

MINISTERIAL CONFERENCE ON RESEARCH FOR HEALTH IN THE AFRICAN REGION

Algiers, Republic of Algeria
23–26 June 2008

Conférence Ministérielle sur la Recherche
pour la Santé dans la Région Africaine



REPORT



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MINISTERIAL CONFERENCE ON RESEARCH FOR HEALTH IN THE AFRICAN REGION

OPENING SESSION

1. The Ministerial Conference on Research for Health in the African Region was held in Algiers, Republic of Algeria, from 23 to 26 June 2008. The Conference brought together ministers from the African Region, researchers, nongovernmental organizations, donors and the private sector, in order to strengthen commitments and agree on a common declaration for submission to the 2008 Global Ministerial Forum on Research for Health, scheduled for Bamako, Mali. The first three days of the Conference were devoted to technical discussions by experts (see Annex 1 for the Programme of the Conference).
2. The Conference, whose theme was “Narrowing the knowledge gap to improve Africa’s health”, had the following specific objectives:
 - To renew commitments to strengthen the generation of knowledge and narrow the gap to improve Africa’s health development and health equity.
 - To highlight innovative approaches and success stories in developing capacity in research, information and knowledge management in the African Region.
 - To strengthen the use of evidence in policy development and decision making.
3. In welcoming participants to the Conference, Ms Rachida Benkheli, Secretary General of the Ministry of Health, Population and Hospital Reform, thanked the Steering Committee comprising representatives from Burkina Faso, Ghana, Kenya, Mali, Nigeria, Rwanda and Senegal, the Algerian Organizing Committee, and the WHO Secretariat for the preparations made to ensure the success of the Conference.
4. The keynote address was delivered by Dr Luis G. Sambo, WHO Regional Director for Africa. He extended his gratitude to the Government of Algeria for accepting to host the Conference and for the resources deployed to make it a success.
5. Dr Sambo recalled that research played a key role in the creation of knowledge, the development of technologies and the evaluation of health programmes. He deplored the paucity of resources allocated to health research in the African Region and recounted how the fifty-sixth session of the WHO Regional Committee for Africa had selected Mali to host the 2008 Global Ministerial Forum on Research for Health. The same session of the Regional Committee had chosen Algeria to host a preparatory interministerial meeting to review the status of research for health in the Region and to prepare an African common position and the Algiers Declaration for submission to the Bamako Conference. This common position was deemed vital for the strengthening of research for health, for health development and for the attainment of the Millennium Development Goals (MDG). Furthermore, that session of the Regional Committee adopted strategic directions for knowledge management in health.
6. In April 2008, the International Conference on Primary Health Care and Health Systems in Africa adopted the Ouagadougou Declaration which invited Member States to, among others, strengthen their health information and surveillance systems, promote operational research, and establish centres of excellence for research in order to generate evidence for decision making.

7. Dr Sambo informed the Conference that in order to facilitate the deliberations, the WHO Regional Office had conducted, with the collaboration of ministries of health and relevant institutions, regional surveys on national systems for health research and a regional consultation on the draft Algiers Declaration. WHO was also well represented at the Algiers Conference by a strong delegation from the WHO headquarters and Regional Offices for Africa and Eastern Mediterranean.

8. He extended a special welcome to the honourable ministers of health from countries of both the African Region and the Eastern Mediterranean Region of the World Health Organization and observed that their presence at the technical meeting was a manifestation of their commitment to health research and the Africa Health Strategy 2007–2015 of the African Union.

9. Dr Sambo indicated that the issues related to research for health, knowledge management and health information systems and the special focus on leadership, strategies, financing, human and institutional capacity, and creation and use of knowledge, would give inputs to the deliberations of the Ministerial Conference including discussion of the draft Algiers Declaration, and to the achievement of health goals in the Region.

10. He stressed that the achievement of the health goals including the health-related MDGs was the primary responsibility of national governments within the framework of their national development plans. This needed to be taken into account in the mobilization of additional resources for strengthening national health systems including systems for research for health. He reiterated the readiness of WHO to provide technical support to Member States in these efforts, in accordance with its mandate. Dr Sambo ended his address by expressing his gratitude to the Member States, the experts and the development partners.

11. The Conference was officially opened by Mr Amar Tou, Honourable Minister of Health, Population and Hospital Reform, Algeria. On behalf of the Government and people of Algeria, Mr Tou officially welcomed the participants and wished them productive deliberations in order to provide concrete suggestions to the honourable ministers in their deliberations and in the adoption of the Algiers Declaration.

12. The Honourable Minister informed participants of recent efforts by the Algerian Government at strengthening research in general and research for health in particular. These included the adoption of a five-year plan for scientific research covering the period 2007 to 2012 and the allocation of additional budget totalling US\$ 1.3 billion. He called on other countries to emulate such best practices, and on the international community to support African countries in their efforts to strengthen national systems for research for health.

PLENARY SESSION 1 – GOVERNANCE/STEWARDSHIP OF NATIONAL HEALTH RESEARCH SYSTEMS

13. The plenary session on Governance/Stewardship of National Health Research Systems was chaired by Ms Rachida Benkheli, Secretary-General of the Ministry of Health, Population and Hospital Reform, Algeria and Chairperson of the Steering Committee of the Conference. Dr Tikki Pang, Director of Research Policy and Cooperation, WHO headquarters, made a presentation entitled “Stewardship of National Health Research Systems: issues and challenges”. He indicated that the national health research systems (NHRS) framework identified ‘stewardship’ as one of the four functions (stewardship, financing, creating and sustaining resources, and producing and using

research) of a NHRS. Stewardship was sometimes referred to as governance, leadership, guidance, harmonization, coordination, direction, steering, or oversight.

14. Dr Tikki Pang indicated that there were four key elements of effective vision and oversight. These included focus on the ultimate goal of research to improve health outcomes and health equity; adopting a holistic and intersectoral approach to research; conducting research to push the frontiers of knowledge; and building public trust. The key skills needed in the performance of the stewardship function included formulating vision, mission and goals for health; setting priorities for health research; addressing ethical considerations in research projects; monitoring and evaluation; designing and implementing effective policies which address existing inequalities in health research; managing health research and "bridging" and "political" skills; thinking 'Out-of-the Box', i.e. moulding interdisciplinary and multidisciplinary approaches by leveraging networking skills; conducting 'research on research'; and communicating and disseminating research findings.

15. In focusing on the ultimate goal of research to improve health outcomes and health equity and not research for the sake of research, it was necessary to strike an appropriate balance between different types of research; curiosity for new knowledge versus economic returns; the needs of researchers versus the needs of policy makers; doing research versus managing research; curiosity-driven researchers versus needs-driven research users; more research versus health information; and national versus regional versus global priorities.

16. Adopting a holistic and intersectoral approach involved not looking at national health research systems in isolation but rather developing a more holistic view of NHRS and its links to national health systems; looking at intersectoral links and need for multidisciplinary views and approaches; seeking congruence, complementarity and synergy with external initiatives in health research and health sectors, and beyond.

17. Conducting research to push the frontiers of knowledge involved questioning why we have the health outcomes that we have; doing "research on research"; building appropriate capacities; and adopting an iterative attitude of a "learning" research system. Building public trust should be based on fundamental values and principles of ethical conduct, equitable relationships, transparency and accountability, inclusiveness, sensitivity and responsiveness. In addition, it required broad-based political, community and media support to ensure sustainability.

18. Dr Pang apprised the Conference of the functions of the Evidence-Informed Policy Network (EVIPNet) which include: promoting systematic use of evidence in policy-making in low and middle-income countries; and promoting partnerships at country level between policy-makers, researchers and civil society to facilitate policy development and implementation through best use of scientific evidence. EVIPNet building blocks consist of (i) country dialogues (safe harbor); (ii) country teams and regional and global support structures; (iii) capacity development and empowerment; (iv) research synthesis and policy briefs; (v) monitoring and evaluation; and (vi) development of new methodologies.

19. Dr Pang concluded his presentation by reminding the Conference of the "The triangle that moves the mountain", i.e. "creation of relevant knowledge", "political involvement" and "social movement". These elements were all needed in order to conduct sustainable research responsive to country needs and used for policy development and programming.

20. In the discussions that ensued, participants observed that the level of awareness of the importance of health research in health development was not appreciated sufficiently by politicians and, as a result, adequate resources were not allocated to research for health. The issue was how to raise awareness among policy-makers on the importance of investing in the development of functional NHRS to ensure the generation of pertinent research for use in national health policy development and planning.

21. Concern was expressed about the uncoordinated manner in which huge amounts of funds for health research were flowing into countries. Often, those external funds were used by foreign researchers, working in African countries, to address the concerns of external partners instead of strengthening national health research capacities and addressing national priority health research problems. Those concerns together undermined the capacities of NHRS and reduced the effectiveness of external research funds. Countries were urged to improve coordination of donor funding for health research.

22. Participants stressed the need to strike a balance between basic and applied research for health. The chances for such a balance could be increased by having clear national health research priorities based on various criteria, e.g. burden of disease, projected disease trends, availability and accessibility of effective interventions, etc. There was a dearth of information on the number of clinical trials being undertaken by domestic and external researchers in countries. The need for registries to facilitate informed stewardship of health research and to incorporate research on traditional medicines within the national health research systems to facilitate their archival, patenting and utilization was underscored. There was also a need for regional mechanisms for facilitating South-South collaboration in research for health

23. It was observed that scientific research was often too technical and, as a result, not intellectually accessible to policy-makers. The need for researchers to report their research findings in a language understandable to policy-makers was underscored. Information on the criteria and procedures for interested countries to become members of EVIPNET should be widely shared. In collaboration with communications experts, countries should develop strategies for communicating health research findings to various target groups, e.g. policy-makers, communities, etc.

24. Countries were urged to develop autonomous multi-actor (stakeholder) centralized mechanisms (e.g. research council) for coordinating research for health in order to optimize research outcomes from the available research resources and to establish functional ethical review committees in order to guarantee that the rights of human research subjects were respected.

PARALLEL SESSION 1.1 – STEWARDSHIP AND GOVERNANCE

25. The paper entitled “Governance and Stewardship of African National Health Research Systems” was presented by Dr Erica Gadsby of the University of Leeds, United Kingdom. It covered issues such as policies, legislation, plans and coordination mechanisms at the national level. At the institutional level, the main issues covered included functions, leadership, types and approaches to research, scientific review policies and criteria, monitoring and evaluation, and collaboration. In all, there were responses from 44 countries.

26. More than 80 per cent of countries had articulated a vision for health research and 84% had national health policies and national strategic health plans. However, only 28% of countries had developed national health research policies and only 16% had developed national health research

plans. Three-quarters of the countries that had no health research policy expressed interest in developing one, and explained that the absence of policy was due to a lack of capacity, rather than willingness.

27. Fifteen countries (35%) reported having a functional national health research system and only 8 countries (19%) had a national health research management forum with clear terms of reference. In these countries, a full range of stakeholders including universities, medical research councils, representatives of nongovernmental hospitals, provincial or regional medical officers of health, national medical associations, and administrators of health research policy were all involved in the process of formulating a health research policy. The group or individuals most influential in determining, guiding or setting institutional priorities for research were the heads of institutions, individual researchers, external institutions and donors.

28. Seventy-two percent of the countries reported having functional Ethical Review Committees (ERC), although 25% of them had written terms of reference. Thirty-five per cent of countries had hospitals with ERCs to review all clinical research proposals and 22% of institutions had written criteria for scientific review of proposals addressing ethical review.

29. As regards monitoring and evaluation of the health research system, only 51% of countries had a scientific review committee, and only 50% of them had written terms of reference. Seven countries had policy document which includes a strategic vision for the national health research system. Forty-three per cent of institutions had an explicit or a written requirement for the institution to undergo independent evaluation and 29% of institutions had scientific review committees that met regularly.

30. There is a rich and varied research culture with a range of institutions such as government/government agency research institutes, hospitals, independent research institutions, medical schools, other institutions such as NGOs and charities, and other universities. The activities of the institutions included submission of proposals (48%), conducting health research (48%), research priority setting (43%), and preparing scientific outputs (43%).

31. The participants in the parallel session noted that while the survey had some limitations, the result provided a good descriptive overview of the functions related to stewardship. They also noted that the dependence on external donor funding and the non-alignment of donor priorities and national priorities were main obstacles to strengthening national systems of research for health. They recommended that countries should take adequate steps to ensure that they have updated national strategic plans and national policies for research for health as components of national strategic health plans. The development of these plans and policies must be informed by the outcomes of national assessments of the current situation. Countries should also allocate adequate human and financial resources to ensure effective implementation of the plans and establish monitoring and evaluation. Coordination mechanisms should also be established or strengthened and steps should be taken to validate the results of research studies, including publications in international journals.

32. The participants called on WHO and other development partners to support the efforts of countries to strengthen national systems of research for health, including making available the results of the survey and other best practices available on the internet, establishing an observatory on health research, and a regional network for health research. They also called on donors to increase their financial support for health research within the framework of the Paris Declaration on aid effectiveness and harmonization.

PARALLEL SESSION 1.2 – COLLABORATION

33. The session on ‘Collaboration’ was chaired by Professor Rose Leke, Professor of Immunology and Parasitology, Faculty of Medicine and Biomedical Sciences, University of Yaounde 1, Cameroon. The panellists were Dr Andrew Kitua, Director General, National Institute for Medical Research, MOH, Tanzania, and Professor Jean Jacques Muyembe Tamfum, member of the WHO African Advisory Committee on Health Research and Development (AACHRD). The presentation entitled ‘Collaboration’ was made by Dr Stuart Gillespie, Director, International Food Policy Research Institute (IFPRI) and Professor Guillermo Paraje, Economics Researcher, Adolfo Ibanez University, Santiago, Chile.

34. This session addressed approaches to enhancing collaboration in research for health within countries, between countries and with other regions. It also addressed the preconditions and enabling environment for collaboration, whether across disciplines, stakeholders, sectors or institutions, including principles and the operational aspects of ensuring balanced partnerships among different partners or institutions and the requisite skills such as research management and negotiation skills.

35. Based primarily on an analysis of the WHO Regional Office for Africa’s implementation of the Health Research System Analysis, an institutional survey covering more than 700 institutions contributing to research for health in 44 countries (2007-2008) and key findings addressing collaboration, were presented. These addressed: (i) outputs (co-authorship patterns for easily accessible journal articles including authors in African institutions drawing on the ISI database of global scientific outputs); (ii) collaboration in financing (source of financing by type of institution and sector); and (iii) strengthening institutional capacities (areas institutions across Africa, identified as priorities to be strengthened in order to better achieve their mission and move towards more balanced research partnerships). As the background paper was not available prior to the Conference, the four key findings are set out below for reference.

36. The main findings were as follows:

- Almost half of all easily accessible journal articles from the Region have no collaboration (untapped potential).
- Foreign financing makes up a large share of funds for some institutions, even more for health policy, systems and service delivery research.
- Many significant strengths of, or barriers to, institutions to achieve their mission reflect the fact that the institutions are part of a multinational network or not.
- Institutions across the Region identify fundamental issues to achieve more balanced research partnerships, including the need for all partners to "decide on priorities and objectives together".

37. Subsequently, panellists drew attention to work across the Region that illustrates intersectoral collaboration and from other international efforts, existing tools to enhance balanced partnerships. In particular, one background paper for the conference addressing the importance of collaboration between health and agriculture research, in all stages of problem identification, the question of policy, research design, implementation, and dissemination, was also discussed by the panel and participants.

38. The participants in the session indicated that African countries focused on: research aimed at improving physical, mental and social health of African people; investigating common regional interest and problems; and developing common agenda and strategies for collaboration. Countries should develop a clear national agenda for collaboration before negotiating collaborations and establishing rules for equitable, balanced partnerships and should set aside 2% of the ministry of health budget for health research.

39. A number of key obstacles and barriers for collaboration were identified including: lack of knowledge about existing African research capacities; uneven distribution of health research resources within and across countries and continents; unbalanced/unequal research partnerships between African and northern institutions. Knowledge sharing across the Region is further hampered by language barriers. For Example, most academic journals are in English and that limits their accessibility to French and Portuguese speaking countries. Majority of the research conducted in Africa do not address national or continental health problems but the problems of concern to the funding countries. Other constraints include lack of supportive environment for researchers and research institutions; and a dearth of knowledge about existing global resources for health research and their conditionalities to be able to negotiate from a position of strength.

40. It was recommended that the following priority actions be implemented by countries: governments should recognize the value of research and create an enabling environment for research including development of career paths for health researchers; governments should involve key stakeholders, sectors, disciplines, civil society, and communities in developing and implementing an agenda of research for health that reflects national health problems; countries should adapt existing guidelines for balanced partnerships, e.g. those of EDCTP; countries should develop multisectoral research teams (e.g. with other sectors and disciplinary perspectives, agriculture, environment, education, science and technology, etc.) to address the broader determinants of health; researchers should, through multi-country studies, address subregional and regional health problems for economies of scale; governments in collaboration with research institutions should encourage collaboration with the private sector; information on potential health research partners should be shared within the Region; and appropriate skills to negotiate and sustain partnerships must be developed.

41. Inputs required from donors included: increased funding for the creation of new health research multilingual networks (other research partnerships) and enlargement of existing ones; supporting and encouraging equitable transfer of technology in a manner that benefits all partners; and permitting inclusion of salaries as part of research costs to foster equity among collaborating researchers and retention of human resources for health research.

42. Potential projects for strengthening collaboration include those aimed at: strengthening research management and networking; coordinating the gathering and wide dissemination of existing information on research capacities, institutions, networks and activities in the Region; setting up an observatory on research for health; formalizing the code of conduct for partnerships, e.g. that of EDCTP; tracking expenditures on research for health from various sources/partnerships; setting up national, subregional and regional centres of excellence that foster collaboration, joint learning, and training of junior researchers; integrating civil society organizations and communities within research processes; and building capacities in contract negotiations for partnerships, high level quantitative analysis, and new information technologies.

PARALLEL SESSION 1.3 –ETHICAL POLICIES AND PRACTICES

43. The paper entitled “Research Ethics Policies and Practices in the African Region” was presented by Dr Sonali Johnson of the London School of Hygiene and Tropical Medicine. The report was based on surveys conducted by the WHO Regional Office among ministries of health and institutions conducting health research. There was a high rate of response to the surveys as 44 of the 46 ministries of health and institutions in 43 Member States responded.

44. The results indicated that 73% of African countries do not have legislation related to health research. Only seven countries reported having a law on health research, six of which addressed ethical issues. On the other hand, 67% of the institutions reported the existence of national legislation or regulations for establishing ethical standards. This inconsistency in the findings may indicate a lack of knowledge or the possibility that ethics might be covered under other legislation e.g. criminal legislation.

45. In general, there seems to be limited information on national ethics policies and guidelines in the national level questionnaire. About half (50%) of the countries reported having a national ethical review council, while 60% of the institutions reported having ethical review committees. Only 41% of research institutions have policies on research ethics, and a similar proportion have a policy of obtaining written informed consent. Seventy-three per cent of the research institutions reported having a functional ethics review committee while more than half of all countries reported having a national ethical review council. About 40% of the institutions that responded (n=365) reported having no ethics review committees, while one-third of these institutions reported having one committee. Only one half of the countries reported having a scientific review committee, while slightly over 40% reported having both an ethics review committee (ERC) and scientific review committee (SRC).

46. With regard to monitoring research activities, about one-fifth of institutions (22%) reported having policies in place to monitor ongoing research work. Only one-fifth of the institutions surveyed reported that the ERC would disapprove of a project that did not have the realistic prospect of serving the health needs of the population (e.g. does the research conform to a formal list of national priorities?)

47. The participants in the parallel session found it satisfactory that most of the countries in the Region had ERCs although there were some inconsistencies in the responses from the ministries of health and research institutions. It was however observed that training in ethics was limited as there was limited institutional support and that decentralized systems of ethics review may lead to ‘fragmentation’, inconsistent operating procedures, and ‘ethics review ‘shopping’. The key obstacles identified were lack of legislation, globalization, particularly multinational collaboration, pressure from external sponsors of research (ethics committees only set up in response to these so this leads to issues around sustainability), unclear roles of various ethics-related structures and guidelines, and lack of a single supervisory research ethics body.

48. It was recommended that legislation of research ethics must go hand in hand with strategic policy and that stewardship in terms of having national structures for providing leadership and oversight on mainstreaming the roles and responsibilities of various national ethics committees and councils should be promoted. It was important that the functions of the various structures be well defined and clarified. Countries should consider ways in which to improve knowledge and capacity

on research ethics and also increase collaboration with other countries that have strong ethics systems.

PLENARY SESSION 2 – FINANCIAL FLOWS AND FUNDING OF NATIONAL HEALTH RESEARCH SYSTEMS, HUMAN AND PHYSICAL RESOURCES

49. The plenary session on Financial Flows and Funding of National Health Systems, Human and Physical Resources was chaired by Prof. Rose Leke, Professor of Immunology and Parasitology, Faculty of Medicine and Biomedical Sciences, University of Yaounde 1, Cameroon. Dr Sara Bennett, Manager of the Alliance for Health Policy and Systems Research made a presentation entitled “Money, People and Institutions: Health Research Capacity for Africa”. The presentation focused on three areas: (i) a systemic and institutional approach to capacity development and not just money and people; (ii) re-thinking how to fund research and development assistance in order to enhance country leadership; and capacity development throughout the research cycle: not forgetting the resources needed to apply evidence to policy and action.

50. Dr Bennett presented data to show that there was a rapid scale up of aid for health and population activities between 2002 and 2006, with an increase of around 25% per year. There was also an increased government investment in health and a continuous and gradual increase in expenditure on research for health. However, there was inequity in geographical distribution with only 5% of research spending directed at meeting the needs of low and middle income countries although 62.5% of child deaths in these countries could be averted through improved use of existing technologies.

51. There is a fragmented funding characterized by a number of small grants from different partners that can push the agenda in very different directions. This increases transactional costs leaving too little for real research. There is a need for strong government leadership to ensure that all this fragmented funding will be coordinated and used to maximize the impact of health research. On the whole, capacity building for research in the Region is weak – 29 out of 53 (54%) African countries offer no postgraduate training in public health, with the largest gaps in Lusophone and Francophone countries. Very few articles are actually published in international journals due to limited quality of training, quality and quantity of human resource, and the level of funding.

52. The systematic approach to building capacities for health system research refers to the people, institutions and activities whose primary purpose is to generate high-quality knowledge that can be used to promote, restore and/or maintain the health status of populations. It includes the mechanisms adopted to encourage the utilization of research. Capacity for health research should be analyzed in terms of the organizational capacities, the organizations that can be involved in health research and their expected functions. There is need to build human resource capacities for health research, develop competencies in priority areas related to health research, and have strong institutions that can retain trained staff. The issue of brain drain is crucial and needs to be addressed by improving the work environment (in terms of availability of resources, leadership role in health research and possibilities for networking) and raising the incomes of health workers.

53. Dr Bennett observed that models of external funding for research are heterogeneous with high levels of short-term and fragmented funding, which undermines the long-term development of the health research system. The use of technical assistance for health research does not help long-term development of health research system, because technical assistance is in general over-priced, ineffective, tied to donor conditionality, and limits local ownership and investment. The need to

invest in strengthening the entire institution including the human resource as well as the enabling environment for capacity building was stressed.

54. An analysis of capacity development initiatives shows that most of them are mainly focused on priority setting and knowledge generation and very little on filtering evidence and policy making. In terms of capacity to apply research evidence, there is need to build the capacity of policy-makers and leaders to demand evidence when defining, reviewing or approving policies. Some of the key obstacles to the application of research evidence by policy makers include lack of incentives for use of evidence; limited skills to identify situations where research can be helpful in articulating research questions and accessing research findings; existence of relatively few policy makers with research training; inadequate financial resources for commissioning studies; limited information and communication technology; limited mechanisms to engage researchers; and lack of empirical evidence as to what works.

55. Strategies for enhancing capacity to use evidence in policy making include enhancing the supply of policy-relevant research products for example supporting systematic reviews and policy briefs; enhancing capacity of policy-making organisations to use evidence (training for staff, incentives for evidence use), establishing new organisational mechanisms to support evidence use, promoting networking, and establishing norms and regulations (which require publication of evidence base for reforms, mandatory evaluations). The presenter gave examples of knowledge translation initiatives such as EvipNet and REACH that were being used in the Region and called for innovation, monitoring and evaluation in this area.

56. In conclusion, Dr Bennett called for the following:

- building system-wide capacity—investing at institutional level is key, researchers need to be motivated and there is need for strong African leadership in developing long-term capacity development plans;
- re-thinking funding for health research - funding for short-term consultancies should be redirected at longer-term research capacity and funding models that foster equitable North-South and South-South partnerships should receive emphasis;
- capacity development for knowledge translation should be prioritized and receive much greater investment and there is need for development and assessment of innovative strategies that enable policy makers, managers, clinicians, media and civil society to better apply evidence in their work;
- measuring and learning from our actions – there is lack of reliable data on capacity for health research as well as limited knowledge about where the real bottlenecks are. Thus, there is need for more institutional and system assessments and more serious evaluations of capacity development initiatives.

57. In the discussions that followed the presentation, participants observed that national governments often do not have budget lines for health research and have not honored their commitments to allocate at least 2% of their national health budgets to research for health. In addition, external funding for health research is highly fragmented, leading to high transaction costs (partly due to multiple financial accounting and reporting) and weakening of national health research systems capacities. Concern was expressed about the rapid ascendancy of young PhD graduates to administrative and managerial positions, which has a high opportunity cost in terms of the research

outputs they would have otherwise produced. PhD holders teaching at the universities are often overwhelmed with heavy teaching loads and have very limited time for research.

58. It was recommended that countries create an enabling environment for research, including providing complementary research inputs and appropriate monetary and non-monetary incentives for human resources for health research. They should develop national health research policies and health research strategic plans and ensure that donors (partners) align their funding to national health research priorities. They should also have budget lines for research for health, fulfill the commitment of allocating at least 2% of their national health budgets to research for health, and earmark a percentage of that budget for research institutions. Countries should establish clear career development paths for human resources for health research and tap into the Diaspora human resources for health research to strengthen research capacities at home. In addition, countries should establish national observatories on research for health and appropriate national forums for disseminating research, as policy-makers often have no information on past and ongoing research in their countries.

59. It was also recommended that countries and partners focus their funding on the development of national health research systems and institutional capacities instead of focusing solely on individual researchers. They should institutionalize national health accounts to regularly track the flows of financial expenditures on health and research for health. The involvement of the private sector in research should be encouraged. More countries should be encouraged to become involved in the existing South-South Initiative Network on Health Research and more countries should be encouraged to join the Board of TDR.

PARALLEL SESSION 2.1 – FINANCIAL FLOWS, DONOR AND INSTITUTIONAL PERSPECTIVES

60. This session was chaired by Dr Ania Grobicki, Chair, Bamako 2008 Secretariat. The panellists were Dr Mary Anne Burke, Health Analyst, Global Forum for Health Research and Professor Hannah Akuffo, Swedish Agency for Research Cooperation with developing countries (SAREC) of the Swedish International Development Cooperation Agency (SIDA). Dr Ritu Sandana, Acting Coordinator, Equity Programme, WHO headquarters made a presentation entitled “Expenditures on health research in African countries, 2005”.

61. It is critically important to track financial flows to better understand, influence and monitor the level and use of funds with a view to obtaining the best impact from health research in countries and to advocate for global support for research that impact on the health of low-income and middle-income countries. The data reported in the paper was obtained from Health Research System Institution Survey in 44 African Countries (WHO, 2007). The presentation reported on health research expenditure estimates for Africa in 2005; health research funding by source; research expenditure by expense item; research expenditures by research topic; and other findings.

62. There were four main findings. Firstly, in 2003, approximately US\$ 125.8 billion was spent globally on health research, out of which US\$ 4.1 billion was spent on low- and middle-income countries¹. The minimum spending on health research in Africa in 2005 was estimated at US\$ 517.5 million, which represents roughly 13% of the 2003 total spending in low- and middle-income

¹ Source: Global Health Research Forum

countries and about 1.3% of the combined Total Health Expenditures (THE) of the 37 African countries covered.

63. Secondly, funding sources for research institution activities are reflective of their functions and operational structures. Research by medical schools and hospitals are partly funded from their own internally-generated funds. These institutions, as service providers, receive fees for services rendered. Government agencies' research relies on government budgets. Hospitals, medical schools, independent research institutions and NGOs rely heavily on donor funds.

64. Thirdly, most research institutions do research activities in-house and through contracts to individual persons. NGOs and other institutions spend more than one-third of their resources on research contracts to individual persons. Only independent research institutions report significant contracting of research work to other research institutions. The ratio of management cost to total research spending is about 2 percent (government agencies and hospitals) and 11 percent (independent research institutions).

65. Fourthly, most research topics receive funding from at least one type of health research institution. Research on the conditions, prevention and treatment of TB, HIV/AIDS and malaria accounts for a significant share of expenditures of most institutions, ranging from one-tenth of hospital expenditures to one-third of the expenditures of government agencies, medical schools, NGOs and others. Research on innovative practices and product development receives the least funding (only in hospitals).

66. As a first-time effort, the institution survey has provided new information and filled some data gaps. It has also provided insights and lessons about what needs to be improved in similar future surveys. There are respondent and questionnaire issues that need to be addressed to improve data quality and response rate particularly to the Financial Module of the survey. Concerning respondent institutions, there are issues as to whether they keep track of what they do in financial terms; whether they are willing to share financial data; and how the sharing of financial data can be promoted. The questionnaire design issues relate to how the design of the Financial Module questionnaire could be improved to encourage and facilitate its completion; and whether there is a better or simpler way to track health research performer expenditures by research topic.

67. In the course of the discussions, a number of research financing obstacles and barriers were noted, namely: dearth of external funding for research and product development for "neglected diseases"; low government funding for research; reluctance among donors to pay for research administration costs. Furthermore, many countries have not institutionalized national health accounts to track health expenditures including spending on research for health; donors funding is biased towards those countries with research and development capacities, which perpetuates existing inequities in health research financing; information on funds for research held by donor agencies is inaccessible; the research agenda is often imposed on African countries by those funding research; most of the external funding for research is tied to donor conditionalities, e.g. compulsory involvement of donor countries' researchers, importation of research inputs from donor countries, etc; reluctance of research institutions to share their data with other researchers; and low institutional response to the survey tracking expenditures on health research.

68. The session participants made recommendations for countries to improve funding options, information resources, research capacity building, analysis, and accountability mechanisms. Regarding funding options, it was recommended that Sector-Wide Approach (SWAP) may be an

option for Research and Development; health research and development should be situated within the larger national science and technology to facilitate drawing of resources from a larger context of national budget pool; advocacy is needed for inclusion of research administration costs in budgets for research grants; young researchers should be allowed to apply for research funding; and the private sector should be encouraged to invest in research and generic product development that will build the capacity of young African researchers and innovators and boost South-South cooperation.

69. In order to improve information resources, the session recommended the establishment of structures, tools and systems to facilitate allocation of resources directly for research for health. For example, this may entail incorporating research within health management information systems. In addition, researchers should demonstrate to decision-makers the usefulness (for policy, planning, product development, etc) of the research outputs produced with the allocated funds.

70. In order to improve research capacities, it was recommended that national universities be encouraged to start-up PhD programmes in order to build a critical mass of human resources for health research; constitute joint North-South and South-South cooperation research platforms for capacity building; and leverage industry support for research leading to innovation and product development.

71. It was also recommended that researchers in African countries should conduct systematic analyses of needs for funding of research, infrastructure, and environment for research for use in advocating health research priorities to donors. In addition, there was a recommendation to conduct an Africa-wide analysis of country-specific research priorities and amounts of resources currently being invested into research. Finally, it was recommended that strategic plans be developed at national and institutional levels based on calculation of the true cost of doing research, not just overhead, but real costs, libraries, research management, mentors, etc.

72. In order to strengthen accountability mechanisms, it was recommended that governments should honour their commitment to spend 2% on research for health and develop clear budget lines for research for health and indicators for financial monitoring; national health accounts should be institutionalized to facilitate tracking of health research expenditures; donors should be held accountable for the allocation of 5% of total aid budget for research and development; and mechanisms for joint review between countries and donors should be institutionalized.

73. It was recommended that donors focus their funding on young researchers to strengthen their capacities for innovation; and sharing of vital equipment for product development targeted at national priority areas. Donors should also increase their funding for strengthening North-South and South-South health research collaboration around core issues such as the Millennium Development Goals.

74. The participants in this session made a number of recommendations for inclusion into the resolutions to be passed at the upcoming Bamako World Conference. Firstly, research for health should be made a factor of development involving all relevant ministries, e.g. health, science and technology, education, economic development, finance, agriculture, trade and commerce. There may be a need to hold a large consultation as part of the Bamako follow-up process.

75. Secondly, there should be assurance that national surveys for tracking financial flows for research for health would be institutionalized within National Health Accounts, Health Management Information Systems and National Statistical Offices to ensure that the information is updated, analysed and reported regularly.

76. Finally, an African research for health funding body should be established to receive and manage funds from donors, national governments and others to allocate research grants based on agreed-upon African research for health priorities aimed at ensuring health for Africa's peoples. In that regard, there was need to build in criteria to ensure, among others, that funding would not go to individuals where there would be no institutional capacity building, knowledge generation and sharing, etc.

PARALLEL SESSION 2.2 – COUNTRY HEALTH INFORMATION SYSTEMS

77. The paper entitled "Health Information Systems in Africa: resources, indicators, data management, dissemination, and use" was presented by Dr Stein-Erik Kruse, Centre for Health and Social Development, Norway. He indicated that the paper was based on a self-assessment on country health information systems in 16 of the 46 countries in the Region. The Health Metrics Network's (HMN) scoring criteria on six dimensions (resources, indicators, data sources, data management, information products, and dissemination and use) was used to rank countries in the study.

78. The overall findings of the assessment were that there were inadequate policy frameworks and legislation, strategic plans were lacking and coordination mechanisms were weak. About half of the countries reported that resources for HMIS were present but not adequate. Lack of policy frameworks (44%) and human and financial resources (48%) were identified as the most important impediments to strengthening HMIS. On the other hand, two-thirds of the countries reported having adequate infrastructure for HMIS.

79. Eleven of the 16 countries reported having adequate indicators for national purposes as well as the health-related Millennium Development Goals. Household surveys were reported as adequate data sources in most of the countries, while vital statistics were not performing well and were difficult to sustain. Censuses were rated as "adequate" although many countries were unable to conduct them in the past 10 years.

80. Data management was categorized as "inadequate" in most countries mainly due to lack of clear procedures for collection, storage and dissemination of data. There were various sources of data, but most of these are not harmonized. About two-thirds of countries rated health information products as "adequate", indicating the availability of accurate and reliable data for national core health indicators. However, data on access to services and essential drugs were lacking in most countries. Data on coverage is often adequate. The dissemination and use of HMIS data was categorized as "present but not adequate" (58%). Resource allocation in this area seems to be a major setback for improving the dissemination and use of health information data.

81. The participants called on countries to take full advantage of the HMN assessment tool in order to assess the situation of their country information systems. The results should be used to prepare multi-year costed strategic plans developed within joint sector investment frameworks as these plans would form a basis for attracting financing and for harmonization and alignment. Countries were urged to increase and sustain investments in human capacity building systems for all aspects of health information systems, including analysis and use of data, data management, and use of computer technology applications. In addition to donor financing, countries were encouraged to actively seek funding for health systems strengthening from the Global Fund to Fight AIDS, TB and Malaria and other funding mechanisms.

PARALLEL SESSION 2.3 – HUMAN RESOURCES

82. The paper entitled “Human Capacity, Training for Research and Staff Movement in African National Health Research Systems” was presented by Dr George Pariyo, Senior Lecturer and Head of Department of Health Policy, Makerere University, Kampala. The paper presents a synthesis and profile of human capacity and training for health research as well as staff movement in national health research systems. It is a result of a review of available literature and a preliminary analysis of primary data collected during a survey undertaken in 46 African countries by the WHO Regional Office for Africa.

83. The literature review showed that much of the research is conducted in academic settings and that most African countries have severe human resource for health shortages. It was also noted that there is low capacity for providing training in health-related research and, to address this situation, some African countries have created their own public health schools, which constitutes the main source of health research training. However, the countries are still unable to meet the huge need for adequate training in health research. Therefore, substantial numbers of professionals are educated abroad and, at the end, settle in developed countries after completing their studies. The review also showed a critical shortage of senior staff due to migration, illness or internal transfer to better-funded positions. Factors accounting for low staffing levels include inadequate pay, poor working conditions and unattractive terms of service.

84. The objective of the survey done by the WHO Regional Office for Africa was to provide estimates for benchmarks of national health research systems as a means to describe, monitor and analyse national health research activities, improve national research capacities and share experiences across low- and middle-income countries. The method used was circulation of self-administered questionnaires to institutions considered to be involved in health research and, at the close of April 2008, data from 44 countries had been obtained representing an overall response rate of 96%. The total number of institutions surveyed was 702.

85. The results of the survey showed that there is a serious shortage of qualified staff engaged in health research; females are under-represented among health researchers; the number of institutions engaged in health research is small in most countries; and only a few institutions produce staff at master’s or doctoral degree levels. Ninety per cent of the employees work on full-time basis, only 16 countries had 50% or more of professional staff employed as researchers and the majority of health researchers were from medical schools (24.8%) and other universities (22.2%). Research doctorate degree holders as a percentage of health researchers are predominantly based in government agencies (32.6%) and holders of masters degree are found mostly in other universities, NGOs and charitable organisations and other business firms.

86. During the discussions, participants recommended that countries focus on: integrating research into their national development programmes; strengthening national or regional training capacity in research; including research on priority health problems in health sector plans and budgets; developing national HRH plans and establishing national observatories in which research for health is incorporated. There should also be mobilisation of local resources, especially countries with better economic situations and “sandwich” training should be encouraged between South and North. External support is also needed to increase capacity to produce qualified health researchers in a number of countries.

87. The key obstacles identified were low prioritization of research by countries; lack of coordination in funding flows for research; low public awareness of the positive role of research; low level of funding at national level; poor pay in Africa, higher salaries elsewhere; poor access to technology; and very low motivation to embark on health research. The participants proposed that donors should: support South-North collaboration, using the approach outlined in the Paris Declaration on alignment and harmonization to make aid more effective; establish coordinating and funding mechanisms; increase development assistance to 0.7% and should commit themselves at a high political level.

PARALLEL SESSION 2.4 – INSTITUTIONAL FACILITIES AND FIELD SITES

88. The paper entitled “Institutional Facilities in African National Health Research Systems” was presented by Ms Marion Motari of the United Nations University, Maastricht, the Netherlands. The paper provided insights into the status of institutional facilities and supporting research infrastructure of health research institutes in the African Region based on data received from 42 countries. It covered issues such as availability and connectivity of information and communication technology, library resources and laboratory operation and resources.

89. The availability and use of ICT facilities in the institutions surveyed was on the whole low. Less than a half of the institutions surveyed have institutional web sites and less than a half provide email addresses to research staff. The presence of a data storage server was critical as institutions that had servers also had a web site and staff email addresses and information technology support.

90. Less than a half (only 46%) of institutions surveyed had a library. Most of libraries do not have online catalogues and very few (32%) of libraries had internet connectivity. Only 28% of libraries had online catalogues and subscription to electronic journals was very low. Most of the institutions that subscribed to international journals also subscribed to locally and regionally published journals. It was observed that on the whole, despite access to ICT infrastructure, health research institutions in Africa did not use these infrastructures for library services.

91. Over 50% of the institutions surveyed reported having laboratories. National reference laboratories were in all instances accredited. Approximately half (48%) of the laboratories had written safety code and procedures. Fifty-eight per cent of the laboratories had attained Level 1 basic bio-safety, 44% had Level 2 basic bio-safety, 25% had containment bio-safety and only 14% had attained maximum containment bio-safety. Most of the laboratories had sterilization equipment, protective clothing and a means for safe disposal of agents. However these laboratories lacked other critical facilities such as personnel safety monitoring capacity, effluent treatment capability, ante rooms and airlock with showers.

92. The participants in the parallel session noted that lack of capacity to establish and maintain databases, inadequate skills, inadequate funding, absence of quality control and assurance systems, lack of equipment and maintenance technicians, and lack of systems for waste disposal were key obstacles in this area. It was recommended that countries should improve laboratory access to electricity including the use of solar and renewable energy; develop plans and guidelines for improving the capabilities of laboratories; establish accreditation and quality control assurance schemes and enforce laboratory standards; and establish local networks of both public and private laboratories. Governments were also urged to pay attention to bio-safety and bio-security including establishing shared facilities for risk management (Risk 3 and 4), supporting training and career development for laboratory technicians, and fostering South-South collaboration.

93. The participants called on WHO, other development partners, and donors to support the establishment of national and regional centres of excellence, accreditation and certification schemes, and the training of laboratory scientists.

PLENARY SESSION 3 – PRODUCING AND USING RESEARCH TO IMPROVE HEALTH

94. The plenary session on Producing and Using Research to Improve Health was chaired by Dr Paul Samson Lusamba-Dikassa, Director of Programme Management, WHO Regional Office for Africa. Dr Robert Ridley, Director of the WHO Special Programme for Research and Training in Tropical Diseases made a presentation entitled “Money, People and Institutions: Health Research Capacity for Africa”. Dr Ridley’s presentation focused on concepts of how research is taken from observation to the laboratory and its use to develop interventions, some historic public health stories, and lessons learned from the public health stories.

95. Dr Ridley drew attention to the fact that that research means different things to different people. For some, it is about new discoveries, while to others it is about new tools, interventions, or strategies. However, for all types of research to make an impact, they need to have two cross-cutting disciplines: knowledge management (intelligence) and capacity development. Evidence comes in a multidisciplinary continuum - from ideas to research or tools to knowledge management to policy decisions. Throughout these steps, i.e. from the beginning of the discovery to end-use of the product, the various processes must interface and work together through continuous feedback mechanisms. The Director described how complex it is to translate research findings into policy or action. The world of research and that of policy are not on a one-way path, but are on continuous dialogue with each other. Research must shape the way health policies work, and health policy mechanisms must demand the type of research it requires in order to achieve the necessary health outcomes.

96. Dr Ridley recounted some stories that represent historic landmarks of how research and public health policy interfaced in order to control communicable diseases. These included John Snow’s discovery of cholera transmission through water from certain pumps in London in 1854 and how it took about 14 years for the scientific community to accept the theory following the work of William Farr in 1868. The lesson to be drawn from this historical event is that new discoveries will not necessarily be followed by instant adoption and use and that further studies and tools are required.

97. He also reminded the participants that the success story surrounding the eradication of smallpox is a well-documented interface between research and health impact. He described some of its historical events from the variolation era in India and China in the 10th-11th century to the World Health Assembly resolution on eradication of smallpox in 1959 and then to its ultimate eradication in 1980. The story of smallpox eradication presents a classic example of how public health impact can be obtained through mutual interaction between research, policy, and service delivery.

98. Another classic example of the interface between research and policy is the discovery and use of Artemisinin-based combination therapy (ACT) against malaria. Although the use of artemisinins has been documented since 200 BC, its recognition as a potent antimalarial materialized only in the early 1990s, after many years of public health research debate. Furthermore, many malaria-endemic countries have recently changed their antimalarial treatment policies after TDR-sponsored studies showed that artemisinin-based combination therapy is far superior to using artemisinin alone. This again demonstrates how research affects the decision-making process for effective public health tools. Research not only demonstrated the benefits of ACTs, through multi-country studies, but

showed that ACTs are safe and effective for paediatric use as well as community and household management of malaria.

99. Dr Ridley also recounted the success story regarding the control of onchocerciasis, including the creation of the African Programme for Onchocerciasis Control (APOC) in 1995 and its community-directed treatment with Ivermectin (CDTi) a year later. Through evidence-based interventions, today, more than 70 million people in sub-Saharan Africa have received CDTi and the target is 100 million by the year 2010. Again, through a multi-country, multi-centre study involving 35 districts and 2.4 million people, multiple public health interventions such as malaria treatment, ITN, vitamin A supplementation, and DOTS, can now be integrated with CDTi in order to reduce missed opportunities. However, further evidence is required to demonstrate the cost-effectiveness, incentives, urban areas, and nomadic and refugee population of this multi-intervention strategy.

100. In conclusion, Dr Ridley underlined the importance of basing major public health decisions on knowledge, in the same way as all historic observations lead to new knowledge and subsequently to effective policies. Experience and insight (research skill) adds value to 'book knowledge' and can lower costs and increase the chances of success. More research is required on how manufacturing and marketing, drug development, and policy development processes can effectively talk to each other in order to lead to a lasting public health impact. Global resolutions such as World Health Assembly resolutions and the Abuja Declaration call for extensive investment in health research - 2% of national health budgets and 5% of donor support for health. He emphasized the need for Africa to strengthen its health research culture, allocate more national resources to research, and establish an African Network for research into new medicines. He pledged the continued support of TDR to foster an effective global research effort on infectious diseases of poverty in which the disease-endemic countries play a pivotal role.

101. Several of the issues that were discussed after the presentation centred on the interface between research and policy. Concern was expressed on the long period between research findings and policy design and implementation, and the lack of capacity of researchers to effectively communicate research findings to policy makers. It was recommended that the conduct of research should involve joint participation by researchers and policy makers throughout the whole process, starting from research prioritization to implementation and interpretation. There is also need to develop monitoring and evaluation systems to guide policy decisions based on research as some policy decisions can be misleading.

102. It was observed that while it is human nature to rally round new technologies and tools, the priority in Africa should be to find innovative ways to deliver known tools and interventions, hence the importance of health systems research, including social, behavioural and operational research. The need to involve communities in the planning, design and conduct of research activities was emphasized. Participants concluded that in order to improve health research in Africa, additional resources must be allocated. Research needs investment and development, as in the case of Europe and United States, where tremendous funds have been allocated for health research, leading to the development of infrastructure and a culture of health research.

103. The session ended with contributions by the WHO Regional Directors for Africa and Eastern Mediterranean. Dr Sambo of the African Region emphasized the need to give additional attention to health systems research, policy, and human behaviours. He indicated that there was a growing need to create demand for evidence in the African Region as data are stored in data warehouses of research institutions and not disseminated to health programme developers. He reminded the participants of

the need to provide additional support to the currently weak health information systems of the countries in the Region. Dr Gezairy of the Eastern Mediterranean Region, recalled the strong partnership between that Region and TDR and stated that research should not be in the abstract but should rather respond to a felt need. He recounted how a South-South collaborative research resulted in an effective response to an outbreak of heat stroke during a summer-time pilgrimage in Mecca.

PARALLEL SESSION 3.1 – RESEARCH OUTPUTS, EVIDENCE TO POLICY AND DECISION-MAKING

104. The paper entitled “Health Research Outputs, Synthesis, Dissemination and Knowledge Management” was presented by Prof. Guillermo Paraje of the University of Adolfo Ibanez in Chile. The report is based on results from 830 institutions in 44 countries and presents information on health research outputs, synthesis, dissemination, and knowledge management.

105. On the question about the most important contribution of research institutions since 2000 (484 institutions responded to this question) the most frequently mentioned option was “Production of new knowledge” and 36% of the institutions mentioned it as their top contribution. The second contribution most frequently mentioned was “influencing health policies and programmes” with an average of 16% and the third was “contributing to train highly-skilled people for labour markets, especially for knowledge-intensive jobs requiring special expertise”, which scored an average of 11%. Concerning the least important contribution, of the 420 institutions that responded to this question, 39% mentioned “increasing profits”, 10% mentioned “developing products” and 10% mentioned “being a technological leader”. These results show that publishing researches is not so important for these institutions and that revenue-generation is not among their main objectives.

106. With regard to the production of knowledge during the previous 12 months, the responses were grouped in three components: academic publications and dissemination, non-academic publication dissemination and patent registration. The results showed that the main producers of academic publications were medical schools and government institutions, followed by hospitals and other institutions (NGOs, charities, etc) and other universities. Concerning non-academic dissemination, the main institutions are government agencies followed by other institutions (NGOs, charities, etc). Concerning the patent registered nationally or internationally, only ten countries reported any patent at all. It is possible that the lack of adequate information on what is being done in institutions in larger economies such as Nigeria and South Africa is responsible for the very low numbers of patents registered because this depends on the linkages between research institutions and productive firms, which are expected to be more frequent and strong in larger economies.

107. A similar picture was on the issue of academic and non-academic research outputs. Medical schools are the main producers of academic health research outputs, accounting for almost 60% of the total academic research outputs, followed by independent research institutions and government agencies. The production of non-academic research outputs is mainly done by NGOs, charities and other institutions.

108. With regards to the frequency with which wider publication and dissemination events are organised during the previous 12 months, more than 2100 academic events were organised by the surveyed institutions, mainly by government agencies (23%), hospitals (21%), medical schools (20%) and independent research institutions (19%). Concerning non-academic events, 1689 were organised mainly by government agencies and other research institutions with each accounting for

25%. Less than 500 forums were organised and, again, the main contributors were government agencies and independent research institutions.

109. On the issue of maintenance and publication of databases containing information on ongoing research project and research findings, it was found that almost 250 databases exist and that a third of them belong to government institutions. Of the 248 existing databases, 62% are accessible to the public. Government agencies and independent research institutions' databases are the most open ones with respectively 68% and 64% of their databases accessible to the public.

110. During the ensuing discussions, participants proposed that countries should ensure that health research is in line with their health priorities. Countries should also facilitate regional approaches by creating regional centres and laboratories of excellence, defining regional research priorities and research topics and by sharing expertise. Policy-makers and donors should be involved in the process of development, monitoring and dissemination of results. There is also need both to ensure funding for dissemination of research results and to define indicators for monitoring the use of research findings.

111. The main obstacles and barriers identified were: inexistence of coordination structures for health research; non-alignment of donor's research interests and national research priorities; insufficient training in research; lack of information sharing among researchers and between policy-makers and researchers; poor national financing for research in general and for health research in particular (lack of status, lack of research incentives or awards, poor enabling environment for research); inadequate access to scientific documentation; poor scientific publication and communication structures; difficulties in publishing in international scientific journals; and linguistic problems.

112. The priority actions proposed by the participants included the development of health research policy with the involvement of other concerned sectors and the creation of a coordination structure at national level including policy-makers, researchers, donors and users. This structure should facilitate and coordinate: training of researchers in the use of tools and in knowledge management; organisation of coordination and evidence dissemination meetings with all stakeholders; definition of research themes if necessary; mobilisation of the resources needed to fund relevant research; promotion of research; and utilisation of research findings to develop health policies.

113. Donors were urged to support the different initiatives such as training of researchers, collaborative South-South and South-North researches, creation of regional centres of excellence, creation of local and regional scientific publications and journals and transfer of technology (between South-South and South-North researchers). They are also expected to facilitate multisectoral collaboration (health, education, research, agriculture, social affairs, etc).

PARALLEL SESSION 3.2 – HEALTH INFORMATION SYSTEMS: DATA SOURCES

114. The paper entitled “The State of Health Information in the African Region: Data Sources, Information Products and Health Statistics” was presented by Dr Yohannes Kinfu of the Measurement and Health Information Systems Department of WHO. The paper described the various types of data sources for health information systems, such as population censuses, civil registration of vital statistics, household surveys, routine service statistics, health facility assessments, and demographic surveillance.

115. Civil registration is the continuous registration of vital events such as live births, deaths, foetal deaths, marriages, etc. Only three countries—Algeria, Mauritius and Seychelles—have a birth registration coverage of 90% or higher. The birth registration coverage for most of the countries in the Region is below 20%. Death registration coverage is similarly very low across the Region—as only four countries (the three above and South Africa) have 75% or higher. One of the probable reasons for this poor coverage is that there is no penalty for not registering a vital event and the public does not see the need to register such events.

116. Census data is another important data source—as it is the basis for population-based information for all sectors. Available data shows that four countries have not conducted any national census in the past twenty years. The vast majority of countries in the Region have conducted national censuses in the past 10 years. As in the case of vital registration, conduct of census is also inadequate as some countries such as the Democratic Republic of Congo and Eritrea have not conducted any census in the last 10 years. Only South Africa has conducted a census every five years.

117. Household surveys are becoming more popular and tend to compensate the relatively poor performance of the routine health information systems. The most commonly used household surveys are the Demographic and Health Surveys (DHS) sponsored by USAID with increasing contribution of other health development partners. The DHS is currently used as a domain for important biomarkers such as HIV and syphilis infections. Since 2000, over 120 household surveys have been conducted in the African Region.

118. The participants in the parallel session noted that weakness of human resource capacity, lack of standardization, verticality of programmes, lack of feedback to local actors, and lack of integrated national health information strategies and plans were barriers and obstacles. Furthermore, they recommended that countries take the following actions: encourage more evidence-based decision making; link health research and health information/statistics; build analytical and data management capacity through long-term and on-the-job training; encourage development of national health information strategies using the HMN framework; develop long-term costed strategic plans for strengthening the system; establish regional health observatory; strengthen routine system (service statistics) including validation of data; establish or strengthen other sources of data including DSS, regular census, etc; learn from best practices in the Region and beyond; and limit political interference.

119. WHO, other development partners and donors were called upon to support the provision of technical skills and training, harmonization of HIS, institutional capacity for health research, more regular censuses, surveys and other systems, and to fund national plans to strengthen national health information systems.

PARALLEL SESSION 3.3 – KNOWLEDGE SYSTEMS IN HEALTH

120. This session on Knowledge Systems was chaired by Dr Shungu Munyati, Ministry of Health, Zimbabwe. The panelists were Dr Margaret Mafe, Member, Steering Committee Algiers Conference and Dr Chad Gardner, Research Policy and Cooperation, WHO headquarters. Mr Chris Zielinski, Technical Coordinator, Research for Health, WHO/AFRO introduced the technical paper entitled 'Knowledge systems in health in the African Region'. The paper consisted of the following sections: Introduction, Review of International Data, Knowledge Systems in Health Survey, and some Conclusions and Recommendations.

121. The survey of knowledge systems in Africa was based on questionnaire data from 46 countries and covered the use of knowledge in health policy formulation and provision of clinical services. Thirty-nine countries (85%) responded to the health policy questionnaire and 38 countries responded to the clinical services questionnaire.

122. Knowledge systems in health include all the mechanisms and systems of knowledge acquisition, creation, diffusion, application, evaluation and improvement. Knowledge is created and used in different ways. In many countries, the ministry of health is involved in health policy formulation, direction and guidance, as well as provision of clinical services, but policy implementation was mostly done at the local level in the majority of the countries assessed. The source of knowledge is a major issue.

123. There was a number of key findings. Central national bodies acknowledged that they have a major role to play in policy setting. Partners play a strong role in all aspects of policy work, i.e. from provision of advice to evaluation of results. Ministries of health and other central policy setting and implementing bodies tend not to have an explicit knowledge management framework and do not map knowledge sources and flows for policy making. Guidelines from WHO and other multilateral organizations were cited by all countries as being key sources of knowledge for policy. National guidelines and recommendations from surveillance data were also listed as important sources of knowledge by over 70% of countries.

124. National health policies are disseminated mainly through the mass media and rarely through the Internet. These policies are used by all stakeholders involved in the health sector. Fifty-nine per cent of countries in East and Southern Africa, 38% of countries in Central Africa, and 43% of countries in West Africa reported to undertake routine monitoring and evaluation of policy implementation. Some countries reported that they had used knowledge in the process of scaling-up health services and interventions aimed at combating communicable diseases, noncommunicable diseases, vaccine-preventable diseases, and maternal and neonatal mortality.

125. In most countries, electronic media records were either completely unused or used only in some hospitals or health centres, and by only some physicians in private practice, civil society and the traditional medicine sector. Seventy-nine per cent of countries cited the ministry of health as the source of health policy directives received at the clinical level while 64% of countries, cited it as the source of procedural guidance received at clinical level. Clinical services providers in all countries reported that they communicate locally with each other mainly through meetings and conferences, and through telephone and fax (77%). Communications with peers living abroad is mainly through meetings and conferences (87%), Internet and e-mail (86%), telephone/fax (69%) and newsletters and specialist journals (59%).

126. In the discussions that ensued, a number of barriers to knowledge systems in health were noted, namely: limited use of systematic reviews; rare conduct of monitoring and evaluation of health policy; lack of libraries, Internet services and computers; limited involvement of the media and communicators; difficulty to differentiate between innovation and implementation research; resistance to innovation; lack of clarity in the relationship between the national research system and national health research systems; strained relationship between the national health education system and national education system; influence on health policy by many factors outside the health sector; and lack of knowledge brokers to facilitate the translation of knowledge into practice.

127. The session participants made a number of recommendations to improve knowledge systems for health in countries. It was recommended that, since much of health information comes from health institutions, partners should assist ministries of health, especially departments of research and development (where they exist) in designing systems and mechanisms for better knowledge management. An enabling knowledge management environment should be created by setting up a national committee for knowledge management and developing national knowledge management plans to ensure a more coherent and well-orchestrated approach. In addition, countries should create and stock libraries, and improve computer connectivity and Internet access.

128. The establishment of an African Programme of Systematic Reviews to develop capacities for creating and applying systematic reviews in Africa was recommended. Countries were urged to incorporate knowledge ideas and techniques into medical, public health and nursing school curricula, and make use of Evipnet (Evidence-Based Policy Network) whose work involves prompting policy makers and researchers to talk to each other, identifying weaknesses in the research-to-policy process, and developing policy briefs to increase utilization of research in policy development and decision-making.

129. Since policy monitoring and evaluation are rarely mentioned in the surveys, guidelines on health policy monitoring and evaluation should be developed and disseminated through workshops at country level. In order to facilitate utilization of existing knowledge, existing pertinent studies in African countries should be disseminated to hospitals, peripheral health centres and the general public through country workshops, seminars and meetings. These efforts can be enhanced by leveraging new initiatives which have tools for networked knowledge to support health policy formulation (e.g. COHRED, TropIKA, AHPSR, African Health Observatory, GFHR, HMN, ECA, Scientists without Borders, etc) and involving the mass media to communicate knowledge.

130. Countries were asked to find ways of involving communities in knowledge production and management. For example, knowledge management experts could work with programme managers and communities during intervention-based and operational research. The knowledge generated through that process would enable programme managers to design programmes in a manner acceptable to communities. It would also help to demystify research.

131. The conclusion from this Parallel session was that knowledge systems in health methodology used in the surveys of knowledge in policy making and clinical services provision yielded clear and useful results. However, further work in this area could examine other layers of the system and develop a clear-cut baseline against which to assess the effectiveness of interventions.

MINISTERIAL SESSION

132. The ministerial session was held on 26 June 2008 under the chairmanship of Mr. Amar Tou, outgoing Minister of Health, Population and Hospital Reform, Algeria. He welcomed the honourable ministers and heads of delegation to the Ministerial Session and recalled that the session would focus its deliberations on the Algiers Declaration which would be the basis for formulating a common African position on research for health for submission to the Global Ministerial Forum on Research for Health scheduled for Bamako, Mali in November 2008.

133. Dr Elias Zerhouni, Director of the National Institutes of Health (NIH) of the United States of America delivered a goodwill message in which he informed the Conference that the NIH had been very active in collaborating with researchers across the world, including Africa. He indicated that

NIH was keen to support the outcomes of the Conference. He underscored the importance of creating and supporting national health research and knowledge management centres of excellence to support the implementation of health programmes. He underscored the interdependence between health development and responsible production, management and use of research and knowledge. NIH looked forward to working together with all countries in the run-up to the Bamako Global Conference and beyond.

134. Dr Luis G. Sambo, WHO Regional Director for Africa, expressed his sincere gratitude to the President and people of Algeria for their warm hospitality and the excellent preparations that had been made for the Conference. He acknowledged the contributions of the Algerian authorities to research for health and to the training of health experts from other African countries. He underscored the importance of research for health in the social and economic development of countries and expressed confidence that the Conference would go down as an historical event in Africa. He hoped that the momentum developed in Algeria would not only culminate in the Bamako Declaration but also generate evidence needed to strengthen national health systems.

135. Dr Sambo acknowledged that despite the increasing resources being made available for health, there were still wide knowledge and financial gaps between developed and developing countries. There were also striking inequalities in the training and distribution of human resources for health and health research, in their career paths and in their research outputs within Africa. He called for increased investments in the strengthening of national health research systems and reminded the Conference that the Ouagadougou Declaration on Primary Health Care and Health Systems urged countries and partners to develop capacities for operational research in health systems.

136. Dr Sambo reiterated the need for a paradigm shift so that research would focus on local needs that took into consideration the cultural and socioeconomic contexts and the research results used for policy development and programming of health interventions. He called for stronger partnerships between researchers, programme managers and policy makers for effective application of research results. He endorsed the creation of a network of centres of excellence to provide support in this area.

137. The Regional Director acknowledged the contributions of countries, WHO headquarters and other partners in the successful conduct of the surveys on health information, research and knowledge management systems and expressed the hope that the results would form a good basis for planning, implementation and monitoring. He also acknowledged the contributions of the WHO Regional Director for the Eastern Mediterranean and thanked other partners for their participation in the Conference. He thanked also the honourable ministers and heads of delegation for their contributions to the Algiers Declaration and assured the Conference that WHO would continue to play its role of supporting countries in these areas.

138. Mr Boughazi Mohamed Ali, Presidential Adviser, opened the Conference on behalf of His Excellency the President of the Republic of Algeria, Mr Abdelaziz Bouteflika. He welcomed the honourable ministers, heads of delegation and delegates to the Conference which would, among other things, prepare for the Bamako Global Summit on Research for Health. He acknowledged the importance of research for the achievement of the Millennium Development Goals and recalled that all the previous commitments made in Mexico, Abuja, Accra and Ouagadougou underscored this fact.

139. He expressed concern that the gap between Africa and the developed world was increasing as a result of growing poverty, trade imbalance, poor governance, wars and civil conflicts, natural

disasters and others. He said that the international community should be mobilized to support research for health and that the recently-passed World Health Assembly Resolution WHA61.21 on Public Health, Innovation and Intellectual Property provided a good framework for research and innovations. In addition, the Africa Health Strategy 2007–2015 of the African Union acknowledges the importance of investing in research for health to produce the necessary products and tools for combating infectious and noncommunicable diseases. He called on countries to develop national health research policies and strategies and conduct research that addressed local problems. He indicated that Algeria was committing US \$ 1.3 billion for research that would cover areas such as prevention, epidemics, clinical trials, bio-engineering and others and that science and technology were key for the economic and social development of nations.

140. The Presidential Adviser indicated that His Excellency the President of the Republic of Algeria expected that the Conference would adopt the Algiers Declaration on Research for Health that would then feed into the Bamako Declaration. He hoped that countries would translate the Declaration into action in order to improve the status of research and health outcomes.

CLOSED SESSION

141. Deliberations on the draft Algiers Declaration were conducted in camera by the honourable ministers and heads of delegation.

ADOPTION OF THE ALGIERS DECLARATION

142. The Algiers Declaration was read out to the Conference by Ms Rachida Benkheli, Secretary-General of the Ministry of Health, Population and Hospital Reform, and Chairperson of the Steering Committee.

143. The declaration was then signed by the following countries whose ministers and heads of delegation were accredited to sign it on behalf of their national governments: Algeria, Angola, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Ghana, Kenya, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Kenya, Seychelles, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

CLOSING SESSION

144. The closing ceremony was conducted under the chairmanship of Mr Amar Tou, outgoing Minister of Health, Population and Hospital Reform.

145. In his remarks on behalf of the World Health Organization, Dr Hussein Abdel Abdel Razzak Al Gezairy, WHO Regional Director for Eastern Mediterranean, indicated that the challenges facing the Eastern Mediterranean Region were similar to those of Africa. He informed the Conference about the partnerships existing between the Eastern Mediterranean Region, WHO headquarters, other WHO Regions, and major research institutions. He apprised the Conference for the support being provided to Member States including capacity building, strengthening research infrastructure, provision of funding grants, and knowledge translation. He called on developing countries to adopt a culture of research in order to generate knowledge for mounting effective responses to local needs.

146. Reading out a vote of thanks on behalf of the Conference, Dr Safiatou Thiam Sy, Minister of Health of Senegal, expressed the gratitude of the honourable ministers and heads of delegation to the

His Excellency the President, the Government and the People of Algeria and the Steering Committee for successfully organizing the Conference and for their excellent hospitality. She said that the Algiers Declaration would be the common voice of Africa at the Bamako World Forum on Health Research.

147. The Conference was closed by Dr Said Barkat, incoming Minister of Health, Population and Hospital Reform of Algeria. He thanked Mr Amar Tou, newly-appointed Minister of Transport and outgoing Minister of Health, Population and Hospital Reform, for his able leadership and the organizers for the successful conduct of the Conference. He recalled the process used for the preparation and adoption of the Algiers Declaration including the work of the Steering Committee, the Regional Consultation, and the meetings of experts on the draft Algiers Declaration and indicated that the Declaration covered all the issues needed to give renewed momentum for strengthening health information, research and knowledge management systems in Africa.

148. Dr Said Barkat reiterated the need to increase investments in health systems and research for health, establish networks of centres of excellence for research, and set up an African Fund for Health Research in order to implement the commitments set out in the Algiers Declaration. He said that the declaration was “proof of the commitment of Africans to shoulder their responsibility of tackling health problems”. It was his expectation that the Algiers Declaration would be consolidated into an Africa common position for submission to the Bamako Global Ministerial Conference on Research for Health.

ANNEX 1

Membership of various committees and WHO/AFRO Secretariat

Steering Committee

Burkina Faso, KI-OUEDRAOGO Salimata Chef de service Recherche en Santé
Ministère de la Santé (DEP)

Burkina Faso, KOUYATE Bocar Amdou, Médecin chercheur, Ministère de la Santé

Ghana, VORDZORGBE Esther, Senior Officer, Health Research

Ghana, WILSON Michael David, Deputy Director, Noguchi Memorial Institute for Health Research

Kenya, MULESHE Stephen K

Mali, DIAKITE Oumou Maiga

Mali, TRAORE Amara Chérif
Conseiller Technique Ministère de la Santé

Nigeria, INYANG Uford S, Director-General, National Institute of Research and Development

Nigeria, MAFE Margaret A, Focal person, Federal Ministry of Health, Federal Secretariat of Health Research PHASE III, Abuja

Rwanda, NIZEYIMANA Vianney Directeur pour la recherche et développement
Ministère de la Santé

Sénégal, DER Doulo Maître en sciences de la Santé
Ministère de la Santé et la Prévention Médicale

WHO Liaison Officer, Dr Bah Keita

Algerian Organizing Committee

Chairperson: Mme Rachida Benkhelil, Secretary-General, MSPRH²

Prof. Khireddine Khelfat, Ministerial Counsellor, MSPRH

Prof. Zaia Chentouf Mentouri, Director General of the National Agency for Health Research (ANDRS)

Prof. Kheira Bendissari, Deputy Director, Ministry of Higher Education and Scientific Research (MESRS)

Prof. Fadila Boulahbal, Chief of Institut Pasteur d'Algerie (IPA)

Dr Djamila Nadir, Chief of Noncommunicable Diseases, MSPRH

Prof. Moussa Arada, Dean of the Medical Faculty of Algiers

Prof. Abdelkader Semid, Ministerial Counsellor, MSPRH

Dr Rachid Bouakaz, Director of Health Services, MSPRH

Mr Aissa Faci, Director of Human Resources, MSPRH

² Ministry of Health, Population and Hospital Reform

Dr Mohamed Ouahdi, Director of Prevention, MSPRH
Mr Louanes Smahdi, Director, Pharmacy, MSPRH
Dr Abdelkader Guennar, Ministerial Counsellor, MSPRH
Mr Zoheir, Ministerial Counsellor, MSPRH
Dr Kamel Kellou, Director-General, INSP
Mr Youssef Benkaci, Ministerial Counsellor, MSPRH
Mme Fatma Zohra Chaieb, Ministerial Counsellor, MSPRH
Prof. Mohamed Mansouri, Director-General, LNCPP, IPA
Prof. Kheireddine Bouyoucef
Prof. A. Helali, Director of Pharmaco-vigilance, IPA
Prof. Kamel Kezzal, Director, National Blood Agency
Prof. Mahmoud Touhami
Prof. Bachira Alamir
Mr Abdelhak Saihi, Director, ENSP
Dr Djamel Fourar, Deputy Director, MSPRH
Mr M'Hand Abdi, Deputy Director, MSPRH
Dr Saiima Magmoun, Programme Director, Health Services (DSS), MSPRH
Mr Abdelhamid Ayadi, MSPRH
Mr Lounnes Bouzidi, MSPRH
Mr Mohamed Amine Chergui, Director of Studies, MSPRH
Mr Abdelaziz Djafri, Minister of Foreign Affairs
Dr Mouna Bourezgue, Cabinet Attaché, MSPRH

Scientific Subcommittee

Prof. Khireddine Khelfat, Ministerial Counsellor, MSPRH (Ministry of Health, Population and Hospital Reform)
Prof. Zaia Chentouf Mentouri, Director-General, National Agency for Health Research (ANDRS)
Prof. Kheira Bendissari, Deputy Director, Ministry of Higher Education and Scientific Research (MESRS)
Prof. Moussa Arada, Dean of the Medical Faculty of Algiers
Prof. Fadila Boulahbal, Head, *Institut Pasteur*, Algeria (IPA)
Dr Kamel Kellou, Director General, INSP
Prof. Mahmoud Touhami
Dr Djamila Nadir, Chief of Noncommunicable Diseases, MSPRH

Protocol, Security and Accreditation Subcommittee

Dr Abdel Kader Guenar, Ministerial Counsellor, MSPRH
M. Zoheir, Ministerial Adviser, MSPRH
Mme Fatma-Zohra Chaieb, Ministerial Counsellor, MSPRH
Dr Mouna Bourezk, Cabinet Attaché, MSPRH
Mr Abdelaziz Djafri, Minister of Foreign Affairs
Mr Djamel Fourar, Deputy Director, MSPRH

Accommodation, Transport and Food Subcommittee

Mr Mustapha Abdelaziz, Deputy Director, MSPRH
Mr Abdelhamid Ayadi, Deputy Director, MSPRH
Mr Mohand Abdi, Deputy Director, MSPRH
Mr Lounes Bouzidi, MSPRH

Communications Subcommittee

Messaoud Belkessam, Ministerial Counsellor, MSPRH
Lounes Boukhalfa, Deputy Director, MSPRH
Djaouida Khemkhoun, Communication Unit, MSPRH
Nadia Mancer, Communication Unit, MSPRH
Laila Chibout, WHO Algeria
Hamid Kessiss, Director General, National Agency for Health Documentation (ANDS)
Dalila Hamma, National Agency for Health Documentation

African Advisory Committee on Health Research for Development

Chairperson: Dr Shyam Shunker Manraj, Mauritius

Prof. Ba Mohamed Lemine, Mauritania
Prof. C Gombé Mbalawa, Congo
Dr L. Haoses-Gorases*, Namibia
Prof. Kuku Voyi, South Africa
Prof. William Macharia, Kenya
Prof. J.C. Nganou Mbanya, Cameroon
Dr Poloko Moloko-Kebaabetswe, Botswana
Prof. J.J. Muyembe Tamfum, Democratic Republic of Congo
Prof. Jean de Dieu Rakotomanga, Madagascar
Dr André Samba, Central African Republic
Prof. Theophile Josenando, Angola

WHO/AFRO Secretariat
Regional Director, Dr Luis G. Sambo
DPM* Dr P.S. Lusamba-Dikassa
DDC Dr Jean Baptiste ROUNGOU

Intercountry Support Team Coordinators

IST/Burkina Faso Dr Mathieu Kamwa
IST/Gabon Dr Lucile Imboua
IST/Zimbabwe ai Dr Chris N. Mwikisa

Secretariat

Dr Derege Kebede* HSA
Dr Issa Sanou* RPC ai
Dr Léodegal Bazira* RPC/HSD
Dr Emil Asamoah-Odei* KMS
Dr Eddoh Soumbey-Alley* HIS
Mr Wenceslas Kouvidila* TO/HSA
Dr Chris Zielinski* TC/RH
Dr Alisalad Abdikamal, Research Focal point, ATM
Dr Djamila Cabral, Research Focal point, DRH
Dr Jose M. Kirigia, Research Focal point, DSD
Dr Fidelis Morfaw TPL
Mr Samuel T. Ajibola INF
Mrs Pierre Lessimi ASO
Mrs Marie Paule Kaboré HLT

ANNEX 2: Programme Overview and Daily Programme

PROGRAMME OVERVIEW

Time	Monday, 23 June 2008	Tuesday, 24 June 2008	Wednesday, 25 June 2008	Thursday, 26 June 2008
0900 - 1030 AM	Opening Session - Experts	Plenary	Plenary	Opening Session - Ministers
1030 - 1115 AM	Break/Exhibitions	Break/Exhibitions	Break/Exhibitions	Break/Exhibitions
1115 - 1245 AM	Plenary session	Parallel sessions	Parallel sessions	Ministerial discussions
1245 - 1400 PM	Lunch	Lunch	Lunch	Break/Exhibitions
1400 - 1530 PM	Parallel sessions	Parallel sessions	Parallel sessions	Presentation of Algiers Declaration
1530 - 1615 PM	Break/Exhibitions	Break/Exhibitions	Break/Exhibitions	Break/Exhibitions
1615 - 1745 PM	Plenary	Plenary	Plenary	Media event
20 00	Opening Reception - Experts		Opening Dinner and cultural evening	Closing Diner

Daily Programme

DAY 1, 23 JUNE 2008

Time	Session	Content	Responsible
0900 - 1030 AM	Opening Plenary	<ul style="list-style-type: none"> - Welcome Remarks - Keynote Address - Opening Address - Group Photo 	<ul style="list-style-type: none"> - Ms. Rachida Benkhelil, Secretary General MSPRH - Dr Luis G. Sambo, Regional Director, WHO/AFRO, - H.E. the Minister of Health, Republic of Algeria - All
1030 - 1115 AM	Break/Exhibitions		
1115 - 1245 PM	Plenary session	1. Governance/Stewardship of National Health Research Systems	Ms. Rachida Benkhelil, Secretary General MSPRH, Chair Dr Tikki Pang, Director Department of Research Policy and Cooperation, WHO/HQ
1245 - 1400 PM	Lunch		
1400 - 1530 PM	Parallel sessions	1.1 Stewardship and governance (including: national policies and strategies; structure & mechanism for governance and stewardship; priority setting mechanisms; monitoring and evaluation)	Pr Zahia Mentouri-Chentouf, Chair Dr Erica Gadsby, Presenter Pr Jean de Dieu Marie Rakotomango, Panelist Dr Pierre Ongolo-Zogo, Panelist
		1.2. Collaboration	Pr Rose Leke, Chair Dr Stuart Gillespie, Presenter Pr Guillermo Paraje, Presenter Dr Andrew Kitua, Panelist Pr Jean Jacques Muyembe Tamfum, Panelist
		1.3. Ethical policies and practices	Pr Moussa Arada, Chair Dr Sonali Johnson, Presenter Dr Abha Saxena, Panelist Dr Juntra Karbwang, Panelist Pr Mohamed Lemine Ba, Panelist
1530 - 1615 PM	Break/Exhibitions		
1615 - 1745 PM	Plenary	<ul style="list-style-type: none"> • Group reports • Discussion and recommendations 	Ms. Rachida Benkhelil, Secretary General MSPRH, Chair
20.00	Reception	Venue: Sheraton Hotel	

DAY 2, 24 JUNE 2008

Time	Session	Content	
0900 - 1030 AM	Plenary session	2. Financial Flows and Funding of National Health Systems, Human and Physical Resources (main presentation followed by a discussion)	Pr Rose Leke, Chair Director Biotechnology Center, Faculty of Medicine & Biomedical Sciences, University of Yaounde I, Cameroon Dr. Sara Bennett, Manager of Alliance for Health Policy and Systems Research
1030 - 1115 AM	Break/Exhibitions		
1115 - 1245 PM	Parallel sessions	2.1. Financial flows, Donor and Institutional Perspectives	Dr Ania Grobicki, Chair Dr Ritu Sadana, Presenter Dr Mary Anne Burke, Panelist Pr Hannah Akuffo, Panelist
		2.2. Country health information systems: resources (including: policy and planning; HIS institutions, human resources and financing; HIS infrastructure), indicators, data management, dissemination and use	Dr Nosa Orobaton, Chair Dr Stein(Erick Kruse, Presenter Dr Anwer Aqil, Panelist Dr Chris Simoonga, Panelist
1245 - 1400 PM	Lunch		
1400 - 1530 PM	Parallel sessions	2.3. Human resources, training for research and staff mobility	Dr Francis Omaswa, Chair Dr George Pariyo, Presenter Dr Sodiomo B. Sirima, Panelist Pr Flabou Bougoudougou, Panelist
		2.4. Institutional Facilities and Field Sites (including international, regional, sub-regional, and in-country collaborations)	Pr Ogobara Doumbo, Chair Dr Marion Moutari, Presenter Pr Koku Voyi, Panelist Pr Mahmoud Touhami, Panelist
1530 - 1615 PM	Break/Exhibitions		
1615 - 1745 PM	Plenary	Group reports Discussion and recommendation	Pr Rose Leke, Director Biotechnology Center, Faculty of Medicine & Biomedical Sciences, University of Yaounde I, Cameroon, Chair

DAY 3, 25 JUNE 2008

Time	Session	Content	
9.00 - 10.30 AM	Plenary session	3. Producing and using research to improve health (main presentation followed by a discussion)	Dr Paul Samson Lusamba-Dikassa, DPM/ AFRO, Chair Dr Robert Ridley, Director Special Programme for Research & Training in Tropical Diseases (TDR)
10.30 - 11.15 AM			
11.15 - 12.45 AM	Parallel sessions	3.1. Research outputs, evidence to policy and decision-making	Pr Gérard Gresenguet, Chair, Pr Guillermo Paraje, Presenter Dr Ulysses Panisset, Panelist Pr Theophile Joseando, Panelist
		3.2. Health Information Systems: data sources (1. census, vital statistics, population-based surveys, 2. health and disease surveillance, health service records, 3. Resource) and information products and health statistics (including: demographic, socioeconomic, environmental statistics; mortality; morbidity; risk factors; health services coverage; health systems; and, equity)	Dr Alex Ezeh, Chair Dr Yohannes Kinfu, Presenter Dr Landry Boussari, Panelist Pr Martin AKogbeto Codjo, Panelist
		3.3. Knowledge systems in health	Dr Sylvester Kwankam Yunkap, Chair Dr Chris Zielinski, Presenter Dr Munyati, Panelist Dr Margaret Mafe, Panelist
12.45 - 2.00 PM	Lunch		
2.00 - 3.30 PM	Plenary	Group reports Discussion and recommendations	Dr Paul Samson Lusamba-Dikassa, DPM/ AFRO, Chair
3.30 - 4.15 PM	Break/Exhibitions		
4.15 - 5.45 PM		Compilation of recommendations (restricted session)	Steering Committee
8.00	Opening Reception for Ministers	Venue: Tent of Safir Mazafran Hotel	

DAY 4, 26 JUNE 2008

Time	Session	Content	Speakers/facilitators proposed
9.00 - 09.45 AM	Opening Plenary	<ul style="list-style-type: none"> - Welcoming Remarks - Keynote Address - Opening remarks - Opening remarks - Opening Address - Group Photo 	<ul style="list-style-type: none"> - H.E. the Minister of Health, Algeria - Dr Elias Zerhouni, Director NIH, USA - Dr Luis G. Sambo, Regional Director, WHO/AFRO - H. E. the Head of Government of the Republic of Algeria - Mr. Boughazi Mohamed Ali, Advisor to H.E. The President of the Republic of Algeria - All
09.45 - 10.00 AM	Break/Exhibitions		
10.00 - 12.00 AM	Plenary	Ministerial session (in camera)	<ul style="list-style-type: none"> - H.E. the Minister of Health, Algeria, Chair - Rapporteurs (Identify Ministers)
12.00 - 3.00 PM	Lunch		
4.00 - 5.30 PM	Plenary	<ul style="list-style-type: none"> - Reading of the Algiers Declaration - Endorsement of Algiers Declaration 	<ul style="list-style-type: none"> - Secretary General of the MSPRH - Ministers and Heads of delegations
5.30 - 6.00 PM	Closing ceremony	<ul style="list-style-type: none"> - Motion of thanks - Closing speech 	<ul style="list-style-type: none"> - Ministers (to be identified) - H.E. the Minister of Health, Algeria
6.00 - 6.45 PM	Press Conference	<ul style="list-style-type: none"> - Presentation of Algiers Declaration - Questions & Answers 	<ul style="list-style-type: none"> - H.E. the Minister of Health, Republic of Algeria - Regional Director AFRO
8.00 PM	Closing diner	Venue: El Mithak residence	

The Algiers Declaration

We, ministers of health and heads of delegation of African countries, meeting in Algiers on 26 June 2008 for the Ministerial Conference on Research for Health in the African Region,

Considering

1. The magnitude of health problems associated with poverty and climate change, including prevalent infectious diseases such as malaria, tuberculosis, HIV/AIDS, emerging diseases, neglected tropical diseases, the resurgence of epidemic-prone diseases and other complex emergency situations;
2. The diseases and conditions affecting sexual and reproductive health, in particular maternal, neonatal and child health, adolescent and geriatric health, as well as non communicable diseases, malnutrition and mental health, including drug and substance abuse;
3. The burden of disease and the limitations due to weak and fragile health systems;
4. The inadequate institutional, infrastructural and regulatory capacity to conduct high-quality investigation in public health, basic science, product development and operational research;
5. The increasing gap in the application of existing and new technologies for improvement of public health in our countries, and the need to expand access to appropriate and cost-effective tools to address numerous health problems;
6. The migration of human resources for health from our countries to developed countries;
7. The critical need to inform and protect human subjects of research;

Recognizing

1. The difficulties encountered by our countries in achieving national and internationally-agreed health targets, including the health-related Millennium Development Goals (MDGs);
2. The need for appropriate platforms to improve our capacities for sharing knowledge and evidence to inform health policies and practices that will positively impact on the health of our peoples;
3. The need for national research agendas responsive to country challenges and priorities, as well as to global public health priorities;
4. The need for adequate and incentive investments in research and development to produce new and effective medicines, diagnostic tools, vector control tools and vaccines, and to promote research in traditional medicine and strengthen health systems, taking into account the socio-cultural and environmental situation of the people;
5. The urgent need for our governments to implement mechanisms for addressing the aforementioned concerns and to promote research and utilize its findings in our health systems;

6. The increased global attention given to development and poverty reduction issues especially as expressed in the Millennium Development Goals (MDGs), thereby creating an unprecedented opportunity for formulating evidence-informed policies and strategies.

Building on previous commitments made by our governments to our people and by the global community in favour of priority health research, including texts or instruments such as the United Nations Millennium Declaration on development, the Africa Health Strategy 2007-2015 of the African Union, the Mexico Statement on health research adopted in November 2004, the Abuja Declaration on health research of March 2006, the Accra Declaration on health research for disease control and development adopted in June 2006 and the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa of April 2008;

1. Commit ourselves to working together to give the necessary impetus to the strengthening of national health research systems, national information and knowledge management systems through the optimization of investments, better coordination of our action and enhanced management in order to improve the health of the people of Africa.

2. Also commit ourselves to launch implementation of the following before the end of 2009:

- (a) to establish or strengthen coordination within the health sector and among other sectors contributing to the development of science and technology including in health, and establish or strengthen governance structures to promote ethics and increase public trust in research;
- (b) to develop or strengthen adequate national health research policies and strategic frameworks that are based on systematic and standardized assessments of national health research and knowledge systems;
- (c) to expand the health research agenda to include broad multidimensional determinants of health;
- (d) to create or strengthen South-South and North-South cooperation including technology transfer;
- (e) to link health research and development efforts with health needs and explore opportunities for partnerships between governments, universities, private sector and civil society organizations;
- (f) to create subregional centres of excellence to promote research and generate evidence for better decision making. The scope of activities of the centres shall focus mainly on disease surveillance, public health laboratories and quality control of food and medicines;
- (g) to support the development of human resources for research through initial and further training and promotion of access to scientific information;
- (h) to establish appropriate mechanisms for scientific and ethical oversight of research for health, including regulation of clinical trials and sensitization of the people to their role, their rights and their obligations in research for health;
- (i) to monitor, evaluate and systematically review health research systems by developing appropriate tools and indicators;

- (j) to allocate at least 2% of national health expenditure and at least 5% of external aid for health projects and programmes to research and research capacity building and invest more in research aimed at improving health systems;
- (k) to create or strengthen an environment that attracts the best skills, for example by providing attractive career structures and incentives, by facilitating access to information and by offering the persons concerned opportunities to teach, do research and participate in communities of practice;
- (l) to develop a critical mass of focal persons and well-trained national researchers, including those working abroad, in various disciplines and areas of health research, including ethics and regulation;
- (m) to develop and strengthen the evidence base for health systems by consolidating and publishing existing evidence and facilitating knowledge generation in priority areas;
- (n) to support the translation of research results into policy and action by establishing appropriate mechanisms and structures, including setting up networks of researchers, decision-makers and policy-makers for evidence-based public health action;
- (o) to continue to promote innovative research in basic sciences and its transformation into new tools such as medicines, vaccines and diagnostics tools;
- (p) to develop and strengthen the national health information system by instituting procedures that ensure the generation and availability of information meeting international norms and standards and by defining clear relations between the various subsystems, and the mechanisms needed for their regular evaluation;
- (q) to identify and integrate the various sources of information into national information systems taking into account the private sector so as to generate accurate and reliable information;
- (r) to acquire information and communication technologies and make them accessible to all sources and potential users of information, in order to have up-to-date evidence for health research development;
- (s) to prepare national strategic directions for knowledge management, including ehealth, ensuring that they are integrated as a priority into national health policies and plans;
- (t) to establish norms and standards, including ethical ones, taking into account technological progress and new knowledge management methods;
- (u) to strengthen national capacity in knowledge management;
- (v) to adopt policies that promote the application of intellectual property rights to benefit the public and North-South and public-private research partnerships so as to enhance the accessibility of research results.

3. *Call upon researchers, research institutions and research and information networks to:*

- (a) to become more actively engaged in collaboration with all stakeholders in setting research priorities;
- (b) to enhance the relevance of research to users, policy-makers and communities by linking research activities to health challenges and priorities in order to bridge the know-do gap.

4. Urge national and international partners including the private sector, civil society, and regional economic communities to make every effort in line with the 2005 Paris Declaration on Aid Effectiveness, :

- (a) to support country policies and mechanisms to honour the aforementioned commitments;
- (b) to promote equitable South-South and North-South cooperation, technology transfer and collaboration in health research, and the establishment and strengthening of knowledge management capacities and practices;
- (c) to invest at least 5% of external aid for health projects and programmes in research and research capacity building with emphasis on implementation of health policies and strengthening of health research systems.

5. Call upon the African Union and regional economic communities:

to advocate for strengthening health research systems and to encourage regional cooperation.

6. Request the World Health Organization:

- (a) to advocate for increased funding from governments and development partners for health research, information and knowledge management and for equitable sharing of that funding among all relevant stakeholders;
- (b) to support Member States to build national health research systems, develop capacity to conduct health research, identify health research priorities, evaluate research outcomes and use acquired knowledge to solve health problems by following evidence-informed policies;
- (c) to facilitate South-South and cross-border collaboration to promote the creation, sharing and use of knowledge to improve the health status of the people;
- (d) to support the establishment of subregional and regional centres of excellence to develop research for health;
- (e) to increase the WHO health research budget and explore innovative financing mechanisms for supporting Member States to strengthen their health research, information and knowledge management systems;
- (f) to establish an African health research, information and knowledge management systems observatory ;
- (g) to continue to support the development of a framework for implementing the Declaration to be presented to the fifty-ninth session of the WHO Regional Committee for Africa;
- (h) to submit the present Declaration to the WHO Regional Committee.

Done at Algiers this twenty-sixth day of June in the year 2008