE CAPACITY OF PARTNERSHIPS

The existing literature on partnership assessments tends to focus on the assessment and monitoring of relations between partners. Based on the model we are proposing, it is important to assess the quality of the relations since this is a key factor to the success of the partnership.

Nevertheless, we believe that the commitment of a partnership to conduct action-driven research as outlined here requires ongoing monitoring, but focussed on assessing the capacity of a partnership to effect the expected changes.

To do so, we propose monitoring the three capacities we identified as important in the partnership building process.

- ❑ Strategic capacity: reflects the building of the partnership, with its diverse modalities and efforts to achieve results based on strategic thinking.
- ❑ Operational capacity: shows that adequate practices and processes are in place to achieve expected results.
- ❑ Capacity to achieve results: shows that results are actually being produced; if necessary, actions and efforts are re-directed.

Monitoring the strategic capacity of a partnership would show how the partnership objectives are related to the results obtained, who the main allies are and what methods were used in the process.

Monitoring the operational capacity would provide information on the changes produced in the context in which they occurred.

Lastly, monitoring the capacity to achieve results would offer information on the types of results obtained compared to the expectations, indicating the obstacles encountered and the solutions implemented to overcome them.

FACTORS AFFECTING THE SUCCESS OF PARTNERSHIP BUILDING

Partnership experiences indicate that the factors determining the success of sound and lasting partnerships are multifarious (RAWOO 2001; Hardy, Hudson et al. 2003; Tennyson 2003; Mancuso 2004; Marselli, Lys et al. 2004; Garza 2005; Valentini and Albert 2005).

Regarding financial support

- ✓ Adequate and sustained financing is an important factor. However, financing is not the only key to success; sometimes, creativity, mutual necessity and the will of players help overcome turbulent periods and achieve greater results.

Relations between partners

- ✓ Relations based on mutual respect and trust
- ✓ Relations established under criteria of equality, equity and respect for diversity
- ✓ Relations that value communication and collaborative work
- ✓ Mutually beneficial interaction: Interaction between partners brings about benefits leveraged by all and also contributes to the objectives of the partnership.
- ✓ Decisions are made and problems identified through an inclusive process.

The partnership building process

- ✓ Defining roles and objectives: the number of partners is not a measure of success; what matters is to know who is participating and what each partner's role is in pursuing the objectives proposed.
- ✓ Evolution of the partnership: a partnership focussed on change expects the partners' capacities and inequitable conditions to evolve progressively; if nothing changes, something must not be working properly.
- ✓ Capacity to manage complex and sometimes very complex situations.
- ✓ Appropriate governance structure contributing to the objectives.
- ✓ Decisions made on the basis of empirical data to identify appropriate actions and strategic decisions.

CONCLUSION

Currently, there are excellent opportunities to address the roots of health problems and development and prevent social and health inequalities.

There is new knowledge, analysis tools and research organization models; there has also been progress identifying the paths that could lead to the eradication of social and health exclusion, deaths, preventable damage and inequalities.

Research has advanced in the production of knowledge and the recognition of the role played by the development and health improvement agenda.

We should be aware of the need for consistency between rhetoric and the action geared towards improving health; this forces us to look differently upon the health problems that appear in a complex and highly interrelated manner on the global level while affecting local communities.

This awareness prompts us to cooperate in order to strengthen the health and research systems, leveraging the expertise acquired by all.

Building a more supportive world, where human dignity is guaranteed, requires that we defer no further the contribution of research to the intended objectives; [and we should be careful not to otherwise impede such contribution.]

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