

DEVELOPMENT ASSISTANCE AND RESEARCH
CAPACITY STRENGTHENING:

THE COMMISSIONING OF HEALTH SOCIAL SCIENCE
RESEARCH IN EAST AFRICA

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ABSTRACT

Research capacity strengthening (RCS) in health social science research is considered a key imperative to achieve health equity. Recent evidence suggests that the knowledge gap between the North and the South, particularly low income developing countries, is growing ever wider in spite of the prominence capacity development and RCS enjoy in development assistance policy.

This paper addresses this concern by analyzing the political economy of the prevailing modes of research commissioning among bilateral, multilateral, non-governmental and philanthropic organizations in East Africa (Uganda, Kenya and Tanzania). In doing so the paper shifts the lens from the conventional focus on recipient countries and institutions to look at the policies and practices of donor and commissioning agencies and the relationship they have with key stakeholders like Southern research institutions.

The research shows that the thinking on RCS has shifted towards partnership models but that this has generally not been translated into policy and action among most commissioning and donor agencies in the field. It can also be argued that the literature on RCS over-generalizes and constructs capacity development in monolithic terms.

In contrast, this study provides a typology of research commissioning practices and identifies eight different modes of engagement. The analysis suggests that the level of RCS relates to institutional type. The paper concludes with some recommendations for enhancing the role of donors and commissioning agencies in RCS.

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DEVELOPMENT ASSISTANCE AND RESEARCH CAPACITY STRENGTHENING: THE COMMISSIONING OF HEALTH SOCIAL SCIENCE RESEARCH IN EAST AFRICA

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Introduction

A key element of health systems development is research capacity strengthening (RCS). The concept of RCS is generally defined as the “process by which individuals, organizations and societies develop abilities (individually and collectively) to perform functions effectively, efficiently and in a sustainable manner to define problems, set objectives and priorities, build sustainable institutions and bring solutions to key national problems” (Global Forum for Health Research 2004: 150). The goal of RCS is to build knowledge and research capabilities so that these countries can respond to the challenges of the global health crisis on a sustained basis. However, recent evidence (Paraje, Sadana & Karam 2005) suggests that the knowledge gap between the North and the South, particularly low-income developing countries, is growing ever wider¹. This problem is compounded by the fact that, “what research into the problems facing developing countries is carried out in the developed countries is on a small scale, and in many cases on the decrease” (DANIDA 2000: 9). Greater dependency on researchers and research institutions from the North is therefore unlikely to provide an adequate, long-term response to the global health burden.

RCS in health is increasingly articulated as an important objective of the development assistance strategies of commissioning and donor agencies. This is exemplified in the growth of literature identifying principles for good partnerships (see Box 1) and research capacity strengthening policies emerging from the multilaterals such as COHRED (1990), OECD-DAC (1999)², UNCTAD (1999) and policy statements by bilateral agencies like DFID (2005), CIDA, RAWOO (2002), DANIDA (also see Helland 2000; Maselli 2004). At the OECD-DAC under the Paris Declaration 2005 donors have committed “to align their analytic and financial support with partners’ capacity development objectives and strategies, make effective use of existing capacities and harmonise support for capacity development accordingly” (OECD DAC Paris Declaration: 2005: 4-5).

There has for some time been a debate on the effectiveness of technical assistance, starting with the influential report by Elliot J. Berg on 'Rethinking Technical Cooperation: Reforms for Capacity Building in Africa' (1993). The issues raised by Berg are echoed in a recent World Bank (2005) evaluation report that points out that traditional tools such as

¹ Utilizing data from internationally recognized reference databases for the period 1992 to 2001 analysts have shown that scientists from 20 countries (principally developed countries) produce more than 90% of international publications. While there was an increase in publications from middle-income countries the share of publications from low-income countries has declined by 10% over the last decade.

² The key partnership principles, according to OECD/DAC (1999) are that: 1) developing country priorities should be at the centre, 2) donor funded activities should fall within the framework of a locally owned strategy and approach, 3) planning and implementation processes should include both state and non-state actors to ensure a high level of local ownership and 4) strengthening local capacity to undertake development initiatives is essential.

technical assistance and training have proved ineffective in building sustained capacity in Africa. It is also argued that technical assistance is “heavily overpriced, under-evaluated and stubborn to change” because

Too much of it continues to be identified, designed and managed by donors themselves, tied to donor countries’ own firms, poorly co-ordinated and based on a set of often untested assumptions about expatriate expertise and recipient ignorance (ActionAid International 2006: 3).

It is from this standpoint that investment in RCS is considered critical for redressing the knowledge imbalance and ultimately achieving health equity (COHRED 1990; GFHR 2004; Sitthi-amorn & Somrongthong 2000). In the health and development literature there have been discussions over the last decade and a half about how the health challenges of the developing world can be addressed by the enhancement of research capacity through development assistance and North-South partnerships (Edejer 1999; Nair & Menon 2002; Nchinda 2002; RAWOO 2001; 2002; Sadana and Pang 2003; Silva et al 1994; Trostle 1992). While there is some consensus on what are some of the failures of development assistance and the key challenges in RCS (Milen 2001; Velho 2002) there is much less clarity on what works and on how it can be implemented. In most part what one finds in the literature are declared principles but no defined measures upon which donors and commissioning agencies are evaluated. In short, what is missing in the literature is an analysis of the actual practices of donor agencies in the field. These concerns are important to consider because the contemporary discourse on development assistance rarely treats with the global political economy of knowledge production and consumption, nor does it deal adequately with the mode of engagement or delivery of the aid (e.g. tied aid) as an area for critical discussion.

This study addresses these concerns by evaluating the prevailing modes of commissioning among donor agencies in terms of key benchmarks or indicators of RCS. It analyzes the prevailing modes of research commissioning among bilateral, multilateral, non-governmental and philanthropic organizations and provides a typology of such practices. In doing so the paper shifts the lens from the conventional focus on recipient countries and institutions to look at the policies and practices of donor or commissioning agencies and the relationship they have with key stakeholders like local research institutions. The fieldwork was conducted in East Africa (Uganda, Kenya and Tanzania) where in-depth interviews were conducted with the major commissioning or donor agencies in health social science research along with the leading research institutions. The paper concludes with some recommendations for enhancing the role of donors and commissioning agencies in RCS.

Methodological Issues

Health research is generally viewed as an area for expanded investment due to the increased demand for evidence-based policy by governmental and international development agencies. However, the investment is often focused on biomedical research to the relative marginalization of the social sciences and within the social sciences the emphasis is largely on public health, epidemiology and health economics. A broad-based approach to the social sciences are critical for understanding the social, economic, political and cultural context of risk practices, developing appropriate and valid measures of health-related behavior, designing intervention strategies,

documentation of best-practices and conducting ethical reviews, operational research, strategic planning and political economy studies. They are considered to be a key pillar in addressing the “knowledge-action” gap in developing countries’ health systems development (Higginbotham 1992; Rosenfeld 1992; RAWOO 2002).

A review of the RCS literature suggests that there is no consistent methodology focused on generating data on the performance of research capacity strengthening initiatives and identifying what could be considered best-practice by commissioning agencies. One analyst argues, “after 20 years of activity to strengthen research capacity and millions of dollars of investment, we still know so little about the impact of these efforts”. It is also noted that, “the contribution of research capacity strengthening in improving health equity is completely unmeasured and has been little more than a rhetorical, though important goal statement” (Simon 2000: 816).

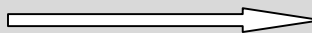

Donor and commissioning agencies have rarely systematically measured or evaluated initiatives in this area. Most evaluations of RCS have been done as internal audits by donor agencies, or the focus has been on measuring the performance of recipients through impact indicators (i.e. number of persons trained, number of publications, number of consultants and experts provided) (Simon 2000: 816). This is largely because the practice of RCS and capacity development has remained in the conventional development assistance mode of “supply-driven, expert-led, short-term and project-based technical cooperation” (Hauck & Land 2000).

Considerably less focus has been placed on the policies and practices of donor or commissioning agencies and the relationship with key stakeholders like local research institutions³. One analyst makes the point that “after a half-century of technical assistance and development cooperation, there have been precious few empirical studies analyzing development-oriented research cooperation” (Box 2001: 26).

In this regard there is a clear need to analyze governance structures and measure processes rather than just outcomes and impact. The argument is that the delivery processes and institutional relationships largely shape results (Jentsch and Pilley 2003). This approach is considered efficacious because it is easier to measure changes in processes than changes in outcomes that may take a generation or more to achieve (Milen 2001: 21). To illustrate the point, it may be more appropriate to see the capacity development process as a continuum with different levels of power, influence and responsibilities among donors and recipients. Figure 1 below shows how capacity development can be analyzed in terms of the structure of the relationship between donors and recipients. At one end of the continuum (A) donors have broad control and recipients have little influence in the shape of aid programs. At the other end donors surrender some of their power to recipients (F) such that the assistance strategy generates a high level of local control and buy-in. The latter is considered to have greater potential for RCS but still relies on the donor agencies to give up power in the relationship.

³ This statement is taken from Louk Box, at his inaugural lecture upon acceptance of the position of Professor in International Cooperation at the Faculty of Cultural Sciences, Maastricht University.

Figure 1: Power, Influence and Responsibility in Donor-Recipient Capacity Building Relationships

 Widening the power and influence of recipients in aid-funded programs					
A	B	C	D	E	F
Donor permits recipients to operate within existing donor prescribed institutional framework as guided by donor interests.	Donor identifies problems, gets views from recipients and makes programs according to donor interests.	Donor maps out and defines limits to which aid can be utilized and asks recipients to make decisions within these controlled limits.	Donor presents alternative solution programs to be worked upon in collaboration with the recipient country. Donor is ready to change to accommodate the recipient country priorities.	Donor and recipient work together to identify problems, develop policy programs and implementation in a responsible relationship. Though donor financed, planning and implementation are the recipient's responsibility.	Donor surrenders fund to recipient's treasury for decision and use by the recipient in what is locally judged to be priority areas.
Widening power and influence of donors in aid-funded programs 					

Source: Adapted from Munishi (2004: 624)

An alternative paradigm for RCS would involve the North and the South working towards a framework of engagement built on new principles such as Southern priorities and ownership, demand-led research, focus on development relevance and mutually beneficial working relationships (see Table 1 for a summary). Many of the changes called for in the alternative paradigm in health research practice are generally viewed as desirable and necessary but “there are only a few examples where such innovations have actually been applied in practice and these have not always been very successful” (RAWOO 2002: 31). While this is the case it is argued that the way forward calls for a radical shift away from the conventional approach to RCS if serious attempts are to be made to address the global health crisis.

Table 1: Summary of Perspectives on Research Capacity Strengthening

Conventional paradigm	Alternative paradigm
Donor designed, controlled and initiated projects	South-North collaboration; Southern priorities, autonomy, ownership & accountability
Donor defined research priorities and methodologies	Demand & user-led research with key stakeholders defining the research agenda
Focus on scientific relevance and peer review publications	Focus on development achievements and health outcomes in tandem with scientific goals
Unequal relationship between commissioning agencies and recipient institutions	Mutually beneficial relationship in terms of division of accountability and transparency
Institutional and knowledge gap between foreign knowledge producers and local users	Creation of national and regional Health Research Systems
Southern partners collect the data; Northern partners publish	Upgrade of Southern researchers and institutions through South-South partnerships
Northern research paradigms are viewed as superior and applied uncritically	Southern researchers develop indigenous frameworks and adapt Northern paradigms

The Case Study

The case study involves an assessment of donor and commissioning agencies in RCS in the health social sciences in East Africa (Kenya, Tanzania, Uganda)⁴. As table 2 illustrates each country is a low-income (i.e. GNP PPP per capita) developing country faced with high mortality rates (e.g. life expectancies below 50 years of age). They also have a low density of human resources for health (below 1.0 per 1,000). Health worker density has a significant impact on health outcomes because it has “a positive effect on mortality rates over and above the effects of income, education and poverty levels across countries” (JLI 2004: 154).

Low levels of spending on health per capita is complimented by high dependence on external resources in health spending, as much as 29.5% and 24.8% in the case of Tanzania and Uganda, respectively. The data on external resources for health in Kenya is at only 9.8% (data from mid-1990s), and total health spending per capita is double that of Uganda and Tanzania. In spite of the relatively favourable position of Kenya, an assessment of health research in the mid-1990s indicates that only 3.4% of the health budget was allocated to research and of this 90% was spent on personnel leaving very little for actual research (Gakunju 1994: 49). The main explanation for the deterioration of the health research has been the negative effects on government funding of structural adjustment policies (Arap Ng’ok, et al 1994).

The situation in Kenya is corroborated by a study of health research in Uganda. The study conducted by the Uganda National Health Research Organization (2000) indicates that less than 1.0% of the funding for health research comes from internal sources. The study also notes that “of the 57 institutions studied only 23% have a budget line for research” (UNHRO 2000: 16).

⁴ The research project involved a month long visit to Kampala (Uganda), Nairobi (Kenya) and Dar es Salaam (Tanzania).

Table 2: Select Economic and Health Data for Kenya, Tanzania and Uganda

Countries	GNP PPP per capita	Life expectancy at birth	Human Resources for Health (per 1,000)	Total Health Spending per capita (US\$)	Share of External Resources in Health Spending (%)
Kenya (1995)	970	47.0	1.03	29	9.8
Tanzania (2002)	520	44.4	0.39	12	29.5
Uganda (2002)	1,460	42.5	0.14	14	24.8

Source: World Health Organization, Statistics on Health Development Systems (2005).

In each of the respective countries there is limited documentation of what health social science research is being done, which organizations are commissioning it, and who is conducting the research. The exception is in Uganda where the Uganda National Health Research Organization has done an inventory of studies on malaria, HIV/AIDS and TB over a five-year period, 1997 – 2002 (UNHRO 2002). The inventory compiles data on the frequency of donor-funded projects, budget and research focus. It shows that international and regional health and medical research institutions like the MRC-UK, CDC-USA, NIH-USA, Population Council, AMREF and Wellcome Trust are the donor group with the highest frequency of funded studies. The other main donors are multilateral organizations such as WHO, the World Bank, UNFPA, and UNICEF; bilateral agencies like the USAID and the European Union; foundations such as Rockefeller and Pfizer; national agencies like the Ministry of Health; and INGOs like Action Aid (see table 3).

The UNHRO (2002) study indicates that the average budget for all the studies covered was US\$ 25,945 and the average by disease was \$36,449 for Malaria, \$19,600 for HIV/AIDS and \$13,833 for TB. In terms of type of research (across the three diseases) it is estimated that almost half of the studies were institutional or investigator-initiated research, about one-third were either masters or doctoral studies, and around twenty percent were short-term consultancies (there were no consultancies for TB). In terms of research focus the study shows that over eighty percent of the studies were focused on six areas: laboratory (28.3 %), operational (24.6 %), KAPB (12.7 %), impact of disease (7.7 %), causative factors/transmission/prevention (7.7 %), case management (3.2 %).

Table 3: The Main Donors* for Research on HIV/AIDS, Tuberculosis and Malaria, Uganda, 1997 - 2002

Donors	Frequency	Percentage
MRC-UK	26	14.4
WHO	19	10.3
USAID	16	8.6
World Bank	15	7.9
MoH	12	6.2
CDC	6	3.2
UNFPA	6	3.2
NIH-USA	5	2.6
Rockefeller Foundation	4	2.2
IPH	4	2.2
European Union	4	2.2
DBL	4	2.2
Population Council	4	2.2
Ptizer Foundation	3	1.6
UNICEF	3	1.6
Action Aid	3	1.6
AMREF	3	1.6
Wellcome Trust	3	1.6

Source: UNHRO (2002): 10.

Notes: * The main donors are those organizations that funded three or more studies.

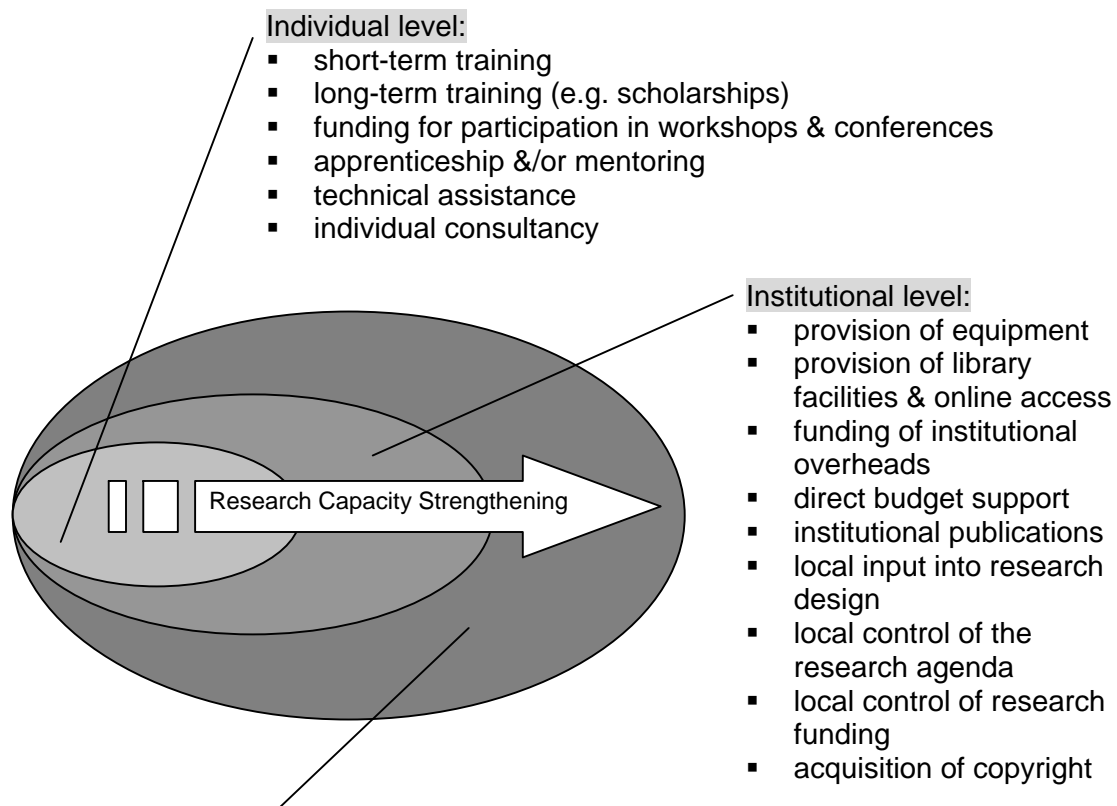
One of the key observations made in the UNHRO (2000) study was that health research in general, and social science research in particular, has been affected by a critical shortage of qualified and trained personnel to meet research needs on account of underinvestment in higher education, lack of priority given to social sciences by students and university managers and the brain drain problem. The study also notes that while “there is a considerable degree of in country networking and collaboration” largely funded externally, there are low levels of regional collaboration and extensive international collaborations most of which are not connected to local institutions. Consequently, there is the problem of weak domestic institutional support and foreign researchers and institutions conduct a large share of the health research. Nationals are mainly incorporated through individual consultancies which has had limited impact on institutional building and research capacity strengthening (Wight 2005).

Framework for the Field Work

The fieldwork involved a situational analysis and review of prevailing practices in health social science research commissioning. In-depth interviews were conducted with a sample of 22 commissioning agencies/organizations (multilateral organizations, donor government overseas aid and development organizations, INGOs, national and regional NGOs, and government agencies (e.g. ministries of health or national HIV/AIDS commissions)) in the three countries of Uganda, Kenya and Tanzania. Interviews were also conducted with key research institutions, particularly senior managers/researchers of the research institution and other researchers who have participated in research capacity strengthening initiatives.

The conceptual framework for the interviews was based on the schema outlined in Figure 2. The listed indicators and benchmarks were used as guideposts to assess the extent of engagement between donors/commissioning agencies and recipients (individuals and institutions). RCS is evaluated across three levels: individual, institutional and systemic. The individual level includes initiatives targeted largely at human resource development and building expertise, through for example, consultancies, training of researchers and research users and exposure through workshops and conferences. It also includes technical assistance from donor countries where foreign expertise is engaged.

Figure 2: Key Indicators of Research Capacity Strengthening



The institutional or organizational level relates to activities and processes that build the capacity of research units, departments and agencies. Included are measures that focus on infrastructural upgrade (e.g. computer equipment, library resources, online access) to the deepening of intellectual output (control of research design, international peer-reviewed publications, copyright ownership). The latter refer to 'learning by doing' and 'organizational self-learning' activities such as proposal writing, research design, policy formulation, research administration and other critical research skills. These are key to building capacity and reducing the dependence on foreign researchers and institutions.

The third level of engagement focuses on wider systemic relationships at the national, regional and international level. Financial and political investment in RCS at the local level is identified as one of the key signals of a stronger environment. Twinning and partnership arrangements at the regional level, between Northern and Southern research institutions and South-South cooperation are an important component at this level as well.

Analysis of Commissioning Relationships

There have been some important innovations in development assistance strategies as exemplified by the growth of basket funding by donors under Sector Wide Approaches (SWAPs) (e.g. Uganda and Tanzania have health SWAPs) and through direct budget support to ministries of health (e.g. Uganda-DANIDA Health Sector Support Programme). There is no clear evidence of the impact of SWAPs on the funding of health research. The main impact of SWAPs on research appears to be in the preparation of strategic plans for the health sector which is anticipated to increase the demand for health social science research.

There is a multiplicity of approaches to commissioning among donor agencies. In many respects it is a reflection of the diversity of the donor community as well the shifting nature of development assistance and research cooperation. Figure 2 provides a typology of commissioning relationships. Based upon the interviews conducted eight types were identified.

The first is the "parachute model" which best exemplifies the conventional approach to technical assistance where the expertise is brought in from outside and has very little impact on the domestic environment. The demand for the research is often determined by global research agendas (e.g. EU projects and international research projects) and bilateral projects. Foreign researchers control the research design and implementation with some participation from local researchers but often in a subordinate role. Issues like publication of results and findings are wholly under the control of the foreign researchers and/or commissioning agencies.

The "consultancy model" has many of the features of the former except that local researchers are often involved in the local research. In most instances the local researchers are contracted by bilateral or multilateral agencies. They have little input into the research design which is developed by external researchers and institutions. The competitive advantage of the local researcher is lower professional fees as well as local knowledge and networks. This commissioning practice is generally found in smaller and short-term projects and audits.

The “twinning model” is essentially an attempt to get away from some of the problematic features associated with conventional technical assistance and consultancy approaches. The twinning approach often emphasizes collaboration and partnership between research institutions from the North and the South. Invariably, the collaborative element of the project is a key criteria for the award of the contract by the funding agency. However, the initiative for the twinning largely comes from research institutions in the North that would, for example, prepare the bid for a research competition and invite a Southern partner. Southern agencies are either far removed from funding circles or are unable to bid independently. Consequently, twinning arrangements are often fraught with unequal power relations (e.g. Jentsch and Pilley, 2003) but there tends to be some collaboration and shared responsibility for things like research design, publication and copyright. This model is often found in longer-term projects and university related projects.

The “corporate model” involves the provision of research services by a corporate entity. For example, this model is largely associated with USAID whereby it commissions a US based corporation which would in turn for the duration of the contract establish overseas offices or a project through a non-governmental organization. An example of this kind of arrangement is the projects managed by the US corporation, John Snow International in Uganda. John Snow is engaged in similar projects in Kenya, Tanzania and all over the developing world. There is limited scope for capacity development in this model due to the fact that the focus is often on individual staff development rather than expanding institutional capabilities. There tends to be some consulting research that is generated at the local level but it is rare for this to extend to broader capacity development initiatives.

The “overseas field unit model” relates to the establishment of overseas or annexed sites (Costello & Zumla 2000) by Northern based research agencies. These tend to be specialized medical research units that service the country and the region as well as collaborate with international research units that are engaged in similar research activities. An example of this is the UK’s Medical Research Council HIV/AIDS Research Unit in Entebbe, Uganda, which is based in the Uganda Virus Research Institute that was established in 1988 on the invitation of the Ugandan government. RCS occurs through in-house and individual training and less so through institutional development. The funding comes largely through external sources. The demand for the research along with the research agenda emerges from a combination of local, regional and international imperatives. Issues like implementation, publication and copyright are held within the organization. Other examples of this kind of arrangement are the US Center for Disease Control in Uganda and the Wellcome Trust in Kenya.

The “Multilateral Agency model” describes the relationship between UN development agencies (e.g. World Bank, UNDP, WHO), the regional offices and researchers, both local and foreign. There are two commissioning styles that emanate from the multilaterals. The first would be global programmes where the regional or local office would be required to facilitate mostly external researchers or to find a local counterpart. The other approach would involve principally the regional office and local researchers. The latter tends to be projects of smaller amounts and they tend to allow for greater local control of the research agenda, design and output.

The next approach is defined as the “capacity development model” since the agencies identified have active policies that facilitate ownership and promote stronger research and institutional capacity development. The Swiss Development Agency offer grantees direct budget support as opposed to just project financing which is common with most

bilateral agencies. The philanthropic foundations also engage in this kind of financing. They are also known to provide funding for more innovative research projects which once successful in terms of efficacy and general acceptance among the research community are often later on funded by the bilateral and multilateral agencies that have larger budgets.

Within the capacity development model there are dedicated development research agencies that define RCS as part of their mandate. The Population Council works with its grantees to prepare project proposals and mentor them all the way through the research process until final publication. This approach requires a long-term view and commitment on the part of commissioning agencies and recipients. The International Development Research Centre (IDRC), which as a matter of policy directs as much as 80% of its funding to Southern partners, operates along similar lines. The IDRC also grants copyright to researchers and in its guidelines (2005) for accessing funding asks the following questions:

- Will the project contribute to the development of local research capacity?
- Will the recipient institution be strengthened as a result of the project?
- Does the project promote South-South cooperation?

What is evident is that agencies like IDRC and the Population Council are geared up to facilitate research capacity strengthening largely because they are themselves research agencies and can provide the necessary mentoring to upgrade the capabilities of Southern research institutions.

Other institutions such the Japanese International Cooperation Agency (JICA) provide a novel approach to RCS in that they forge stronger linkages between researchers, research users and communities. They also tend to approach capacity development from a more wholistic framework by linking its health research initiatives to food production and employment. JICA's work in this area is coordinated through the African Institute for Capacity and Development (AICAD) which was established and funded by JICA along with the governments of Kenya, Uganda and Tanzania. AICAD has a large campus in Kenya where short-term training is conducted throughout the year. Participants are drawn mainly from East Africa.

The last two models outlined in figure 3 are existing innovations in the capacity development framework but have not been applied to RCS in any specific manner. In Uganda there is a health support unit in the Ministry of Health that is largely funded by DANIDA. There is some funding of consultancy research but no clear emphasis on institutional capacity development. This is also the case with the SWAp's model that is in force in Tanzania. However, both approaches have the potential for facilitating RCS with greater involvement by the state. The SWAps model is particularly useful in that it can promote greater harmonization and coordination between donors and recipient countries in terms of funding for research. The health SWAp in Tanzania would be an interesting context to test such a model given its relative success in forging a recipient-led assistance strategy that is now viewed as a pilot for "a new type of development cooperation partnership for all of Africa" (Wohlgemuth 2006: 2).

Findings

The paper assessed the relationship between RCS and health equity by examining the role of donor and commissioning agencies in the case of health social science research. A review of global initiatives was done along with a situational analysis of commissioning practices in health social sciences research in the East Africa context. This was followed by a typology and analysis of the various modes of commissioning by bilateral, multilateral, non-governmental and philanthropic organizations.

One of the key observations is that the RCS practices of donor and funding agencies are largely viewed as homogenous and are criticized on this basis but the East Africa case study shows that there is a diversity of commissioning practices with varied capacity impacts. From this standpoint there needs to be greater recognition of the diversity of RCS practices and modes of commissioning. The study identified eight different modes of research commissioning among bilateral, multilateral, philanthropic and INGOs. The variation in commissioning practices more often than not related to organizational type:

- Bilateral and multilateral agencies tend to engage in higher levels of tied commissioning and project-based research that relies heavily on expatriate researchers and local consultants with marginal impact on RCS. These agencies because they are governmental and inter-governmental tended to be constrained by narrow timeframes, geopolitical considerations as well as laborious funding and reporting systems.
- International development research institutions like the IDRC and the Population Council appear to be better equipped to facilitate RCS than bilateral and multilateral donor agencies as they are themselves research institutions and thus can provide a range of services such as mentoring and facilitation to recipient institutions and researchers.
- Specialized health research institutions (e.g. MRC, Wellcome, CDC) tend to establish overseas field units/offices as a means of globalizing their operations and RCS is focused largely on training indigenous professionals and researchers. These agencies also engage in building specialized local research institutions which often become islands of excellence.
- Philanthropic organizations (e.g. Ford, Rockefeller) were predisposed to invest in new methodologies and research innovations that bring new stakeholders and new ideas into RCS. They also tend to focus on project funding but hope that successful projects would be picked up by bilateral and multilateral agencies with larger budgets.

Based upon this analysis it can be argued that the literature on RCS over-generalizes and constructs capacity development in monolithic terms. Alternatively, this paper identifies a multiplicity of commissioning practices and modes of engagement. The key findings are that the structure of the relationship between donors and recipients as well as the governance structures of the commissioning agencies has a critical influence on RCS. Conventional approaches to technical assistance such as project-based financing under the parachute and consultancy models predominate and are the least impactful. Among the commissioning and donor agencies interviewed the majority had provided support only at the level of individual training and research consultancies.

Most research capacity strengthening efforts have been targeted at the level of individuals in terms of training (short & long term). International research organizations like Wellcome Trust and the Medical Research Council have been involved in such initiatives with differing levels of success. There is concern about the gains made at this level given the shortage of capable trainees/candidates and the high rate of brain drain intra-regionally (e.g. from East Africa to South Africa) and across continents (from Africa to Europe and North America).

There are few examples of research capacity strengthening at the level of institutional capacity building (e.g. provision of institutional overheads, direct budget support, facilitation of regional networking) and at the broader level of support for strengthening intellectual output and expanding the research environment. The key indicator is the extent to which there are high-level research capabilities exemplified by internationally recognized peer-reviewed publications in the field of health social sciences.

The institutions that have benefited from RCS operate as virtual islands of excellence given the paucity of local and regional health research institutions. Many of the capable researchers and institutions are in high demand and are generally over-stretched. Sustained and long-term financial, political and intellectual support from donor agencies and external research organizations has been critical to the few successful cases of RCS. Given the dependence on external donor funding these successes are highly vulnerable to changes in donor agencies policies and to the exit of a major donor. This is unsustainable given the rising demand for knowledge production in the health social sciences.

The general view of the local or regional research institutions is that capacity building initiatives targeted at institutional development and wider sectoral development have been few and far between. Some of the other related concerns and criticisms raised were:

- General frustration with the lack of local research funding (generally < 1% of the health budget) and with the politics of accessing such funds.
- Over dependence on external funding for health research.
- The challenge of bridging the geographical, cultural and epistemological divides between local researchers/institutions and external funding, commissioning, research agencies and academic journals.
- Many of the foreign funded and controlled research projects lack local coherence and consequently result in fragmented research outputs and duplication in some instances.
- Local researchers/institutions often find themselves in a subordinate relationship even in cases of twinning and collaborative arrangements with external research teams.
- The various initiatives have largely focused on the research agenda defined by donors or external research agencies.
- The fundable issues are not always the priority areas for the country.

In summary, many of the local researchers and research institutions see RCS practices as piecemeal or stopgap measures at best because they rarely lead to institutional building and/or the deepening of the research environment. In many instances, the impact has been to distort the research environment in terms of research agendas and salary levels that ultimately deepen dependency on external resources, expertise and agencies. Furthermore, these processes lead to capacity depletion over time largely

through the brain drain of frustrated local researchers. This reinforces the view that the problem is not just a matter of finances and that the structure and nature of relationships and delivery processes can determine outcomes and impact.

Conclusion

The research shows that the thinking on RCS has shifted towards partnership models but that this has generally not been translated into policy and action among most commissioning and donor agencies in the field. New policy guidelines on aid effectiveness and harmonization, for example, the OECD Paris Declaration, do not specifically target research capacity strengthening.

While it is increasingly recognized that it is very difficult to implement genuine partnership between unequal partners given the structural inequalities and power dynamics between Northern and Southern institutions, this study suggests that there are some alternative modes of delivery that can move the process forward.

The first recommendation is that the donor community needs to move beyond the rhetoric of new principles for RCS to establish clearly defined benchmarks and indicators for actual implementation and monitoring. For example, commissioning agencies can be assessed based on RCS criteria on the three levels identified in figure 2: individual, institutional and research environment. The OECD-DAC can play a role here in terms of establishing a more rigorous template for assessing how donors are doing in RCS. As it now stands this is an area that is not included in the various declarations on aid harmonization. For example, a code of ethics on RCS that the OECD-DAC could monitor would provide a guide for impactful and consistent modes of delivery among donors and commissioning agencies.

A key recommendation is that RCS requires capable and specialized staffing in commissioning agencies. One of the problems with RCS is that it is largely viewed as an automatic process once resources and researchers are brought together. However, the more successful cases suggest that what is required often is not just partnership but also mentorship and facilitation. This kind of input is normally outside of the remit of bilateral and multilateral agencies and the training of its staff. If these agencies are unable or unwilling to offer such services they may well find that it is best to outsource RCS to development research agencies.

Another key recommendation is for the encouragement of greater investment by developing countries, along with greater provisions for regional networking and South-South cooperation. The key point here is that a higher level of success may be achieved through collaborations among countries that have similar development problems. Several large developing countries have advanced capabilities and well-developed academies and should be encouraged, funded and facilitated to respond to the global health crisis in this way. There are also a number of regional health networks such as AFRO-NETS and SOMA-NET that could play a larger role in RCS and need to be strengthened.

Given the financial situation in many low-income developing countries, what is required is development assistance that is more predictable and consistent over a long period to facilitate strategic planning. What is also needed is greater ownership and control of development assistance by developing countries (i.e. moving RCS to sectors E and F in

figure 1). It is on this basis that it is proposed that national health research systems should be funded under a SWAp approach. In this scheme donor funding would be pooled and provide direct budget support which in turn would be disbursed through ministries or national agencies to fund research programmes in qualified research institutions.

What is called for in the above list of recommendations are innovations that would fit into the emerging best-practice of a recipient-led assistance strategy. Giving greater levels of control and authority to the recipient country and its key institutions is critical for RCS to be realized. This calls for a new governance structure within commissioning agencies and between them and recipients. In this respect the RCS issue is at the cutting edge of the development assistance debate and provides much impetus for adopting an alternative approach to capacity development.

Figure 3: Typology of Commissioning and Partnering Practices

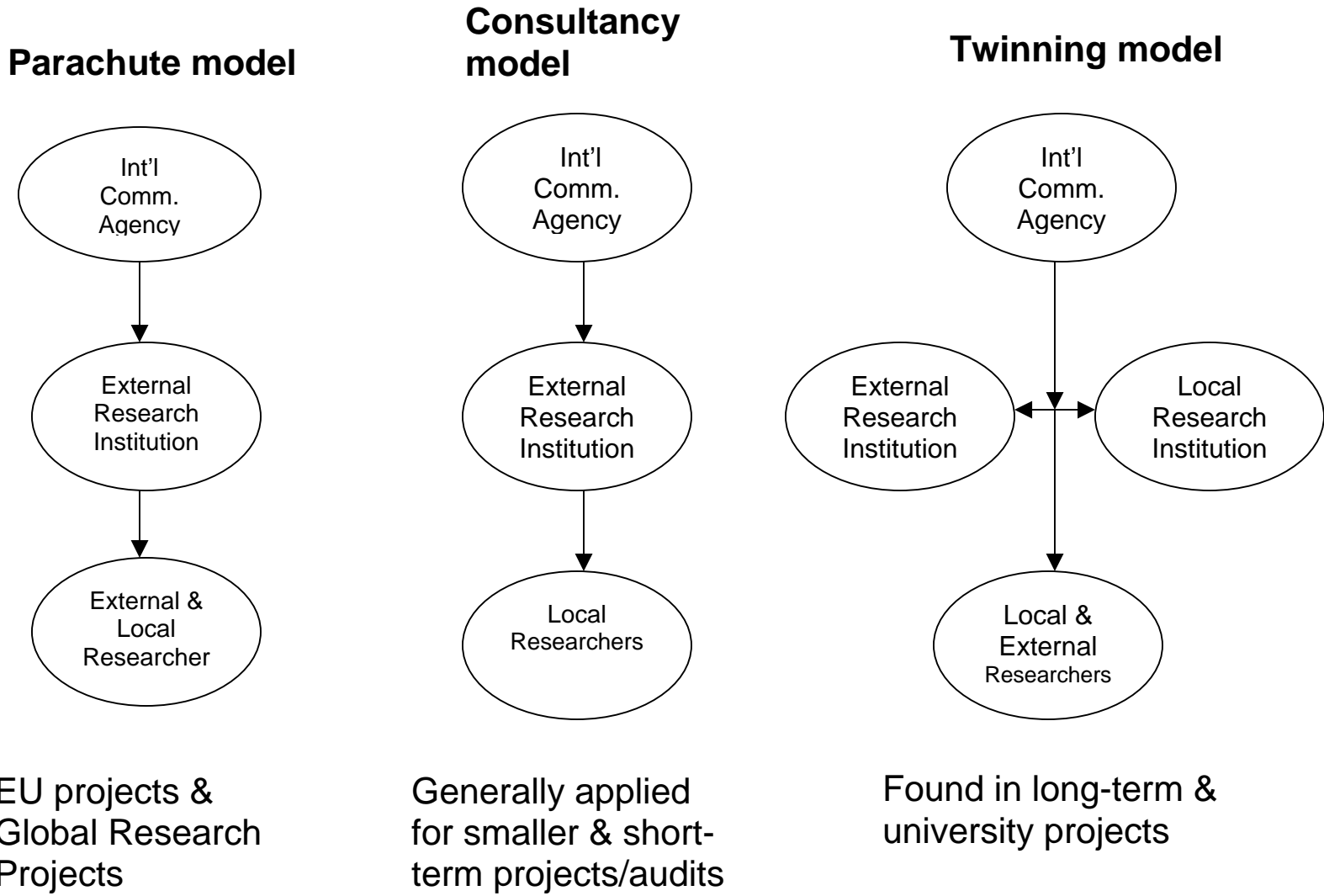


Figure 3: Typology of Research Commissioning and Partnering Practices (cont'd)

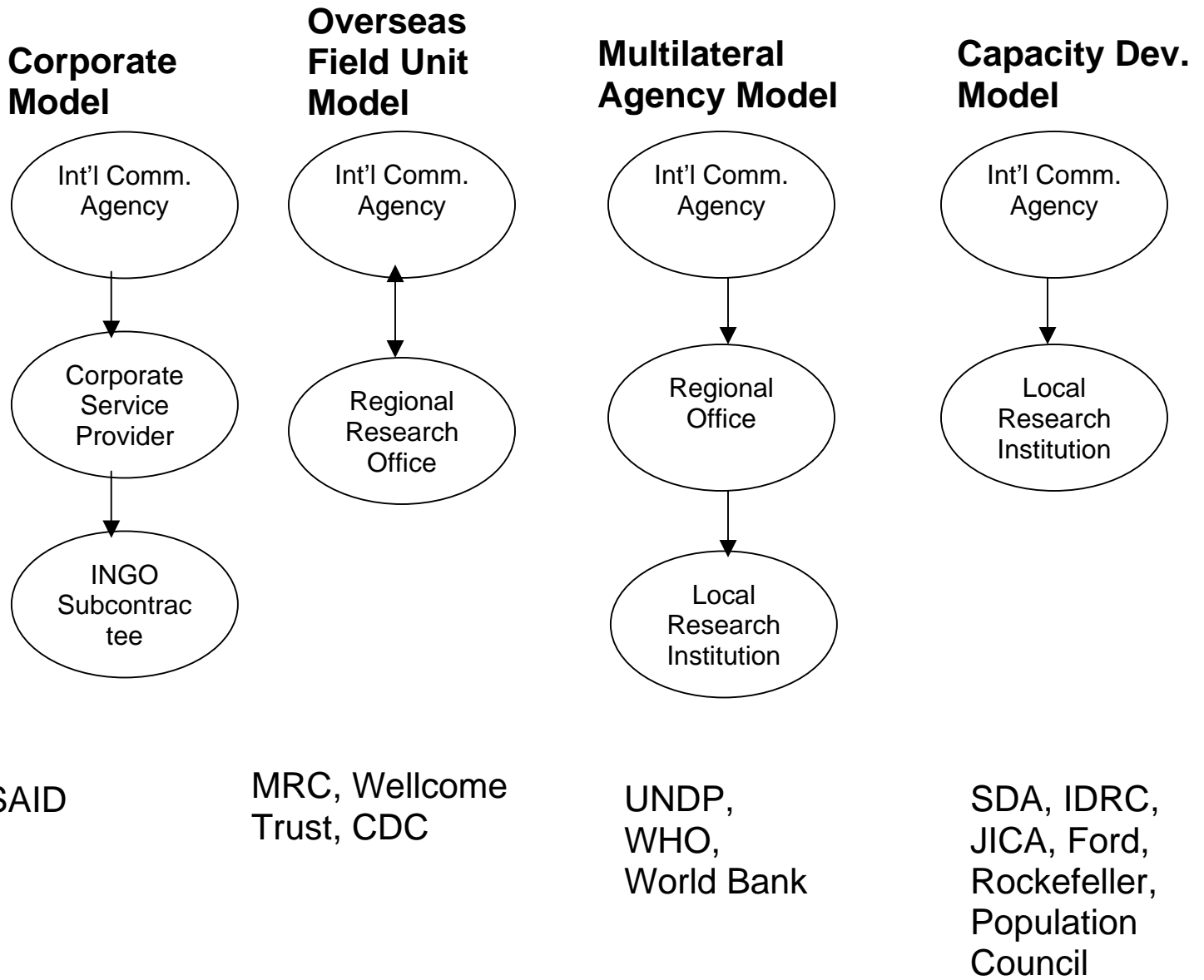
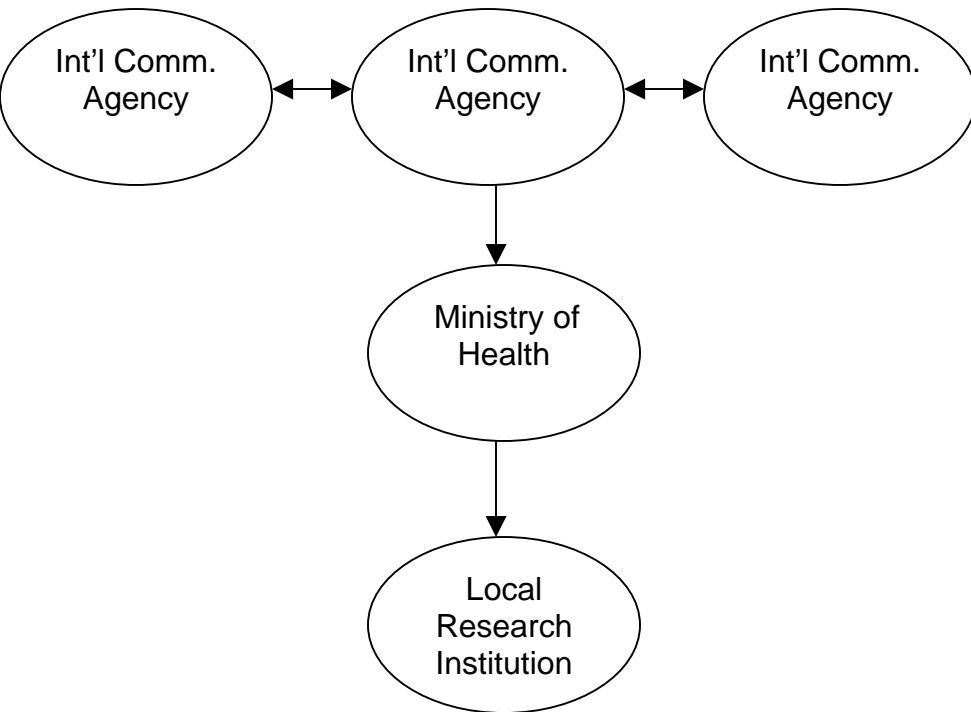


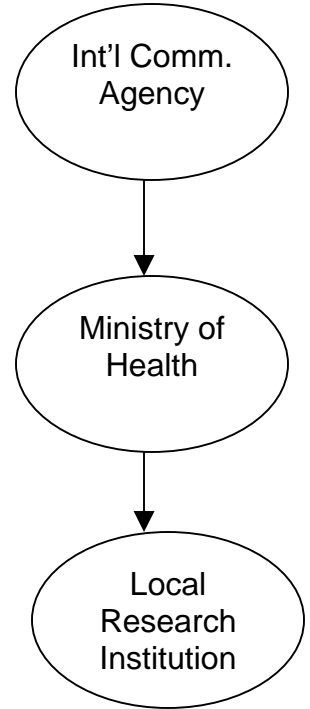
Figure 3: Typology of Commissioning and Partnership Practices (cont'd)

SWAps Model



Health Sector SWAp in Tanzania

Health Support Unit Model



Danida, Italian coop.

Bibliography

- ActionAid International (2006) *Real Aid: Making Technical Assistance Work*. Johannesburg: ActionAid International.
- Arap Ng'ok, Joseph, et al (1994) "Impact of Structural Adjustment Policies on Health Research" in R.N. Oduwo, et al eds. *Proceedings of the Convention on National Health Research Plan*. National Health Research and Development Centre, Nairobi, Kenya: 52 – 66.
- Berg, Elliot J (1993) *Rethinking Technical Cooperation. Reform for Capacity Building in Africa*, (E. Berg, coordinator), Regional Bureau, United Nations Programme and Development Alternatives, Inc. Nations-Unies.
- Box, Louk (2001) *To and Fro: International Cooperation in Research and Research on International Cooperation* Maastricht (Inaugural lecture, Maastricht University Press).
- COHRED (1990) *Health Research: Essential Link to Equity in Development*. Commission on Health Research for Development: New York: Oxford University Press.
- COHRED (2004) *Principles of Good Partnerships For Strengthening Public Health Education Capacity in Africa. Report of a Consultative Meeting*. Commission on Health Research for Development: Geneva.
- Costello, A. and Zumla, A. (2000) Moving to research partnerships in developing countries. *British Medical Journal* 321,827-9.
- DFID (2005) *Research Funding Framework, 2005 – 2007*. Sourced: www.dfid.org.
- Danida (2000) *Evaluation of Danida's Bilateral Programme for Enhancement of Research Capacity in Developing Countries (ENRECA)* Ministry of Foreign Affairs/Danida, Copenhagen.
- Edejer, T.T. (1999) North-South Research partnerships: The Ethics of Carrying out Research in Developing Countries. *British Medical Journal* 319: 438-441.
- DGIS (2001) *Comparative study of the impacts of donor-initiated programmes on research capacity in the south. Report to the Directorate-General for Development Cooperation (DGIS) Division for Research and Communication, Ministry of Foreign Affairs, The Netherlands*,
- Gakunju, Dolly (1994) "The Role of Research in Health Service Reforms" in R.N. Oduwo, et al eds. *Proceedings of the Convention on National Health Research Plan*. National Health Research and Development Centre, Nairobi, Kenya: 49 – 51.
- Global Forum for Health Research (2004) *The 10/90 Report on Health Research, 2003-2004*. www.globalforumhealth.org.
- Hauck, V and T. Land (2000) Beyond the Partnership Rhetoric: Reviewing the Experience and Policy Considerations for Implementing 'Genuine' Partnerships in North-South Cooperation. (ECDPM Discussion Paper 20). Maastricht: ECDPM.
- Helland, J. 2000. Research capacity building through partnership: the Tanzanian-Norwegian case. *Capcaity.org*, (6).
- Higginbotham, N (1992). "Developing Partnerships for Health and Social Science Research: The International Clinical Epidemiology Network (INCLIN) Social Science Component" *Social Science and Medicine* 35.11: 1325-1327.

- IDRC (2005) How to Approach IDRC for Funding. (accessed 10/11/2005. http://www.idrc.ca/admin/brochures/Proposition_e.htm).
- Jentsch, B. and Pilley, C. (2003) Research relationships between the South and the North: Cinderella and the ugly sisters? *Social Science and Medicine* 57 (10), 1957-67.
- Joint Learning Initiative (JLI) (2004) *Human resources for health: overcoming the crisis* Cambridge (MA): Harvard University Press.
- Maselli P, Lys J-A, Schmid J (2004) *Improving Impacts of Research Partnerships*. Berne: Swiss Commission for Research Partnerships with Developing Countries.
- Milèn, Anneli (2001) *What do we know about capacity building? An overview of existing knowledge and good practice* Geneva: World Health Organization.
- Munishi, Gaspar (2004) "Donor Participation in Tanzanian Health Sector Reform: Development of Local Accountability and Sustainability". In G. Mwabu, et al, eds. *Improving Health Policy in Africa*. Nairobi: University of Nairobi Press: 607 – 627.
- Nair, K.N. and Menon, V. (2002) *Capacity Building for Demand-Led Research: Issues and Priorities*. ECDPM Policy Management Brief 14.
- Nchinda, Thomas C (2002) "Research Capacity Strengthening in the South" *Social Science and Medicine* 54.11: 1699-1711.
- OECD/DAC. (1999) Criteria for donor agencies' self-assessment in capacity development. Rome.
- OECD (2003) "Managing for Development Results and Aid Effectiveness" (Report on the DAC Development Partnership Forum) *DAC Journal* 4.3: 41-72.
- Paraje, G R. Sadana & G. Karam (2005) "Increasing International Gaps in Health-Related Publications" *Science* 308: 5724: 959-960.
- RAWOO (2002). *Making Social Sciences Matter in the Fight Against HIV/AIDS*. Netherlands Development Assistance Research Council, Publication 24.
- RAWOO (2001a). *North-South Research Partnerships: Issues and Challenges*. Netherlands Development Assistance Research Council, Publication 22.
- Rosenfeld, P (1992) "The Potential of Transdisciplinary Research for Sustaining and Extending Linkages between Health and Social Sciences" *Social Science and Medicine* 35.11: 1343-1357.
- Sadana, R & T. Pang (2003) "Health Research Systems: A Framework for the Future." *Bulletin of the World Health Organization* 81.3.
- Silva, Kalinga Tudor, et al (1994) "Promoting interdisciplinary collaboration in health research in developing countries: lessons from the triangle programme in Sri Lanka" *Acta Tropica* 57, Issues 2-3: 175-184.
- Simon, Jonathon (2000) "Commentary: Does strengthening research capacity improve health equity?" *BMJ* 321: 816-817.
- Sitthi-amorn, Chitr & Ratana Somrongthong (2000) "Strengthening health research capacity in developing countries: a critical element for achieving health equity" *BMJ* 321: 813-815.

Trostle, J (1992) "Research Capacity Building in International Health: Definitions, Evaluations and Strategies for Success" *Social Science and Medicine* 35.11: 1321-1324.

Trostle, J. and J. Simon (1992) "Building Applied Health Research Capacity in Less-Developed Countries: Problems Encountered by the ADDR Project" *Social Science and Medicine* 35.11: 1379-1387.

UNCTAD (1999) *Making North-South Research Networks Work*. UN: Geneva.
UNCTAD/ITE/EDS/7.

UNHRO (2002). *An Inventory of Studies on Malaria, HIV/AIDS and TB in Uganda over the past 5 years (1997 – 2002)*. Uganda National Health Research Organization, Entebbe, Uganda.

UNHRO (2000) *An Analysis of Institutions Doing Health Research in Uganda - Year 2000*. Uganda National Health Research Organization, Entebbe, Uganda.

Velho, Léa (2002) *Research Capacity Building in Nicaragua: From Partnership with Sweden to Ownership and Social Accountability* UNU/INTECH Discussion Paper 2002-9. Maastricht: UNU/INTECH

Wight, Danny (2005). *Impediments to Developing Social Science Research Capacity in East Africa*. Medical Research Council Social and Public Health Sciences Unit, Occasional paper No. 14.

Wohlgemuth, L. (2006) *Changing Aid Modalities in Tanzania* (ECDPM Policy Management Brief no. 17). Maastricht: ECDPM.

World Bank (2005) *Capacity Building in Africa: An OED Assessment of World Bank Support*. Washington DC, World Bank.