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Review of DANIDA-supported health research in developing countries

Main report

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List of abbreviations

AAMVM	African Association of Medical and Veterinary Malacology
ACT	Artemisinin-based Combination Therapy
AJSC	Annual Joint Scientific Conference
AMBRELA	Amani Modern Biomedical Research Laboratory
AMANET	African Malaria Network Trust
AMVTN	African Malaria Vaccine Testing Network
ART	Antiretroviral Treatment
AU	Aarhus University (Denmark)
Bandim	Bandim Research Centre in Guinee Bissau
BMGF	Bill and Melinda Gates Foundation
CC	Co-ordinating Committee
CDR	Centre for Development Research, Denmark
CEEMI	Centre for Enhancement of Effective Malaria Interventions
CESA	Cysticercosis in Eastern and Southern Africa
CET	College of Engineering and Technology
CHDC	Child Health Development Centre, Makerere University, Uganda
CISU	Centre for International Health and Development, Denmark
CMO	Chief Medical Officer
CMP	Centre for Medical Parasitology
COHRED	Council on Health Research for Development
COSTEC	Commission for Science and Technology
CSP	Corporate Strategic Plan
CW	Constructed Wetlands
CWEGESA	Cysticercosis Working Group in Eastern and Southern Africa
DANIDA	Danish Development Agency
DBL	Danish Bilharzia Laboratory, now called DBL-Institute for Health Research and Development
DBL-IHRD	DBL-Institute for Health Research and Development
DC	Developing Country
DFSC	Danish Forest Seed Centre
DFU	Danish University of Pharmaceutical Sciences, now Faculty of Pharmaceutical Sciences in UC
DFVF	Danish Institute for Food and Veterinary Research
DGISP	Danish Government Institute of Seed Pathology
DKK	Danish Krone
DOTs	Direct Observed Therapy
DRNIH	Danish Research Network for International Health
EANMAT	East African Network for Monitoring Antimalarial Treatment
EDCTP	European and Developing Countries Clinical Trials Partnership
EMVI	European Malaria Vaccine Initiative
ENHR	Essential National Health Research
ENRECA	Enhancement of Research Capacity
ESA	Eastern and Southern Africa
FFU	Advisory Committee to the Danish Research Council
FGD	Focus Group Discussion
FIBOZOPA	Fishborne Zoonoses
GCP	Good Clinical Practice
GEPPA	Network concerning Governance, Economic Policy and Public Administration
GFHR	Global Forum for Health Research
GLP	Good Laboratory Practice
GMP	Gates Malaria Partnership
GSK	GlaxonSmithKline
DRNIH	(Danish) Health Research Network or Network for International Health, also called SUNET
HRUTF	Health Research User Trust Fund
HRU	Health Research Unit
HSPS	Health Sector Programme Support
IAVI	International Aids Vaccine Initiative
ICDDR	International Centre for Diarrhoeal Diseases Research, Bangladesh

IHRDC	Ifakara Health Research and Development Centre
ILRI	International Livestock Research Institute
INDEPTH	International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries
IPTi	Intermittent Preventive Treatment in Infants
IPTp	Intermittent Preventive Treatment in Pregnancy
JICA	Japanese International Cooperation Agency
JMP	Joint Malaria Programme
KCMC	Kilimanjaro Christian Medical College
KIT	Koninklijk Instituut der Tropen (Netherlands Institute of Tropical Medcine)
KVL	The Royal Veterinary and Agricultural University
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goal
MIM	Multilateral Initiative on Malaria
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoFA	Ministry of Foreign Affairs
MoU	Memorandum of Understanding
MRC	Mwanza Research Centre
MVI	Malaria Vaccine Initiative
NETARD	Network for Agricultural Research and Development
NGO	Non-Governmental Organization
NHRERC	National Health Research Ethics Review Committee
NHRS	National Health Research System
NIH	Network for International Health, Denmark (also called Health Research Network or SUNET)
NIMR	National Institute for Medical Research, Tanzania
NORAD	Norwegian Agency for Development Cooperation
PHC	Primary Health Care
PI	Principal Investigator
ReNED	Network for Environment-related Development Research
Rigshospitalet	Danish State University Hospital
RNAS	Regional Network for Research, Surveillance and Control of Asian Schistosomiasis
RNSA	Research Network for Schistosomiasis in Africa
RUF	Advisory Committee to DANIDA on Research (no longer functioning)
SC	Steering Committee
SDC	Steno Diabetes Centre
SOP	Standard Operating Procedure
SP	Sulfadoxine-pyrimethamine
SSI	Statens Serum Institute
STA	Senior Technical Adviser
STI	Swiss Tropical Institute
SUA	Sokoine University of Agriculture
SUNET	Network for International Health, Denmark
SWAp	Sector-Wide Approach
TANESA	Tanzania-Netherlands Project to Support HIV/AIDS
TANHER	Tanzania National Health Research Forum
TAS	Technical Advisory Services, DANIDA, Ministry of Foreign Affairs
TDR	UNICEF/UNDP/World Bank/WHO Special Programme for Research and Teaching in Tropical Countries
TOR	Terms of Reference
UC	University of Copenhagen
UC-CMP	University of Copenhagen, Centre for Medical Parasitology
UC-DA	University of Copenhagen, Department of Anthropology
UC-DIH	University of Copenhagen, Department of International Health
UC-SD	University of Copenhagen, School of Dentistry, Community Oral Health University of Copenhagen
VCD	Vector Control Division, MoH, Uganda
WHO	World Health Organization
WHO-CC	World Health Organisation Collaborating Centre

WSP	Waste Stabilization Ponds
VLIR	Vlaamse Inter Universitaire Raad (Inter University Board of Flanders)

1 Resources allocated to health and health-related activities

Introduction

This section presents the full text with all tables and figures, which has been presented in a shorter version in Volume I, section 5.4.

1.1 Health and health-related research funding: ENRECA and RUF/FFU

The following analysis is mainly based on the existing database of the Research Unit of DANIDA. The database[1] stores information on each approved research project, including ENRECA, research projects, PhDs projects and post-doctoral research projects (the latter two both classified as research projects), research initiatives (limited funding of preparatory work of larger projects) and some stipends (to attend national/international conferences, contribution to publication fees, development of dissemination materials (e.g. films), etc.). The Research Unit provided the information to the review team regarding approved health research projects for the period under review (1997-2006), including those ENRECA projects approved earlier but still ongoing during the period under review. Projects are listed per starting date[2]. Financial data concern approved allocations, which cover the whole project period. It does mean that for more recent projects those amounts can go beyond 2006. Note that reviewing annual expenditure data was beyond the scope of the current review.

The database excludes support to international research organisations or national/international research networks. In addition, research supported through core-funding is not recorded in the database. Analysis of research supported through DBL-IHRD, network and international funding is presented in the following sections.

For the purpose of this review, it was decided to include all health research projects and all health-related research projects in the fields of nutrition, as well as water and sanitation. The scope includes all HIV/AIDS projects, but excludes social sector projects.

The analysis includes 15 ENRECA projects that commenced prior to 1997, but were ongoing in the period under review. For those projects it was impossible to define which resources were already spent before the arbitrary cut-off point of 1997. It is important to note that in the overview these ENRECA projects represent a substantial amount (i.e. DKK 233.7 million). It is also noteworthy that a number of projects are ongoing that have not yet spent all resources allocated. Consequently, the analysis of the allocations presented should be viewed as approximate only.

Including the 15 ongoing ENRECA projects that commenced prior to 1997, DANIDA has allocated a total of DKK 537.1 million to health and health-related research. This included 30 ENRECA projects and 101 research projects. Excluding the ENRECA projects approved before 1997, the total amount is DKK 305 million, divide over 116 projects (and contracts). The average amount allocated to an ENRECA project prior to 1997 was DKK 15.5 million and in the period under review (i.e. 1997-2006), DKK 9.9 million. Excluding smaller ENRECA

[1] Because of a new database system being under development at DANIDA, the 'old' database did not include complete data for the year 2006. Those data have been provided separately by the Research Unit and have been added by the review team. The review team's underlying assumption is that the database is sufficiently accurate to carry forward the current financial analysis.

[2] This is different from the date of approval. A project approved in 2005, may still start in 2005, but most often only starts in the following year. Data presented for certain time periods reflect therefore in general decisions made in the preceding year. Decisions made on research proposals in 2006 (in general starting only in 2007) are therefore excluded from the overall analysis.

allocations[3], the average ENRECA allocation in 1997-2006 was equivalent to DKK 12.9 million.

Table 1. Allocations to health and health-related research implemented in the period 1997-2006, including 15 ENRECA projects that were approved prior to 1997

Category	Number of projects	Total allocation (DKK)	Average allocation per project (DKK)
Research	101	156,966,886	1,554,128
ENRECA	30	380,146,531	12,671,551
Total	**131**	**537,113,417**	**4,100,102**

Table 2. Allocations to health and health-related research implemented in the period 1997-2006, excluding ENRECA projects that were approved prior to 1997

Category	Number of projects	Total allocation (DKK)	Average allocation per project (DKK)
Research	101	156,966,886	1,554,128
ENRECA	15	147,995,657	9,866,377
Total	**116**	**304,962,543**	**2,628,987**

Excluding smaller allocations in the database, mainly used for publication fees, costs for development of dissemination materials, conference fees, costs for preparing larger projects or stipends, the average allocation was DKK 1.7 million for a research project (including individual PhD projects) and DKK 14.6 million, for an ENRECA programme.

Table 3. Allocations to health and health-related research implemented in the period 1997-2006, including ENRECA projects that were launched prior to 1997, but excluding research projects below DKK 100,000 and ENRECA programmes below DKK 220,000

Category	Number of projects	Total allocation (DKK)	Average allocation per project (DKK)
Research	90	156,564,805	1,739,609
ENRECA	26	379,690,449	14,603,479
Total	**116**	**536,255,254**	**4,622,890**

Over the past decade, Africa was by far the most important sub-region of the world in terms of DANIDA resources allocated for health and health-related research, representing 73% of the total number of projects and 72% of the total resources allocated. Asia received 21% of the resources and Latin America less than 1%. Inter-regional projects[4] received 5%.

[3] Three allocations below DKK 220,000 have been excluded from this analysis in order to calculate a more meaningful average value.

[4] Interregional projects include multi-country programmes covering countries in different regions (e.g. Africa and Asia).

Table 4. Regional allocations of DANIDA-supported health and health-related research covering the period 1997-2006

Region	Number of projects	%	Total allocation (DKK)	%	Average allocation by project (DKK)
Africa	95	73%	387,097,961	72%	4,074,715
Asia	25	19%	112,795,538	21%	4,511,822
Latin America	3	2%	1,917,270	0%	639,090
Inter - regional	6	5%	28,360,882	5%	4,726,814
Research Network	1	1%	7,748,000	1%	

The scope of the research focus is quite varied, but 83% of all resources are allocated to the three major poverty-promoting diseases, namely malaria[5], HIV/AIDS and tuberculosis (31%), health-related sectors[6] (24%), priority health programmes[7] (17%) and health systems research[8] (11%). The analysis below is based on the main focus of each project. It should be noted, however that the classification categories are not mutually exclusive (e.g. a malaria research and control project can also have health systems research components). In addition, for a few projects an arbitrary decision had to be taken[9]. The list of topics covered under each focus is presented in Volume I, Annex 2.

Table 5. Allocations of DANIDA-supported health and health-related research per focus area in the period 1997-2006

Focus	Total allocation (million DKK)	Proportion	Region[10]	ENRECA	Research
Major "poverty" diseases	171.61	31%	Africa+++/Asia	9	30
Health-related interventions	132.19	24%	Afr/As/LatAm/Reg	6	13
Priority health programmes	86.81	17%	Africa/Asia/LatAm	4	30
Health systems research	73.21	11%	Africa/Asia/Regional	3	9
Pharmaceuticals	27.98	6%	Africa/Asia	3	2
Neglected tropical diseases	21.43	5%	Africa/Asia	2	8
Health in conflict zones	9.11	1%	Africa	0	1
Health Research Network	7.75	2%	Denmark	1	0
Chronic diseases	3.35	1%	Africa/Latin America	0	2
Acute diseases	2.95	1%	Africa/Asia	0	3
Unclassified	0.92	3%		1	1

[5] Malaria was by far the "leading" poverty disease in terms of resources allocated to the main poverty diseases: 87% (equal to 26% of the total resources allocated to ENRECA and research projects).

[6] Health related interventions include human health related nutrition, water and sanitation projects.

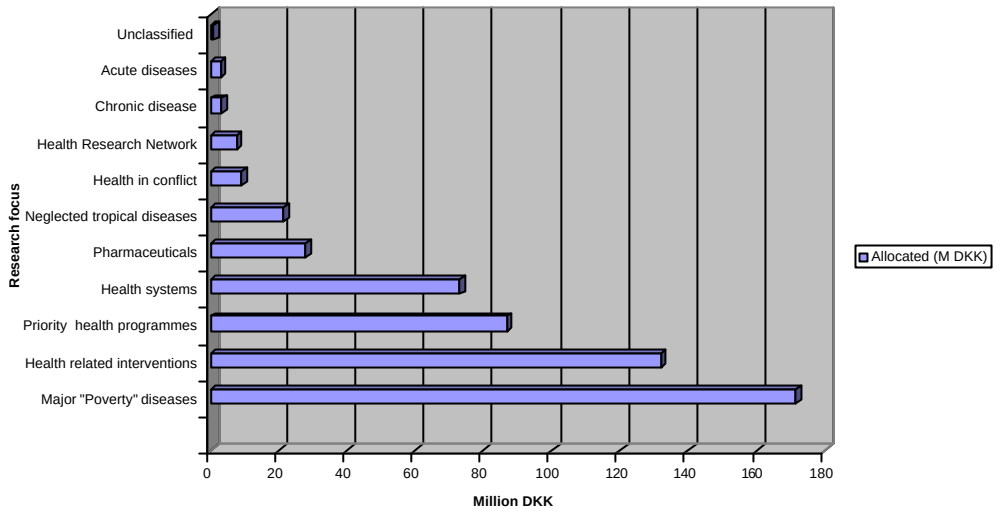
[7] Priority health programmes include reproductive health, sexual health, child health and oral health. Projects dealing with nutrition and reproductive health have also been included under this category.

[8] Health systems research includes research dealing with health systems, human resources, health financing and health promotion. Pharmaceuticals have been put separately but could also fall under the category of health systems.

[9] This concerns mainly two major projects where the focus was on different tropical diseases: (i) malaria and leishmaniasis in Sudan, and (ii) malaria, lymphatic filariasis and health reform in Tanzania. Both of these ENRECA projects were classified as malaria due to their main research focus. Also, some ENRECA projects cover a wide variety of different research topics and are difficult to classify. For example, TORCH and Khedar have been classified as health systems research. Again, some focus areas could be presented differently, for example research on access to essential medicines could also be classified as health systems research.

[10] Abbreviations used: Afr for Africa, As for Asia, LatAm for Latin America, Reg. for Inter-regional projects. For example: Afr/As/Lat.Am/Reg means that the majority of projects is in Africa, followed by Asia, Latin America and Inter-regional projects (based on the total resources allocated). Africa +++ / Asia means that almost all projects are in Africa and few in Asia.

Figure 1. Allocations of DANIDA-supported health and health-related research per focus area in the period 1997-2006



Interestingly, the research focus shifted substantially over time. The analysis below divides the data in three distinct time zones, namely (i) 1990-1996 (decisions taken prior to the review period), (ii) 1997-2001, and (iii) 2002-2006. As explained above, projects are listed according to the start date rather than the date of the final decision made and funding coming forward. The following conclusions can be drawn. First, the overall allocation to health and health-related research shows a substantial decrease over time[11]. Second, there is a strongly declining trend for health-related interventions (i.e. nutrition and water/sanitation), for health systems and for pharmaceuticals. Major poverty-promoting diseases and priority health programmes show a 'swinging' trend. Progressively more resources were allocated to neglected tropical diseases. It is not clear whether these trends are based on a clear policy-based choice, or whether they are in line with changes in DANIDA's priorities.

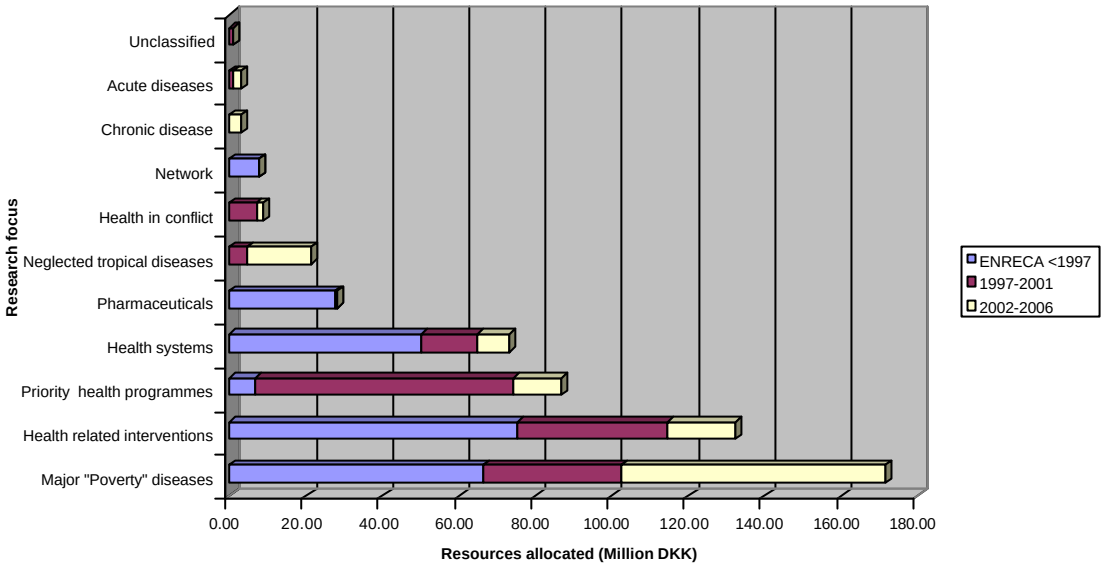
Table 6. Allocations of DANIDA-supported health and health-related research per focus area, stratified into three distinct time periods (all figures are expressed in million DKK)

	ENRECA <1997	%	1997-2001	%	2002-2006	%
Major "poverty" diseases	66.44	28%	36.09	21%	69.08	52%
Health-related interventions	75.22	32%	39.59	23%	17.38	13%
Priority health programmes	6.72	3%	67.33	39%	12.73	10%
Health systems	50.02	21%	14.63	9%	8.56	6%
Pharmaceuticals	27.54	12%	0.44	0%	0	0%
Neglected tropical diseases	0	0%	4.79	3%	16.64	13%
Health in conflict	0	0%	6.99	4%	2.11	2%
Health Research Network	7.75	3%	0	0%	0	0%
Chronic diseases	0	0%	0	0%	3.35	3%

[11] The number of ENRECA projects still ongoing during the period under review (1997-2006) but decided before 1997 totals 15. However, only 10 ENRECA projects were decided in the 5 years prior to 1997. If only the 5 year period 1992-1996 is taken into account, in order to be more comparable with the two other 5-year periods, this would cover 10 ENRECA projects at a total value of DKK 136.5 million But this figure excludes all research projects, for which the review team has no data. However, if the same ratio of research projects versus ENRECA projects would be applied as for the period under review (see Table 2), the total of research and ENRECA projects for the period 1992-1996 would be equivalent to DKK 281 million, confirming a declining trend.

Acute diseases	0	0%	0.81	0%	2.15	2%
Unclassified	0	0%	0.92	1%	0	0%
Total	**233.68**	100%	**171.59**	100%	**132**	100%

Figure 2. Allocations of DANIDA-supported health and health-related research per focus area, stratified into three distinct time periods (all figures expressed in million DKK)



To obtain a more complete picture it is interesting to add to the above equation, the research projects supported by DBL-IHRD over the same time frame. The results of this additional analysis are presented in the next section.

1.2 Health research funding: DBL-IHRD

DBL-IHRD receives core-funding from DANIDA, similar to some other Danish research institutions. Over the period 1997-2006, this amounted to DKK 267.6 million, of which an estimated DKK 136.5 million (51%) has been allocated to research and capacity building in the South[12]. Using the same focus classification as above, DBL-IHRD has provided the information on how resources were spent[13]. The main focus areas include neglected tropical diseases, major poverty-promoting diseases and health systems research, as summarized in Table 7.

[12] This figure is based on actual accounts for 1997-2005 and budget figures for 2006.

[13] The analysis is not based on a project-by-project allocation to different categories but rather as a percentage allocation of the total accounts. In this presentation, the percentage allocation has remained stable throughout the period under review. It should be considered as a rough estimation only, based on the figure that 51% of resources (salaries included) have been used for research and research capacity building and on estimates of how resources are used under the different domains. The other 49% are allocated to other activities including: basic admin, knowledge management, internal capacity building and service provision.

Table 7. Resources allocated by DBL-IHRD to research and capacity building in the period 1997-2006

Research focus	Total allocation (DKK)	Proportion
Neglected tropical diseases	75,075,208	55%
Major "poverty" diseases	54,600,151	40%
Health systems	6,825,019	5%
Total allocation	**136,500,377**	

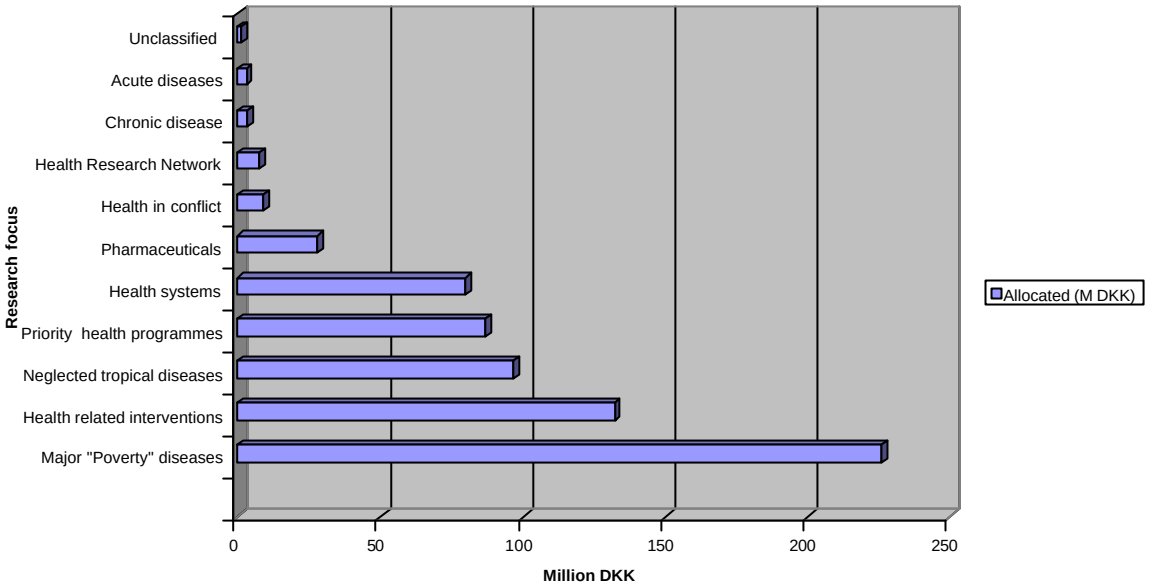
1.3 Health research funding: ENRECA, RUF/FFU and DBL-IHRD

Adding the DBL-IHRD research-related expenditures to the ENRECA and RUF/FFU allocations provides a more complete overview of how the DANIDA support to health research was focused over the past decade. The scope and sequence of the different foci remain largely unchanged, but neglected tropical diseases have become an important third priority area. Total allocations are estimated at DKK 673.8 million or DKK 441.6 million when excluding the 15 ENRECA projects that commenced prior to 1997.

Table 8. Allocations of DANIDA-supported health and health-related research per focus area including DBL-IHRD funds

Research focus	Total allocation (million DKK)	Proportion
Major "poverty" diseases	226.21	34%
Health-related interventions	132.19	20%
Neglected tropical diseases	96.50	14%
Priority health programmes	86.81	13%
Health systems	80.03	12%
Pharmaceuticals	27.98	4%
Health in conflict	9.11	1%
Health Research Networks	7.75	1%
Chronic diseases	3.35	0%
Acute diseases	2.95	0%
Unclassified	0.92	0%
Total allocation	**673.80**	

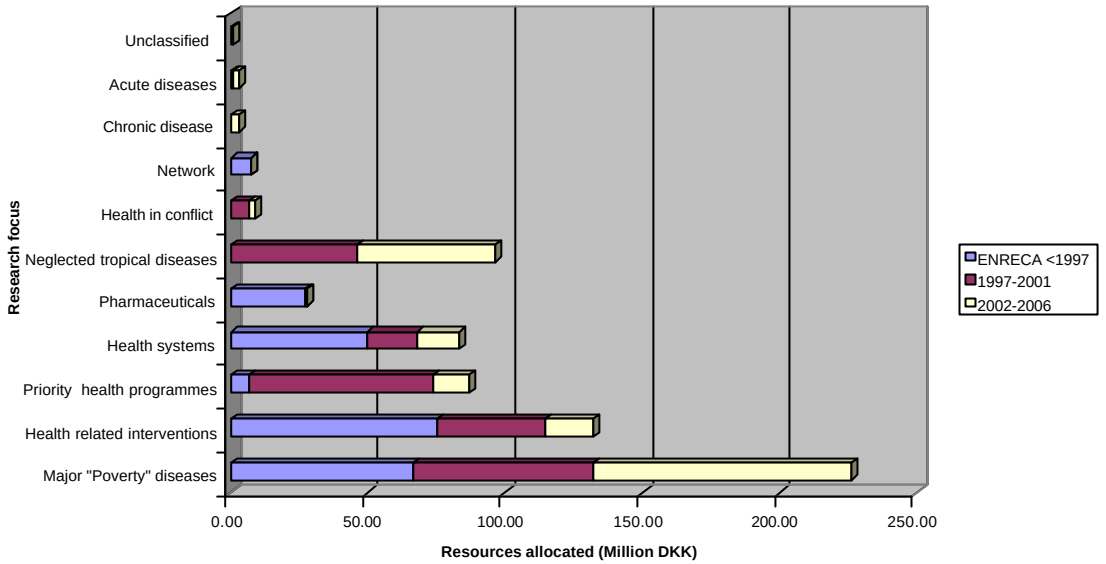
Figure 3. Allocations of DANIDA-supported health and health-related research per focus area including DBL-IHRD funds (all figures expressed in million DKK)



Trends in resource allocation by focus area over the review period are presented in Figure 4. The following trends are worth highlighting. First, there is a more stable and increasingly important funding for the three major poverty-promoting diseases. Second, health-related research[14] funding remained the second most important focus, but resource allocations in this field are rapidly diminishing. Third, research pertaining to neglected tropical diseases is the third priority, and resource allocation remained rather stable in the period 1997-2006. Interestingly, this area was primarily funded through DBL-IHRD. Fourth, priority health programmes received the fourth priority, but with 'insecure' financing or an important drop observed over the last 5 years. Fifth, there was a decrease in importance of health systems, being the fifth priority area overall, but reflecting some large ENRECA projects that commenced before 1997. Sixth, limited new resources had been allocated on pharmaceuticals in the period 1997-2006, and hence the major projects focusing on this area were all started before 1997. Seventh and finally, there is one new area, namely chronic diseases, with modest resource allocation.

[14] As indicated before the review includes research on nutrition, water and sanitation as health-related research activities.

Figure 4. Allocations of DANIDA-supported health and health-related research, including DBL-IHRD funds, per focus area, stratified by time period (all figures expressed in million DKK)



1.4 Funding of Danish research networks and Danish research centres

Funding of Danish research networks and Danish research centres occurs under budget heading 06.35.01.10 of the Finance Act. On average, for the period under review, allocations were about DKK 50 million per year for all sectors.

Table 9 summarizes funding of different research networks supported by DANIDA for the period under review (1997-2006), and includes allocations as agreed with DANIDA till 2009.

Table 9. Funding of DANIDA-supported Danish research networks in million DKK (1997-2009)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
NETWORKS													
The ENRECA Health Network	2.398				0.34	4.26				0.08			
Danish Research Network for International Health										0.77	4.495		
Network for Smallholder Poultry Development		10			10				4.8				
Network for Agricultural Research for Development					0.86	2.825		4.434					
Network for Environment-related Development Research (ReNED)							3.724						
GEPPA. Network concerning Governance, Economic Policy and Public Administration								3.216					
Danish Development Research Network (continuation of GEPPA, ReNED and NETARD)											9.98		

Financing of the networks is being approved by the DANIDA board. The ENRECA health network is the oldest network and has been funded as from 1997 onwards. From 2006 the funding continued as the Danish Research Network for International Health. On average, the health research network received DKK 745,000 per year between 1997 and 2006. Under the ENRECA, the network also received an additional DKK 7.75 million for the period 1995-2005. Its financing is being secured until 2009. Financing of the other networks will be stopped by 2007. The networks concerning (i) Governance, Economic Policy and Public Administration, (ii) Environment, and (iii) Agriculture are being merged in a single Network for Development Research as from 2007 onwards.

Table 10. Core-funding of Danish research centres (not only health) in million DKK

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
CENTRES													
DBL-IHRD	28	30	30	30	31	29	24	92				…	…
Centre for Forest and Landscape	30.5			7	7	6	6	24				…	…
Danish Seed Health Centre	13.4	20		15		13	10	47.5					

DIIS (formerly CDR or CUF) has been managed outside the research office since 2003. It has its own budget line (6.11.13) in the Finance Act.

1.5 Multilateral or international health research funding

The allocations to international health research networks and international health research organisations are presented in Table 11. Data have been provided by DANIDA and some by the networks[15].

The data support the following observations: (i) the level of international funding varies substantially between years, but this may reflect incomplete data for the earlier years under review; (ii) the allocation pattern seems to be more 'stable' in the last couple of years; (iii) the total allocation to international health research organisations has increased and almost doubled over the period under review; (iv) the level of financial support varies substantially between different research organisations.

The reasons why some organisations get support up to DKK 1 million and others up to DKK 10 million are not clear. The review team is not aware of specific criteria used by DANIDA to decide on: (i) which international organisations to support (or which not); (ii) the level of support. It should be noted that decisions may be taken by different DANIDA units as not all of the allocations fall under the authority of the International Development Research that has a budget of DKK 50 million (of which DKK 35 million is earmarked for agricultural research). For example, support to IAVI and IPM was funded through a specific budget line under the DANIDA multilateral office. However, all international support is being approved by the DANIDA Board (and is thus outside of the scope of RUF/FFU).

Table 11. Allocations to international health research organisations and networks

[15] Some data have been cross-checked with the international research organisation, but not consistently. The Review Team is not sure whether the above data are complete as data collection both at DANIDA and recipient institutions may have been incomplete.

International research	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total
EMVI			0.4		0.2	0.8			1	1	**3.4**
AMANET					0.6		1	1	1	1	**4.6**
IAVI					15.0	10	10	10	10	10	**65.0**
IPM						1	4	5	7.5	10	**27.5**
TDR	16.5	16.5	8.25	15	10.0	10	10	10	10	10	**116.3**
COHRED	1	1	1	0.8	0.8	1	1	1			**7.6**
GFHR						0.7	2	2			**4.7**
Total	**17.5**	**17.5**	**9.7**	**15.8**	**26.6**	**23.5**	**28.0**	**29.0**	**29.5**	**32.0**	**229.1**

1.6 Summary of all health research funding during the period under review

The financial resources allocated to health research through different channels over the period under review is summarised in Table 12. The presentation excludes the 15 ENRECA projects that commenced prior to 1997 (and were still ongoing during the period under review). For DBL-IHRD it takes into account the full core-funding allocated. For multi-annual funding (e.g. for the Research Network for International Health and for DBL-IHRD) allocations have been equally divided over the years covered.

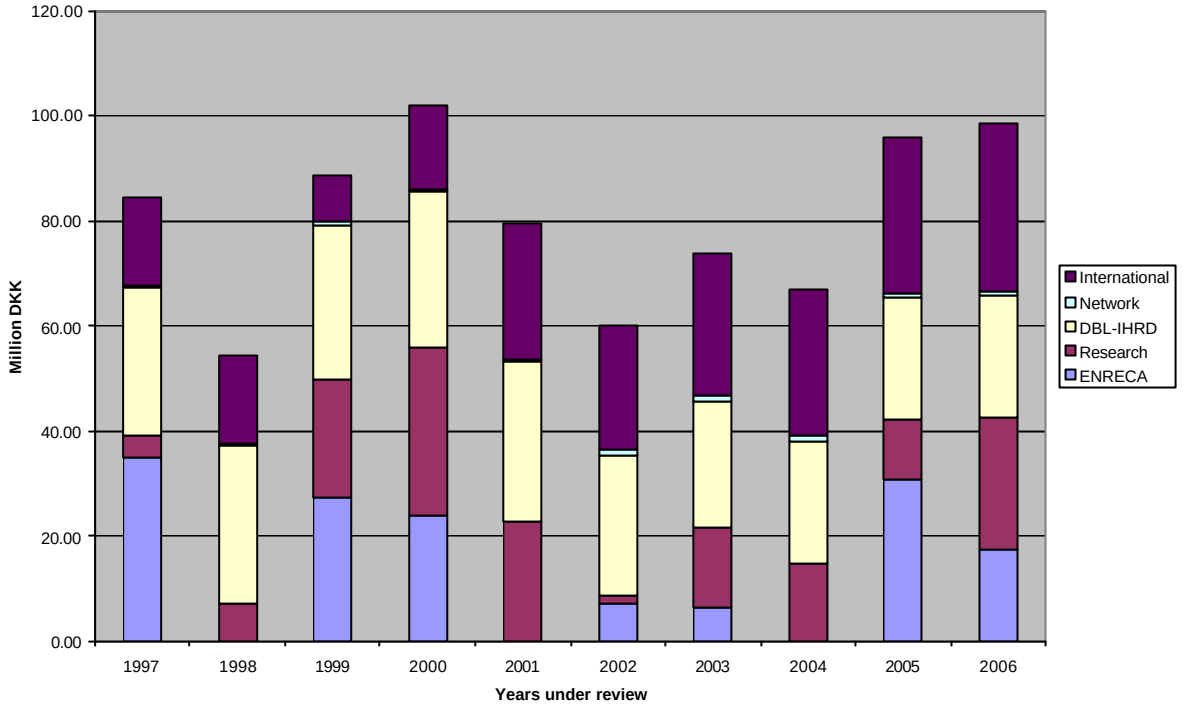
It should be noted that the DANIDA Finance Act includes several budget lines under the budget heading "Research and Information Activities in Denmark". Budget line 06.35.01.11 covers "Research activities", a budget of almost DDK 100 million annually, including ENRECA and research projects for all sectors. The other budget lnes cover a variety of activities, of which some may also be related to research (e.g. conferences, seminars; fact finding; evaluation; information). The latter budget lines have not been taken into account in this review.

Table 12. Total health research funding in million DKK during the period 1997-2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total	%
ENRECA	35.05	0.00	27.39	23.82	0.00	7.30	6.34	0.00	30.71	17.40	148.00	18%
Research	4.02	7.25	22.43	32.00	22.75	1.26	15.28	14.97	11.65	25.32	156.93	19%
DBL-IHRD	28.18	29.93	29.49	29.76	30.42	26.94	23.99	22.96	22.97	23.00	267.65	33%
Network	0.60	0.60	0.60	0.60	0.34	1.07	1.07	1.07	1.07	0.85	7.85	1%
International	17.50	17.50	9.65	15.80	26.62	23.50	28.00	29.00	29.50	32.00	229.07	28%
TOTAL	85.35	55.28	89.55	101.97	80.12	60.07	74.67	68.00	95.90	98.57	809.49	100%

It should be noted that Table 12 above includes a mix of decisions on allocations for research and ENRECA projects (covering multi-annual budgets) and annual allocations made (DBL-IHRD, DRNIH and international research). Total amounts reflect thus rather "decisions made" on resources for health research (see above regarding ENRECA and research projects). Actual funds allocated per year may thus differ from the above presentation.

Figure 5. Total health research funding in million DKK during the period 1997-2006



More than DKK 800 million have been allocated to health and health-related research in the 10-year period reviewed, averaging about DKK 80 million per year. About one third of this was allocated through DBL-IHRD. International research got about 28%. The remaining 39% was allocated to research projects (20%), ENRECA (18%) and the Network for International Health (1%)[16].

Funding levels for health research varied considerably over the past 10 years, from a low DKK 54 million in 1997 to a high DKK 102 million in 2000. Resource allocation to some budget headings seems more consistent than others. The decline in funding ENRECA projects up to 2004 is noteworthy. In 2005 and 2006 again a larger share was allocated to ENRECA. The resources being allocated per year to ENRECA also varied considerably. But the same applies to health research projects and to international health research, where funding levels have changed considerably from one year to another. Other budget headings such as DBL-IHRD and the Network for International Health have been more consistent throughout the period under review. While, if estimating that the annual allocation for all sectors has been about DKK 200 to 250 million, health and health-related sectors have received a substantial share of about 32-40%, it is surprising to note that allocations vary so much between years. This may to some extent reflect the absence of a research policy and/or the absence of clear criteria for decision-making on resource allocation.

[16] The Network for International Health also received some funding under the ENRECA projects. If that is taken into account, ENRECA has been financed at 17% and the Network got 2% of the total envelope.

2 Brief overview of DANIDA's support to international institutions and networks

2.1 Context

The MoFA/DANIDA provides contributions to several international and regional organisations. First and foremost to the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), but also to the International AIDS Vaccine Initiative (IAVI), the European Malaria Vaccine Initiative (EMVI), the International Partnership on Microbicides (IMP), the Council on Health Research for Development (COHRED), the Global Forum for Health Research (GFHR), and the African Malaria Network Trust (AMANET). Previously, some financial support has also been granted to, the Onchocerciasis Control Programme (OCP) and other WHO-supported programmes with some more limited research activities.

The continuous and stable contribution of DANIDA, for instance to TDR since inception of this special programme more than 30 years ago has made Denmark internationally recognised as a serious and reliable partner in health research for equity in development. In addition, the Danish research capacity building efforts (e.g. DBL-IHRD and ENRECA) are widely acknowledged in the South and have gained international recognition. As a result, Danish health research for development is often requested to attend international meetings or join scientific committees.

Below, a succinct overview is given to five of the most important DANIDA-supported international institutions and networks, namely (i) TDR, (ii) IAVI, (iii) COHRED, (iv) GFHR and (v) AMANET. In early January 2007, these institutions and networks were also interviewed by telephone. Emphasis was placed on funding activities covering the past five years, achievements made and prospects for the near future.

2.2 DANIDA-supported international institutions and networks

2.2.1 TDR

When TDR was initiated in 1975, it became the first global programme to intensify research and training into neglected diseases (e.g. malaria, schistosomiasis, trypanosomiasis, etc.). In the meantime, the programme has played a central role in the establishment of private-public partnerships, strengthening of basic and strategic research, product development and research capacity building in the developing world. TDR has, as a leading funding source, assisted the development and adaptation of products for local use in the prevention and control of major neglected diseases. TDR has supported the strengthening of numerous institutions in over 80 countries and awarded for more than 1000 research-training grants for formal graduate degree training of individuals from the developing world.

Thus far, TDR has undergone four external reviews, the latest of which was completed in May 2006. Since DANIDA is an important funding source of TDR, it is important to highlight some of the key findings of the latest external review.

Firstly, TDR has been highly successful in the past and it continues to be moderately successful with regard to fulfilling its mandate, which is the promotion of tropical disease research, both directly and through training activities. In fact, TDR has an unmatched track record in research capacity building in the South.

Secondly, in many aspects TDR is unique (i.e. sustained focus on neglected diseases affecting some of the most vulnerable population groups, institutional arrangements and convening/leveraging functions) and has become an extremely important organization. However, in a rapidly changing landscape of global health initiatives and changing modalities of development assistance, TDR seems in danger of getting marginalized. For example,

large amounts of funding are being channelled into product-developing public-private partnerships. Thus far, TDR failed to initiate and negotiate partnerships with some of these new entities or to define respective functions and tasks and set up linkages that are built on mutual trust. Thus, there is a pressing need that TDR positions itself correctly, so that it can continue to fulfil its mission.

Thirdly, TDR has a number of strengths, including (i) its scientific staff, governing structures, steering committees and expert working groups, (ii) the research catalyzed and fostered by TDR, (iii) the essential and sustained role in research capacity building and strengthening. Further advantages include its structure – TDR is a multilateral, intergovernmental, intersectoral, co-sponsored organization, largely within the UN system with WHO acting as its executing agency. There is pressing need to build on these strengths, which will include seriously negotiated alliances, partnerships and networks.

The external review concluded that TDR indeed will need to grow in the foreseeable future. To do so, TDR needs reorientation and new impetus, and hence it should evolve and grow, so that it becomes more firmly integrated into the new global health scene and can continue to play its unique role in capacity strengthening in disease-endemic countries in the tropics and subtropics.

2.2.2 IAVI

IAVI was established in 1996 with the goal to ensure the development of safe, effective, accessible, preventive HIV vaccines. IAVI pursues research and development of HIV vaccine candidates, conducts policy analyses, and serves as an advocate for the field with offices in Africa, Europe and India.

2.2.3 COHRED

COHRED was established in 1993 as an international NGO, and its goal is to promote, facilitate, support and evaluate the essential national health research (ENHR) strategy and other health issues of international priority. The need for equity and improved global prioritisation in health research, put forward in the report of the Commission on Health Research for Development in 1990, was the driving force for the establishment of COHRED. The commission concluded that the global health research was overwhelmingly focused on the health problems of the developed world, and that there was a gross mismatch between the burden of disease, and the investment in health research (i.e. the 10/90 gap). The commission emphasised that developing countries need stronger scientific and institutional capacity to address local problems. However, insufficient investments were made to build and sustain their health research capacity. Four main recommendations were made, namely (i) all countries should invest at least 2% of the national health expenditures in ENHR, including a long-term strategy of building and sustaining research capacity; (ii) setting up international partnerships to mobilise and focus the world's scientific capacity on the highest-priority health problems; (iii) mobilisation of more sustained international financial support to supplement investments by developing countries in research, including development assistance agencies committing at least 5% of health aid for ENHR and research capacity building, and engagement in more long-term commitments, for at least 10 years when embarking on support for institutional capacity building; and (iv) establishment of international mechanisms to monitor progress and to promote financial and technical support for research on key public health problems in the developing world.

2.2.4 GFHR

The GFHR was created in 1997, as an independent forum of donors, NGOs, foundations, industry and others. GFHR arranges annual fora for communication, information, review and

priority setting of global health research; conducts analytic work in priority setting, and has generated a large number of publications and initiatives, amongst these, on public-private partnership. The impetus for the creation of the GFHR came from an "Ad Hoc Committee on Health Research relating to future Intervention Options" for which WHO, in 1994, provided the secretariat. This Ad Hoc Committee prepared a landmark report emphasising that investing in health research will facilitate development. The report describes four key challenges which governments and health systems in the developing world were facing, namely (i) the traditional threats to maternal and child health, (ii) the changing threats from microbial evolution, (iii) the emerging epidemics of non-communicable diseases and injuries, and (iv) how to improve efficiency and equity in light of experience.

2.2.5 AMANET

AMANET is the successor of the African Malaria Vaccine Testing Network (AMVTN), which was initiated in the mid-1990s. AMANET focuses on malaria vaccine development and testing, but its scope has widened, thus covering other malaria control interventions (e.g. antimalarial drugs and integrated vector control).

2.3 DANIDA's financial support

These five international institutions and networks received financial support from DANIDA in the period 2002-2006 (Table 13)[17]. DANIDA's allocation to the annual budget of TDR was between 5% and 10% before the year 2002. Since then, DANIDA's share varies around 5% (e.g. 6.5% in 2002, 4.7% in 2005). Over the past five years, DANIDA has allocated almost US$ 9 million to TDR. Over the same period, a slightly lower amount of funding has been granted to IAVI; US$ 8.3 million in total. The contribution from DANIDA as compared to the total expenses of IAVI was, on average, 2.7% for the period 2002-2006. Pledged support for the next two years is US$ 3.5 million, which translates to an increase to 4.5% of the annual share of IAVI.

DANIDA's contribution to the overall budget of both COHRED and GFHR is in the order of 10% for each of the two organisations. However, DANIDA ceased its financial support to COHRED and GFHR at the end of 2004 with no commitments made thus far for renewal. Support to AMANET was DKK 2 million in the years 2003 (45% of AMANET's budget for that year) and 2004 (13%). In the two subsequent years, funding was halved to DKK 1 million, which represented 6% in the year 2005[18].

Table 13. Financial contributions from DANIDA over the period 2002-2006 (all figures are expressed in US$)

International organisations	2002	2003	2004	2005	2006	Total
TDR*	1,929,805	1,984,127	1,594,896	1,709,402	1,709,402**	**8,927,632**
IAVI	1,798,469	1,560,056	1,617,645	1,593,083	1,746,474	**8,315,727**
COHRED	132,000	150,000	165,000	-	-	**447,000**
GFHR	131,463	315,521	339,283	-	-	**786,267**
AMANET		315.521	339,283	172,000	175,000	**686,599**
Total	**3,991,737**	**4,010,020**	**4,056,107**	**3,474,485**	**3,630,876**	**19,163,225**

Source: data collected by the interviewees.
Note:
* For financial contributions to TDR see: http://www.who.int/tdr/about/resources/contributions.htm
** No exact figure available yet.

[17] Amounts presented in this table have been provided by the respective organisations.
[18] AMANET's budget increased substantially from 2004 onwards, with major contributions from the EU and DGIS (Netherlands). At the same time expenditures dropped significantly because of delays in vaccine trials implementation. A reduction of DANIDA support is understandable.

The above-mentioned organisations highly appreciate the DANIDA support, which is justified on the following grounds. First, there is a high level of flexibility, as the funding is not designated or earmarked for a specific issue, but instead can be pooled with all other funds. Second, there is a long-term perspective of the funding. COHRED and GFHR of course regret the withdrawal of significant DANIDA funds at the end of 2004 that lead to a considerable reduction of these organizations' activities that had been planned for 2005 and 2006.

2.4 Concrete results of DANIDA support

Because the funds from DANIDA (and most other development aid donors) are not earmarked, it is difficult for the organisations interviewed to clearly assess what the concrete results of the Danish financial contribution have been over the years. This is somewhat different in the case of AMANET[19] where resources were supposedly utilized to maintain the basic operation of the organisation (e.g. salaries and running costs of the secretariat). DANIDA has been the main donor of AMANET in the first few years (annual support of € 285,000), which was crucial to set up the network and facilitated its expansion and smooth operation. Today, AMANET has multiple funding sources, and hence the relative importance of DANIDA-support has decreased. The fact that two Danish experts in malariology and vaccinology are current members of the 20-head scientific coordinating committee shows that DANIDA still plays an important role in this trust.

The long-term funding horizon and the reliability of the DANIDA support are highly valued by TDR and IAVI. TDR has built up a productive working relationship with one of the DANIDA core-funded institutions (i.e. DBL-IHRD), for training, networking and joint projects. It is also important to note that the director of DBL-IHRD is a member of the scientific and technical advisory committee (STAC) of TDR. Apart from the financial contribution, IAVI also highlights the importance of the immaterial support from Denmark and DANIDA in particular, by referring to the international lobbying activities carried out by Denmark and other European countries to get research pertaining to AIDS vaccines on the international agenda.

The fact that DANIDA was one of the initial funding agents of COHRED has certainly contributed to the structuring and programming of COHRED in its early years. The GFHR welcomes the intellectual challenge and exchange of ideas with DANIDA and confirms the crucial role DANIDA plays in research capacity strengthening in developing countries, which is seen as a valuable support to their organisation.

Since the international health research institutions and networks cannot specify which output is due to DANIDA or to other donors, their appreciation of the donors' support is expressed in more general terms.

❖ Research and capacity building in the North

All organisations appreciate the cooperation with the DANIDA development partners in terms of capacity building (COHRED and TDR), in maturing the professionalisation regarding AIDS vaccine development (IAVI), and in supporting and leveraging the activities of the GFHR.

❖ Research and capacity building in the South

The focus of TDR on research capability strengthening has already resulted in strong partnerships and a core of well trained and experienced health researchers in the South. Also IAVI makes a long-term effort to train and retrain the local staff and to build partnerships by linking up with existing infrastructure (e.g. in Kenya and Uganda). COHRED perceives their cooperation with low-income countries in terms of research and capacity building as a

[19] This trust commenced its activities, initially as the African Malaria Vaccine Testing Network (AMVTN), in the mid-1990s. While the original goal was to prepare Africa in the planning and implementation of malaria vaccine trials, in 2002, the scope of AMANET broadened and a more holistic approach was adopted in the fight against malaria.

crucial output of the donors' support. The GFHR considers their annual fora to become increasingly important to the South because these fora provide a sound platform for exposure of the southern participants to new issues and opportunities to exchange ideas and share experiences with colleagues from the South and North. In turn, the South partners gain experience and expertise in setting priorities and to support health systems in their own countries. GFHR also strives for initiatives in the South on specific health areas that are of considerable public-health significance, but were largely neglected before by international organisations and funding agencies (e.g. mental health, neglected tropical disease, etc.).

The National Institute of Medical Research (NIMR) and Muhimbili University College of Health Sciences are two Tanzanian institutions that have received support from AMANET, although support to the latter has been terminated recently. Generally, AMANET works with malaria vaccine trial sites in five African countries. It organises a variety of short-term courses (e.g. on ethical issues, GCP, GLP, etc.) and hosts the Multilateral Initiative on Malaria (MIM) as from January 2006 onwards. A recent review analysed the reasons for delays in vaccine trial implementation and a plan is being developed to address these issues.

❖ **Harmonising the international research agenda**

COHRED recognizes the various initiatives and efforts to implement the Paris Declaration on Aid Effectiveness, but wonders what the impact has been thus far, although it might still be too early to be assessed. The GFHR confirms that harmonisation and alignment of development aid are very important issues, but recognize the difficulties to bring all donors and their views together. The outcome of the harmonisation efforts done so far is not visible, but GFHR wants to play an important role and advocates for the inclusion of stakeholders from the South in the meetings, discussion groups and other fora. According to COHRED, the main initiator for harmonisation in international health research is Sweden. In 2006 COHRED has initiated a research project on harmonisation and alignment of priorities at country level. SIDA has shown particular interest (also financially) and NORAD, Ireland, the Netherlands, SDC, CIDA, DANIDA, and DFID are supportive but not (yet) in financial terms.

According to TDR there is certainly scope for harmonisation of development aid, but synergies are only possible if the different parties are ready to talk to each other. The many existing initiatives, institutions (also with respect to health research), public-private partnerships, etc., render the process of harmonisation and alignment rather difficult. TDR's new strategy, which was elaborated after the fourth external review completed in May 2006, is built on stewardship in two ways, namely (i) by always taking into account the country's perspective, and (ii) by convening development partners to map (and fill) the gaps.

IAVI commends the European countries focus on low-income countries, including efforts to bridge the public and private sector, and the need to accept product development as a step towards decision-taking. On the other hand, IAVI regrets that only eight (out of 34) OECD countries contribute effectively.

2.5 Future DANIDA support for more effective development of research capacity in the South?

In line with the efforts on harmonizing and aligning development aid effectiveness, COHRED hopes that donors will, in the future, focus more on the national priorities set by the (southern) governments and that duplication of initiatives will be avoided.

IAVI stresses the need for regional centres of excellence for health research in general and HIV/AIDS research in particular in the South. Achieving this goal will require developing an adequate research capacity in the South (individual and institutional), which in turn will strengthen health systems, by financing more research and development activities. IAVI wishes that more OECD countries would contribute to their Initiative.

TDR will further its efforts to empower the South so that the southern countries will eventually lead the development process of the most pressing public-health issues in the developing world, and will define the international research agenda.

The GFHR sees DANIDA's future role and support in more effective development of research capacity in the South by (i) joining the support given to TDR, COHRED and GFHR regarding research capacity strengthening, (ii) assigning funds to the pre-project stage (teaching how to write proposals, how to do fundraising, etc.), and (iii) helping to make some target groups more visible at the international level (e.g. invitation for young people to attend the institution's annual forum).

2.6 Future funding?

The similarities and complementarity between GFHR (active at the global level; develop fora) and COHRED (working at the national level; build capacity) made the organisations realize that they can present themselves together to donors, by signing up only one contract. In fact, a Memorandum of Understanding between GFHR and COHRED was signed in Rio de Janeiro in 2005. Both GFHR and COHRED hope that DANIDA will consider signing such an agreement with them in the near future.

3 Desk study review: overview of main observations

Introduction
In addition to the eight research projects and three ENRECA projects that were reviewed in-depth in the three country studies (i.e. Ghana, Tanzania and Uganda), the desk study, covered 13 projects, of which there were four ENRECA projects[20] and nine research projects (three PhD research projects[21], two post-doctoral research projects[22] and four research projects[23]). In addition, two more ENRECA projects were briefly covered but not included in the analysis below[24]. It should be noted that the desk review is solely based on information provided by the North partners.

3.1 Partnership

The most prominent South partners are universities (in eight out of the 13 projects evaluated). Partnerships with the MoH and national research institutions were evident in three projects each. Finally, there was one partnership with a national hospital. In two projects no South institutional partnerships were developed, either because the research work was mainly Denmark-based or because it concerned a brief field study of only five weeks.

Institutional budgets and source of financing of South partners are generally not known by the North partner (with the exception of DBL-IHRD). Many of the North promoters do not know whether the South partner has an institutional development plan. Exceptions are DBL-IHRD, UC-DS, AU-DA and KVL. The projects reviewed focus primarily on research. If capacity building forms an integral part, it is mainly focused on training individuals, also by means of PhD projects. Institutional capacity building is evident in the FIBOZOPA, KEDAHR and the UC-DS projects. Institutional capacity building includes project management training, accounting courses, etc.

Partnership benefits to the South partner are multiple and varied. They are largely the same as specified in the country studies. One example of multiple institutional benefits is described by KEDAHR as follows: "The present project should be seen as part of a much bigger context of collaboration between IAS and DBL-IHRD. The collaboration has been ongoing since 1993, partly as part of KEDAHR 1994-2004, partly as a bilateral collaboration between IAS and DBL-IHRD which has been running in parallel and which is still ongoing. This collaboration has encompassed: (a) human resource development (27 Kenyan plus 14 Danish students have received training, most of them at MSc or PhD level, with joint supervision from Kenyan and Danish seniors; (b) provision of tangible support to IAS mainly

[20] Kenyan-Danish Health Research (KEDAHR) project, Fish-borne Zoonotic Parasites (FIBOZOPA) in Vietnam, Prenatal diagnostic screening in Vietnam, Improvement of oral health systems research in Madagascar.
[21] The ecobiodiversity and possible toxicity of some traditional leafy vegetables of Nyang'oma, western Kenya (Orech, DBL); Support systems for orphaned children in Nyang'oma sub-location, Bondo district, western Kenya (Nyambedha, DBL); age specific malaria morbidity and mortality, treatment seeking behaviour, and the sensitivity and specificity of symptoms and signs people use to diagnose malaria in an area of low transmission in Uganda (Ndyomugyenyi, DBL).
[22] Post-abortion care, prevention of repeated, unwanted pregnancies and of STD's/HIV in a group of women with high risk sexual behaviour (Tanzania, Institute of Public Health, University of Southern Denmark); identification of molecular markers responsible for drug resistance in malaria parasites by DNA micro-arrays (Denmark based, UC-CMP).
[23] The role of vitamin D in the pathogenesis and treatment of tuberculosis (Guinee-Bissau, AU-DA); health systems reform and ethics: private practitioners in poor neighbourhoods in urban South and Southeast Asia. A multidisciplinary, comparative study (SE Asia, AU-DA); development of new drugs against hepatitis (Egypt, Department of Chemistry, University of Southern Denmark); studies on the epidemiology and control of lymphatic filariasis in Tanga region, north-eastern Tanzania (UC, Institute of Public Health).
[24] For those two projects no questionnaire was completed. The review has therefore been limited to publications provided. These include: content and bio-availability of vitamin A, iron and zinc in commonly consumed foods in developing countries (Bangladesh, KVL); and enhancement of research capacity in Nepal (DFU).

in terms of computers and library books; (c) support to IAS institutional scientific journal, called MILA; (d) influence on training activities and strategy priorities at IAS. Thus, teaching in research methodology and advanced theories (both essential to anthropology) has been significantly strengthened. Furthermore, medical anthropology and child anthropology have been introduced as priorities". Another example is the establishment of enabling environments that foster opportunities for South-South collaborations.

Partnership benefits to the North institutions are also similar to those discussed in the country studies. Interesting examples are the strengthening of the Danish resource base within reproductive health; strengthened interdisciplinary networks; contacts and networks for participation in grant applications to other funding bodies, such as the EU, World Bank, FAO and WHO; a bio-bank and a new research column in global health care issues; several new aspects of malaria research that have been undertaken by a Danish research group largely as a result of the development of a molecular fingerprinting of malaria parasites[25]; and the experience gained in trans-national research through networking with both English and French-speaking developing countries.

Some ENRECA programmes have resulted in impressive numbers of experts trained. For example, the University of Southern Denmark awarded 31 MSc and 20 PhD degrees to Egyptian students between 1992 and 2005. 113 articles have been published in the peer-reviewed international literature, and a large number of papers have been presented at national and international conferences. Some members of the research group in Egypt have made use of these publications and oral presentations to achieve promotions either to assistant professorship of professorship levels. Twenty-five research fellows from Egypt have been trained at the University of Southern Denmark during the period 1992-2005. A number of fellowships were also offered by the State Serum Institute.

The DANIDA support to the South institutions is generally perceived as important. This issue is underscored by the following quotes: "Highly relevant as the colonial dominance factor is more absent in the ENRECA than in any other known research capacity building and collaboration programme". Regarding Bandim: "Very relevant indeed as a large part of the research made possible at the south institution is DANIDA financed and yearly resulting in around 40 high impact international publications. It is my claim that nowhere else DANIDA will find an equivalent amount of high-profile publications per million DKK granted in support. The DANIDA support covers many baseline activities difficult to obtain support for from other international funding agencies"

Regarding Tanzania: "The research has resulted in a **communication with HSPS** who have supported the scale up of post-abortion care in Dar es Salaam and Kagera region. A joint initiative between EngenderHealth and HSPS in further scaling up post-abortion care is currently being planned.

Perceived **added values of partnering with Danish institutions** are as indicated in the country studies, including (i) long-term support, (ii) "less colonial attitudes", (iii) equal partnerships, (iv) know-how of other developing countries, (v) active also in places where few other donors are present (e.g. Guinea Bissau), (vi) complementary to other donor inputs (who cannot finance certain inputs, e.g. USAID and post-abortion equipment), (vii) high degree of flexibility, and (viii) exemplary model for PhD sandwich between North and South institutions. Examples: (1) In Uganda, scientists trained under DANIDA financial support at PhD level are now programme managers of disease control. (2) A high proportion of the Tanzanian medical researchers and medical workers placed elsewhere in the health system

[25] For example: examining human disorders such as Sickle cell trait and G6PD deficiency in relation to malaria severity; examining P. vivax drug resistance in Sri Lanka and examining human disorders in the Complement receptor 1 and severity to Malaria.

have obtained their MSc and PhD degrees with strong support from DANIDA during the past decade. Irrespectively of their present status, these individuals now form an important part of the human resource base for both public health and health-related research.

Beyond capacity building in research, the Danish support also results in **broader benefits to the partner countries** such as: Bandim: All health research in Guinea Bissau is conducted by the Bandim Health Project and a large part of ministerial and health care system professionals have been trained there. By engaging locals to obtain MSc and PhD degrees, their level of motivation is enhanced and the likelihood that these individuals would emigrate to Europe or other Northern countries is reduced. AU-DA in SEA: A research-to-policy workshop is conducted in 2007 with participation of policy makers from all involved countries to utilise the findings in the national health policies. UC-DS in Madagascar: National capacity building in policy formulation in health, national health systems and surveillance. FIBOZOPA: Increased national knowledge and recognition of the public health significance of fish-borne zoonotic parasites. Before FIBOZOPA was initiated very little (if any) research was carried out on fish-borne zoonotic parasites, covering prevention and control issues of trematode parasites that are transmitted in aquaculture. Previous efforts have primarily focused on mass drug administration which, however, failed to control fish-borne parasitic disease in a sustainable manner. Post-abortion care: DANIDA has – via HSPS – been instrumental in the above-mentioned approval of Nurse-Midwives performing manual vacuum aspiration. Lymphatic filariasis in Tanzania: Emphasized the needs for rigorous monitoring of the national lymphatic filariasis control programme. A sound monitoring approach was implemented shortly after key findings and recommendations were published.

Seven projects are perceived as equally **owned** by the North and South partners. One PhD project is fully owned by the South partner. Four projects were perceived as more owned by the North than the South.

All projects are considered as a **win-win situation** for North and South. Administrative management is generally not considered an additional burden. Only some of the ENRECA projects mention the need for using different administrative staff to manage these rather complex programmes. Also a range of different training activities are implemented and staff take various courses in project management and international accounting (e.g. FIBOZOPA). Costs of Danish staff time on management and technical inputs are not well covered by DANIDA. Managerial support is mainly provided in the context of ENRECA projects.

It is felt by some of the North partners that **future partnerships** should focus more on institutional strengthening, rather than individual capacity building. Institutional capacity building would include the establishment or strengthening of existing laboratory and hospital facilities, administrative capacities within the partner institutions, etc. In addition, the research should focus more on national research priorities. Another interesting issue articulated by some North partners is that incentives should be created (e.g. career path for individuals) to foster researchers at partner institutions. Finally, there is scope to enhance the translation of research findings into policy formulations, by more actively involving relevant stakeholders (e.g. through policy stakeholder workshops).

Most projects are in favour of **extension or continuation**, in the same or a different setting. For example Bandim claims that an extension would enable important public health research to be undertaken in one of the world's poorest countries where such research otherwise would not be possible, potentially saving many lives globally through the obtained results leading to better strategies for vaccination of children or control of HIV/AIDS, tuberculosis and malaria; and that the institution would not be able to stand alone without Danish support for the next at least 10 years.

3.2 Relevance and focus of research

According to the North promoters, all but one project address **national health sector policy issues** or elements of the national health strategic plan, which are all perceived as global health issues.

All projects are considered to **respond to locally perceived health needs**. Examples: (1) Some projects started with a series of participatory community and district level needs assessments. (2) In Kenya, the orphan issue had not drawn serious attention from the authorities at that time. Thus, in a way the project was ahead of its time. This has probably also contributed to its success, because it was just ready when the public 'discovered', the problem. (3) The research was carried out in the context of the national population strategy (4) Post-abortion care is part of the national reproductive and child health strategy. (5) Tuberculosis, hepatitis, schistosomiasis, malaria and lymphatic filariasis are locally perceived priority health problems. (6) The ministries of fisheries and health are recognizing trematode parasite infections as a major health issue in Vietnam.

Strengthening the **national health research system** is most often not the objective of the research or ENRECA projects. It may happen indirectly through strengthening institutions by training individuals. UC-DS has integrated health systems research with health programmes in Madagascar. FIBOZOPA mentions explicitly national network activities in output 3. KEDAHR is perceived by DBL-IHRD as a strong factor in the further development of the Essential National Health Research process.

Strengthening the health system does not seem to be high on the agenda. Only few examples are given, such as working with districts, teaching new techniques (e.g. laboratory training courses), diagnostic techniques, and workshops with decision-makers. It should be acknowledged that for the health-related projects, strengthening the health system may be irrelevant. On the other hand the ENRECA Nepal project has had direct impact on strengthening the health system, for example through rationalising the HMIS. And so has the UC-DS support in Madagascar contributed to orienting the health services towards health promotion and prevention.

Interestingly, several proposals are made to improve health system strengthening. Examples include the following. (1) Closer collaboration with the HSPS. (2) If funding for research were supplemented by funding for interventions (e.g. community mobilization, awareness raising), research results could be disseminated more effectively. (3) A stronger involvement of the district and regional health management teams to assure the sustainability of both post-abortion contraceptive services and ongoing supplies of manual vacuum aspiration kits.

Community participation is often present (in eight out of 13 projects evaluated). Participation can cover different aspects of the research process, such as problem identification, priority setting, data collection, dissemination, and selective use of results. Specific examples include the following: (1) Community meetings are held prior to new research projects, dissemination of results has been for example publishing results in the local language, initiating local conferences, providing staff with information to bring out to the community. The civil society in form of ministerial partners is often a key player in suggesting new areas of research or data collection. (2) The project involves inhabitants in urban slum areas through participatory methods. Professional organisations will be directly targeted for dissemination of findings. (3) At our field sites we work closely with the local people's committees and other local organizations, including mass organizations like farmers and women's unions.

Assuring community participation is not always easy but generally receives a considerable amount of efforts. Several means or methods are being used. Examples: (1) Special feedback sessions in primary schools and among women's groups. (2) Anthropological fieldwork is inherently based on interaction with the local community. In addition, the regular

community feedback sessions held in the study area allowed feedback of the main study findings to key informants, local authorities and opinion leaders. For instance, it was during one of these sessions that a community member suggested that the principal investigator should study the role played by community-based groups, specifically a women's groups regarding the care of orphans. This was subsequently done as a sub-study and an article has been submitted to a scientific journal on this particular subject. (3) Facility and community meetings. (4) Focus group discussions. (5) Awareness campaigns. (6) Numerous meetings and discussions have been held with village authorities and general village communities in order to facilitate a level of mutual understanding with regards to both public health relevance and other specific aspects of the study. (7) Regional medical officers and activity plans. (8) At all field sites, the local stakeholder institutions and local authorities are invited to planning and kick-off workshops.

3.3 Managing research and capacity building projects

The main focus of the reviewed projects is on building research capacity and to a lesser extent also on training capacity. **Management support** regarding organisation, finances and administration is the exception rather than the norm. If the latter is done it happens mostly through training of accountants or administrative staff for project financial management. Financial audit is standard procedure.

Projects are generally **designed** in a participatory manner by both North and South partners. Sometimes this is achieved through specific workshops, with local communities or stakeholders. For example, KEDAHR: Research proposals were developed with the five institutions in the North and the five institutions in the South and focused on problems identified by the health sector, including community representatives in the study district. FIBOZOPA: Through two stakeholder workshops hosted by the Ministry of Fisheries in Hanoi.

Resources are always jointly decided by South and North partners. In general, resource allocations are perceived as sufficient. Two exceptions are KEDAHR where some supplementary funds proved necessary, and the tuberculosis research project in Guinea-Bissau where less than half of the initially requested budget of DKK 2.5 million was received, which meant no funds were available for the last one and a half years of the project. Fortunately an EU-funded project was able to ensure the last part of patient inclusion and all follow-up.

The Danish partner is most often not participating in sector coordination or sector reviews. Some of the South partners are, however, involved in health sector activities. **Coordination** happens mainly at project level, not at national level (with the exception of two projects).

It is the perception of some that DANIDA administrative procedures may be better tuned to national systems, not to overload local capacity. One **drawback** mentioned to these North-South partnerships is that DANIDA does not cover the actual costs of Danish staff time inputs which to a large extend is on non-core research activities (training courses; project management; supervision, etc).

Quality assurance mechanisms are generally in place. Some interesting examples are: (1) A governance document to ensure the quality of the research process. Researchers from all four countries meet once or twice every year to develop analysis and discuss findings and publications. (2) A standard format for quality assurance of clinical and parasitological measures, as well as computer-based data entries was developed and adhered to. This involved 15% quality control of all measures. (3) All activities can only be implemented when a standard research protocol format has been prepared, agreed upon by all participating researchers (which normally always includes at least one Danish researcher) and approved by the project management. Status reports must be forwarded to the project management,

usually on a monthly basis. MSc and PhD students always have both an international and national supervisor.

Institutional analysis of the South partner is not standard practice. It was done to a certain extent in five of the 13 projects evaluated and has now become part of the DBL-IHRD and also of the ENRECA vocabulary. One example is FIBOZOPA, where institutional visits were made and self-assessments, as well as an appraisal by a team of national and international experts for identification of individual and institutional needs for training and research capacity building.

Know-how is being transferred mainly through individual training and collaboration. Some find that greater integration of research projects with the Danish development expertise and systems would be desirable in order to improve on organisational and project management skills.

3.4 Impact of research

All projects are **on track** or have achieved the stated objectives as per research proposal. The impact the projects had on partnerships and on national partners and institutions have been described above.

Impact on national health policy is evident or likely in eight of the 13 projects evaluated For three of the projects, this issues is still too early to be assessed. Some examples are: (1) DBL-IHRD KEDAHR: Focuses mainly on nutritional, school health and health education policies. The project is likely to influence national research and control aspects pertaining to soil-transmitted helminthiasis and malaria. Health systems development is likely to be influenced through the development of a strategic district health plan (and the process that lead to developing this plan). The district plan for Bondo district is much referred to in the MoH, but perceived as too participatory stakeholder based and bottom up to be acceptable to most donor driven programmes. This issue is now being approached in a new conceptual frame in an EU project entitled "REACH", coordinated by DBL-IHRD and implemented in Kenya, Tanzania and Zambia. (2) DBL-IHRD activities in Uganda: The findings of the project indicate that three-quarters of the patients receive antimalarial drugs although they do not have malaria. Consequently, there is a need to develop and use rapid diagnostic tests, so that only those patients who actually have malaria are treated with antimalarial drugs. In view of the quite expensive artemisinin-based combination therapy becoming the first-line antimalarial drugs in many parts of Africa, a rapid diagnostic test and treatment of positive individuals only has become cost-effective. Moreover, in low malaria transmission areas (e.g. urban areas), more attention needs to be paid to differential diagnosis of febrile illnesses. (3) AU SEA: Input to policies regarding regulation of private sector and on health financing schemes. (4) Post-abortion care in Tanzania: Based on the results from the study, HSPS decided to facilitate the scale up of post-abortion care. As part of this scale up, nurses and midwives, after some basic training, have been entitled to perform manual vacuum aspiration.

Impact on global health policy is perceived as rather limited, non-existing at all or too early to be judged upon. One example is the research centred on lymphatic filariasis in Tanzania, which added important knowledge and facilitated to launch a national control programme, which is in line with the global programme to eliminate lymphatic filariasis as a public health problem by the year 2020.

Impact on non-health sectors is the exception unless the other sector is the main focus of the project (e.g. FIBOZOPA; nutrition in Bangladesh). One example is **KEDHAR**: On education for health and new action competence-oriented teaching approaches.

More than half of the projects (seven out of 13 projects evaluated) have also achieved **non-planned results**. Examples include the following: (1) Projects have been more successful than expected in terms of dissemination to end users. (2) What started out as a simple two months MSc training scholarship turned into a highly successful cluster of research projects with a broad range of outcomes. (3) Paving the way for other tuberculosis projects and capacity building of the local health laboratory within tuberculosis and HIV diagnostics was not initially planned. (4) Malaria dug resistance: gained quick unique results from several sites in the South as well as developed new collaborations with other institutions in the South interested in transferring the method to their institutions. (5) The collaboration with HSPS was not planned, this collaboration has made it possible to implement the study in both an urban and an rural setting and thereby perform comparative analyses between these two settings. (6) Originally, it was not expected that a good proportion (a total of 123 individuals) from a study carried out in 1975 could be re-identified and re-examined in the year 2001. These non-planned results made it possible to perform a 26-year follow-up analysis, and the results were published a separate paper.

Capacity building in the South has focused mainly on research capacity (capacities of individual researchers to plan, conduct, write-up and publish their research; qualitative research skills), MSc and PhD projects, laboratory training, new techniques (e.g. malaria finger printing in Tanzania), institutional capacity development (e.g. anthropology in Kenya), policy development (e.g. Madagascar). For some projects it is still too early to evaluate the impact on capacity building. Examples: 1) KEDHAR: A well-performing interdisciplinary network was created including six (now expected nine) and 16 (now expected 21) Kenyan MSc degrees with mainly continued attachment or employment at their institutions. Each of the involved disciplines was strengthened and, in particular, a gap for qualitative methodologies could be filled. Note that qualitative methodologies were largely absent in the country's social science environment. This medical and general anthropology capacity achieved a new and sustainable platform. (2) Malaria finger printing in Tanzania: The research capacity at two institutions in the South (KCMC and NIMR, Tanga) has been promoted by the project and several spin-offs have been created largely as a result of the method development. At KCMC both the capacity to monitor antimalarial drug resistance at molecular level and the capacity to monitor insecticide resistance in the malaria vectors has been established and resulted in peer-reviewed publications in high-impact factor journals. Additionally, a course in the methodology was financed by the Gates Malaria Partnership and implemented in 2006 where 10 researchers from Tanzania and Benin were trained. At NIMR, Tanga, transfer of a molecular method enabling "fingerprinting" of malaria parasites were established in 2006, also funded by the Gates Malaria Partnership. Finally, a course in methodology of monitoring human disorders at molecular level (based on the similar method) will be implemented in of the first half of 2007. A total of 12 researchers from Tanzania will be trained.

Sustainability is aimed at through different mechanisms such as maintaining research networks, designing new projects and attracting other resources for capacity building projects (e.g. EU, UNITID, TDR in Kenya; EU and SAREC in Guinea-Bissau) and supporting local capacity (e.g. in the FIBOZOPA project, the salaries of all MSc and PhD fellows are paid by their home institutions, who are permanently employed). All projects claim that research results can be replicated elsewhere. Some are doing this explicitly. For example, in FIBOZOPA results/experiences are already used by several other ENRECA projects implemented in Vietnam, e.g. within water, sanitation and health. FIBOZOPA is also conducting various training courses for other DANIDA-supported projects in Vietnam, e.g. within accounting.

3.5 Lessons learned

Specific lessons learned from different projects are as follows: (1) Small projects, even at MSc level, can be highly innovative, have important practical relevance and utility (from local community perspective in particular) and can result in high scientific quality (as seen from

publications). (2) The appropriate combination of an excellent student, necessary resources, sound supervision, good timing, nested within a solid institutional collaboration can achieve significant outcomes, even at a MSc level and with relatively modest funding. (3) It might be worth allocating resources for wider dissemination of research results and continued efforts should be made to translate research findings into policy applications. (4) The comparative design involving three countries has proved an important asset to establish best practices and lessons learned across the countries. (5) Communication with HSPS and local stakeholders such as RMOs has facilitated a wider implementation of post-abortion care.

Lessons learned are being shared through specific mechanisms, mainly the same as identified in the field studies. Peer-reviewed publications is the standard mechanism used. Sometimes through networks (INDEPTH, GFHR, WHO); or workshops (project, national, regional); annual partner meetings or annual Scientific Conference (NIMR); and through international conferences, for example the co-organization of a regional meeting on fish-borne zoonotic parasites held in December 2006 in Bangkok.

3.6 Development focus

Eight of the 13 projects have a concrete **poverty alleviation** focus or de facto deal with poverty-related health problems. Some projects have taken into account poverty by providing free treatment or covering transport costs to facilities.

As found in the country studies, **health financing** mechanisms are not high on the research agenda. Some research or ENRECA projects have taken into account costs of proposed treatments (e.g. costing study of prenatal screening in Vietnam; free tuberculosis treatment provided in Guinea-Bissau; cost implications of oral health programmes in Madagascar) or analysed financing strategies (e.g. private sector in South East Asia).

Few projects address directly **gender** issues. A common reply on the issue of gender is that the research covered both women and men, and that a number of researchers were female. This is seemingly an area of concern that is being addressed. Some projects are focusing on women's health problems (post-abortion, prenatal care). Some projects deal with issues that affect one gender more (e.g. Kenya, nutrition). And most interventions' impact was gender specifically monitored (e.g. tuberculosis research done in Guinea-Bissau).

4 Brief overview of selected donor's views and practices

Introduction
Donors interviewed on heath research strategies and approaches are DFID (United Kingdom), DGIS (the Netherlands), NORAD (Norway), and SIDA (Sweden). Telephone interviews were focused, based on pre-sent questionnaires. Additional information has been collected from respective websites and from documents received.

4.1 Funding health research

All of the above-mentioned donors finance health research in developing countries. DFID and SIDA have a separate specific budget for health research. NORAD and DGIS have cross-sector budgets.

DFID's human development research budget is 5 to 6 % of the budget for development aid on health, of which health and HIV/AIDS have by large the lion share (UK£ 45 million out of UK£ 47 million). SIDA, DGIS and NORAD spent 7%, 5-6% and less than 3%, respectively, from their development aid budgets for health on health research. DFID has recently announced to double its budget for research in all sectors in developing countries over the next three years, an increase to UK£ 220 million by 2010; the health research budget will be almost half of the total budget. NORAD aims at reaching the Mexico 5% target[26]. Both SIDA and DGIS will continue to spend 5% of their health budget allocations to health research in developing countries.

4.2 Research and strategic priorities

DFID has defined four broad target areas for health research, using a range of bilateral, joint and multilateral funding instruments. The target areas are as follows:

i) communicable diseases (sometimes referred to as "killer diseases"), e.g. HIV/AIDS, tuberculosis and malaria, as well as other neglected tropical diseases and diarrhoeal diseases;
ii) non-communicable diseases, e.g. research into tobacco-related health issues and mental health;
iii) maternal and child health; and
iv) health systems.

DGIS health policy priority areas include HIV/AIDS, tuberculosis, malaria, as well as sexual and reproductive health. NORAD favours health systems and policy, vaccines, sexual and reproductive health, tuberculosis, HIV/AIDS and infectious neglected diseases. SIDA prioritises health research in HIV/AIDS, but also reproductive health, chronic diseases and child health.

Common themes for all four donors are some or all of the main poverty-promoting diseases, sexual and reproductive health, often also including child health. Areas that are not consistently covered by all four development agencies include health systems and health policy, neglected tropical diseases, chronic or non-communicable diseases. All four donors confirm to aim at strengthening national health research systems (NHRS), but modestly and not always coherently. For DFID it is a rather new approach to invest in research capacity building programmes, for example in Kenya and Malawi. DGIS supports NHRS only in Ghana and Bangladesh. SIDA has three funding modalities, namely support to (i) health research itself, (ii) research reform and management, and (iii) research facilitating infrastructure (strengthening laboratory facilities, libraries, information and communication

[26] Forum 8 of the GFHR held in Mexico in November 2004 on the main theme of research in health for achieving the MDGS made the following recommendation: "In order to ensure sufficient resources for research in developing countries, the governments of those countries should devote at least 2% of their health budgets to research and to strengthening research capacity. Moreover donors are invited to devote at least 5% of their budget for cooperation on health to research activities in health".

technology, etc.). NORAD still has limited experience in supporting national health research systems.

4.3 Channels for supporting health research

Channels for supporting health research in developing countries always include bilateral activities and supporting international research partners. In the case of DFID, these two channels receive about half of the total resources spent (international: ICDDRB; network on MMR with USAID and Bill and Melinda Gates Foundation; project on tobacco control with Canada; product development partnerships[27]). On the other hand, DGIS spends approximately 90% through bilateral partners (NGOs, public-private partnerships, Universities, etc.). The remaining 10% are allocated to international partners (WHO/HRP; TDR; World Bank; ICDDR). The opposite is the case for SIDA, spending approximately two-thirds of its research resources on multilateral partners (principally TDR, COHRED, ICDDR, IAVI, MIM) and one-third through Universities. Multilateral partners of NORAD are GFHR, Alliance for Health Policy and Systems Research, IAVI, GAVI for vaccines research, TDR, WHO, International Partnership for Microbicides for a total of NOK 103 million.

Co-financing programmes with others allows DFID to leverage funding in their four target areas mentioned above. Current health development research investments with the United Kingdom and international public and private funders include:

- a concordat with the UK Medical Research Council (MRC) to promote research addressing diseases of poverty;
- emerging joint working with the Wellcome Trust on research capacity strengthening in Kenya and Malawi;
- joint funding of research into tobacco control with IDRC (Canada);
- joint funding with the Bill and Melinda Gates Foundation and USAID of a global research initiative whose ultimate goal is to improve maternal health and survival in developing countries (IMMPACT[28]);
- support to the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training on Tropical Disease (TDR) and the human reproductive programme;
- joint funding with UK MRC for a clinical trial of one microbicide (microbicide development programme, MDP);
- joint funding with UK MRC for two clinical trials of antiretroviral therapy in Africa (DART for adults and ARROW for children); and
- core funding to the International Centre for Diarrhoeal Disease Research (ICDDRB) in Bangladesh[29].

[27] Only 14 new drugs – less than 1% of all new drugs – were produced for developing country markets between 1975 and 2000, due to lack of commercial incentive. Public/Private Product Development Partnerships (PDPs) have emerged as one mechanism to close this gap, with the UK currently the largest Government investor. PDPs act as virtual pharmaceutical companies, leveraging technologies, financial and in-kind contributions from the public and private sectors, as well as bringing in the expertise of research institutes and ministries of health in the South. A dozen PDPs are currently in existence, and expected to bring eight or nine new products to market in the next five years. DFID currently supports five of these initiatives: Medicines for Malaria Venture (MMV), Global Alliance for TB (TB drugs), Drugs for Neglected Diseases initiative (DNDi), International Partnership for Microbicides (IPM), International AIDS Vaccine (IAVI). At the Gleneagles Summit in 2005, the G8 committed to invest both in "push" PDP funding mechanisms to improve the supply and uptake of new drugs and health technologies and a complementary "pull" mechanisms to create viable market demand, in the form of Advanced Market Commitment (AMC). An AMC would require sponsors to make legally binding financial commitments to support a market of a pre-agreed value, which would be sufficiently large and credible to stimulate private investment in vaccine research and development (R&D) and manufacturing capacity. Whilst the first AMC is still to come into effect, most commentators agree that great potential can be achieved through PDPs and AMCs working together in mutually reinforcing ways.

[28] http://www.abdn.ac.uk/immpact/

[29] Note that ICDDRB is generally recognised as the foremost developing country health research institute, capable of producing world class research).

4.4 Priority setting

All donors involve the South partners in setting the overall research agenda. DGIS and NORAD[30] do this always through involving South partners and aligning with South national research priorities. SIDA does the same for the bilateral funds, but sets its own agenda for multilateral funding. Setting the health research funding framework for DFID is outsourced to an external firm (involving the South), but the Central Research Department of DFID sets the global priorities/priority areas. For example, the UK's drive to invest more in non-communicable diseases in the future is inspired by the South partners.

4.5 Criteria for selection of research proposals

The main criteria to approve or select research proposals vary between donors. DFID, within its four main priority areas, favours mainly "capacity building". Criteria used by SIDA are whether the research proposals are "being in line with the SIDA health strategy paper". NORAD uses a concept called "essential health research" based on essential health research priorities. DGIS has no specific main criteria other than the priority areas cited above.

4.6 Dissemination of research results

Using the research results is considered a priority by all donors interviewed. In case of DFID's bilateral research funds, 10% of the budget needs to be spent on communication, being the responsibility of the participating country or South research institution[31]. This is stipulated in the overall contract. In case of multilateral aid, dissemination is the responsibility of the multilateral organisation. DGIS has no specific means to assure dissemination of research results apart from incorporating it in the research set up. Utilisation of research findings is emphasized at international level. Furthermore DGIS has started a specific collaboration with selected Universities to strengthen the link between research and policy making. NORAD has engaged in a recent agreement with the 'Norwegian Centre for Health Services' which ensures systematic reviews and good practices for national research and now also for international research, in order to promote the link between research, practices and policy. SIDA accepts the increasing importance to involve policy makers (not only MoH, but also other Ministries); and is member of the REACH Policy Initiative (East Africa)[32], trying to bridge the gap between research and policy.

Dissemination or communication strategies are not explicitly supported by different donors, except DFID that includes the activity and an earmarked budget within the research contract and SIDA. Also, DFID asks each contract holder a summary of case studies or lessons learned (e.g. scientific and managerial; innovation) at the end of the year so that they can disseminate this information to other researchers (mainly within DFID or their networks) and include it in the annual report. SIDA gets sometimes policy briefs, but a recent evaluation pointed out that SIDA's research outcomes need to become more visible and that SIDA can do better to inform all stakeholders.

4.7 Coordination

DFID considers harmonisation of research an important issue, especially at the global level. In that respect, DFID aims to have joint research programmes, silent partnerships (in case of health, the PDPs articulated before); and will most likely support IFORD (International Forum for Research Donors), which is a new initiative to facilitate collaboration and information sharing among a group of policy makers from within agencies which have a mandate to support research in the South[33]. Also DGIS has very recently started jointly with some like-

[30] NORAD confirms that its experience is limited and that it has to invest more in health sector policy dialogue, because priority stetting by the South is key, in particular for essential health research

[31] 10% of the budget is reserved for communications activities and each contract holder has to develop a coherent communications strategy with the help of the CRD communications team.

[32] http://www.idrc.ca/en/ev-101084-201-1-DO_TOPIC.html

[33] Currently the following agencies are involved: World Bank, SIDA, SDC, NORAD, DFID, DANIDA, CIDA, Rockefeller, MOORE, MEN, MacArthur, IDRC, Ford, Carnegie and BMBF.

minded donors to look for ways to align and harmonize research efforts at national level. Both NORAD and SIDA are strongly in favour of aligning research priorities with priorities identified and articulated in the South, but SIDA still notes the gap between these stated objectives and real action. How to improve the process of alignment and harmonisation is still being debated[34].

4.8 Managing research: DFID modalities

DFID contracts with research programme consortia (RPCs), which are large bilaterally-funded managed programmes that usually run over 5-year periods. RPCs are consortia of different North and South institutions. Previous experience of managed research has shown that long-term programmes produce significant and coherent bodies of knowledge relevant to the health of the poor, build research capacity within developing country partner institutions and support the translation of knowledge into policy and practice. As said, 10% of the budget is reserved for communication activities and each RPC has to develop a coherent communication strategy with the help of the CRD communications team.

The current RPC portfolio covers all four research areas. There are currently 11 RPCs in health and three in education. A list is provided in Annex A. All but one RPCs have a contract for a period of 5 years, of a value between UK£ 2.5-5 million. Because of untied aid, DFID works with call for proposals for research, according to strict criteria. Only consortia of North-South research institutions can apply. Each RPC has a contract with DFID and the lead organisation takes responsibility for all coordination between partners. Monitoring is done annually based on the work plan in the proposal (a sort of performing-based monitoring). The consortia have to report annually on progress made. A formal evaluation is done every two years. If the evaluation is negative and no or insufficient progress is made in the following year, the contract is stopped.

The Human Development team has recently provided inputs to the emerging DFID Health Strategy paper. The implications of the strategy are two-fold:

- the need for DFID's health research portfolio to respond to changes in the disease burden predicted over the next 30 years, including a significant rise in non-communicable diseases, impacts of climate change and new disease threats; and
- the need to strengthen mechanisms for capacity strengthening of South institutions.

DFID's emphasis on developing a coherent health research strategy is further confirmed by the promise to triple the already significant health budget for developing countries by 2010 and by the merging of the Policy and Central Research Department into a single Policy and Research Division. According to the CRD, future research has to be demand-led by the South and should be health-based (more than policy relevant). DFID has a commitment to provide global public goods.

[34] This was also the subject of the GFHR's Forum 10 held in Cairo in 2006, where the donor groups discussed ways of more effective cooperation on the country level.

ANNEX A. DFID Health Research Programme Consortia

Team for Applied Research to Generate Effective Tools and Strategies - TARGETS RPC	London School of Hygiene and Tropical Medicine	£4,996,135
Future Health Systems: Making Health Systems Work for the poor RPC	John Hopkins Bloomberg School of Public Health	£3,750,000
Consortium for Research on Equitable Health Systems (CREHS)	London School of Hygiene and Tropical Medicine	£3,750,000
Realising Rights: improving sexual and reproductive health for poor and vulnerable populations RPC	Institute of Development Studies. University of Sussex	£2,500,000
Research and Capacity building in reproductive and sexual health and HIV/AIDS in developing countries	London School of Hygiene and Tropical Medicine	£2,499,76
Achieving MDG's 4 & 5: Strategic research to develop the evidence – base for policy for mother and infant care at facility and community level	Institute of Child Health	£2,499,395
Mental health policy development and implementation in four African countries: breaking the cycle of mental ill-health and poverty.	Department of Psychiatry and Mental Health, University of Cape Town	£2,198,552
Evidence for Action: An International Research Consortium to Maximise Benefits & Equity of HIV Treatment & Care Systems	London School of Hygiene and Tropical Medicine	£3,749,328
Addressing the Balance of Burden in HIV/AIDS	Liverpool School of Tropical Medicine	£3,750,013
Communicable diseases: vulnerability, risk and poverty (COMDIS)	Nuffield Centre for International Health & Development, University of Leeds	£5,000,000
Effective Healthcare Alliance RPC (EHCAP) 2005-08	Liverpool School of Tropical Medicine	£2,256,063

Education Research Programme Consortia

Implementing Quality Education in Low Income Countries	Graduate School of Education. University of Bristol	£2,499,695
Improving the Outcomes of education for Pro-Poor Development: Breaking the Cycle of Deprivation	Centre for Commonweatlh Education, University of Cambridge	£2,500,000
Consortium for Research on Educational Access, Transitions and Equity (CREATE)	University of Sussex	£2,499,980

5 Views, experiences and opinions of Danish research groups

Introduction
Fifteen different Danish research groups have responded to the questionnaires and most (12) have been interviewed by the Review Team. The views below present the views of researchers and research groups but can not always be interpreted as reflecting the view of the institution to which they belong as often the research group is only one department in a large institution (e.g. university). However, the researchers that have contributed to this review are amongst the most important researchers in the Danish research community dealing with health and health related development research that is being financed from DANIDA. It is probably fair to say that the views presented reflect the ideas and opinions of that part of the Danish research community.

5.1 Application procedures

5.1.1 General procedures regarding the period under review

A. ENRECA and research projects

Positive comments on the application procedures include the grant volume, opportunities for long-term grants and the important focus on human capacity building in the South. The possibility to submit proposals electronically, and the possibility of application for initiative funds are also appreciated by the Danish research community.

Negative comments include the understaffing of the secretariat to the RUF/FFU, calls for proposals only once a year, lack of detailed feedback regarding the peer-review process of applications, evaluation reports that are seemingly not in line with the set criteria (e.g. which often seems based on non-scientific criteria), and rather long processing of applications;, little relation between on the one hand the application format, the requirements in terms of logical frameworks and budget forms and on the other hand the evaluation procedure, the outcome and the quality of the reviews (mainly regarding external peer reviewers); applications in Danish, thus limiting South participation; limited sector expertise in advisory committee; increasingly less transparent and more bureaucratic procedures[35]; too much effort to develop detailed proposals vis-à-vis the chance that the application is being successful; the criteria being increasingly more focused on applied research; limiting opportunities for fundamental research (grundforskning, in Danish); the narrow national focus on programme countries resulting in missed opportunities of gaining more generic research insight into theory and methodology from other country studies.

It is unclear how the apparent and perceived decline of priority given to health research within the MoFA goes hand-in-hand with the increased emphasis on direct linkages between research proposals and DANIDA development projects and country priorities. While it is positive that research utilization may be strengthened, it is problematic if scientifically sound and innovative research proposals are dismissed mainly because they fall outside DANIDA country priorities.

B. PhD projects

Positive comments: RUF/FFU has opened up for applications from foreigners.

[35] If there is a technical mistake in the application, FFU could inform the applicant and give a few days for correction, rather than informing the applicant after 4 months that the application was not considered because something was missing. An applicant for a PhD project then has to wait for an entire year before there is another chance to apply.

Mixed: Generally, it has become more difficult to fund individual PhDs projects. It is part of a general tendency that PhD projects should be embedded in larger research projects/programmes, e.g. multi-year ENRECA or framework projects. Underlying reasons for this shift include the overall quality of research and utilization/translation of research findings into public health action. Others, however, view this shift as problematic, leaving little room for individuals who put forward good ideas that could break new ground. Mainstreaming and an enhanced focus on prioritisation and the implementation of efficiency-driven approaches can result in diminished degrees of creativeness, innovation and imagination that are currently present in submitted proposals. Research is a creative process, pursuing a good idea, interpreting assembled data creatively, and developing thoughts in different directions. These qualities need space and place to grow, but they seem to be increasingly threatened when everything is packaged according to big projects and annual research focus. In relation to PhD projects, it is not being argued that 'small' (individual PhD) necessarily is beautiful, but small is indeed valuable (and relatively inexpensive).

C. Research initiatives (seed funds for preparing larger project proposals):

Positive: The initiative grant scheme is a good idea, provided that the RUF/FFU strategy is sufficiently long-termed to allow funding of the full proposal being the result of the initiative grant. There is a problem here.

Negative: In most recent years the granting has been pretty unclear, sometimes even contradictive to DANIDA's own policies and/or against reviewers' recommendations.

5.1.2 Criteria for appraising applications

Not all respondents seem to know the criteria used (3). Most are aware of the criteria of scientific quality, relevance and "local" ownership. Some are aware that comprehensive guidelines are available on the internet, which is appreciated (as opposed to personal communication and lobbying before). Criteria however require a policy, an ability to assess the set criteria, willingness to prioritise and coherence to policies and criteria. Decisions made and the lack of transparency (feedback of arguments) make one wonder if they are followed.

These criteria, unfortunately, are not very clear and not weighted. Moreover, the criteria seem to have changed over the last ten years from a focus away from the more "classical" disease-specific research questions to the more recent focus on "applicable" and policy-related questions relating to health systems etc. When it comes to evaluating the RUF/FFU-funded projects over the last 5-10 years it should be borne in mind that these projects were in general initiated and conducted according to the previous "classical" focus and not the recent more "applicable" focus.

5.1.3 Annual focus for health research

All but two research groups find the recent annual focus a good initiative: impact will increase by focussing as funds are limited. However, the focus should not change on an annual basis but cover a longer period in order to be comprehensive and should not be applied to all research funds. Those who disagree either would prefer a different focus or would prefer the focus to be linked to HSPS embedded research, while other research funds should encourage ideas based on scientific quality and creativity. However, judged by the outcome of the latest funding round, the fact that there was an annual focus had limited bearing on what was funded. Initiatives not followed by funding waste a lot of resources in terms of time used to prepare proposals. It is the researcher's understanding that the quality of a proposal continues to be more important than whether it fits within a given focus area.

In previous years handling of research applications was perceived as more swift, fair and transparent. The new focus area program was up for the first time this year. The application form and guidelines were not tailored to a big program proposal, such as encouraged. Little advice was provided on how to do it. There was not enough time given to set up a big North-South collaborative program of the kind that was being encouraged. Some just received a refusal letter with no explanation. Some feel that efforts invested were not supported, appreciated or respected by FFU.

5.2 Changes over the 10 years regarding research focus/strategy

5.2.1 Changes in research agenda

Negative comments prevail and are being mentioned by all respondents. There has been an increased emphasis on applied research and a tendency that research should be instrumental vis-á-vis development projects. It is important to balance this agenda against other relevant research interests, both in terms of optimal use of the available research resource base and in terms of pertinent research priorities in countries not currently receiving DANIDA grants. The change in government in 2001 has led to a very strong change in research priorities, and in a stronger focus on applied research and tying the research much closer to the programme cooperation in the limited number of countries. There is a small opening to include research money within sector programmes. This could be expanded, and in principle become the core manner whereby applied research, relevant to the prioritised sectors and countries, can be supported. Thereby, the research grants in RUF/FFU should be opened up, allowing new ideas and new innovative and creative ideas, as well as younger researchers to gain access to the limited research funds available.

Positive comments: The introduction of the logical framework approach (LFA) is a positive development for some but not for all. The need for involvement of the sector programs is in principle a positive development. However, the danger is that it leads to big variations between countries and sectors, depending on individual viewpoints of key staff such as STA.

Negative: In spite of various DANIDA initiatives over the years, no firm and long term research policy and no clear strategy for supporting research exists. Hence, DANIDA positions become too person based and ad hoc. There is decreasing interest in sustaining results achieved through previous commitment. It is the impression that the formal requirements from applicants have become stricter, while the quality of the decision process has decreased. Furthermore, there is widening gap between what is expected and the resources available. The Hernes report gave a very positive evaluation of the achievements made in ENRECA projects and suggested that the scope of the projects should be widened, so that the projects should provide broad support to “supporting a full research system within institutions”. The report made it very clear that this would require funding at a considerable higher level than before. DANIDA implemented the idea of institutional support requiring institutional assessments and LFA to reflect strategies based on the assessment, but reduced rather than increased funding. DANIDA manpower has been reduced dramatically. This is out pf proportion, considering the research portfolio. During the last year, there has been quite some chaos as to the rules and regulations, the visions and the purpose of the ENRECA programme – in spite of dedicated and committed staff members at the MoFA.

What initially made DANIDA/ENRECA grants unique and highly attractive (long-term commitment, substantial financial volume) has increasingly been replaced by more traditional small-volume, short-duration grants, that are awarded without any apparent or consistent research plan or ambition. Research grants are much more vulnerable to the decisions of the committee especially if the percentage of successful grants is low. In the current system it seems that the likelihood of continued funding in ENRECA is less than certain (even though performance is good) and the requirements in terms of institutional assessments etc. have

increased. The Danish capacity should increasingly be build by the general research councils. This will ensure a mainstreaming of development research in a Danish context.

It has during the last 10 years been considered as a major problem by the research environment that there has never been a DANIDA research policy or strategy or guidelines, although former ENRECA evaluations and reports 2000 and Hernes 2001 strongly recommended the development of such a strategy/policy. A first important step was done by a DANIDA health task force (see Pia Rockhold 2002) with substantial inputs from researchers in the Health Research Network and "A discussion paper on Danish support to health research for development with focus on the need for a more system-oriented approach, research needs identification and priority setting" was developed (DANIDA working paper, 2002). In 2004, F Schleimann contributed with a working paper on "Role of Research in a SWAp/SPS Context". Both working papers never got a more official status. In 2002, a reorganisation of the research development aid took place within the MoFA, including a merge of the ENRECA and RUF programmes, as a follow up of Hernes recommendations. It was decided to establish external peer reviews of research applications, which was generally considered as an improvement. Yet researchers often experience lack of transparency, explanation in the approval or rejection of applications. FFU has recently attempted to develop criteria for research applications so as to promote research that is more directly relevant to Danish Development Aid. However, it is the impression of the research community that there is little coherence and consistency in what different levels and sections of DANIDA (Embassies, Technical and Policy levels & FFU) value as relevant and useful research. Here again there is a lack of joint and agreed-upon strategy between FFU and the different DANIDA levels.

5.2.2 Satisfaction with allocation of research grants

Satisfaction with allocations of research grants varies substantially between research groups. Three are univocally positive. Five respondents are explicitly negative. Four are partially satisfied but request more funding.

Positive: The broad interpretation of relevance to development assistance and the increased emphasis on applied research. A key discussion remains the issue of core-funding to Danish based institutions. Although quality is driven by competition, experience shows that a bilaterally based, long-term aim of building sustainable research capacity in developing countries requires institutional stability, continuity and institutional memory in Denmark. This is only achievable through a certain level of core-funding or long-term funding to key players, especially when focus is increasingly given to capacity building in a broader institutional context.

Negative: What initially made DANIDA/ENRECA grants unique and highly attractive (long-term commitment, substantial financial volume) has increasingly been replaced by more traditional small-volume, short-duration grants, that are awarded without any apparent or consistent research plan or ambition. To some it is particularly disappointing that such a low priority is given to support of clinical trials research and of capacity building in this area.

5.2.3 Opening up opportunities for linking health research and HSPS

Most researchers are in favour of this development.

Positive comments: Let it be one possibility among others, but research should not be exclusively operational. Most feel that it should be encouraged and developed much more than it is now. Currently, it seems to be highly ad hoc and person-dependent. It would be useful to have some research done through this mechanism – to better integrate results into practice – but not all. There should be room for basic research too.

Constraints: Recent experience in Tanzania indicated some of the possible constraints and the fact that most HSPS are not yet geared towards hosting research. Much bridging is needed before research becomes an integrated element of health projects/programmes. The policy framework is presently not in place. The sector program approach may pose a structural hindrance for cross-disciplinary and inter-sectoral research initiatives.

Ideas: With the basket funding approach coming in, we need to go "beyond" the HSPS (need than to liberate core funds for projects that lie beyond, beside, above HSPS) in our attempts to put research higher up the agenda. DBL-IHRD is now starting doing that in Zambia.

Health systems research should be an integral part of health sector programmes and DANIDA should strengthen the development of health research systems in countries where they have health sector programmes. This process should take place through support to relevant local health research networks that are linked with relevant research milieus in Denmark and elsewhere.

With the exception of DBL-IHRD, involvement with HSPS has been very limited so far (10 research groups have never been involved or 'were never invited'). Examples of recent involvement with HSPS are: The FIBOZOPA project, of which DBL-IHRD and KVL are partners, co-funded by the Fishery Sector Programme Support in Vietnam. DBL-IHRD has collaborated with the HSPS in Bhutan regarding research capacity building and establishment of a health research system with funds provided by the HSPS. DBL-IHRD has collaborated with the DANIDA funded health project (not a HSPS) in Kenya on research capacity building among HSPS staff. DBL-IHRD, UC-DIH and UC-CMP were through its membership of the DRNIH involved in the health research priority setting process in Tanzania. The DRNIH is presently involved in a child mortality study in Tanzania, financed by HSPS. The CHDC in Uganda has done some research for HSPS.

Most research groups agree that there is an opportunity here to grasp (e.g. by including representatives of Danish health research institutions in appraisal teams). Health research should become integrated in DANIDA's project planning/aid guidelines, which is presently not the case, and STA and other advisors should be trained. Most are in favour of HSPS having a research component included, if relevant. But the target should be to integrate research in the health system as such. There could also be a role for Danish research institutions in partnership with South research institutions to be involved in scientific follow-up, monitoring and evaluation of HSPS. It should however be noted that only one (1) researcher interviewed has previously participated in an annual SWAP meeting, confirming the divide between the research and development community.

5.2.4 Views on future research agenda

There are very different views expressed by the Danish research community. Some are in favour of research being linked to health sector support, others want HSPS linked research (also promoting health systems research and applied research as part of health programmes) being part of the development budget and keep earmarked health research budgets separate and flexible, without limiting it too much to a few strategic areas, and to be assessed in view of global development priorities. Some are in favour of health research limited to DANIDA partner countries, others not. Some want research funds to go to the best research (independent of whether basic, applied, etc.) and for DANIDA to support Danish research most likely to produce results at a high international level and relevant to important third world health problems. One person stated: *"Good research can make a direct contribution to promoting development and should not be seen as primarily a "sub-contractor" to other Danish aid".* Another view is that development research should be mainstreamed and strengthened as a part of the overall Danish research strategy to prevent

its marginalisation as a "special program". This especially applies to more basic research and product development. And still others say that nothing has to change.

With increasingly unclear RUF/FFU mandate and priorities some researchers may re-consider whether collaboration with DANIDA-partners may be that worth-while. This may in the long run dry up inflow of young researchers, i.e. lead to major gaps. Some research areas are presently underdeveloped, such as on human resources, chronic diseases other than HIV/AIDS (but research on HIV is also limited), the composite health care system, commercial aspects of health care, health care for elderly people, health economics, health systems research, intersectoral research, vaccine research and clinical trials, herbal medicine.

The emphasis should be on high-quality research, long-term, sustainable research, and collaborative North-South research. Major health problems in low- and middle-income societies should be addressed, particulalry in DC that are in rapid transition and where the risk of vulnerability is highest. The agenda should be demand-driven and based on nationally identified needs. Focus on applied/operational research (interventions, access to interventions). Relevance and quality are essential and the link to development is important. Priorities should be decided continuously, and not fixed, at present, to stimulate innovation. DANIDA should again prioritise human capacity building. One other view: DANIDA should emphasize priority problems rather than priority countries (or regions). To some extent, they overlap, but to some extent they may not, and research-based contributions towards solutions to global health problems may not necessarily be found in those countries where DANIDA focuses its development activities. DOTS, developed in India, is given as one example of this.

High quality capacity strengthening can only be provided by groups, which perform high quality research. DANIDA should support Danish centres of excellence and help to build and sustain high quality research groups. This means creating a pool of interested young researchers (e.g. continue the travel stipends for MSc students), PhD and post-doctoral students, more humanities (history, communication, education), more critical intervention research; but acknowledging where resources and interest are actually present. Life-sciences may be a joint theme, including social sciences. Health system research, health social sciences and management require more attention. Networking plays a very important role here and the current support to the Danish Research Network for International Health is appreciated and should be continued.

Capacity building in the south should be continued: training of MSc, PhD, post-doctoral research and ENRECA. A particular problem is the lack of career opportunities/structures for post-doctoral students. This means that a depressingly high proportion of trained PhD scientists may not continue an active research career (although this is not yet the case in our projects). It is increasingly clear that establishment of sustainable research teams in Africa requires considerable funding. DANIDA should focus support to capacity building activities, and support a broad range of activities at the chosen sites and institutions; long-term contracts between N-S institutions, particular universities. Increased attention should be given to broader and also more cross-cutting aspects of research capacity, i.e. priority setting, ethics and research management.

Most agree that international research organisations should continue to be supported, but the overall balance should be on bilateral research. One research group would prefer 100% funding of bilateral research. In those international research organisations that are being supported by DANIDA, the Danish research community should be visible at the governance level. Ideally, support to international research institutions and bilateral research should be linked to some extent, also with a view to achieving synergy and complementarity. Some believe that DANIDA support has been more cost effective than the support to some of the larger multilateral organisations (e.g. TDR, CGIAR).

Views on which networks to continue supporting varies of course between research groups. However several groups have provided the following view. COHRED (i) may be replaced by Global Forum (iii), TDR (iiii) should focus e.g. on orphan diseases. AMANET should continue to be supported (ii). DANIDA is not supporting IAMCR, EMVI or INDEPTH. It is not very clear on what basis DANIDA decides to support a particular network. Given the broader health research and health system focus, support to GFHR seems warranted. Also, the aim of DANIDA to support tropical neglected diseases is in line with the idea to support TDR, if performing well. The specific capacity of the Danish research community in malaria also underscores support to AMANET. But a similar stance could be taken regarding supporting INDEPTH, EDTCP or EMVI. Some research groups would appreciate more risk-taking, more flexibility to support emerging networks, networks in new and innovative fields, thus combining long-standing good partnerships with the possibility to grasp moments of opportunity, ideas, networks that emerge, but that will fall again if no 'risk capital' is available to give them a chance. Other research groups think scarce resources are better invested in the South via the Danish resource base.

5.2.5 Views on future support to health research in DC by Danish research community

University of Copenhagen has shown its commitment to the this field by creating first a department for international health, by supporting several new educations, by creating the Center for international heath and development (CISU) and the cluster in International Health, by appointing 3 new professors within the field during the last 2 years, by electing international health as a priority area, by making an investment to move malaria research from Rigshospitalet and the Panum Institute to new buildings at Center for Sundhed og Samfund, and by working with and developing joint courses with new partners e.g. Royal Veterinary School and Pharmaceutical High School. The Faculty of health sciences have reduced the number of institutes and as a part reshaping of the organisation it has decided to form a new Institute of International Health, Microbiology and Immunology. Thus, University of Copenhagen has documented its willingness to support the field, and have on a number of occasions invited DANIDA to collaborate on this, however with little effect thus far.

DBL-IHRD is in the process of preparing its 2008-2012 strategy and is in the process of merging with the new University of Copenhagen. DBL-IHRD will here become a driving force in the university's intensified efforts within international health and development. This streamlining of DBL-IHRD will benefit the overall Danish support to health research for development. In this new context it is important to maintain the unique expertise and south-directed RCS perspective which DBL-IHRD represents. This includes DBL-IHRD's strong, equity-based long term links with southern institutions and its so-called position between academic research and "real life" implementation.

5.2.6 Should health research be relevant to DANIDA policy?

DANIDA funded research should be seen as a Danish contribution to the global health community's efforts to sustainably improve human health with due reflection to national and international priorities. It should, in addition, be relevant for DANIDA health policy development which it would be if reflecting national priorities. But the framework for this is presently not in place neither nationally in developing countries nor in DANIDA (the latter reflects a lack of consensus in what "relevance" means).

The whole idea of research is that relevance may not be obvious immediately. If false expectations are a problem, then a distinction can be made between research leading to immediate policy results or not. In general, note that research may contribute to a change in

orientation over time and this may be just as important as the 'big bang' of direct impact by a single piece of research (cfr. enlightenment versus engineering models of impact). There is a need for different kinds of research. New methods to combat diseases such as malaria are urgently needed, and at the same time there is a need to use the methods we have better. Research to promote both agendas is pivotal and should not exclude each other. If we take medical conditions affecting Northern populations, for instance cancer, nobody would question the need to do basic research to understand the disease mechanisms, strategic research to develop new drugs or vaccines and applicable research to use the tools better.

5.3 Research-process related issues

5.3.1 Dissemination of results

What happens to the reports submitted to DANIDA? One has the feeling that the final reports are not read by many before filing. Since the publication of the nice booklets in Danish and English on the ENRECA projects, based on interviews with South partners, and edited by professional journalist, Lise Penter Madsen, there has not been much proper publicity on RUF and results – except what researchers have done themselves. In general, too little is done and procedures for dissemination are in fact non existing. For example, RUF/FFU is not making a "popular" annual report, addressing broadly the research community and other relevant stakeholders. As a rule, dissemination and utilization should be part of the original research application and grant.

DFU/Social Pharmacy has some good examples of working with HSPS to disseminate research results in Zimbabwe. It also uses the International Network for Drug Use for dissemination and discussion of research results from Zimbabwe and Nepal. DFU is in favour of having a dissemination strategy built in the research as from the beginning (e.g. using WHO).

Table 14 Dissemination strategies employed by DANIDA-supported health research in DC

Dissemination strategies used	Always	General	Seldom	Never
Peer-reviewed journal	10	3	0	0
Local journal (developing countries)	1	4	5	3
On-line journal	1	4	6	3
Policy brief	1	0	7	5
Press articles	1	2	8	1
Popular magazines	1	2	8	2
Training courses	4	5	4	0
International conferences/workshops	6	6	1	0
Partnerships between researchers, policymakers and policy end-users	4	4	3	2
Networks (specify which one)	1	10	0	1
Face-to-face communication with DANIDA staff	2	1	7	2
Face-to-face communication with national authorities	2	4	5	2

Noteworthy from the above Table 14 is that local journals, popular journals, press articles, on-line journals, policy briefs and face-to-face communication are less used for dissemination of research results. As to be expected peer reviewed journals, international conferences, workshops, training courses are the standard dissemination channels. Surprisingly, partnerships between researchers, policy makers and end-users is also popular (but how is this understood)?

Many confirm that translating research results into policy happens more effectively through best practice papers, policy briefs, personal continued contact to key persons, policy meetings, networking and international meetings (e.g. GFHR, WHO, EU). Good South

examples reported on are the annual research meetings of NIMR (Tanzania), annual conferences and awareness raising through securing participation or research partners in national workshops, seminars and meetings.

There is no consensus in the Danish research community on the need to include a section in the research proposal and logframe on how research results may/would be used. It would be more meaningful when the research is completed.

5.3.2 Decision making and ownership

According to the research groups interviewed, setting the overall Danish research agenda is mainly done by DANIDA and the FFU, but influenced by the global health research agenda (e.g. TDR, COHRED, Global Forum). However, it is not clear as no research policy exists and dialogue on research priorities has become less open. Danish or South research institutions, nor the health research network are involved. The South is not consulted for setting the overall agenda, but this is being perceived by some as acceptable as it is 'Danish business' and it would be impossible to identify who are representative for the south. Also, the research agenda is being set at a higher, global level. However there are strongly different views on this in the Danish research community, from a strong yes (the south should be involved) to a strong no.

Regarding the selection of research applications, this is perceived as only slightly different. Decisions are made by DANIDA and FFU. The RDE has some limited influence. All other stakeholders, North and South have little influence.

Regarding the decisions at project level (preparation of research proposal; deciding on objectives and activities), North and South institutions are involved. Ownership of the South authorities and South institutions varies. It is reported as being more equal for ENRECA projects than for research projects, where the ownership is more with the Danish partners. But also the latter varies between Danish research groups and type of projects (e.g. South PhDs are more South driven).

Research applications and decisions have seemingly not or only slightly become more demand driven over the past ten years. However, two institutions disagree (DBL-IHRD[36] and UC-DS). Regarding ENRECA, most agree that the approach has always been more demand driven[37,38]. Regarding research projects, the increasing disarray within RUF with short timelines between announcements and application deadlines, changing signals, the increasing demand for different kinds of documentation, has necessitated that one person based in Denmark drives the application process. Also, contextual factors seem to have worked in the opposite direction. According to the researchers, it has become more difficult to fund fellowships from many countries, and it has become more difficult for South partners generally to access Denmark.

[36] DBL works with a 'partnership approach' and DBL's DANIDA funded research activities are to a large extent determined by Southern partners. The South is represented in DBL's Board of Directors, and DBL's Southern partners provide inputs to DBL's strategy and annual work plans.

[37] For example, CMP states the following : "We have always formulated ENRECA proposals jointly with our partners and in many instances the partners have defined our research agenda. Similarly, much of our drug work has been initiated on the request of southern partners. Within the Joint Malaria Programme in Tanzania, we have a formal forum to identify research topics".

[38] According to the HRN, research in the ENRECA programmes has been "demand" driven in so far that the studies have been conceived in a close collaboration between researchers in the South and North. As described in the ENRECA evaluation: A high level of N/S equity in the decision-making process.- However, there is no overall deliberate south research agenda. There is little demand from the south other than research institutions. National ministries, sector programmes and embassies are generally not demanding research, but more consultancies.

If the South has a greater say today, it is mainly in setting its own research agenda (although also that one is very much determined by available financing and thus by outside forces) and in implementing the research. Much less in using the research results.

5.3.3 Capacity building

Individual capacity building

Capacity building both of Danish and South experts has been on the forefront of both ENRECA and research projects supported by DANIDA. The Danish resource base has been strengthened through MSc and PhD training and different post-graduate courses and post-doctoral students. Specific initiatives that have contributed to capacity building are:

- establishing and running the Graduate School for International Health (PhD);
- establishing and running the Masters in International Health at UC;
- establishing and running the Masters in Parasitology at KVL;
- establishing the International Health Research Network;
- establishing and running CISU; and
- research methodology course by DBL-IHRD[39].

A considerable number of Danish researchers has been trained and Danish research on malaria immunology and pathogenesis has moved from a relatively inferior position to the international cutting edge. Also the field of medical anthropology and development has been more firmly established.

Lead research groups in building the capacity of the Danish resource base[40] have been UC (IH, Anthroplogy, CMP), DBL-IHRD, Rigshospital, SSI (mainly through Bandim), and AU (in terms of numbers of experts trained). Interestingly, several research groups are founding members of the above MSc courses and all are members of the International Health Research Network.

Capacity building in the South has focused mainly on building individual capacity through the same initiatives as listed above, but also a large number of specific local courses and workshops for Southern partners, visiting scholar programmes, exchange programmes, teaching activities at Southern partner institutions.

The feedback provided by the Danish research groups on numbers of North and South MSc students and PhDs trained is presented in the table below. The information did not allow exclusion of double counting. This is important for PhDs as DBL-IHRD has trained many South PhDs, but all are registered with Danish Universities (and may have been reported twice). Also some institutions provided a best guess rather than evidence based figures. Totals should therefore be regarded as approximate. Based on the figures below, the output of the DANIDA supported research has resulted in an average output per year of 16 North MSc, 26 South MSc, 8-10 North PhDs and 6-11 South PhDs. In addition many diploma courses have been provided (e.g. KVL, UC-DS, DFU, etc.).

Table 15. Number of MSc and PhD degrees as a result of DANIDA support

Degree	North	South
MSc level	155	248-273

[39] PhD preparatory course of 4 ½ month duration held at DBL in Charlottenlund. From 2006, the course is also implemented with University of Nairobi Institute for Tropical and Infectious Diseases.

[40] According to the HRN, FFU seems to have some reservations towards research applications if they don't include more students and researchers from the South as compared to the North. However, in the ENRECA due consideration has been given also to capacity development in the North.

PhD level[41]	79-104	58-109

Research related skills or competencies built include always protocol development, research methodology, writing skills (report writing, peer reviewed publications), knowledge transfer and priority setting. Skills that receive lesser attention in some research groups are skills to attract non-DANIDA financial resources, skills to respond to international calls for research and information technology.

The DRNIH has invested in complementary skills-building such as cross-disciplinary skills, including gender aspects; research ethics in low income societies[42]. Interestingly, a research methodology "light" course has been conducted by DBL-IHRD for Danish NGOs and other stakeholders.

Institutional capacity building in the South

Support to institutional capacity building has been mainly implemented by training individuals (see above). Specific focus on institutional capacity building has been present in some ENRECA programmes but one wonders whether the concept of institutional strengthening is understood the same by all. The easy stance is that through training individuals you strengthen the institution. Some do not see it as a specific objective. For example, institutional strengthening is understood as follows: "employing personnel, developing processes for generation and administration of grants; conducting several project development and writing workshops". It should be noted that in the mid nineties DANIDA did not encourage institutional strengthening as such through ENRECA programmes[43].

DBL-IHRD supports the building of institutional capacity at core collaborating institutions, i.e. capacity extending beyond individual capacity. This include research strategy development at for example PHCI, VCD, IAS and UNITID, support to establishment of a health research system in Bhutan, support to establishment of the legal framework for research and for national research priority processes in Gambia and Zambia. In addition, administrative staff from core collaborating institutions is trained in budgeting, accounting and financial management. Tangible support (IT, library, laboratory equipment) is also provided. SSI has built the main Guinean institution for health research, notably through the Bandim project. UC-DA has supported institutional development of CHDC in Uganda. UC-DS has supported research priority setting in Madagascar[44]; and supported developing a public health journal in Madagascar and Tanzania. UC-IH and DBL-IHRD, through the DRNIH also supported research priority setting in Tanzania.

Institutional capacity strengthening focuses more on partner research institutions, much less on MoH or on the NHRS (11 out of 15 respondent research groups confirm not to support the NHRS directly). Strengthening MoH is rather the exception. Most examples given relate to supporting setting ENHR priorities, which processes have recently been supported in Tanzania, Zambia, Gambia and Bhutan[45]. Support to MoH capacity building happens for example in Uganda, through institutional capacity building of VCD and indirectly through PhD training of MoH staff. Also in Guinea-Bissau indirect support to MoH is provided through

[41] DBL has trained 25 Danish PhDs and 51 South PhDs.

[42] Other, more conceptual or technical topics included for example rethinking primary health care; treatment seeking practices: social actors and health systems; biomedical technologies in the context of low income societies; epidemiology/ statistics/ in the context of DC; Malaria control in Africa; etc.

[43] According to the research community, ENRECA guidelines in the mid nineties explicitly stated not to support institutional strengthening. Regarding Bandim for example this view was only changed after the last evaluation in 2003.

[44] Both Bandim / Guinee Bissau and UC-DS / Madagascar are examples of a continuous long-term support to research capacity building in the South, going beyond the ENRECA period of 12 years. For example UC-DS in Madagascar had RUF research funds from 1983 to 1990 and ENRECA funds from 1990 to 2002. Bandim has received DANIDA funding for many years.

[45] DBL provided support in all 4 countries. UC (CMP, IH) and DBL provided support through the HRN in Tanzania.

training all post-graduate students (some, including the Director of Health, are now in charge of health programmes). In Madagascar the MoH cadre of chief dental officer has been created as a result of the ENRECA support. Other target groups of specific research initiatives include provincial and district health management teams, health workers, hospital staff and NGOs. To facility transformation of research into practice, research methodology "light" courses have been held for health staff under the HSPS in Bhutan and Kenya.

South-south collaboration[46] gets less emphasis than North-South collaboration. Several research groups confirm that they have not supported south-south collaboration. Examples of support to south-south collaboration are a) participation in southern regional networks such as AMVTN, AMANET, EANMAT, IN-DEPTH, RNAS, RNSA, AAMVM, CWEGESA[47]; b) some specific programmes such as the Joint Malaria Programme, CESA and waste water management in Tanzania; VCD in Uganda; and c) regional projects such as in SE Asia.

Link between research and training

Translation of research results in course content is standard for most, but not all research groups[48]. 8 out of 14 research groups are involved in MSc training, and 11 support PhD training. Post-doctoral training has been provided by five research groups. E-learning[49] is still the exception (only 2 out of 14). Five research groups[50] have sent students to the MSc on international health.

Effect of the MSc International health on research agenda, research quality and South capacity

A correct assessment would require a quantitative follow-up of outcome/impact. How many have published? How many continue in research? These criteria have been applied earlier on, on DBL-IHRD supported MSc students registered at developing country universities, showing high impact.

The participants of the MSc course are mainly health practitioners or managers. Some of the students from partner countries are working with research questions which have been formulated in home countries, sometimes in HSPS. The course may help to develop a larger pool of people to be recruited for research activities/trained for actual research (PhD programmes). The capacity building aspect of the Master programme was highly appreciated in the external DANIDA evaluation of the MSc IH programme 2003-2004.

According to the research groups involved in the present review the research agenda has been influenced by some training modules of the MSc IH, by stimulating the interest for international health issues in Denmark and by the research becoming more applicable. South research capacity has been improved through training, by enhancing basic research skills and establishing a stepping stone for PhD-training.

ENRECA

ENRECA has contributed much to capacity building and is generally very much appreciated throughout the Danish research community. Strong points are perceived to be the long time frame, comprehensiveness, greater South initiative, more collaborative, more reciprocity,

[46] South-south collaboration is often encouraged in EU INCO research projects such as CONTRAST, REACT, MUSTschistUKEMA

[47] Regional Network for Research, Surveillance and Control of Asian Schistosomiasis (RNAS); Research Network for Schistosomiasis in Africa (RNSA); African Association of Medical and Veterinary Malacology (AAMVM); Cysticercosis Working Group in Eastern and Southern Africa (CWEGESA).

[48] Specific examples were provided by UC-DA: Various medical anthropology courses in DK, Vietnam and Uganda. Master in International Health, Master in Health Anthropology (in Danish, jointly with AU). UC CMP and IH: PhD and masters courses in international health. DBL: integrated part of all DBL teaching, including DBL's research methodology course. AU: Master in Health Anthropology (in Danish, jointly with UC-DA) Research methodology, Medical anthropology. UC-DS: dental public health course. DFU: course in modern spectroscopic methods at the University of Ghana, Legon.

[49] The two examples are DBL with the University of Nairobi & Institute for Tropical and Infectious Diseases in Kenya (under development); and UC-DS in Madagascar, Burkina Faso and Tanzania.

[50] UC-DA (9 students), UC-CMP (2) and UC-IH (about 20); DBL (4); Bandim (5).

research being cumulative, Danish students being welcome, more applied research, research capacity and results staying in the country, more institutional focus, more capacity building at institutional level, sandwich type of PhDs. Such capacity is essential for sustainable health development in developing countries and supports knowledge-based decision making. ENRECA allows for capacity development to be a legitimate activity, whereas in a regular research project the level of expertise involved needs to be higher than may be available in a country with a poor research infrastructure. All research groups are in favour of continuing and even extending the ENRECA approach, but this should go hand in hand with more resources. Most are also in favour of regular research projects having a capacity building element. Ten out of 14 consider this a must, while 4 research groups say that this is not always relevant. Twelve out of 13 respondents agree that a standard research proposal should specify how capacity in the North and the South will be strengthened by the project.

Views on future capacity building needs

While all research groups agree that a lot has been achieved in terms of North capacity building over the review period, more could be done. For example, the DANIDA support would benefit greatly from the development of a consistent, long-term strategy. However, views differ as to what DANIDA should support. Some are of the opinion that DANIDA needs to accept that it has a rationale and an obligation to support its local research capacity for development research, as no other substantial Danish funding agencies are available for international health research. Others are of the opinion that DANIDA should emphasise capacity building in the South, while capacity building regarding (health) development research should increasingly be the responsibility of the other Danish research councils.

Regarding capacity building in the south, only 6 out of 14 research groups state that the approach has been fully appropriate. Others propose ways to improve it. The most cited advise is for DANIDA to broaden its capacity building approach, increasingly looking at broader and longer-term institutional capacity building; increasingly reflect on national processes and priorities in southern collaborating countries; and increasingly support collaboration across sectors. Another view is for DANIDA to define a policy for Human Resource Development in the South and take higher education serious, not only primary & secondary school.

5.3.4 Harmonisation/coordination

The term coordination reflects better the reality than harmonisation.

Most institutions coordinate through active participation in formal and non formal Danish and International research networks (as indicated above), as being a formal WHO collaborative centre, through international congresses and expert meetings (e.g. in TDR, WHO), through ongoing contacts with researchers, through reading recent publications. An example is a researcher being a member of an Amsterdam based expert group on ART in resource-poor settings, which coordinates research on antiretroviral treatment of AIDS. Other channels used include the health research network, EMVI, Gates Malaria Programme, Grand Challenge of Global Health programme, European Malaria Vaccine Consortium, numerous southern networks (AMANET, RNAS+, CWEGESA, RNSA, AAMVM). Southern national dialogue mechanisms do not exist or are generally perceived as weak. Positive examples in the South are the annual research meetings by NIMR (Tanzania). And the recent attempts to support national research priority setting (see above). Some project set-up may also foster coordination, such as for example in the JMP and regional research projects. At south institutional level, quality of coordination with other research partners varies. However some research groups try to encourage this through full transparency in interaction and dialogue with collaborating institutions; through the “buying in” on strategies and work plans of collaborating institutions based on needs assessment which include a total donor profile; through requesting, from central collaborating institutions and networks, of annual reporting;

through support to institutional strategy development at key collaborating institutions. It is the view of most that the role for international coordination is with international research networks or forum such as the GFHR and WHO.

There exist different views on harmonisation in the Danish research community. Most prefer the word 'coordination' rather than harmonisation. Scientific progress is seldom harmonious. There is a trade-off between harmonisation and too much bureaucracy that may jeopardize concrete research opportunities because of bottlenecks. And as one person stated: "*If harmonisation means that everybody plays the same tune – as it usually does - it is unwarranted and dangerous for science".* It may be debatable how much "harmonisation" is necessary and desirable but there is a role for DANIDA to encourage and assist national authorities and south institutions in improving the coordination of research carried out in collaboration with various external partners so a to optimise synergies.

Not everybody agrees that coordination is an issue, but most agree that it should be done in order to use scarce resources best. Most also agree that in Denmark the DRNIH is doing a good job in sharing information and organising meetings, which helps to coordinate between Danish researchers. Areas where more or better coordination is required is the remuneration packages of southern scientists promoted by different funding agencies. At the international level, researchers should avoid duplication and that is why scientists use quite a lot of time communicating and at meetings. At institutional and national level it is important that research initiatives do not impede on each other (could happen if two activities are taking place at the same place and at the same time) and that possibilities for enhancing the quality by collaboration between projects are acted upon. Some consider coordination a research ethical issue and see consensus on national research priorities as an important initial step.

Researchers have different opinions on the role of DANIDA in terms of supporting harmonisation. DANIDA should start by developing its own health research policy. At the international level, DANIDA could delegate this to the expert networks or forum (e.g. GFHR). To affect international priority setting, continued support to for example TDR; GFHR could be important. At the south national level, DANIDA should support research priority setting. Often, the problem of duplication of research etc. may be due to donor-driven research and lack of coordination between funding agencies. It may be impossible for researchers who need funding to ensure harmonisation.

Both DANIDA and Danish research groups can contribute by remaining a visible and active partner in the global health research community. Contributing to stewardship initiatives is essential. DANIDA and Danish institutions should remain active and visible towards for example COHRED, Global Forum for Health Research and TDR. By supporting research of high quality. Innovative research of high quality does not copy other research activities, but is sometimes copied by others. The fact of the matter is that research leading to new insights (no matter the research area or paradigm) generally is published in journals with higher impact than research that confirms existing knowledge.

5.4 Impact of health research

Several research groups subscribe to the 'enlightenment' rather than 'engineering' view of impact: research contributes to a change in perception and practice and is one among other factors that influence change.

5.4.1 Impact on national health policy in DC

Several examples have been provided. Community Drug Use project in Uganda helped create recognition of self-medication and contributed to acceptance of Home Based Management of Malaria/fever, as part of malaria control strategy. Malaria drug resistance monitoring in Tanzania has contributed to the decisions on when to change first line malaria drug policies. Publications on assumptive preventive treatment of malaria in infants (IPTi)

has led to research on how this strategy should be implemented. UNICEF has been pressing to implement the strategy immediately. Non-communicable diseases are now on the agenda in several countries. Re-enforcing the existing guideline on inclusion of iron supplementation in antenatal care in Uganda. Development of an approved National Health Impact Policy in Lao PDR. Strategies developed for control of filariasis and schistosomiasis in Uganda were basis for the respective national control programmes. Evidence provided that lime protects against cholera. Definition of the current health situation and health priorities in Guinea-Bissau. Evidence provided that HIV2 was not as severe as HIV1. Ongoing research on private health sector in India is feeding directly into the formulation of a new urban health policy by the Indian Government. Formulation of national policy for oral health in Madagascar. Evidence of poor health data quality (over-reporting of immunisation data, underestimation of MMR by sisterhood method) has lead to reviewing the HMIS and national plans for adapting it in Nepal.

5.4.2 Impact on health service delivery and health action in DC

Several examples have been provided. Quality of Care study in eastern Uganda contributed to change in injection practices in health units. The finding that most cases of malaria in district hospitals in northern Tanzania are diagnosed in patients that are aparasitaemic and carry a high mortality rate, should result in a change of practices at these hospitals. This being implemented now at hospitals in the Northern regions and new guidelines are being designed for district hospitals. Intermittent presumptive treatment for malaria in infants (IPTi) and pregnancy (IPTp) via village workers has been adopted. Treatment guidelines for malaria have been changed. Physiotherapy has been introduced for management of lymphatic filariasis morbidity. Change from surgery to ultrasound guided medical treatment (de-worming) has been introduced in management of severe Oesophagostomum infections. The first outreach immunisations ever in Guinea-Bissau were introduced. Better organisation of staff reduces hospital mortality. Public health programmes and national school oral health programme have been introduced in Madagascar.

5.4.3 Impact on international health knowledge

Some examples are provided. In collaboration with Dutch medical anthropologists, the role of informal sales of pharmaceuticals in developing countries has been documented. Malaria research carried out at CMP and Rigshospitalet over the last decade has undoubtedly contributed in a major way to the rapid progress in the understanding of the immunology and pathogenesis of this disease. Other malaria related achievements are a publication on intermittent treatment of malaria in infancy, the discovery of the lead candidate for a malaria vaccine to pregnant women; the definition of the subgroup of proteins that are responsible for the development of severe malaria in small children, which forms the basis for developing a malaria vaccine for children; the evidence that impregnated bed nets can reduce drug-resistance in malaria and that flooding can be used in malaria control. Other internationally relevant knowledge relates to the evidence that low birth weight may induce early type 2 diabetes, and that BMI is not reliable indicator of diabetes risk in Indians; the inclusion of bednets in programs for control of filariasis; the inclusion of micronutrient supplementation in child health programs; guidelines for integrated chemotherapy based control of schistosomiasis and intestinal helminth infections; evidence that chronic diarrhoea is more important than acute diarrhoea; and research evidence that lead to the withdrawal of the high titre measles vaccine.

5.4.4 Impact on DANIDA health policy

DANIDA has no specific official health policy but a broad development policy. In general, research groups confirmed that research results probably have had limited influence on official DANIDA policy. But maybe some ideas have indirectly done so. For example there

may be now a greater recognition by DANIDA of the informal health sector. Non-communicable diseases may have become better known to DANIDA in – at least – Tanzania, Uganda and India. DANIDA's strategy for child focused development may have been influenced by some research evidence.

5.5 Danish Research Network for International Health (DRNIH)

5.5.1 Added value of the network

According to the network, its main value is the interaction and communication within the resource base, and for DANIDA its function as a one-stop centre. The Network serves somewhat as the interface between different researchers, and between researchers and developers. The challenge is to create cross disciplinary and cross institutional platforms and focus that engages both players, which according to the network has been possible in a series of activities during the years.

All research groups interviewed agree the DRNIH has an added value, mainly in information sharing, communication and cross-disciplinary interaction. With the DRNIH, there has been a better channel of communication to DANIDA[51]. DRNIH provided a forum for exchange and collaboration between Danish researchers that are otherwise scattered between many different institutions. Also, DRNIH organised a series of excellent workshops and conferences, and facilitated funding for workshops. Some of these seminars have contributed to and influenced the Danish research agenda. More recently, the DRNIH has been instrumental in forging links with some HSPS. The DRNIH has also advocated for more funding with DANIDA, but with limited or no success lately.

However, according to some research groups, the old ENRECA network worked much better, when interference from DANIDA was less, and trust was higher. Another concern voiced is that the network is not (yet) covering a sufficiently large number of institutions. In reality, active members are limited (and becomes increasingly limited) in numbers. The network is no stronger than the inputs from the participating institutions. Several research groups find the University of Copenhagen ownership of the network too pronounced. Some research groups suggest the network secretariat to focus more on facilitation and coordination and less on being the implementer, and find that over the years too much emphasis has been paid to activities in Denmark. The network did not sufficiently reach out to the southern collaborators. Others expect even more output in terms of collaborative research.

Reportedly, the network has since 2003-04 been hampered by the lack of clear overall mandate for the Network from the point of view of DANIDA. It has been difficult to know what DANIDA wanted from the Network. As with the research agenda, the DRNIH feels that there is little coherence between what different levels of DANIDA think the Networks should be doing and how they should do it. This makes communication and collaboration with DANIDA rather difficult and time consuming and hampers the performance of the secretariat. Unclear research policies in DANIDA may deplete resources from the network and decrease value for money invested. In addition, untimely transfer of funds for the network has sometimes created practical problems. The frequent bridging periods which included reworking the budgets and the accounts, wasted resources on extra administrative tasks. On the positive side, the new strategy and work plans for the network are perceived as promising. But it requires that the network participants participate fully and actively. It is presently not felt by some research groups that the inputs pay off.

As the role of the Network initially was to strengthen cross-disciplinary collaboration and interaction between researchers and towards DANIDA, it is to be expected that the DRNIH

[51] According to the HRN, the quality of the dialogue with DANIDA has varied over the years, mainly depending on the level of interest in research of the technical staff available.

has influenced the research agenda, contributed to cross-disciplinary research and indirectly improved research quality through training. Not all research groups are convinced that the DRNIH has had a significant influence on the research agenda and research quality. Rather, impact of the DRNIH has reportedly been greater in the area of capacity building (e.g. training) and promoting cross-disciplinary collaboration. Others are of the opinion that the DRNIH has influenced the research agenda through exchanging information between researchers and communication. Also, more recently, the contacts between the DRNIH and HSPS may influence future research agendas. Quality of research is dependent on expertise of North and South researchers. However, some feel that the DRNIH has indirectly contributed to research quality, by linking up different people, also cross-disciplinary. Also, as a one-stop centre between DANIDA and the Danish research community, the DRNIH has contributed to assuring that relevant information (e.g. for applications, funding) was timely shared with all members.

The network agrees that it has been less efficient in disseminating research results and could have spent more time probing researchers for 'research results' to be published on the website. However, it is felt to be time consuming and that researchers don't always find it gratifying enough to spend time disseminating through the Network. Indeed, views of the research groups differ, from 'fine' to 'could have been doing much more'. Also, some query whether this should be the role of the network, given its limited resources. However, the network has made some nice publications on different ENRECA and some research projects[52].

The network has also not firmly taken up the role to translate research results into digestible information for developers, policymakers and society at large. It is perceived by several research groups that this could be a relevant role for the network. However, the network feels that they have not the resources nor the expertise or scientific insight to translate all fields of research results into digestible briefs. Also, relevance is not always obvious and the implications for policy must be discussed by researchers and policymakers. This work could be facilitated and monitored by the network but outsourced or commissioned to others.

The network feels it can still improve its support to research in DC by contributing even better to research by maintaining the focus on creating links between HSPS and the researchers; by expanding with more south institutions; by being provided more resources and if the participating institutions take their participation more seriously. In the future, the network's focus should be moved towards the south, involving the southern partners. However, the DRNIH feels frustrated that it no longer can support PhDs and other courses (work that it did before but should leave to the universities, according to the new contract with DANIDA). It is convinced that this input was a major contribution to research in the South and a convincing element for south institutions to partner with the network.

[52] Website : http://enrecahealth.ku.dk

6 Opinions and views of some staff of Danish Embassies

Introduction

Some Royal Danish Embassy (RDE) staff did complete questionnaires[53] and were interviewed by the review team in Arusha, Tanzania. The summary below presents the views of 4 RDE staff (Ghana, Mozambique, Tanzania and Uganda).

Research agenda and annual focus

In general RDE staff are not aware of an overall DANIDA research agenda, but know that there is an annual focus for health research[54]. How the agenda is being set is not well known. Feedback to RDE on decisions taken by headquarters regarding research is often lacking. The general idea is that the agenda is mostly North driven. The South could get more involved by research proposals looking more at national strategies, priorities and work plans for health; and by more systematically involving as well policy makers as research institutions in agenda setting.

RDE staff have generally no idea whether and how well south is involved in preparation of research proposals (the example of the child mortality study in Tanzania was mentioned : "*the MoH and HSPS defined the first ToR but felt strongly that they were bypassed in the finalization of the ToR. The local research institutions felt by-passed the whole way through which caused a lot of hard feelings as they felt they were treated as research assistants and not as partners*".

The **annual focus** is considered a good initiative. However it is being questioned whether the focus is really been applied, as the recently granted research applications have no to any significant extend focused on systems.

The table below is based on one respondent's view only. Strengthening the NHRS is seen as the most important priority (80%).

Table 16. Repartition of a hypothetical resource envelope to different support areas (in %, both range and average values)

Support focus	Range	Average
Strengthening the national health research system	N/A	80%
Strengthening of specific research institutions		
Developing capacities of individual researchers	N/A	10%
Implementing research with research institution outside HSPS/health project		
Implementing research within HSPS or health project	N/A	10%
Total	N/A	100%

No answers were provided on the other preferential allocations. Choices between sectors should be in line with DANIDA national sector priorities (where DANIDA is actively involved).

Health research should be relevant for DANIDA development policy, but it is much more important that it is relevant to the national policy agenda and research agenda AND that it is at least attempted to cooperate in joint (joint donor, joint research institutions and joint MoH/research institutions) forum. It makes little sense to have specific DANIDA relevant research if not linked to the national agenda, and in some countries like Tanzania it will be

[53] Questionnaires were received from HSPS STA in Ghana, Tanzania and Uganda.

[54] The respondent of the RDE in Mozambique, responsible for health, has worked previously at the TAS in MOFA, Copenhagen. She was generally much better informed about health research issues.

increasingly difficult to have it accepted (i.e. get research permits etc.) if not harmonised and aligned, and with clear (joint) ownership.

In general, the RDE is in favour of having research funded within HSPS, as key policy areas can be targeted.

Grants are being allocated from Copenhagen. The RDE is not involved but has the impression that national institutions have little influence. Most RDE staff do not know the criteria used for deciding resource allocations between different modalities and for accepting an application. RDE staff would appreciate proper feedback from RUF/FFU regarding information provided to RUF/FFU and final selections made (reasons).

RDE staff do not see a role for RDE managing resources (unless in HSPS) but rather a role for the RDE on providing information on areas of relevance for research, feedback on applications; facilitating cooperation between local and Danish institutions, and particularly with other development partners initiatives in the same area, aligning with national priorities.

Most RDE staff see little scope for Danish researchers to be involved in the HSPS research, unless it is part of the HSPS design. Local researchers could be involved in the HSPS design; Danish researchers could eventually get the opportunity to comment on the design. It could be relevant –if there is a local demand- to include a research budget in HSPS, but in that case with more focus on local research, who could team up with Danish researchers/institutions if felt and deemed necessary and be requested. RDE staff sees a limited role for the Danish researchers in possibly scientific follow-up and reviews of HSPS.

Capacity building
No information is provided on ENRECA. Capacity building should be part of each research application.

It is being perceived that capacity building is less oriented towards the south and more towards the north. There are no sufficient training opportunities for southern and Danish researchers.

Harmonisation
It is felt that DANIDA should actively support harmonisation, by being actively engaged at the national and international levels.

Danish Research Network for International Health
The value is mainly seen as a focal point, a place where one can access info and contacts as well as exchange of research initiatives, but it is assumed that the value is more obvious in Denmark and among researchers than at the field level. Communication by the network could be improved as it is not well known in the south. .

Dissemination
No comments on means or modalities to translate research into policy.

Performance of the DRNIH in disseminating research results is either not known or perceived as more targeted towards researchers than to policy makers. Translation into digestible information is valued as poor or is not known.

Research applications should include a section on how results will be used, but there should also be a reference as to whom has expressed the need/wish for the research and has shown commitment to use it.

Specifying whether the research regards policy support or not could also help solving some problems or expectations later.

Future priorities

Danish health research could be managed differently in the future in the sense that a) communication could be improved, and b) maybe distinct procedures could be developed for research relevant for development efforts (more jointly) and other more scientific base research for international consumption. Research should help DANIDA to deliver/support better health programmes.

Individual comments:

"*The context today is one of a "new world" of harmonisation and alignment, need to de-link Danish funding from Danish "supplies" and follow more country defined priority setting. I have a strong feeling that too much research is still developed, conducted and owned by Danish researchers and not trying to reflect the need to respect national priority setting*".

There may be need for clear distinction between different kinds of research with different purposes: On the one hand there is the not-nationally-requested research which often will be of bio-medical or of cross country comparative nature and can create new and comparative knowledge which may not necessarily be used nationally directly, but be translated into new global understanding, maybe new treatment guidelines, exchange of experience etc. And on the other hand research which more directly are felt – and requested - nationally as needed and applied for improving local policy/strategy changes and therefore also should be identified and managed locally in some kind of a national joint set up including MoH, development partners involved and research institutions – who then may ask for collaboration with Danish or other national researchers/institutions.

Clearer differentiations between different purposes, clearer common understanding of ownership and priority setting, and closer collaboration between development partners involved in the same process. It may also reduce the competition and donor-shopping for funds (in Denmark as well as in partner country and globally). Maybe some kind of local representation in key partner countries from the different health research networks north could facilitate such processes. The Embassy for example has so many visitors from Norwegian Health Researchers, Dutch, HO related etc. who all ask for DANIDA funding for their own proposals for research in this country. Differentiation could be based on research done IN the partner country and research done FOR the partner country.

7 Selected views of some staff form the Technical Advisory Services, DANIDA

Introduction

Two TAS staff did complete the questionnaires and were interviewed by the review team in Copenhagen. The summary below presents their views.

Research agenda and annual focus

There is no overall research agenda. Different actors are involved in decision making regarding research in a fairly in-transparent manner. Decisions on setting research priorities are North driven.

In order to establish an appropriate research agenda and have the south more involved in setting priorities, the following is needed: First a research policy must be established, then a health research policy, then a health research agenda in developing countries, covering both the research support and the Sector Programmes. Criteria for research support and Aid Management Guidelines could then ensure the demand driven-ness from the South. Involving the south could also be more achieved by engaging more at country level, through SWAp.
Today, the South is more involved in HSPS based research; both South and North more equally involved in ENRECA and the North more involved in FFU research projects.

The annual focus is considered a good initiative, but it only covers FFU funding and has not been discussed with the south partners nor with the researchers.

Areas of support and instruments used

A research resources envelope would preferentially be allocated to specific support areas as indicated in the table below. As the different categories are not mutually exclusive, interpretation is to be done with caution. Also, the number of respondents has been only two. Strengthening institutional capacity (28%) and HSPS research (23%) get the highest scores. Strengthening the individual capacity (17.50%) and the national HRS (11%) are also considered relatively important. Other categories mentioned are strengthening the Danish resource base and long-term projects (e.g. Bandim).

Table 17. Repartition of a hypothetical resource envelope to different support areas (in %, both range and average values[55])

Support Focus	Range	Average
Strengthening the national health research system	10-13%	11%
Strengthening of specific research institutions	25-30%	28%
Developing capacities of individual researchers	10-25%	18%
Implementing research with research institution outside HSPS/health project	0-20%	10%
Implementing research within HSPS or health project	20-25%	23%
Total		89%

Preferential allocation between different types of DANIDA support is proposed as follows. Views are quite different. One respondent sees ENRECA projects as the only choice (100%). The other respondent perceives ENRECA as most important (50%), while research projects receive 40% and PhDs 10%.

[55] Average values only represent the views of 2 people.

Table 18 Repartition of a hypothetical resource envelope to different types of projects (in %, both range and average values)

Type of project	Variation	Average
ENRECA	50-100%	75%
Research projects	0-40%	20%
PhD projects	0-10%	5%

Most of the research funds should be allocated to bilateral research (80%), as summarized in Table 19.

Table 19. Repartition of a hypothetical resource envelope to different channels of supporting research (in %, both range and average values)

Channel of support	Variation	Average
Bilateral activities	70-90%	80%
International institutions and networks	10-30%	20%

Regarding allocation of resources between sectors, the view is that no % allocation should be done. Rather global and south research needs in partners countries, comparative advantage of the Danish research resource base and concrete north-South research proposals should betaken as criteria.

The advantage of funding research within HSPS is that it is automatically integrated in the SWAp, linked to the DANIDA country & development focus, is more applied research and demand based. Limitations are that research is competing with other funding, that some global priority areas may not be part of HSPS; that it may be too short-term, linked to persons.

Opposite views on basic versus applied research. A. the difference should be clearly made. B. This debate is out of date. All research supported should be responsive to the development of a country/countries.

Danish research resources are not well managed at present. An overall research policy is needed, as well as a national debate on the support to global research issues, as pointed out by the Hernes report, and whom should support the Danish knowledge base on International Health. The prioritisation of the research project applications has been outsourced to an external body, FFU and DSF, which do not necessarily follow the criteria set up and the prioritisation of the partner countries. The FFU may also require access to experience with south research capacity building and the balancing of N-S partnerships. The problem of the dilemma between relevance and research excellence has not been solved.

As criteria for accepting research applications, the relevance and appropriateness for the partner country and the relevance in a development context should be the most important.

The RDE suggests subjects and projects, and evaluates also FFU applications. But their input is limited due to lack of technical expertise or expertise with research. The role of the RDE in managing resources is important in HSPS but low in FFU research projects. The Embassies could appoint a person responsible for research, maybe with other donors.

Regarding greater involvement of Danish research institutions in HSPS there are the following observations. One is in favour of greater involvement by more actively identifying

research needs and opportunities; and by more effectively linking researchers to HSPS implementation. However whether this possible depends on the research policy chosen: Should the Danish research resource base be supported through bilateral aid funds? If yes, Aid Management Guidelines should include ways for Sector Programmes to include Danish researchers, maybe by setting aside separate funds, if that is possible concerning the untying of aid. And the Danish researchers should be competitive and cost-effective in a global competition

Researchers should not necessarily be involved in the design of HSPS unless the partners request it. A research budget under HSPS can only be included if a strengthening component is the objective, and only when the south demands it. Otherwise research should be a support modality such as funds, technical support, etc.

Capacity building

The value of ENRECA is its clear focus on capacity building. ENRECA has been positively evaluated. As there has never been an evaluation of the other research project types supported, it cannot be compared what the added value is. But it remains to be measured what the effect has been of closing the ENRECA programme and include the projects in the RUF/FFU support, and thereby not any longer in the selection process use the 13 years of experience with managing the projects.

It is felt that ENRECA should rather be expanded but as a separate programme. Both agree that capacity building aspects should be specified in the research proposals.

Capacity building of the North is not perceived as satisfactory today. More institutional strengthening is required. The question whether there are sufficient opportunities for Danish researchers should be addressed in the much needed Danish debate on who should support research in global issues. And the also much needed debate in the Ministry of which policy to follow for the research support. Also for the south funds are too limited vis-à-vis the needs.

The link between research and training may need to be addressed. No coordination exists between PhD and MSc support within the Fellowship programme and the FFU and centre support. Thus, no general criteria for quality and selection criteria, support modalities and quality assurance exist.

Harmonisation

Harmonisation and aligning research can be achieved through different modalities such as through furthering donor co-ordination at local level, as well as between research support managers of the different donor organisations, and in international health research bodies; and by furthering national mechanisms for priority setting and complying with them. DANIDA could support harmonisation more effectively through SWAP processes in-country, putting it on the agenda internationally. And by allocating more staff time, to meetings, to setting up a data base, etc.

Danish Research Network for International Health

The DRNIH has several values as follows: (i) it provides one-stop-shop for DANIDA; (ii) it increases communication between researchers and between research community and DANIDA; 3) as an instrument to catalyse initiatives. Its agenda has been recently changed towards more South orientation and more involvement of south partners. And no support is to be given to Danish activities, which the universities ought to take care of. This could lead to an improved output for the DRNIH.

Dissemination of information

Translating research results into policy in the North can best be achieved by consensus reports; defining priority actions arising from research ("top 10"). But policymakers have often

too much information and are not interested. And there is no overall knowledge management policy in the Ministry. Research should be mentioned in the AMG and advisors, as part of their briefing before they start, should also learn about research.
Translating research results into policy in the South can best be achieved by assuring MoH/Gov ownership to research initiatives; involve the local decision makers in research committees, ask for their demand for research and knowledge; researchers participating in sector dialogue; educating local researchers and build capacity; look at what other donors do in that direction, coordinate with them; developing consensus reports; support research within HSPS. Put the demand, the dissemination and the use high on the selection criteria list, and make sure that the research project plans that from the start and allocate sufficient resources for communication and application of the results to the users at all levels

The DRNIH is reasonably performing in dissemination of research results and it is high on their new agenda (contract). Translating results into digestible information is much less done, but again high on their new agenda.

Research applications should include a section on how research results will be used.

Future priorities
Health research funding should be managed differently in the future, along with all development research funding, following the formulation of a strategy and a national debate, linked to the globalisation debate. DANIDA staff should have more influence.

The research agenda should change: 1) be more aligned to national agendas, 2) more coordination with other donors, 3) more emphasis on institutional capacity & health research systems; 4) more focus on health systems research & follow-up of global initiatives (e.g. GAVI, ARVs).

Impact could be greater if research got a higher profile in the development aid and a policy, and the integration of research in the sector programmes thus could be approached more systematically. And, equally important, if the universities and national research foundations put research in global health much higher on their agenda, and allocated more funds. And if we had the national debate of who should do what, and of how the (health) research agenda should be in a global world. This has not been taken up so far in the globalisation debate.

Future priorities would depend on the overall development research policy. Setting proper priorities, nationally as well as internationally, and subsequently financing and aligning with the chosen priorities. Urgently addressing the research needs imposed by the emerging global initiatives. Building relevant research capacity in countries utilising SWAp modalities to ensure coordination. Communicating research findings in a way that is compatible with the situation and reality of decision makers, rather than with the preferences of researchers.

Support to capacity development in the North should avoid core funding, and be more based on a combination of short and long term project funding. In the south more emphasis should be given to systems and institutional support.

DANIDA can improve its support by initialising a national debate linked to the globalisation debate, formulate a research strategy, include research in AMG, find out what the demand is from the South, link it with the Danish supply side, increase the resources also to the administration and the output management.

8 Opinions and views of some FFU members

Introduction

Some FFU members did complete questionnaires[56] and/or were interviewed by the review team in Copenhagen. The summary below presents the views of 4 FFU members.

Research agenda and annual focus

The present research agenda is in general perceived as a mixed pull and push process. FFU announces a few focal areas to the research community. The Ministry/Ministers have decided research must be relevant to Danish development assistance (which is confirmed or not by the Ministry and relevant embassies). The agenda is to a wide extent set by researchers applying for grants. Most are satisfied with this process and feel that individual researchers should have a say. Some find that research competes for resources with many other areas in an unstructured manner. Also, health research should be prioritised. Whether priority setting in the overall research agenda has become more demand driven is viewed differently by the interviewees (yes & no). FFU members are not sure how the south could and whether it should become more involved in setting the overall research agenda. However, more consultation could be beneficial. Regarding the involvement of the south in preparing a specific research proposal, all agree that today the North partner is more involved than the south partner.

Regarding the annual focus, some find it a good initiative and some not. Some state that creation of new foci for research is difficult in a small country with a small research resource base. "We should rather support the existing most productive areas of research". Some FFU members are not too happy with focus areas: "it did not help much in decisions as applications will do lip service to the specific focus". FFU members are generally more in favour of integrated projects.

Areas of support and instruments used

A research resource envelope would preferentially be allocated to specific support areas as indicated in the table below. As the different categories are not mutually exclusive, interpretation is to be done with caution. Also, the number of respondents has been small. Developing individual research capacity gets the highest score (30%), but research within HSPS is also felt to be important (23%). The other categories get roughly the same value (15-18%). Interestingly, strengthening the national health research system is felt as a very important priority (30%) by some and not at all by others (0%).

Table 20. Repartition of a hypothetical resource envelope to different support areas

(in %, both range and average values)

Support focus	Range	Average
Strengthening the national health research system	0-30%	15%
Strengthening of specific research institutions	10-20%	15%
Developing capacities of individual researchers	--	30%
Implementing research with research institution outside HSPS/health project	10-25	18%
Implementing research within HSPS or health project	20-25	23%
Total		100%

Preferential allocation between different types of DANIDA support is proposed as follows. Research projects are perceived as most important (55%) or even more when PhDs are added (72%). ENRECA is perceived as less important at 28%. Interestingly, if research and PhDs are taken together, the scope of variation in opinions is small.

Table 21. Repartition of a hypothetical resource envelope to different types of projects

[56] Questionnaires were received from HSPS STA in Ghana, Tanzania and Uganda.

(in %, both range and average values)

Type of project	Variation	Average
ENRECA	25-30%	28%
Research projects	50-65%	55%
PhD projects	5-25%	17%

Most of the research funds should be allocated to bilateral research (70%), as indicated in Table 22.

Table 22. Repartition of a hypothetical resource envelope to different channels of supporting research (in %, both range and average values)

Channel of support	Variation	Average
Bilateral activities	80-60%	70%
International institutions and networks	20-40%	30%

Regarding allocation of resources between sectors, the view is that strictly scientific criteria should prevail and no % allocation to specific sectors. However choice of sectors should be in line with overall DANIDA development policy/priorities.

Regarding criteria to allocate financial resources between ENRECA, research grants and PhDs, most state that no explicit criteria exist and that 'tradition' prevails. Some say they exist but do not list them. From the interviews the Review Team got the impression that resource allocation to ENRECA would rather be reduced or at best maintained. Criteria for accepting a research application are clear to the FFU members. Some state that the merit of the researcher and the scientific quality and feasibility of the proposal are the most important criteria used. While it is agreed that research should be in line with and supportive to DANIDA development policy, it is felt by some that resources are so limited that they should be allocated to scientific research. No difference should be made between policy supportive research and other research.

The added value of the Strategic Research Council reviewing the list of applications accepted by the FFU is perceived as being limited, but part of the required legal procedures. There are no examples of the SRC not accepting the choices made by FFU. The role of the Embassy is seen as important in providing a reality check on the research application, especially the alignment with DANIDA and country specific policy and the reputation and capacity of the South research partner(s).

The concept of HSPS is not familiar to all FFU members. Most are in favour of Danish research institutions becoming more involved in HSPS related research. There seems to be a consensus that HSPS should include a research budget and that Danish researchers can have a role to play in design, scientific follow-up and evaluation of HSPS.

Capacity building

ENRECA's added value is perceived to be the sustained capacity building. While it's importance is clear, not all agree that it should be extended. The main reason mentioned was that "resources are being used for activities beyond scientific goals".

Most view that capacity building modalities should be specified in the research application. Some say that this is not always possible. All FFU members interviewed believe that the present DANIDA approach to strengthening capacity in the North and the South is appropriate.

Views differ on whether ongoing institutional changes in the Danish research community will positively affect the existing research resource base. The link between research and training is viewed as appropriate, but more grants for southern PhD students would be welcomed.

Harmonisation/coordination
DANIDA has to relay on existing knowledge within research groups and remain updated on the forefront of research, through existing international mechanisms (e.g. WHO) and networks.

Research network for international health
The DRNIH is perceived as a valuable forum for exchanging knowledge, research plans and establish collaboration. It is however perceived by some as too much centred on the UC. The performance of the network in disseminating research results is qualified as being poor to probably good. Translating results in digestible information for policy decisions is an area that the network has not sufficiently developed.

Dissemination of results
Translating research into policy is perceived as important. Some ideas to improve this in the North are the following: (i) Organising seminars/meetings; (ii) Grant receivers should be requested to write a brief report on relevant applications of results; (iii) More formal account on conducted projects, PhD degrees etc. by summarizing important results obtained and publications in annual reports; and (iv) Personal interactions between researchers and policy makers.
Improving research into policy in the South could be achieved through: (i) personal communication between researchers and decision makers, preferably through the RDE; and (ii) scientific publications and end-of-study reports.

Most are of the opinion that research applications or logframes should specify how research results will be used. Some say that this is not always relevant and that addressing the scientific problems should be the main goal. Also, no difference should be made between policy supportive research and other research.

Future priorities
FFU members request some time to see and evaluate how the new system is working before discussing changes. Future priorities should not be fixed. Rather, "improved support should be provided to those few research groups in Denmark who can and will focus on topics relevant to the developing world". Capacity building in the south should continue as it happens now. International research should be reduced and/or depend on advise of the FFU or a specific advisory board. DANIDA can best improve its support to health research in DC by increasing research budgets and prioritising health. The DRNIH could support more south-south collaboration. There is no need to change the DANIDA research agenda as such.

9 Opinions and views of some technical staff in health sector support programmes (HSPS)

Introduction

HSPS technical staff did complete questionnaires[57] and were interviewed by the review team in the country visits (Ghana, Tanzania, Uganda). In addition, two brainstorming sessions were held during the DANIDA Arusha meeting in Tanzania[58]. The summary below presents the summary of the main views shared by different contributors.

Research agenda and annual focus

In general HSPS staff are not aware of the existence of a DANIDA health research agenda. Only one TSA (out of eight) was aware of the 2006 research focus[59]. Knowledge about research priorities, criteria for selection of applications, allocation of funds and FFU guidelines is very limited or absent. Some view that most choices of research have been based primarily on the interests of the researchers; and that although some developing countries have specific research policies, these are not normally followed by many donors including DANIDA.

Views on how demand-driven research is and how much the south is in the driving seat differ. However most agree that DANIDA funding and the research institutions of the North have become more sensitive to the issue and do try to encourage greater participation and to respond to local demand. The South definitely has a say regarding research activities related to the DANIDA Health SWAps that have emerged over the past ten years. ENRECA also aimed at involving the South in defining the research agenda. To what extend this was successful is not known. In Uganda, HSPS is playing a role in setting research questions, stimulating others, including MoH, to define research questions.

Some feel that South representatives could be invited to participate in the Network for International Health (Board) meetings and in some of the MoFA meetings on setting the research agenda. However, there would be need for clearly mandated national institutions in the countries of the South, which is not always existing (see country reports).

It is the general feeling that the North is more involved in preparing a specific research proposal than the South, but in the context of HSPS experiences differ: the South is perceived as being more in the driving seat in Ghana and Uganda; depending on the specific project either the North or the South has been in the driving seat in Tanzania.

All agree that the newly initiated research focus is a good initiative, especially if it is aligned with South priorities. Two observations are important: a) the focus should not change annually; b) a focus at global/regional level needs to be linked to the country focus or priorities. The present themes are not perceived as very restrictive and can cover a wide range of different research topics.

All research activities which take place in a developing country obviously should be relevant to that particular country. Health research done in the framework of the country's priorities should in general also answer any questions that DANIDA health policy makers will require answers for. It is fully justified if DANIDA sponsors health research which is also relevant for DANIDA's "own consumption". However, it is not likely to dominate DANIDA's health research agenda. Long-time support to health systems research and health policy research should top the agenda. DANIDA could perhaps more explicitly focus on research capacity

[57] Questionnaires were received from HSPS STA in Ghana, Tanzania and Uganda.
[58] Participants included HSPS and MOH staff from Bhutan, Ghana, Kenya, Mozambique, Tanzania, Uganda and Zanzibar.
[59] In 2006 there is an overall focus at health care systems in Africa and at children and youth.

when appraising and reviewing HSPS. However, any support should be considered in its particular context and balanced against other needs in the health sector, DANIDA's or possibly other development agencies' comparative advantage and previous research support to that particular country.

There is no need perceived for a dramatic change in DANIDA's health research agenda, but some possible adjustments are proposed. DANIDA should be modest and not pretend to have the capacity and long & strong experience that is found in institutions like for example LSH&TM and KIT. DANIDA has so far had a comparative advantage from having a strong "presence" in most developing countries where it provides health sector support. This presence should be utilized and backed up with relevant and competent research support from Danish research institutions where and when these institutions have a comparative advantage. However, HSPS and DANIDA should also continue to have the freedom and flexibility to use other international research institutions when and where this is more appropriate and where we can expect a better outcome from engaging such research institutions. DANIDA should continue to be able to support long-term valuable health research in areas like malaria and longitudinal epidemiological studies, where some Danish research institutions have a comparative advantage, even if such research is not of primary relevance to DANIDA HSPS. Not all research should be demand driven. Increased priority on research into SWAps and budgets support mechanisms including the ignored area of private or non-governmental health sector (also ignored in many SWAps) would be appreciated.

Areas of support and instruments used

A research resources envelope would preferentially be allocated to specific support areas as indicated in Table 23. As the different categories are not mutually exclusive, interpretation is to be done with caution. Implementing research within HSPS gets the largest allocation (30%). The other categories get roughly the same value (18-23%). Interestingly, it is felt that strengthening the national health research system is also important.

Table 23. Repartition of a hypothetical resource envelope to different support areas (in %, both range and average values)

Support focus	Range	Average
Strengthening the national health research system	10-25%	18%
Strengthening of specific research institutions	15-20%	19%
Developing capacities of individual researchers	5-20%	11%
Implementing research with research institution outside HSPS/health project	10-30%	23%
Implementing research within HSPS or health project	20-40%	30%
Total		100%

Preferential allocation between different types of DANIDA support is proposed as follows. ENRECA is perceived as important, but HSPS staff also see the need for being responsive to urgent needs and operational questions, which may be better fit within "research projects".

Table 24. Repartition of a hypothetical resource envelope to different types of projects (in %, both range and average values)

Type of project	Variation	Average
ENRECA	30-50%	37%
Research projects	20-60%	45%
PhD projects	10-20%	19%

Most of the research funds should be allocated to bilateral research (75%), as indicated in Table 25.

Table 25. Repartition of a hypothetical resource envelope to different channels of supporting research (in %, both range and average values)

Channel of support	Variation	Average
Bilateral activities	67-80%	75%
International institutions and networks	20-33%	25%

Proposed criteria to be used by DANIDA to allocate funds between sectors should primarily be based on local demand (including the needs identified within HSPS, but they should be aligned with national priorities) and be based on a specific assessment as follows: a) Need - how big is the problem to be researched - as perceived by the local health authorities and DANIDA technical staff; b) Chance of success - which broadly depends on expected political readiness to use the research results, and on local research capacity. And c) Would likely outcomes of the research be cost-effective and would it be possible to finance the recommended outcome of the research. Some believe that also the choice of the sector is important and that the choice should be determined by DANIDA development priority on the different sectors, prioritisation of research in the sector and the funding framework for research in the sector.

Linking research to HSPS is seen by all as positive. Arguments pro are as follows: The research is likely to address identified local health sector needs and it is more likely that research would be relevant to local authorities, and hence the chances of utilizing the results are probably greater. If technical DANIDA/Embassy staff is available, DANIDA will have good opportunities to monitor progress, to provide technical assistance if required, to act as link to Danish research institutions, and not least to disseminate the results most appropriately in the HSPS country. DANIDA can still promote its priority research agenda, e.g. poverty, gender etc.

Constraints may be as follows: If DANIDA continues to aim at reducing its technical staff in developing countries, it will be difficult to provide the necessary support to properly monitor and assist HSPS research activities and to disseminate the results in the developing country. This type of research is likely to be on a shorter time horizon (immediate gain), may be less rigorous and less able to tackle the more complex research. It may be less able to address research capacity or institution building or "basic scientific research"; and be less appropriate to deal with politically sensitive issues – e.g. medicines leakage.

According to the HSPS TA, the role of the Royal Danish Embassy (RDE) should be important in decisions on resource allocation, but not so on resource management (unless as part of HSPS). If research funds would be provided to the country in generic terms than it would be up to the RDE to decide on sector specific funding levels, in consultation with national authorities. Within the sector the RDE is to work through the system – SWAP – to determine research priorities and appropriate framework and necessary funding.

In the context on untying aid, Danish research institutions should not get a preferential treatment. They can be involved if research requirements have been identified during appraisal and reviews, and a Danish research institution has a comparative advantage with respect to fulfilling the research requirements. However local ownership is considered more important than involving Danish research institutions. Danish research institutions would best get involved as support and back-stoppers to local research institutions through framework agreements and/or grants. Local institutions would already have a "presence" in the health sector, credibility, and be able to respond to requests for proposals from government or development partners, etc.

In general researchers should not be involved in the design phase of a HSPS. However, local and/or Danish researchers could be involved in the HSPS design phase if research strengthening is already identified as a particular requirement in a HSPS, e.g. as a desired component or in cases where appraisal or reviews have identified such particular requirements.

A HSPS without a budget for operational research is perceived as a 'handicapped' HSPS, but to introduce a particular research component in all HSPS would be a mistake and not in accordance with DANIDA's tradition for flexible and need-based development assistance. A budget for research should be flexible and allow a mix of short and medium term research questions to be answered, using most appropriate institutions and modalities. It is being recommended to include a budget for strategic research in HSPS, where relevant.

Local and Danish researchers can be involved in mentoring, follow-up, supervision and evaluation of HSPS, if and when requirements have been identified by the MoH and the RDE.

Capacity building

ENRECA is not that well known to a number of TA. Only four out of eight HSPS STA knew of ENRECA prior to the Arusha meeting. It is difficult to understand why a DANIDA STA who has been in-country for so many years is not aware of an ENRECA programme in place during the same years. However, those familiar with ENRECA are in favour of the long-term and capacity strengthening approach. ENRECA (or the Network) often has, with its large pool of health research institutions represented, a comparative advantage when it comes to research in the health sector. But ENRECA or the Network participants are also perceived as being prejudiced and biased as they are trying to promote their personal and their institution's vested interests.

The DBL-IHRD four month research methodology course was only known by one of eight HSPS TA (through NIMR). DBL-IHRD's reputation is apparently not linked to the concept of health systems research (KIT Amsterdam, ITM Antwerp and several UK institutions have a better reputation in health systems research).

Capacity building should be included in research proposals if and when the need is identified, i.e. capacity building could be introduced in the format, but should not be a pre-requisite for DANIDA support. Others feel that capacity building should always be part of a research proposal.

Being not directly involved, HSPS TA have no specific views on whether capacity building in the North and South is appropriate.

Harmonisation/coordination

DANIDA should continue to support harmonisation both at local and global level, especially in the sense of coordination and alignment. Support to developing an appropriate and functional national research system may be a way forward. Some believe that there may be a separate and important role for the Danish health research: being "small and friendly", dynamic, having special links with individuals (so important for good research) and supporting institutional collaboration which some of the larger international initiatives lack.

The Research Network for International Health is not well known by many HSPS STA. Those who know see the potential added value in creation of partnership of researchers, coordination and dissemination for specific audiences. Performance of the network in disseminating research results is unknown.

Dissemination of results

Important tools for translating research into policy are thought to be policy briefs (written independently of the researchers involved). Developing policy briefs could be outsourced and is not really seen as a role for the Network for International Health. Involvement of local stakeholders and decision makers as from the beginning is key. The local policy dialogue should be used to bring forward relevant research results. Information on research results should also include how they can be implemented. Some refer to dissemination "models" such as ELDIS[60] and id21[61]. According to the HSPS TA the research logical framework should always indicate how results will be used.

Most are in favour of making a difference between policy supportive research and other research (in order not to create false expectations). If by policy supportive research in general is meant research that has the direct purpose to inform (and hence direct) health policies and strategies, some believe this type of research should be given preference particularly in a HSPS setting.

[60] Eldis is funded by Sida, NORAD, DFID and SDC, and is one of a family of knowledge services provided by the Institute of Development Studies, Sussex. Eldis aims to share the best in development, policy, practice and research http://www.eldis.org/health/index.htm

[61] id21 is funded by DFID and communicates UK-sourced international development research to policymakers and practitioners worldwide http://www.id21.org/

10 Literature review

The approach taken for the in-depth bibliometric analysis is summarized in Volume I, section 6.2. In brief, Danish research institutions that received DANIDA support in the period 2001-2005 were invited to hand in annual publication lists. Each publication was checked for internal consistency (e.g. author(s) name, year of publication, etc.). Care was exerted to avoid duplicate counting of publications (e.g. UC-CMP and Rigshospitalet have established an effective and productive collaboration, and hence produced a large number of joint publications). Next, the impact factor of each publication was retrieved from the ISI Web of Science for the respective year of publication and the number of citations was counted and stratified by year. The raw data is provided in the tables overleaf.

Institution IPH IPH
Data source Publication list received from Bygberg on 10 October 2006
Date of evaluation 21 December 2006
Name Barbara Matthys

Already cited in CMP
Not DANIDA supported
Master's Theses not included

2001 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

#	IPH Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
44	Herrel N et al.	1	6	2001	*Med Vet Entomol*	1		1.148	3	1	2	0	0		6
45	Samuelsen H et al.	1	2	2001	*Med Anthro*	?		not found in ISI							
46	Samuelsen H et al.	1	4	2001	*Med Anthro*	?		not found in ISI							
47	Samuelsen H et al.	1	2	2001	*Med Anthro*	?		not found in ISI							
48	Samuelsen H et al.	1	3	2001	*Med Anthro*	?		not found in ISI							
49	Samuelsen H et al.	1	7	2001	*Med Anthro*	?		not found in ISI							
50	van der Hoek HW et al.	1	5	2001	*Trop Med Int Health*	1		1.796	1	0	1	3	2		7

2002 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

#	IPH Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
39	Eddleston M et al.	1	13	2002	*Lancet*	1		15.397	9	11	11	7	0		38
40	Khalil I et al.	1	7	2002	*Am J Trop Med Hyg*	1		2.063	1	4	3	4	0		12
41	Magesa SM et al.	1	9	2002	*Acta Trop*	1		1.332	2	7	6	1	0		16
42	Tarimo DS et al.	1	3	2002	*Trop Med Int Health*	1		1.796	0	4	3	2	0		9
43	van der Hoek HW et al.	1	3	2002	*J Health Popul Nutr*	1		0.483	1	1	0	1	0		3

2003 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

IPH Authors IF Citations

#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001	TOTAL
26	Alifrangis M et al.	1	8	2003	*Am J Trop Med Hyg*	1		2.105	6	7	3	0			16
27	Alifrangis M et al.	1	7	2003	*Am J Trop Med Hyg*	1		2.105	0	0	0	0			0
28	David KP et al.	1	6	2003	*Scand J Infect Dis*	1		1.117	3	1	3	0			7
29	Khalil IF et al.	1	6	2003	*Am J Trop Med Hyg*	1		2.105	0	0	0	0			0
30	Konradsen F et al.	1	6	2003	*Am J Trop Med Hyg*	1		2.105	2	2	2	0			6
31	Konradsen F et al.	1	7	2003	*Toxicology*	1		2.061	7	4	0	0			11
32	Massaga JJ et al.	1	8	2003	*Lancet*	1		18.316	10	11	11	2			34
33	Mukhtar M et al.	1	6	2003	*SE Asian J Trop Med Public Health*	1		not found in ISI							
34	Nielsen M et al.	1	5	2003	*SE Asian J Trop Med Public Health*	1		not found in ISI							
35	Rasch V	1	1	2003	*Acta Obstet Gynecol Scand*	2		not found in ISI							
36	van der Hoek HW et al.	1	3	2003	*Trop Med Int Health*	1		2.156	0	0	0	0			0
37	van der Hoek HW et al.	1	6	2003	*Int J Epidemiology*	1		3.289	1	5	4	0			12
38	van der Hoek HW et al.	1	7	2003	*SE Asian J Trop Med Public Health*	1		not found in ISI							

2004 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

IPH Authors IF Citations

#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
17	Alifrangis M et al.	1	10	2004	*Malaria J*	1		0.000	0	0	0				0
18	Alilio M et al.	1	3	2004	*Am J Trop Med Hyg*	1		2.013	6	0	1				7
19	Alilio M et al.	1	12	2004	*Am J Trop Med Hyg*	1		2.013	3	1	1				5
20	Herrel N et al.	1	6	2004	*Med Vet Entomol*	1		1.405	3	1	0				4
21	Jensen PK et al.	1	5	2004	*Trop Med Int Health*	1		1.969	0	0	0				0
22	Samuelsen H	1	1	2004	*Med Anthropol*	1		not found in ISI							
23	Samuelsen H	1	1	2004	*Anthro & Med*	1		not found in ISI							
24	Samuelsen H	1	1	2004	*Anthro & Med*	1		not found in ISI							
25	Samuelsen H	1	1	2004	*Soc Sci & Med*	1		2.088	2	0	0				2

2005 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

IPH

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Alifrangis et al.	1	10	2005	*Am J Trop Med Hyg*	1		2.482	4	3					7
02	Briët OJT et al.	1	5	2005	*Malaria J*	1		2.137	2	4					6
03	Dittrich S et al.	1	9	2005	*Trop Med Int Health*	1		2.021	0	0					0
04	Donnelly MJ et al.	1	12	2005	*Malaria J*	1		2.137	7	3					10
05	Hoegberg LCG et al.	1	4	2005	*Clin Toxicol*	1		IF not found in ISI							
06	Jensen PK et al.	1	4	2005	*Bull World Health Organ*	1		3.961	0	0					0
07	Khalil IF et al.	1	8	2005	*Ann Trop Med Parasitol*	1		1.212	1	0					1
08	Khalil IF et al.	1	7	2005	*Am J Trop Med Hyg*	1		2.482	1	0					1
09	Konradsen F et al.	1	4	2005	*Bull World Health Organ*	1		3.961	3	0					3
10	Lazarus JV et al.	1	3	2005	*Acta Obstetrica et Gynecologia Scandinavia*	2		not found in ISI							
11	Lusingu JP et al.	1	8	2005	*Malaria J*	1		2.137	0	0					0
12	Mutero CM et al.	1	7	2005	*Ecohealth*	1		not found in ISI, publications available from 2006 on ISI							
13	Piyaratne MK et al.	1	4	2005	*J Vector Borne Dis*	1		not found in ISI							
14	Rasch V et al.	1	3	2005	*Contraception*	1		1.713	1	0					1
15	Rasch V et al.	1	2	2005	*Stud Fam Plann*	1		0.830	1	0					1
16	van der Hoek W et al.	1	2	2005	*Trop Med Int Health*	1		2.021	2	0					2

Institution CMP - Centre for Medical Parasitology

Data source Publication list received from CMP (T. Theander) on 13 November 2006

Date of evaluation 12/20 December 2006

Name Barbara Matthys

already cited in CMP

Not DANIDA supported

Master's Theses not included

2001 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

CMP

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
59	Askjaer N et al.	1	8	2001	*Clin Diag Lab Immunol*	1		1.483	1	2	3	4	1	0	11
60	Cavanagh DR et al.	1	10	2001	*Infect Immun*	1		4.212	8	4	4	6	2	1	25
61	Chen M et al.	1	5	2001	*Antimicrob Agents Chemother*	1		4.562	4	10	6	4	6	0	30
62	Dodoo D et al.	1	10	2001	*Infect Immun*	1		4.212	7	5	8	8	6	0	34
63	Goka BQ et al.	1	9	2001	*J Trop Paediatr*	1		0.425	0	0	0	0	0	0	0
64	Goka BQ et al.	1	9	2001	*Trans R Soc Trop Med Hyg*	1		1.693	3	3	1	2	1	0	11
65	Hviid L et al.	1	10	2001	*Infect Immun*	1		4.212	1	5	3	2	3	2	16
66	Jensen ATR et al.	0	5	2001	*Biochim Biophys Acta*	1		no IF in ISI	0	2	0	3	2	0	7
67	Jensen ATR et al.	0	4	2001	*APMIS*	1		1.924	0	2	0	1	1	0	4
68	Kemp K et al.	1	3	2001	*Clin Exp Immunol*	1		2.716	1	0	0	0	3	0	4
69	Kurtzhals JAL et al.	1	4	2001	*Trends Parasitol*	1		0.000	1	1	0	0	1	0	3
70	Magesa SM et al.	1	6	2001	*Am J Trop Med Hyg*	1		2.126	1	1	3	4	3	0	12
71	Theisen M et al.	1	10	2001	*Infect Immun*	1		4.212	3	2	5	2	0	0	12

	2002	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor						
	CMP		Authors					IF	Citations					
#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001	TOTAL
44	Barfod L et al.	1	4	2002	*Int Immunopharmacol*	1		1.655	2	6	2	2	0		12
45	Hamad AA et al.	1	10	2002	*Acta Trop*	1		1.332	4	5	2	2	0		13
46	Jelinek T et al.	0	21	2002	*Malar J*	1		0.000	Publication not found in ISI						
47	Jensen ATR et al.	1	5	2002	*Trop Med Int Health*	1		1.796	3	0	1	1	0		5
48	Kemp K et al.	1	7	2002	*Clin Exp Immunol*	1		2.305	1	3	2	5	3		14
49	Kemp K et al.	1	6	2002	*Parasite Immunol*	1		1.633	Publication not found in ISI						
50	Kemp K et al.	1	7	2002	*Clin Diagn Lab Immunol*	1		1.654	1	0	0	0	0		1
51	Khalil IF et al.	1	7	2002	*Am J Trop Med Hyg*	1		2.063	1	4	3	4	0		12
52	Magesa SM et al.	1	9	2002	*Acta Trop*	1		1.332	2	7	6	1	0		16
53	Nielsen MA et al.	1	9	2002	*J Immunol*	1		7.014	8	9	12	9	2		40
54	Ofori MF et al.	1	8	2002	*Infect Immun*	1		4.039	5	7	19	5	1		37
55	Salanti A et al.	0	11	2002	*Mol Biochem Parasitol*	1		2.911	2	3	10	11	0		26
56	Staalsoe T et al.	1	6	2002	*J Infect Dis*	1		4.857	2	2	4	1	1		10
57	Staalsoe T et al.	0	4	2002	*Immunol Lett*			1.847	0	1	3	2	0		6
58	Tarimo DS	1	3	2002	*J Infect Dis*	1		4.857	0	4	3	2	0		9

	2003	1=DANIDA; 0=Non-DANIDA			International=1; National=2		IF=Impact Factor							
	CMP		Authors					IF	Citations					
#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001	TOTAL
28	Alifrangis M et al.	1	8	2003	*Am J Trop Med Hyg*	1		2.105	6	7	3	0			12
29	Alifrangis M et al.	1	7	2003	*Am J Trop Med Hyg*	1		2.105	1	6	2	1			10
30	Cot M et al.	0	6	2003	*Am J Epidemiol*	1		4.486	3	4	4	0			11
31	Creasey A et al.	0	5	2003	*Infect Immun*	1		3.875	5	7	5	0			17
32	David KP et al.	1	6	2003	*Scand J Infect Dis*	1		1.117	3	1	3	0			7
33	Hviid L et al.	0	4	2003	*Infect Immun*	1		3.875	0	1	0	0			1
34	Jensen ATR et al.	1	8 (ISI: 9)	2003	*Infect Immun*	1		3.875	0	2	3	0			5
35	Khalil IF et al.	1	6	2003	*Am J Trop Med Hyg*	1		2.105	0	0	0	0			0
36	Kurtzhals JAL et al.	1	4	2003	*Lancet*	1		18.316	0	4	1	0			5
37	Lavstsen T et al.	0	5	2003	*Malaria J*	1		0.000	15	8	6	0			29
38	Massaga JJ et al.	1	8	2003	*Lancet*	1		18.316	10	11	11	2			34
39	Ofori MF et al.	1	8	2003	*Infect Immun*	1		3.875	3	2	4	2			11
40	Salanti A et al.	0	8	2003	*Mol Microbiol*	1		5.563	22	22	25	3			72
41	Schwöbel B et al.	1	4	2003	*Malaria J*	1		0.000	3	6	5	3			17
42	Staalsoe T et al.	0	6	2003	*Parasite Immunol*	1		1.956	3	4	3	0			10
43	Wichmann O et al.	0	20	2003	*Malaria J*	1		0.000	0	2	1	2			5

	2004	1=DANIDA; 0=Non-DANIDA				International=1; National=2					IF=Impact Factor						
	CMP		Authors					IF	Citations								
#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
13	Abacassamo F et al.	1	11	2004	*Trop Med Int Health*	1		1.969	7	3	2				12
14	Alifrangis A et al.	1	10	2004	*Malaria J*	1		0.000	0	0	0				0
15	Alilio MS et al.	1	3	2004	*Am J Trop Med Hyg*	1		2.013	6	0	4				7
16	Alilio MS et al.	1	12	2004	*Am J Trop Med Hyg*	1		2.013	3	1	1				5
17	Cavanagh DR et al.	1	10	2004	*Infect Immun*	1		4.033	8	5	0				13
18	Creasey A et al.	1	6	2004	*Parasitology*	1		1.685	0	0	0				0
19	Ellekvist P et al.	0	7	2004	*Biochem Biophys Res Commun*	1		2.904	0	2	1				3
20	Jensen ATR et al.	1	17	2004	*J Exp Med*	1		14.586	19	15	5				39
21	Kofoed PE et al.	1	7	2004	*Trop Med Int Health*	1		1.969	1	1	0				2
22	Lusingu JPA et al.	1	10	2004	*Malaria J*	1		0.000	4	2	0				6
23	Nielsen MA et al.	1	13	2004	*Infect Immun*	1		4.033	2	6	1				9
24	Salanti A et al.	1	12	2004	*J Exp Med*	1		14.586	20	12	2				34
25	Sharling L et al.	1	5	2004	*Malaria J*	1		0.000	0	0	0				0
26	Staalsoe T et al.	0	6	2004	*Lancet*	1		21.713	16	21	8				45
27	Wichmann O et al.	0	24	2004	*J Infect Dis*	1		4.943	7	5	0				12

	2005	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor							
	CMP		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2005]	2006	2005	2004	2003	2002	2001	TOTAL
01	Alifrangis M et al.	1	10	2005	*Am J Trop Med Hyg*	1		2.482	4	3					7
02	Amaresinghe PH et al.	1	6	2005	*Southeast Asian J Trop Med and Pub Health*	2		IFnot found in ISI							
03	Dittrich S et al.	1	9	2005	*Trop Med Int Health*	1		2.021	0	0					0
04	Drakeley CJ et al.	1	10	2005	*J Infect Dis*	1		4.952	7	0					7
05	Enevold A et al.	1	1	2005	*Malaria J*	1		2.137	1	0					1
06	Giha HA et al.	1	11	2005	*Trans R Soc Trop Med Hyg*	1		1.665	3	2					5
07	Khalil IF et al.	1	8	2005	*Ann Trop Med Parasitol*	1		1.212	1	0					1
08	Khalil IF et al.	1	7	2005	*Am J Trop Med Hyg*	1		2.482	1	0					1
09	Lavstsen T et al.	0	9	2005	*Malaria J*	1		2.137	6	0					6
10	Lusingu JPA et al.	1	8	2005	*Malaria J*	1		2.137	0	0					0
11	Nielsen MA et al.	1	8	2005	*J Infect Dis*	1		4.953	0	0					0
12	Tukie Ndam NG	0	9	2005	*J Infect Dis*	1		4.953	7	2					9

Institution CMP-RH - Centre for Medical Parasitology / Ringhospitalet

Data source Publication list received from CMP-RH (L. Hviid) on 21 November 2006

Date of evaluation 19/20 December 2006

Name Barbara Matthys

Already cited in CMP

Not DANIDA supported

Master's Theses not included

2001 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

CMP-RH

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
59	Askjaer N et al.	1	8	2001	*Clin Diag Lab Immunol*	1		1.483	1	2	3	4	1	0	11
60	Cavanagh DR et al.	1	10	2001	*Infect Immun*	1		4.212	8	4	4	6	2	1	25
62	Dodoo D et al.	1	10	2001	*Infect Immun*	1		4.212	7	5	8	8	6	0	34
63	Goka BQ et al.	1	9	2001	*J Trop Paediatr*	1		0.425	0	0	0	0	0	0	0
64	Goka BQ et al.	1	9	2001	*Trans R Soc Trop Med Hyg*	1		1.693	3	3	1	2	1	0	11
65	Hviid L et al.	1	10	2001	*Infect Immun*	1		4.212	1	5	3	2	3	2	16
68	Kemp K et al.	1	3	2001	*Clin Exp Immunol*	1		2.716	1	0	0	0	3	0	4
69	Kurtzhals JAL et al.	1	4	2001	*Trends Parasitol*	1		0.000	1	1	0	0	1	0	3
70	Magesa SM et al.	1	6	2001	*Am J Trop Med Hyg*	1		2.126	1	1	3	4	3	0	12
71	Theisen M et al.	1	10	2001	*Infect Immun*	1		4.212	3	2	5	2	0	0	12
72	Staalsoe T et al.	1	9	2001	*J Infect Dis*	1		4.910	1	5	16	20	12	7	61
73	Tarimo DS et al.	1	3	2001	*Ann Trop Med Parasitol*	1		1.049	3	1	0	1	2	0	7
74	Tarimo DS et al.	1	3	2001	*Trop Med Int Health*	1		1.500	2	2	2	0	1	0	7

	2002	1=DANIDA; 0=Non-DANIDA				International=1; National=2			IF=Impact Factor						
	CMP-RH		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001	TOTAL
44	Barfod L et al.	1	4	2002	*Int Immunopharmacol*	1		1.655	2	6	2	2	0		12
45	Hamad AA et al.	1	10	2002	*Acta Trop*	1		1.332	4	5	2	2	0		13
48	Kemp K et al.	1	7	2002	*Clin Exp Immunol*	1		2.305	1	3	2	5	3		14
49	Kemp K et al.	1	6	2002	*Parasite Immunol*	1		not found in ISI							
50	Kemp K et al.	1	7	2002	*Clin Diagn Lab Immunol*	1		1.654	1	0	0	0	0		1
51	Khalil IF et al.	1	7	2002	*Am J Trop Med Hyg*	1		2.063	1	4	3	4	0		12
52	Magesa SM et al.	1	9	2002	*Acta Trop*	1		1.332	2	7	6	1	0		16
53	Nielsen MA et al.	1	9	2002	*J Immunol*	1		7.014	8	9	12	9	2		40
54	Ofori MF et al.	1	8	2002	*Infect Immun*	1		4.039	5	7	19	5	1		37
55	Salanti A et al.	0	11	2002	*Mol Biochem Parasitol*	1		2.911	2	3	10	11	0		26
56	Staalsoe T et al.	1	6	2002	*J Infect Dis*	1		4.857	2	2	4	1	1		10
57	Staalsoe T et al.	0	4	2002	*Immunol Lett*	1		1.847	0	1	3	2	0		6
58	Tarimo DS	1	3	2002	*J Infect Dis*	1		4.857	0	4	3	2	0		9
75	Gyan B et al.	1	7	2002	*Acta Trop*	1		1.332	2	3	0	1	0		6
76	Ziegler HL et al.	1	10	2002	*Planta Med*	1		2.289	2	2	3	1	2		10
77	Ziegler HL et al.	1	6	2002	*Antimicrob Agents Chemother*	1		4.215	6	3	5	2	2		18

	2003	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor							
	CMP-RH		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001	TOTAL
28	Alifrangis M et al.	1	8	2003	*Am J Trop Med Hyg*	1		2.105	6	7	3	0			12
29	Alifrangis M et al.	1	7	2003	*Am J Trop Med Hyg*	1		2.105	1	6	2	1			10
30	Cot M et al.	0	6	2003	*Am J Epidemiol*	1		4.486	3	4	4	0			11
31	Creasey A et al.	0	5	2003	*Infect Immun*	1		3.875	5	7	5	0			17
32	David KP et al.	1	6	2003	*Scand J Infect Dis*	1		1.117	3	1	3	0			7
33	Hviid L et al.	0	4	2003	*Infect Immun*	1		3.875	0	1	0	0			1
34	Jensen ATR et al.	1	8 (ISI: 9)	2003	*Infect Immun*	1		3.875	0	2	3	0			5
35	Khalil IF et al.	1	6	2003	*Am J Trop Med Hyg*	1		2.105	3	6	3	1			13
36	Kurtzhals JAL et al.	1	4	2003	*Lancet*	1		18.316	0	4	1	0			5
38	Massaga JJ et al.	1	8	2003	*Lancet*	1		18.316	10	11	11	2			34
39	Ofori MF et al.	1	8	2003	*Infect Immun*	1		3.875	3	2	4	2			11
40	Salanti A et al.	0	8	2003	*Mol Microbiol*	1		5.563	22	22	25	3			72
41	Schwöbel B et al.	1	4	2003	*Malaria J*	1		0.000	3	6	5	3			17
42	Staalsoe T et al.	0	6	2003	*Parasite Immunol*	1		1.956	3	4	3	0			10
78	Garred P et al.	1	9	2003	*Infect Immun*	1		4.039	4	1	1	1			7
79	Goka BQ et al.	1	7	2003	*Ghana Med J*	2		not found in ISI							

	2004	1=DANIDA; 0=Non-DANIDA				International=1; National=2			IF=Impact Factor							
	CMP-RH		Authors					IF	Citations							
#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
13	Abacassamo F et al.	1	11	2004	*J Infect Dis*	1		4.943	7	3	2				12
14	Alifrangis A et al.	1	10	2004	*Malaria J*	1		0.000	0	0	0				0
15	Alilio MS et al.	1	3	2004	*Am J Trop Med Hyg*	1		2.013	6	0	4				7
16	Alilio MS et al.	1	12	2004	*Am J Trop Med Hyg*	1		2.013	3	1	1				5
17	Cavanagh DR et al.	1	10	2004	*Infect Immun*	1		4.033	8	5	0				13
18	Creasey A et al.	1	6	2004	*Parasitology*	1		1.685	0	0	0				0
20	Jensen ATR et al.	1	17	2004	*J Exp Med*	1		14.586	19	15	5				39
21	Kofoed PE et al.	1	7	2004	*Trop Med Int Health*	1		1.969	1	1	0				2
22	Lusingu JPA et al.	1	10	2004	*Malaria J*	1		0.000	4	2	0				6
23	Nielsen MA et al.	1	13	2004	*Infect Immun*	1		4.033	2	6	1				9
24	Salanti A et al.	1	12	2004	*J Exp Med*	1		14.586	20	12	2				34
25	Sharling L et al.	1	5	2004	*Malaria J*	1		0.000	0	0	0				0
26	Staalsoe T et al.	0	6	2004	*Lancet*	1		21.713	16	21	8				45
27	Wichmann O et al.	0	24	2004	*J Infect Dis*	1		4.943	7	5	0				12
80	Deitsch KW et al.	1	2	2004	*Trends Parasitol*	1		5.497	6	1	0				7
81	Gyan BA et al.	1	9	2004	*Clin Exp Immunol*	1		2.518	1	1	0				2
82	Hviid L	1	1	2004	*Parasite Immunol*	1		1.474	5	1	0				6
83	Hviid L et al.	1	2	2004	*Trends Parasitol*	1		5.497	3	3	3				9
84	Khattab A	1	8	2004	*Malaria J*	1		0.000	1	2	2				5
85	Staalsoe T et al.	1	6	2004	*Infect Immun*	1		4.033	1	0	0				1
86	Thybo S et al.	1	5	2004	*J Travel Med*	1		0.766	1	0	0				1
87	Wilcke	1	6	2004	*Int J Tuberc Lung Dis*	1		1.484	0	0	0				0

	2005	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor							
	CMP-RH		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2005]	2006	2005	2004	2003	2002	2001	TOTAL
05	Enevold A et al.	1	1	2005	*Malaria J*	1		2.137	1	0					1
07	Khalil IF et al.	1	8	2005	*Ann Trop Med Parasitol*	1		1.212	1	0					1
09	Lavstsen T et al.	0	9	2005	*Malaria J*	1		2.137	6	0					6
10	Lusingu JPA et al.	1	8	2005	*Malaria J*	1		2.137	0	0					0
11	Nielsen MA et al.	1	8	2005	*J Infect Dis*	1		4.953	0	0					0
88	Quashie NB et al.	1	5	2005	*J Trop Pediatr*	1		0.719	0	0					0
89	Cox SE et al.	1	8	2005	*Infect Immun*	1		3.933	2	1					3
90	Cox SE et al.	1	9	2005	*Trop Med Int Health*	1		2.021	2	0					2
91	Helleberg M et al.	1	6	2005	*Malaria J*	1		2.137	1	0					1
92	Hviid L	1	1	2005	*Acta Trop*	1		1.800	3	0					3
93	Megnekou R et al.	1	5	2005	*Infect Immun*	1		3.933	3	0					3
94	Ostrowski SR et al.	1	8	2005	*J Infect Dis*	1		4.953	1	1					2
95	(Ben) Quashie NB et al.	1	5	2005	*J Trop Pediatr*	1		0.719	0	0					0
96	Rasti N et al.	1	13	2005	*Scand J Immunol*	2		2.023	3	0					3

Institution DBL-IHRD

Data source Publication list received from DBL-IHRD on 16 November 2006 (N. Ornbjerg)

Date of evaluation 15/18/19 December 2006

Name Barbara Matthys

Already cited in CMP

Not DANIDA supported

Master's Theses not included

2001 DBL-IHRD

1=DANIDA; 0=Non-DANIDA

International=1; National=2

IF=Impact Factor

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Ahorlu CK et al.	1	4	2001	*Acta Trop*	1		1.045	0	1	1	0	0	0	2
02	Balemba OB et al.	1	5	2001	*Int J Parasitol*	1		2.814	1	1	0	2	2	0	7
03	Bendixen M et al.	1	5	2001	*Trans R Soc Trop Med Hyg*	1		1.693	4	2	4	4	3	0	17
04	Bernhard P et al.	1	3	2001	*Trans R Soc Trop Med Hyg*	1		1.693	1	1	2	0	0	0	4
05	Bickle QD et al.	1	4	2001	*Vet Parasitol*	1		1.401	1	1	1	2	0	0	5
06	Bogh C et al.	1	5	2001	*J of Medical Entomology*	1		0.949	0	3	3	1	1	0	8
07	Charlwood JD et al.	1	3	2001	*Trends Parasitol*	1		0.000	0	0	0	1	0	0	1
08	Charlwood JD et al.	1	1	2001	*Trends Parasitol*	1		0.000	0	0	0	0	0	0	0
09	Clarke SE et al.	1	6	2001	*Trans R Soc Trop Med Hyg*	1		1.693	4	4	6	7	9	0	30
10	Friis H et al.	1	7	2001	*Am J Clin Nutr*	1		5.021	4	5	2	5	4	1	21
11	Friis H et al.	1	7	2001	*Am J Clin Nutr*	1		5.021	3	2	4	5	4	1	19
12	Geissler PW et al.	1	7	2001	*Health Policy Plan*	1		0.646	1	1	0	2	1	0	7
13	Gomo E et al.	1	5	2001	*Central African J of Medicine*	2		not found in ISI							
14	Hansen JG et al.	1	3	2001	*Zool Anz*	2		0.732	0	2	3	1	0	1	7
15	Ijumba JN et al.	1	2	2001	*Med Vet Entomol*	1		0.909	9	6	15	5	3	1	39
16	Jaoko WG et al.	1	6	2001	*Ann Trop Med Parasitol*	1		1.049	0	0	2	1	2	0	5
17	Jaoko WG et al.	1	4	2001	*Acta Trop*	1		1.045	1	0	0	0	1	0	2
18	Johansen MV et al.	1	4	2001	*J Parasitol*	1		1.521	0	1	3	1	3	0	8
19	Jorgensen A et al.	1	1	2001	*Zool Anz*	2		0.732	1	0	0	1	0	0	2
20	Jorgensen A et al.	1	2	2001	*Zool Anz*	2		0.732	2	0	0	1	0	1	4
21	Jorgensen A et al.	1	1	2001	*Helgoland Marine Research*	2		0.837	0	0	0	0	1	0	1
22	Killeen GF et al.	1	5	2001	*Trans R Soc Trop Med Hyg*	1		1.693	0	3	4	4	2	0	13

23	Kristensen TK et al.	1	3	2001	*Acta Trop*			1		1.045	1	4	2	0	1	0	8
24	Madsen H et al.	1	5	2001	*Ann Trop Med Parasitol*			1		1.049	4	1	1	2	1	0	9
25	Magesa SM et al.	1	6	2001	*Am J Trop Med Hyg*			1		2.126	1	1	3	4	3	0	12
26	Magnussen P et al.	1	5	2001	*Trop Med Int Health*			1		1.500	4	3	3	2	2	1	15
27	Magnussen P et al.	1	6	2001	*Trans R Soc Trop Med Hyg*			1		1.693	1	1	0	3	3	2	10
28	Malone JB et al.	1	11	2001	*Acta Trop*			1		1.045	1	0	1	1	2	0	11
29	McGready R et al.	1	6	2001	*Trans R Soc Trop Med Hyg*			1		1.693	1	0	2	0	1	2	6
30	McGready R et al.	1	10	2001	*Am J Trop Med Hyg*			1		2.126	5	4	0	4	2	0	15
31	Meyrowitsch DW et al.	1	2	2001	*Trop Med Int Health*			1		1.500	2	0	1	1	1	0	5
32	Michael E et al.	1	8	2001	*Parasite Immunol*			1		2.182	3	2	9	2	4	0	20
33	Muchiri EM et al.	1	4	2001	*J Parasitol*			1		1.521	0	1	0	3	1	0	5
34	Ndlela B et al.	1	2	2001	*African J of Aquatic Science*	2			not found in ISI								
35	Ndyomugyenyi R et al.	1	2	2001	*Trans R Soc Trop Med Hyg*	1			1.693	1	2	4	1	1	0	9	
36	Nyambedha EO et al.	1	3	2001	*Health Policy*	1			0.798	3	5	0	1	2	0	11	
37	Olsen A et al.	1	3	2001	*Parasitology*	1			2.114	1	0	2	1	0	0	4	
38	Olsen A et al.	1	3	2001	*J Biosoc Sci*	1			0.676	1	3	3	1	1	0	9	
39	Onapa AW et al.	1	3	2001	*Acta Trop*	1			1.045	0	2	1	0	1	0	4	
40	Onapa AW et al.	1	4	2001	*Trans R Soc Trop Med Hyg*	1			1.693	0	3	2	2	3	0	10	
41	Onyango-Ouma	1	10	2001	*Health Policy Plan*	1			0.646	0	0	0	0	0	5	5	
42	Oswald IP et al.	1	6	2001	*Parasitology*	1			2.114	1	4	4	0	2	0	11	
43	Ouma JH et al.	1	4	2001	*Trends Parasitol*	1			not found in ISI (conference article)								
44	Pedersen JH et al.	1	5	2001	*Trans R Soc Trop Med Hyg*	1			1.693	0	0	0	1	2	0	3	
45	Pedersen JH et al.	1	4	2001	*Parasitology*	1			2.114	1	0	1	3	0	1	6	
46	Prince RJ et al.	1	7	2001	*Anthropology and Medicine*	1			not found in ISI								
47	Shi YE et al.	1	8	2001	*SEAsian J of Trop Med Publ Health*	1			not found in ISI								
48	Stokholm A et al.	1	1	2001	*The Oriental Anthropologist*	2			not found in ISI								
49	Storey PA et al.	1	4	2001	*Ann Trop Med Parasitol*	1			1.049	2	1	0	2	1	0	6	
50	Storey PA et al.	1	8?	2001	*Gut*	1	author Storey PA cited 2x		6.170	1	1	0	2	2	0	6	
51	Storey PA et al.	1	6	2001	*Trans R Soc Trop Med Hyg*	1			1.693	3	1	0	1	0	0	5	
52	Strandgaard H et al.	1	5	2001	*J Parasitol*	1			1.521	0	0	2	0	1	0	3	
53	Zhou XN et al.	1	4	2001	*Acta Trop*	1			1.045	2	6	1	1	2	0	12	

2002 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

DBL-IHRD

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Aagard-Hansen et al.	1	2	2002	*Int J of Health Plann Manage*	1		0.488	2	0	1	1	0		4
02	Balemba OB et al.	1	6	2002	*Auton Neurosci*	1		1.305	1	3	0	1	0		5
03	Bogh C et al.	1	4	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	1	1	0	0		3
04	Brodersen J et al.	1	3	2002	*J Mollusc Studies*	1		0.611	0	0	0	0	0		0
05	Brodersen J et al.	1	3	2002	*African Zoology*	2		0.516	0	0	0	0	0		0
06	Charlwood JD et al.	1	6	2002	*J Vector Ecol*	1		0.717	4	2	0	4	0		10
07	Charlwood JD et al.	1	1	2002	*Trends Parasitol*	1		5.375	0	0	0	1	0		1
08	Chingwena G et al.	1	4	2002	*J Helminthol*	1		0.796	1	4	1	0	0		6
09	Chingwena G et al.	1	4	2002	*J Parasitol*	1		1.336	2	2	2	0	0		6
10	Clarke SE et al.	1	6	2002	*Trans R Soc Trop Med Hyg*	1		1.724	4	2	9	3	0		18
11	Dunyo SK et al.	1	2	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	2	1	2	0		6
12	Friis H et al.	1	6	2002	*Int J Obes*	1		2.363	0	0	1	0	1		2
13	Friis H et al.	1	4	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	0	0	2	0		3
14	Geissler PW et al.	1	9	2002	*J Ethnopharmacol*	1		1.188	1	2	0	0	0		3
15	Ghebreyesus TA et al.	1	7	2002	*Ann Trop Med Parasitol*	1		0.978	2	0	0	0	0		2
16	Iburg T et al.	1	5	2002	*J Parasitol*	1		1.336	0	1	2	0	0		3
17	Ijumba JN et al.	1	3	2002	*Med Vet Entomol*	1		1.148	4	4	7	0	1		16
18	Ijumba JN et al.	1	5	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	2	4	0	0		7
19	Johansen MV et al.	1	4	2002	*J Parasitol*	1		1.336	1	2	2	0	1		6
20	Jorgensen A et al.	1	1	2002	*Helgoland Marine Research*	1		1.000	0	0	0	0	0		0
21	Lindsay SW et al.	1	3	2002	*Trends Parasitol*	1		5.375	2	1	3	4	0		10
22	Magesa SM et al.	1	9	2002	*Acta Trop*	1		1.332	2	7	6	1	0		16
23	Magnussen P et al.	1	5	2002	*Ann Trop Med Parasitol*	1		0.978	0	0	0	0	0		0
24	Mwaniki D et al.	1	9	2002	*European J of Clinical Nutrition*	1		1.943	0	1	1	1	0		3
25	Nielsen NO et al.	1	3	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	0	0	0	1		2
26	Nielsen NO et al.	1	3	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	0	0	0	0		1
27	Nielsen NO et al.	1	6	2002	*Trans R Soc Trop Med Hyg*	1		1.724	1	3	1	1	1		7
28	Ogoye-Ndegwa C et al.	1	3	2002	*Development in Practice*	2		not found in ISI							
29	Olsen A	1	1	2002	*Trends Parasitol*	1		5.375	0	0	0	0	0		0
30	Pedersen EM	1	2	2002	*Ann Trop Med Parasitol*	1		0.978	5	2	2	0	1		10

31	Pedersen EM	1	5	2002	*Parasitology*	1	1.828	1	1	1	1	0	4
32	Pedersen EM	1	5	2002	*Acta Trop*	1	1.332	0	0	0	0	0	0
33	Quan S et al.	1	8	2002	*J of Immunol Methods*	1	2.598	0	1	1	0	0	2
34	Saathoff E et al.	1	4	2002	*Trans R Soc Trop Med Hyg*	1	1.724	1	4	5	0	0	10
35	Simonsen PE et al.	1	12	2002	*Am J Trop Med Hyg*	1	2.063	2	4	6	2	1	15
36	Simonsen PE et al.	1	7	2002	*Trans R Soc Trop Med Hyg*	1	1.724	0	0	1	0	0	1
37	Storey PA et al.	1	8	2002	*Am J Trop Med Hyg*	1	2.063	0	0	0	0	0	0
38	Stothard JR et al.	1	8	2002	*Trans R Soc Trop Med Hyg*	1	1.724	1	1	0	1	0	3
39	Stothard JR et al.	1	6	2002	*Mem Inst Oswaldo Cruz*	2	0.635	1	0	1	0	0	2
40	von Seidlin L et al.	1	8	2002	*Bull World Health Organ*	1	2.694	3	3	2	2	0	10
41	Zhang Y et al.	1	4	2002	*Vaccine*	1	2.811	1	6	3	6	0	16

2003 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

DBL-IHRD

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Bernhard L et al.	1	3	2003	*Physiotherapy*			not found in ISI							
02	Boa M et al.	1	4	2003	*Acta Trop*	1	not found in ISI	1.336							
03	Bodker R et al.	1	7	2003	*J Med Entomol*	1		1.394	14	5	6	0			25
04	Bogh C et al.	1	5	2003	*Bull Entomol Res*	1		1.018	1	2	2	0			5
05	Brodersen J et al	1	2	2003	*Hydrobiologia*	1		0.720	2	1	0	0			3
06	Brodersen J et al	1	3	2003	*Afr J Acquatic Sciences*	2		not found in ISI							
07	Charlwood JD et al.	1	1	2003	*Trends Parasitol*	1		6.788	0	0	0	0			0
08	Charlwood JD et al.	1	1	2003	*Kluwer Academic Publishers*	1	Bookchapter								
09	Charlwood JD et al.	1	6	2003	*Ann Trop Med Parasitol*	1		1.101	0	2	1	1			4
10	Charlwood JD et al.	1	6	2003	*Malaria J*	1		0.000	1	2	1	2			6
11	Charlwood JD et al.	1	3	2003	*Malaria J*	1		0.000	11	12	1	0			24
12	Chimbari MJ et al.	1	2	2003	*Afr J Acquatic Sciences*	2		not found in ISI							
13	Clarke SE et al.	1	5	2003	*Trop Med Int Health*	1		2.156	0	0	0	0			0
14	Eldblom C et al.	1	2	2003	*Afr Zoology*	2	different title in ISI	0.393	1	1	0	0			2
15	Friis H et al.	1	9	2003	*Eur J Clin Nutr*	1		1.864	4	1	1	0			6
16	Geissler PW	1	1	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI							
17	Gomo E et al.	1	6	2003	*Trans R Soc Trop Med Hyg*	1		2.114	2	2	1	0			5
18	Gomo E et al.	1	6	2003	*Eur J Obstet Gynecol*	1		1.002	1	2	0	0			3
19	Hagmann R et al.	1	6	2003	*Malaria J*	1		0.000	4	1	2	2			9
20	Joshi DD et al.	1	5	2003	*Acta Trop*	1		1.336	1	1	1	0			3
21	Kabatereine NB et al.	1	9	2003	*Am J Trop Med Hyg*	1		2.105	0	0	1	1			2
22	Kardorff R et al.	1	4	2003	*Acta Trop*	1		1.336							
23	Leutscher PDC et al.	1	8	2003	*Sex Transm Dis*	1		2.243	2	1	0	0			3
24	Magnussen P et al.	1	1	2003	*PERMA-EU Newsletter*	2		not found in ISI							
25	Magnussen P et al.	1	1	2003	*Acta Trop*	1		1.336	8	3	2	1			14
26	Midzi N et al.	1	11	2003	*Parasit Immun*	1		1.956	0	1	1	0			2
27	Mulemi BA	1	1	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI							
28	Muthanje A et al.	1	2	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI							
29	Naus CWA et al.	1	9	2003	*Trop Med Int Health*	1		2.156	6	1	5	0			12
30	Naus CWA et al.	1	12	2003	*J Infect Dis*	1		4.481	5	1	4	1			11

31	Ndekha A et al.	1	5	2003	*Acta Trop*	1		1.336	1	0	1	0		2
32	Njagi JK et al.	1	5	2003	*Trans R Soc Trop Med Hyg*	1		2.114	9	1	1	0		11
33	Nyambedha EO et al.	1	2	2003	*Children's places:crosscultural perspectives*		Bookchapter							
34	Nyambedha EO et al.	1	3	2003	*Journal of Cross-Cultural Gerontology*		2		not found in ISI					
35	Nyambedha EO et al.	1	3	2003	*Soc Sci Med*	1		1.983	4	8	2	0		14
36	Nyikuri MM et al.	1	2	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI						
37	Ogoye-Ndegwa C et al.	1	2	2003	*Ecol Food Nutr*	1		0.150	4	2	1	0		7
38	Olsen A	1	1	2003	*Acta Trop*	1		1.336	2	1	2	0		5
39	Olsen A et al.	1	8	2003	*Trans R Soc Trop Med Hyg*	1		2.114	1	2	0	0		3
40	Onyango-Ouma W	1	1	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI						
41	Ouko GA et al.	1	2	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI						
42	Pedersen EM	1	3	2003	*Parasitology*	1		1.821	0	0	1	0		1
43	Ringsted M	1	1	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI						
44	Shrivastava J et al.	1	7	2003	*Mol Ecol*	1		1.145	3	2	1	0		6
45	Simon M et al.	1	3 (ISI: 5)	2003	*Sarsia*	1		0.449	1	0	1	0		2
46	Suda CA et al.	1	2	2003	*MILA, a J of the Institute of African Studies*	2		not found in ISI						
47	van der Geest S et al.	1	2	2003	*Trop Med Int Health*	1		2.156	1	0	0	1		2

	2004	1=DANIDA; 0=Non-DANIDA				International=1; National=2						IF=Impact Factor			
	DBL-IHRD		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
01	Aagaard-Hansen J et al.	1		2004	*Dan Med Bull*	2		not found in ISI							
02	Aagaard-Hansen J et al.	1		2004	*Ugeskrift for laeger*	2		not found in ISI							
03	Abacassamo F et al.	1	11	2004	*Trop Med Int Health*	1		1.969	7	3	2				12
04	Balls MJ et al.	1	6	2004	*Trans R Soc Trop Med Hyg*	1		1.746	6	2	2				10
05	Bindseil E et al.	1	4	2004	*Trends Parasitol*	1		5.497	0	0	0				0
06	Booth M et al.	1	11	2004	*BMC Medicine*	1		not found in ISI							
07	Booth M et al.	1	10	2004	*Trans R Soc Trop Med Hyg*	1		not found in ISI							
08	Booth M et al.	1	14	2004	*BMC Infect Dis*	1		2.066	7	2	2				11
09	Booth M et al.	1	14	2004	*J Immun*	1		6.486	15	10	12				37
10	Brooker S et al.	1	9	2004	*Trop Med Int Health*	1		1.969	6	3	2				11
11	Charlwood D et al.	1	1	2004	*Trends Parasitol*	1		5.497	2	1	0				3
12	Chingwena G et al.	1	5	2004	*African Zoology*	2		0.386	0	0	0				0
13	Clarke SE et al.	1	7	2004	*Am J Trop Med Hyg*	1		2.013	4	0	0				4
14	Coulibaly G et al.	1	6	2004	*Acta Trop*	1		1.952	2	1	0				3
15	Fitzpatrick JM et al.	1	5	2004	*Mol Biochem Parasitol*	1		2.803	5	4	2				11
16	Fitzsimmons CM et al.	1	13 (ISI: 14)	2004	*Infect Imm*	1		4.033	4	0	1				5
17	Johansen MV et al.	1	2	2004	*J of Parasitology*	1		1.439	0	1	1				2
18	Jorgensen A et al.	1	3	2004	*Mol Phylogenet Evol*	1		4.213	2	0	0				2
19	Joseph S et al.	1	13 (ISI: 14)	2004	*J Infect Dis*	1		4.943	4	3	2				9
20	Joseph S et al.	1	13	2004	*Infect Imm*	1		4.033	5	1	5				11
21	Kabatereine NB et al.	1	10	2004	*Trans R Soc Trop Med Hyg*	1		1.746	4	0	0				4
22	Kenworthy ST et al.	1	2	2004	*Haliotis*	?		not found in ISI							
23	Kenworthy ST et al.	1	2	2004	*Haliotis*	?		not found in ISI							
24	Luoba AI et al.	1	9	2004	*Trans R Soc Trop Med Hyg*	1		1.746	0	0	0				0
25	Madsen H et al.	1	6	2004	*African J of Aquatic Science*	2		not found in ISI							
26	Makoni P et al.	1	3	2004	*J Molluscan Stud*	1		0.411	0	0	0				0
27	Melamed P. et al.	1	3	2004	*Nat Genet*	1	2nd author: different name	25.797	0	0	0				0
28	Mentink-Kane MM et al.	1	13	2004	*PNAS*	1		10.452	9	3	7				19
29	Meyrowitsch DW et	1	3	2004	*Ann Trop Med Parasitol*	1		1.162	1	0	0				1

	al.												
30	Meyrowitsch DW et al.	1	4	2004	*Trans R Soc Trop Med Hyg*	1	1.746	3	1	0		4	
31	Michael E et al.	1	7	2004	*Lancet Infect Dis*	1	10.788	12	3	2		17	
32	Mukoko DAN et al.	1	5	2004	*Ann Trop Med Parasitol*	1	1.162	0	0	0		0	
33	Mwanga JR et al.	1	5	2004	*J Biosocial Science*	1	0.945	1	0	1		2	
34	Nchito M et al.	1	5	2004	*Trans R Soc Trop Med Hyg*	1	1.746	3	1	1		5	
35	Ndomugyenyi R et al.	1	2	2004	*Ann Trop Med Parasitol*	1	1.162	0	0	0		0	
36	Ndomugyenyi R et al.	1	3	2004	*Trop Med Int Health*	1	1.969	2	3	2		7	
37	Olsen A et al.	1	4	2004	*J Acquir Immune Defic Syndr*	1	4.100	3	0	1		4	
38	Oyango-Ouma W et al.	1	3	2004	*Health Education Research*	1	1.405	2	0	0		2	
39	Saathoff E et al.	1	4	2004	*BMC Infect Dis*	1	2.066	2	3	1		6	
40	Saathoff E et al.	1	6	2004	*BmC Infect Dis*	1	2.066	3	3	0		6	
41	Satti MZ et al.	1	16	2004	*BMC Immunology*	1	not found in ISI						
42	Simonsen PE et al.	1	2	2004	*Trop Med Int Health*	1	1.969	0	0	0		0	
43	Simonsen PE et al.	1	5	2004	*Trans R Soc Trop Med Hyg*	1	1.746	1	5	0		6	
44	Simonsen PE et al.	1	10	2004	*Am J Trop Med Hyg*	1	2.013	1	1	2		4	
45	Techau ME et al.	1	4	2004	*Parasitology*	1	1.685	0	2	0		2	
46	Vennervald BJ et al.	1	2	2004	*Curr Opin Infect Dis*	1	4.000	8	3	0		11	
47	Vennervald BJ et al.	1	13	2004	*Trop Med Int Health*	1	1.969	4	2	3		9	
48	Ziem JB et al.	1	9	2004	*Ann Trop Med Parasitol*	1	1.162	0	0	0		0	

	2005	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor						
	DBL-IHRD		Authors					IF	Citations					
#	Name	0/1	Total	Year	Journal	I/N	Other	[2005]	2006	2005	2004	2003	2002	2001
01	Carabin H et al.	1	8	2005	*Int J Parasitol*	1		3.346	5	0				
02	Charlwood JD et al.	1	7	2005	*Trans R Soc Trop Med Hyg*	1		1.665	2	0				
03	Kouriba B et al.	1	11	2005	*J Infect Dis*	1		4.953	0	0				
04	Laamrani H et al.	1	3	2005	*African Zoology*	2		0.425	0	0				
05	Leutscher PDC et al.	1	10	2005	*J Infect Dis*	1		4.953	4	1				
06	Luoba AI et al.	1	9	2005	*Trop Med Int Health*	1		2.021	0	0				
07	Makoni P et al.	1	3	2005	*African Journal of Aquatic Science*	2		not found in ISI						
08	Mbonye AK et al.	1	3	2005	*J Biosoc Sci*	1		0.802	0	0				
~~09~~	~~Mbonye AK et al.~~	1	~~3~~	~~2006~~	~~*Health Policy & Planning*~~									
~~10~~	~~Mbonye AK et al.~~	1	~~3~~	~~2006~~	~~*Health Policy*~~									
11	Mubyazi GM et al.	1	5	2005	*Malar J*	1		2.137	3	0				
12	Nyambedha EO et al.	1	1	2005	*African Sociological Review*	2		not found in ISI						
13	Onapa AW et al.	1	4	2005	*Ann Trop Med Parasitol*	1		1.212	0	0				
14	Onapa AW et al.	1	4	2005	*Ann Trop Med Parasitol*	1		1.212	1	2				
15	Onyango-Ouma W et al.	1	3	2005	*Soc Sci Med*	1		2.619	0	0				
16	Orech FO et al.	1	5	2005	*African J of Food and Nutr Sciences*	?		not found in ISI						
17	Pointier JP et al.	1	5	2005	*Acta Trop*	1		1.800	1	1				
18	Range N et al.	1	5	2005	*Trop Med Int Health*	1		2.021	2	0				
19	Rwegoshora RT et al.	1	9	2005	*Ann Trop Med Parasitol*	1		1.212	2	0				
20	Saathoff E et al.	1	6	2005	*Trop Med Int Health*	1		2.021	0	0				
21	Saathoff E et al.	1	6	2005	*Trop Med Int Health*	1		2.021	2	0				
22	Simonsen PE et al.	1	7	2005	*Trans R Soc Trop Med Hyg*	1		1.665	0	0				
23	Skallerup P et al.	1	4	2005	*Preventive Veterinary Medicine*	1		1.354	0	0				
24	Sorensen LvG et al.	1	3	2005	*African Zoology*	2		0.425	1	0				
25	Stensgaard A et al.	1	5	2005	*Parassitologia*	1		not found in ISI						
26	Vennervald BJ et al.	1	12	2005	*Trans R Soc Trop Med Hyg*	1		1.665	4	0				
27	Wang T et al.	1	9	2005	*Acta Trop*	1		1.800	1	1				
28	Yelifari L et al.	1	8	2005	*Trans R Soc Trop Med Hyg*	1		1.665	5	3				
29	Ziem JB et al.	1	9	2005	*Trans R Soc Trop Med Hyg*	1		1.665	5	0				
30	Shapiro AE et al.	1	9	2005	*Trans R Soc Trop Med Hyg*	1		1.665	9	4				

Institution KVL
Data source Publication list received from Anders Dalsgaard on 31 January 2007
Date of evaluation 31 January 2007
Name Barbara Matthys

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2001 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor
KVL

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
22	Dalsgaard et al.	1	8	2001	*J Clin Microbiol*	1		3.965	4	2	6	4	1	0	17
23	Dalsgaard et al.	1	5	2001	*J Antimicrob Chemoth*	1		3.490	8	5	7	3	2	0	25
24	Jensen et al.	1	4	2001	*J Microbiol Methods*	1		1.810	1	1	1	1	1	0	5
25	Van Anh NT et al.	1	3	2001	*SE Asian J Trop Med Publ Health*	1		Journal not available in ISI							

2002 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
15	Dalsgaard A et al.	1	3	2002	*J Food Protect*	1		1.686	0	1	1	0	0		2
16	Dalsgaard A et al.	0	1	2002	*Culture*	1	publication not found in ISI								
17	Guardabassi L et al.	0	3	2002	*Water Res*	1		1.611	0	1	3	1	0		5
18	Guardabassi L et al.	0	5	2002	*Water Res*	1		1.611	1	0	1	0	0		2
19	Guardabassi L et al.	0	5	2002	*Microbial Drug Resist*	1		2.656	0	0	1	1	0		2
20	Jensen PK et al.	1	6	2002	*Trop Med Int Health*	1		1.796	3	0	1	1	0		5
21	Pedersen A et al.	1	5	2002	*Appl Environm Microbiol*	1	different author name in ISI: Petersen A	3.691	7	3	5	3	0		18

2003 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

KVL #	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
08	De NV et al.	1	7	2003	*SE As. J Trop Med Publ Hlth*	1		journal not available in ISI							
09	DePaola A et al.	0	8	2003	*Appl Environm Microbiol*	1		3.820	4	5	3	0			12
10	Iversen JB et al.	1	5	2003	*Microbial Drug Resist*	1		2.320	1	1	0	0			2
11	Jensen PK et al.	1	6	2003	*J Health Popul Nutr*	1		0.564	2	4	1	0			7
12	Pedersen A et al.	1	2	2003	*Aquaculture*	1	different author name in ISI: Petersen A	1.507	3	0	2	0			5
13	Pedersen A et al.	1	2	2003	*Environm Microbiol*	1	different author name in ISI: Petersen A	3.699	1	2	2	0			5
14	Willingham AL et al.	1	8	2003	*SE As. J Trop Med Publ Hlth*	1		journal not available in ISI							

2004 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

KVL #	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2004]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
05	Guardabassi L et al.	0	2	2004	*Appl Environm Microbiol*	1		3.81	5	2	2				9
06	Guardabassi L et al.	0	4	2004	*Agents Chemotherap*	1		4.216	3	4	0				7
07	Jensen PK et al.	1	5	2004	*Trop Med Int Health*	1		1.969	0	0	0				0

2005 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

KVL #	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Jensen AN et al.	0	5	2005	*J Appl Microbiol*	1		2.127	1	0					1
02	Jensen PK et al.	1	4	2005	*WHO Bulletin*	1		3.961	0	0					0
03	Loeffler A et al.	0	8 (ISI: 9)	2005	*J Antimicrob Chemother*	1		3.886	10	0					10
04	van der Hoek W et al.	1	5	2005	*Urban Agriculture Magazine*	1		not peer-reviewed							

Institution Aaby
Data source Publication list received from P Aaby on 16 January 2007
Date of evaluation 18-31 January 2007
Name Barbara Matthys

Already cited in CMP
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Master's Theses not included

2001 | 1=DANIDA; 0=Non-DANIDA | International=1; National=2 | IF=Impact Factor
Aaby

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
145	Aaby P et al.	1	2	2001	*BMJ*	1	Response letter	6.629	0	2	2	0	0	0	4
146	Aaby P et al.	1	2	2001	*BMJ*	1	Response letter	6.629	not found in ISI and PubMed						
147	Aaby P et al.	1	2	2001	*BMJ*	1	Response letter	6.629	not found in ISI and PubMed						
148	Aaby P et al.	1	2	2001	*BMJ*	1	Response letter	6.629	not found in ISI and PubMed						
149	Aaby P et al.	1	2	2001	*BMJ*	1	Response letter	6.629	0	2	2	0	0	0	4
150	Aaby P et al.	1	6	2001	*Vaccine*	1		2.943	0	1	0	0	0	0	1
151	Benn CS et al.	1	8	2001	*Clin Exp Allergy*	1		3.826	4	1	4	4	2	1	16
152	Benn CS et al.	1	5	2001	*Allergy*	1		2.852	1	0	0	0	0	0	1
153	Garly ML et al.	1	9	2001	*Vaccine*	1		2.943	2	1	1	3	1	0	8
154	Garly ML et al.	1	7	2001	*Vaccine*	1		2.943	4	4	4	2	1	0	15
155	Gustafson P et al.	1	7 (ISI: 9)	2001	*JAMA*	1		17.569	1	2	2	2	3	1	11
156	Nielsen NM et al.	1	6	2001	*Scand J Inf Dis*	1		1.108	0	2	0	0	1	0	3
157	Nielsen NM et al.	1	7	2001	*Int J Cancer*	1		4.233	0	0	2	0	1	0	3
158	Nielsen NM et al.	1	3	2001	*J Infect*	1		1.213	0	1	1	1	1	0	4
159	Olsen J et al.	1	15	2001	*Scan J Publ Health*	1		0.728	24	14	24	11	2	0	75
160	Perch M et al.	1	9	2001	*Ann Trop Pediatr*	1		0.243	1	3	1	1	0	0	6
161	Quigley MA et al.	1	7	2001	*AIDS*	1		6.881	9	8	3	6	6	1	33
162	Rodrigues A	1	1	2001		2	PhD Thesis	University of Copenhagen							
163	Valentiner-Branth P et al.	1	10	2001	*Am J Clin Nutr*	1		5.021	0	0	0	0	0	0	0
164	van der Loeff MFS et al.	1	11	2001	*AIDS*	1		6.881	1	2	0	4	1	0	8

	2002	1=DANIDA; 0=Non-DANIDA				International=1; National=2			IF=Impact Factor						
	Aaby		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001	TOTAL
110	Aaby P et al.	1	7	2002	*Acta Pediatr*	1		1.26	2	0	0	4	0		6
111	Aaby P et al.	1	8	2002	*Vaccine*	1		2.811	3	3	0	1	0		7
112	Aaby P et al.	1	6	2002	*Vaccine*	1		2.811	9	6	5	2	0		22
113	Aaby P et al.	1	2	2002	*BMJ*	1		7.585	response letter not found in ISI and PubMed						
114	Benn CS et al.	1	7	2002	*Lancet*	1		15.397	1	4	2	5	0		12
115	Benn CS et al.	1	9	2002	*J Allergy Clin Immunol*	1		6.282	3	3	2	3	2		13
116	Benn CS et al.	1	4	2002	*J Allergy Clin Immunol*	1		6.282	0	0	1	1	2		4
117	Benn CS et al.	1	4	2002	*J Nutr*	1		3.620	0	0	0	0	0		0
118	Bennet S et al.	1	10	2002	*Am J Epidemiol*	1		4.189	3	1	4	2	2		12
119	Berry N et al.	1	12	2002	*AIDS Research & Hum Retrovir*	1		2.278	5	2	2	3	0		12
120	Eugen-Olsen J et al.	1	8	2002	*Int J Tuberc Lung Dis*	1		1.888	3	7	4	0	0		14
121	Fischer TK et al.	1	8	2002	*J Infect Dis*	1		4.857	4	3	4	4	1		16
122	Fischer TK et al.	1	3	2002	*J Clin Microbiol*	1		3.565	0	0	3	2	0		5
123	Hoj L	1	1	2002		2	PhD Thesis	University of Aarhus							
124	Hoj L et al.	1	5	2002	*BJOG-AN Int J Obstet Gyn*	1		1.864	1	3	1	1	0		7
125	Holmgren B	1	1	2002		2	PhD Thesis	University of Copenhagen							
126	Holmgren B et al.	1	6 (ISI: 8)	2002	*J AIDS*	1		3.902	1	0	0	3	0		4
127	Jakobsen M et al.	1	5	2002	*FNUAP (Bissau)*	2		not found in ISI							
128	Jensen H	1	1	2002		2	PhD Thesis	University of Copenhagen							
129	Kofoed PE et al.	1	7	2002	*Trans R Soc Trop Med Hyg*	1		1.724	0	0	3	0	0		3
130	Kofoed PE et al.	1	8	2002	*Trans R Soc Trop Med Hyg*	1		1.724	0	0	1	1	0		2
131	Kofoed PE et al.	1	7	2002	*Am J Trop Med Hyg*	1		2.063	1	0	1	2	0		4
132	Lienhardt C et al.	1	10	2002	*Am J Epidemiol*	1		4.189	3	3	4	4	1		15
133	Lienhardt C et al.	1	12	2002	*Eur J Immunol*	1	different title in IS I	4.832	16	11	11	5	1		44
134	Nielsen NM et al.	1	5	2002	*Scand J Infect Dis*	1		1.023	1	0	2	0	1		4
135	Nielsen NM et al.	1	5	2002	*Int J Epidemiol*	1		2.368	1	3	0	1	1		6
136	Nielsen NM et al.	1	5	2002	*JAMA*	1		16.586	1	0	1	1	0		3
137	Ota M et al.	1	12 (ISI: 13)	2002	*J Immunol*	1		7.014	7	14	13	10	2		46
138	Poulsen A et al.	1	7	2002	*J Infection*	1		1.493	0	5	1	0	0		6
139	Quinlivan M et al.	1	15 (ISI: 18)	2002	*J Infect Dis*	1		4.857	5	1	4	1	0		11

140	Seng R et al.	1	10	2002	*AIDS*	1		5.983	1	3	1	1	0	6
141	Sodemann M et al.	1	5	2002		1	Book section	Eds: Indepth Network, IDRC Ottawa						
142	Steinsland H et al.	1	8	2002	*J Infect Dis*	1		4.857	4	5	3	2	0	14
143	Stensballe LG	1	1	2002	*Respir Res*	1		no IF in ISI	0	0	0	1	0	1
144	Stensballe LG et al.	1	7	2002	*Trop Med Int Health*	1		1.796	0	1	0	1	0	2

	2003	1=DANIDA; 0=Non-DANIDA				International=1; National=2						IF=Impact Factor						
	Aaby		Authors					IF	Citations									
#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001	TOTAL
75	Aaby P et al.	1	6	2003	*Int J Epidemiol*	1		3.289	4	4	6	5			19
76	Aaby P et al.	1	7	2003	*Pediatr Inf Dis J*	1		2.262	5	2	2	0			9
77	Aaby P et al.	1	4	2003	*Seminars in Pediatr Inf Dis*	2		no IF in ISI							
78	Aaby P et al.	1	11	2003	*Lancet*	1		18.316	7	7	8	2			24
79	Aaby P et al.	1	3	2003	*Lancet*	1		18.316	0	1	0	0			1
80	Ariyoshi K et al.	1	11	2003	*J Infect Dis*	1		4.481	0	1	0	0			1
81	Bager P et al.	1	6	2003	*J Allergy Clin Immunol*	1		6.831	1	1	4	0			6
82	Bager P et al.	1	5	2003	*J Allergy Clin Immunol*	1		6.831	2	1	6	0			9
83	Benn CS	1	1	2003		2	PhD Thesis	University of Copenhagen							
84	Benn CS	1	6	2003	*Acta Derm Venerol*	1		1.558	2	2	3	0			7
85	Benn CS et al.	1	5	2003	*Int J Epidemiol*	1		3.289	1	6	0	1			8
86	Campbell SJ et al.	1	15 (ISI: 16)	2003	*Immunogenetics*	1		2.690	0	2	1	0			3
87	Fischer TK et al.	1	2	2003	*Rev Med Virol*	1		4.920	0	4	2	0			6
88	Fischer TK et al.	1	1	2003	*Dan Med Bull*	1		0.447	1	0	0	1			2
89	Fischer TK et al.	1	10	2003	*Virology*	1	different title in ISI	3.391	6	5	3				14
90	Garly ML et al.	1	2	2003	*Acta Trop*	1		1.332	4	3	4	2			13
91	Garly ML et al.	1	9	2003	*Vaccine*	1		3.007	9	6	4	1			20
92	Hoj L et al.	1	5	2003	*BJOG Br J Obstet Gynaecol*	1		1.991	2	1	0	0			3
93	Holmgren B et al.	1	6	2003	*AIDS*	1		5.521	5	1	2	0			8
94	Jakobsen MS et al.	1	6	2003	*Int J Epidemiol*	1		3.289	2	1	0	1			4
95	Jakobsen MS et al.	1	8 (ISI: 7)	2003	*Trop Med Int Health*	1		2.156	0	0	1	0			1
96	Kofoed PE et al.	1	5	2003	*Acta Trop*	1		1.332	1	1	1	0			3
97	Lagarde E et al.	1	13	2003	*Int J Epidemiol*	1		3.289	7	1	2	1			11
98	Marret-Muir W et al.	1	10	2003	*J Med Virol*	1		article not available in ISI							
99	Nielsen NM et al.	1	5	2003	*Epidemiology*	1	different title in ISI	4.220	3	1	0	0			4
100	Ronsmans C et al.	1	7	2003	*Trop Med Int Health*	1		2.156	7	2	1	0			10
101	Steinsland H	1	1	2003		2	PhD Thesis	Bergen University, Norway							
102	Steinsland H et al.	1	6	2003	*Diagn Microbiol Infect Dis*	1		2.032	2	3	3	2			10
103	Steinsland H et al.	1	6	2003	*Lancet*	1		18.316	7	4	1	0			12
104	Stensballe LG et al.	1	3	2003	*Pediatr Inf Dis J*	1		2.262	6	5	9	2			22

105	Valentiner-Branth P et al.	1	9	2003	*J Clin Microbiol*	1		3.489	5	1	2	0		8
106	van der Loeff MS	1	1	2003		2	PhD Thesis							
107	Veirum JE	1	1	2003		2	PhD Thesis	University of Copenhagen						
108	Vigh H et al.	1	1	2003		2	PhD Thesis	University of Copenhagen						
109	Westergaard T et al.	1	6	2003	*Clin Exp Allergy*	1		3.176	2	4	3	3		12

2004 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor

Aaby

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2004]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
41	Aaby P	1	1	2004	*Lancet*	1	different title in ISI	21.713	0	0	0				0
42	Aaby P et al.	1	4	2004	*BMJ*	1	Rapid responses	7.038	not found in ISI						
43	Aaby P et al.	1	7	2004	*Int J Epidemiol*	1		3.735	6	6	3				15
44	Aaby P et al.	1	5	2004	*Int J Epidemiol*	1		3.735	7	3	2				12
45	Aaby P et al.	1	7	2004	*Vaccine*	1		2.824	3	3	0				6
46	Aaby P et al.	1	4	2004	*BMJ*	1	Rapid responses	7.038	not found in ISI						
47	Benn CS et al.	1	5	2004	*BMJ*	1		7.038	12	15	1				28
48	Benn CS et al.	1	8	2004	*Am J Epidemiol*	1	different title in ISI	4.933	6	3	0				9
49	Benn CS et al.	1	5	2004	*Pediatr Allergy Immunol*	1		2.151	1	1	0				2
50	Bornmann L et al.	1	17	2004	*J Infect Dis*	1		4.943	6	4	0				10
51	Draebel TA	1	1	2004		2	PhD Thesis	University of Copenhagen							
52	Garly ML et al.	1	7	2004	*Pediatr Infect Dis J*	1		2.735	2	0	0				2
53	Gustafson P et al.	1	12	2004	*Int J Epidemiol*	1		3.735	2	4	2				8
54	Jensen H et al.	1	4	2004		2	Research Report	Department of Biostatistics, University of Copenhagen							
55	Jensen H et al.	1	4	2004	*BMJ*	1	Rapid responses	7.038	not found in ISI						
56	Jeppesen DL et al.	1	5	2004	*Pediatr Allergy Immunol*	1		2.151	2	0	0				2
57	Kaestel P	1	1	2004		2	PhD Thesis	The Royal Veterinary and Agricultural University, Denmark							
58	Kofoed PE et al.	1	6	2004	*Acta Tropica*	1		1.952	2	1	0				3
59	Kofoed PE et al.	1	6	2004	*Trans R Soc Trop Med Hyg*	1		1.746	0	0	0				0
60	Kofoed PE et al.	1	7	2004	*Trop Med Int Health*	1		1.969	1	1	0				2
61	Linneberg A et al.	1	4	2004	*Clin Exp Allergy*	1		3.069	4	0	0				4
62	Lizeng et al.	1	8	2004	*J Virol*	1	first author in ISI: Qin LZ	5.398	0	0	0				0
63	Masmas T et al.	1	7	2004	*Acta Paediatr*	1		1.143	3	0	0				3
64	Masmas TN et al.	1	6	2004	*Soc Sci Med*	1		2.088	3	0	0				3
65	Newport MJ et al.	1	7	2004	*Genes and Immunity*	1		3.718	5	1	1				7
66	Nielsen J et al.	1	5	2004	*Am J Clin Nut*	1		5.433	1	2	0				3
67	Nielsen NM et al.	1	5	2004	*Arch Phys Med Rehabil*	1		1.656	1	2	0				3
68	Perch M et al.	1	7	2004	*Parasite Immunol*	1		1.474	1	2	0				3
69	Roth A	1	1	2004		2	PhD Thesis	University of Copenhagen							
70	Roth A et al.	1	8	2004	*Pediatr Infect Dis J*	1	different title in ISI	2.735	5	3	0				8
71	Simondon KB et al.	1	6	2004	*Int J Epidemiol*	1		3.735	3	4	2				9

72	Sodemann M et al.	1	8	2004	*Acta Paediatr*	1	1.143	3	2	1	5
73	Steinsland H et al.	1	5	2004	*J Clinical Microbiol*	1	3.439	2	3	0	5
74	Stensballe L et al.	1	7	2004	*Scand J Infect Dis*	1	1.141	2	0	0	2

2005 | 1=DANIDA; 0=Non-DANIDA | International=1; National=2 | IF=Impact Factor

Aaby

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Aaby P et al.	1	2	2005	*Int J Epidemiol*	1		4.045	2	2					4
02	Aaby P et al.	1	9	2005	*Vaccine*	1		2.822	3	0					3
03	Aaby P et al.	1	7	2005	*Vaccine*	1		2.822	0	0					0
04	Aaby P et al.	1	2	2005	*Bull World Health Organ*	1		3.961	1	2					3
05	Aaby P et al.	1	4	2005	*BMJ*	1	different title in ISI	9.052	2	0					2
06	Andersson S et al.	1	9	2005	*Clin Exp Immunol*	1	different title in ISI	2.805	0	0					0
07	Benn CS et al.	1	2	2005	*J Pediatr*	1		3.837	0	0					0
08	Benn CS et al.	1	5 (ISI: 6)	2005	*BMJ*	1		9.052	2	0					2
09	Broutin H et al.	1	7	2005	*Microb Infect*	1		3.154	1	0					1
10	Hoj L et al.	1	6	2005	*BMJ*	1		9.052	4	0					4
11	Jaffar S et al.	1	10	2005	*Aids Res Hum Retrovir*	1		2.531	0	0					0
12	Jensen H et al.	1	6	2005	*BMJ*	1	Rapid Responses	9.052	not found in ISI						
13	Jensen H et al.	1	3	2005	*BMJ*	1		9.052	4	1					5
14	Kabir Z et al.	1	2	2005	*Indian Pediatrics Journal*	2		no IF in ISI	0	0					0
15	Kaestel P et al.	1	4	2005	*Eur J Clin Nut*	1		2.163	1	1					2
16	Knudsen TB et al.	1	11	2005	*Clin Microb Infect*	1	different title in ISI	2.679	1	0					1
17	Leutscher PD et al.	1	10	2005	*J Infect Dis*	1		4.953	4	1					5
18	Lienhardt C et al.	1	16	2005	*Int J Epidemiol*	1		4.045	3	0					3
19	Lisse IM et al.	1	7	2005	*J Infection*	1		1.882	1	0					1
20	Nielsen J	1	1	2005		2	PhD Thesis	University of Copenhagen							
21	Nielsen J et al.	1	3	2005	*J Applied Stat*	1	different title in ISI	0.306	1	0					1
22	Nielsen J et al.	1	5	2005	*Acta Trop*	1	different title in ISI	1.800	0	0					0
23	Nielsen J et al.	1	4	2005	*Int J Epidemiol*	1		4.045	1	0					0
24	Nielsen NM et al.	1	6	2005	*J Clin Virol*	1		2.623	2	0					2
25	Olesen AB et al.	1	6	2005	*Acta Derm Venerol*	1		1.741	0	0					0
26	Poulsen A	1	1			2	PhD Thesis	University of Copenhagen							
27	Poulsen A et al.	1	6 (ISI: 7)	2005	*Pediatr Infect Dis J*	1		3.047	1	1					2
28	Poulsen A et al.	1	6	2005	*J Infect Dis*	1		4.953	1	0					1
29	Roth A et al.	1	10	2005	*Int J Epidemiol*	1		4.045	4	0					4
30	Roth A et al.	1	11	2005	*Vaccine*	1		2.822	4	0					3

31	Roth A et al.	1	2	2005	*Vaccine*	1		2.822	not found in ISI			
32	Sodemann et al.	1	4	2005		1	Book chapter	Indepth Network, London, Ashgate				
33	Steenhard NR	1	1	2005		2	PhD Thesis	The Royal Veterinary and Agricultural University, Copenhagen				
34	Stensballe LG et al.	1	9	2005	*Vaccine*	1		2.822	7	1	8	
35	Stensballe LG et al.	1	1	2005		2	PhD Thesis	University of Copenhagen				
36	Stensballe LG et al.	1	4	2005	*Scand J Infect Dis*	1		1.308	1	0	1	
37	Veirum JE et al.	1	7 (ISI: 8)	2005	*Vaccine*	1		2.822	5	0	5	
38	Westergaard T et al.	1	6	2005	*Am J Epidemiol*	1		5.068	5	2	7	
39	Westergaard T et al.	1	6	2005	*Am J Epidemiol*	1		5.068	0	0	0	
40	Whittle H et al.	1	2	2005		1	Book	Eds: Weatherall DJ et al, Oxford University Press				

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Date of evaluation 21/22 December 2006
Name Barbara Matthys

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Not DANIDA supported
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2001 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor
Uni South Denm

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
38	Abdel Megied AES et al.	1	4	2001	*Nucleosides Nucleotides & Nucleic Acids*	1		0.508	0	0	0	0	0	0	0
39	El-Emam A et al.	1	5	2001	*Phosphorus Sulfur Silicon*	1		0.331	0	0	1	0	0	0	1
40	Filichev VV et al.	0	3	2001	*Carbohydr Res*	1		1.349	3	4	3	6	1	1	18
41	Filichev VV et al.	0	2	2001	*Tetrahedron*	1		2.276	1	3	2	1	0	0	7
42	Larsen JS et al.	1	4	2001	*J Heterocyl Chem*	1		0.746	0	0	1	0	0	0	1
43	Petersen L et al.	0	3	2001	*Synthesis*	1		1.985	1	0	1	1	1	1	5
44	Zahran MA et al.	1	3	2001	*J Chem Research*	1		0.643	0	0	0	0	0	0	0

2002 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor
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#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
32	Christensen UB et al.	0	2	2002	*Nucleic Acids Res*	1		6.373	11	7	15	4	0		37
33	El-Brollosy NR et al.	1	6	2002	*J Med Chem*	1		4.139	3	5	3	5	0		16
34	Filichev VV et al.	0	4	2002	*Helvetica Chim Acta*	1		2.027	0	0	0	0	0		0
35	Imam DR et al.	1	4	2002	*Monatsh Chem*	1		0.821	1	1	0	0	0		2
36	Loksha YM et al.	1	6	2002	*J Heterocycl Chem*	1		0.701	0	1	1	1	0		3
37	Petersen L et al.	1	6	2002	*Monatsh Chem*	1		0.813	0	0	0	0	0		0

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#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
23	Christensen UB et al.	0	2	2003	*Helvetica Chim Acta*	1		1.861	6	9	8	0			23
24	El-Brollosy NR et al.	1	3	2003	*Arch Pharmazie*	1		0.624	0	3	1	0			4
25	El-Essawy FA et al.	1	4	2003	*J Heterocycl Chem*	1		0.711	1	1	0	0			2
26	Filichev VV et al.	0	2	2003	*Org Biomol Chem*	1		0.000	3	3	6	1			13
27	Khattab AF et al.	1	4	2003	*Nucleosides, Nucleotides & Nucleic Acids*	1		0.813	1	0	1	0			2
28	Loksha YM et al.	1	5	2003	*Arch Pharmazie*	1		0.624	0	1	2	0			3
29	Loksha YM et al.	1	5	2003	*J Heterocyclic Chem*	1		0.711	1	0	0	0			1
30	Petersen L et al.	0	4	2003	*Org Biomol Chem*	1		0.000	0	0	1	0			1
31	Therkelsen FD et al.	0	4	2003	*Org Biomol Chem*	1		0.000	3	1	0	0			4

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#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2004]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
09	Christensen UB et al.	0	9	2004	*Nucleosides, Nucleotides & Nucleic Acids*	1		0.429	2	8	2				12
10	Filichev VV et al.	0	5	2004	*ChemBioChem*	1		3.474	2	4	0				6
11	Filichev VV et al.	0	4	2004	*Tetrahedron Letters*	1		2.484	2	3	1				6
12	Filichev VV et al.	0	2	2004	*Bioorganic & Medicinal Chemistry Letters*	1		2.233	1	0	1				2
13	Filichev VV et al.	0	3	2004	*Bioorganic & Medicinal Chemistry Letters*	1		2.233	1	0	0				1
14	Hassan AA et al.	1	6	2004	*Carbohydrate Research*	1		1.451	1	0	0				1
15	Jessen CH et al.	0	2	2004	*Helvetica Chimica Acta*	1		1.833	1	1	0				0
16	Larsen JS et al.	0	3	2004	*Synthesis-Stuttgart*	1		2.203	0	0	0				0
17	Loksha YM et al.	1	5	2004	*Synthesis-Stuttgart*	1		2.203	0	0	0				0
18	Nielsen CB et al.	0	5	2004	*Bioconjugate Chemistry*	1		3.766	5	6	5				16
19	Therkelsen FD et al.	0	4	2004	*Organic Letters*	1		4.195	0	1	1				2
20	Walczak K et al.	0	3	2004	*Helvetica Chimica Acta*	1		1.833	1	1	1				3
21	Wamberg M et al.	1	4	2004	*Bioorganic & Medicinal Chemistry Letters*	1		2.233	0	0	0				0
22	Wamberg M et al.	0	3	2004	*Archiv der Pharmazie*	1		0.653	0	2	0				2

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#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Aly YL et al.	1	2	2005	*Monatsh Chem*	1		0.935	1	0					0
02	Aly YL et al.	1	3	2005	*Helv Chim Acta*	1		1.650	0	0					0
03	El Brollosy NR et al.	1	3	2005	*Monatsh Chem*	1		0.935	0	0					0
04	Filichev VV et al.	0	2	2005	*J Am Chem Soc*	1		7.419	5	0					5
05	Filichev VV et al.	1	4	2005	*Nucleic Acids Res*	1		7.552	0	0					0
06	Loksha YM et al.	1	5	2005	*Bioorg Med Chem*	1		2.478	2	0					2
07	Petersen L et al.	0	6	2005	*J Med Chem*	1		4.926	0	0					0
08	Sorensen ER et al.	1	5	2005	*Arch Pharm*	1		1.129	0	0					0

Institution University of Aarhus
Data source Publication list received from Seeberg on 07 March 2007
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#	Name	0/1	Total	Year	Journal	I/N	Other	[2001]	2006	2005	2004	2003	2002	2001	TOT
39	Christensen T	0	4	2001	*AIDS Res Human Retroviruses*	1		2.523	0	0	0	0	0	0	0
40	Jensen-Fangel S et al.	0	5	2001	*J AIDS*	1		3.586	0	0	2	4	2	0	8
41	Kirk O et al.	0	8	2001	*HIV Medicin*	?	not found in ISI								
65	Geissler PW et al.	1	7	2001	Heallth Policy Plann	1		0.646	1	1	0	2	1	0	5
66	Kaharuza	1		2001	East Afr Med J	2		journal not in ISI							
67	Nielsen BB et al.	1	5	2001	Health Soc Care Community		no IF in ISI		0	0	2	0	0	0	2

2002 1=Danida; 0=Non-Danida International=1; National=2 IF=Impact Factor
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#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001	TOT
33	Christensen T et al.	0	4	2002	*AIDS Res Hum Retroviruses*	1		2.278	2	2	4	1	0		9
34	Jorgensen ME et al.	0	8	2002	*Scand J Clin Lab Invest*	2		0.937	1	1	2	1	0		6
35	Kaharuza FM	0	1	2002			Scientific book		Institut for Epidemiologi og Socialmedicin, Arhus, De						
36	Korbo L et al.	0	3	2002	*Neuroradiology*	1		1.040	0	0	2	0	0		2
37	Madsen KM et al.	0	8	2002	*N Engl J Med*	1		31.736	21	29	30	31	2		113
38	Pungrassami P et al.	0	4	2002	*Trop Med Int Health*	1		1.796	2	1	2	2	1		8
62	Baleum V	1	2	2002	Periodontol	1		2.493	1	2	2	1	4		10
63	Lu ML et al	1	10	2002	Clin Cancer Res	1		5.991	7	12	9	11	7		46
64	Scheutz F et al.	1	4	2002	Commun Dent Health	?		journal not found in ISI							

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#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001	TOT
27	Chapman G et al.	0	7	2003	*Trop Med & Int Health*	1		2.156	1	0	0	0			1

28	Iversen AKN et al.	0	14	2003	*J Infect Dis*	1		4.481	0	0	1	0		1
29	Kofoed K et al.	0	2	2003	*J Travel Med*	1		0.864	2	1	0	0		3
30	Nordentoft I et al.	0	2	2003	*Biochem J*	1		4.101	3	2	4	1		10
31	Petersen E et al.	0	1	2003	*J Travel Med*	1		0.864	1	3	1	0		5
56	Andersen LT et al.	1	4	2003	Public Health Nutr	1		2.123	0	0	0	0		0
57	Jeppesen PB et al.	1	10	2003	Metab Clin Exp	1		2.013	4	6	4	0		14
58	Meinert L.	1	1	2003			Book section	Eds: Fog Olwig & Gullov. London & New York: Routledge						
59	Meinert L. et al.	1	2	2003	J Applied Anthropol Pol Pract			journal not found in ISI						
60	Scheutz F et al.	1	4	2003	Commun Dent Health	?		journal not found in ISI						
32	Seeberg J et al.	1	3	2003			Book section	Ed: Seeberg, New Dehli, DANLEP						
61	Sserunjogi L et al.	1	3	2003	Health Policy Plann	1	1.145		1	0	0	1		2

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#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOT
14	Behbehani JM et al.	0		2004	*Int Dent J*	1		0.504	0	0	0				0
15	Brimnes N	0	1	2004	*Med Hist*	1		0.405	1	0	0				1
16	Brudek T et al.	0	5	2004	*AIDS Res Hum Retroviruses*	1		2.375	1	3	0				4
17	Dalsgard AL	1	1	2004		?	Book section	Kobnhaven, Museum Tusculanum Press, Denmark							
18	Friis H et al.	0	7	2004	*Br J Nutrition*	1		2.710	1	1	0				2
19	Jensen-Fangel S et al.	0	8	2004	*AIDS*	1		5.893	4	4	3				11
20	Katahoire A et al.	0	4	2004	*J Health Popul Dev Ctries*	?		not found in ISI							
21	Lerbaek A et al.	0	11	2004	*Scand J Infect Dis*	2		1.141	0	1	0				1
22	Meinert L et al.	1	4	2004	*FOLK*	?		not found in ISI							
23	Olsen J et al.	0	5	2004	*Int J Circumpolar Health*	1		not found in ISI							
24	Tolstrup M et al.	0	5	2004	*Curr HIV Res*	1		1.571	6	2	0				8
25	Whyte SR et al.	1	4	2004	*J of Social Aspects of HIV/AIDS*	?		not found in ISI							
26	Woolley IJ et al.	0	9	2004	*Clin Microbiol Infect*	1		2.361	0	0	0				0
47	Abdula R et al.	1	5	2004	Metabolism			2.143	0	1	0				1
48	Gregersen S et al.	1	4	2004	Metabolism		different title in ISI	2.143	5	2	0				7
49	Hels O et al.	1	6	2004	J Food Composition Analysis			0.765	1	1	0				2
50	Kahatoire A et al.	1	4	2004	J Health Popul Dev Ctries			not found in ISI							
51	Kidmose U	1	1	2004			PhD Thesis	University of Aarhus							
52	Rajendra RW	1	3	2004	BMC Pregnancy and Childbirth	1		not found in ISI							
53	Rajendra RW	1	3		J of the Institute of Medicine	2		not found in ISI							

54	Wagle RR et al.	1	3	2004	BMC Pregnancy and Childbirth	?		not found in ISI
55	Wagle RR et al.	1	3	2004	J of the Institute of Medicine	2		not found in ISI

2005 **1=Danida; 0=Non-Danida** **International=1; National=2** **IF=Impact Factor**

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#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	2006	2005	2004	2003	2002	2001	TOT
01	Barfoed TS et al.	0	8	2005	*Aids Patient Care & STDS*	?		not found in ISI							
02	Hansen KS	0	1	2005		2	Scientific book	Okonomisk Institut Kobenhavs Universitet, Fakultets ReproCenter							
03	Hoj L et al.	1	6	2005	*BMJ*	1		9.052	3	0					3
04	Jensen TB et al.	0	4	2005	*Int Orthop*	1		0.676	1	0					1
05	Kivumbi G et al.	1	6	2005			Scientific book	TORCH, Child Health & Development Centre, Kampala, Uganda							
06	Larsen TB et al.	0	5	2005	*J Clin Epidemiol*			2.538	0	0					0
07	Lohse N et al.	0	9	2005	*AIDS*			5.835	2	0					2
08	Lohse N et al.	0	10	2005	*Scand J Infect Dis*			1.308	6	1					7
09	Monster TB et al.	0	7	2005	*Am J Ther*	1		not found in ISI							
10	Petersen I et al.	0	1	2005	*Expert Rev Anti Infect Ther*			jrnl not found in ISI	1	0					1
11	Ramlau Hansen C et al.	0	3	2005	*Eur J Clin Nutr*			2.163	0	0					0
12	Schmid J et al.	0	7	2005	*Scand J Infect Dis*			1.308	0	0					0
13	Seeberg J	0	1	2005			Report	New Dehli, World Health Organization							
42	Avogbe PH	1	8	2005	Carcinogenesis	1		5.108	7	0					7
43	Dyrskog S et al.	1	5	2005	Metabolism			2.294	1	0					1
44	Dyrskog S et al.	1	5	2005	Review of Diabetes studies			not found in ISI							
45	Mutuluuza H et al.	1	2	2005			Book	Access to Antiretroviral Therapy. Current African Issues							
46	Reynolds Whyte S	1	4	2005	WHO Essent. Drugs Monitor	1		not found in ISI							

Group	**S.B. Christensen – E.B. Hansen**
Data source	**Publication list received from S. Brogger Christensen on 08 January 2007**
Date of evaluation	**08/17 January 2007**
Name	**Barbara Matthys**

Already cited in CMP

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Master's Theses not included

2001 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

S.B. Christensen – E.B. Hansen **Authors** **IF** **Citations**

#	Name	0/1	Total	Year	Journal	I/N	Other	[2001]	2006	2005	2004	2003	2002	2001
22	Andersen L et al.	1	7	2001	*Biochem Syst Ecol*	1		0.729	0	0	0	0	2	1
23	Clausen V et al.	0	5	2001	*Biochem Syst Ecol*	1		0.729	0	0	0	0	3	2
24	Sairafianpour M et al.	0	7	2001	*J Nat Prod*	1		1.737	6	6	6	5	5	0

2002 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

S.B. Christensen – E.B. Hansen **Authors** **IF** **Citations**

#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001
15	Ballin NZ et al.	1	8	2002	*J Nat Prod*	2		1.885	1	2	0	1	0	
16	Clausen V et al.	0	4	2002	*Biochem Syst Ecol*	1		0.909	0	0	0	3	2	
17	Duker-Eshun G et al.	1	6	2002	*Planta Medica*	1		2.289	1	1	4	0	0	
18	Jaroszewski JW et al.	0	9	2002	*Phytochemistry*	1		1.686	1	0	2	0	2	
19	Sairafianpour M et al.	0	7	2002	*J Nat Prod*	1		1.855	0	1	2	1	0	
20	Ziegler HL et al.	0	10	2002	*Planta Medica*	1		2.289	2	2	3	1	2	
21	Ziegler HL et al.	1	6	2002	*J Nat Prod*	1		1.855	0	1	2	0	0	

2003 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

S.B. Christensen – E.B. Hansen **Authors** **IF** **Citations**

#	Name	0/1	Total	Year	Journal	I/N	Other	[2003]	2006	2005	2004	2003	2002	2001
11	Bringmann G et al.	0	12	2003	*J Nat Prod*	1		1.849	2	3	5	0		
12	Kirk LF et al.	0	6	2003	*Biochem Syst Ecol*	1		0.891	0	0	0	0		
13	Sairafianpour M et al.	0	6	2003	*Planta Med*	1		1.879	3	0	1	0		
14	Staerk D et al.	0	4	2003	*Org Lett*	1		4.092	1	0	1	0		

2004 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

S.B. Christensen – E.B. Hansen

		Authors						IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
04	Asili J et al.	0	9	2004	*J Nat Prod*	1		2.202	3	3	1				7
05	Bringmann G eta l.	0	10	2004	*J Nat Prod*	1		2.202	3	2	2				7
06	Duker-Eshun G et al.	1	2	2004	*Phytetherapy Research*	1		0.975	3	0	0				3
07	Jaroszewski JW et al.	0	3	2004	*Planta Med*	1		1.639	0	0	0				0
08	Jensen AA et al.	0	9	2004	*Eur J Pharmacol*	?		no IF in ISI	0	1	0				1
09	Staerk D et al.	0	6	2004	*J Nat Prod*	1		2.202	0	0	0				0
10	Ziegler HL et al.	0	9	2004	*Bioorg Med Chem*	1		2.018	9	1	2				12

2005 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

S.B. Christensen – E.B. Hansen

		Authors						IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2005]	2006	2005	2004	2003	2002	2001	TOTAL
01	Jaroszewski JW et al.	0	6	2005	*Nat Prod Res*	1		0.572	0	0	0				0
02	Lambert M et al.	0	5	2005	*J Nat Prod*	1		2.267	3	0	0				3
03	Staerk et al.	0	7	2005	*Biochem Syst Ecol*	1		0.704	0	0	0				0

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Data source Publication list received from S. N. Nielsen on 16 January 2007

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Name Barbara Matthys

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Not DANIDA supported

Master's Theses not included

2001 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

Nielsen

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
22	Kaseva ME et al.	1	5	2001		1	Book section	Eds: Mbwette TSA et al. University of Dar Es Salaam, ISBN 9976-911-55-9							
23	Kayombo S	1	1	2001		2	PhD Thesis	The Pharmaceutical University of Denmark, Copenhagen							
24	Kayombo S et al.	1	5	2001		1	Book section	Eds: Mbwette TSA et al. University of Dar Es Salaam, ISBN 9976-911-55-6							
25	Kimwaga RJ et al.	1	5	2001		1	Book section	Eds: Mbwette TSA et al. University of Dar Es Salaam, ISBN 9976-911-55-10							
26	Mwegoha W et al.	1	5	2001		1	Book section	Eds: Mbwette TSA et al. University of Dar Es Salaam, ISBN 9976-911-55-8							
27	Senzia MA et al.	1	6	2001		1	Book section	Eds: Mbwette TSA et al. University of Dar Es Salaam, ISBN 9976-911-55-7							

2002 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

Nielsen

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
10	Haule AT et al.	1	5	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
11	Kaseva TSA et al.	1	3	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
12	Kayombo S et al.	1	5	2001	*Ecolog. Engineering*	1		0.892	1	1	1	0	0		3
13	Kimwaga DA et al.	1	5	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
14	Kimwaga DA et al.	1	5	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
15	Mashauri DA et al.	1	2	2002	*Physics & Chemistry of the Earth*	1		0.000	1	0	0	1	0		2
16	Mwegoha W et al.	1	6	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
17	Njau KN et al.	1	3	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
18	Senzia MA et al.	1	6	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
19	Senzia MA et al.	1	6	2002		?	Conference proceed.	*The 8th internat conference on wetland syst. for water pollution contr.							
20	Senzia MA et al.	1	3	2002		?	Conference proceed.	*3rd Waternet/WARFSA Symposium on Integrated water supply & water demand for sustainable use of water resources							

21	Senzia MA et al.	1	5	2002	*Ecolog. Modelling*	1		1.308	1	0	0	0	0		1	

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			Authors					IF	Citations						
#	**Name**	**0/1**	**Total**	**Year**	**Journal**	**I/N**	**Other**	**[2003]**	**2006**	**2005**	**2004**	**2003**	**2002**	**2001**	**TOTAL**
08	Kayombo S et al	1	4	2003	*Water Research*	1		1.812	5	1	0	0			6
09	Njau KN et al.	1	3	2003	*Water Science and Technology*	1		0.710	0	1	2	0			3

2004 **1=DANIDA; 0=Non-DANIDA** **International=1; National=2** **IF=Impact Factor**

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			Authors					IF	Citations						
#	**Name**	**0/1**	**Total**	**Year**	**Journal**	**I/N**	**Other**	**[2004]**	**2006**	**2005**	**2004**	**2003**	**2002**	**2001**	**TOTAL**
06	Kimwaga RJ et al.	1	4	2004	*Physics & Chemistry of the Earth*	1		0.577	0	0	0				0
07	Mlay H et al.	1	3	2004		?	Conference proceedings	Proceed. of the 9th internat. Cemnistry Conference in Arusha							

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			Authors					IF	Citations						
#	**Name**	**0/1**	**Total**	**Year**	**Journal**	**IN**	**Other**	**[2005]**	**2006**	**2005**	**2004**	**2003**	**2002**	**2001**	**TOTAL**
01	Kimwaga RJ	1	3	2005		?	Symposium proceed.	Proceed. of 6th WATERNET/WARFSA Symposium, Ezwulini, Swaziland							
02	Kimwaga RJ	1	4	2005		?	Symposium proceed.	Proceed. of Int. Symp. on Wetland Pollutant Dynamics & Contr., Gent, Belgi							
03	Kimwaga RJ	1	3	2005		?	Symposium proceed.	Proceed.of the 15th Stockholm Water Symposium August 2005							
04	Mlay H. et al.	1	4	2005		?	Conference proceed.	Proceed. of the 2005 IET Annual Seminar on the Contribution of Engineering on Meeting Millenium Development Goals							
05	Mlay H. et al.	1	4	2005		1	not found in ISI	0.981							

Institution Danish Pharmaceutical University
Data source Publication list received from S. B. Christensen on 16 January 2007
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2001 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor
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#	Name	0/1	Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTA
11	Haling-Sorensen B et al.	1	1	2001	*Arch Environ Contam Toxicol*	1		1.301	4	6	2	3	1		16
12	Karkee SB	1	2	2001	*GPAN Bulletin*	2		not found in ISI							
13	Kayombo S	1	1	2001		2	PhD Thesis	Royal Danish School of Pharmacy, Dept of Analyt. & Pharmaceut. Cemistry							
14	Ndeka A	1	1	2001		2	PhD Thesis	Royal Danish School of Pharmacy, Dept of Social Pharmacy							
15	Trap B et al.	1	4	2001	*Health Policy Plann*	1		0.646	0	3	1	0	0		4

2002 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor
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#	Name	0/1	Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002	2001	TOTA
05	Karkee SB	1	1	2002		2	PhD Thesis	The Royal Danish School of Pharmacy, Department of Social Pharmacy							
06	Karkee SB	1	2	2002	*GPAN Bulletin*	2		not found in ISI							
07	Trap B	1	1	2002		2	PhD Thesis	The Royal Danish School of Pharmacy, Department of Social Pharmacy							
08	Trap B et al.	1	2	2002	*Trop Med Int Health*	1		1.796	0	1	0	0	0		1
09	Trap B et al.	1	2	2002	*J Clin Pharm Ther*	1		1.324	0	1	2	0	0		3
10	Trap B et al.	1	3	2002	*Health Policy Plann*	1		0.790	1	3	1	0	2		7

2003 1=DANIDA; 0=Non-DANIDA International=1; National=2 IF=Impact Factor
S.B.Christensen Authors

#	Name	0/1	Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002	2001	TOTA
02	Mitsch W et al.	1	2	2003		1	Book	New York, John Wiley and sons							
03	Ndekha A et al.	1	5	2003	*Acta Tropica*	1		1.336	1	0	1	0			2
04	Trap B et al.	1	2	2003	*Essential Drugs Monitor*	1		article not found in ISI							

	2004	1=DANIDA; 0=Non-DANIDA				International=1; National=2			IF=Impact Factor							
	S.B.Christensen		Authors			I/N	Other	IF	Citations							
#	Name	0/1	Total	Year	Journal			[2004]	2006	2005	2004	2003	2002	2001	TOTAL
01	Kimwaga RJ et al.	1	5	2004	*Phys Chem Earth*	1		0.577	0	0	0				0

	2005	1=DANIDA; 0=Non-DANIDA				International=1; National=2			IF=Impact Factor							
	S.B.Christensen		Authors	Year	Journal			IF	Citations							
#	Name	0/1	Total			I/N	Other	[2005]	2006	2005	2004	2003	2002	2001	TOTAL

No publications in 2005

Institution TORCH - Tororo Community Health Project
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2001 Whyte | 1=DANIDA; 0=Non-DANIDA | International=1; National=2 | IF=Impact Factor

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
65	Kabwigu S	1	1	2001		2	Master Thesis	Faculty of Medicine, Makerere University							
66	Kagwire F	1	1	2001		2	Master Thesis	Institute of Public Health, Makerere University							
67	Kaharuza FM et al	1	3	2001	Acta Obstet et Gynocologia Scand.	2	not found in ISI								
68	Kaharuza FM et al	1	3	2001	East African Medical Journal	2	not found in ISI	only publications from 1974-2000 available in ISI							
69	Kalyowa F	1	1	2001		2	Master Thesis	Dept of Information Sciences, Makerere University							
70	Kasoro A	1	1	2001		2	Master Thesis	Faculty of Medicine, Makerere University							
71	Kivumbi GW et al.	1	2	2001		2	Conference document	General Population..., Salvador de Bahia, Brazil							
72	Meinert L	1	1	2001		2	PhD Thesis	Institute of Anthropology, University of Copenhagen							
73	Nangendo F	1	1	2001		2	PhD Thesis	Johannes Kepler Universtat Linz, Austria							
74	Tumwete J	1	1	2001		2	Master Thesis								
75	Whyte SR	1	1	2001		1	Book Chapter	Eds: V Neufeld and N Johnson, IDRC, Ottawa							
76	Whyte SR	1	1	2001		1	Book Chapter	Eds: J Liep, Pluto Press London							

	2002	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor							
	Whyte		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2002]	2006	2005	2004	2003	2002	2001	TOTAL
47	Fiedrich M	1	1	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
48	Kaharuza F	1	1	2002		2	PhD Thesis	Faculty of Health Sciences, University of Aarhus, Denmark							
49	Kaharuza F	1	1	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
50	Katahoire A et al.	1	2	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
51	Kirumira E	1	2	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
52	Kivumbi G et al.	1	2	2002	*Health Policy Plan*	1		0.790	2	3	3	0	0		8
53	Meinert L	1	1	2002		2	Book Chapter	Eds: E Gullov, S Hojlund, Gyldendal, Denmark							
54	Meinert L	1	1	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
55	Mogensen H	1	1	2002	*Africa*	2		0.412	0	0	0	0	0		0
56	Mogensen H	1	1	2002		2	Conference document	African Studies Association 45th annual meeting, Washington DC							
57	Mogensen H	1	1	2002		2	Conference document	Africa in an Age of Globalisation, Columbia University, New York							
58	Nshakira N et al.	1	4	2002	*Trop Med Int Health*	1		1.796	6	1	8	4	1		20
59	Olsen N	1	1	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
60	Parikh S	1	1	2002		2	Book Chapter	Eds: SR Whyte, J Jitta, Kampala, Fountain Press							
61	Whyte SR et al.	1	2	2002		2	Book Chapter	Eds: R Werbner, Zed Press, London							
62	Whyte SR et al.	1	2	2002		2	Book Chapter	Eds: S Hartley Centre for Int. Child Health, University College, London							
63	Whyte SR et al.	1	3	2002		2	Book	Cambridge University Press							
64	Whyte SR et al.	1	1	2002		2	Book Chapter	Eds: B Hauser-Schäublin, U Braukämper, Dietrich Reimer Verlag, Berlin							

2003 | 1=DANIDA; 0=Non-DANIDA | International=1; National=2 | IF=Impact Factor

Whyte

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
21	Andersen HA	1	1	2003		2	Report phase II	Tororo District							
22	Andersen HA	1	1	2003		2	Report phase I	Jinja School of Nursing/Midwifery							
23	Bagambe V	1	1	2003		2	Master Thesis	Institute of Public Health, Makerere University							
24	Baliddawa H	1	1	2003		2	Master Thesis	Faculty of Medicine, Makerere University							
25	Idro R	1	1	2003		2	Master Thesis	Department of Peadiatrics, Faculty of Medicine, Makerere University							
26	Idro R	1	1	2003		2	CHDC document								
27	Jitta J et al.	1	3	2003	*Health Policy*	1		0.754	0	1	0	0			1
28	Kalyowa F et al.	1	3	2003		2	CHDC document								
29	Kivumbi WG	1	1	2003		2	PhD Thesis	Faculty of Health Sciences, University of Copenhagen							
30	Kyaddondo D et al.	1	2	2003	*Int J Health Plann Manage*	1		0.500	0	1	1	0			2
31	Kyaddondo D et al.	1	2	2003		2	Workshop paper	Institute of Geography, University of Copenhagen							
32	Kyaddondo D et al.	1	1	2003		2	Conference doc.	46th African Studies Association Conference, Boston							
33	Kyaddondo D et al.	1	1	2003		2	Workshop paper	Institute of Development Studies, University of Sussex, England							
34	Meinert L	1	1	2003		2	Book chapter	Eds: C Fog Olwig and E Gullov, Routledge London and NY							
35	Meinert L et al.	1	2	2003	*Anthropology in Action*	?	not found in ISI	Anthropology in Action: J for Applied Anthropology in Policy and Practice							
36	Meinert L et al.	1	2	2003	*Anthropology in Action*	?	not found in ISI	Anthropology in Action: J for Applied Anthropology in Policy and Practice							
37	Mogensen H	1	1	2003		2	Conference doc.	Uncertainity in Contemporary African Lives, Nordic Africa Institute, Arusha							
38	Muhwezi E	1	1	2003		2	CHDC document								
39	Mutebi A	1	1	2003		2	Master Thesis	Institute of Public Health, Makerere University							
40	Ntuyo P	1	1	2003		2	Master Thesis	Faculty of Medicine, Makerere University							
41	Okone KN	1	1	2003		2	Master Thesis	Institute of Public Health, Makerere University							
42	Otine A et al.	1	2	2003		2	CHDC document								
43	Ssekiwunga R	1	1	2003		2	CHDC document								
44	Sserunjogi et al.	1	3	2003	*Health Policy Plan*	1		1.145	1	0	0	1			2
45	Wanyama J	1	1	2003		2	Master Thesis	Faculty of Medicine, Makerere University							
46	Wanyama J	1	1	2003		2	CHDC document								

	2004	1=DANIDA; 0=Non-DANIDA		International=1; National=2			IF=Impact Factor							
	Whyte		Authors			I=1 or N=2	IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2004]	2006	2005	2004	2003	2002	2001	TOTAL
14	Katahoire A et al.	1	4	2004	*J Health Popul Dev Ctries*	1		not found in ISI							
15	Kivumbi G	1	2	2004		2	CHDC document								
16	Meinert L	1	1	2004	*Anthropology and Medicine*	?		not found in ISI							
17	Meinert L et al.	1	4	2004	*FOLK*	?		not found in ISI							
18	Oundo G et al	1	3	2004		2	CHDC document								
19	Whyte SR	1	1	2004		1	Bookchapter	Eds: C Casey and R Edgerton, Blackwells London							
20	Whyte SR et al.	1	4	2004	*SAHARA J: J of Social Aspects of HIV/AIDS*	2		not found in ISI							
77	Whyte SR et al.	1	2	2004	*Africa*	2		0.417	1	0	0	0			1

	2005	1=DANIDA; 0=Non-DANIDA				International=1; National=2		IF=Impact Factor							
	Whyte		Authors					IF	Citations						
#	Name	0/1	Total	Year	Journal	I/N	Other	[2005]	2006	2005	2004	2003	2002	2001	TOTAL
01	Kajubi P et al.	1	?	2005		2	Conference document	Annual meeting of the African Studies Assiciation, San Francisco							
02	Mogensen H.	1	1	2005		2	Book Chapter	Eds: Jenkins R and Jessen HB, Museum Tusculanum Press							
03	Mogensen H.	1	1	2005		2	Conference document	Aids and the Moral Order, Berlin							
04	Mogensen H.	1	1	2005	*Med Anthropol*	1		not found in ISI							
05	Nsabagansi X et al.	1	2	2005		2	CHDC document								
06	Stanley Y et al.	1	3	2005		2	Conference document	Locating the Field: The Ethnography of Medical Research..., Kilifi K							
07	Whyte M	1	1	2005		2	Workshop document	Problems and Possibilities in Multi-sited ethnography, Univ. of Suss							
08	Whyte SR	1	1	2005		2	Conference document	Unveiling the Hidden..., Univ. of Copenhagen							
09	Whyte SR	1	1	2005		2	Conference document								
10	Whyte SR	1	1	2005		2	Book Chapter	Eds: V Steffen and R Jenkins, Museum Tusculanum Press, Copenh							
11	Whyte SR	1	1	2005	*Africa*	2		0.245	0	0					0
12	Whyte SR	1	4	2005	*Essential Drugs Monitor*	?		not found in ISI; not as source in ISI							
13	Whyte SR et al.	1	3	2005	*Der Überblick*	2		not found in ISI							

Institution Roskilde University
Data source Publication list received from Thomas Tufte on 22 December 2006
Date of evaluation 19 December 2006
Name Barbara Matthys

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#	Tufte Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2001]	Citations 2006	2005	2004	2003	2002
12	Tufte T	1	1	2001	*Revista Brasileira de Ciencias da Communicao, S. Paulo*	2		not available in ISI					
13	Tufte T	1	1	2001	*Journal of International Communication*			journal not found in ISI					

2002 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

#	Tufte Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2002]	Citations 2006	2005	2004	2003	2002
11	Tufte T	1	1	2002		1	CD Rom	Eds: J Servaes, UNESCO, Paris					

2003 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

#	Tufte Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2003]	Citations 2006	2005	2004	2003	2002
10	Tufte T	1	1	2003		1	Book chapter	Eds: J Servaes, UNESCO, Paris					

2004 1=DANIDA; 0=Non-DANIDA; International=1; National=2; IF=Impact Factor

#	Tufte Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2004]	Citations 2006	2005	2004	2003	2002
06	Tufte T	1	1	2004		2	Book chapter	Eds: C von Feilitzen, U Carlsson, Nordicom, Götebo					
07	Tufte T	1	1	2004		1	Book chapter	Eds: M Immacolata, Sao Paulo, Edicoes Loyola and					
08	Tufte T	1	1	2004	*Investigacion & Desarrollo*	2		not available in ISI (Universidyd Arollo)					
09	Tufte T	1	1	2004		1	Book chapter	Eds: Everett Rogers & Arvind Singhal, Lawrence Ed					

2005 | 1=DANIDA; 0=Non-DANIDA | International=1; National=2 | IF=Impact Factor

Tufte

#	Name	0/1	Authors Total	Year	Journal	I/N	Other	IF [2005]	Citations 2006	2005	2004	2003	2002	2001	TOTAL
01	Hemer O et al.	1	2	2005		2	Book	Eds: O Hemer, T Tufte, Nordicom, Sweden							
02	Hemer O et al.	1	2	2005		2	Book chapter	Eds: O Hemer, T Tufte, Nordicom/Göteborg and CLASO/Buenos Aires							
03	Tufte T	1	1	2005		2	Book chapter	Eds: O Hemer, T Tufte, Nordicom/Göteborg and CLASO/Buenos Aires							
04	Tufte T	1	1	2005		2	Book chapter	Eds: O Hemer, T Tufte, Nordicom/Göteborg and CLASO/Buenos Aires							
05	Tufte T	1	1	2005	*J Health Commun*	1		0.802	0	0					0

Table 26. Impact factors of peer-reviewed journals utilized as outlet for DANIDA-supported research in the period 2001-2005 (Source: ISI Web of Science)

Journal Name	Impact factor				
	2001	2002	2003	2004	2005
Acta Dermato-Venereologica	1.477	1.580	1.558	1.585	1.741
Acta Paediatrica	1.582	1.260	1.128	1.143	1.277
Acta Tropica	1.045	1.332	1.336	1.952	1.800
Africa	0.490	0.412	0.204	0.417	0.245
African Zoology	0.294	0.516	0.393	0.386	0.425
AIDS	6.881	5.983	5.521	5.893	5.835
AIDS Research and Human Retroviruses	2.523	2.278	2.291	2.375	2.531
Allergy	2.852	3.666	3.161	3.496	4.120
American Journal of Clinical Nutrition	5.021	5.601	5.692	5.433	5.853
American Journal of Epidemiology	3.948	4.189	4.486	4.933	5.068
American Journal of Tropical Medicine and Hygiene	2.126	2.063	2.105	2.013	2.482
Annals of Tropical Medicine and Parasitology	1.049	0.978	1.010	1.162	1.212
Annals of Tropical Paediatrics	0.243	0.429	0.704	0.562	0.644
Antimicrobial Agents and Chemotherapy	4.562	4.215	4.246	4.216	4.379
Applied and Environmental Microbiology	3.688	3.691	3.820	3.810	3.818
Aquaculture	1.536	1.367	1.507	1.627	1.374
Archiv der Pharmazie	0.891	0.621	0.624	0.653	1.129
Archives of Environmental Contamination and Toxicology	1.301	1.516	1.857	1.612	1.408
Archives of Physical Medicine and Rehabilitation	1.371	1.327	1.350	1.656	1.734
Autonomic Neuroscience: Basic and Clinical	0.930	1.305	1.258	1.311	1.389
Biochemical Systematics and Ecology	0.729	0.909	0.891	0.704	0.827
Bioorganic & Medical Chemistry	1.798	2.043	2.185	2.018	2.286
Bioorganic & Medical Chemistry Letters	1.747	2.051	2.182	2.333	2.478
BJOG-AN International J of Obstetrics and Gynaecology	2.321	1.864	1.991	2.326	2.171
BMC Infectious Diseases	0.000	0.958	1.255	2.066	1.956
British Medical Journal	6.629	7.585	7.209	7.038	9.052
Bulletin of Entomological Research	0.696	1.029	1.018	1.298	1.333
Bulletin of the World Health Organization	2.755	2.694	2.442	2.870	3.961
Carbohydrate Research	1.349	1.631	1.533	1.451	1.669
Clinical and Diagnostic Laboratory Immunology	1.483	1.654	1.809	1.724	2.056
Clinical and Experimental Allergy	3.826	3.721	3.176	3.069	3.553
Clinical and Experimental Immunology	2.716	2.305	2.347	2.518	2.805
Clinical Microbiology and Infection	0.000	1.198	2.238	2.361	2.679
Clinical Toxicology	N/A				
Contraception	1.758	1.443	1.571	1.488	1.713
Current Opinion in Infectious Diseases	0.820	1.000	2.674	4.000	4.258
Danish Medical Bulletin	1.315	0.975	0.447	0.556	0.521
Diagnostic Microbiology and Infectious Disease	2.086	1.691	2.032	2.316	2.738
Ecological Engineering	0.601	0.892	1.058	0.890	0.981
Ecological Modelling	1.182	1.308	1.561	1.652	1.700
Ecology of Food and Nutrition	0.222	0.215	0.150	0.159	0.213
Environmental Microbiology	3.276	3.649	3.699	3.995	4.559
Epidemiology	3.359	3.962	4.220	3.840	4.043
European Journal of Clinical Nutrition	1.765	1.943	1.864	2.132	2.163
European Journal of Immunology	4.990	4.832	4.536	5.005	4.876
European J of Obstetics Gynecology and Reprod Biology	0.884	0.854	1.002	0.955	1.141
Genes and Immunity	3.787	3.060	3.637	3.718	3.779
GUT	6.170	6.323	5.883	6.601	7.692
Health Education Research	0.992	1.177	1.358	1.405	1.303
Health Policy	0.798	0.877	0.754	1.201	0.964
Health Policy and Planning	0.646	0.790	1.145	1.343	1.419
Helgoland Marine Research	0.837	1.000	0.836	0.861	0.974
Helvetica Chimica Acta	2.027	1.949	1.861	1.833	1.650
Hydrobiologia	0.659	0.694	0.720	0.653	0.798
Immunogenetics	2.268	2.475	2.690	2.875	2.976
Infection and Immunity	4.212	4.039	3.875	4.033	3.933
International Immunopharmacology	0.000	1.655	2.203	1.827	2.008
International Journal of Cancer	4.233	4.056	4.375	4.416	4.700

International Journal of Epidem iology	1.899	2.368	3.289	3.735	4.045
International Journal of Health Planning and Management	0.333	0.488	0.500	0.327	0.541
International Journal of Obesity	2.196	2.363	2.794	3.459	4.482
International Journal for Parasitology	2.814	2.850	2.881	3.092	3.346
International Journal of Tuberculosis and Lung Disease	1.737	1.888	1.634	1.484	1.456
J AIDS - Journal of Acquired Immune Deficiency Syndrome	3.586	3.902	3.681	4.100	3.871
JAMA Journal of the American Medical Association	17.569	16.586	21.455	24.831	23.494
Journal of Allergy and Clinical Immunology	5.506	6.282	6.831	7.205	7.667
Journal of Antimicrobial Chemotherapy	3.490	3.329	3.080	3.611	3.886
Journal of Applied Statistics	0.296	0.265	0.597	0.665	0.306
Journal of Biosocial Science	0.676	0.493	0.686	0.945	0.802
Journal of Chemical Research	0.643	0.444	0.382	0.368	0.319
Journal of Clinical Microbiology	3.965	3.565	3.489	3.439	3.537
Journal of Clinical Pharmacy and Therapeutics	1.245	1.324	1.157	0.984	1.164
Journal of Clinical Virology	2.159	2.568	2.020	2.447	2.623
Journal of Ethnopharmacology	0.780	1.188	1.269	1.420	1.554
Journal of Experimental Medicine	15.340	15.837	15.302	14.588	13.965
Journal of Food Protection	1.808	1.686	2.154	1.874	1.687
Journal of Health Communication	0.756	1.222	0.925	0.671	0.802
Journal of Health Population and Nutrition	0.185	0.483	0.564	0.625	0.611
Journal of Helminthology	0.698	0.796	0.939	0.676	0.581
Journal of Heterocyclic Chemistry	0.746	0.701	0.711	0.814	0.735
Journal of Immunological Methods	2.283	2.598	2.744	2.464	2.572
Journal of Immunology	7.065	7.014	6.702	6.486	6.387
Journal of Infection	1.213	1.493	1.221	1.502	1.882
Journal of Infectious Diseases	4.910	4.857	4.481	4.943	4.953
Journal of Medicinal Chemistry	4.139	4.566	4.820	5.076	4.926
Journal of Medical Entomology	0.949	1.137	1.394	1.609	1.489
Journal of Microbiological Methods	1.810	1.749	2.015	2.146	2.297
Journal of Molluscan Studies	0.759	0.611	0.486	0.411	0.758
Journal of Natural Products	1.737	1.855	1.849	2.202	2.267
Journal of Nutrition	3.246	3.620	3.321	3.245	3.689
Journal of Parasitology	1.521	1.336	1.137	1.439	1.524
Journal of Pediatrics	3.536	3.219	2.913	3.117	3.837
Journal of Travel Medicine	1.164	0.846	0.864	0.766	1.329
Journal of Tropical Pediatrics	0.425	0.413	0.514	0.579	0.719
Journal of Vector Ecology	0.360	0.717	1.231	0.912	0.658
Journal of Virology	5.662	5.241	5.225	5.398	5.178
Lancet	13.251	15.397	18.316	21.713	23.878
Lancet Infectious Diseases	0.000	0.000	0.000	10.788	10.008
Malaria Journal	0.000	0.000	0.000	0.000	2.137
Medical and Veterinary Entomology	0.909	1.148	1.040	1.405	1.488
Memorias do Instituto Oswaldo Cruz	0.643	0.635	0.688	0.740	0.847
Microbes and Infection	1.960	3.026	3.772	3.753	3.154
Microbial Drug Resistance-Mechanisms Epidemiol. and Disease	2.600	2.656	2.320	1.807	2.072
Molecular and Biochemical Parasitology	2.397	2.911	2.882	2.803	2.733
Molecular Ecology Notes	0.000	0.000	1.145	1.175	1.219
Molecular Phylogenetics and Evolution	2.979	2.590	2.826	4.213	3.431
Monatshefte fur Chemie	0.821	0.813	0.886	0.904	0.935
Nature Genetics	29.600	26.711	26.494	24.695	25.797
Nucleic Acids Research	6.373	7.501	6.575	7.260	7.552
Nucleosides, Nucleotides & Nucleic Acids	0.508	0.781	0.813	0.429	0.565
Pediatric Infectious Disease Journal	2.289	2.376	2.262	2.735	3.047
Parasite Immunology	2.182	1.633	1.956	1.474	1.445
Parasitology	2.114	1.828	1.821	1.685	1.703
Pediatric Allergy and Immunology	1.753	1.807	1.573	2.151	2.126
Phosphorus Sulfur and Silicon and the related Elements	0.331	0.433	0.323	0.426	0.564
Physics and Chemistry of the Earth	0.000	0.000	0.574	0.577	0.993
Phytotherapy Research	0.603	0.875	0.803	0.975	1.192
Planta Medica	2.085	2.289	1.879	1.639	1.628
Preventive Veterinary Medicine	1.368	1.433	1.063	1.260	1.354
Proceedings of the National Academy of Sciences of (PNAS)	10.896	10.700	10.272	10.452	10.231
Reviews in Medical Virology	5.050	5.229	4.920	5.170	5.685
Sarsia	1.086	0.849	0.449	0.506	0.541

Scandinavian J of Public Health	0.728	0.769	1.018	0.881	0.727
Scandinavian Journal of Immunology	1.739	1.782	1.942	1.912	2.023
Scandinavian Journal of Infectious Diseases	1.108	1.023	1.117	1.141	1.308
Sexually Transmitted Diseases	3.212	2.419	2.243	2.081	2.738
Social Science & Medicine	1.840	1.931	1.983	2.088	2.619
Studies in Family Planning	1.081	0.672	1.049	1.000	0.830
Synthesis-Stuttgart	1.985	2.201	2.074	2.203	2.401
Toxicology	1.752	2.470	2.061	2.691	2.584
Transactions of the Royal Society of Tropical Medicine and Hygiene	1.693	1.724	2.114	1.746	1.665
Trends in Parasitology	0.000	5.375	6.788	5.497	4.526
Tropical Medicine and International Helath	1.500	1.796	2.156	1.969	2.021
Vaccine	2.943	2.811	3.007	2.824	2.822
Veterinary Parasitology	1.401	1.473	1.583	1.445	1.686
Virology	3.270	3.363	3.391	3.071	3.080
Water Research	1.376	1.611	1.812	2.304	3.019
Water Science and Technology	0.605	0.661	0.710	0.586	0.875
Zoologischer Anzeiger	0.732	0.961	0.679	0.694	0.750

Table 27. Classification of peer-reviewed journals utilizes as outlet for DANIDA-supported health research in DC in the periof of 2001-2005 (Source: ISI Web of Science)

Group	Group (ISI)	Journal name
Chemistry, Biochemistry	Biochemical Research Methods Biochemistry & Molecular Biology Chemistry, applied Chemistry, medicinal Chemistry, multidisciplinary Chemistry, nuclear Chemistry, organic	*Archiv der Pharmazie* *Biochemical Systematics and Ecology* *Bioorganic & Medical Chemistry* *Bioorganic & Medical Chemistry Letters* *Carbohydrate Research* *Helvetica Chimica Acta* *Journal of Chemical Research* *Journal of Ethnopharmacology* *Journal of Heterocyclic Chemistry* *Journal of Immunological Methods* *Journal of Medicinal Chemistry* *Journal of Microbiological Methods* *Journal of Natural Products* *Molecular and Biochemical Parasitology* *Molecular Ecology Notes* *Molecular Microbiology* *Molecular Phylogenetics and Evolution* *Monatshefte fur Chemie* *Nature Genetics* *Nucleic Acids Research* *Nucleosides, Nucleotides & Nucleic Acids* *Phosphorus Sulfur and Silicon and the related Elements* *Phytotherapy Research* *Planta Medica* *Synthesis-Stuttgart*
Food & Nutrition	Food Sciences and Technology Nutrition & Dietetics	*American Journal of Clinical Nutrition* *Ecology of Food and Nutrition* *European Journal of Clinical Nutrition* *International Journal of Obesity* *Journal of Food Protection* *Journal of Nutrition*
Biotechnology, Microbiology	Biotechnology and Applied Microbiology Microbiology	*Antimicrobial Agents and Chemotherapy* *Applied and Environmental Microbiology* *Clinical and Diagnostic Laboratory Immunology* *Clinical Microbiology and Infection* *Diagnostic Microbiology and Infectious Disease* *Environmental Microbiology* *Journal of Antimicrobial Chemotherapy* *Journal of Clinical Microbiology* *Journal of Food Protection* *Journal of Microbiological Methods* *Microbes and Infection* *Microbial Drug Resistance-Mechanisms Epidemiol. and Disease* *Molecular Microbiology*
Ecology, Evolutionary Biology, Genetics	Ecology Evolutionary Biology Genetics & Heredity	*Biochemical Systematics and Ecology* *Ecological Engineering* *Ecological Modelling* *Genes and Immunity* *Immunogenetics* *Journal of Helminthology* *Molecular Ecology Notes* *Molecular Phylogenetics and Evolution* *Sarsia*
Water Sciences	Fisheries Marine & Freshwater Biology	*Aquaculture* *Helgoland Marine Research*

	Oceanography	*Hydrobiologia*
	Water resources	*Journal of Molluscan Studies*
		Physics and Chemistry of the Earth
		Sarsia
		Water Research
		Water Science and Technology
Zoology, Botanics	Entomology	*African Zoology*
	Plant Sciences	*Bulletin of Entomological Research*
	Zoology	*Journal of Ethnopharmacology*
		Journal of Medical Entomology
		Journal of Molluscan Studies
		Journal of Vector Ecology
		Journal of Natural Products
		Medical and Veterinary Entomology
		Planta Medica
		Zoologischer Anzeiger
Health Services	Health Care Sciences & Services	*Health Policy*
	Health Policy & Services	*Health Policy and Planning*
		International Journal of Health Planning and Management
Information Sciences & Education		
	Communication	*Health Education Research*
	Education & Educational Research	*Journal of Health Communication*
	Information & Library Sciences	
Demography, Reproduction		*European J of Obstetics Gynecology and Reprod Biology*
	Demography	*Journal of Biosocial Science*
	Reproductive Biology	*Studies in Family Planning*
Social sciences, Anthropology		
	Anthropology	*Africa*
	Social Sciences biomedical	*Journal of Biosocial Science*
		Social Science & Medicine
Geosciences	Area Studies	*Africa*
	Geosciences, multidisciplinary	*Physics and Chemistry of the Earth*
	Meteorology & atmospheric Sciences	
Medical Science	Allergy	*Acta Dermato-Venereologica*
	Dermatology	*Acta Paediatrica*
	Endocrinology & Metabolism	*Allergy*
	Gastroenterology & Hepatology	*Annals of Tropical Paediatrics*
		Autonomic Neurosciences Clinical & Basic
		BJOG-AN International J of Obstetrics and
	Integrative & complementary Medicine	*Gynaecology*
	Medicine, general & internal	*British Medical Journal*
	Obstetrics & Gynecology	*Clinical and Experimental Allergy*
	Oncology	*Contraception*
	Pediatrics	*Danish Medical Bulletin*
		European J of Obstetics Gynecology and
	Respiratory System	*Reprod Biology*
		GUT
		International Journal of Cancer
		International Journal of Obesity
		International Journal of Tuberculosis and Lung Disease
		JAMA Journal of the American Medical Association
		Journal of Allergy and Clinical Immunology
		Journal of Ethnopharmacology
		Journal of Pediatrics
		Journal of Travel Medicine
		Journal of Tropical Pediatrics
		Lancet
		Pediatric Allergy and Immunology
		Pediatric Infectious Disease Journal
Medicine, Research & Technology		*Clinical and Diagnostic Laboratory*
	Medical Laboratory Technology	*Immunology*
	Medicine, Research & experimental	*Journal of Experimental Medicine*
		Medical and Veterinary Entomology

		Vaccine
Veterinary Sciences	Veterinary Sciences	*Journal of Medical Entomology* *Preventive Veterinary Medicine* *Vaccine* *Veterinary Parasitology*
Tropical & Environmental Health	Immunology	*Acta Tropica*
	Infectious Diseases	*AIDS*
	Parasitology	*AIDS Research and Human Retroviruses*
	Public, Environmental & Occupational Health	*Allergy*
	Tropical Medicine	*American Journal of Epidemiology* *American Journal of Tropical Medicine and Hygiene*
	Virology	*Annals of Tropical Medicine and Parasitology* *Annals of Tropical Paediatrics* *BMC Infectious Diseases* *Bulletin of the World Health Organization* *Clinical and Diagnostic Laboratory Immunology* *Clinical and Experimental Allergy* *Clinical and Experimental Immunology* *Clinical Microbiology and Infection* *Current Opinion in Infectious Diseases* *Diagnostic Microbiology and Infectious Disease* *Epidemiology* *European Journal of Immunology* *Genes and Immunity* *Health Education Research* *Immunogenetics* *Immunology Letters* *Infection and Immunity* *International Immunopharmacology* *International Journal for Parasitology* *International Journal of Epidemiology* *International Journal of Health Planning and Management* *International Journal of Tuberculosis and Lung Disease* *J AIDS - Journal of Acquired Immune Deficiency Syndrome* *Journal of Allergy and Clinical Immunology* *Journal of Clinical Virology* *Journal of Experimental Medicine* *Journal of Helminthology* *Journal of Immunological Methods* *Journal of Immunology* *Journal of Infection* *Journal of Infectious Diseases* *Journal of Parasitology* *Journal of Tropical Pediatrics* *Journal of Virology* *Lancet Infectious Diseases* *Malaria Journal* *Memorias do Instituto Oswaldo Cruz* *Microbes and Infection* *Microbial Drug Resistance-Mechanisms Epidemiol. and Disease* *Molecular and Biochemical Parasitology* *Parasite Immunology* *Parasitology* *Pediatric Allergy and Immunology* *Pediatric Infectious Disease Journal* *Reviews in Medical Virology* *Scandinavian Journal of Public Health* *Scandinavian Journal of Immunology*

		Scandinavian Journal of Infectious Diseases *Sexually Transmitted Diseases* *Social Science & Medicine* *Studies in Family Planning* *Transactions of the Royal Society of Tropical Medicine...* *Trends in Parasitology* *Tropical Medicine and International Helath* *Vaccine* *Veterinary Parasitology* *Virology*
Environmental Sciences	Engineering, environmental Environmental Sciences Environmentl Sciences, occupat hlth	*Archives of Environmental Contamination and Toxicology* *Ecological Engineering* *Journal of Health Population and Nutrition* *Water Research* *Water Science and Technology* *Journal of Vector Ecology*
Pharmacy & Toxicology	Pharmacol & Pharmacy Toxicology	*Antimicrobial Agents and Chemotherapy* *Archiv der Pharmazie* *Archives of Environmental Contamination and Toxicology* *Clinical Toxicology* IF not available in ISI* *International Immunopharmacology* *Journal of Antimicrobial Chemotherapy* *Journal of Clinical Pharmacy and Therapeutics* *Journal of Ethnopharmacology* *Microbial Drug Resistance-Mechanisms Epidemiol. and Disease* *Phytotherapy Research* *Planta Medica* *Toxicology*
Multidisciplinary Sciences	Multidisciplinary Sciences	*Proceedings of the National Academy of Sciences of the USA (PNAS)*
Other	Rehabilitation Sport Sciences Stats & Probability	*Archives of Physical Medicine and Rehabilitation* *Journal of Applied Statistics*

11 Main documents consulted by the Review Team

This list excludes all research project related information reviewed during this assignment. Documents reviewed during country visits are referred to in the country reports;

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